TUBERCULOSIS OF THE BLADDER AND KIDNEY.

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My first duty is to thank the members of the Surgical Section of the Academy of Medicine for the honour they have done me in electing me President. The honour came as a complete surprise, and almost overwhelmed me, especially as I discovered that it meant something in the way of an opening address. I confess that I was quite unprepared for this, and must throw myself on your mercy in my effort to carry out this duty at such short notice.

Some months ago I had the curiosity to go over the notes of my cases of tuberculosis of the kidney and bladder with a view to finding out, if possible, the relative end-results of non-operative and operative treatment. The task involved in investigating over 150 cases has proved up to the present too stupendous for me, but I have formed certain impressions which may be of interest. I propose, therefore, to say a few words on the investigation and treatment of tuberculosis of the bladder and kidney.

In the title I have emphasised the bladder, as in the great majority of cases the bladder symptoms predominate. The source of the infection is, however, elsewhere. Primary tuberculous disease of the bladder is so rare that it may almost be said not to exist, and yet I have seen one or two cases in which, though the bladder showed signs of disease and tubercle bacilli were found in the urine, I was unable to obtain evidence of disease in either kidney.

It is stated in text-books that a frequent source of infection of the bladder is the epididymis. Before admitting this mode of infection in a given case the surgeon ought to investigate the condition of the kidneys, when he will be surprised to find how often they are involved. Let me give an example. A gentleman, aged 44, presented himself with a tuberculous infection of the left epididymis with some nodules in both lobes of the prostate. Tubercle bacilli were found in the urine. There was some frequency of micturition, and the cystoscope showed some involvement of the bladder. It was assumed that his bladder condition was secondary to the tuberculous epididymis. Ureteral catheterisation, however, on several occasions, showed a moderate degree of diuresis on the right side, in the urine of which a few pus cells and tubercle bacilli were found. There was an entirely unsuspected lesion of the right kidney, which may well have been the cause of the bladder condition and of the involvement of the prostate and epididymis. Further, I have seen several times a
tuberculous epididymitis follow on infection of the kidney, and a
good many of my cases show the double lesion. I am becoming
more and more convinced that the sequence of events in many
cases is: infection of the kidney, followed by secondary involve-
ment of the prostate, vesicula, and epididymis.

In a certain proportion of cases there has been an antecedent
tuberculous affection elsewhere in the body, such as tuberculous
glands in the neck, pleurisy, hip joint disease, caries of the
spine, or even pulmonary tuberculosis which has undergone cure
or has remained more or less active. On the other hand, I have
been struck with the healthy appearance of a number of these
patients. Notwithstanding a known infection of the kidney and
bladder and, perhaps, of the genital organs, with a call to mic-
turate almost every few minutes, many of these people look the
picture of health and may live for many years. In this class
there is no evening rise of temperature, and, except for the dis-
tressing frequency of micturition, the patient appears to enjoy
almost robust health.

Another class of case is seen in which the constant and intoler-
able frequency produces such a wearing effect that the patient
loses strength and colour, and soon becomes exhausted. A rise
of temperature in the evening is of frequent occurrence in this
class.

Symptoms.

A patient with a tuberculous urinary lesion nearly always
suffers from frequency of micturition. This is slight at first,
and is attended with some scalding along the course of the
urethra, and pain at the point of the penis in the male,
or at the external meatus in the female. These symptoms tend
to increase, with remissions during which the patient appears to
be almost, if not quite, well. Later, blood appears at the end of
micturition and the symptoms become aggravated so that the
unfortunate sufferer is continually passing water with much pain
and straining.

In a few cases the first symptom is an attack of renal pain
sometimes quite indistinguishable from the colic due to calculus.
In about 50% of my cases of renal tuberculosis pain was present,
varying from a dull ache to the most severe agony.

In very few cases indeed have I noted severe renal hæmaturia
as a sign, early or late, of tuberculosis of the kidney. Blood in
the urine, when present, generally comes from inflammation or
ulceration of the bladder.

In all cases of frequency of micturition with pus, even in small
quantities, in the urine, the possibility of tuberculosis must be
kept in mind and, if tubercle bacilli are found, the primary
source must be determined by ureteral catheterisation. The prac-
titioner will often be surprised, and indeed sceptical, when a
robust patient is pronounced by the urologist to have a tuber-
culous kidney demanding nephrectomy. One word of warning
is necessary regarding the presence of tubercle bacilli in the