Unilateral Renal Haematuria

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Several cases of unilateral renal haematuria have come under my care which are of sufficient interest to warrant publication from several points in their histories and treatment.

(1) R. was a married man of about forty with an uneventful medical history. About eight months ago he came to the genito-urinary clinique with a complaint of blood in the urine. Examination of the urine showed blood alone as an abnormal constituent of the urine. There were no casts, pus, or organisms.

Cystoscopic examination showed bloody urine spurting from the right ureter. The jet from the left ureter was apparently normal. The right ureteral orifice seemed slightly congested, the left normal. The pulse and temperature were normal. The bodily examination showed an easily palpable, movable right kidney, slightly enlarged, but painless and insensible, otherwise the examination was negative. He was advised to undergo further examination, as the possibility was renal tumour, and an operation advisable. But he promptly disappeared from my ken, and I did not see him again for many months. Subsequently he was referred back to me by Dr. Whetter, as the haematuria had continued unabated, and latterly had been accompanied by renal colic on the right side.

His condition was unchanged except that he was thinner and felt poorly, and the examination again revealed only the blood in the urine and the palpable right kidney.

I cystoscoped him again and catheterised the left ureter. The right ureter was spurting blood and was slightly congested. The urine from the left kidney was quite normal. X-ray photographs were negative.

My provisional diagnosis was malignant disease of the right kidney, tuberculosis and calculi being negatived by the absence of pus and organisms and the X-ray photographs.

On 21st March, 1918, I explored the right kidney, which, except for the thickening of the capsule which so commonly accompanies movable kidney, appeared normal. I explored the kidney substance completely by incision and found nothing. I therefore closed the kidney and fixed it posteriorly by Thompson Walker's method.

His convalescence was normal. The renal colic, which I put down to the passage of clots, disappeared, and the urine became completely bloodless by the end of a week. He left the hospital in three weeks, and has remained since quite well.

(2) M.J.W., aet. 54, strained his back a year ago, and was off work for some weeks in consequence. A few weeks later he noticed blood in the urine, and this had been present ever since. He had no pain, but lost weight and felt weak.

Examination, apart from the facts of obvious anaemia, an insensitive palpable right kidney, and blood in the urine, disclosed nothing. The urine contained blood, transitional cells, and scanty polymorphs—no tubercle bacilli or other organisms.

Cystoscopy revealed blood spurting from the right ureter, and none from the left. Ureteral catheterisation yielded "profuse blood-transitional cells, scanty polymorphs, no tubercle bacilli" from the right ureter, and "scanty blood (probably due to the slight traumatism of catheterisation), scanty polymorphs, transitional cells, no tubercle bacilli" from the left ureter.

On 24th February, 1919, I explored the right kidney and found it normal except for the same thickening of the capsule referred to in Case 1. I incised the kidney and found nothing and removed a piece for microscopical examination. I fixed the kidney to the posterior wall, removing a part of the posterior capsule for the purposes of the fixation. By 28th February the urine was free

from the appearances of blood, and, healing without complications, he was ultimately discharged, apparently completely cured.

(3) P.K., a young girl, aet. 13, had had haematuria with right-sided renal colic accompanied with the passage of blood clots for a considerable time. Dr. Irving, with whom I saw her, had tried varied and many remedies. There had been some loss of weight and languor. The right kidney was palpable. The urine contained blood, but no casts, pus, or organisms, and X-ray photograph showed no stone. Cystoscopy and ureteral catheterisation showed the blood limited to the right side. The palpable kidney and localisation of the haematuria, combined with her age, were suspicious of malignancy. Exploration of the right kidney was therefore advised.

Dr. Irving informs me that her kidney was explored by Dr. Barnett, of Dunedin, and, thorough examination being negative, it was moored in its place. The immediate and subsequent result was complete recovery.

The features which these cases above noted have in common are—(1) Limitation of the haematuria to one side; (2) right kidney in all; (3) kidney easily palpable; (4) absence of pus, casts, and organisms; (5) two had renal colic on the right side; (6) there was clotting of blood in all of them; (7) my own cases had thickening of the capsule; (8) all were treated by nephrotomy; (9) all have apparently perfectly recovered.

They differ from those cases classed as essential haematuria in the facts that—(1) there were blood clots; (2) pain was a feature.

It is difficult to account for the bleeding, in view of the relief obtained by operation. It is also not possible to do other than credit the exploration of the kidney with the cure, as their histories were prolonged and the result immediate. Whether the fixation alone, or the nephrotomy in addition, produced the favourable result is a matter of speculation. Certainly one is obliged to incise the kidney for the exclusion of tumour, varix, or papilloma. On the other hand, the negative finding thus made excludes these causes and makes one wonder how incision could be effective in view of the linear character of nephrotomy and the obvious limitation of the severing of any dilated vessels unobserved to a definite linear area.

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