

CASE 1. Nephrectomy for painful movable kidney. An unsuccessful nephrorrhaphy had been done two and a half years previously. The patient had been bedridden four years. A lumbar nephrectomy was done, the patient recovering and obtaining entire relief from pain. The author deplores the necessity of removing a healthy kidney only because movable and painful. He thinks that the success of recent methods for anchoring the kidney will obviate the necessity of such a procedure.

CASE 2. Nephrectomy for persistent hydronephrosis due to stricture of the ureter at its pelvic extremity. The tumor was mistaken for an ovarian one. It was removed by a median abdominal incision.

CASE 3. Sarcoma of the kidney in a child two years old. Nephrectomy and recovery. The tumor had been discovered only four weeks previously. A median incision (abdominal) was employed.

The writer has collected the histories of twenty cases of sarcoma of the kidney operated upon since 1885, in children under five and a half years of age. Of these, five perished and fifteen survived the operation, thus showing a mortality of twenty-five per cent. This is a surprising decrease in mortality, and is probably due to improved details in technique rather than to radical changes in the method of operation.

CASE 4. Nephrectomy for uretero-vaginal fistula following vaginal extirpation of a cancerous uterus. The operation was done four weeks after the hysterectomy. The ureter was torn across in enucleating a nodule of cancerous tissue from the folds of the broad ligament on removal of the uterus. Nephrectomy was done four weeks subsequently because of intermittent closure of the fistula and the morbid mental condition of the patient. The cancer had recurred in seven weeks, and patient died three months later of exhaustion and septicæmia.

Dr. Rosenwasser spoke of the differential diagnosis of these cases. Little dependence could be put upon the patient's statement that the tumor grew upward or downward. Patients never knew. Retro-peritoneal tumors tended to crowd the large intestine inward toward the median line; hence one could get a tympanitic sound over that region. Again, it was more or less fixed. This fixity was a feature of the ligamentous cyst, but it dipped down into the vagina, and could thus be diagnosed differentially.

Dr. Davis did not believe it was good surgery to operate on these sarcomatous kidneys where recurrence was certain and fatal. He gave the history of an ectopic gestation which he had thought was a cyst of the kidney, showing how difficult the diagnosis sometimes was.

Dr. Cordier spoke of the value of ureteral cauterization in establishing a diagnosis. He said we could look forward to the time when resection would be done for stricture of the ureter.