

## SOCIETY PROCEEDINGS.

### CHICAGO MEDICAL SOCIETY.

*Stated Meeting, August 2, 1886.*

E. J. DOERING, M.D., PRESIDENT, IN THE CHAIR.

#### OFFICIAL REPORT.

DR. L. L. McARTHUR read a paper on

#### DIAGNOSIS AND TREATMENT OF HEPATIC ABSCESS.

Dr. McArthur divided the causes for abscess of the liver into intrinsic, or causes resident in the liver, and extrinsic, or causes external to and independent of the gland. To the former belong acute congestions, (said to result from heat and cold) tumors, echinococci, biliary calculi, or lumbrici in bile ducts. To the latter, infective emboli, whether carried through the portal vein or hepatic artery, traumatism, use of alcoholics in excess, high temperatures, surgical operations or lesions anywhere in tract of vena porta or its communications. All abscesses may be divided into idiopathic, infective or embolic and traumatic, in the order of their frequency respectively. First variety most frequently met with in tropics, and hitherto supposed to be due to high temperature irrespective of pathological conditions. Dr. McArthur believes them to be due generally to formation of biliary calculi. Most frequent abscess in this zone is the infective variety. Sources of infection are two: *Per arteriam hepaticum* and *per venam portae*. First arise most frequently in pyæmia. Aseptic surgery has lessened the number of these cases. We can readily see how abscess of the liver may ensue by infecting particles reaching the liver when we remember all blood of the abdominal organs is returned to the general circulation via the liver. Hence, dysentery, ulcerations of the intestines, operations about anus and rectum, cystotomy, may cause abscess of the liver. Dysentery complicated the four cases he reported. The last variety of abscess, traumatic, comes from direct or indirect violence. The pain in abscess of the liver is severe according to the size of the abscess, its location in the liver, deeply seated or near the peritoneum, the amount of other tissues involved, lungs, stomach, pleura, etc., and its causation. When deeply seated may be symptoms only of "pus somewhere," chills, fever, sweating, etc., with general malaise. Locally, generally sense of weight and uneasiness on jolting. Tenderness variable, usually increase in hepatic area, and bulging of side. Temperature not often high, except when peritonitis; then present an important symptom, a peritoneal friction sound. This is hardly mentioned in literature, and yet is worthy of remembrance. Care should be taken to differentiate between pleurisy, or pneumonia of right lower lobe and hepatic abscess opening in this direction. Surgical interference by Volkmann's or Grave's method should be made as soon as possible. In the following cases two were operated upon and recovered; in the third the expectant treatment was followed and death ensued;

in the fourth case a diagnosis was not made because of absence of characteristic symptoms.

On concluding his paper Dr. McArthur gave the following verbal report of cases: The first case was a man, 35 years old, formerly strong and healthy, weighing 160 pounds, a roustabout. Family history good. Four years previous to coming under my observation, while in Louisiana, he had had hepatitis with enlarged liver, from malaria. He was engaged when taken in present illness in unloading a cargo of peaches. He ate freely of them, and an acute diarrhœa ensued, which became dysenteric in character. One week prior to admission to the hospital he complained of pain in the hepatic area. At the time of his admission his general nutrition was good, temperature 103, complained of tenderness in the hepatic area, had diarrhœa. (On making an examination I found the hepatic area enlarged, with tenderness over it, slight redness of the integument over the right lobe of the liver. On completing the auscultation of the lungs I placed my stethoscope over the liver and heard a very distinct friction sound which characterized the invasion of the peritoneum by inflammation. Three days later a hypodermic syringe was introduced into the liver and pus, and a sero-purulent fluid withdrawn, and the diagnosis of abscess of the liver was completed. As soon as the friction sound had ceased, that is, when adhesion had taken place, an operation was performed by making an incision about two inches in length and carefully dividing the tissues until the peritoneum was reached and the adhesions found; when the abscess was opened, the contents evacuated and a drainage tube inserted. The man was discharged cured in the course of forty-two days. The second case was a man formerly in good health; family history good. He came to the hospital complaining of fever, disagreeable taste in the mouth, pain in the right shoulder and down the back. Normal heart and lung sounds, except on the right side, where there was evidence of commencing pneumonia in the right lower lobe. Marked enlargement of liver in the right hepatic area. In this case the attending physician advised the expectant treatment, hoping that the suspected abscess would open through the lungs, and a cure be effected in that way. In ten days the man died and a large abscess was found in the liver filled with normally appearing pus, complicated by circumscribed pneumonia and diaphragmatic pleurisy, showing the efforts of nature to get rid of the pus in a natural way. The third case was one in which the abscess was deeply situated in the liver substance. There was no local tenderness, no enlargement of the liver, only the sensation of pus somewhere, with rigors, fever, chills and sweating. There had also been a diarrhœa. He finally succumbed to blood poisoning. Post-mortem showed an abscess in liver. The fourth case was in St. Luke's Hospital, and was operated upon and recovered.

DR. FRANK BILLINGS upon invitation said: I probably have had less experience with living patients with abscess of the liver than any one present, and consequently have less that is practical to say about it. While in Vienna I saw a great number of autopsies of abscesses of the liver. Several cases occurred in the

wards, but no diagnosis of abscess was made, the patients suffering from what appeared to be intermittent fever, and usually a diagnosis of that kind was made. A curious thing to me was the fact that a great number of these abscesses were found in new born children. In Vienna, one often sees in the dead-house abscesses which were the result of badly attended cord. The pus had formed in the vein and the inflammation spread upward, finally producing abscess in the liver.

Dr. H. A. JOHNSON said: While listening to this paper, a somewhat unusual case was recalled to my mind which occurred in the County Hospital when we were down on 18th street. This was a case of abscess in the left lobe of the liver which had communicated, evidently some time before death, with the left lung, and was discharged through the bronchus. When the case came into the hospital it presented all the signs of empyema, and the complication of the abscess with the liver was only discovered in the dead-house. Another case occurs to me in which there was abscess in the right lobe of the liver discharging through the right lung. The patient recovered, but five or six years after a recurrence of the abscess took place, and it discharged into the vena cava, producing instant death. Post-mortem revealed the cavity of the abscess communicating with the vena cava. Both of these cases seemed to me to be somewhat out of the history of abscesses.

Dr. J. J. M. ANGEAR said: In all cases that I have seen the discharge had a fearful odor, and I began to think that if the pus did not have that odor, I should have doubts of its being an abscess of the liver.

Dr. J. A. ROBISON said: I have just had in the County Hospital a case of abscess of the liver in which the diagnosis was made only after death. The remark of Dr. Billings, that abscess of the liver is often diagnosed as malaria, leads me to speak of it. The case was that of a woman who had been ill for several months. When I first saw her in the Hospital about a month ago, she was greatly emaciated, jaundiced, and complaining a great deal of pain in the hypogastric region. The liver was not enlarged, temperature ranged from 100 to 102, she had chills every few days, and it was supposed they were due to malaria. She finally died of exhaustion.

There was no diarrhoea, but there was great tenderness over the hypogastric region together with general jaundice. There was also a cachectic appearance which led me to believe there might be catarrhal inflammation of the duodenum which would account for the jaundice. But upon post-mortem examination it was found to be a case of multiple abscesses of the liver, with purulent inflammation of the gall ducts. I have in the hospital another case in which nearly all the signs that Dr. McArthur has spoken of here occurred. The patient is a woman about 40 years of age, in whom the area of liver dulness is greatly increased. Temperature 100, extremely jaundiced, and when she first came into the hospital I heard the friction sound as mentioned in the paper, but that has now disappeared. Since hearing this paper I am led to believe we will find a large abscess of the liver in this case.

Dr. JOHN BARTLETT said: At the time of the Mexican War, many of the soldiers returned affected with chronic diarrhoea. In seven of these cases which came under my observation, enormous abscesses of the liver followed. They were not opened, but were particularly examined in the dead-room, some of them containing at least a gallon of pus. As a general rule the patients lived for months. About a year ago I was called to see a case in consultation. The man had been tread upon in a crowd and received a slight injury about the epigastrium. Inflammation followed and abscess of the liver was diagnosed, but owing to a difference of opinion among the consultants no effort was made even to aspirate. After death, which followed in due course, multiple abscesses were found, one as large as a small cocoanut, another as large as an orange, and fifty other smaller ones. I mention this to prove how hopeless would have been an attempt to improve the condition of this man by aspiration. I saw another case of some interest: The man was shot and some weeks afterward died. I opened the body and found a piece of wadding and the bullet in the liver. The abscess was about as large as two fists and opened into the vena porta. In another case I was called in consultation to see a man who appeared to have an affection of the liver. Both of the attending physicians thought it was a case of abscess. Presently he had symptoms indicating that there was some difficulty in the respiratory organs, and later, but in time to act if we had been more prompt, we discovered that there was a retro-pharyngeal abscess. I immediately expressed the opinion that the abscess in the liver had opened into the anterior mediastinum. I deemed it inexpedient to open this abscess without having other instruments than we had with us. We went to get these, and when we returned we were advised at the gate that the man had been taken with a difficulty of breathing which simulated croup and had immediately expired. Upon examination we found that he had been drowned, as it were, by the pus from the bursting of this large abscess.

Dr. H. N. MOYER asked Dr. McArthur if in the literature on the subject he had seen anything in reference to the presence of acetone in these cases? Jaffey has laid down indications of diagnostic value when this substance is formed. He thought the symptoms might lead to the development of this substance in the urine, and that it might be of some diagnostic value, in suspected cases of abscess of the liver.

Dr. L. L. MCARTHUR said, in closing the discussion, I was interested to learn of another source of abscess of the liver to be by infection from the umbilical cord as related by Dr. Billings. Dr. Johnson's case of abscess of the liver breaking into the left pleura and left lung is the only one I have known of. Rupture into the vena cava is also rare. To Dr. Angear I would say that in the cases I saw the discharge was odorless, and I emphasized that fact in the paper because the books all state that as a rule it possesses a very offensive odor, and is usually of a purulent character. In two of the cases I saw it was of a chocolate color being mixed with blood and liver-

tissue. Dr. Robison speaks of a case as markedly jaundiced. This is set down as an exceedingly rare complication in abscess of the liver. He said that in his case the liver was found in post-mortem to contain multiple abscesses, I would like to ask if the cause was found? (Dr. Robison: We found no cause.) I would ask Dr. Bartlett if his case proved to be a case of abscess of liver with a mediastinal opening? (Dr. Bartlett: We presumed it to be hepatic, but no post-mortem was allowed). As to acetone, I have seen no literature on the subject in connection with the liver. In those cases in which I used the hypodermic needle to make a diagnosis (three in number) two were operated on and recovered, the third was treated by the expectant treatment and died. No careful search was made for the puncture of the needle in the abscess of the liver. After the first two cases I became bold in the use of the hypodermic needle and punctured for the fourth time in one case before I obtained purulent matter.

DR. SCOTT HELM read a paper entitled

A SUBCUTANEOUS METHOD OF THE TREATMENT OF  
BUBOES, WITH EXHIBITION OF THE INJECTING  
INSTRUMENT.

His method consists in injecting the suppurating gland, after the pus is withdrawn, with a solution of carbolic acid to wash out the cavity, and then injecting and allowing to remain an emulsion of iodol in pure oleic acid. The injecting instrument consists of a barrel holding two drams, which is mounted on either side by two rings for the fore and middle fingers, and a ring in the end of the piston for the thumb. Three needles, two different sizes of aspirator needles, and one a canula with trocar. To these is attached the centre joint, in which is a stopcock, the opposite extremity of which is attached by a smooth joint to the barrel. In twenty-three cases the treatment was successful in all but the nineteenth, this patient having gone on a protracted spree following the operation. The advantages of the operation are that when there are two or more suppurating buboes in the same chain of lymphatics, the second or third appear further away from the initial one; by placing the first glandular abscess in a perfectly aseptic condition you prevent the inflammations of neighboring glands; secondly, there is no cicatrix remaining.

DR. J. ZEISLER: If conservative surgery has any place I think it is in the treatment of buboes, and I think the final bad result of treating buboes by section might be avoided by carrying out the idea of Dr. Helm. It is a good idea to inject iodol as it may be regarded as a specific against the venereal poisons, and their can be hardly a doubt that the suppuration is due generally to the poisons. I would like to know if the doctor has found it sufficient to introduce this iodol emulsion more than once?

DR. G. C. PAOLI said: In the treatment of buboes of course the sooner we get out the pus the better, but those who have had experience with the treatment of buboes know that there are cases in which, in spite of aspirations and subcutaneous injections there is still a morbid process going on which produces mischief and ulcerations of the tissues. I never

use carbolic acid, but I have used a watery solution of permanganate of potash,  $\frac{1}{2}$  gr. to 6 ounces, injecting it into the cavity. But we all know that we have cases of buboes which in spite of all the skill of the physician produce the greatest suffering. I saw a case where the femoral artery had to be ligated. In temperate persons we have very tedious buboes. Again, where mercury has been used too freely there are often mischievous buboes. Very difficult cases are those in business men who are busy, active, and produce more congestion of the abscesses by their activity. But if we can get the patient to go to bed and rest we succeed better in our treatment. However, I think favorably of the subcutaneous method.

DR. FRANK asked Dr. Helm how many of these buboes were due to gonorrhœa and how many to chancres or chancroids, if any?

DR. H. N. PIERCE said: I had the pleasure of seeing Agnew, Jr., four years ago experiment with the subcutaneous treatment of buboes. He first evacuated the pus by use of the canula, then injected an antiseptic solution, washing it out and afterwards applying a compress bandage. The buboes generally went on from bad to worse, and he tried the same method over again but with no success, and finally he had to cut down upon them and treat them by the old method.

DR. SCOTT HELM in closing the discussion said: I have made, in any case, only one injection, and the time that has elapsed before the patient was discharged has been from eight to fourteen days. In reply to Dr. Feder I would say that these buboes have been aspirated as early as possible, as soon as there was fluctuation. All the pus was removed and the cavity injected with a like quantity of the oleic acid emulsion of iodoform. I have had no case in which there has been a return of the disease in the same chain of glands. I had one case in which there was a bubo appeared some two weeks afterward in the opposite groin, evidently due to gonorrhœa. In the second case, and the last one, which only occurred a few days ago and was not reported, the buboes were caused by gonorrhœa, all the others were due to chancroids.

IN MEMORIAM.

*Mr. President:* Since our last meeting it has pleased Divine Providence to call from our midst Dr. Robert C. Hamill. The Committee on Necrology respectfully submit the following resolutions:

*Resolved*, that this Society has learned with profound sorrow of the death of Dr. Hamill, one of the earlier as well as one of the most earnest and efficient members of this Society.

*Resolved*, that in the death of Dr. Hamill this Society has lost a member typical of the true gentleman in the kindness of his manner, in the great force and energy of his character; typical of the good citizen in his ceaseless efforts to advance the interests of institutions tending to ameliorate the condition of the sick and unfortunate; typical of the patriot in his unceasing efforts to aid and cherish the disabled soldiery of his country; typical of the wise counsellor in the soundness of his judgments; typical of the

true physician in his earnest cultivation of medical knowledge and in his philanthropic practice of the healing art; typical of the faithful Christian in his never flagging zeal in all good works.

*Resolved*, that the Society extend to the bereaved widow of the deceased in her great loss, sympathy and condolence.

JOHN BARTLETT,  
CHAS. GILMAN SMITH,  
H. A. JOHNSON  
*Committee on Necrology.*

#### CHICAGO GYNÆCOLOGICAL SOCIETY.

*Forty-Seventh Regular Meeting, Friday Evening,  
May 28, 1886.*

THE PRESIDENT, DANIEL T. NELSON, M.D., IN  
THE CHAIR.

W. W. JAGGARD, M.D., EDITOR.

*(Concluded from page 191.)*

The PRESIDENT exhibited specimens removed from

#### A CASE OF SUPERNUMERARY DIGITS.

While I know the condition is not exceedingly rare, I thought the specimen was so beautiful as to be worthy of presentation to the Society. The specimen consists simply of two supernumerary little fingers, which I found in a beautiful, healthy baby just after it was born, attached by small pedicles, consisting simply of the skin and the vessels needed to supply them, about the middle of the first phalanx of the little finger; the pedicles were perhaps one-sixteenth of an inch in length, just long enough to ligature. They look like little beans; the finger nails are fairly developed in both. They were very vascular. They looked, before removal, like bangles. This was the sixth pregnancy; the other children were all perfect; no other case of this condition in the family that is known. The condition is usually hereditary. In one there is a very good nail formed, upon the other there is only a slight nail. The mother is in good vigor and health. They were united to the larger little finger about the middle of the first phalanx—one was just about the middle of the phalanx, on the outer border; the other half way between the middle line and the outer border. They both feel as if there are bones in them—two phalanges in each, the third being represented by the pedicle.

DR. CHARLES T. PARKES, (Rush Medical College, 1868,) read a paper entitled

#### UTERINE FIBROIDS TREATED BY THE FLUID EXTRACT OF ERGOT.

My intention is to relate to you the history of four cases of uterine tumor, and to present a few remarks suggested by them. These four cases were treated by the internal administration of Squibb's fluid extract of ergot. They all resulted in recovery by expulsion of the growth.

I found no insurmountable difficulty in giving the

medicine, although when given for a prolonged period it creates nausea and disgust in some. This was counteracted, and the pain following its use controlled by combining it with morphine. It seemed to me preferable to the hypodermatic use—the latter being locally painful and often producing abscess, besides it is not followed by any better result. Two of the cases, treated by ergot, when thrown off, proved to be pure uterine fibroma—dense and hard—white and glistening when cut open—consisting of simple fibrous tissue. The other two following the action of ergot were soft myomata—pultaceous and semi-elastic—consisting mostly of connective tissue, confirming the diagnosis made. All four of these were evidently submucous tumors, or so slightly interstitial as to be practically covered only by mucous membrane.

CASE I.—Mrs. S., American, 43 years old, widow, three children, no miscarriages, menstruated first when 16 years old. Never had any noticeable trouble with menstruation until three years previous to my first examination; during these years she had suffered with irregular profuse hæmorrhages which were now continuous, accompanied with exacerbations on the slightest exertion. My first examination was made February 20th, 1876. As my memory brings this patient before me she presented the most perfect example of transparent flesh that I had ever seen. A large, finely formed woman, her flesh looked like alabaster, apparently destitute of blood. The legs were œdematous, the heart beat feeble and rapid, and the slightest exertion was followed by extreme palpitation and the most fearful feelings of suffocation. Her answer as to what she had done for her trouble was that she had taken "quarts of medicine." Vaginal examination revealed an enlarged uterus and patulous os, from which blood was rather freely oozing. The sound entered the uterus about five inches, the handle being deviated forwards and to the left side. A diagnosis of submucous uterine fibroid was made.

The treatment adopted was the administration of strychnia and iron, together with wine and good diet for the general condition, and one-half drachm doses Squibb's fluid extract of ergot every six hours, to either expel or kill the growth. Locally, to stay the hæmorrhage, a small tampon of pulverized alum was applied to the *os uteri* and held in position by ordinary cotton tampons.

The first forty-eight hours' use of the ergot produced quite serious uterine pains, so acute that the patient in her weakened condition said they were unbearable. At this visit Professor T. D. Fitch was with me in consultation. The tampon of alum was removed, and Dr. Fitch's examination confirmed the diagnosis made, and advised the continuation of the treatment. As the bleeding had been entirely controlled by the tamponade, it was left out. The ergot was continued as before, and a sufficient dosage of morphine ordered, to make the pains bearable if they persisted. No further use of the tampon was required, the uterine contractions never ceased while the ergot was administered. On the sixth day of its use a foul-smelling serous discharge came on *per vagi*.