

and a good pathologist who was present at the observation said that undoubtedly it presented all the appearances of scirrhus. The operation was complete, however, without further attack on the axillary glands, and subsequent pathologic examination revealed marked tuberculosis, which healed rapidly.

It is time to call attention to this subject and give these patients the advantage of early operation.

DR. WILLIAM KNIGHT, Hartford, Conn.—Just a little criticism of one point in regard to abscess. Dr. Levings said you could open the tumor and drain thoroughly. The tendency in treatment of those cases is to prevent absorption. It seems to me that it is folly to interfere with it. It also seems to me much better to open it and drain thoroughly with plenty of absorbent cotton. I think we will get much better results by the treatment of abscess in this manner.

DR. ANDREW W. MORTON, San Francisco—I have had experience with only one case which puzzled us considerably. We used the tubercular serum to make the diagnosis, and got the characteristic reaction which we usually get in using this serum where there are tubercles. After the removal of the gland the microscopic examination showed the diagnosis to be correct.

DR. A. H. LEVINGS, Milwaukee—I may add that one additional case has come under my observation since this article was written. Of my cases of tuberculosis of the mammary gland one was secondary to a tubercular process of the lungs, while two were secondary to tubercular processes in the axilla. The others, so far as I was able to determine, were primary within the breast itself. In some of these I think the infection was through the milk ducts. In others the infection was through the circulation, arterial or lymphatic. I am very confident that we have been mistaking these cases for carcinoma because the two conditions may present practically the same symptoms, in that there is a hard nodule, retraction of the nipple and enlargement of the axillary glands.

In regard to the treatment of opening and curetting an abscess, I am of the opinion that in a case in which there is but a single abscess with no out-lying nodes, this treatment may be recommended, and probably will, if properly carried out, result in a large number of cures. This, in fact, is the treatment generally which we are accustomed to follow in cases of tubercular abscess.

ABSCESS OF THE SPLEEN.*

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Abscess of the spleen is rare, and when a case falls into our hands and is operated on successfully, it is worthy of record.

About the middle of May, 1901, I was called to see Mr. A., and obtained the following history:

History.—American, age 74 years, weight 211 lbs. Family history: Mother and one sister died of consumption. Father died of some brain trouble. Previous history: Has had two severe falls, the last one two years ago, from which he never fully recovered. Jan. 10, 1901, was seized with a severe attack of influenza, which completely prostrated him. At the end of three weeks the temperature and pulse were normal. He has never lived in a malarial district and has never suffered from typhoid or malarial fever. Since the beginning of his sickness he has constantly lost in weight.

Present Illness.—Patient in bed, anemic, covered with a cold perspiration, very nervous, anorexia, night sweats, slight constipation. Complains of numbness in legs and feet, slight though constant pain in left thorax just above lower border of ribs. At times he is pressed for breath, which appears to be due to his nervous condition.

Physical Examination.—Temperature normal, pulse 100, weight about 175 lbs., heart's action very feeble, slight tenderness on deep pressure under lower border of ribs on left side,

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reflexes normal. I thought that his condition was due to the severe attack of influenza which he experienced. Gave him strychnin and tonics. The improvement in his condition was marked, so much so that in a few days he was up and down stairs. I did not see him again until May 30, 1901. His physician then stated to me that the patient, while being carried upstairs on his son's back the night before, cried out that something had given way in his left side and that he was very faint. He was immediately put to bed and stimulants administered, to which he at once responded. I saw him the next morning and found his pulse 64, and temperature normal. He was very nervous, had a sallow cachectic look, and had lost a great deal of flesh. He complained of constipation, and of severe pain in left hypochondrium. Some edema of legs and ankles was present. His heart was much stronger. Hard tumor in left side extending above lower border of ribs, tender, no fluctuation, urine negative. I considered the tumor malignant, which diagnosis was coincided in by several physicians. Advised exploratory laparotomy.

Operation.—June 8, 1901. On examination under ether I found a hard, non-fluctuating tumor extending from above the lower border of the ribs downward to the crest of the ilium and inward to the linea alba, smooth, most prominent just below ribs. Incision made over most prominent part of the tumor. Found an enlarged spleen very dark in color, which was bound down by numerous adhesions. The anterior surface was comparatively free. Anterior wall of abscess thick, posterior wall very thin, indicating that it would have soon ruptured, allowing contents to escape into abdominal cavity. Because of the thinness of the wall and the numerous adhesions I considered an attempt at removal dangerous. Walled off with gauze and made an incision into the spleen through which was evacuated two quarts of creamy pus mixed with a little blood and cheesy-looking material. Cavity curetted, washed out and spleen sutured to abdominal wall with chromicized catgut, iodoform gauze drain. Convalescence rapid and uneventful and in five weeks he was up and dressed. On Aug. 2, 1901, he suddenly became unable to swallow. Aphasia and hemiplegia of the right side appeared, and after this he rapidly failed and died Aug. 4, 1901. Unfortunately an autopsy was not obtained.

Report of Dr. C. D. Smith, who made an examination of the pus: "I fail to find tubercle bacilli, yet the presence of calcareous material is strong evidence of that nature of the abscess. It contains a multitude of lymphoid cells, much pus, a few crystals of hematoidin showing that there has been a hemorrhagic area in the organ or an embolus, and a few bits of characteristic yellow elastic tissue and fragments of spleen tissue."

Several cases of abscess of the spleen have been reported in which the pus was sterile, and from the absence of any previous septic condition, and the constant normal temperature, I am inclined to think that it was sterile in this case.

I ought to have made a correct diagnosis, but was led astray by the absence of fever, the slight pain, the rapid emaciation and extreme constipation. A blood count would have been of great assistance. Bessel-Hagen thinks the considerable increase of leucocytes in the blood of the greatest diagnostic significance.

The condition in this case was probably due to an embolus lodging in the splenic vessels which, on account of the slowness of the blood-current in terminal arteries, are peculiarly susceptible to the lodgment of emboli.

SUMMARY OF THE LITERATURE.

In looking over the literature on this subject, I have collected 65 cases, 23 of which occurred after an attack of malaria or typhoid fever, 1 after yellow fever and 3 after appendectomy. The others were ascribed to various causes, such as trauma, disease of heart, sudden chilling of the body after excessive heat, tuberculosis, anthrax, alcoholism and exhaustion. Eight cases in which the

etiology was doubtful were probably due to malaria, and in eleven the etiology was unknown. Metastatic abscesses have been reported following osteomyelitis, gunshot wound of the knee and amputations.

Grand-Moursel reports 57 cases, 20 of which were due to malaria; 9 of them diagnosticated, with 8 recoveries, while 11 were recognized only at autopsy. From this it would seem that more cases occur than we are led to believe, which are not diagnosed either before or after death.

ETIOLOGY AND DIAGNOSIS.

The hyperemia of the spleen during malaria and typhoid renders it particularly susceptible to inflammation and abscess formation. All writers agree that the diagnosis is extremely difficult. The chief diagnostic symptoms are history of infectious disease, pain in left hypochondrium which may radiate to left shoulder, night sweats, anemia, loss of appetite and usually chills. Fever may or may not be present; if present, it is of little significance, as it may be due to the original disease. Occasionally extreme constipation is present, but more often diarrhea. Blood count shows increase of leucocytes (Bessel-Hagen). Tenderness on deep pressure usually present in the beginning of the attack. Fluctuation is of value as a diagnostic sign only in those cases which are palpable under the abdominal wall.

In such diseases as malaria and typhoid, in which there is commonly an increase in the size of the spleen, the increase alone is not symptomatic of abscess formation, but if the increase in dulness is progressive, and added to this there are one or two or all of the above-named symptoms, it is at least very suggestive of abscess of the spleen.

If an embolus lodges in the spleen, it may be some time before any enlargement is apparent, and, in fact, I think that a small abscess may form in this way, become encapsulated, remain latent for a long time, and then either be absorbed or receive a severe blow or strain, which may cause a rupture of the capsule, after which a rapid increase in size of the spleen becomes apparent, or several abscesses may coalesce, forming one large abscess. I believe that this occurred in the case described above, and that the abscess ruptured into the substance of the spleen at the time he cried out, while his son was carrying him upstairs. From this time on the increase in size was remarkably rapid.

PROGNOSIS.

If recognized and operated on sufficiently early, the prognosis is fairly favorable. If not operated on, the abscess may rupture into a hollow viscus and the pus be evacuated by means of that organ. More often it will rupture into the peritoneal cavity and death ensue. Three cases among the sixty-five reported above recovered after rupture of the abscess, one opened into the cecum, one into the left lung, and one into the left lung and stomach.

Death of the patient can be attributed more often to the debility following such diseases as malaria, typhoid and tuberculosis than to the operation or the abscess itself.

TREATMENT.

This is purely a surgical disease. In a few cases splenectomy has been performed, but in order to do this operation successfully the diagnosis must be made very early in the course of the disease, before adhesions have formed. Bessel-Hagen states that splenectomy for splenic, perisplenic and parasplenic abscess was performed seven times, three up to 1890, four in 1891.

The same author reports two cases of splenotomy in which the abscess was reached by resection of a portion of the ninth and tenth ribs. Lauenstein also reports one similar case. In the greater number of cases aspiration was first employed, then later incision through the abdominal wall. Splenectomy is the operation to be preferred, but it is limited to those cases in which adhesions have not formed, and to those in which there is no danger of infecting the peritoneal cavity. By this operation we remove the entire organ and its contents at once, thus giving a clean wound, and a much more rapid and satisfactory convalescence. Until we are able to make an early diagnosis, splenotomy is the operation of necessity, and it should be chosen in those cases in which there is great debility and in those in which the abscess wall is thin.

I do not believe that aspiration is necessary in the majority of cases, and its use should be condemned. We should be able to make the diagnosis without its aid, and it subjects the patient to one more chance of infection.

In the early stages of the disease, when the abscess cavity is small and the spleen has enlarged but little, if at all, it is very doubtful if the aspirating needle would throw any light on the diagnosis. Later, when the spleen has increased in size, and possibly fluctuation is present, its use is unnecessary and dangerous. If, after the exposure of the tumor, it is found to be very large, it is wise to aspirate before making a free incision into the spleen, thus diminishing the danger of infection.

CONCLUSIONS.

1. Abscess of the spleen is rare, but not as rare as we are led to believe.
2. It is most likely to occur after malarial or typhoid fever, because of the hyperemic condition of the spleen in these diseases.
3. Absence of fever does not preclude the possibility of an abscess.
4. Early diagnosis and operation are very essential, and give a fairly favorable prognosis.
5. Splenectomy is the operation of choice, but its application is limited.
6. Preliminary aspiration is an unnecessary procedure, and its use should be condemned.

ACUTE EPIPHYSITIS CAUSING A CONDITION SUBSEQUENTLY SIMULATING CONGENITAL HIP MISPLACEMENT.*

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OMAHA.

The writer uses the word misplacement, instead of dislocation, agreeing with Tubby, who says that dislocation can not properly be applied to a condition where the bone never was in place; the word misplacement seems to be better suited to describe the congenital condition. Epiphysitis does, however, result in a dislocation, and the condition might therefore be properly called pathologic dislocation of the hip, resulting from epiphysitis.

May 12, 1902, a female child of 2 years was referred to me by Dr. McClanahan. It was delicate, but well nourished. Appearances indicated congenital misplacement of the right hip. Indeed, all the conditions were typical of this condition.

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