A case of renal abscess treated by free incision / by Theodore A. M'Graw.

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—OF—

RENAL ABSCESS

—TREATED—

BY FREE INCISION.

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Renal Abscess Treated by Free Incision.

ABSCESSES of the kidney and its neighborhood, although not altogether uncommon have as yet rarely been made the objects of surgical procedure. In most cases the diagnosis has been unsatisfactory. Either the pus has discharged freely through the ureters and all tumefaction of the lumbar region has been wanting, or the tumor has been mistaken for a cyst or malignant growth, or the case has been diagnosed as one of spinal caries, or the local trouble has been altogether overlooked and the constitutional disturbance been referred to some vague general disease. Even when surgeons have been confident of the presence of pus, they have hesitated to expose an enormous cavity to the air with the manifold experiences of the evils which have followed such action in similar cases of deep-seated abscess.

The case I am about to relate is of interest on account of the well defined symptoms, which permitted of easy diagnosis and successful treatment. Mrs. F., aged 37 years, the mother of three children, consulted me last July on account of a fluctuating tumor

on the right side of the body, which extended from the spine nearly to the navel, and from the ribs to the ilium. It had been first noticed in the lumbar region two years before, had had no apparent cause and had gradually increased in size. It caused paroxysms of pain of a dull aching, but never colicy character, which extended from the kidney to the urethra. She suffered greatly from an irritable bladder and the evacuation of urine caused often severe burning pain. For six months she had passed large quantities of pus with her urine. It was neither tenacious nor stringy, and under the microscope appeared unmixed with crystals, casts, or other foreign substances. Her general health had finally failed, and she had become incapacitated for her household duties.

The tumor could not be detected by the finger in the vagina, nor did vaginal examination reveal any abnormality of any pelvic organ. Her bowels moved daily and her menstrual function was regularly performed. I diagnosticated a renal abscess, and sought to confirm my opinion by the aspirator. This I attempted on the 19th of July by passing a needle into the tumor at the edge of the quadratus lumborum muscle. I succeeded in getting a tablespoonful of fœtid pus, and then, with my usual experience whenever matter has been cheesy or stringy, the instrument became clogged and refused to do its duty. The little operation was fol-

lowed by unexpected symptoms of pain and tenderness of the bowels, which did not subside for nearly a week. I then advised an operation for radical cure, but was obliged to wait until the advent of cooler weather in September before she would consent to its performance.

On the 23d of that month, assisted by Drs. Noyes, Cleland, Inglis, Farrand, Chapoton, Hawes, Jackson and others, I proceeded to operate. During the operation and for weeks afterwards, in dressing the wound, I used Lyster's antiseptic method with scrupulous care. The patient was anæsthetized and turned upon her left side and face. An incision was then made on the line which separates the external oblique from the muscles of the back—the fascia transversalis having been divided, the cyst, tense with its contained fluid, bulged into the cut. As soon as a trocar was thrust into it the pus gushed through and alongside of it, in a great volume of liquid, over the table and floor as well as into the basin which was held to receive it. The opening of the trocar was then enlarged by the knife and the cavity of the sac explored. It was at once evident that it was the kidney itself, presenting the same appearance which is familiar to every student of morbid anatomy who has made post-mortem examinations of suppurating kidneys, of a sac partly divided by partitions into connecting chambers. The wall

of the cyst was closely adherent to the surrounding structures, and I therefore abandoned my original intention of extirpating the diseased organ and contented myself with the insertion of a rubber drainage tube and thorough antiseptic dressing. The wound was dressed without changing the patient's position on the table, and she was then put to bed. She did well from the beginning, and I may say here that there was at no time any bad odor from the wound and that her temperature never rose above 100° F. The discharge being, however, very profuse. I was obliged for a time to dress the wound daily.

On the very first dressing, I was chagrined to find that there was still á fluctuating mass on the inner side of the kidney sac. Before the operation the fluctuation had seemed to be uniform from one end of the tumor to the other. The discharge of pus had been so profuse that I had supposed it to flow from the whole tumor, and although I pressed my hand upon the abdomen, the position of the patient had permitted the remaining peri-nephritic sac to escape observation. As it was, I felt obliged, at the end of a week, in which this newly discovered tumefaction had not diminished at all in size, to make a passage into it, rupturing the inner kidney wall with a sound. I had then the gratification of seeing the swelling disappear as pus flowed profusely through the

wound. The patient steadily improved in health, and now, eight months after the operation, though not well, is in comparatively good condition. The sinus still discharges slightly and admits a probe to the depth of six inches. A tumefaction can still be felt in the abdomen, but only on deep pressure, and it no longer fluctuates, being evidently formed by the remains of the abscess wall. Occasionally the bladder shows a slight degree of irritability, and pus makes its appearance in the urine.

There could hardly have been a more unfavorable case for operative interference by the old methods than this, an immense abscess of the kidney, complicated by a secondary abscess in the adjacent cellular tissue. The free exposure of such a sac to the air, without anti-septic precautions, would almost inevitably have produced the most alarming constitutional disturbance. It is in these cases that Lyster's method is invaluable. Under the anti-septic spray and carbolized dressings the surgeon need never hesitate to cut boldly into any abscess whatever whose anatomical position renders it accessible to the knife. However large the sac, or extensive the sinuses, he may expect nothing but favorable results, as far at least as concerns the perfect sweetness of the wound and its secretions. Neither pyemia nor any other form of septic poisoning can possibly occur when the dressings are applied with that

scrupulous exactness which alone deserves success.

I may say that the anti-septic method has revolutionized the treatment of all deep-seated abscesses, from whatever cause they may have originated. We need no longer counsel students to beware of opening lumbar or psoas abscesses, but must insist upon their early evacuation, reserving our cautions for the methods of procedure, especially emphasizing the fact that success depends upon earnest attention to matters of detail, both in the operation and the subsequent treatment of the wound.