THE ANTISEPTIC TREATMENT OF HEPATIC ABSCESS.

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PRIVATE THOMAS DEBELL, 4th Hussars, aged 39, twenty years' service, of which seven were spent in India, was invalided from India, and admitted into the Royal Victoria Hospital, Netley, on May 10th, 1878. He had suffered from primary syphilis in 1865, for which he was treated with iodide of potassium and mercurial fumigations. In 1870, he had repeated mild attacks of ague at Meerut, followed by syphilitic rheumatism. In 1871, he was sixty-three days in hospital, according to the medical history sheet, for "Bright's disease, cause unknown". There is, however, reason to believe that the symptoms which were supposed to indicate Bright's disease were in reality due to injury to one or both kidneys, the result of a heavy fall on his back from his horse. No symptoms of Bright's disease, nor any affection of the kidneys, were present on admission. He was invalided for the results of this accident, and sent home, arriving at Netley in April 1872, well and fit for duty, and at once sent to his dépôt, and, after a time, returned to his regiment in India.

In March 1878, he had what he describes as a slight attack of dysentery, from which, on embarkation for England, he was convalescing. During the voyage, while on night-duty, he slept on deck, was chilled, and suddenly seized with acute pain in the hepatic region, with rigors and vomiting. The following was his condition towards the end of May. He was emaciated; his tongue was clean; no diarrhoea; appetite bad; morning nausea. He was very restless, sleeping badly, yet his spirits were always good. Morning temperature 100 deg.; evening, 101 to 102 deg. Fahr. Pulse 80 to 90. The cardiac sounds were normal. Cough was troublesome at night; there was slight crepitation at the base of both lungs. Hepatic dullness in the mammary line extended from the sixth rib to within two inches of the crest of the ilium. Just below the cartilage of the ninth rib, there was a well-defined prominence, four inches in diameter, extremely tender, but without fluctuation. There were, in addition, general hepatic pain, and impatience of palpation over any part of that region; and the superficial veins on the right side of the abdomen were prominent.

On June 6th, an unsuccessful attempt was made to evacuate an abscess, the existence of which was diagnosed, with an aspirating needle. No pus was found, but rather more than half an ounce of blood was withdrawn by the exhausting syringe. For two days, the patient experienced considerable relief of the local symptoms from the operation. Soon, however, diarrhoea and night-sweats set in. It was then determined to operate again, this time according to the antiseptic method. The operation was performed by Surgeon-Major Porter, Assistant-Professor of Surgery, the patient being under the influence of ether, a powerful steam-generated carbolic spray playing on the part. An opening was made with a full-sized trocar between the ninth and tenth ribs. Twelve ounces of thick creamy-looking pus having been withdrawn, a drainage-tube was introduced and secured in the usual way; the part was dressed with carbolised gauze and tow, and secured with a carbolised bandage, according to Mr. Lister's method, the spray playing until the dressing was completed. At every subsequent dressing, the same method was carried out with scrupulous care, so as to avoid the entrance of uncarbolised air, and the discharge was received in the carbolised dressings.

It is not necessary to give the details of the case further than to say that the case progressed favourably, and that, the great heat of the weather notwithstanding, the discharge continued free from every trace of mal-odour to the last. Some difficulty was experienced in introducing fresh drainage-tubes, owing to contraction of the wound, which was overcome by careful dilatation with bougies. During treatment, the patient was troubled by a return of syphilitic rheumatic pains, which were relieved by iodide of potassium in full doses. On August 25th, the tube was withdrawn, the wound, however, being still dressed with carbolised lint. By the end of August, the wound was quite closed, all pain and tenderness on pressure had ceased, his general health was good, his temperature was normal, he had gained flesh, and was able to make himself useful to patients in the ward. The liver was greatly reduced in size; in fact, in all directions, little exceeding its normal limits. Having completed his time of service, he was finally discharged "to pension", in very good health.

We see at Netley more hepatic abscesses than are probably to be found in all the hospitals in this kingdom. We have given an extensive trial to treatment by aspiration; and although, in a few instances, the results have been satisfactory, and in almost all attended with considerable temporary relief to the sufferers, we have, on the whole, been

disappointed by this mode of treatment, which at first promised so well. Very rarely has one tapping sufficed; in by far the majority of our cases, aspiration had to be repeated again and again, the pus withdrawn often amounting in the aggregate to hundreds of ounces; in one case, recorded by me in the *Army Medical Reports*, to six hundred ounces; until patients, worn out by this immense discharge, and the great destruction of liver-substance, at last succumb. Nor is this to be wondered at; nine out of ten of the cases of liver-abscess that come to us at Netley are of old-standing, have a dysenteric origin, and are multiple, and the sufferers are worn out by the previous dysentery and its formidable sequel. In the army medical report above referred to, I gave a series of cases of this kind, and urged the desirability of trying the plan of drainage on antiseptic principles, as strictly carried out in the case reported above. I hope that an extensive trial of this more hopeful method will be made in the civil and military hospitals of India, where tropical abscess of the liver is of only too frequent occurrence.

In the report of the case given above, the relief of symptoms following the direct removal of a small quantity of blood by the aspiratory instrument at the unsuccessful attempt to find the abscess is noted. This has occurred to me so often, that I have frequently taken occasion to point it out to our young medical officers about to go to India, as a promising method in acute cases for cutting short inflammations of the liver, and preventing suppuration. No one has been more urgent against the coarse and unsurgical methods of exploration with large instruments, at one time in fashion, than I have; but with the fine needles and aspirating instruments now available, the liver may be punctured and blood abstracted directly from it, without fear of evil consequences, and, I believe, often with great benefit. The method is, at all events, worth a fair trial in those parts of the world where this important organ is subject to suppurative inflammation.

A NEGLECTED PROXIMATE CAUSE OF DYSPEPSIA, WITH A NEW DIVISION OF THE DISEASE.

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ALL cases of true dyspepsia may be referred to two proximate causes. Instead, then, of the classification into atonic dyspepsia, which is not used in any precise sense, and gastritis or gastric catarrh, neither of which terms is applicable to all the cases they are often made to include, I propose the following divisions.

Dyspepsia from impaired motion;

Dyspepsia from defects of secretion.

We have nothing at present to do with the latter, beyond what concerns the differential diagnosis between the two classes.

Avoiding minor details, the leading symptoms of dyspepsia, namely, uneasiness in the stomach after meals, described variously as a sense of weight, fullness, or pressure, flatulence, pain, and constipation, are, for sake of comparison, arranged in parallel columns, and each is separately considered under the two above named heads.

IMPAIRED MOTION.

Uneasiness after Meals.—A constant symptom; generally soon replaced by the sense of tension accompanying flatulency.

Flatulence.—This is the most characteristic symptom of impaired motion.

Gastric Pain.—Unfrequent; but occurs occasionally as a result of flatulence, and is peculiar in kind.

Constipation.—Almost always a marked symptom.

Although the great importance of gastric peristalsis has not been hitherto recognised as a cause of dyspepsia, due weight has long been

DEFECTS OF SECRETION.

Uneasiness after Meals.—Not unfrequent, but commonly soon merged in actual pain.

Flatulence.—Comparatively unfrequent. Some of the worst cases, in which pain after food and other symptoms are particularly severe, are entirely free from flatus. The tendency is to lactic, butyric, and, perhaps, other forms of fermentation, in which gases are not evolved.

Gastric Pain.—Variously described as sharp, shooting, dull, or dragging, is the most characteristic symptom of defective secretion of gastric juice.

Constipation.—Not generally present; and the bowels are in many cases relaxed.