This is probably the first case of its kind reported in this country.

A careful review of the literature of the subject reveals several cases on record abroad in which placental tissue was undoubtedly attached to the cervix.

L. Müller has reviewed the literature, but without finding cases in which the anatomic investigations were thorough enough to assure the correctness of the diagnosis.

In more recent years several cases have been reported which are so convincing in their clinical and anatomic aspects that the occasional existence of a placenta praevia cervicalis cannot longer be doubted.

Dr. Otto v. Weiss¹ reported a case of a quintipara, aged 33, who was admitted at full term on account of profuse hemorrhage, with a diagnosis of placenta praevia. Tamponade was followed by podalic version and delivery, with the loss of a large amount of blood. The child died during the attempt at delivery. The placenta was found intimately adherent to the cervical mucous membrane and was separated from it with great difficulty by manual extraction. A chill and fever occurred and it was found that there was a streptococcus infection with retained shreds of placenta. Vaginal hysterectomy was followed by death on the third day.

A. Keilmann² reported a case of a tertipara admitted with ruptured membranes, slight labor pains and some hemorrhage. Spontaneous delivery occurred. Two hours later a portion of undelivered placenta was found adherent to the anterior lip of the cervix and was removed with great difficulty by manual separation.

E. Ponfick³ reported a case of a nonipara with repeated hemorrhages during pregnancy. A diagnosis of placenta praevia was made and on the left and posterior aspect, the placenta was found to be continued down inseparably adherent as far as the vaginal portion of the cervix.

Jaschke⁴ reports a recent case of placenta isthmica et cervicalis.

The cases which have been so far reported in the literature have not been supported by microscopic evidence and are so few in number as to warrant the assumption that placenta praevia cervicalis is either a very rare condition or one which is very rarely recognized.

969 Madison Avenue.

SUBPARIETAL RUPTURE OF SOLITARY KIDNEY *

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NEW ORLEANS

The horseshoe kidney, while rare, is sufficiently common to require no especial comment. Those anomalous conditions in which the kidneys are completely fused into one mass are of much less common occurrence. To this condition, the *Kuchinniere* of the Germans, Rokitsansky applied the term "solitary kidney," to differentiate it from the true single, or "unsymmetrical" kidney.

Morris, reviewing the statistical reports of four of the largest of the London hospitals, found that while the "horse-shoe" kidney was present once in each 1,000

autopsies, the fused kidney, not of the "horseshoe" variety, was found only once in 15,908 necropsies.

Subparietal rupture of the kidney is comparatively rare. Connell, in a paper read before the Western Surgical Association,¹ collected from all sources a total of 841 cases.

Our case of subparietal rupture of a "solitary" kidney is, we believe, unique in the literature.

History.—Our patient was a white man, 30 years of age, a native of England, and a sailor by occupation. We were unable to get a connected account of his injury and the sequelae, but, as far as we were able to gather, seven days prior to applying for treatment, while climbing a ladder, he had fallen a distance of from four to six feet. In falling his body swung around, and he struck with his right lumbar region on an iron rail. He complained of some pain in his right side, following the injury, but continued to void urine up to seven days after the accident. We were unable to learn whether or not this urine contained blood. His urine stopping suddenly (?), the captain of his ship sent him to the Touro for treatment.

Examination.—The patient was admitted to the service of Dr. Matas who requested Dr. Mayer to look after him. On admission the patient's general condition was good, his temperature was normal. He showed considerable ecchymosis in the right lumbar region and in the perineum. A large diffuse swelling could be felt in the right side almost to the umbilicus, and longitudinally from the last rib to the pelvis. The abdomen was distended and very tense. About two ounces of bloody urine were withdrawn by catheter. He was catheterized twice more in the following twenty-four hours, but no urine was obtained. He vomited three times the day following admission.

Diagnosis.—The question of diagnosis was interesting. The history of the injury and the mass in the right side suggested at once rupture of the right kidney. But rupture of the right kidney would not explain the absence of urine in the bladder, since there was no evidence of damage to the left kidney. Rupture of the bladder, with postperitoneal infiltration of urine was contra-indicated by the nature of the injury, and, especially, by the fact that the patient had voided urine normally for seven days after the accident.

The possibility of there being but one kidney was discussed, but, if this rare anomaly was present, we could not explain why a ruptured single kidney should secrete what the patient described as being comparatively normal urine for seven days, and then suddenly cease functioning. Rupture of the right kidney, with subsequent sloughing of the bladder-wall, the reason for which we did not understand, seemed to us to be the only plausible explanation of the conditions present.

Because of this opinion, and because the condition of the patient did not justify any unnecessary delay, no attempt at cystoscopy was made. As was demonstrated by subsequent findings, cystoscopy with catheterization of the ureters would have been unintelligible or even misleading, unless styleted catheters had been used and a radiograph taken.

Operation.—At Dr. Matas' suggestion, an exploratory laparotomy was done. The incision was made to the left of the median line, to avoid possible contamination of the peritoneal cavity with what appeared to be infiltrated urine beneath the abdominal wall on the right side. When the peritoneum was opened, the cavity was found to contain about a pint of clear fluid which had no urinary odor. To the right, postperitoneal, extending from the last rib to the crest of the ilium was a large oval swelling which evidently included the right kidney. No left kidney could be found, although search was made as high as the spleen and as low as the pelvis. The bladder was tested and found to be intact. The abdominal wound was closed with some difficulty because of the intestinal distention and the patient turned over on his left side. The ordinary loin incision was made over the right kidney. As the muscles were being cut through there was a gush of bloody urine. The wound was enlarged and the hand introduced. The kid-

1. Weiss: *Centralbl. f. Gynec.*, 1897, p. 641.

2. Keilmann: *Centralbl. f. Gynec.*, 1897, p. 857.

3. Ponfick, E., and Ponfick, W.: *Ueber placenten praevia; insbesondere Placenta praevia cervicalis*, Berl. klin. Wochenschr., 1899, No. 35.

4. Jaschke: *Ztschr. f. Gynec.*, March, 1911, p. 1409.

* Pathologic report by F. B. Gurd, M.D.

† Deceased, Jan. 14, 1911.

1. Connell: *THE JOURNAL A. M. A.*, March 25, 1911, p. 875.

ney was found to be lying slightly lower than usual, but otherwise its position was normal. The lower pole of the kidney was roughly broken off and sloughing. The cavity below the kidney was filled with what seemed to be sloughing tissue and partially organized blood-clots. The ureter was felt to be hard and considerably thickened, but there was no dilatation either of the ureter or of the pelvis of the kidney.

As the condition of the patient was bad, no time was lost in careful examination. Drainage with tubes and gauze was done, the wound dressed, and the patient was returned to the ward. Shortly after the operation, the patient voided urine, and he continued to void normal quantities of clear urine. But he never rallied from the operation, and died thirty-six hours thereafter.

From the findings at autopsy, we concluded that, following the injury to the kidney, the upper segment continued to function until the gradually contracting blood-clot finally completely occluded the ureter.

The operation, by removing the obstruction, permitted the kidney to resume its function. The autopsy findings showed that there had been no hydronephrosis.

The autopsy was performed by Dr. F. B. Gurd, whose report is appended.

Autopsy.—This was performed six hours after death; a general examination of the body revealed nothing worthy of note with the exception of those parts in the neighborhood of the right kidney.

Over the loin on the right side is an incision 10 cm. in length, also a second incision of a similar length opening into the mid-line of the abdomen, its lower extremity being 8 cm. above the pubis.

On opening the abdomen, the posterior peritoneum appears to be deep reddish-black in color, the result of a blood-clot lying behind it. This appearance is especially marked in the neighborhood of the right kidney. Separation of this blood-clot, which measures from 2 to 6 cm. in thickness and is moderately friable, deep red in color and firm, discloses the right kidney. This organ is large (weight 380 gm.) and normally firm. Somewhat below the center of the organ from above downward there has been a solution of continuity, the separated surfaces lying about 4 cm. apart, the intervening space being filled with blood-clot and greyish friable masses, apparently necrotic material.

On the removal of the two portions of the kidney and the placing them in opposition, a more or less normal shaped large kidney is seen. The surface is smooth and normal in color, with the exception of an area 2 cm. wide on either side of the rupture. In these zones the surface is mottled deep red and greyish-yellow in color. On section the organ appears in general more or less normal, though somewhat pale. The cut surface bulges and exudes fluid blood. The cortex is thickened, measuring from 0.6 to 0.8 cm. in diameter. The glomeruli are somewhat more distinctly prominent than usual. Differentiation between the cortex and medulla is moderately well marked. The central portion of the kidney on either side of the line of rupture shows irregular deep purple, somewhat

softer areas between which lie triangular yellowish portions with the apex pointing toward the medulla. These areas correspond to yellowish blotches seen on the surface.

At the point mentioned, namely 4 cm. from the kidney, the ureter is constricted measuring not more than 0.35 cm. in diameter for a distance of 4 cm. The wall of this ureter throughout its entire length is somewhat thickened.

The second ureter which is approximately half the size of the other arises from the lower portion of the kidney, at the point of rupture. No pelvis, and no calices are present.

Two sets of blood-vessels supply the kidney. One in the neighborhood of the upper, the other in the neighborhood of the lower ureter.

Absolutely no evidence of a second or left kidney can be found.

The bladder contains two normal-looking ureteral openings, the left opening being situated slightly further from the urethral opening than the right, giving the trigone an irregular appearance. The two ureters cross one another about 8 cm. above the bifurcation of the aorta, the right going to the upper pole of the kidney and the left to the lower. On removal, the kidney is found to weigh 400 gm., and, though large when the two portions are approximated, is normal in size. The kidney substance is moderately firm and somewhat paler than normal. On the upper surface of the lower portion several irregular, yellowish blotches are noted.

Anatomic Diagnosis: Congenital absence of left kidney; traumatic rupture of right kidney, retroperitoneal hematoma (perirenal).

Microscopic Examination of Kidney: A section cut from a more normal-looking area of the kidney shows an injection of the renal vessels and a few sclerosed Malpighian tufts. The cells lining the tubules are somewhat swollen and take the red stain with moderate intensity. The nuclei stain well. Within the tubules and about the glomeruli there is a moderate amount of granular red staining material (serum).

Other sections cut from the greyish purple area in the line of rupture consist of blood-clot, made up chiefly of necrotic blood-cells and kidney substance infiltrated here and there with polymorphonuclear leukocytes.

Section 3 cut from one of the yellowish nodules in the lower portion shows a necrosis *in situ* of the kidney substance surrounded by a zone characterized by injection of the blood-vessels and interstitial exudate of serum.

Microscopic Diagnosis: Acute nephritis
Infarcts of the kidney (traumatic).

Perrin Building.

A NEW BLOOD-VESSEL FORCEPS

BERTRAM M. BERNHEIM, M.D.

BALTIMORE

The slightest scratch given the intima during the manipulations required in any blood-vessel work almost invariably spells failure in the form of a thrombus. Sharp-pointed instruments are, therefore, scrupulously avoided in all such work. Indeed, most men find their fingers the best and safest of all instruments.

Blood-vessel forceps, with small ball-tipped ends

But since the work can at times be facilitated by a delicate pair of forceps, I have had one constructed which has a small, polished metal knob about the size of an ordinary pin-head on each end. These knobs enable one to grasp the vessel firmly without doing the slightest damage to the intima.

2319 Linden Avenue.