CASE REPORTS

PATIENT was a white male, 25 years of age, first admitted to hospital on April 18th, 1938. The chief of his many complaints were: pain in the chest and stomach, loss of weight, vomiting and headaches.

The family and personal histories disclosed the death of two paternal uncles from pulmonary tuberculosis and the patient's own stay in the Tuberculosis Hospital for three months in 1927.

His present illness dated back several months. In February, 1938, he began to have a pain along the right border of the sternum about the level of the 5th rib, this pain being aggravated by food. He also had epigastric pain after meals and vomiting, rather suggestive of a peptic ulcer. He complained, too, of a loss in weight of about 10 pounds since January, 1938; headaches for about a year following a blow on the head; a cough since April 11, 1938; coughing up of blood; night sweats; palpitation; constipation; loss of appetite and insomnia.

In the main, then, his symptoms pointed towards the respiratory and gastro-intestinal tracts. Physical examination of the chest disclosed only some impaired resonance and broncho-vesicular breathing at the apices; X-ray showed some old disease of both apices, and the sputum was negative for tubercle bacilli. Abdominal examination was negative except for a little tenderness on both sides above the umbilicus; gastric analysis was normal; X-ray of the gastro-intestinal tract by barium series revealed nothing, and the stools were negative for occult blood. In addition, X-ray of the skull showed no fracture or tumour; blood chemistry was normal; Kahn and Hinton tests were negative; blood picture was normal; eye grounds showed nothing of a pathological nature; and temperature and pulse were normal.

Patient was discharged and returned two months later, on June 17th, with the same complaints. Much of the previous investigation was repeated, the only change in the findings being the presence of an opacity at the base of the right lung, suggesting a localized atelectasis. Examinations of the naso-pharynx and sinuses, bronchoscopy and oesophagoscopy were done by the nose and throat specialists with negative findings.

He was discharged to return in two months but came back in less than four weeks. Now the pain was not only in the right chest but also in the hips and back and shooting down to the scrotum. A flat plate of the abdomen and X-rays of thoracic and lumbar spines were negative. A cystoscopic examination was negative and ureteropyelography showed only some blunting of the calices on both sides. Cystoscopic urine was negative except for numerous red blood cells from both sides. No tubercle bacilli

were found in the urine and the urinary output was normal. X-ray of the lungs showed a diminution of the opacity at the right base. He ran a mild irregular fever for a time. There was a leucocytosis of 13,450, a mild secondary anaemia and quite an apparent loss of weight since his previous admission.

Patient was sent out again but was back in about three weeks. There was now marked tenderness in the right loin with some sense of resistance on bimanual palpation. White blood cells were 15-16,000 and blood smear showed a polymorphonuclear leucocytosis with a slight shift to the left. X-ray of abdomen showed an apparent increase in the size of the right kidney. Gall bladder disease was ruled out by a Graham test. X-rays of the spine, pelvis and femurs were done, searching for secondaries from a possible primary malignancy somewhere in the vicinity of the site of the right-sided pain, but were negative. The possibility of a perinephric abscess seemed a logical one, but no pus was obtained on aspiration. However, on September 21st, 1938, the right loin was incised and the kidney exposed. It was found to be large, hard and nodular, apparently malignant, with infiltration of the renal pedicle. Nephrectomy was performed. Patient gradually declined, however, and expired on November 2nd, 1938.

Histologically, the tissue showed an embryonal adenocarcinoma with transition to sarcoma-like masses of spindle-shaped cells, some of which seemed to be forming glomerulus-like bodies—that is, a nephroblastoma, malignant embryonal carcinoma type, or Wilm's tumour.

Discussion.

There are several particularly noteworthy features regarding this case. The first is that there were practically no symptoms referable to the urinary system. The diagnostic triad of haematuria, pain and tumour was not characteristically present to suggest renal neoplasm. Ureteropyelography, often the most important diagnostic aid, did not help very much. The next point concerns the difficulty in differential diagnosis once the condition was apparently a renal one. There was more evidence here of infection than of neoplasm and this was apparently confirmed by negative pyelograms. Conversely, it may be noted, a perirenal abscess can give a pyelogram identical with that considered characteristic (No. "5") of a renal tumour such as hypernephroma. Finally, a combination of circumstances might presumably have left the case undiagnosed. The patient was of a non-cooperative nature—he did everything he was told not to do. His complaints were many and variable. He had a purpose in malingering since it was more comfortable in hospital than in jail. It might, therefore, have been very easy to tag him as a "neurasthenic" and discharge him for good had it not been for the presence of the definite abnormality at his right base (probably due to pressure), the marked tenderness in his right

loin and a progressive decline in his general condition noticeable on each admission.

R. L. AIKENS, '39.

INTESTINAL OBSTRUCTION

Mrs. C. O. Age 34.

Admitted to hospital complaining of convulsions, dizzy spells and unconsciousness in association with pregnancies.

Personal history, other than that associated with obstetrical history, was negative.

This woman had had nine children, the eldest being 15, the youngest 4 months. She had difficulty with all her pregnancies beginning with the first when she had dizzy spells, spots in front of her eyes, and oedema of the ankles. Just before the birth of her last child she had a recurrence of all symptoms and in addition, convulsions. She stated that one period of unconsciousness lasted three days.

Her heart was enlarged. There was a systolic murmur at the apex and blood pressure was 160/98. Oedema of the ankles was present.

In view of the hypertension, general evidence of cardio-vascular renal disease and her age, it was decided to do a vaginal hysterectomy.

Operation was uneventful; the vagina was packed after placing a drain in the pelvis. Packing was removed 12 hours later, the removal being followed by a slight haemorrhage.

The next day there was some slight bleeding P. V. On the third post-operative day the drain was removed.

During the next three days she complained of crampy abdominal pains but there was no elevation of temperature or pulse. The next day, the seventh, there was considerable bleeding P. V. accompanied by a foul discharge and her pulse jumped to 120. On examination a large haematoma was found in the vault of the vagina and lower part of the pelvis. This was evacuated. Her condition was good for two days until she suddenly developed severe abdominal pain and distension. The distended coils of small bowel could be felt through the very thin abdominal wall. It was probable that a loop of bowel had been caught in the pelvis and had become involved in the infected haematoma, thus causing the obstruction.

An ileostomy was performed at once and a continuous intravenous set up as well as a gastric lavage. The distension was relieved.

The next day she was given 70 c.c. of 20% saline intravenously with no apparent result.

The following day three ounces of liquid paraffin were given via the lavage tube and the tube removed. Her condition was good, pulse being 96. On the morning of the next day three ounces of liquid paraffin were given via the ileostomy tube followed by ½c.c. of pitressin. About fifteen minutes later the patient had a copious bowel movement. The paraffin was repeated the next day as was the pitressin which again was successful.

The intravenous was discontinued, the patient was put on a light diet and had daily nourishment without therapeutic aid.

Ten days following the ileostomy the ileostomy tube was removed. Five days later the patient was discharged.

This case is presented as a lesson in prompt and efficient treatment. Where an ileostomy is performed for intestinal obstruction, the mortality is high and the procedure should not be undertaken lightly.

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Solution to "A Puzzling Review of Medicine"

Down

1. Histamine
2. Eosins
3. Inanimate
4. X-ray
5. By
6. Islet
7. Sabina
13. Aroma
14. Inert
15. AE
22. Ear
24. Sanguine
25. Ash
28. Alexia
29. NE
32. Sat.
34. Dec.
35. Iron
36. Carus
37. MS
38. Utero
39. Lyssa
43. Zea
45. SA

Across

1. Helix
5. Biosis
8. IO
9. N-Rays
10. SS
11. AA
12. Labia
16. TI
17. Nycterine
18. Anti
19. Tone
20. MS
21. Mel
23. Mars
25. AAA
26. TA
27. Strain
30. HE
31. EK
32. SG
33. AV
34. Dick
37. Multi
40. Era
41. Sty
42. Coryza
44. Esse
46. NU
47. RSA
48. Swab
49. LOA

No correct solutions received. Sorry, no awards.