PAINLESS HAEMATURIA.

A PLEA FOR EARLY INVESTIGATION, WITH
REPORT OF A CASE.

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THE case reported below seems worthy of placing on record because mistakes of the kind mentioned are very common.

A single woman, aged 54, consulted her doctor because she had noticed blood in her urine. It had come on suddenly and had lasted for forty-eight hours. There were no other symptoms whatsoever. She was placed on an alkaline diuretic mixture and assured that she had no cause for alarm. Nine months later the bleeding recurred, after which the patient was referred for investigation.

Apart from some loss of weight and the two bouts of haematuria there was nothing of interest in the history. Physical examination was negative, neither kidney being palpable or tender. The urine was clear and free from albumin and other abnormal constituents. Cystoscopic examination was normal, but on exerting firm pressure in both loins blood was seen to emerge from the left ureteric orifice. A catheter specimen from the right kidney was normal. Indigo-carmin injected intravenously was returned by the right kidney in three and

a half minutes and by the left in eight. Pyelography showed a normal pelvis on the right side, but definite filling defect on the left.

A diagnosis of hypernephroma was accordingly made and nephrectomy performed, all the perinephric fat removed, and the renal vessels ligatured as close to their origin as possible. This diagnosis was subsequently confirmed by microscopic section.

After an uneventful recovery the patient was seen at three-monthly intervals. She put on two stone in weight and apparently promised to do very well.

Fifteen months after the operation two small nodules were noticed about four inches above the lumbar incision. These were freely mobile in the subcutaneous tissues. A month later a nodule appeared over the lower part of the sternum and two others in the rectus sheath. One nodule was excised and microscopically examined. It had the typical structure of a hypernephroma. Deep x rays were applied to the nodules, but in spite of this the patient went downhill, losing weight and strength, and her end is rapidly approaching. The remains of the left kidney with the hypernephroma are shown in the accompanying illustration.

Comment.

This case clearly brings out several important points:

1. Painless haematuria is a symptom of the gravest import, and calls for urological investigation without delay, its commonest cause being either renal or vesical growth.
2. The amount and frequency of the haematuria may bear no relation to the extent of the disease. In this case it had only occurred twice and had lasted only forty-eight hours each time, yet at least three-quarters of the kidney was replaced by growth.
3. Had there not been a delay of nine months between the first bout of bleeding and an adequate examination, the patient might have been free from recurrence at the present date with a good prospect of a cure.

Memoranda:

MEDICAL, SURGICAL, OBSTETRICAL.

TWO UNUSUAL CASES OF INTUSSUSCEPTION.

INTUSSUSCEPTION DUE TO GUMMA.

An intussusception in a boy, due to a gumma, makes the following case worthy of record.

A healthy boy, aged 14, was admitted with a history of abdominal pain for two days prior to admission. During these two days he had two motions of the bowel, a very small quantity of faeces being passed on each occasion. He vomited for the first time three and a half hours before admission. The pain persisted, and he passed frequent motions consisting entirely of blood and mucus.

On admission he was obviously in great pain. Temperature 37° C., pulse 58. The abdomen was not rigid; there was a definite very tender mass in the lower segment of the abdomen. A rectal examination confirmed the presence of this tender mass. There was mucus and blood only on the examining finger, and the subsequent motions consisted of mucus and blood only. The tongue was dirty.

An acute intussusception was diagnosed, and laparotomy revealed an intussusception of the type ileo-ileal becoming ileo-colic. After reduction a mass could be felt through the intestinal wall, in that part of the ileum close to the ileo-caecal valve, the mass being part of the bowel wall. To prevent recurrence the terminal portion of the ileum together with the caecum was excised and end-to-end anastomosis performed. The boy made an uninterrupted recovery.

The tumour, on examination, proved to be a typical gumma. A Wassermann test was negative, both before and after a provocative dose of kharsulphan.

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INTUSSUSCEPTION OF THE APPENDIX.

A boy, aged 12, was admitted as a straightforward case of acute appendicitis of eighteen hours' duration. At operation the appendix was found to be acutely inflamed and the site of an intussusception, the tip having invaginated itself almost to the base of the appendix. Recovery was uneventful.

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Thanks are due to Dr. J. D'Ewart, medical superintendent, Booth Hall Hospital for Children, Manchester, and to Mr. E. E. Hughes, the visiting surgeon, for permission to publish these cases, and also to Dr. G. Dawson for the pathological investigation.

A SERIES OF GASTRIC PERFORATIONS.

In view of the fact that acute perforation of the stomach is not very common in malignant disease of that organ, and acute gastric perforation in a patient lying in bed and under medical treatment must be very rare, the following case may be of interest.

A man, aged 46, was admitted to the Royal Albert Hospital, Devonport, on March 5th, 1930, with all the signs and symptoms of acute gastric perforation. He was at work when the attack occurred, and there was a history of "indigestion" for fifteen years.

At operation a perforation about a quarter of an inch in diameter was found on the lesser curvature near the pylorus. This was closed with difficulty on account of the friability of the edges, and an omental graft was placed over the perforation. The remainder of the stomach and duodenum appeared normal. A drainage tube was inserted down to the pelvis through a separate stab wound, the main incision being completely closed. The operation only took thirteen minutes.

The patient appeared quite well the next day, and on the second day was sitting up in bed playing cards with some of the other patients. Forty-eight hours after operation fluid was given by the mouth, and the patient was put on citrated milk in gradually increasing doses up to 6 oz. every two hours, followed by 1 drachm pulv. alk. (McLean). He did perfectly well for ten days, when he suddenly collapsed; and had subnormal temperature, rapid pulse, etc. He complained of no pain, and nothing abnormal was found on examination. A haemorrhage was thought to be the cause, and the usual treatment adopted for this. Next day he passed some altered blood in stool. Recovery began, and went on perfectly well for a further ten days, when another collapse, similar to the previous one, occurred. Again the patient did not complain of anything but weakness, and nothing abnormal was