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ON THE NATURE, DIAGNOSIS AND TREATMENT OF INCIPIENT
PHTHISIS.

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SINCE the immortal discovery of auscultation by Laennec, perhaps no disease has more fully occupied the attention of pathologists than the one under consideration ; and few indeed, it may be added, have advanced more progressively towards precision, or yielded more definite results.

The laborers in this extensive field have been by no means confined to a single country. England, France, Germany, America and Italy, have alike produced inquirers, who, by their zealous and successful investigations, have assuredly brought the diagnosis of phthisis, in its earlier stages, to a degree of certainty previously unknown.

The mortality caused by pulmonary consumption is estimated as producing at least one fifth of the entire deaths in this country ; which fact alone proves, with melancholy truth, the almost hopeless amount of benefit that we can expect to derive from medicine, save as a palliative in the *very advanced* stages of the malady.

That nature does occasionally, though rarely, bring the disease to a happy termination, I am fully convinced ; and as the views of M. Rokitsky, of Vienna, on this subject, are the most recent, I make no apology for introducing a somewhat lengthened quotation from the notice of his work on Morbid Anatomy, in the January No. of the British and Foreign Medical Review, for the present year.

This author has shown that the phenomena of phthisis may proceed towards a curative termination by six different modes :—" 1st. By a callos degeneration of the tissue around the cavity, or the formation of a membrane within it, like a serous or a mucous membrane ; the former being usually found when the disease is tranquil ; the latter when there is much irritation. 2d. The cavity may completely cicatrize, its walls gradually falling in and uniting, with obliteration of the bronchi, and sinking in of the surface of the lung, and perhaps of the wall of the chest also. 3d. The cavity may, after partially shrinking, be filled by chalky matter, from the metamorphosis of some remaining tubercle. 4th. In the place of the cavity there may be produced a large callous mass of tissue, like that of cicatrices. 5th. The tubercle may not proceed to the formation of the cavity, but being arrested

in its earlier progress, may diminish in size, and may be changed into a gray or dirty-white mass of chalky matter, and at last into a hard concretion. And lastly, at a still earlier stage, the tubercle being arrested in its progress, may retrograde and become *obsolete*, shrivelling into an opaque, blueish-gray, cartilaginous knot, which is indisposed to any further metamorphosis."

Such are the conclusions to which M. Rokitansky has arrived; to the correctness of some of which my own observations lead me to concur, more especially in reference to the occasional cicatrization of cavities, and the shrivelled condition of the tubercular deposit.

Nature of Tubercle.—This paper being professedly practical, my observations on the pathology of incipient consumption must necessarily be very brief. Without entering upon the multiform theories that have been advanced, I may state that I believe phthisis to be caused by the deposition of an unorganizable matter from the blood, presenting the form of miliary granulations, yellow caseous opaque matter, or, thirdly, as tuberculous infiltration; which latter deposit, save in the cases of acute phthisis, less frequently obtains in the early stages of the disease. This secretion forming tubercle is closely connected with the strumous diathesis, either hereditary or acquired, and, according to M. Andral, appears especially influenced by irritation, inflammation or congestion of the blood-vessels of the part in which it is earliest deposited.

The ordinary and primary seat of tubercle, as shown by Dr. Carswell, is principally on the free surface of mucous membranes; and at the commencement of the disease the lesser bronchi, the air-cells, and the interstitial cellular tissue, appear peculiarly obnoxious to its presence. Of the origin of the miliary tubercle, or granulations of Bayle, many different opinions are entertained. That of Laennec, who viewed them as similar in nature to the yellow crude tubercle, but existing in an incipient or nascent state, may perhaps be considered on the whole as the most satisfactory. M. Rokitansky appears to maintain a somewhat similar opinion, and believes the peculiar form of deposit to depend upon the degree of the tuberculous diathesis which exists at the time. The tubercular granulations, whether deposited singly or in clusters, appear first, according to this pathologist, in the form of miliary grains, "or, in an intense degree of the tuberculous diathesis, it may be deposited at once as the yellow tubercle."

In tubercular infiltration, the deposit appears completely diffused throughout the cellular and interstitial portion of the lungs, presenting the appearance as if the matter had been poured into the lung in a liquid form, and had subsequently become solidified.

This tuberculous infiltration is considered by M. Rokitansky as "hepatization by a tuberculous product." He maintains that the ordinary deposit of pneumonia, when occurring in a strumous habit, instead of being absorbed or becoming purulent, is gradually metamorphosed into the yellow tuberculous matter; and further, that the change from the fibrinous to the tuberculous secretion can be distinctly demonstrated.

This tuberculous infiltration, in which are not unfrequently detected isolated portions of caseous matter, sometimes obtains in a more fluid form;

this constitutes the *infiltration tuberculeuse gélatiniforme* of Laennec, and not a deposit *sui generis*, as has been supposed by some authors.

It is now, I believe, an undisputed fact, and one which we shall hereafter find to be of great practical importance in the diagnosis, that when tuberculous deposit in the lungs takes place gradually, in almost all cases the superior lobes will be found first affected; and of these the upper and posterior parts are most prone. Upon what circumstance this increased liability to tuberculous deposit depends, I confess that I cannot decide; neither has it, I believe, hitherto been satisfactorily explained. I do, however, conceive, that the rash exposure of the upper parts of the chest in both sexes, must, by exerting a local influence on the circulation in the corresponding part of the lungs, materially increase the power of the already existing cause, whatever that may be. Another curious and valuable fact, although of less practical importance than the preceding, is this, viz., that in the earliest period of tuberculous deposit the left lung is more obnoxious to the disease than the right. As the affection, however, increases, it will be found to advance with nearly equal rapidity on both sides.

Diagnosis.—In investigating the earliest signs by which tuberculous phthisis may be detected, I may remark that it is my intention to limit my inquiry to the physical phenomena of the affection. The general symptoms are so ably and fully described by Sir James Clark, in his valuable treatise on Consumption, that to his work, especially his remarks on tuberculous cachexy, and to Dr. Todd's learned essay on strumous dyspepsia, in the *Cyclopædia of Practical Medicine*, I beg unhesitatingly to refer, as embracing all that can be said on the general symptoms of the disease. Notwithstanding the determined opposition and ridicule which the stethoscope long encountered in its earlier career, its value as a diagnostic agent is now, I believe, too fully admitted to require any comment.

I must, however, strenuously urge the necessity and incalculable importance of investigating the earliest and most incipient threatenings of the disease; for, as Sir James Clark graphically observes, "I do not hesitate to express my conviction, that by adopting a rigid examination on being first consulted, the greater number of cases of tuberculous phthisis would be discovered at a much earlier period of their course—often, I am persuaded, many months, nay, occasionally years, before they now are, from the careless manner in which this class of patients is too commonly examined. In the present superficial mode of inquiry, it is too often far advanced, when the patient is said to be merely threatened with it, and tracheal or bronchial irritation are the terms employed to account for symptoms which a closer investigation would trace to a deeper source. We must not be satisfied with a few rough and slovenly thumps on the upper part of the chest, or even with the use of the ear or stethoscope for a few moments, applied as if we were afraid, rather than desirous, of ascertaining the real condition of the lungs. Such superficial examination, if it deserves the name, is worse than useless: with the semblance of doing something, it really effects nothing, unless it be to deceive the patient and his friends, and bring this method of diagnosis into unmerited disrepute."

Much of the apparent difficulty in stethoscopic examination may be easily removed by adopting in our investigation a more regular and methodical method; and, with this view, I may preface my observations on physical diagnosis by a few remarks on the practical application of the instrument.

In performing auscultation several rules are to be attended to, affecting both the observer and the patient. In a first examination, especially in the female sex, a nervous alarm is very commonly excited, rendering the respiratory movements irregular, abrupt, and wholly inefficient for the purpose of a correct diagnosis. This state we must endeavor quietly to overcome; we must guide, but not alarm, our patient, using as little parade as possible. "Avoid," says M. Fournet, "a stern air, an abrupt address, and solemnity; these throw the patient into a state of nervousness. There is a calm, simple, benevolent mode of accosting a patient, a certain gentleness and earnestness of manner, that at once wins his confidence, and renders him composed, so that he answers correctly, does what he is desired well; and then his features, influenced only by the morbid state, express accurately all he feels."

We must endeavor to give our entire attention to one sound at a time, avoiding with equal care any liability to distraction by surrounding noises. This faculty of concentration can, as I have personally proved, be greatly strengthened by habit, and then, like many other qualifications, it becomes more and more amenable to the will.

In examining the lungs in incipient phthisis, the sitting posture is to be preferred; the chest should be moderately rounded, and, if possible, uncovered; this, in the infra-clavicular regions, can generally be effected without outraging the feelings of the most delicate. The arms should be allowed to hang unconstrainedly at the sides. After glancing at the general contour of the thorax, and ascertaining the facility with which the ribs rise and fall, we should direct the patient to breathe naturally, so as in the first place to become acquainted with the normal state of the respiration.

The examination should be always conducted slowly, not trusting too much to medical tact; at the same time it is incumbent on us to be extremely careful not to allow any preconceived judgment which we may have formed to influence us in the investigation of the true state of the lung. The stethoscope should be applied firmly, but lightly, and in close proximity to the chest; all unnecessary rustling of the clothes must be sedulously avoided. The patient should then be directed slowly to take some deep inspirations, then a *single* cough, and repeated; this latter act will frequently enable us to discover the click of incipient phthisis, when other means have failed. Both sides of the chest must be examined in a precisely similar manner: this ought never to be omitted, however clearly and indisputably the disease may be indicated. In auscultating a chest where we have reason to fear deposit, the infra-clavicular, the acromial, the supra-scapular and the axillary regions, will obtain our especial attention. Still, however, in a doubtful case, we must never rest satisfied until the condition of the entire chest has been patiently and carefully investigated. The physical examination of the earliest local signs of phthi-

sis may be referred to three heads—inspection, auscultation, and percussion. To each of these I shall briefly direct attention.

[To be continued.]

SEMINAL AND OTHER DISCHARGES FROM THE URETHRA.*

By Benjamin Phillips, F.R.S., Surgeon to St. Marylebone Infirmary.

It is now many weeks since I forwarded to you two communications having reference to the subject of involuntary discharges of spermatic fluid. And as those communications have considerably enlarged my experience, and that in comparatively a very short time, so as to enable me to bring the cases more vividly to my mind than I could do on a former occasion, I have concluded that the results of my experience on the subject during the last three months might go far to show the value of the remedy to which, on those occasions, I endeavored to direct attention.

The number of cases which have come under my notice since that time amounts to thirty-three; of these, twenty-three have been medical men—some in practice, others in *statu pupillaris*. In twenty-four instances it was admitted that masturbation had been practised; in some cases so frequently as twice or three times a day, but in all those cases it was stated that the habit had been abandoned. In two cases it was said that masturbation had never been practised; supposing that to be true, the only way to account for the discharge was to assume that irritation was set up by a natural phymosis. We frequently see, even in young children, that when there is inability to uncover the glans, the secretion around the corona glandis does become acrid and troublesome. Whether in adults a similar irritation will of *itself* induce spermatic discharges, is to me very doubtful; I can readily understand that it may induce masturbation. In two cases the affection was said to be the result of sexual excesses. In two cases the only apparent cause was stricture. In one case the cause seemed to be a frequent indulgence in reading lascivious books. In one instance the genital excitement resulted from study, or from the perusal of works of imagination.

Such have been the probable causes of the complaint. Its urgency was very variable; in some cases the discharge did not happen more than once in a week or ten days; in others daily; in others twice or even three times a day. The effects on the constitution were not less variable. In one case, where the discharge happened commonly three times a day, and where it had continued more or less for twelve years, the patient being at present 24, the buoyancy of his frame was very little disturbed; he could walk eight or ten miles without fatigue; whilst in other cases, where it happened once or twice a week, the physical and moral impression has been most profound. Much of this, no doubt, results from the hold the complaint obtains upon the apprehension of the patient.

In two cases the complaint co-existed with epilepsy; what direct relation the diseases bore to each other was not very evident. In two cases

* See pages 35 and 89.