TWO UNUSUAL CASES OF LIVER ABSCESS.

BY

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Intrahepatic Suppuration due to Infection, conveyed by Exploratory Puncture, from a Right-sided Empyema.

In the following case intrahepatic suppuration was evidently due to infection, conveyed by means of exploratory puncture, from the empyema:

A groom, aged 25 years, admitted under my care at St. George's Hospital on April 23rd, 1913, had been taken ill fourteen days previously with a rigor and a dry cough, and had remained in bed since. Three days after the onset he began to cough up "phlegm," but had not had any haemoptysis. On April 21st he had acute pleuritic pain on the right side. On admission he presented the signs of a right pleural effusion; the liver did not come below the costal arch in the right nipple line. Under novocain an exploring needle was inserted in the sixth intercostal space in the axillary line and in the eighth intercostal space in the line of the inferior angle of the scapula, but no fluid was withdrawn from these two punctures. Next day the trocar of an aspirator was inserted into the eighth space in the line of the inferior angle of the scapula, and in the sixth space in the posterior axillary line, but only a small quantity of blood and serum was withdrawn. From the fifth space in the anterior axillary line about 1 oz. of thick pus was aspirated with difficulty; it contained a Gram-positive coccus. At 8 p.m. Mr. Fedden resected 1 in. of the eighth rib below the inferior angle of the right scapula, opened the pleura, and found solid lung; the wound was plugged. One inch of the sixth rib in the anterior axillary line was then resected, and about a pint of creamy, odourless pus was evacuated from the fissure between the upper and middle lobes. After this the temperature continued to oscillate between 103° and 97° F.; the pulse varied between 140 and 100, and the respirations between 44 and 24. It was obvious that there was retained pus although the discharge was free, but his condition rendered further operative interference undesirable. Death from sudden collapse occurred on May 6th.

The necropsy was performed by Dr. R. S. Trevor. The right pleural cavity contained two distinct abscess cavities of which one had been drained and the other had not been opened. The liver, which weighed 4 lb. 12 oz., was enlarged, and was adherent to the diaphragm. Over the anterior and diaphragmatic surface of the right lobe there was an area the size of the palm of the hand projecting from the surrounding liver tissue. It was obviously an area of suppuration, and showed a small puncture on a level with the fifth rib. Section revealed a large multilocular abscess, several of the loculi near the puncture being full of blood clot. The puncture opened directly into a space containing blood clot and pus.

It is important to realize the danger of causing intrahepatic suppuration in this way. The risk has not attracted much attention. Bryant¹ thought that a case of suppurative pylephlebitis in which the primary disease was an empyema rupturing into the lung was possibly due to exploratory punctures which had passed through the empyema into the liver, and thus infected the intrahepatic branches of the portal vein.

Small Latent Solitary Hepatic Abscess in an Infant.

In the following case the abscess was quite recent, and possibly formed during the last week of life:

A premature female twin, 10 weeks old, was admitted to the Victoria Hospital for Children, Chelsea, on October 26th, 1912, for wasting. Her weight, which had been 6 lb. two weeks before, was 4 lb. 6 oz. The infant had been breast-fed since birth, but had taken the feeds badly. Three other children, including the twin (who was doing well on borough council milk), were healthy. The infant had not been sick; the faeces were constipated and offensive. The abdomen was somewhat lax and retracted, but nothing abnormal was felt. The skin generally was inelastic. On careful feeding the infant gained weight, until, on March 28th, it scaled 9 lb. 1 oz. For the first two months the temperature was usually subnormal, but later on it was about normal; on a few occasions it ran up temporarily to 99° F. The pulse was usually about 120. There were a few intercurrent attacks of diarrhoea. On March 29th, 1913, the temperature shot up to 101°; the next day it reached 104°, the pulse being 150 and the respirations 42. The temperature remained at 104° until April 3rd, when it fell to 97.4°, going up to 102.8° shortly before death. On March 30th the skin showed a dark mottled rash.

The necropsy by Dr. W. J. Penfold showed 4 oz. of serum in the right pleura without any evidence of pleurisy, and bronchopneumonia of the lower lobe of the right lung. In the right lobe of the liver there was a loculated abscess the size of a pigeon's egg; the abscess abutted on the convexity of the liver, but did not cause any bulging or any marked perihepatitis. Microscopically the abscess was quite recent, and did not show any fibrous capsule. The pus contained streptococci but no tubercle bacilli. The vermiform appendix and all the other organs, except the liver and right lung, were healthy.

It does not appear certain that in this instance there was any direct association between the abscess and the appearances of bronchopneumonia and serous pleural effusion at the base of the right lung. It is said that hepatic abscess is more often latent in children than in adults, and that it may give rise to extra-hepatic manifestations only such as purulent pleurisy or peritonitis (Castaigne et Simon²). Legrand³ collected 112 cases in children, of which 31 were dysenteric, 19 traumatic, 9 of doubtful origin, and 1 influenzal; the remainder were multiple and small. Apart from pylephlebitic abscesses, usually due to appendicitis, intrahepatic suppuration in children is very rare in this country.

REFERENCES.

- ¹Bryant, J. H., *Guy's Hospital Reports*, London, 1900, liv, 77.
²Castaigne et Simon, *Pratique des mal. des enfants*, 1910, iii, 115.
³Legrand, *Arch. de méd. des enfants*, Par., 1906, ix, 129.

SPLENOMEGALY.

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UNTIL we know more about splenomegaly, I believe that resection of the spleen is the only chance we have to save a patient's life. Hitherto this disease has always been fatal, and no medical treatment has been of any value.

Osler has grouped under this head cases characterized by idiopathic enlargement of the spleen, with anaemia. Whether this is secondary to the splenic condition or otherwise, or both, or secondary to some other cause, is not known. Attention was first called to it in England in 1871; before this, splenic anaemia was regarded as the splenic form of Hodgkin's disease.

To a group of cases of enlarged spleen and cirrhosis of the liver accompanied by ascites the name of "Banti's disease" is given; it is, I believe, the last phase of splenic anaemia. The main symptoms are enlargement of the spleen and anaemia of a secondary type but without leucocytosis, with, in most cases, various haemorrhages and a downward course. The spleen is greatly enlarged; in some cases this enlargement seems to have preceded the anaemia; the lymphatic glands are not usually enlarged, the average of red blood corpuscles is below normal, the haemoglobin is relatively low, the leucocytes are diminished in number, but the differential count shows no special feature. There is often marked pigmentation of the skin, and as the disease advances so does asthenia.

Rolleston has summarized the above symptoms as follows: Anaemia of the type usually spoken of as chlorotic, namely, a diminution of red corpuscles with a diminished corpuscular value of haemoglobin; absence of leucocytosis, usually leucopenia, considerable splenic enlargement which cannot be correlated with any other known causes such as leukaemia, tuberculosis, malaria, syphilis, and hepatic cirrhosis, the long duration of the disease, and the tendency to gastro-intestinal haemorrhages.

The diagnosis lies between splenic leukaemia, Hodgkin's disease with enlarged spleen, hepatic cirrhosis (alcoholic, syphilitic, or hypertrophic), and old cases of malaria with hypertrophy.

As to the cause of the disease, nothing is certain, and we must remain in doubt until more is found relative to the functions of that organ.

The spleen is classified in our works on physiology as a blood-forming organ, and the most important one. It is known that this function exists only during the prenatal period; at birth it apparently ceases, and other organs—namely, bone marrow and lymph cells—take up that work, or continue to manufacture blood, a function which they may have shared with the spleen during the fetal period. Since when the spleen is removed, in case of rupture or dislocation, no changes occur in the blood, we must admit that the spleen is not essential to life, and that its removal does not interfere with the health of the individual. A prevalent theory is that after birth its function alters, and that it takes a prominent part in consuming the broken-down blood cells.

When the spleen is removed in cases of splenomegaly the blood almost immediately improves in quality, and