The effects of this we cannot change by treatment, but we can never tell how much more disease there may be, disease we can remove, nor can we tell how near such disease may be to the closure of a branch or trunk. Such possible effects we may prevent by prompt measures, and I have seen cases in which the gravest results were distinctly obviated. Yet treatment has to be carefully adjusted to the patient's state. In this case the mercury had to be discontinued on account of weakness and the fear of further enfeebling her heart. It was wise, and even wiser than was then discerned, because the imminent risk of a fresh thrombosis could not be perceived. On account of this danger it is not well to give in such cases the very large doses of potassium iodide that are sometimes employed. Iodide is credited, as you know, and I think with reason, with the power of promoting coagulation of the blood, and has been employed for this purpose in aneurysm. Hence very large doses may facilitate the formation of a clot in a narrowed vessel. The dose which the patient had—15 grs. three times a day—is large enough, as I have many times seen, to influence such disease as rapidly as is reasonably possible, if the patient has not already been taking it, and is as much as it is wise to give under the circumstances.

But the proviso I have just mentioned is one not to be forgotten. To obtain the full influence of iodide the system must not be accustomed to its presence. I watched a case long ago—indeed it was under my care—which taught me a lesson I have never forgotten. Iodide in moderate doses, 10 grs. three times a day, quickly caused the complete disappearance of all symptoms of a gumma in the brain. It was continued for several months, and then, in spite of it, there developed another gumma in the spinal cord from which the patient died. Its nature was certain. I have since met with other illustrations of the same lesson, regarding moderate doses of mercury as well as iodide. They were not, indeed, in my own practice, but they were clear. Just as Dallinger found that organisms become gradually able to develop at a temperature which at first killed them, if they were gradually inured to it, so it seems to be with the organisms of this disease and the agents which control them. They may become so accustomed to the continued presence of the remedy as to develop in spite of it. The importance of energetic but intermittent treatment is the lesson which should be impressed upon us.

Yet one more fact should be discerned, which is indeed so obvious that it is hardly necessary for me to point it out to you. It is the care which is desirable in giving a prognosis in cases of such disease of the cerebral arteries. There is a tendency to allow the constitutional malady to influence the prognosis without sufficient consideration of the way it has worked, and the process to which the symptoms are directly due. This process, as a matter of fact, is independent of that which is truly syphilitic; it is secondary and in itself simple, not specific. It is even so when the structures are compressed by a gumma. The symptoms are immediately due to the effects of the pressure and irritation, effects which are the same whatever be the nature of their cause. Still more clear must be the purely secondary and simple nature of the effects of the vascular disease we have been considering. It is on these that the symptoms depend, and the fact of syphilis could not influence the prognosis; it cannot do so in any case of necrotic softening. The effects of simple pressure would have quickly lessened with their cause, and the constitutional malady might then have been allowed its full weight.

Thus you see that the correctness of the diagnosis, of little importance for treatment, was all important for the forecast. But let me impress on you, not only in reference to such disease, but for all organic diseases, the importance of cultivating your imagination. You have heard of the "scientific imagination" and the part it has played in discovery. Not less important in our practical work is the use of what I may call the "pathological imagination." By this I do not mean a morbid fancy; that springs up only too luxuriantly, unaided. I mean the habit of picturing in your mind that which probably exists, and which you cannot see, considering on what the symptoms depend and its probable course. You can thus often discern more securely the future of the case. I need not dwell upon this in detail. If you consider the character of such disease as we have been dealing with; if you consider the mechanism by which its symptoms

are produced; if you can fancy yourself doing this at the bedside of the patient, doing it with the knowledge you now have but could not have had during life, you will realise what I would convey to you.

Let me end by looking back at our starting place. This was the fact that we sometimes fail to save life when we expect to succeed, even when we have reason for our expectation. Such failure is among the sources of the distress which the incidents of our work so often cause, especially to young practitioners. But the facts of the case we have considered should fix in your mind the truth that even the full knowledge, which so seldom is within reach in ordinary practice, may demonstrate that the failure was inevitable, that the end could not have been averted by any means we could have used, or delayed by any effort we could have made. It was so here, and the same is often true when it cannot be ascertained. Therefore, do not let the discrepancy between your early forecast and the later fact cause you to give way to misgivings which may be groundless and regrets that must be vain.

A Clinical Lecture

ON

SOME CASES ILLUSTRATING THE NECESSITY FOR ACCURATE OBSERVATION IN THE MANAGEMENT OF SURGICAL CASES.

Delivered at St. George's Hospital, Tuesday, October 8th, 1901,

By SIR WILLIAM H. BENNETT, K.C.V.O., F.R.C.S.ENG.,

Senior Surgeon to the Hospital; Member of the Court of Examiners,
Royal College of Surgeons of England; etc.

GENTLEMEN,—In the practice of surgery, as in other circumstances, things are not always exactly what they seem at first sight; a very important point to bear in mind in connection with many cases with which you will be confronted later on in your career. Speaking generally, you will find, when your experience is rather greater than it probably is now, that first impressions formed as to the nature of a case are, as a rule, good. But first impressions are not infallible, and to be of real value, must always be corroborated by some clear objective evidence.

It is particularly important that you should bear this point in mind just at the present time because it cannot, I think, be denied that there is a growing tendency with latter-day surgeons to minimise the importance of surgical diagnosis in the sense it was formerly understood. In these days it is in many cases so easy by means of an operation, which in itself may not involve material risk, and which may, perhaps, be easy to perform, to make an investigation which, it is hoped, will show to a certainty the nature of a disease, whilst the arriving at a diagnosis by ordinary means without the performance of an operation, although it may be generally possible, is difficult, and perhaps tedious. At the same time, it is obviously always highly desirable, when possible, that a diagnosis of the patient's condition should be made without resort to an operation, especially in private practice, in which operations cannot always be resorted to so easily and so safely as in hospital work. In the majority of diseases, you know as well as I do that there are described in the ordinary books certain definite sets of symptoms or signs, if you care to distinguish between symptoms and signs. Now, in any case it does not matter what the nature of it may be, if during its examination there is found any symptom or sign which is not quite usual, or which is anomalous, your suspicion as to the orthodoxy of the case should immediately be aroused, and throughout the treatment of that case you must be on the alert, lest the general impression which the case conveyed to you at first should be wrong. On the other hand, you will find in the books, too, that in at least many, if not in the majority, of surgical diseases there is one symptom especially relied upon in each as especially important, or perhaps as pathognomonic of the condition, the mere existence of such a symptom or sign being held to be enough in itself to establish the identity

of the disease. Let me beg that you will at once dismiss from your mind any possibility of a single symptom alone being conclusive evidence of any disease.

The object of these introductory remarks is merely to urge upon you the necessity in all cases of keeping your eyes very widely open and all your powers of observation keenly alert, and not to assume, because a case seems at first sight simple, that it is safe to proceed as if it were certainly so without regard to the possible fallacies in diagnosis by which it may be surrounded, although for ordinary purposes its symptoms and signs may appear to be typical and complete.

THE NECESSITY FOR ATTENTION TO MINUTE DETAILS OF DIAGNOSIS.

Let me now call your attention to some cases which illustrate what I mean:

CASE I.

The first case is that of a married woman, of middle age, who was admitted some months ago, under my care, with what was said to be strangulated inguinal hernia. Inguinal hernia, as you know, is not the commonest form of hernia occurring in women, the femoral variety being that from which they generally suffer, and strangulated inguinal hernia is rather uncommon in women. A little fact which, in a case like this, should be sufficient to lead you to approach it with a critical mind. Upon examination there was found in the right groin, passing out from the inguinal canal, a rounded tumour, irreducible, and without impulse on coughing. There were at the same time all the signs of intestinal obstruction. The patient had been unable to pass a motion for several days, there had been frequent vomiting, and she complained of pain about the umbilicus and the lower portion of the belly—exactly the symptoms that arise in connection with the strangulation of a hernia. In addition to this there had occurred at the commencement of the case the symptom to which so much importance is attached in strangulated hernia—namely, a rapid or sudden increase in the size of the tumour which had existed previously for years without change.

Taking the case as it was, it seemed a pretty clear example of strangulated inguinal hernia, not, as I have said, a very common thing in women, but one which is from time to time met with in them. Upon examining this tumour, it was quite characteristic of that found in strangulated hernia, excepting that instead of being tense it was softish. The tumour associated with strangulated hernia is almost always tense, so that following the lines of my opening remarks a flabby sac in a case of apparent strangulation should arouse suspicion, the condition being an anomalous one. We here, then, had to deal with a case presenting two features which gave rise to some doubt in my mind. It is true, that the tumours associated with strangulated hernia are sometimes flaccid, and when they are it is, as a rule, because, in consequence of manipulation and taxis, the bowel has given way; in such cases, however, the flaccidity only lasts for a short time; the tension soon returns, as is only natural. In spite of this unorthodox sign there was nothing about the patient which seemed to show that her symptoms depended upon anything else than strangulation of a hernia. You will understand, however, that I approached the treatment of the case with a mind full of suspicion, which, under the circumstances, was the right surgical mood, and it will be seen presently that by doing so I was led to detect a condition of things which I might have missed if I had been less critical.

The patient was operated upon in the ordinary way. The sac was opened, first by a small incision, from which came some black fluid—altered blood, in point of fact—just the sort of material which comes from the sac of a hernia which has been subjected to violent taxis; so that at this stage of the operation there naturally passed through my mind the possibility of the condition I mentioned just now—a ruptured piece of gut in the sac of the hernia, which might have accounted for the condition of the tumour. Upon laying the tumour freely open, however, there was nothing in the sac, which was a peritoneal one, beyond more of this dark fluid, about 6 drachms in all escaping. Between the abdominal cavity and the sac was a communication so small that it admitted with difficulty a small probe. Now, it seemed to me impossible at the time, in the face of the almost flaccid condition of the sac, that the symptoms could depend

upon any condition immediately connected with it. At the same time, as I said, there was no other condition apparent to which the symptoms could be attributed, and it is well known that symptoms of strangulation have subsided after operation in some cases in which a peritoneal sac containing fluid has been only found. Therefore, under ordinary circumstances, had I not been suspicious, I should probably have ligatured the neck of this sac, performed an operation for the radical cure, closed the external wound, and sent the patient back to bed. But upon examining the sac very carefully, after clearing away the fluid from the inside, as I was dragging it up I saw coming from the belly, through the small communication which, as I have said, would only admit a fine probe, a little drop of black fluid, precisely similar to that which was found in the sac. I thought at first that this might have been a drop of fluid which I had not removed, but, on clearing it away and holding up the sac again, another drop appeared. We had now obtained the key of the situation. The symptoms were not due to any condition of the sac, which was an accidental association in the case. The partially distended hernial sac was of no consequence in itself; its contents consisting of altered blood which had entered it from the abdomen, by increasing the size of the tumour, had led to attention being concentrated upon it. The symptoms being those of intestinal obstruction, and attention having been called to the rapid increase in the size of this irreducible tumour naturally led the medical man whom the patient consulted to conclude that the case was one of strangulated hernia. Obviously the inside of the belly had to be examined; the communication with the abdomen was consequently enlarged, so that I could pass my finger through it. On entering the belly the finger passed into some jelly-like material, and immediately came upon a tumour about the size of a tennis ball. On withdrawing the finger it had upon it a few pieces of old broken-down blood clot and a little fresh hæmorrhage. On laying the abdomen open freely for the purpose of dealing with this tumour, the pelvis was found to be full of blood clot, which surrounded a blackish tumour with a small hole in it, from which fresh blood was coming freely. The case was, in fact, a very early extra-uterine pregnancy. The tumour was removed in the usual way, and the patient did very well, her progress being rapid and uneventful.

This is an excellent example to show the importance of approaching with suspicion any case presenting symptoms which in the least diverge from the ordinary path. The only two points in the case which aroused suspicion were the comparatively uncommon occurrence of strangulated hernia in women, and the only partly distended sac, and had I been less critical I think it quite possible that I may not have examined the sac sufficiently carefully to have noticed the escape of the drop of fluid from the abdomen which gave me the key of the case, and enabled us to cure the patient, instead perhaps of sending her back to bed with a condition unrelieved, from which she might have died. In this instance very little harm arose from the fact that we did not diagnose the actual condition at first; indeed, I do not know that the exact state of affairs could have been diagnosed; but the moral of the case remains clear, namely, that the patient probably owed her life to a close attention to the diagnostic indications which were present.

CASE II.

The next example is less grave, and less important, perhaps, from the patient's point of view, but it is even more instructive in showing the necessity for very strict attention to small details in arriving at a diagnosis.

A young married woman was admitted under my care with what was called an inguinal hernia. It was not strangulated, but it caused her some pain, especially at her menstrual times, and as the distress often was enough to interfere with her household work she sought relief. There is a condition in young women which is not very uncommon, although it often attracts no attention because it does not give rise to any trouble, which consists of a congenital patency of the canal of Nuck, the process of peritoneum which corresponds to the funicular process in the male. The tumours resulting from partial or complete filling of these patent processes of peritoneum with fluid are often called

herniæ, and they are operated upon, the sac being obliterated, and a "radical cure" performed in the usual way. In the old times, before operations were so common as they are now, these cases were frequently spoken of with very great confidence as hernia of the ovary, mainly, it appeared, because the tumour tended to become swollen and painful at the catamenial times. But when operations began to be performed more freely, it was found that these cases were practically never herniæ of the ovary; they were simply peritoneal pouches containing fluid, which became a little tense at the menstrual periods in consequence of the general increase of vascular tension at that time, combined with an increase of the fluid contents. In the intervals between the "monthly periods" the patients are comfortable, but in hard-working young women these pouches, when once they become distended, may give rise to all the symptoms of hernia, and, indeed, when greatly distended, have been mistaken for, and operated upon as, strangulated herniæ. It is, moreover, a common thing to find a truss being worn in such cases under the impression that hernia exists. In some of the cases the tumour disappears upon the patient assuming the recumbent position in consequence of the return of the contained fluid into the peritoneal cavity. In some cases, on the other hand, position produces no material effect upon the tumour, either because the communication with the peritoneum has been obliterated spontaneously, or because the fluid cannot return into the peritoneal cavity in consequence of a peculiar valve-like arrangement which sometimes exists at the mouth of the sac.¹

Such was the nature of the condition from which the young woman in the Drummond Ward was suffering. The tumour jumped a little on coughing, it was tender to the touch, and it caused a good deal of distress. She had been told to wear a truss, and had done so, but only for a short time; in consequence of the tenderness she left off using the instrument, and came for radical treatment. Upon investigation a point which immediately arrested attention was that the pain about the belly was very much diffused, being felt especially about the lower part of the rectum, which is very uncommon in hernial pain. Pain in hernial tumours, except of the obturator kind, is generally of the ascending sort, although in the inguinal hernia of men it may pass down to the testicle. Under the impression that this obvious tumour might have been the cause of the patient's trouble we operated, obliterating the sac in the ordinary way. The operation had no effect whatever in abating the symptoms; upon the healing of the wound the symptoms were precisely as they had been before operation; in fact, so far as any relief to the patient was concerned, the operation was an entire failure. She now told us what she had not mentioned before, that she had noticed from time to time a similar tumour on the other side. Upon examining the opposite side, whilst she was in the erect position after the operation wound had healed, an indistinct fullness, which entirely disappeared when the patient lay down, was certainly apparent at the outlet of the inguinal canal. It was clear that the operation already performed had done no good, and she very properly insisted that, as she had come to the hospital to have the complaint cured, she was entitled to relief, and asked what it was proposed to do next—a practical but somewhat embarrassing question. It was suggested that the continuance of the symptoms might have been due to the fact that the ligature about the stump of the sac which I had removed was causing some irritation, as ligatures sometimes will, and that the removal of the ligature offered a reasonable hope of relieving the distress. But taking into consideration the extensive area of the pain, and the fact that the side upon which no operation had been performed was very tender, it did not appear to me that the solution of the difficulty lay in the removal of the ligature around the stump, although it is quite true that some crossed pains like these may be the result of irritation of a ligature around the stump of a cord, or about the pedicle of a kidney; but, as I say, I could not satisfy myself on that point. A consultation was held, and it was decided that a rational measure would be to cut down and see whether there was any evidence of irritation about the ligatured stump, and deal with the condition as the circumstances at the time indicated. At the same time it was suggested that it would be a good thing to operate upon the

opposite side, to satisfy the woman, and so produce a moral effect, as seemed likely, seeing that she was so anxious to have something done on that side. The matter was one of some importance; an operation on the other side was either the right or the wrong thing. Had I operated and still failed to relieve the patient, our position would have been worse than before. Upon consideration I came to the conclusion that as my operation had given no relief of any kind, and that the origin of the trouble from which the patient suffered was independent of the condition for which I had operated. So with this conviction fully established, in spite of the conclusion come to at the consultation, before proceeding to further operation, I had the patient again very carefully examined from the obstetric point of view. Finally, it was found that the origin of her trouble was perimetritis. I had, in fact, operated on a condition in the patient which, although it seemed to account for her pain, or at least might have done so, was really quite harmless in that respect.

No fault was committed in performing the first operation, because under any circumstances it is a good surgical rule that when a person suffers from pain or discomfort apparently due to an obvious abnormality or disease, the obvious condition should be dealt with, if it appears to be the predominating factor in the case. But, having dealt with the obvious factor without success, if I had gone on to operate upon the other side in this case I should have been wrong, and should have been undoubtedly guilty of some very bad surgery. Having had my suspicion aroused by the fact that no relief even for a moment occurred from the first operation, I did not proceed to the second, and so saved myself from making a grave blunder. If my first operation had been followed by an interval of relief, subsequently followed by the occurrence of pain on the other side, I should probably have concluded that this was caused by a condition on the opposite side, similar to that upon which I had operated, or that it might have been due to the irritation of a stitch or a ligature used in the previous operation. As there was no interval of relief at all, it was clear to my mind that the pain associated with the condition I had dealt with was not dependent upon that condition but upon some deeper cause.

It would be difficult to find more suitable cases than these I have described to impress upon your minds the necessity for attention to minute details in the management of surgical maladies.

THE DANGER OF TOO MUCH RELIANCE UPON A PREDOMINANT SYMPTOM IN DIAGNOSIS.

A reference to the ordinary educational manuals or treatises will show you that in many diseases one symptom is regarded as of special importance in the diagnosis of the case, and in some cases this predominating symptom is regarded as "pathognomonic," that is, as a certain indication of the nature of the disease. I am sure that any observant person who watches the matter will see that nearly all students and some practitioners are too greatly influenced in the diagnosis of disease by these predominant or pathognomonic symptoms. I am most anxious to impress upon you as strongly as possible the danger which may be incurred in thus valuing too highly these predominant symptoms without giving due weight to corroborating evidence. I do not suppose that anything contributes more to mistakes in diagnosis than the reliance upon certain highly-lauded symptoms as a rapid road to determining the nature of a disease. It is easy to illustrate this fact by examples, of which perhaps the following is as typical a one as could be found.

CASE III.

The "pathognomonic" sign in strangulated hernia is, as you well know, the disappearance of impulse in the tumour on coughing; and it is generally said that if, in a case of hernia, there is a free impulse in the tumour on coughing, the question of strangulation is hardly worth a thought—a fallacy which may under some circumstances lead to dire results. I was on one occasion called to a man of middle age who for some days had been suffering apparently from intestinal obstruction; no earlier consultation was possible in consequence of the patient's objection. When I saw him he appeared to be nearing his end; the vomiting was fecal and his aspect of the typical abdominal type; acute pain was

complained of about the umbilicus; there was not much abdominal distension. The right side of the scrotum was occupied by a large hernia, which the patient declared gave no pain, and in which the impulse upon coughing was quite free and typical of unstrangulated hernia; there was no tenderness of any kind in the tumour, the handling of which, however, seemed in a small degree to increase the intra-abdominal pain. Desperate as the man's condition seemed to be, it was clearly right to attempt to relieve the obstruction by operation, and the important question at once arose as to whether the operation should be abdominal section or herniotomy, as it was manifest that the patient's state would not allow of two operations or of one which was very prolonged; the selection of the right proceeding was, therefore, of unusual moment in this case. In spite of the symptoms being so distinctly abdominal in indication, and in spite of the free impulse in the hernia, I selected herniotomy, because the hernia was an obvious abnormality, and because I knew that, although a hernial tumour may give free impulse on coughing, a strangulation of the gut in the sac may be present. My selection proved to be wise, for the hernia was found to contain in its upper part a large quantity of unstrangulated gut; but at the extreme lower end of the tumour, passing through a little hole in the middle of a diaphragm in the sac, was a small portion of the circumference of a piece of gut (Richter's hernia). Thus, the explanation of free impulse in a hernial tumour containing strangulated gut was easy, as the small strangulated nodule was completely surrounded by unstrangulated intestine, which not only gave free impulse, but entirely concealed the strangulated part. This case is an extreme example, and I do not suppose that any surgeon would have been guilty of such a gross error of judgment as to have performed a laparotomy in the circumstances, but the case serves excellently the purpose of emphasising the point now under discussion.

CASE IV.

The following case illustrates the same point, and also shows the importance of attention to details in arriving at a conclusion with regard to the course of treatment to be adopted:

A man of middle age was admitted into St. George's Hospital under my care after a fall from a high scaffold: in falling he was thrown across a plank. On admission he was collapsed, and semi-conscious only. Upon recovering complete consciousness he complained of acute abdominal pain, and vomited twice. On being summoned to see him I found him pale and weak, with a small pulse. There was much abdominal pain across the hypochondrium. *The liver dulness was quite absent.* The whole abdomen moved in respiration, but the movements were rather stammering in character. There was tenderness along the line of a bruise which crossed the belly about the level of the crests of the ilia. Taking into consideration the history of this case, the collapse, vomiting, and abdominal pain, there was certainly a strong probability of the existence of some grave internal lesion, such, for example, as ruptured intestine and the absence of liver dulness, made the matter practically certain in the minds of some. In spite of the importance which is commonly attached to this sign, I did not in this instance attach much importance to the absence of liver dulness for the following reasons:

First, absence of liver dulness is one of the least reliable of symptoms as evidence of intra-abdominal lesions; and, secondly, I noticed as the patient lay on the bed a constriction just above the level of the iliac crests commonly seen in labourers and others who during hard manual work wear a tight strap or belt around the waist, a common practice with people of that class, and I have come to know from practical experience that in such people the *liver dulness is frequently altogether absent and nearly always diminished*, which led me in this case to eliminate the absence of liver dulness as an urgent factor. I therefore waited for a few hours. The patient recovered from the shock, the vomiting ceased, the stammering abdominal movement passed off, and in four days he was convalescent. He finally recovered perfectly but the absence of liver dulness persisted, as it naturally would do in this man since to him it was a normal condition. Had I here been over-impressed with the importance of predominant sym-

ptoms I should certainly have opened the abdomen upon the strength of the absence of liver dulness, which would have been a grievous surgical blunder. On one occasion I was induced, somewhat against my judgment, to operate on this account in a case the symptoms of which resembled perforating gastric ulcer, and found nothing wrong inside the abdomen, the disease from which the patient suffered and subsequently died being in a different region altogether. My operation, it is true, had no effect upon the ultimate result of the case, but it was an error in judgment which I have since continually regretted, and one which I am not, I hope, likely to repeat.

CONCLUSION.

I could give many more examples to illustrate the point with which I am now dealing, but those already related are sufficient for the time being. My main object, as I have already said, is to impress upon you as much as possible that the necessity for attention to details in surgical diagnosis is as great now as ever it was, and that the constant appeal to exploratory operations for the elucidation of difficult cases is unscientific and harmful until every other means of diagnosis has failed to determine what is necessary. In hospital work and in a certain class of private work operations for investigating purposes can be performed with safety and sometimes with benefit, but in the circumstances in which the majority of practitioners work, the resort to frequent operations for diagnostic purposes is out of the question. In any case, it is in my opinion the duty of the surgeon to spare no pains in diagnosis without appealing to operation. The extreme readiness sometimes shown to operate for merely diagnostic purposes is I think unfortunate for surgery, both from an educational and practical point of view, since it directly tends to minimise the importance of the study of diagnosis as it is commonly understood, and to degrade the practice of surgery to a mere handicraft.

The physician must of necessity cultivate to the extreme his powers of diagnosis, as in the majority of his cases no operation can be, with justification, called to his aid. Judging, therefore, from the present day tendencies, the physician will be a scientific practitioner when the surgeon has ceased to be anything more than a craftsman—a state of affairs happily yet some distance off. Be that as it may, let me beg of you, in conclusion, to cultivate to the utmost extent a methodical habit in diagnosis, to avoid being misled by placing too much reliance upon any single sign or symptom, no matter how great its reputation may be; and, above all, to regard with the most critical suspicion any unusual or anomalous symptom arising in the course of the diagnosis or treatment of a case although this may seem to be of the most simple kind.

REFERENCE.

¹ See Clinical Lectures on Abdominal Hernia.

A Clinical Lecture

ON

ACUTE YELLOW ATROPHY OF THE LIVER.

Delivered at the Liverpool Royal Infirmary.

By T. R. BRADSHAW, B.A., M.D., M.R.C.P.,

Physician to the Infirmary; Lecturer on Clinical Medicine in University College, Liverpool.

THE disease which is generally known by the name of acute yellow atrophy of the liver, sometimes by that of icterus gravis, is one that is rarely met with; but when it occurs in a pronounced form its features are so characteristic that its recognition presents no great difficulty to the skilled observer. Some authorities regard icterus gravis as distinct from acute yellow atrophy, but the distinction seems to be one of degree rather than of kind, depending on the extent to which the liver is reduced in size, and, so far as our present knowledge goes, I think we are justified in using the terms as synonymous. The most obvious symptoms of the disease are intense gastro-intestinal disturbance, extreme prostration with nervous symptoms, jaundice, and in most cases rapid diminu-