Clinical Notes

A CASE OF RENAL TUBERCULOSIS.

JOHN C. SPENCER, M. D.

SAN FRANCISCO.

Patient.—F. M., male, aged 33, carpenter, native of the United States.

Family History.—The cause of the father's death is unknown, although he lived to an advanced age. Mother died of mammary cancer. One brother died from pulmonary tuberculosis.

Personal History.—The patient had gonorrhea in early youth. About twelve years ago he had apparently a first attack of appendicitis. Symptoms continued for about five days and then subsided. The patient has always been rather susceptible to "colds," with a vague history of having had one or two very persistent attacks. Six years ago he had a pleurisy with effusion, which necessitated my removing about 500 c.c. of clear fluid from the left pleural sac. Convalescence was uneventful. About four years ago I operated on him for perityphlitic abscess caused by ruptured and partly gangrenous appendix. During the first week fragments of a fecal concretion about the size and shape of a date pit were washed out in irrigating the wound. Aside from this, convalescence was uneventful.

Present Illness.—His general health after this was very good until about two years ago, when some hernial protrusion developed at the site of the abdominal scar. Coincidentally, he began to have symptoms of intestinal obstruction, as shown by dyspeptic symptoms, large accumulations of gas in the intestines, and obstinate constipation, only relieved temporarily by purgatives and enemas. The chief center of disturbance seemed to be definitely localized in the left hypochondrium.

Operation.—He sought my advice in August, 1905. After examination and consultation with Dr. W. I. Terry, it was decided that some band-like structure was the cause of his obstructive symptoms. In September, assisted by Dr. Terry, I reopened the abdomen at the site of the scar. A number of dense adhesions between coils of intestine and the abdominal parietes were separated. A velamentous falciform band started from about the umbilicus, seemingly connected at its upper part with the urachus. This band passed along the parietal peritoneum downward, outward and backward and toward the left, to the brim of the true pelvis. I followed this to about the region of the sacro-iliac synchondrosis, where it merged into the peritoneum and subperitoneal connective tissue. This band was excised. The abdominal wound was closed in tiers and healed normally. During convalescence, irritability of the bladder, from which he had suffered temporarily about six months before, reappeared. Boric acid irrigations were ordered, but the patient complained bitterly of the pain and discomfort they caused. The urine was turbid and contained a moderate amount of pus, and bladder epithelia, but no blood or other abnormalities.

Postoperative History.—Patient left the hospital in about three weeks, but failed to gain strength or flesh, and was unable to work. He received various tonics and roborants, but declined steadily in general health. In the meantime his bladder was almost constantly under treatment. I observed that any attempt at irrigation with silver nitrate solutions of from 1 up to 15—to 10,000, was invariably followed by a very intense symptomatic reaction. The conclusion began to force itself on me that I was dealing with a tuberculous cystitis. Consequently I determined to make a cystoscopic examination under cocain anesthesia. This excited such an intense bladder spasm that a cystoscopic examination was rendered impossible. Owing to the intense pain and severe reaction, and his enfeebled condition, he positively refused any further attempts at examination of the bladder. A specimen of urine from the bladder was collected by catheter, *secundum artem*; it was centrifugated and the sediment examined for tubercle bacilli in vain. Shortly after this the man began to walk bent slightly forward and to the right. This attitude, his progressive marasmus, with daily rise of temperature, forced on me the

conclusion that the trouble was in all probability a tuberculous pyelo-nephritis, affecting the right kidney. Examining him in conjunction with Dr. Terry we found the right kidney somewhat ectopic, and sensitive to pressure. The left kidney was barely palpable, and not especially sensitive.

Second Operation.—A nephrotomy with a possible nephrectomy was determined on by us, and agreed to by the patient. On February 21, at St. Mary's Hospital, I delivered the right kidney through a Simon lumbar incision. The kidney appeared to be about one-quarter larger than normal. This, with its general appearance, determined me to do a nephrectomy without a preliminary exploratory incision. The operation offered no unusual features. The vessels were tied separately; the mucosa of the ureter presented a few fairly well-defined hemorrhagic areas. I stitched the upper end of the ureter into the lower angle of the wound. In 24 hours the ureter stitches had cut through and the ureter undiscoverably retracted. The suture ends from the vessels were brought out at the upper angle and the wound closed by through and through silk-worm gut sutures, supplemented by catgut sutures.

Termination of Case.—The temperature dropped to normal the following day, and did not rise again. For the first week after the operation the amount of urine excreted almost equaled the amount of fluid ingested, the difference being about 100 c.c. The man drank distilled water exclusively.

From the end of the first week his condition became progressively worse, with moderate uremic symptoms directed chiefly to his stomach. At the end of ten days the external wound became infected and was freely reopened at the upper and lower ends. The urine became more scanty in amount and at times bloody. Occasionally there was some tenesmus. Exactly four weeks from the operation the patient died, the sensorium remaining clear to the end.

Report on Excised Kidney.—(By A. J. Lartigau, M.D.) The center of the excised kidney contained a number of yellowish areas about the size of a pinhead, which proved to be tuberculous.

Postmortem.—Postmortem examination showed evidences of old tuberculosis at both apices, adhesion to the parietal pleura and miliary tuberculosis of the lower lobes of both lungs. The left kidney and ureter, the left lobe of the prostate, the left epididymis and the vasa deferentia and seminal vesicles showed advanced tubercular lesions. The brain was not examined.

SUMMARY.

An adult with a poor family history, evidently passed through a pulmonary tuberculosis at some time during his earlier years, the process undoubtedly terminating spontaneously. Then followed a period of reasonably good health, broken by an acute pleuritis with effusion and culminating in an acute appendiceal outbreak necessitating operative interference. During the next four years he had only moderately good health. Then a second celiotomy was performed, followed by rapid decline in general health, and development of symptoms of apparent tuberculosis of the urinary bladder. Two months before death there were strongly marked symptoms of renal tuberculosis.

The diagnosis of bladder tuberculosis was only possible, inferentially, from the symptoms, and was confirmed in a measure by the man's intolerance of silver nitrate solutions. The only positive diagnostic means—cystoscopy—was unsuccessful, at the single attempt, and impossible of repetition. A guinea-pig test was not tried, but in the face of so many corroborating factors, it may be regarded as a superfluous diagnostic refinement, in this case. The symptoms pointing toward renal tuberculosis seemed to point so positively to the right kidney, that not finding this one affected at the time of the nephrectomy, was a source of unqualified surprise. Furthermore, the failure to discover the gross lesions at that time, on sagittal section, reveals the inefficiency of a nephrotomy as a diagnostic precaution preliminary to

a nephrectomy. Nothing short of multiple sectioning of this kidney would have revealed the presence of the microscopic lesions found by A. J. Lartigau, M. D.

The course of the tuberculous process in this individual is a matter of some speculative interest.

The possibility of the original or secondary appendiceal attacks being of tuberculous origin can not be excluded. The healed pulmonary lesions certainly antedated the first attack.

It would seem that the tuberculous process remained in abeyance—probably encysted in the lung apices—and received a fresh impetus through the lessening of the patient's resistance, consequent on the long period of obstructive bowel disturbance, terminating in the last celiotomy. It would appear further that the fresh outbreak originated below the diaphragm, either in the pericecal region or else directly in the left kidney. The manifestations were most marked at first in the bladder. The tuberculous process extended down the left ureter and thence ascended the right ureter to the right kidney. The extensive involvement of the left kidney would make it seem most likely that the peritoneum over fundus of the bladder became involved through the lymphatic channels. A similar theory may explain the involvement of the genital adnexa.

836 Turk Street.

A CASE OF PEMPHIGUS LIMITED TO THE MUCOUS MEMBRANES.*

EDMUND M. COCKS, M.D.

NEW YORK CITY.

My object in presenting the history of a fatal case of pemphigus limited to the mucous membranes is to bring before you a case seen almost from its incipency to a few days prior to the patient's death, a dermatosis so rare that its existence has been denied by a majority of dermatologists, Brock and Bernier claiming to have seen but four cases.

History.—Mrs. B., aged 37, a thin, nervous woman, the mother of five living children, was born at Pittsburg, Pa., of German parents. She had the usual diseases of childhood and developed into a strong, healthy woman. She married at the age of 24. Her health commenced to deteriorate after a miscarriage due to overlifting.

One year previous to the illness under consideration, Feb. 15, 1904, she experienced her first chill, which lasted two hours. Later in the day she menstruated. A year later she had a second chill lasting the same length of time. The following morning on account of the swollen condition of the tongue, she was unable to talk, and swallowed food with great pain and difficulty. Numerous pea-size vesicles were to be seen on the tongue, buccal mucous membrane, pharynx and lips. This condition persisted for two weeks, the older vesicles rupturing, swelling and subsiding. Deglutition became less painful.

The date of her next menstruation was ushered in by a severe chill, followed by a repetition of the first attack, which ran a like course. The third was similar to the two previous attacks, also the fourth, but the menses did not appear the following month.

Up to the seventh month of her pregnancy each was a duplicate of the previous month, the patient becoming more and more discouraged and emaciated. The two weeks preceding the seventh month of her pregnancy she was very comfortable but, she painfully remarked, January 14 was a banner day. The chill lasted three hours, with a slight remission.

Examination.—I saw her the following day; there was not a

pea-size space of tongue, lips, buccal mucous membrane, pharynx or nasopharynx that was not the site of vesicles. There were several vesicles on the conjunctivæ. In the vagina were several bullæ; cervix was free. The rectoscope revealed vesicles as far as could be seen.

Treatment.—Lancing the vesicles of the mouth and touching their bases with an aqueous solution of methylene blue, 20 grains to the ounce, gave the patient considerable relief. Those of the vagina and nasopharynx were not incised but ruptured within three or four days. Small painful ulcerations resulted which did not heal for several days. Although at no time during her pregnancy was she free, by opening the vesicles as soon as they appeared, a fair degree of comfort and health was maintained.

Her food consisted of milk, to which cream had been added, eggs and concentrated liquid food. She gained slightly in weight until the fatal attack. She was seen almost daily and arsenic was prescribed and pushed from the first. All known local remedies were tried but methylene blue gave the greatest relief.

Further History.—The eighth month was no exception to the rule. The ninth month was ushered in by a chill and in a few hours the patient's tongue was so swollen that at the height of her labor she could not cry out for pain, or laugh for joy at its termination. Two weeks after her confinement she commenced to gain rapidly and we were all hopeful, though I had given my opinion that the pregnancy was not an etiologic factor. This quiescent period lasted three months then a return of all the symptoms, persistent vomiting and uncontrollable diarrhea greatly aggravated the patient's condition and rapid emaciation and death followed in one week. At no time was there a cutaneous symptom of any kind.

Historical Report.—During the height of an attack the contents of a vesicle situated on the tongue were aseptically drawn into a pipette and proved to be sterile. The contents of a flabby vesicle or one several days old showed numerous staphylococci. The blood at this time showed a leucocytosis of about 10 per cent. Between the attacks the blood was normal. The urine, examined numerous times, showed nothing abnormal but indican, which was present in a greater or less quantity during her entire sickness.

Postmortem Findings 24 Hours After Death.—Vesicles occluded the nares, they were also present in great number in mouth, on tongue, pharynx and esophagus. The mucous membrane of the stomach was also affected, the intestinal track from pylorus to anus was involved. The vesicles of the intestines were flatter and in some places where they had ruptured, ulceration to the muscular coat had taken place.

There were a few disseminated vesicles on the serous surface of the liver, spleen, intestines and pleura.

This case seems to have been one of pemphigus limited to the mucous membranes, probably due to indican, the result of intestinal fermentation, for which her family physician had treated her for several years, her pregnancy having had little, if anything, to do with her condition, in spite of the fact that her symptoms were worse at her menstrual periods preceding her pregnancy and at the time she would have menstruated if not pregnant.

DISCUSSION.

DR. WILLIAM S. GOTTHEIL, New York City, said that in his clinical work, on the lower east side of New York City pemphigus is a comparatively common affection. There are always two or three such cases in the City Hospital, and the same is true of the Lebanon Hospital. In two patients recently under his care the lesions were restricted to the mouth for a long time. One of these patients had been referred to him as presenting a case of syphilis, and his own diagnosis at the time was mercurial stomatitis. It proved to be a case of pemphigus, affecting first the mouth and later the cutaneous surfaces, and finally proved fatal. Dr. Gottheil said that he has never seen pemphigus limited to the mucous and serous membranes end fatally, as in the case reported by Dr. Cocks.

DR. L. DUNCAN BULKLEY, New York City, said he could cor-

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