CONGENITAL TRANSPOSITION OF KIDNEY.

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By presenting this illustration of renal abnormality found by Dr. Charles H. Parkes, demonstrator in the Department of Operative Surgery and Anatomy at the Chicago Polyclinic Laboratory, I wish to call attention to the uncertainties, even after accurate ureteral catheterization (unless *x-ray* pictures are taken with catheter *in situ* or a double exploratory incision) in surgical procedures on the kidneys. A study of this illustration, which is remarkably accurate, will show the clinical possibilities.

Due to some congenital misarrangement, the right

V, vena cava; A, abdominal aorta; LK, left kidney; RK, right kidney; LU, left ureter; RU, right ureter; R, rectum; T, trigon of bladder; Ps, psoas muscle; LRA, left renal artery; LRV, left renal vein; RRV, right renal vein; RRA, right renal artery.

kidney is transposed to the left side. The blood vessels to this kidney, however, arise as though it were properly placed, from the normal level and side of the aorta and vena cava. The ureter enters the bladder normally at the right side of the trigon after crossing the posterior abdominal wall at the level of the fifth vertebra.

The left kidney is normally located, except that, if the generally accepted facts of the regional anatomy of the kidney placing two-thirds of the kidney above the twelfth rib are accurate, this kidney is too low. It will be noticed that the ureteral meatus in the trigon from

this kidney is considerably higher than that of the right side, which condition is probably due to traction. The kidney mass on the left side showed one common fatty capsule. The fibrous capsule is also one continuous covering for both kidneys with a depression around the circumference of the mass indicating the upper limit of the right and the lower limit of the left kidney. The parenchyma is fused by fibrous connective tissue rather than being continuous in structure. The mass showed two distinct pelvis with the vessels relatively distributed, as shown by illustration.

PRIMARY TYPHLITIS SIMULATING APPENDICEAL ABSCESS AND ILEOCECAL TUBERCULOSIS.

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The following case is deemed worthy of a detailed report on account of the paucity of the literature regarding primary typhlitis and the consequent difficulties in diagnosis which it presents, and on account of the unusual complications in the present case. None of the works on appendicitis or on diseases of the intestines or the general works on surgery give any adequate account of this trouble. Hemmeter gives only two sources of ileocecal tumor not due to primary appendicitis, i. e., cecal tuberculosis and carcinoma of the cecum. Eisendrath in his recent work on "Surgical Diagnosis" adds a third, ileocecal actinomycosis. Dr. Clarence A. McWilliams, in a paper read before the New York Surgical Society, Feb. 27, 1907,¹ under the title "Primary Typhlitis Without Appendicitis," gives the history of a case very similar to mine in which he assumed that the cecal tumor was either tubercular or carcinomatous, and resected it. Pathologic examination showed simple inflammation and infiltration affecting all the intestinal layers adjacent to the cecum, the inflammation proceeding from within the cecum. My case is as follows:

History.—Mrs. N. S., aged 30, gave no history of previous illness except the usual diseases of childhood. She menstruated first at the age of 13 years, and then regularly up to date excepting when pregnant, the flow lasting usually four or five days. She had had three children, her labors being normal; no miscarriages. Youngest child 4 months old. She menstruated again in May, 1907, for the first time since the birth of last child, the flow lasting about thirty-six hours and being unaccompanied with pain. In January, 1907, she woke one night with severe pain in the right iliac region. This grew better in an hour or so, but her right side had since been more or less tender. I first saw the patient May 19, 1907, and learned that aside from tenderness in her right side she had been perfectly well up to the evening of May 16, when she began vomiting and developed a severe pain in the epigastrium, some fever and diarrhea. The condition continued except that the pain gradually localized itself in the right iliac fossa.

Examination.—This showed heart, lungs and pelvic organs to be normal. The area over the region of the appendix was very sensitive, but nothing further could be found out that day on account of rigid abdominal muscles. Her temperature at this time was 102.5 F. and pulse 100. She was removed to Blessing Hospital the following day and all food withheld. Her

1. Anns. of Surgery, 1907.