

INTERSTITIAL NEPHRITIS WITH MULTIPLE ABSCESS FORMATION.

DR. GEORGE WOOLSEY presented a woman, 28 years old, who was admitted to the Gynecological Service of Bellevue Hospital on January 6, 1908, complaining of headache, backache, nausea, pain in the abdomen, vaginal discharge and perineal weakness. She had a cystocele, a small rectocele, a retro-flexed uterus and a relaxed perineum. On January 14th Dr. Barrows did a perineorrhaphy and a double Alexander operation, and the patient was discharged on January 30 in good condition.

She was re-admitted to the Surgical Division on February 5 with the history that during the night prior to her admission she had had a chill, followed by fever and nausea, but no vomiting. She complained of a severe pain in the right hypochondriac and lumbar regions, and stated that she had some cough, with blood tinged sputum. She was poorly nourished, and the physical signs at the apex of the right lung indicated tubercular trouble. There was marked rigidity of the upper right rectus and in the right lumbar region. On palpation, a very tender mass was felt below the right costal margin. This moved slightly with respiration. Her temperature on admission was 104; pulse, 140; respirations, 32. Leucocyte count, 15,000. The urine contained a heavy trace of albumin and a marked trace of indican. No blood nor tubercle bacilli; no casts. The patient micturated from two to four times at night: there was no frequency during the day. A cystoscopic examination made by the Kelly method showed that there was no congestion about the mouths of the ureters nor of the bladder generally.

Operation, February 14, 1908. When the abdomen was opened through a small exploratory incision through the right rectus the right kidney was found to be much enlarged. The other organs were apparently normal. The kidney was then fully exposed through a lumbar incision. The fibrous capsule was very adherent to the fatty capsule, and the former was torn in freeing the kidney. The kidney showed numerous elevated areas of lighter color and various size, round and oval, and softer than the main portion of the organ. A nephrectomy was done, from which the patient made an uneventful recovery.

A pathological examination of the removed kidney showed it to be the seat of an acute interstitial nephritis, with multiple

abscess formation. Smears showed diplococci; no tubercle bacilli. Cultures gave a colon bacillus-like growth.

Since the operation, the patient's symptoms had improved, and the nocturnal frequency had diminished. The case was not regarded by the pathologist as one of infarct of the kidney, but as an acute interstitial process, with marked leucocytic infiltration, which was beginning to break down into small abscesses.

DR. GEORGE E. BREWER said the gross pathological appearance of the lesions in the specimen shown by Dr. Woolsey seemed to be of the same type as those described under the name of hemorrhagic infarcts. The speaker thought it was undoubtedly a blood infection. We could get a good many different microscopic appearances in these cases, which was explained by Albaran on the ground that in a kidney excreting bacteria from the blood, many different pathological conditions might occur. Primarily, however, they originated from a blood infection, and were due to the fact that the bacteria were carried into the arteries.

DR. BLAKE said he had seen quite a number of cases in which the appearance of the kidneys was typical of the specimen shown by Dr. Woolsey, and, like Dr. Brewer, he had always looked upon them as the result of an infection carried by the arteries. They also closely resembled the lesions found in early tuberculosis of the kidney. Here we had to deal with small multiple foci which later on might perhaps coalesce and form a condition resembling infarct.

EXCISION OF CARCINOMA OF THE RECTUM BY THE COMBINED METHOD.

DR. JOSEPH A. BLAKE read a paper with the above title for which see page 80.

DR. WOOLSEY said the combined method possessed one advantage which was perhaps not always sufficiently emphasized, namely, that it allowed the operator to learn the extent of the pelvic involvement in a way that could not be secured by the parasacral method. The speaker said that when he employed the latter method he was in favor of doing a preliminary colostomy, and in this way discovering the extent of the disease in the pelvis. With the combined method we could go right ahead and remove much more extensive growths, or determine whether they were operable or not.

DR. BLAKE, in closing, said that in none of his cases had he made an attempt to construct a competent abdominal anus other than bringing the end of the bowel through an ordinary McBurney intermuscular incision. He rather hesitated to employ the procedure of separating the muscle planes and drawing the end of the gut through between them, because he felt that unless great care was taken regarding the blood supply, there was some danger of necrosis. He had found the pneumatic ring a rather good arrangement. In operating, he always took some pains to leave a long segment of the gut, so that there was a loop hanging down into the pelvis, which acted as a sort of reservoir for the feces, and prevented a constant discharge. Such an arrangement gave the fluid portion of the feces time to be absorbed.