LECTURES
ON THE
DISEASES OF CHILDREN,

DELIVERED IN THE

Chatham Street School of Medicine, Manchester.

By DR. MEREI,

Fellow of the Hungarian Academy, late Professor of the History of Medicine at the University of Pesth, Clinical Professor of the Diseases of Children, and Director of the Children's Hospital at Pesth; Fellow of the Imperial Society of Vienna, etc.

LECTURE XIV.

Bilious Fever; a summer disease, rare in children.

Characteristics. Head symptoms. Combination with other fevers. Valuing of bilious vomiting. Complications—meningitis, pneumonia, hepatitis. Cause and disposition. Prognosis—transitions, issues. Treatment—emetics, purgatives, and antibilious indication.

GENTLEMEN,—*Bilious fever*, an acute disease, spread over all Europe, but more common and vehement in the southern countries, and in hot summer-time, seldom occurs before the eighth year, or at least not strongly characterised before that age.

This fever consists not in a mere functional derangement of the liver—a frequent complication of many acute diseases, but apparently in a chemical alteration of the blood, by the influence of heat and rarefied atmosphere upon our respiratory organs and skin. The effect of this seems to be overcarbonisation, or overvenosity of the blood, of which superabundant bilious secretion, or accumulation of bilious elements in the liver, is but a consequence. *Post-mortem* examination confirms the same. I have dissected patients, amongst whom some were children, who died of this fever, and in whom no structural alterations could be detected, except those of accidental complications, but in whom, besides a great quantity of bile in the gall-bladder and liver, there was a striking abundance of dark venous blood in the abdominal and other organs. In southern Europe, in Italy, Hungary, and Austria, it is a frequent epidemic of *hot summers*, along with dysentery and summer cholera. In this country (Great Britain) it appears to be rarer, and less violent, though last week I saw two children strongly affected. Now, this acute bilious dyscrasy, in its full development, I seldom meet with before the eighth year, (just like that of typhus,) and in very few cases, and not so clearly developed, before the second year of life.

One case I have quoted in my Hungarian work, of which the history is recorded in the case-book of the Children's Hospital of Pesth, under the number 1084, of the year 1844; it concerns a child only nineteen months' old, the youngest I ever saw. Neither in this, nor in any other instance of a young child, however, could we determine the diagnosis before the third or fourth day after the beginning of the fever. Between the second and fourth year I have seen some more characteristic cases. In almost all of them, for the first day or two, bilious fever approaches the

description we gave of the hypersthenic fever, from which we may be able to distinguish it towards the third or fourth day, by the dark-brown, greenish, apparently bilious quality of the intestinal discharge, or the intense yellow, or green, of the vomited liquids, if the one or the other came either naturally or by medicine. The skin is dryer than in other fevers, except the gastric and typhoid. Sooner than the third day bilious discharges have much less distinctive signification, because the case might yet become, at that time, scarlatina. With measles and small-pox you will less easily confound it, when you reflect that bilious fever offers a greater dryness of the skin than the two latter, before the eruption comes out. A careful examination of the epigastric and right hypochondriac regions, verifies a tumid state of the liver, along with a more or less visible yellow cover of the tongue, though never so thick as in adults: all this will scarcely be discoverable before the fourth day. The urine leaves a brownish or yellow stain. A yellowish hue in the face, about the cheeks, mouth, or the conjunctiva, if present, serves us as an excellent guide; but this is seldom the case, and scarcely ever before the third day.

We see of what value in this fever are the words of an adult patient, who tells us about the bitter taste in his mouth, and some sensation in the region of the liver, all of which are wanting in young children. The want of these subjective symptoms leads to many a mischievous mistake, because the head of the child affected with bilious fever, presents very alarming symptoms. We know what violent kind of headache grown-up persons complain of in these cases. It can cause mischief to the little patient, if overlooking the tense state of the right hypochondrium, we would apply leeches to the head, instead of giving an emetic—mischief both positive and negative.

The diagnosis seems to be difficult also, inasmuch as acute bilious dyscrasy frequently combines with or joins scarlet fever, more seldom measles, typhus, and almost all kinds of continued fever. But this difficulty is but apparent. Your purpose will be to detect the bilious state in the child, if present, and then act against it, whatever name you may give the fever.

As to the diagnostic value of *bilious vomiting*, if it be the symptom of an affection of the brain, or of an exanthema to come, it is far less in degree and less constantly connected with such fulness of the epigastrium, and yellowish appearance of the tongue, than if it comes from bilious fever.

But bilious fever does not exclude the possibility of the development of meningitis during its course. It also sometimes engenders pneumonia, more frequently hepatitis or enteritis.

Concerning *prognosis*, it is certain that acute bilious dyscrasy attacks more frequently and more dangerously children of a full plethoric constitution, with dark hair. The general bilious character of a constitution, in addition to the degree of the fever, makes the latter always proportionally more severe.

In hot summer this fever becomes very dangerous. It goes sometimes along with summer cholera. I have

seen instances, when a child under a sudden attack of high fever, was seized by bilious vomiting and similar diarrhoea (the evacuated liquids of real cholera have not that character), with an excessive appearance of languor, almost threatening death: when an hour after that happened, fever was gone, and the little sufferer at once relieved to cheerfulness. This again shows how dangerous it might be to directly check bilious evacuations. If, however, this crisis does not appear at an early stage, the effect will scarcely be so complete. The bilious dyscrasy once established, runs a longer course, for several days, even weeks, towards recovery. I have seen it in some instances of young children, to come on suddenly, when, as soon as the bilious aspect appeared, the hypersthenic form of reaction declined into astheny, ending fatally under profuse bilious diarrhoea in three or four days. I have seen it sometimes pass into a kind of low remittent, or gastric form, to be spoken of on a further occasion.

The transition of bilious fever into icterus, as in adults, I do not remember to have seen in young children. There is another transition: that into bilious dysentery, which, though fever may sometimes considerably decrease in such case, still forms a very dangerous affection for the tender age. The extraordinary heat which we have here just at present, (July, 1852,) proves also in this country as productive of bilious affections, though certainly they are more violent in Italy or Hungary.

The treatment consists of emetics and purgatives, according to directions given, when we spoke on febrile gastric disorder, and in the use of acids against hypercarbonization and bile. The emetic, the sooner the better; but if the child is above three or four years, even the third or fourth day of it will allow yet the use of the emetic, whilst children under two years, will before that time have fallen into astheny, and no more admit that remedy.

Amongst purgatives, whenever the skin is very hot and dry, and the dryness of the mouth indicates a similar state of the gastric mucous membrane, in general in very high fever, I prefer the liquid ones to others, *f. e.*, from one ounce and a half to two ounces of simple infusion of senna, with two to three drachms of sal. sedlitz; under other circumstances, however, one or two full doses of calomel may be useful.

The *antibilious indication* I use to fulfil by the following:—R. Acet. Rub. Idæi, dr. iij.; Aquæ Dest. Simp., oz. ij.; Acidi Tartarici, scr. ss.—gr. xv.; Syrup. Rub. Idæi, vel. Citr., dr. iij. Every hour or two one or two teaspoonfuls. As to the treatment of hepatitis, pneumonia, meningitis, or other complication, it is too well known to be mentioned in this place, and must be applied in stronger or more moderate measure, according to the degree of those local affections, and the stage of fever; but it can scarcely be inculcated too much to the young practitioner, that *if liver and gall-bladder are turgid with bile, in vain we subtract blood from the head, lungs or liver, and in vain we order "antibilious" medicines*; the emetic alone can lay the foundation of successful treatment in this case.

ON THE DIAGNOSIS OF CHRONIC OVARIAN TUMOURS.

By E. J. TILT, M.D.,

Senior Physician to the Farringdon General Dispensary and Lying-in Charity, and to the Paddington Free Dispensary for Diseases of Women and Children.

"Hydrops ovariorum ut plurimum steriles annosæque mulieres occupat difficulter cognoscitur et vix sine sectio cadavere."—Boerhaave (*Aph.* 1233.)

(i) *The Impregnated Womb may be mistaken for an Ovarian Tumour.*

NOTWITHSTANDING the greater degree of perfection of our means of diagnosis, our knowledge is still so imperfect that the most eminent practitioners often fall into erroneous diagnosis.

Cases.—M. Taignot relates that a country doctor in France was consulted by a girl for an abdominal swelling, which she persisted in denying the possibility of being physiological. Thus led astray, he, with an inexcusable precipitation, punctured what he supposed to be an ovarian cyst. Premature labour brought from the womb an eight-months still-born child, and the mother died three months after.

Dr. Corfe in his lectures, (*Medical Times*, July 15,) states:—"I knew of two circumstances in the country where the patients have been tapped for supposed dropsy, and the *post-mortem* examination brought to light that they were both advanced in pregnancy." But such cases are not confined to country practitioners, Professor Murphy, whose well-earned reputation cannot suffer from the avowal of a mistake, informs us that in two cases he had mistaken pregnancy for ovarian dropsy. Mr. Phillips told us that, in a case upon which he was called in consultation, (with two of the most eminent physician-accoucheurs in town,) the tumour had existed eleven months. The two obstetricians said it was ovarian, but Mr. Phillips thought it pregnancy and advised the husband to wait as women were often wrong in their calculations; and some time after the lady was confined. We also, once made a fatal mistake of this description, and record it in order that others may seek for and know how to wait for the signs by which the error may be avoided.

Case.—In June, 1849, we were consulted by the wife of an officer, and at first sight were struck with the emaciated appearance and care-worn expression, so characteristic of an advanced stage of ovarian growths. The patient was 40, and had been married nine years without having been pregnant. Some months previously and after derangement and suspension of the monthly function, a swelling of the abdomen made her hope that she was in the family way, and a month before calling upon us she had consulted Dr. Mayo, of Winchester, who after a careful examination, pronounced her case to be one of ovarian dropsy. Feeling still confident that she was pregnant she came to town.

From a careful examination of the womb and breasts, and after seeking in vain for the sound of the foetal