

NERVOUS DEBILITY; PLEURITIS.

CLINICAL LECTURE DELIVERED AT THE RUSH MEDICAL COLLEGE, CHICAGO.

BY NORMAN BRIDGE, A.M., M.D.,

Professor of Clinical Medicine in the Rush Medical College, Chicago.

THIS young man has been here before. Previous to coming here he had been a heavy drinker; had been troubled with vomiting, gastric catarrh, and nervous debility. He complained also of disorder of his bowels,—of having a passage immediately after eating each time. He had lost flesh very extensively and rapidly,—nearly a pound per day. He comes back now to report. He says he feels like a new man.

He was given for the chief treatment the stale bread and milk diet. He has stopped his drinking. He says he feels well; his diarrhoea and vomiting have ceased. He complains of a discharge of mucus from his nose. I do not think that needs any particular attention. He has partaken of this food about five times a day, and often a swallow between-times. The first two days his bowels did not move at all, and yesterday he went out twice. He has gained three pounds in a week. This is a very interesting account. We found him without fever, and I only threw out a hint that he had some zymotic disease that had lowered his flesh. Now he says he has had no trouble with his stomach, no diarrhoea. His digestive system has been at work throughout the whole day, and not simply three brief periods of the day. At the same time each task put upon it has been so light that it could be accomplished easily: hence there has been no longer a tendency to diarrhoea, and he has gained three pounds in weight. While that does not disprove that he had a zymotic disease, it does not increase the likelihood that he had such an affliction, and I am disposed to take it all—that is, the results—as an example of what can be done by proper regimen. He has had a tonic of quinine and strychnine in small doses, and a little pepsin. The case is very satisfactory. It would have been more satisfactory as a scientific study if we could have had him upon this regimen a week without his taking any medicine at all. It would

have been more fair to science, but not so fair to him. Patients want and have a right to get well as rapidly as they can. Let us continue the treatment. Always when you find yourself on the right track, stick to it.

PLEURITIS.

This young man tells a story of having been sick about a month. He has had some pain during that time along the border of the right ribs. Some days he has had it, and some days not. It hurt him to take a deep breath at times; but he was at first in fair general health. He went on with his occupation until about two weeks ago, when he was seized with severe pain in the right side of the chest, and had a good deal of fever, lost weight, and was obliged to quit work. The fever continued for a number of days, but is now about gone. He had profuse night-sweats during a part of this sickness, and expectorated a great deal,—about one teacupful a day. The expectoration contained no blood, but was mucoid in appearance, and some of it had a darkish color, not black; there was evidently no pus in it. The man has now about regained his normal temperature. He is now breathing over forty times a minute; his pulse is nearly eighty-four. He is short of breath,—that is, he has had dyspnoea since he got up. Vocal fremitus over the lower part of the right chest is nearly abolished. Percussion reveals flatness on the right side, up to a line on a level with the nipple; above that line or under the clavicle resonance is perfect, possibly better than normal. On the opposite side resonance is perfect and beautiful. Let us make a lower-pitched percussion with a hammer that is softer. That gives a sound as flat as percussion over a thick muscle would. That is evidently fluid. Let us see if the level of the fluid will change as the patient changes his posture. The line of the fluid seems to be, as he sits, an inch below the nipple. Yes, as he lies supine it is a little more resonant below the line than it was before, but it does not change greatly. The apex-beat of the heart is to the left of its normal place. Now we will listen over this region. Auscultation over a pleural cavity containing fluid is a very important matter. If it is very full of fluid, if the pleura is tense with fluid, sometimes the lung-sounds are transmitted from the opposite side and over compressed portions of the lungs on the same side that yet contain and receive some air, and an error of diagnosis is easy to be made by a careless study of the facts when those sounds occur. They are never like the sounds on the opposite side, which are puerile. But from a study of the facts of this patient we have been able to make a diagnosis before reaching this point and before making auscultation at all, and

satisfied ourselves that the man must have had a pleurisy and that he must almost certainly have fluid in his right pleural cavity. Percussion has substantially settled that question, but not absolutely. I hear on auscultation a very distant suggestion of the lung-sound. I hear on the left side distinct puerile and normal lung-sounds, and the normal sounds of the heart, which proves again that the apex must be displaced by a change in the position of the heart, and not by a disease of the heart itself with hypertrophy. Percussion over the back reveals flatness in the lower right lung region and resonance everywhere else. Fremitus is more marked on the left side. Now we know to a practical certainty that there is fluid there. Is there any other way to be sure of it? Yes; note the character of the intercostal spaces. They are less depressed on the right side, but they do not bulge. Another important question to settle is the character of the fluid; and he has been sick so long that it would be well for him to be relieved of it even if it is not purulent. We will explore with an instrument and get away a part of the fluid. If it is serum he would probably get rid of it by slow degrees by absorption in the course of a month or two, for if we can withdraw even half a pint—better, a pint and a half—it will start into more rapid activity the process of absorption. It is important to introduce the needle at about the centre of the mass of fluid, but at a distance from the lower part of it, so as not to plunge it into the curved portion of the diaphragm, for fear it might pass through into the liver. But we ought to remember, in this connection, that with some pints of fluid in the pleural cavity the diaphragm is always more or less depressed, and therefore less convex upon its upper surface. This needle has been antisepticized. I pass it through the seventh interspace. Fluid comes, but not very rapidly. The color is a demonstration that we have only serum. Now, having accomplished this much, the needle should be held perfectly still, and the hand should constantly have hold of it. It should not be intrusted to one who would not perceive any movement of the needle. Holding it yourself, you would perceive a motion should anything touch its point. Then if any motion takes place in the needle you must know that it is due to some disturbance at its point. You can then move it or withdraw it, so as to keep its point away from the lung. No considerable harm would come if the lung should be touched, but it is best not to puncture this organ. Various apparatuses have been invented for doing away with the point of the sharp instrument in the cavity while the fluid is flowing; for instance, a set of trocars with canulas somewhat like this used for drawing off fluid from the abdomen, but smaller. There is one

objection to them: it always hurts about tenfold more to plunge the instrument into the chest-cavity than it does to use this plain needle. That is because the canula has to be so much larger than the trocar. We shall continue this process as long as the fluid will flow, or until the patient complains of dyspnoea or commences to cough. The patient begins to cough, and I withdraw the needle. The cough and dyspnoea are the proper expressions of danger, and the aspiration should be stopped when they occur. The patient says he feels very well. I think another insertion of the needle will not be necessary, and it is not necessary to put a plaster over the puncture. [Patient expressed some pain when the needle was withdrawn, after about a quart of fluid had been removed.]