A Mirror

OF THE PRACTICE OF MEDICINE AND SURGERY IN THE HOSPITALS OF LONDON.

Nulla autem est alia pro certo noscendi via, nisi quamplurimas et morborum et dissectionum historias, tum aliorum, tum proprias collectas habere, et inter se comparare.—MORGAGNI *De Sed. et Caus. Morb.*, lib. iv. Proœmium.

WESTMINSTER HOSPITAL.

CASE OF ACUTE ATROPHY OF THE LIVER.

(Under the care of Dr. ANSTIE.)

CASES of acute yellow atrophy of the liver are so rare that it is important to record every example of this remarkable and obscure affection. It is a fact of some interest, as regards the following instance, that two or three of the man's family had died rapidly of "liver disease," which came on suddenly.

H. A. B—, aged twenty-four, by trade a wood turner, admitted into the Westminster Hospital on Sept. 11th, 1869. He was a tallish young man, of steady habits and fair strength, and had always been of a lively disposition; but began to get despondent and low-spirited a fortnight previous to his admission. On Sept. 2nd he applied at the hospital for advice as an out-patient: he was then very depressed, vomiting occasionally, and there was loss of memory. He was recommended to become an in-patient, but strongly objected to do so. Four days later he again attended: all the symptoms were worse. On Sept. 8th he again made his appearance: he was now very weak; the eyes were jaundiced; there was profound mental depression, and a considerable hesitation of speech, but no paralysis. On the 11th, at 9 A.M., he was admitted: he was then suffering from active delirium, continually talking, very restless, and twitching the bed-clothes. He was ordered beef-tea, two pints (extra strength); milk, one pint; brandy, six ounces,—for the twenty-four hours: a calomel aperient, and a mixture containing acetate of ammonia, hydrocyanic acid, and spirit of nitrous ether, every four hours. He continually vomited dark-yellow matter, however, and rejected both food and medicine. The pupils were dilated and equal, the tongue brown and dry, and the lips covered with sordes. The bowels not being relieved, in the evening he had a common enema, and soon afterwards they acted; the motions were of a dark-olive colour. The urine was very free, and passed involuntarily; it was very high-coloured, and stained the bed-clothes. At 11 P.M. the delirium became so wild that twenty minims of sedative solution of opium were given; he then slept for three hours.

Next morning he was a little quieter, if anything, but still talked incessantly, and moved his arms and legs continually. He complained of a little tenderness in the hepatic region. Took but little food. About 7 P.M. he became very noisy, and screamed loudly. Cold affusions were applied to the scalp; he then became very quiet, and at 11 P.M. sank into a comatose state.

On the 13th he was still comatose. His wife, who had remained with him during the night, thought he had been sleeping quietly. Pupils unequal; the breathing was slightly stertorous, and he could not be roused. The bowels were freely open, and large quantities of dark urine were passed. Mustard poultices were applied to the calves and the feet, stimulants and coffee were given, but he sank, and died at 5.30 P.M.

Dr. Anstie, who was requested to attend this patient in the absence from town of Dr. Fincham, had no hesitation in making the diagnosis of acute hepatic atrophy. Percussion plainly showed the liver to be extraordinarily small; in fact, the liver dulness was more nearly *absent* than Dr. Anstie had ever found it. This circumstance, joined to the unbroken health of the patient up to the commencement of his short fatal illness, the symptoms which he displayed, and the remarkable fact that two or three of the family had died in a very similar manner, seemed enough to decide

the question. It was unfortunately impossible to collect urine during his stay in the hospital, so that leucine and tyrosine could not be searched for.

The post-mortem was made by Dr. Cavafy twenty hours after death. The body was fairly well nourished. There was deep jaundice of the trunk and upper third of the thighs, and a good deal about the neck. Considerable cadaveric staining, especially at the nape of the neck, and along the back. On turning over the body, about a pint of blood escaped from the mouth and nose. Rigor mortis well developed.—Thorax: Pleuræ healthy, but a quantity of clear yellow serum in the right one. Both lungs intensely congested in the lower lobes, but pieces cut from the most congested part floated in water. A small quantity of frothy mucus in the bronchial tubes; mucous membrane congested. The pericardium contained a little yellow serum. The heart had both ventricles contracted; there was a small quantity of fluid blood in the right one.—Abdomen: The liver was entirely hidden beneath the diaphragm. It weighed *twenty-three ounces and a quarter*, and was of a dark-reddish colour, with blotches and raised nodules of a bright-yellow colour. The gall bladder was small and shrunken, and contained a drachm of thick bile. On cutting into the liver-substance, the contrast between the bright-yellow of the projecting nodules and the dark-red of the remaining substance was most marked. The lobular structure was very clearly marked in all the bright-yellow portions. In the darker red parts no traces of nodules could be distinguished by the naked eye. The atrophy seemed to have attacked chiefly the left lobe, which was shrunken, and almost leaf-like. The capsule was minutely puckered, more especially in the upper surface.—Spleen small and congested; structure tolerably firm. Kidneys much congested; the right one rather more so than the left; cortical substance projecting downwards between pyramids. Pancreas hard and congested. Bladder semi-contracted; contained three ounces of urine, on examination of which leucine was found, but no tyrosine.—Brain: Firm, with no excess of puncta vasculosa. About half a drachm of reddish serum in the ventricles. Pia mater on the cerebral convolutions rather adherent; in attempting to strip it off, portions of grey matter came away with it.—No marked venous congestion. The blood was fluid throughout the whole body.

GUY'S HOSPITAL.

WOUND IN THE ABDOMEN FROM A STAB; PROTRUSION OF INCISED INTESTINE; DEATH ON THE FOLLOWING DAY.

(Under the care of Mr. BIRKETT.)

THE following case is interesting on account of the rarity of the accident, the rapid development of fatal peritonitis, and the state of the injured parts revealed on post-mortem examination.

John A—, aged forty-eight years, was admitted into Guy's Hospital on the morning of October 19th, with a penetrating wound of the abdominal walls, caused by a stab during a brawl in a public-house.

State on admission.—Was pallid, and under the influence of shock. A little below and to the right side of the apex of the xiphoid cartilage was the orifice of a punctured wound which extended under the integument for some distance in a direction inwards and slightly upwards. At the lower part of the abdomen, on the left side, and in the course of a line passing from the junction of the inner to the middle third of Poupart's ligament to the umbilicus, was a wound in the abdominal wall, about three-quarters of an inch in length. Through this protruded a knuckle of small intestine, which was much distended, and of a bright claret colour. At the upper portion of this protruded knuckle was an incised wound, which extended deeply, and through the whole of the serous coat at one part, and was tailed off at its extremities, thus presenting the appearance of having been made by the light touch of a sharp knife. Mr. Birkett could not make out, on close examination, that the inner and mucous coat of the wounded intestine had been cut through. From the distended state of the intestine, and the absence of any faecal discharge, it was thought that this layer still remained intact. There was slight oozing of blood from the wound, but the man had bled but very little before his admission.

Shortly after his admission, the patient was taken into the operating theatre. The edges of the incised wound in the intestine were brought together by sutures of very fine silk, carefully passed through the serous coat by means of a common sewing needle. Chloroform was afterwards administered, and the protruded knuckle returned within the abdominal cavity. Some hæmorrhage then occurred, and Mr. Birkett felt at the inner portion of the wound a thick mass of coagulated blood. The margins of the external wound were brought together by needles and twisted suture.

Mr. Birkett, in some remarks made in the theatre, stated that, according to his experience and also that of his colleagues, this case was an extremely rare one. The exposure of omentum through a rent in the abdominal walls had been occasionally observed in surgical practice; but the protrusion of a portion of intestine, that portion at the same time being wounded, was a very uncommon lesion. In the total absence of any signs of perforation of the intestinal wall, he had closed the wound in the serous coat by sutures, and returned the protruded knuckle. He had no doubt that, in case of the man's survival, speedy union would take place, and that the sutures would either become enclosed in a capsule of lymph or pass into the intestinal canal. Allusion was made to a remarkable case in which, after recovery from a large wound in the intestines, requiring considerable time in stitching up, none of the many sutures were afterwards observed. The prognosis in the present case was very bad. Wounds of the intestines, except in lunatics, were frequently fatal. And there was much uncertainty in this instance as to the extent of the injury: some other portion of the intestinal canal might have been wounded, or a mesenteric artery opened. A wound in the small intestines, too, was much more dangerous than one in any part of the colon, in consequence of the great mobility and frequent action of the former.

The subsequent treatment consisted in perfect rest and the frequent administration of opium. Symptoms of traumatic peritonitis, however, soon came on, and the patient died on the following day, Oct. 20th, at 2.30 p.m.

An examination was made by Dr. Moxon twenty-four hours after death. Around the lower wound in the abdominal wall the subcutaneous and muscular tissues were extensively infiltrated with coagulated blood. Some fluid blood was also found in the abdomen and pelvis. The total quantity was estimated at about eleven ounces. The intestines were much distended, and the serous surface was much congested. Near the region of the kidneys was a small quantity of turbid serous effusion. Some difficulty was experienced in discovering the sutures at the seat of the intestinal wound, as they had been completely enclosed in a capsule of soft gelatinous lymph. On examining carefully the wounded portion of intestine, it was found that the incision at one part of its extent had passed through the inner and mucous coat, and perforated the intestine. This orifice, which was very minute, had evidently been made by the sweep of the knife at the time of the original injury. There was marked rigor mortis, and the heart was firmly contracted.

HOSPITAL FOR CONSUMPTION, BROMPTON.

ACUTE PULMONARY TUBERCULOSIS, SIMULATING TYPHOID FEVER.

(Under the care of Dr. COTTON.)

THE following case well illustrates a difficulty of diagnosis which is not very unfrequent in occurrence, but which is always important, at least as regards the prognosis. Its publication may suggest caution in expressing a positive opinion in cases marked by similar symptoms, and may, therefore, prove useful in practice.

We are indebted to Dr. Robert W. Foss, resident clinical assistant, for the following notes:—

G. T. F.—, aged forty-two, joiner, became an out-patient of this hospital on July 2nd, 1869. He was then complaining of shortness of breath, and slight dry cough, together with pain in the right hypochondrium; but there were no physical signs of chest disease.

On September 28th, he was admitted an in-patient, when he stated that for the last three weeks he had been suffering

from great languor, debility, and loss of appetite; but that he had no pain anywhere. His tongue was furred and white, but moist; there was a slight tendency to diarrhœa; the pulse was 120. The mind was confused; there was great prostration; the skin was hot and dry, and there was altogether the general appearance of typhoid, without, however, the dry tongue and the typhoid diarrhœa. He was deaf, and had been so for the last three weeks. There was some harsh breathing under the right clavicle, and pain on pressure over the hepatic region. He was ordered a mixture of chlorate of potash and dilute hydrochloric acid, with port wine and abundant nourishment.

The patient continued in much the same condition till the 9th of October, when he began to suffer from oppression of breathing; the prostration was increased; there were delirium at night, and illusions during the day. The pulse was 120; tongue slightly dry; anorexia; bowels regular; borborygmi; abdomen slightly tympanitic. The physical examination of the chest revealed slightly tubular breathing, with fine crepitation under the right clavicle; also some scattered clicks under the left clavicle. There was no dulness on either side. From these facts Dr. Cotton now diagnosed that the patient was suffering, not, as had been all along supposed, from typhoid fever, but from acute pulmonary tuberculosis, which was subsequently verified. On the 11th the general symptoms were the same. The stethoscope showed large crepitation at the apex, and all over the anterior surface of the left lung; also some crepitation on the right side. On the 13th profuse diarrhœa set in, the dyspnœa was much greater, and there were audible rhonchi in the throat. The pulse was 130, full and compressible. He was completely prostrate; face very much congested; mind very confused and wandering; still deaf. He said he had no pain. He was ordered poultices to be constantly applied to the chest; to have ammonia and senega mixture; hot bottles to his feet. The stimulants and nourishment were increased; but he gradually sank, and expired early next morning.

His temperature in the axilla was taken from Oct. 6th to the 11th, and was as follows:—Oct. 6th: Even., 100·4°. 7th: Morn., 104·2°; even., 103·2°. 8th: Morn., 101·1°; even., 104°. 9th: Morn., 103·2°; even., 103·4°. 10th: Morn., 102·2°; even., 103·4°. 11th: Morn., 102·4°; even., 103·1°.

Autopsy.—The lungs, on being removed from the thorax, felt exactly like bags filled with small seeds. The left lung, on section, showed the whole of its substance studded with miliary tubercles, some isolated, and some grouping themselves together, none being larger than a coriander seed; there were quite a hundred in each square inch of divided lung, roughly estimated. The right lung presented some slight adhesions at the base, and section of it showed exactly the same appearance as that of the left lung, being completely studded with miliary tubercles. At the apex there were two masses of old cheesy tubercle, not larger than a small marble. There was also some hypostatic congestion at the base of this lung. The heart was normal. Several small tubercles were found in the liver, and also in the kidneys. The small intestines were very much congested in patches, including two or three inches of the whole circumference of the tube. Peyer's patches were normal. The brain was examined, but nothing beyond an excess of bloody points after section of the centrum ovale was seen. The lymphatic glands were normal.

Provincial Hospital Reports.

LIVERPOOL WORKHOUSE HOSPITAL.

CASES ILLUSTRATING THE EMPLOYMENT OF CHLORAL HYDRATE IN DELIRIUM TREMENS.

(Under the care of Mr. J. H. BARNES.)

IN considering the history of these ten cases, it will be at once evident that chloral, like most other remedies, varies very considerably in its action with various constitutions. While in one case thirty grains were sufficient to compose and give a night's sleep to a most excited and sleepless patient, in another case seventy grains produced no effect,