

## CORRESPONDENCE

found in them. This diarrhoea cleared up without treatment before drainage of abscess was complete. No emetine preparation was given at any time. Relief was immediate, following drainage, and recovery was complete.

ROBERT BOOTH ACKER,  
*Assistant Surgeon, U. S. Public Health Service,  
U. S. Marine Hospital, New Orleans, La.*

### To Contributors and Subscribers :

All contributions for Publication, Books for Review, and Exchanges should be sent to the Editorial Office, 145 Gates Ave., Brooklyn, N. Y.

Remittances for Subscriptions and Advertising and all business communications should be addressed to the

**ANNALS of SURGERY**  
227-231 S. 6th Street  
Philadelphia, Penna.

## CORRESPONDENCE

### SINGLE ABSCESS OF LEFT LOBE OF LIVER OF PYOGENIC ORIGIN

EDITOR ANNALS OF SURGERY:

It is generally recognized that a high percentage of abscess of the liver is caused by infection with *amœba coli*, most cases being a complication or sequel of *amœbic dysentery*. Tropical abscesses, however, are found in which it is impossible to demonstrate *amœbæ*, and with no coincident dysentery or history of same. Tropical abscesses are nearly always found in the right lobe, some writers placing the proportion as high as 90 per cent. Left lobe abscesses are rare. In approximately 75 per cent. of cases solitary abscess exists.

Abscesses of pyogenic origin are usually multiple. Single abscess is seldom met with. They may be in any portion of the liver. They frequently are caused by suppuration in the small branches of the portal vein, within the liver, or are secondary to a focus of infection elsewhere, as the appendix or gall-bladder, etc. In view of the above mentioned accepted data as to liver abscess the following case has several points of interest which would seem to warrant its reporting:

A marine fireman presented himself complaining of epigastric pain, diarrhœa, fever, loss of weight, weakness, loss of appetite, nausea and vomiting.

The present illness began about two weeks ago with frequent bowel movements, which became progressively more frequent (as many as seven per day), some of which he states contained blood (?). He had a feeling of weakness, had very little appetite and lost about ten pounds in weight.

Five days ago, he indulged in a prolonged drinking bout, during which he was suddenly taken with a severe pain in the epigastrium. He was nauseated, and vomited. The pain was very sharp in character, and, as the patient states, "doubled him up." He went to bed and remained until the following morning, when he felt better. Later in the following day the pain returned—sharp and cramp-like. He was nauseated, and vomited. The pain persisted, and he was brought to the hospital for relief. He is unable to eat. Food nauseates him. He is passing two or three stools daily. They contain no blood.

*Past History.*—Five years ago the man had an attack of dysentery which was complicated by an abscess of the right lobe of the liver. The abscess was drained transpleurally. Drainage continued for about 2½ months after operation.

## CORRESPONDENCE

When admitted he was very restless and apparently in great pain. Eyes bright, facies drawn and anxious. The breath is foul and the tongue coated and tremulous. There is an operative scar about  $1\frac{1}{2}$  inches in length in the posterior axillary line at level of tenth rib. Tenderness is marked in epigastrium and under costal margin. Gentle palpation in these regions causes patient to wince. This tenderness seems a trifle more in the right epigastrium. The liver dulness is increased both upward and downward.

Fluoroscopic examination shows a diffuse enlargement of liver—both right and left lobes. The enlargement is very marked in the right lobe. A skiagraph confirms the above.

*Laboratory.*—White cell count, 14,000 and 12,800. Polymorphonuclears, 90 per cent. Amœbæ not found in stools. Malarial parasites not found. Urine negative.

*Operation.*—A modified Mayo-Robson incision made over right rectus. On entering the peritoneal cavity, dry adhesions between the surface of the liver and parietal peritoneum were found.

The liver presented itself considerably below the costal margin. The right lobe was diffusely enlarged. The presence of an abscess in this lobe could not be demonstrated. On examination the left lobe was also enlarged. An elevation of about six centimetres in diameter was palpated on its upper anterior surface.

A second, small incision was then made through the left rectus, directly over the elevation. The area was packed off with gauze strips. A trochar and cannula were introduced, and a thick, creamy, yellow pus was evacuated, which was not foul smelling. There was no reddish or chocolate colored material in the abscess cavity. The abscess cavity was irregular in outline, about the size of a hen's egg, and was traversed by trabeculæ. The first incision was closed completely and a rubber drainage tube inserted through the second opening. Amœbæ were not found in the pus evacuated or that taken from the walls of the abscess cavity. No bacteria were visible in stained smears. Staphylococci appeared in later cultures.

With the exception of a few minor difficulties, the man's recovery was uneventful and he was discharged from the hospital entirely free from symptoms and with operative wounds entirely healed.

We have in this case a single abscess apparently of pyogenic origin, occurring in the left lobe of the liver five years after an abscess, etiology unknown, but probably amœbic, in the right lobe of the liver. A second liver abscess, with recovery, in the same individual is not common. Abscess of the left lobe is uncommon; a single pyogenic abscess is rare.

Amœbic infection cannot be absolutely ruled out, but their presence was not demonstrated. A diarrhœa was present at time of admission. The stools were not typical of amœbic dysentery and amœbæ were not