

## **On the so-called movable kidney disease / by Gustave Monod.**

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By  
GUSTAVE MONOD, M.D., M.R.C.P., Vichy.



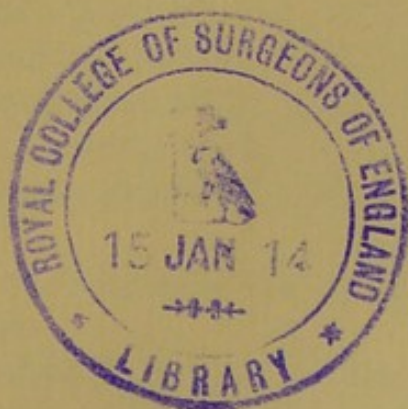
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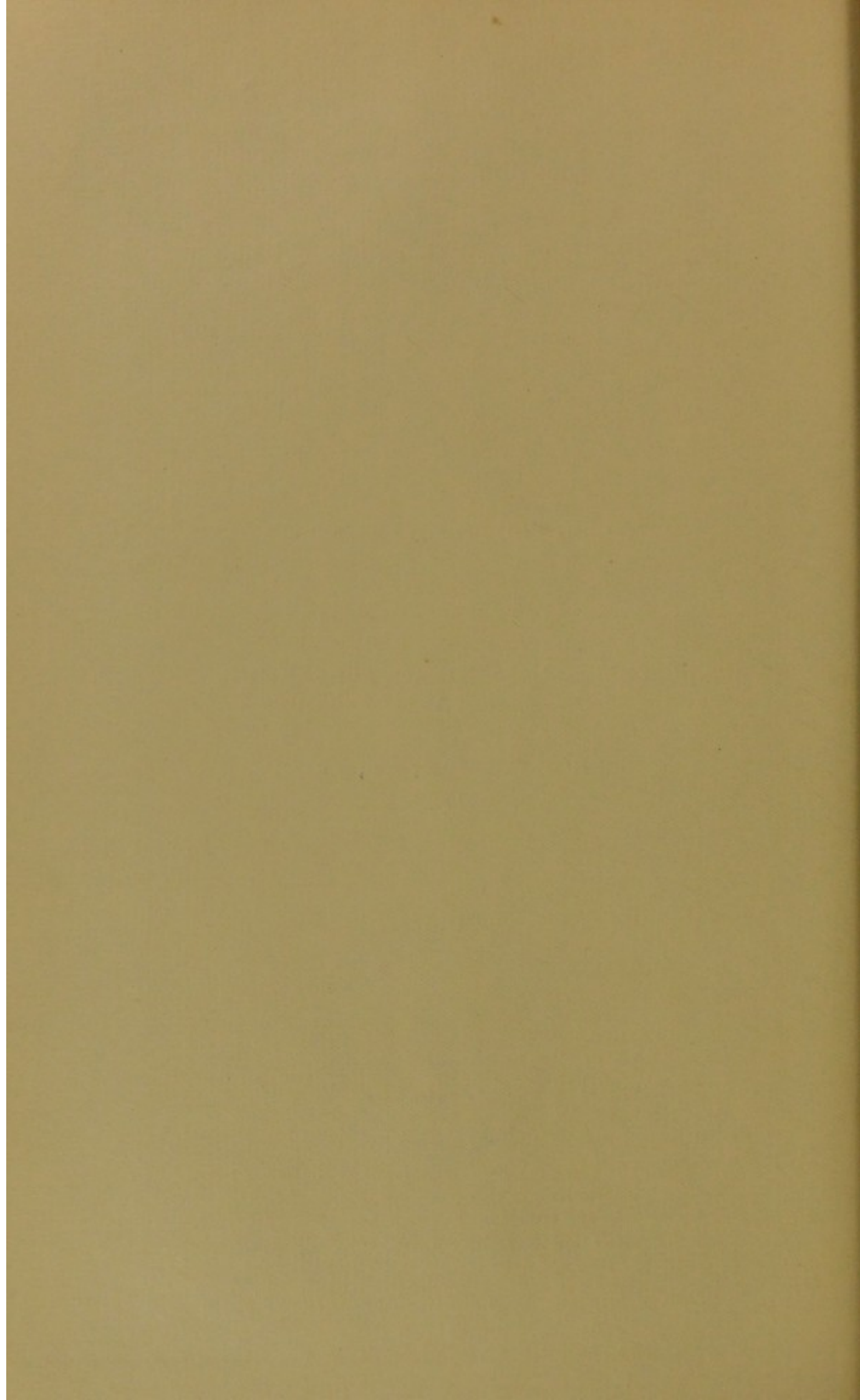
ON THE SO-CALLED MOVABLE KIDNEY  
DISEASE.

By GUSTAVE MONOD, M.D., M.R.C.P.

*Vichy.*



"THE PRACTITIONER," LIMITED,  
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## ON THE SO-CALLED MOVABLE KIDNEY DISEASE.

BY GUSTAVE MONOD, M.D., M.R.C.P.

*Vichy.*

WHEN reading the remarkable paper published by Dr. Philip Hicks (of Leamington) in *THE PRACTITIONER*,<sup>1</sup> I could not but feel astonished at a slight omission, though according full justice to his accurate method. I was surprised to see that the work of Dr. Glénard, the leading authority on the question, seemed to be ignored, quite *bonâ fide*. But my disappointment lessened when I found that clinical observations alone had led to conclusions closely akin to those of my master. There is no doubt that two investigators, having equal capacity for observation, and the same scientific accuracy, will arrive, in time, at the same conclusions. As regards the ætiology and pathology of movable kidney, the question is not one of purely academic interest. Therapeutics are thereby directly served. As is clearly pointed out in the article in *THE PRACTITIONER*, the fate of a patient may depend upon the accuracy of his physician's views ; and at the present time many invalids are living a miserable life, who, if properly treated, might be doing well.

Before proceeding any further, I wish to thank Dr. Glénard for kindly taking a practical interest in this paper. Nobody has a more complete knowledge of the subject than he ; during a life wholly devoted to clinical studies, he has collected more than 20,000 observations concerning patients suffering from nutrition defects.

*The modern school of Vichy holds that movable kidney is not a disease, but a symptom.*

Let me sum up, in chronological order, the successive steps that have led us to this conclusion. It is worthy of remark that, amongst dyspeptic patients, a few who do not present

<sup>1</sup> *THE PRACTITIONER*, March, 1912.

any particular symptoms, derive no benefit whatever when treated by the ordinary methods. Careful examination of these cases enables us to distinguish the following characteristics:—

Various perceptions, difficult to describe, ill-defined, but invariably referred to the mesogastric region: a constant ratio appears between these perceptions and the meal hours: they are increased by the ingestion of fatty substances, of feculents, of uncooked fruits or vegetables, of milk or of wine. These patients also suffer from weakness, from insomnia and from constipation, which no tonics, sedatives, or laxatives can relieve.

We are then induced to examine the abdominal region, using the method invented by Glénard, and described by him in his treatise on ptosis. We shall follow the path, which led him to the discovery of enteroptosis.

The abdomen of these patients is usually flabby. Along the median line in the epigastric region one can feel the pulsation of the aorta; and sometimes, lying transversely in front of the artery, the "*procédé de glissement*" will reveal a stretched cord, which is nothing else than the stenosed transverse colon. On the right side, deeper examination will detect the distended and roll-shaped cæcum, which may be traced with unusual facility.

The next step is to ascertain whether any obstacle (obstruction) exists between these two segments, viz.:—stenosed transverse colon and distended cæcum. With the fingers of our left hand lifting up the lumbar region, whilst the left thumb runs along the front of the same region, the physician may feel, whilst the patient inspires deeply, a lump moving downwards; this is not, as might be expected, the hepatic flexure of the colon, it is the right kidney.

Let us here remark that Glénard's original observations were made in 1885; that the admitted percentage of movable kidneys did not exceed 1 per cent. according to classical treatises: that Trousseau throughout his long career recorded altogether 12 cases only: and that suddenly the admitted percentage rises to 14 per cent. in diseases of nutrition. In 1893, statistics show that out of 4,215 patients examined in a thermal hospital where movable kidney had never previously

been recorded, no fewer than 537 presented that symptom ; a figure which by itself is equal to the total number of cases recorded in scientific writings between Raye's first observations in 1839 and 1885, when Glenard started upon his investigation.

Naturally enough, as soon as the kidney was found to be movable, the idea of fixing it with a belt followed ; and therapeutic success proved the soundness of what seemed to be a correct theory. The weakness that patients complained of and all the other minor symptoms were relieved, and their general condition was markedly improved as soon as the abdomen was firmly supported.

Those who have read Dr. Hicks's paper may observe that up to this point both he and the French clinician, having followed the same track, arrived at the same conclusion. Symptoms on the one hand, therapeutics on the other, seem at this point of our investigation to establish the nosological entity of movable kidney. But let us now carry our analysis further. We notice that in order to ensure the best results, it is essential that the belt must actually support the whole abdomen : and very quickly we are compelled to remark firstly, that amongst the patients who are marvellously relieved by their belts, there are several whose kidneys are *not* movable : and secondly, that in the instance of those who do present a movable kidney, it is by no means fixed by a belt ; and this in spite of the fact that their symptoms have been relieved. Therefore we may assert that it is not because we have fixed the kidney that the belt relieves the patient, but because the belt effectively supports the abdominal contents, preventing intestinal prolapse.

It is upon this evidence that the doctrine of enteroptosis has been built. It seems probable that incompetence of the intestinal wall leads to the lowering of the intra-intestinal tension, and to the visceral prolapse. The prolapse begins with the intestines : then follow in the order of their descent the right kidney, stomach, left kidney, liver and spleen ; for these organs are interdependent both as regards their suspension in the abdomen, and as regards their functions, circulation and innervation. Intestinal prolapse, which is pathogenic, is rarely primary, but is secondary to causes which are either infective or toxic ; and the malady of which movable

kidney is nothing more than a frequent symptom is *Enteroptosis*. I wish to point out that British treatises label as enteroptosis (or as Glénard's disease) only cases of dislocation of all the abdominal organs: this is according to Glénard's teaching the last and most severe phase of the disease, and is a very rare occurrence. The common form is marked by one or two symptoms only *e.g.* colloptosis and nephroptosis. Exactly in the same way "floating kidney" has for long been the only recognized form of movable kidney.

Modern research, especially radiography, has confirmed in the most decisive way the results obtained by clinical observation, and has thrown light upon the mode of action of the belt. I have myself more than once been able to verify on the screen that the sudden relief, experienced by a patient when I supported her abdomen with my hand, corresponded with the instant when I raised the fundus of the stomach. Reversing the test, as soon as I allowed the stomach to drop, the patient experienced a sudden pain (sometimes sharp enough to induce syncopal symptoms); and this pain, though exaggerated, was of exactly the same character as the spontaneous abdominal pain that had induced the patient to consult me. This sign, on which I lay great stress, corresponds to "*la douleur-signal*" of Leven, and proves the state of hyperæsthesia of the solar plexus. In the vicious circle that leads from enteroptosis to nervous trouble and from nervous trouble to enteroptosis, we believe that the nervous trouble is secondary.

Now that by an analytical method we have tried to demonstrate the principal symptoms of enteroptosis, let us by synthesis, reconstruct that nosological entity.

Enteroptosis is a malady of nutrition.<sup>1</sup> The subjective symptoms of enteroptosis are general weakness, intestinal troubles, and disturbance of sleep, all of which are periodic in appearance, closely following the periodicity of meals; these symptoms are aggravated by the ingestion of acids, of fats, and more particularly of milk. The most conspicuous

<sup>1</sup> I may, perhaps, mention that Glénard classes this malady in the large family of Hepatism. The Galenic teaching is thereby modernized. This view is supported by the fact that ætiology, symptomatology and treatment of enteroptosis on the one hand, and of inadequacy of the bile function on the other, authorize by their similarity this doctrinal theory.

objective symptoms are a delimitable and palpable cæcum (an early sign of enteroptosis), the great relief that occurs when the abdomen is mechanically supported (*épreuve de la sangle*), and perhaps, and very often, a movable kidney. But this movable kidney is nothing more than an epiphenomenon. We are still waiting for a single case in which the movable kidney syndrome can be demonstrated to be due to movable kidney alone. On the other hand we are prepared to show scores of cases in which we can demonstrate that movable kidney is not the cause of the symptoms observed; and these are the cases in which all troubles disappear, and the kidney remains unfixed. In the latter cases, careful investigation will always find some other cause which accounts for the troubles; most often gastro-intestinal atony, frequently more or less marked visceroptosis, sometimes unsuspected biliary lithiasis.

The surgical treatment of movable kidney is once for all condemned. It is based upon an error in pathology. This opinion has so much prevailed, at any rate in France, that I have not met one single instance where an operation was advisable, though there has been a period when it was taught that movable kidney was an indication for nephrectomy. Such an operation "is like amputating a leg to cure sciatica," used to say Loudon; or, may I suggest, is like operating on a syphilitic strabismus. Nevertheless, nephropexy has been advocated strongly by Suckling, but his reports do not often mention the *ultimate* results; and I believe that rest and suggestion account for amelioration rather than his adventurous stitching.

The treatment of nephroptosis (a far better name than movable kidney, because it is ætiological, and not merely symptomatic) is the treatment of enteroptosis.

- (1) *A belt.* Any model, any shape, any material, with or without pads, as long as it effectually supports the abdominal region. I prefer a large firm belt encircling both hips, with a pneumatic pad. Experience has taught me that the pad should not be fixed upon the belt, for it must be allowed to follow the fundus of the stomach as it gradually, and day by day, retracts upwards.

- (2) Free action of the bowels must be obtained, preferably by means of salines, because of their action as cholagogues.
- (3) The diet, paradoxical as it may seem, must be principally of meat (for the reduced intestine of enteroptosis resembles the gut of the carnivora).
- (4) Sodium bicarbonate, which we prescribe as Vichy water. (Grand Grille, half a tumbler every morning, heated to 104°).

Many of these patients do very well at Spas, such as Leamington, Harrogate, and Cheltenham, in England; and in France at Vichy, where the pure bicarbonated waters seem to have a specific action upon the hepatic cells.

But do not touch the kidney. In my practice, I do not even mention its condition to a patient, who is ignorant of it. The word hypochondria is a well-made one. How many times has hypochondria been manufactured by the doctor himself?

In cases of therapeutic failure, the cause of the failure must be looked for in the kidney itself, which may be affected independently of nephroptosis. Movable kidney is, by inference, a sound kidney; if it is diseased, we call it by the name of the disease; and hold the mobility to be quite a secondary symptom. Or else, if it is a case of enteroptosis that does not yield to treatment, then it is a case of complicated enteroptosis (and the complication has nothing to do with the mobility of the kidney).

Compelled as I have been to be dogmatical, I feel sorry that I cannot strengthen my argument with clinical observations; for those I must refer my readers to Glénard's records. I have given here, on this important question, my present convictions; and I ask for nothing more, but for nothing less, than consideration.

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