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CLINICAL LECTURE ON HYPERTROPHIC FIBROSIS OF THE LIVER.

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GENTLEMEN,—I take for the subject of my lecture to-day two cases illustrating forms of hepatic enlargement. You will remember that we discussed on the last occasion the case of a woman who died of acute atrophy of the liver, and I directed your attention to the remarkable series of cases in my wards illustrating many varieties of hepatic disease.

The case of malignant disease has already terminated. We have now two cases of jaundice under observation, one in a woman, the subject of the catarrhal form, and another which I shall bring before you in this theatre.

The first case I show you is that of J. H., aged 26, a ship-steward, who came in on the 27th October, 1891, and is in John Ward. You notice that he is a well-developed young man, with a somewhat sallow and sickly aspect. His chief complaint is of pain in the right lateral and hypochondriac regions. His history is that he has travelled in all parts of the world, chiefly by sea. He was in India in 1883, and suffered from dysentery and ague when there. He states that he had pleurisy in the left side three years ago. About two years since he found a swelling in his right side, and went into hospital at Sydney on account of it. While there this swelling was punctured, but nothing but blood came out. He was recommended to return to England. He was landed at Port Said in February of this year, and remained in hospital there for a month. The pain he complains of returns from time to time. Since his admission here he has had no pyrexia, and he is more comfortable. Examination of the abdomen reveals a great enlargement of his liver. The dulness begins at the fourth rib in front, and extends to a level with the navel, where the edge can be felt. Behind, the dulness extends upwards and encroaches a good deal on the area properly occupied by the base of the right lung. The spleen is not felt. The surface of the liver is smooth and hard, and the protuberance is marked in the epigastrium and right hypochondrium. It descends fairly well on inspiration. There are no enlarged veins on the abdomen, and no fluid is detected in the peritoneal cavity. There is no jaundice. Both legs are œdematous. The urine is of rather low specific gravity, 1005, and presents no trace of albumen. On several occasions I thought I could detect a thrill on percussion over the most prominent portion of the liver. There is no history of syphilis. In respect of alcoholic habits, there is no history of intemperance, and no obvious physiognomical appearance of such. At the base of the right lung can be heard some finely crepitant sounds and doubtful friction.

The heart-sounds and other characters are normal. The family history is not noteworthy.

Such are the main features of the case. What have we to deal with, and how shall we interpret the physical signs and history which it presents?

Having regard to the history, the long duration of the signs and symptoms, and the little inroad on the general health

made by the disorder, the absence of syphilitic history, and the character of the enlargement, I formed the opinion that we had probably to deal with a hydatid cyst of large size, deeply seated in the liver, and pressing upwards towards the base of the right lung. Sir Andrew Clark had occasion to see the case with me one day last week, and concurred in this view of it. Mr. Langton was, therefore, summoned to make an exploratory puncture, and he did so in the most prominent portion of the tumour. Nothing was withdrawn by aspiration, however, although a trocar was passed in for nearly four inches. No trouble followed this puncture, which was made without employing an anæsthetic.

Being still of opinion that a cyst existed, it was determined to wait for a few days, and make fresh punctures in various situations under ether. Accordingly, ten days later, Mr. Langton repeated these measures in two places, and I took the opportunity of puncturing in another. In all of these, failure to reach any fluid ensued. The trocar appeared to pass through very dense fibrous texture, which creaked as it was traversed. No ill effects of any kind followed these punctures. At the site of one of them, venous bleeding occurred near the suspensory ligament, which soon ceased. What opinion are we to form now after failing to find evidence of any hydatid cyst?

We have excluded ordinary cirrhosis, due to alcoholic excess, and syphiloma, and are sure it is not a fatty liver which is before us. It is practically a painless form of enlargement; the capsule of Glisson is not specially involved, and there is no sign of perihepatitis. It is not a lardaceous liver. It is not a new malignant infiltration. It is not a tropical abscess of the liver. It is not a form of cirrhosis due to obstruction of the bile-ducts, for there is neither history of biliary colic nor jaundice. The portal vein is not specially involved or compressed, for there is no ascites. The œdema of the legs we must attribute to some pressure on the inferior vena cava of gross mechanical nature, due to the greatly-enlarged liver itself. Hepatic metabolism is not very gravely compromised, for the general nutrition has been singularly well-maintained for two years past, and bile is formed and passed into the bowels. Such are the arguments I lay before you by way of exclusion. Do they bring us any nearer the truth or a correct diagnosis of the case?

It is not infrequently the case that it is easier to say what a disease is not than what it is. But I shall venture on a diagnosis. My opinion now is that we are in presence of a form of cirrhosis, or rather I would say, to be etymologically accurate, a form of fibrosis of the liver, due to tropical influence—to use a somewhat wide term. By this I mean, that the hepatic enlargement is mainly due to a hypertrophous condition of the connective tissue, induced by heat, by malarial irritation, and probably to some extent by alcohol, and by an indolent life with good feeding. Why such a condition is not more commonly met with, I would explain by the doctrine of personal and tissue proclivity. The liver in this man is more than ordinarily a vulnerable organ, and has yielded to all these influences accordingly. You may reckon the case as illustrating one of the forms of hypertrophic cirrhosis or fibrosis, for there are, I feel sure, several varieties of this condition. Amongst them I plainly recognize (a) ordinary cirrhosis, due to alcohol, with enlargement, not progressing towards contraction, with and without ascites; (b) biliary cirrhosis, in which the fibrosis mainly pursues the lines of the duct-system, following on gross obstruction to the common duct, of permanent character; and (c) such a form as is before you, due to long continued engorgement of the organ from malarial and other influences due to improper ingesta.

Such then is my reading of this case. What will benefit our patient? In the first place, a suitable dietary of plain

non-irritating food, without alcohol; life in temperate climates, avoiding cold and exposure. As to drugs, I counsel the use of chloride of ammonium, in doses of twenty or thirty grains, with nitro-hydrochloric acid, and perhaps strychnine. We shall try the inunction of biniodide of mercury ointment, so as to secure smart counter-irritation. In private life, recourse to the waters of Carlsbad, Vichy, or Kissingen would be desirable.

As to prognosis, we may look forward to a fairly good result. This man will never be a thoroughly robust or sound man. You would reject him were he a candidate for life assurance, because it would be an improper speculation for a sound society to take such a risk. But apart from that ordeal, you may, as his attendant, think better of him, and determine to persevere with treatment for years, if need be. In its further course, you might do well to try iodides of potassium and iron from time to time. I doubt if mercurials would much assist in a case of this kind. In any case, you may feel sure that the better the general health, and the higher the level of general nutrition you secure, the better it will be for the particular condition of the liver.

(The patient left the hospital a few weeks subsequently, greatly improved in general health, and having gained weight. He proposed to return to his duties at sea.)

The next case I direct your attention to, is that of C. D., aged 45, a country labourer. You notice at once that he is much jaundiced, a spare wiry-looking man. He came into Matthew Ward on October 26th. He tells us that he has always been healthy and active. In the beginning of August last he became jaundiced, and he thinks he was more yellow six weeks ago than now. He has suffered severely from prurigo with the jaundice, and you see over his trunk and extremities papules, which have been violently scratched. This is common enough in such cases, and is attributable to the irritation of biliary pigment and acids on sensory nerve twigs in the skin. His motions are white, and his urine bile-stained. There is no xanthopsia. He has had no pain whatever, and no vomiting or disturbance of digestion. His family history is unimportant, except as respects his father, who died of cancer of the tongue at the age of 60. He gives a very uncertain history of syphilis at the age of 18. He has never been abroad. In earlier life he drank freely of beer. His temperature is subnormal. In his thorax we find signs of slight general emphysema of the lungs. He suffers somewhat from cough in winter. A few rhonchi are audible over the lungs. The heart is natural, though a little overlapped by the left lung. The pulse is 60, rather infrequent, as is common in jaundice. The arteries are thickened. The liver is very large, uniformly so, and smooth. The dullness begins at the seventh rib, and extends for eleven inches in the right nipple line to the level of the anterior superior iliac spine. The spleen is impalpable. There is neither ascites, enlarged abdominal veins, nor oedema of the legs. The urine is sp. gr. 1016, and void of albumen.

Here then is another example of a painless hepatic enlargement without ascites, but with jaundice. What is the cause of it? In the first place, there is pressure somewhere on the biliary ducts. This has come on insidiously, and it is of an abiding nature. Patients with chronic jaundice are apt to waste from interference with hepatic metabolism, and diversion of bile from the alimentary canal. You may thus be led to suspect malignant disease when there is none. Is there such here? This man's father died of cancer of the tongue. But there are two factors against the likelihood of it in this case. First, his age is somewhat early for cancer, and there is no pain. These are neither absolutely against the idea of malignant disease, but they count for something. We can exclude blocking of the common duct by gall-stones, for there is no history of this and the gall-bladder is not palpable. The long history of the case tells against simple catarrh of the upper bowel and gall-ducts. It is a somewhat obscure case. There may be some new growth in the fissure of the liver, or in the head of the pancreas compressing the common-duct. There may be a small hydatid tumour causing the same symptoms. In neither case would you look for pyrexia, and the biliary disturbance explains the wasting if the latter be the cause. I do not believe that the whole organ is infiltrated with new growth, and I regard the hypertrophy as due to a biliary cirrhosis or fibrosis. This may follow on an abiding

source of pressure, as we know by the results of direct experiments on animals when the common duct is ligatured.

For treatment we must be content to employ such a diet as can best be digested, avoiding excess of hydrocarbons, as fat and sugar. We are giving ox-gall in capsules after meals, and at present employing the benzoate of sodium in full doses (gr. xv) thrice daily.

Warm alkaline and carbolio acid baths and carbolized ointment best relieve the intolerable itching.

Chloride of ammonium and bicarbonate of sodium are amongst the best drugs we know of to aid in such a condition, and we must wait and watch for any new developments or indications.

The prognosis is not satisfactory in view of the history of the case. General wasting and loss of strength are likely to follow, and we have, I fear, not much to hope for. Nevertheless, now and then I have been agreeably surprised to find patients I had condemned live on for many years and carry on their duties fairly well, not as rural labourers certainly, but in some light avocation; and it is not justifiable to make either for oneself, or for the patient and his friends, too gloomy a prognosis, till by long observation we feel satisfied that the outlook is really hopeless.

AN ADDRESS

ON

SOME OF THE MORE UNUSUAL PHENOMENA OF EPILEPSY.¹

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I NEED scarcely remark how unsystematic is our nomenclature of disease. Some diseases have for their appellations an anatomical basis, whilst others are named after a group of symptoms, or, rather, after the most prominent of the symptoms. This method is more satisfactory than the other, as it does not tie us to any pathological fact from which there is never afterwards any escape. If we see a combination of symptoms, which is repeated over and over again in different persons, we are warranted in giving a distinct appellation to that group. Having done this, we ask ourselves, Are we bound to require the presence of every one of those symptoms to constitute the disease? We say no; but then comes the more difficult question, Which are the essential ones? Take, for example, exophthalmic goitre; we have all agreed to give this name in any particular case, even if the eye is not affected, the other symptoms of the disease being present. We have also agreed to do the same, under like circumstances, even if the thyroid be unaffected. I myself go further than this, and believe I see the same affection when neither throat nor eye is involved, so that we have in fact the play of *Hamlet* without *Hamlet*. When I see, for example, a patient much wasted, with very quick pulse, sweating, etc., and relieved by the same remedies which cure Graves's disease, I believe I have pathologically this complaint to deal with.

Now, as regards epilepsy. No disease is more characteristic in its typical form, that is, where a person falls down with a loss of consciousness, followed by convulsions, and terminating in a deep sleep. One of our latest writers, and I should also say in this (Guy's) hospital a great authority—I mean Dr. Frederick Taylor, in his *Manual of Medicine*—still keeps to the definition. There is no doubt that as a definition, and applicable to the majority of cases, this is good; but when one takes in the whole field of possible examples of the disease we find a difficulty in so restricting the name. That the definition is generally good is seen from the fact that where a local lesion is found in the brain, which is not the case in ordinary epilepsy, there may be no loss of consciousness during the fit. So it may be said we have a different disease to deal with. And yet it is this very case which prevents us

¹ Read at a meeting of the South London District of the Metropolitan Counties Branch of the British Medical Association.