Clinical and other Notes.

TWO CASES OF PERINEPHRIC ABSCESS.

By MAJOR N. CANTLIE, M.C.,
Royal Army Medical Corps.

The condition of perinephric abscess is often difficult to diagnose, and the following short account of two such cases may be of interest:—

(1) Private, aged 22. The patient was admitted to another hospital with fever of an irregular type. The usual blood tests were negative. On the fifth day he complained of pain in the left groin, which was generally persistent during the illness. The left hip-joint was held in a position of flexion to ease the pain in the groin. Emaciation was rapid, and by the twenty-second day of illness he had lost fifteen pounds in weight. Total white blood-cells on the fifteenth day was 9,600 per cubic millimetre. He was transferred to my care on twenty-third day with a diagnosis of tuberculosis of the left hip-joint. On admission the most noticeable feature was the deformity of the left thigh, which was flexed almost to a right angle. Extension of the hip-joint caused pain, while the movements of adduction, abduction and rotation were free and painless, which made the diagnosis of tuberculosis unlikely. On standing, there was a marked degree of lumbar scoliosis with concavity to the left. A radiogram of the hip-joints and lumbar vertebrae failed to show any evidence of bone disease.

On the thirty-seventh day tenderness was complained of on deep pressure in the left lumbar region. The total white blood-count was 10,000, with 69 per cent polymorphs. There were no urinary symptoms. I made a note on that day, "The pain over the left lumbar region would indicate a kidney or perinephric affection, but the blood-count does not appear to indicate any severe degree of sepsis." A general anaesthetic was given to investigate the condition of the hip-joint, and the leg was straightened with comparative ease after breaking down a few periarticular adhesions. A Thomas's splint was then applied. The temperature now became markedly remittent, and the pulse-rate averaged 115.

On the fifty-third day of illness there appeared slight oedema on palpation below the twelfth rib on the left side.

Operation was carried out on the next day, a posterior kidney incision being employed, and above the kidney a perinephric abscess having several pockets of thick greyish grumous pus was opened. A culture showed the presence of B. coli. Improvement followed for a few days, after which the temperature again became remittent, due evidently to a further hidden source of sepsis. The kidney had appeared normal at operation, and investigation on the occasion showed no extension of suppuration behind
the organ or any track along the ureter. On the seventy-fourth day a fresh radiogram of the hip-joint was taken which showed the presence of an acute arthritis, loss of joint space, destruction of joint surfaces and a commencing ankylosis. The patient’s condition was now very poor with emaciation, hectic fever and rapid pulse. A blood-transfusion was accordingly given as a preliminary to operation. At the operation on the following day, the hip-joint was explored by an anterior incision, but on exposure the bones, as far as they could be inspected, were normal, and the joint was free from pus. The wound was accordingly closed without drainage. Following this second operation, the temperature became normal on the seventh day. An autogenous vaccine was prepared and administered. Progress was slowly maintained after this, and the patient was finally invalidated with a firm osseous ankylosis of the hip-joint, walking with an elevated sole on the left boot. Scoliosis was still present.

The sequence of events in this case appears to have been: (1) Hematogenous infection of the perinephric tissues; (2) irritation of the ilio-psoas muscle causing a flexion deformity of the thigh; (3) postural scoliosis; (4) perinephric abscess; (5) direct extension of infection along the ilio-psoas sheath causing an acute arthritis of the hip-joint. The sheath of the ilio-psoas was not explored at the operation or direct evidence of this might have been found.

The good result following the second operation on the hip-joint is of interest. One cannot imagine that the actual operation proved of benefit as no pus was found and the joint was immediately closed. I believe that recovery was due to the blood-transfusion given the day previous to the operation, the introduction of fresh blood stimulating the resisting powers of the patient sufficiently to combat the infection.

(2) Signaller D., aged 20. This patient was admitted to another hospital in the district with fever, which quickly took on a remittent character. Pain in the lumbar region and a rising leucocytosis were also noted. The usual tests for malaria and enteric group were negative. The urine was normal throughout. The pulse-rate gradually rose and loss of weight was noted. The patient was diagnosed clinically enteric group. On the seventh day of disease the total white blood-count was 18,750, on the twenty-fourth day 24,375, and on the forty-first 31,875.

On admission to my care, on the forty-seventh day, the patient was emaciated and ill. Examination revealed pain and stiffness on movement of the right hip-joint, together with pain in the right loin on palpation and above Poupart’s ligament. There was no oedema present in the loin. Radiograms of the hip-joint, pelvis and vertebrae were normal. The total white blood-count two days after admission was 14,400. With the previous case in mind one did not hesitate to diagnose a perinephritis, and an operation revealed a large abscess, which was drained. A culture from the pus showed that Staphylococcus aureus was the causative organism. A normal recovery followed the operation, the patient putting on ten...
pounds in weight during a period of seven days. He was discharged to duty after an illness lasting sixty-two days.

Choyce's Surgery, referring to the diagnosis of perinephritic abscess, states, "The condition may be mistaken for typhoid fever in the early state, and for hip-joint disease or pyonephrosis at a later period." It is of interest to note that the two cases treated fit this description very well, as tuberculosis of the hip and clinically enteric group were the primary diagnoses in these cases respectively.

Another contrasting feature was the absence of leucocytosis in the first case and the high leucocyte count in the second. Was this perhaps due to the fact that B. coli was the causative organism in the former and Staph. aureus in the latter?

A CASE OF LOOSE BODY IN THE KNEE-JOINT.

By MAJOR C. B. C. ANDERSON.

Royal Army Medical Corps.

Articular loose bodies are fairly frequently met with in the surgical practice of the Services. The fact that they are usually found in young adults, with a definite history of injury to the joint involved, supports the view that the majority of single loose bodies in these cases can primarily be accounted for by fracture of the articular cartilage and subjacent cancellous bone, rather than to the condition known as osteo-chondritis dissecans.

The case described here is remarkable, not for any unusual aspects as regards history, symptoms or treatment, but on account of the dimensions of the actual loose body itself.

Gunner W., aged 21. Service three years. Reported sick with constant pain and disability in the right knee. The origin of the trouble was put down to a severe "sprain" of the right knee sustained during a game of football. He stated that he had experienced a severe sudden pain on the inner side of the knee which had temporarily disabled him, but that he had managed to finish the game, although with difficulty. His knee thereafter became swollen and painful, but he did not "go sick," and he continued to carry out his duties. The swelling and pain on the inner side of the knee had persisted, and at times he had experienced a "click" in the joint.

About four months after the original injury he was detained in hospital for X-ray investigations, etc., as there was fluid in the joint. Apparently nothing serious was found on this occasion, as he was returned to duty after a course of massage.

The day before he was referred to me for examination he had been playing football, and had "felt something go" on the inner side of the right knee. He was unable to finish the game on account of the acute pain. There was no evidence of "locking" of the joint.