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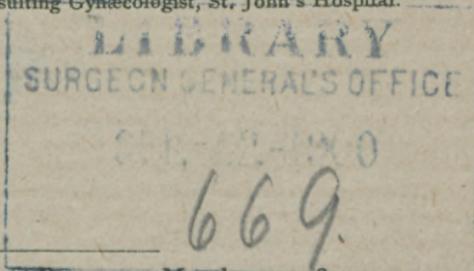
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The Relations of Movable Kidney
and Appendicitis to Each Other
and to the Practice of Modern
Gynæcology

BY

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THE RELATIONS OF MOVABLE KIDNEY AND APPENDICITIS TO EACH OTHER AND TO THE PRACTICE OF MODERN GYNÆCOLOGY.¹

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DURING the fourteen years in which the writer was engaged in the general practice of medicine he occupied himself, among other things, with the then universally current, and almost as universally unsuccessful, attempts to cure the special ills of womankind. He painted the vaginal vault, the exterior and interior of the cervix with iodine and other drugs; occasionally even ventured to attack the mucous membrane of the uterine body with applications of more or less critically and judiciously selected medicinal agents; distended the vagina to a greater or less degree with medicated tampons of cotton, sheep's wool, etc.; fitted and refitted pessaries for ante-, retro-, and latero-flexions and versions and prolapsus of the uterus; solemnly prescribed more or less endless vaginal douching with water, plain or medicated, at exactly such and such a temperature, etc. The end of treatment was never in sight for the unfortunate woman who once began it; the "local treatment" habit became chronic or recurrent with many. Leaving out of count those cases cured by the surgical removal of abdominal and pelvic tumors, but a comparatively few of the luckier women escaped the endless slavery of the gynæcological chair by successful plastic surgery of

¹ Read before the Medical Society of the State of New York, February 1, 1899.

the cervix, vagina, and perineum, and that only when plastic surgery constituted the correct and only indication in their particular case.

For the gynæcological sins of commission and omission of this portion of his professional career the writer has ever felt the most profound contrition—a slight and altogether inadequate atonement, but still the only one that the nature of the case admits of. In extenuation of his offences he can plead only the then prevalent ignorance and misconception of the science and art of gynæcology under which he in common with so many others labored.

Early in my career as a specialist, having entirely abandoned general practice and devoting my time and energies exclusively to the study and practice of gynæcology and abdominal surgery, I became convinced and predicted that the development of gynæcology in the immediate future lay in the direction of surgery. How completely this prediction has been verified is matter of medical history. With attention to major pelvic surgery, repair of genital lesions, curettage, permanent correction of uterine and ovarian malpositions by operative measures, etc., meeting the indications in each case more and more clearly and fully by the light of increasing skill in diagnosis, greater perfection of operative technics and conscientious study of results, a proportionately greater degree of therapeutic success was obtained as compared with the local-treatment efforts of general practice. Still it must, in all truth and humility, be admitted that less than one-half of the women who presented themselves as patients for gynæcological treatment, and were properly accepted as such, could be made perfectly well by attention, even of the most skilful order, to their pelvic organs, and full and satisfactory surgical correction of all disorders and abnormalities thereof. In other words, a great many of the symptoms usually regarded as pertaining to, or emanating from, the genital sphere, of which these women complained, persisted even after the condition of the pelvic organs was found unexceptionable by the most

critical expert. In still other words, the practice of gynæcology as a specialty concerning itself exclusively with the pelvic organs, including as such the bladder and rectum, was far from satisfying in its results to either patient or physician. Very soon the importance of the rôle played by a movable kidney in the perpetuation of symptoms usually ascribed to diseased conditions of the female pelvic organs began to dawn upon me. With the aid of nephropexy added to operative procedures more distinctly gynæcological in character, an increasing number of my patients were fully cured. A few years later still, after I had learned how to diagnosticate chronic appendicitis, the frequent association of that condition with symptom-producing movable right kidney, the apparent dependence of the former upon the latter, and the important part played by the appendix in matters gynæcological, arrested my attention. With the added resource, when indicated, of appendectomy, I finally found myself in a position fully and permanently to cure by surgical measures almost every patient who came to me as a proper subject for gynæcological treatment, and who was willing to accept all the measures I considered indicated to meet fully the requirements of her case. Working along these lines and with the ability acquired by increasing experience and observation of results to establish clearly and from the beginning the indications presented in each case, modern gynæcology, so far as applied to the cure and relief of existing diseased conditions, has finally almost approached the ideal of an exact science, and its practice has become as completely satisfying as that of any other branch of the healing art.

The successful practice of modern gynæcology implies and presupposes a broad practical acquaintance with all the ills human flesh is heir to in as great a degree, at least, as that demanded in the successful practice of any of the other so-called specialties. A previous training in general medicine and surgery is absolutely essential to enable the gynæcologist to establish clearly the sum total of the indications for

treatment presented in each case, and to render him a safe guide and adviser of suffering womanhood.

To consider fully the relations of gynæcology to general medicine and surgery would be to write a text-book on the diseases of women. The object of this paper is to call attention, and that in an outline way merely, to the relations existing between the diseases of women, in the limited sense, and the conditions of movable kidney and appendicitis, and incidentally to the relations existing between the two last-named affections.

The Relations of a Movable Kidney and Appendicitis.—A consideration of the relations existing between movable kidney and appendicitis will enable us to approach more intelligently and to grasp more fully the relations existing between the two conditions named and the diseases of the female pelvic organs. The writer has on two previous occasions called attention to this subject, and to state the matter as succinctly and briefly as possible will take the liberty of quoting the summary of the latter of the two publications, referring those who may wish to enter more fully into details and to judge of the validity of his conclusions to the paper itself. The summary reads:

“Chronic appendicitis, as proven by the writer’s clinical and operative work, is present in from eighty to ninety per cent. of women with *symptom-producing* movable right kidney. This frequency constitutes chronic appendicitis one of the chief, if not *the* chief, symptom of movable kidney.

“Chronic appendicitis, by reason of its frequency, the protracted suffering and serious impairment of health which it entails, and the dangerous possibilities of implanted acute attacks of appendicitis, may be considered the most important complication of movable right kidney.

“The writer’s statistics show: that twenty per cent. of all women have movable kidney or kidneys; that four per cent. of all women have *symptom-producing* movable kidney or kidneys; that four per cent. of all women have appendicitis; that, while three and one-

half per cent. of all women have both *symptom-producing* movable kidney and appendicitis, only one-half per cent. of all women have appendicitis and well-anchored kidneys. The startling nature and importance of the conclusions to be drawn from these statistics does not invalidate the latter.

“Satisfactory investigation of the relations of movable kidney and appendicitis became possible only after the discovery and elaboration of the writer’s method of palpation of the vermiform appendix. It remains impossible to those not practically familiar with the method.

“Chronic appendicitis may be the *only* symptom of movable right kidney.

“Some of the symptoms commonly ascribed to movable kidney are often in reality due to the concomitant appendicitis.

“The relations existing between movable *right* kidney and chronic appendicitis are those of cause and effect, for reasons detailed in the paper. A movable *left* kidney never produces appendicitis.

“Movable right kidney probably produces chronic appendicitis by indirect pressure upon the superior mesenteric vein, the return circulation of the appendix being hampered by compression of the vein between the head of the pancreas and the spinal column.

“Chronic appendicitis associated with movable kidney shows no tendency to resolution or spontaneous cure, with restoration of a normal appendix, while the right kidney remains movable. The only cure possible, under these conditions, is by slow progress to appendicitis obliterans.

“In twelve of the writer’s cases of coexisting movable right kidney and appendicitis, the appendicitis apparently ended in resolution and remained permanently cured, after right or bilateral nephropexy, without any attention to the appendix.

“Recovery from appendicitis after right nephropexy may only be expected in cases in which the associated chronic appendicitis is of comparatively recent origin.

“In a minority of cases only of associated movable right kidney and chronic appendicitis will either nephropexy alone, or appendectomy alone, meet *all* the indications. The majority of patients require both operations to restore them to *full* health.

“Both operations, right nephropexy and appendectomy, may be simultaneously performed through one and the same lumbar incision extending along the outer margin of the erector spinæ muscle from the twelfth rib to the crest of the ilium.”

The Relations of Movable Kidney to Diseases of the Female Pelvic Organs.—Nearly every writer upon the subject of movable kidney has dwelt upon the evident and unmistakable frequency of the association or coexistence of movable kidney with nearly every form of disease of the female pelvic viscera, retroversion and its accompanying endometritis being especially well represented. Exacerbation of the symptoms due to movable kidney at the menstrual epoch is also frequently noted, although the explanation of renal congestion with each menstruation advanced by a number of writers is doubted by many others, among them the writer, who believes that the nervous manifestations of movable kidney, in common with all other nervous phenomena, are more apt to be accentuated at the menstrual period. Equally far-fetched is the explanation of Landau, that malpositions of the uterus, notably retroversion and prolapsus, dislocate the kidney downward by traction upon the ureter.

When we call to mind the essential pathological condition underlying the development of movable kidney, its relations to posterior and downward displacements of the uterus do not appear difficult to understand. The one thing settled about the etiology of movable kidney is that it is due to a relaxation and stretching of the lamina fibrosa of the renal adipose capsule, the tissue upon the integrity of which depends the retention of the kidney in its proper place. The same diseased action resulting in elongation and stretching of the essential supports of the other ab-

dominal and pelvic viscera leads to enteroptosis, partial or general. When in the progress of the disease the supports of the uterus are attacked, and the round, broad, and other ligaments of the uterus lose their tonicity and lengthen, the uterus becomes retroverted and prolapsed. Glénard has pointedly and with all the emphasis at his command called attention to the fact that mobility of the right kidney is the first step in the development of enteroptosis; that there is no enteroptosis without movable kidney, although there may be, and frequently is, movable kidney without enteroptosis. Often and often has the writer witnessed and followed the successive development, in the same woman, of mobility of the right kidney, mobility of the left kidney, and retroversion of the uterus, the first named of these three conditions almost invariably developing first, while either of the latter two sometimes preceded and sometimes followed the other.

While the connection between movable kidney and malpositions of the uterus is, therefore, perfectly clear, the association of movable kidney with other diseases of the female pelvic organs is probably simply accidental, the frequency of the coincidence being readily explicable by the frequency both of movable kidney and of pelvic disease.

So much for the etiologic relations existing between movable kidney and the diseases of woman's special organs. From a practical point of view these relations are of important and far-reaching significance. They explain, as already stated, why the most perfect success in removing diseased states of the female pelvic organs, and restoring these to practically normal conditions, so often fails of therapeutic relief, fails to make our patients fully well. An unsuspected, undetected, or disregarded movable kidney causing symptoms will very frequently explain the discrepancy between the opinion of the surgeon, after successful pelvic surgery, that nothing further ails his patient, and the assertions of the patient herself that she feels no better than before operation. It will explain, to

cite only one instance, why a successful treatment of retroversion of the uterus, or the repair of a lacerated cervix or perineum, may relieve the patient of a small part only, or even of none, of her multitudinous complaints. Of four women each having a movable kidney and movable retroversion, the symptoms in one may be due exclusively to mobility of the kidney, in the second exclusively to retroversion, in the third to both movable kidney and retroversion, while the fourth woman may not suffer in any way from either condition. If you perform a retroversion operation in the first, or anchor a movable kidney in the second, you will have helped neither of them. If you do either of these operations alone upon the third, the result will be at best but partial relief, while if you perform either or both of them upon the fourth, you will have been guilty of an entirely unnecessary and uncalled-for procedure.

Further practical applications of the facts adduced and to be adduced, on which the making or losing of professional reputation largely hinges, lie in the direction of diagnosis, the proper establishment of indications for treatment, and prognosis. Given a patient with movable kidney or kidneys, various disorders of the pelvic viscera, and perhaps chronic appendicitis, it goes without saying that it is first of all of vital importance to be able to diagnosticate each and every one of these conditions. Next, as to the proper establishment of rational indications for treatment, it is essential that we learn how to analyze the patient's symptoms, so as to be able correctly to refer each of these symptoms to the special pathologic condition causing it. Then first will we be in a position to apply intelligently the proper remedy—not to anchor, for instance, a movable kidney when that condition is producing no symptoms, but the sufferings of the patient are due to chronic appendicitis, diseases of the pelvic viscera, etc., or *vice versa*. Often, indeed, will it be necessary to correct all the pathologic conditions named before full therapeutic success is obtained and the patient is made entirely well.

This analysis of the symptoms presented by a given patient, with their correct reference to the specific abnormality causing each of them, is not quite so easy and simple a matter as the discovery or diagnosis of the various existing pathologic conditions themselves. It requires training, close observation, correct induction, experience, and a judicial cast of mind joined to habitual, painstaking, full and complete routine examination of every patient presenting, to reach its highest development and greatest capabilities. Once acquired, however, this faculty of correct analysis of symptoms becomes the richest possession and greatest power for good of the gynæcologist, or, for that matter, of the general practitioner. With it, diagnosis in its fullest sense and prognosis approach the dignity of exact sciences. Its possession and correct application will enable the surgeon to determine at the start if the case is one requiring several operations to be performed at different sittings, will restrain him from promising a complete cure after performance of a part only of the surgical work required, and will prevent his losing the confidence of his patient after the first operation or series of operations, as the case may be. On the contrary, possessing a full and intelligent grasp of the patient's entire condition and all the therapeutic requirements called for in her case, he will inform her that such and such of the symptoms she presents are due to such and such of her pathologic conditions, and such and such other symptoms to such and such other abnormalities; that after the operations immediately contemplated she may expect to be rid of certain specified complaints, but that the rest of her symptoms will disappear only after all the remaining abnormalities producing symptoms in her case have been finally corrected. The confidence of the patient is thus retained when she finds her attendant's predictions come true after her first operation or operations, and she unhesitatingly follows his further lead toward perfect health.

To be specific, I may state that in my own practice I have never required more than two sittings to cor-

rect by operation all the pathologic abnormalities present at my first examination in the abdomen and pelvis of any one woman. An extreme case, though by no means a very infrequent one, is the following taken at random from among a number of similar ones on my records: A married woman, aged thirty-one years, had a large, heavy uterus, retroverted, tied down by adhesions; there were multiple lacerations of the cervix; an extensive cicatrix following a childbirth tear of the left vaginal vault and left parametrium; chronic appendicitis, and movable right and left kidneys—each of the pathologic conditions named being responsible for one or another or several of the numerous symptoms complained of, and each requiring correction before a complete therapeutic success could be hoped for. She was informed of her condition, and that a number of operations to be performed at two sittings would be required for her relief. On February 16, 1898, at the patient's home, I performed curettage of the uterus, amputation of the cervix, and vaginoplasty for the removal of the vaginal and parametric scar; then, through a five-centimetre incision through the right rectus abdominis muscle, I performed inversion of the appendix and liberation of the uterus by breaking up the adhesions binding it down posteriorly, concluding with inguinal shortening of the round ligaments. At the second sitting, exactly four weeks later, bilateral nephropexy was performed. Smooth convalescence from both series of operations, primary union of all wounds, and a patient perfectly cured and remaining cured of all her many previous complaints, resulted. Again, in another somewhat similar case, bilateral nephropexy for movable right and left kidneys, and inversion of the appendix for chronic appendicitis through the lumbar right nephropexy incision, were performed at the first, and the pelvic surgery required in the case, curettage of the uterus, amputation of the cervix, and shortening of round ligaments at the second sitting.

When such a large number of operations demanding two sittings are required in a given case, it fre-

quently becomes a nice matter to determine which series of operations is the more important and urgent, and should be first undertaken. Experience and the demands of surgical technics will prove the best guides in determining the proper course. One rule, however, should probably hold almost inflexibly good: When the appendix is involved and its removal becomes necessary, appendectomy should be included in the first series of operations. The risks of delay in appendicitis should not be assumed without grave and cogent reasons.

A practical point relating to prognosis, which it is well to bear in mind, is that large abdominal tumors and the pregnant uterus in the later months form the best possible contrivances or splints to support in its proper place a movable kidney, and while doing so to keep in abeyance all the symptoms of the latter condition. Consequently, we must be prepared for the recurrence or even the new development of symptoms of movable kidney after the termination of pregnancy or the removal of large ovarian and uterine tumors, an experience which the writer has encountered on numerous occasions.

The Relations of Appendicitis and Disease of the Female Pelvic Organs.—This part of my subject has come to be more generally and better understood and acted upon by gynæcological surgeons as a whole than the two subdivisions already discussed. I can limit myself, therefore, to an attempt at indicating merely a few of the practical aspects of the relations existing between appendicitis, acute and chronic, and the various disorders of the female pelvic organs. To consider them *in extenso* would far exceed the limits of an ordinary paper.

In the first place no examination of the pelvic viscera should be regarded as complete that does not take note of the appendix and determine whether that organ is in normal condition or inflamed. This can be readily established in practically every woman, the very stoutest and those having abdominal tumors only excepted, by properly executed palpation of the appen-

dix. It is unnecessary to say another word upon the importance of the knowledge thus obtained.

Appendicitis and inflammatory diseases of the uterine adnexa and of the pelvic peritoneum are very frequently found associated. The inflammation may be primary in either the appendix, the adnexa, or the pelvic peritoneum, and one or both of the other two of the three tissues mentioned may become secondarily involved. Generally it is not difficult to determine from the history of the case, as well as from the findings at cœliotomy, the order of involvement of the various organs. Practically the condition of the appendix should always be investigated by inspection on the occasion of cœliotomy for diseased adnexa or pelvic inflammation. Should any doubt be entertained in regard to the perfect health of the appendix, the latter must invariably be removed. The writer, in his own practice, has carried this rule still further and inverts the normal appendix on the occasion of cœliotomy undertaken on any indication, provided always that such inversion does not call for enlargement of the incision required to do the other work in hand, and that the patient's condition is not so critical that her safety is jeopardized by the additional two or three minutes required for inversion. Inversion of the entire, unopened, normal appendix can be performed in two or three minutes; is in itself, if properly performed, entirely devoid of risk; does not add to the dangers of whatever other operation may have been undertaken, and absolutely insures the patient's future against a possible appendicitis. The premium paid for such insurance, two to three minutes' prolongation of anæsthesia, is insignificant when compared with the amount of future suffering from a possible chronic appendicitis, or the risk of a possible acute appendicitis, which it covers. As already stated, four per cent. of all women whom I have examined during the past six years had appendicitis. To be absolutely certain of not being one of the four per hundred is worth something to any woman. As a matter of fact I know of at least five of my patients who at periods

more or less remote following a cœliotomy performed by myself, and at which cœliotomy the appendix was found normal, acquired appendicitis, acute or chronic. This experience has led me to live up to the following rule: The abdomen should never be opened anywhere within a finger's length of the appendix without investigation of the condition of the latter. If the appendix is found diseased, it should be removed, even if it is necessary to enlarge the incision for this purpose. If found normal it should be inverted entire and uncut, if this can be done without enlarging the incision or imperilling the patient's chances of recovery from the operation or operations in hand.

The diagnosis between appendicitis and diseases of the right uterine adnexa, particularly their various inflammations and new growths, forms an interesting topic, which, however, time will not permit me to go into at length. The general rule for guidance, which, however, frequently fails, is that adnexal diseases are more pelvic, appendicular inflammations more abdominal, in location. The history of the case forms an important element in diagnosis, but is likewise susceptible of misinterpretation. An inflamed and even gangrenous appendix may have taken up its abode in the depths of Douglas' sac, or other parts of the pelvis, as well as in unusual places in the abdomen. In one case of abscess situated in Douglas' sac the writer was able to diagnosticate the tumor as probably appendicular in origin, from the fact that careful palpation proved the appendix to be absent from its normal site. Operation verified the correctness of the diagnosis. In other doubtful cases the writer has been able repeatedly to exclude appendicitis by palpating a normal appendix occupying its normal situation above the suspected tumor mass.

The frequent involvement of the appendix in various pathologic conditions affecting the female pelvic organs should always be taken into account in arriving at a decision as to whether a given case of disease of the pelvic organs requiring operation is to be approached by the vaginal or by the suprapubic route.

Palpation of the appendix should always be practised before operation in each such case. If the appendix is found normal, the vaginal route *may* be selected. If the appendix, on the contrary, is found inflamed or even not entirely above suspicion, suprapubic abdominal section is indicated, as enabling one to deal with the appendix as well as to perform the other work required. This point is so evident that to dwell upon it longer would be waste of time.

Appendicitis complicating pregnancy and labor is a subject that has lately come in for a fair share of deserved attention, which, I might add, it should have received long ago. I merely mention it, as it does not come, strictly speaking, within the limitations of my theme.

The relations of movable kidney, appendicitis, and the diseases of the female pelvic organs are of interest and importance alike to the general practitioner, the surgeon, and the gynæcologist. Among the women consulting the latter a large number present two, or frequently even all three, of the conditions named, though suffering only from the symptoms caused by one or more of them, and healthy in all other respects. This large class of women can be relieved of their multitudinous complaints and be made perfectly well and happy by the physician who possesses both the power correctly to analyze their symptoms and the surgical skill necessary to perform properly the operations indicated. Nothing short of malignant disease should baffle him in this class of cases. He must not, of course, perform nephropexy when the movable kidney or kidneys produce no symptoms, as is the case in about eighty per cent. of all women having movable kidneys, nor should he operate upon the pelvic organs without making certain that they are the cause of the woman's complaints. The appendix, if diseased, he will never go amiss in removing.

A certain number of these patients will need nephropexy, appendectomy, and surgical correction of abnormalities in the genital sphere to restore them to complete health. With a large experience based upon

constant study of these cases for a number of years past and critical observation of results, I have no hesitation in saying that the indications in each case can always be fully and clearly established. Basing my actions upon this fact, I now decline to accept for treatment any patient, unless with the proviso and express understanding that she will have all the operations indicated in her case. I act thus both in the interests of the patient herself and for the protection of my professional reputation, which is not enhanced by the fact of a patient upon whom I have operated still going about in quest of complete relief and cure.

The writer has seen quite a number of cases in which all the symptoms the patient ever complained of, all of which had been referred to disease of the pelvic organs, persisted, with now and then a new one added, after complete removal of uterus, tubes, and ovaries. The patient's complaints after operation were sometimes referred by the operator to sudden establishment of the menopause, sometimes to the fact that both ovaries had been entirely removed, and again to the circumstance that a remnant of ovary had been allowed to remain. Several of these cases were restored to complete health by subsequent nephropexy, by removal of a diseased appendix, or by both operations when indicated. It is superfluous to add that the genital organs had been needlessly sacrificed.

A list of the author's previous publications upon the topics above treated of is appended. It will serve to illustrate the evolution, in his practice, of the principles enunciated and the gradual steps by which his present position was reached.

1. "Movable Kidney; with a Report of Cases Treated by Nephrorrhaphy." *American Journal of the Medical Sciences*, March and April, 1893.

2. "Diagnostic Palpation of the Vermiform Appendix." *American Journal of the Medical Sciences*, 1894, n. s., cvii., 487.

3. "A Clinical Lecture on Palpation of the Vermiform Appendix." *Post-Graduate*, 1894, ix., 154.

4. "Notes on Movable Kidney and Nephrorrhaphy.

Part III. The Relations of Movable Kidney and Appendicitis." *American Journal of Obstetrics*, 1895, xxxi., 161.

5. "Inversion of the Vermiform Appendix." *American Journal of the Medical Sciences*, 1895, n. s., cix., 650.

6. "Wanderniere und Appendicitis; deren häufige Coexistenz und deren simultane Operation mittels Lumbalschnitt." *Centralblatt für Gynäkologie*, 1898, xxii., 1084.

7. "Chronic Appendicitis the Chief Symptom and Most Important Complication of Movable Right Kidney." *Post-Graduate*, 1899, xiv., 85.

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