A RIGHT PELVIC KIDNEY. ABSENCE OF THE LEFT KIDNEY; ABSENCE OF THE UTERUS; BOTH OVARIES IN THE INGUINAL CANALS

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C. H. I., 1677. O. C. J., aged 17, single, white; admitted to the Church Home and Infirmary, March 5, 1907. The patient has been under the care of Dr. Paul Jones of Snow Hill for some time. She had been thought to have an imperforate hymen and a double inguinal hernia. She had always been somewhat delicate and nervous.

Five years before a left inguinal hernia had been noted, which annoyed the patient considerably. Three years later a hernia made its appearance on the right side. The hernial protrusion on the right was larger in dimension than that on the left, at times reaching 9 to 10 cm. in diameter. On one occasion it had become temporarily incarcerated, and she had been wearing a truss on the right side. The patient had never menstruated, but nearly every month she had had hot flushes and had been very dizzy. The flushes would persist for two or three days at a time. She had no definite headache, but her head had felt "big and queer." There had never been any vomiting, but nausea had been noted at these times and a burning sensation in the region of the stomach. The patient entered the hospital seeking relief for her inability to menstruate. The menstrual symptoms had commenced three and half years before. The urine was found to be normal.

Examination under anæsthesia. The breasts were not well developed for a girl of her age. The pubic hair was normal. On pelvic examination a small urethral orifice was found. This readily admitted the catheter and the bladder was at once emptied. There was absolutely no evidence of a vagina apart from a slight depression 1 mm. in depth (Fig. 1). On rectal examination we found a large oval mass which appeared to be slightly cystic. This filled the right side of the pelvis and was thought to be either the enlarged uterus or a dilated vagina.

Operation. I passed four guy sutures at the poin where the vagina would naturally have been and then made a transverse incision 1.5 cm. anterior to the rectum. In my dissection I kept close to the rectum one finger in the bowel serving as a guide and a pair of forceps introduced into the bladder serving to outline this organ when necessary. Finally I was able to separate the bladder from the rectum for a distance of five inches, although the septum between the bladder and rectum was not over 2 to 3 mm. in thickness. I then encountered the firm mass which had been detected in the right side of the pelvis. On making firm pressure from above the mass could be felt directly under the finger introduced into the wound. We expected to find fluid but the growth seemed to be solid or semi-fluctuant. We at once realized that an unusual condition existed and an abdominal section was decided upon as the wiser procedure.

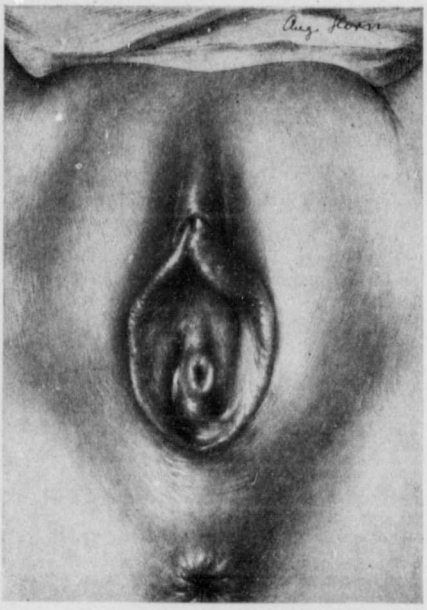

Fig. 1. Absence of the vagina. The urethral orifice is normal. Beneath it is a small pit, the only remnant of the vagina.

On making an abdominal incision we first encountered the fimbriated end of the right tube (Fig. 2). This could be seen and followed for 1.5 cm. The remaining portion lay in the hernial sac on the right side. After slitting the sac slightly and examining the extraperitoneal portion I was able to detect the remaining portion of the tube. In the inguinal sac lay also the right ovary, which was perfectly normal. The ovarian vessels came from the usual source. The utero-ovarian vessels passed down into the right inguinal canal as did the tube. The right round ligament emerged from the canal, formed a loop on itself and re-entered the canal.

[1] Read before the American Gynecological Society, Washington, D. C., May 3, 1910.

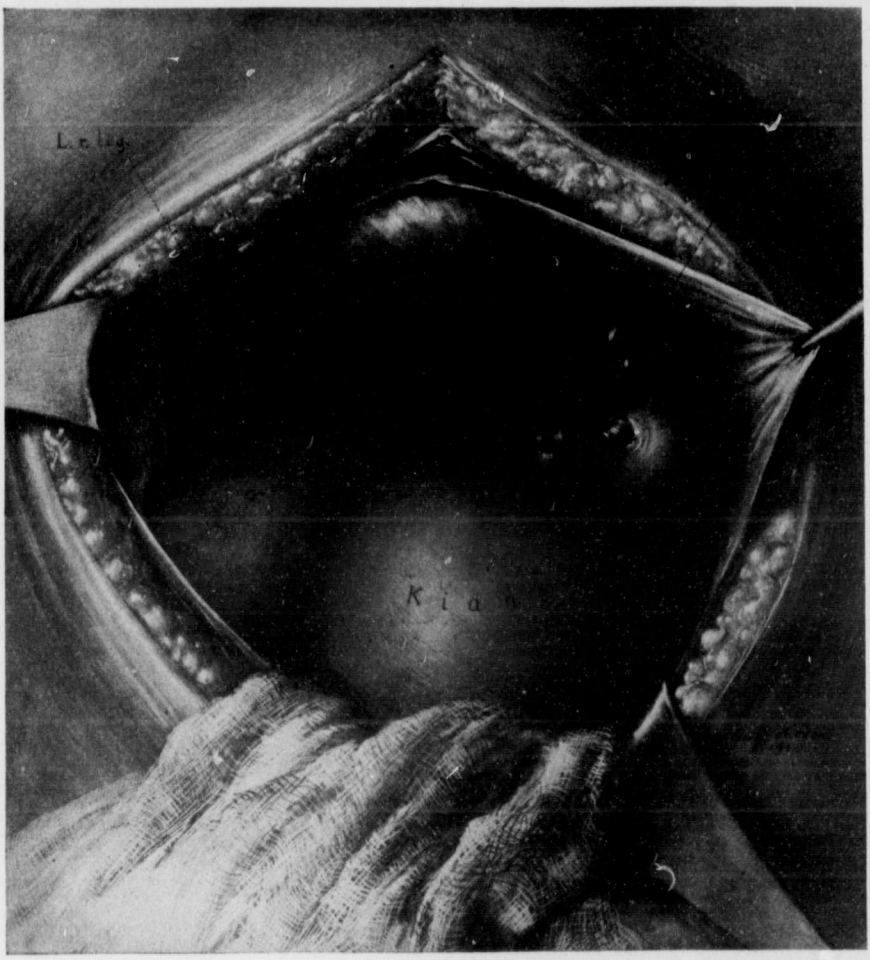

Fig. 2. A right pelvic kidney. The kidney is seen from above through the abdominal incision. It fills the right half of the pelvis and extends to the pelvic brim. On the left side the kidney is wanting. There is no uterus. A portion of the right tube is seen emerging from the inguinal ring. The bulging at the inguinal ring is made by the ovary and the remaining portion of the tube both of which are extraperitoneal. The right round ligament emerges from the inguinal canal, forms a loop on itself and then again disappears. The left round ligament is recognized as a little bud. The left tube and ovary were in the inguinal canal.

The firm mass felt in the vagina and thought to be due to an accumulation of retained menstrual flow proved to be solid. It felt like a kidney, the hilus being easily demonstrable on the inner side. It was about half as large again as a normal kidney and lay extraperitoneally. It almost completely filled the right half of the pelvis. I examined the usual site of the right kidney and found no kidney in this position.

There was no trace whatever of the uterus. The bladder and rectum were the only organs in the pelvis except the kidney.

The left round ligament could be seen peeping out of the inguinal canal for about 5 mm. It could be pulled out much farther. It formed a loop on itself and then disappeared into the inguinal canal. In other words both ends of the round ligament were in the canal.

The left side of the pelvis was perfectly smooth, there being no left tube or ovary visible. The mass in the left inguinal canal was, however, apparently the left ovary.

The left kidney was absent.

We at once closed the abdomen and then brought the tissue between the rectum and the bladder together as far as possible and left in a small drain. The patient did not stand the anæsthetic well and was exceedingly blue. Her pulse when she left the table was 160, but full. She rapidly recovered from the effects of the operation, and was discharged in practically the same condition as that in which she entered the hospital.

A case of this character was operated upon by Dr. Polk of New York in 1882. The mass in the pelvis was removed and it proved to be a right pelvic kidney. The patient lived thirteen days and at autopsy Dr. Wm. H. Welch found that this was the only kidney.

We are deeply indebted to Dr. Polk for having reported this case in full and for his timely warning that in all cases in which a pelvic kidney is found careful examination should be made to determine whether the operator is dealing with a case of unilateral kidney.

The advisability of making an artificial vagina has to be considered in these cases. The ingenious operation suggested by Baldwin in which a loop of small gut is disassociated and brought down to form the lining of the new vagina may be tried. This procedure is clearly outlined in The Journal of the American Medical Association, April 23, 1910, page 1362. The operation as carried out by Alex. Hugh Ferguson appeals more strongly to me as it is naturally less dangerous. It consists of separating the bladder from the rectum. A U-shaped flap is then taken from the skin between the urethra and the rectum and attached to the bladder which has been well pulled down. When the traction on the bladder is released the bladder retracts and carries the flap well up into the newly formed cavity. The posterior wall is now made by using two flaps consisting of the labia. The rectum is pulled well down and the flaps are attached to it. When the rectum is allowed to recede the flaps are carried far up into the cavity. A plug covered with rubber is now tightly packed into the vagina. Ferguson reports excellent results in three cases in which he has employed this method.