Clinical Notes :

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

EXTRUSION OF A RENAL CALCULUS CAUSING A SINUS IN THE LOIN.

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THE following case is recorded as unusual, and presenting special features of interest:—

History.—N. G., a native Arab village woman, aged about 30, came to hospital from Nablous on Oct. 18th. She stated that she was suffering from a wound in her back, which had been discharging for a year. She said that she knew of no cause for this "wound"; no history was obtainable of injury, acute illness, pain, or disability of any kind. In the Moslem idiom, she stated that it was "Min Allah"—in other words, it had developed spontaneously; apart from the wound she felt very well.

On examination she proved to be a fine, apparently healthy woman, who had all her life been accustomed to the hardest manual labour in a country where all the heavy work is done by women. Nothing abnormal was discovered in chest or abdomen; the spine showed no tenderness, deformity, or rigidity; the urine was quite normal, specific gravity 1015, slightly acid, no albumin, no blood, no casts, no deposits of any kind visible to the naked eye. Over the left loin, about 2 in. from the middle line, at the level of the first lumbar vertebra, was a wound, or sinus, discharging yellow pus of a thin consistency; there was no urinary element in the discharge. The sinus passed downwards and outwards; a probe was inserted and a foreign body was discovered lying 1 to 1½ in. from the surface. This body felt like dead bone. A provisional diagnosis of tuberculous abscess was made. The difficulty lay in the origin of the "dead bone"; the wound was above the crest of the ilium, quite a distance from the vertebra, and the twelfth rib could be traced intact above. The patient was admitted to hospital, where her temperature for three days remained subnormal and her pulse-rate 70–80.

Treatment.—On the 22nd she was anaesthetised and a transverse incision was made with a view to enlarging the opening of the sinus. A probe was now passed beyond the foreign body, and the sinus found to go directly in the direction of the left kidney. The supposed bone was grasped by necrosis forceps and pulled out through the enlarged exit wound. It was found to be a large renal calculus, roughly circular in circumference, and somewhat loaf-shaped. It was encrusted thickly with what was presumably uratic substance, and the interior, I imagine, was uric acid (I did not cut it up owing to the patient's desire to possess the trophy); the diameter of the stone would be about five-eighths of an inch. The sinus was then thoroughly cleared, packed with iodoform and drained, the remainder of the wound being sutured. She has made a good recovery: in no way affected by a temperature of 104° F. the night after the operation, and 103.5° the next night; this proved upon blood examination to be due to the ubiquitous malarial parasite, and speedily yielded to appropriate treatment. The sinus is healing up from the bottom, and although once in the daily dressing I washed out of the wound some gravelly material, there has not been the slightest urinary odour, nor any evidence of the presence of urinary matter in the discharge.

Remarks.—The woman, who was carefully questioned in view of the findings above, still denied any history of pain such as renal colic, and stated that she never had any pain during micturition, never suffered from frequency, nor had she had any passage of gravel. Her obstetric history had been uneventful. The history in these cases is notoriously inaccurate, but there seems no reason to suspect deception. The patient is an exceptionally intelligent woman for her class and race. In these days such cases must be fairly rare; even in Palestine the native usually seeks medical advice comparatively early. Nothing either in the history, symptoms, or urinary investigation led us to suspect the renal cause of the trouble; true, there were difficulties in the spinal caries diagnosis, but tuberculosis, especially of bones and joints, is very prevalent amongst the Fellaheen and Bedouin Arabs, and to suspect renal

calculus in the absence of any indications of an affection of the kidney seemed to be uncalled for.

I have no access to the literature of similar cases, but I seem to remember that most, if not all, of the recorded cases have given rise to suspicions as to their causation, by some, at any rate, of the symptoms and signs so conspicuously lacking in this case. It was quite a minute before I realised that I was looking at a renal calculus, and not at the possible result of an attack with a slung stone from the rear.

A FURTHER NOTE ON THE LYMPHOIDOCYTE AND ITS CLINICAL SIGNIFICANCE.

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IN a previous communication to THE LANCET of July 19th, 1919, I recorded the finding of lymphoidocytes—which are regarded as the parents not only of leucocytes and lymphocytes but of red cells also—in the circulating blood in fatal illnesses other than primary anaemia. I have since extended these observations, and give a brief summary of the results.

Twenty-six patients were selected, who were described as moribund, and who certainly appeared to be in extremis. Lymphoidocytes were found in 24, associated in every case with a marked leucopenia and the presence of leucoblasts—the parent both of leucocytes and lymphocytes—and in six cases with a few myelocytes also. The diagnosis is as follows: Diabetic gangrene 3, carcinoma with generalised metastases 3, senile decay 2, advanced tuberculosis 6, cardiac valvular disease with broken-down compensation 7, severe malaria 1, relapsing fever (with presence of the characteristic parasites) 2. All of these subsequently died. The two remaining somewhat unexpectedly recovered, and the lymphoidocytes could no longer be found. One was suffering from alcoholic pneumonia and cirrhosis of the liver, and the other from influenzal pneumonia.

In addition, I have observed 15 cases of primary disease of the hæmopoietic organs—namely, lymphatic leukaemia 6, "pernicious" anaemia 3, secondary carcinoma of the bone-marrow 2, myeloid leukaemia 2, Banti's disease 2, in all of which death took place, and lymphoidocytes were present in the circulating blood. The proportion of lymphoidocytes in the films varied in the first series from 3 to 11 per cent., and in the second from 5 to 20 per cent. I do not, however, suggest any correlation between these proportions and the severity of the disease, as it is by no means certain that the proportion of primitive cells of various types does not vary from time to time when they are present.

These observations show that the appearance of the primordial cell in the circulation is not confined to disease of the hæmopoietic organs, though I have been unable to find any record of their presence in man except in the leukaemias. So far as this goes, it serves, I think, to emphasise the importance of studying the histological features of the blood cells instead of merely relying on their numerical proportions as found in a mechanical count where they are classified under rigid types. It is frequently possible not only to trace in the same film gradations between the recognised mature cells and their progenitors, but also to observe a shift towards one or the other end as the patient improves or gets worse, and it is therefore probable that as our knowledge of the biology of the blood cells deepens, the opinion of the pathologist on the extent of the patient's resistance to disease in general will become of increasing service to the clinician. The value of a mechanical count with the hæmocytometer is but small, unless it be supplemented by a histological study of the cells themselves in properly stained films. For this purpose I have found Leishman's stain useful for a general survey of the film, but for the finer details Pappenheim's panoptic stain is preferable and less liable to variation. Latterly I have come across no fewer than five different samples of alleged Leishman stain which were quite useless for hæmatological work, and could not be made to give the characteristic reactions by any manipulation whatsoever.