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**CHRONIC NEPHRITIS AFFECTING A MOVA-
BLE KIDNEY AS AN INDICATION
FOR NEPHROPEXY.**

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THE voluminous literature of movable kidney is practically silent upon the subject matter indicated in the title of this paper. The few and scattered words devoted to the matter serve simply to give expression to the sentiment that in the presence of chronic nephritis nephropexy for movable kidney is to be avoided in common with all other operations not called for as a vital indication. In quite an extensive search of the literature I have been unable to find the record of a single case of nephropexy for movable kidney performed upon a patient suffering at the time of operation from either acute or chronic nephritis.

While recently reviewing the clinical records of 154 nephropexies performed by myself upon 118 patients during the past nine years, with a view to ascertaining the final results, I found that I had anchored the kidney or kidneys of six patients, who, at the time of operation and for a greater or less period preceding were known to have had chronic nephritis. In view of the paucity, or rather non-existence of similar records, I may be pardoned a little prolixity. I will premise by stating, and wish to emphasize the point, that in none of the five first

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cases was the nephropexy undertaken with any idea of favorably influencing the chronic nephritis known to exist; the indication for operation was given simply by the existence, in an aggravated degree, of the usual symptoms due to *mobility* of the kidney or kidneys. The effects of the nephropexy upon the chronic renal inflammation, whatever they might prove to be, were simply hazarded in view of the necessity of relieving the patient of a number of intolerable symptoms. The fortunate effects in three of these five cases influenced me to regard the chronic nephritis of the sixth as a new indication, additional to other well recognized and admitted existing indications, of nephropexy for movable kidney. I have recently seen two further cases of chronic nephritis associated with movable kidney, and have advised nephropexy in the hope of favorably influencing the kidney inflammation; both patients are having operation under consideration.

CASE I.—Miss A. B., eighteen years of age, came under my care in November, 1891, suffering from chronic metritis and anteflexion, for which curettage and amputation of the cervix were performed in December, 1891. Cysts of both ovaries subsequently developed and grew to a considerable size during the first half of 1892. On June 28, 1892, I performed bilateral ovariectomy and ventral fixation of the uterus. Examination of urine preceding these operations showed diffuse chronic nephritis. Soon after the removal of the ovarian tumors the right kidney became movable, producing serious derangement of health, the chronic nephritis at the same time persisting. Right nephropexy was performed on November 29, 1892. At operation the structural

changes in the right kidney due to chronic inflammation were plainly recognizable. Primary union. Two months after nephropexy the albumin and casts disappeared permanently from the urine. The left kidney subsequently became movable but, causing no symptoms, did not and does not to this day call for nephropexy. The patient has now been under constant observation for a period of more than six years, during all of which time she has enjoyed perfect health. The right kidney remains securely anchored and the urine free from albumin and casts.

CASE II.—Mrs. G. H., aged thirty-nine years, came under my care in March, 1893. The conditions recorded as found on examination were: Right kidney movable 12 cm.; left kidney movable 10 cm.; endometritis; salpingo oophoritis sinistra; nephritis diffusa chronica; hysteria. Bilateral nephropexy, March 10, 1893. My records do not contain any note of the appearance and feel of the kidneys at operation. The wilful and unmanageable patient repeatedly sat up in bed and removed the dressings during the first days following operation with resultant infection of both wounds, necessitating healing by granulation. The nephritis still persisted on her discharge from hospital six weeks after operation. A year and a half after operation I learned from Dr. Ernest Palmer of Brooklyn that the right kidney was again movable, the left remaining firmly anchored. No information as to the presence or absence of nephritis.

CASE III.—Mrs. M. M., aged twenty-eight years, was seen by me in consultation with her physician, Dr. R. G. Wiener, in May, 1893. She had a movable large right kidney, chronic interstitial nephritis, endometritis, and bilateral salpingo-oophoritis. The nephritis to Dr. Wiener's personal knowledge was of several years' standing. The symptoms due to the

mobility of the right kidney were so urgent that both Dr. Wiener and his patient, the latter also with a full knowledge of her nephritis, desired nephropexy. The operation was performed at the home of the patient, with the kind assistance of Dr. Wiener, on May 11, 1893. The kidney was found extensively diseased, its surface being nodular and the capsule irregularly thickened and very adherent as a result of inflammatory changes. On the posterior aspect of the kidney, near its lower pole, squarely in the center of that portion of the kidney we depended upon for adhesion to the lumbar incision, a cyst nearly four centimeters in diameter was encountered. The contents of the cyst, a turbid serum, were evacuated by incision through the kidney substance, the wound of the kidney being closed by running cat-gut suture. The kidney was then anchored in the usual way.

The wound healed by primary union throughout. Dr. Wiener informs me that all the symptoms due to the movable kidney disappeared for a period of eight to ten months when the kidney again became as movable as ever with a return of all her former symptoms. The nephritis remains uninfluenced for better or for worse.

CASE IV.—Miss L. G., aged twenty-five years, was referred to me by Dr. B. R. Morrow in January, 1896. She presented movable right and left kidneys causing symptoms, chronic appendicitis, bilateral oophoritis, and chronic nephritis, although the duration of the latter could not be ascertained. Bilateral nephropexy, January 11, 1896, on which occasion the left kidney was found to be the seat of chronic interstitial nephritis, the right kidney being healthy. Primary union of both wounds. A pain persisting after operation in the region of the left kidney disappeared after inversion of the vermiform appendix and breaking up of ovarian adhesions on

May 31, 1898. Both albumin and casts permanently disappeared from the urine some four months after bilateral nephropexy. It is now two years since operation and the patient remains well and free from nephritis. Both kidneys securely anchored.

CASE V.—Mrs. M. F., aged forty-two years, came under my care in April, 1897, with movable right kidney, chronic metritis, chronic pelviperitonitis, chronic appendicitis, and chronic interstitial nephritis. She had previously had several operations for pelvic abscess by various operators. The symptoms due to *mobility* of the right kidney were so distressing as to lead me to advise nephropexy in spite of the fact that she was known to have had chronic nephritis for six years past and had been under treatment for that condition constantly during all that time. On April 1, 1897, at the home of the patient, I performed curettage of the uterus, amputation of the cervix, and right nephropexy, the kidney at operation being found the seat of chronic interstitial nephritis. Primary union, uneventful convalescence, and marked and progressive improvement of general health followed operation.

Oft-repeated careful chemical and microscopical examinations of the urine were made before and after operation by Professor H. T. Brooks, who, one year after operation, pronounced the nephritis as practically cured. During this year she received absolutely no treatment for the nephritis, so the gratifying result may fairly be ascribed solely to the operation. The patient remains well with well-anchored right kidney and with urine free from albumin and casts at the present writing, nearly two years after operation.

CASE VI.—Miss S. O., aged twenty years, came under observation in January, 1898, suffering from mobility of both kidneys, endometritis, and interstitial nephritis. The duration of the latter could

not be ascertained. In view of the favorable results obtained in the cases already cited bilateral nephropexy was advised, both to relieve the symptoms due to mobility of the kidney, and with the hope of favorably influencing the nephritis. Both kidneys were anchored and the uterus curetted, January 10, 1898.

At operation the right kidney was found perfectly healthy. The left kidney on the other hand was large, irregular in shape, hard from increase of connective tissue, and with firmly adherent capsule proper; in short it presented the changes characteristic of chronic interstitial nephritis. Primary union of both wounds, uneventful convalescence, and rapid disappearance of every former symptom. Frequent examinations of the urine were made by Professor H. T. Brooks and by Dr. A. Strong, who kindly assumed the treatment of patient after operation. Albumin and casts disappeared permanently from the urine one month after operation. One year after operation patient perfectly well, both kidneys securely anchored and urine free from albumin and casts.

The fact that stands out strikingly in the above record of clinical experience is the disappearance of all symptoms and signs of chronic nephritis in four out of six patients after and, in all human probability, as a consequence of nephropexy. For, be it recalled, none of the patients subsequently to nephropexy received any treatment whatsoever directed to the nephritis. In one patient with extensive interstitial and cystic changes in the anchored kidney the latter became detached eight to ten months after operation and the nephritis persists. The redetachment of the kidney in this case was probably due to the advanced cystic degeneration. One patient finally has been lost track of after bilateral nephro-

pexy and nothing is known respecting the continuance of her nephritis except that it still persisted six weeks after operation.

An important clinical fact indicated by the four successful cases is that chronic nephritis is probably unilateral much oftener than is usually suspected. In two of the four cases all the symptoms and signs of chronic nephritis disappeared after fixation of a movable right kidney proved at operation to be the seat of chronic interstitial changes. The left kidney in these cases must have been healthy, otherwise the urine would have continued to furnish albumin and casts even after convalescence of the right kidney. In each of the other two patients upon whom bilateral nephropexy was performed the nephritis was found unilateral, affecting the right kidney in one and the left in the other. In all of these four cases the chronic nephritis was unilateral, *i.e.*, it affected only one organ, a fact pregnant with hope and comfort to sufferers from chronic nephritis.

Judging from the evidence afforded by frequent examinations of the urine the chronic nephritis in each of the four cases disappeared in two months, four months, one year, and one month respectively after nephropexy. The fact of the disappearance of chronic nephritis without further treatment after nephropexy amounts to almost proof positive that the displacement of the kidney was the original cause of the nephritis. My own not inconsiderable experience with movable kidney has furnished numerous examples of congestion of the kidney, as evidenced by traces of albumin and hyalin casts in the urine accompanying this condition. This congestion of the kidney, due to displacement with consequent distortion and greater or less obstruction of the renal vessels, and especially of the renal vein, is as good as uniformly relieved by a successful nephropexy. If displacement of the kidney gives

rise to congestion why may not the latter condition occasionally progress to inflammation? And if nephropexy of a movable kidney will do away with renal congestion why may not the beneficial effects of the operation, occasionally at least, assert themselves even when the circulatory disturbances have already progressed so far and been so long maintained as to result in the changes characteristic of chronic nephritis?

That a well-anchored kidney is in a better position and condition to maintain or regain its organic integrity, as the case may be, than a movable kidney, is patent from the evidence already adduced. An added proof is afforded by the investigations of Wolff into the subsequent histories of fourteen cases of nephropexy performed by E. Rose, and corroborated by my own observations upon a much larger number of patients upon whom I have performed nephropexy, unilateral or bilateral. In not one of Rose's cases and in none of my own, except the cases of chronic nephritis existing at operation detailed in this paper, could any evidences of renal changes as evidenced by the presence of albumin or casts in the urine be found at the last examination, made from six months to fourteen years after operation.

The various experiences and observations recorded in this paper, will, if corroborated in larger numbers, necessitate a modification of current opinions on the etiology of chronic nephritis. Mobility of the kidney will probably be found as playing a *very* important part in the causation of chronic nephritis. Just as probably the therapy of chronic nephritis, in so far as the latter be found to be dependent upon and connected with movable kidney, will become surgical. My own favorable experience warrants me for the present in regarding chronic nephritis affecting a movable kidney as an important indication for nephropexy.

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