

**CIRRHOSIS OF LIVER AND KIDNEYS; STENOSIS
OF PULMONARY ARTERY; ACUTE PLEURISY;
LOBAR PNEUMONIA WITH PLEURISY.**

CLINICAL LECTURE DELIVERED AT THE BELLEVUE HOSPITAL.

BY ALFRED L. LOOMIS, M.D.,

Professor of the Practice of Medicine in the Medical Department of the University
of the City of New York.

Reported by Dr. Ogden C. Ludlow.

GENTLEMEN,—The first patient which I present to you to-day is a married woman, forty years of age, who has had four children, and who has enjoyed good health previous to the present illness. She says that she drinks "very seldom," but, on further questioning, I find that she means by this "a little every day." She is accustomed to take whiskey-punch on going to bed, and occasionally also in the morning, and has been in the habit of doing this for the past five years. Her present trouble began with a slight swelling of the feet, which would be present on rising in the morning, and which was not painful. Almost at the same time her abdomen began to enlarge, and this has steadily increased, although the œdema of the feet has subsided. She has also had vomiting in the evening, and "dry retching" in the morning, which would be relieved by a little hot whiskey and water. Jaundice has developed gradually along with the other symptoms.

This history suggests a diagnosis of cirrhosis of the liver and kidneys.

On inspection, we find the abdomen uniformly enlarged; the sclerotic of the eye deeply tinged with yellow; the tongue dry and red at the tip, and covered with a light coating on either side. The skin is of a dark yellow color, such as indicates chronic jaundice due to some disease of the liver which gives rise to more than simple obstruction of the gall-duct. On closer inspection, you will notice that the superficial veins of the abdomen are enlarged, denoting ob-

struction of the portal veins. The abdominal enlargement which is present in this case might be due to gas in the intestines or to fluid in the peritoneal cavity; the question to decide is whether it is due to gas or fluid. On palpation, fluctuation is readily obtained, but this is not sufficient to establish the presence of ascitic fluid. You must change the position of the patient from one side to the other, and observe whether the portion which is uppermost is tympanitic on percussion, while the most depending portion is flat. On examination we find this to be the case, except that on the right side the percussion note instead of being flat becomes dull, due probably to the fact that a portion of intestine is adherent at this point. The abdominal distention makes palpation of the liver quite difficult, but it seems to be slightly irregular. Percussion shows hepatic dullness about twice the normal area in the line of the right nipple; over the left lobe it is relatively greater, for the dullness in the median line is fully four inches greater than normal. There is flatness over an abnormal area in the region of the spleen, denoting either fluid in the left pleural cavity or enlargement of the spleen. On palpation, the spleen can be distinctly felt below the free border of the ribs. The apex-beat of the heart is about one and a half inches above its normal level; the sounds are very distinct; the heart's action is rapid. There is no murmur. Pulse is 120, small and regular. There is no elevation of temperature. On percussion of the chest posteriorly, there is found an increased area of flatness on both sides, corresponding to the liver on the right and the spleen on the left, so that both liver and spleen are enlarged.

Fatty changes are sometimes associated with the cirrhotic or fibroid changes which occur in hepatic fibrosis, and under such circumstances the liver may be enlarged, a condition called fatty hypertrophic cirrhosis. The connective tissue, hepatic cells, and the radicals of the bile-ducts are all involved, and there is also obstruction of the portal circulation sufficient to cause ascites: with the enlargement of the liver there is enlargement of the spleen. Hepatic cancer is the only hepatic disease which might be confounded with this condition. This patient, however, gives a distinct alcoholic history, and the case has behaved like one of cirrhosis. It is quite probable that this disease existed for some time before the patient gave up work. The degeneration of the liver-cells and the change in the connective tissue, causing interference with the radicals of the bile-ducts, account for the jaundice.

Our second case is that of a woman, twenty-one years of age, whose family history is entirely negative as regards its bearing upon

her present condition. She has never had any acute disease except measles. She tells us that there has been some trouble with her heart as far back as she can remember, associated with pain along the central portion of the chest. She has always suffered from shortness of breath on going up- and down-stairs, and at such times she would become blue. She has been free from œdema of the extremities, with the exception of a slight swelling of the ankles. Her appetite and general condition are good. An examination of the urine shows it to be of a light amber color, acid in reaction, of a specific gravity of 1005, and to contain a mere trace of albumin. The quantity excreted is normal, and the microscopical examination is entirely negative.

On physical examination a murmur is heard, about which there have been differences of opinion. Its maximum intensity is directly over the pulmonic orifice, and it is heard to-day with the first sound of the heart, and is conveyed to the left. It is not heard in the carotids, nor at the apex, but at the apex you hear instead a distant diastolic murmur. I am told that the diastolic sound is at times more intense than at others. There is no hypertrophy of either the right or left heart. The systolic murmur has all the characteristics of one produced by pulmonic obstruction. It is perhaps one of the rarest forms of murmur, and indicates pulmonary stenosis. From the history of the patient it would seem that the change which produces this murmur in this patient is an hereditary one. When she exercises or has a paroxysm of coughing, she gets quite blue, and even now her fingertips and lips show this color. Stenosis of the pulmonary artery is usually due to arrested development during uterine life, and it is usually associated with a patent foramen ovale or an imperfect intra-ventricular septum. In some instances the lesion is very extensive, and the child dies immediately after birth. In cases in which the lesion is slight, as in this case, adult life is reached, and the symptoms of heart-disease are intermittent. These cases are rather curiosities of medicine than of practical importance.

Our third patient is a boy, who previous to the beginning of his present illness, two weeks ago, was in unusually good health. His father died of consumption, and his mother of the "grippe." His brothers and sisters are healthy. He has never been sufficiently ill before to be confined to his bed. The present trouble began with dizziness and "a short chill," and the physician attending him at this time told him he had the grippe. Within twenty-four hours from the beginning of this attack he experienced pain in the right side. There was no expectoration at first, but subsequently he had an abundant

yellowish expectoration, as at present. There has been at no time a high temperature, and no spitting of blood.

This patient's history is not exactly what we would expect in a case of acute pulmonary tuberculosis or acute pneumonia. The boy was perfectly well up to the time of this illness,—in fact, he said he was gaining flesh,—yet he suddenly developed active symptoms which could be referred to some acute disease of the lungs or pleura. Many of his symptoms unquestionably point to acute pleurisy, for he has had constant and severe pain in his side, increased by deep inspiration. But with this pain there has been a cough, with muco-purulent expectoration. There must be present then something more than a pleurisy. One of the students has wisely suggested that this patient has an irregular type of pneumonia. There are several irregular forms of pneumonia. Occasionally we meet with a lobar pneumonia that is slow in its development and in its resolution, and frequently leaves behind it more or less permanent lesions in the lungs. This is sometimes called chronic pneumonia. This form of pneumonia is most frequently met with in the aged, and usually complicates some chronic disease. The term "chronic pneumonia" is a very unsatisfactory one, for it may mean interstitial pneumonia, chronic lobar, or chronic lobular pneumonia; ordinarily, however, the term is applied to interstitial pneumonia. Another irregular form of pneumonia is a broncho-pneumonia, which develops in an unusual way on account of some peculiar infection. This is the kind of pneumonia which is occurring so frequently with epidemic influenza. They are not frank lobar pneumonias, nor are they typical lobular pneumonias. They are accompanied by more or less pleurisy; they often involve a whole lung, the development being slow and progressive. The characteristic expectoration of pneumonia is never present; the temperature is never very high; the characteristic pneumonic countenance is absent, as well as all the other ordinary symptoms which are regarded as characteristic of acute lobar pneumonia. Physical signs indicate lobar consolidation, but the rational signs are against lobar pneumonia. These pneumonias are very slow of resolution, the physical signs of pulmonary consolidation often continuing for weeks, causing one to suspect acute pulmonary tuberculosis.

Now let us examine this patient. He is of the age and presents the appearance of one whom we should expect to have pulmonary tuberculosis. I have told you that the temperature in those irregular pneumonias to which I have referred never goes very high. This patient's highest temperature has been 102° F., and it has ranged

between 99° and 101° during the four days he has been in the hospital. This is about the range of temperature which I have seen in similar cases of so-called "grippe pneumonia": it is not the temperature you would expect to find in tuberculosis. He is anæmic, the eyes are clear, respiration is not accelerated, and there is a full expansion of the upper part of the chest, more marked on the left side than on the right. His pulse is now about 90, and is of fair quality. We notice particularly that he has that fair skin which suggests anæmia, yet his lips are red and contradict this first impression. The apex of the heart is in its normal position, and is beating normally. There seems to be very slight dulness in the left infra-clavicular region. On auscultation, the only difference noted in the respiratory murmur in this region on the two sides is, that on the left it has its normal "breezy" quality, while on the right side it approaches "rude respiration." You notice that even while talking he catches his breath and coughs; the voice is so feeble that vocal fremitus is not of much help in this case. The percussion note over the left side posteriorly is extra-resonant; on the right side there is dulness over the scapular region, which indicates pulmonary consolidation, and a flat note over the lower portion, such as we should expect to get over fluid or a thickened pleura. Just at the border of the scapula and under it on the right side, there is distinct bronchial expiration, which is not intense, and there is some vesicular element on inspiration. As you go a little lower you get typical bronchial breathing. When he coughs, a few crackling râles are heard, having a metallic quality. As you pass farther downward the bronchial breathing becomes less and less distinct, until it is scarcely audible at the base of the lung. You also get bronchophony until you reach the point where you began to lose the bronchial respiration, and then the voice-sounds seem distant. We have then the physical signs of consolidation in the upper and central portions of the lung; in fact, over all the posterior portion of the chest there is a bronchial character to the breathing, and in the central portion pure bronchial respiration. Very few râles are heard at any point over the chest, and those which are heard are over the central portion, corresponding to the area of most intense bronchial breathing. We are now prepared to make a diagnosis. From the history and temperature record I should exclude pulmonary tuberculosis, nor can it be regarded as chronic pneumonia according to the definition of this condition which I have already given. I regard it as a straightforward lobular pneumonia with pleurisy which has involved the entire lung posteriorly,—in other words, a broncho-pneumonia complicated by pleurisy. There is, of course, a

chance for a difference of opinion. Should an examination of the sputum show tubercle bacilli, I would certainly relinquish my diagnosis, but I do not think tubercle bacilli will be found, for I have seen a number of similar cases within the last few months, all commencing with the symptoms of epidemic influenza.

[Repeated examinations of his sputum did not reveal the presence of tubercle bacilli. At the expiration of two weeks he was completely convalescent and left the hospital.]