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PHYSICAL DIAGNOSIS.

CHAPTER I.

DATA RELATING TO THE BODY AS A WHOLE.

I. WEIGHT.

To weigh the patient should be part of every physical examination, and every physician's office should contain a good set of scales.

1. *Gain in weight*, aside from seasonal changes, the increase in normal growth, and convalescence from wasting diseases, means usually:

(a) Obesity.

(b) The accumulation of serous fluid in the body—dropsy, evident or latent.

The first of these needs no comment. *Latent* accumulation of fluid, not evident in the subcutaneous tissues or serous spaces, occurs in some forms of uncompensated cardiac or renal disease, and gives rise to an increase in weight which may delude the physician with the false hope of an improvement in the patient's condition, but in reality calls for derivative treatment (diuresis, sweating).

Obvious dropsy has, of course, the same effect on the weight and the same significance.

(c) Myxoedema is occasionally a cause of increased weight, *i.e.*, when the myxoedematous infiltration is widespread (see below, page 10).

2. *Loss of Weight.*—The aging process is so often associated with loss of weight that some writers speak of the "*cachexia of old age.*" In some, a rapid loss of superfluous fat may occur at moderate age, *e.g.*, at fifty-five, and may give rise to grave apprehension though the general health remains good and no known disease develops.

Aside from this physiological change of later life, most cases of loss of weight are due to:

- (a) Malnutrition.
- (b) Loss of sleep (whether from pain or other cause).
- (c) Infectious fevers and other toxæmic states.

Under the head of *malnutrition* come the cases of œsophageal stricture, chronic dyspepsia (with or without gastric ulcer or dilatation) and gastric cancer, chronic diarrhœa, the atrophies of infancy, diabetes mellitus, and the rare cases of anorexia nervosa.

Loss of sleep is, I believe, the chief factor in the emaciation occurring in many painful illnesses as well as in various other types of disease. It is only in this way that I can account for the marked emaciation in many cases of thoracic aneurism.

Toxæmia is, I suppose, accountable for part at least of the emaciation in typhoid, cirrhotic liver, and tuberculosis.

II. TEMPERATURE.

The method of taking temperature is too familiar to need explanation, but the student should be aware of the fact that hysterics and malingerers can and often do raise the mercury in the bulb by various manœuvres, unless they are vigilantly watched. Dipping the bulb into hot water, shaking the mercury upward toward the higher degrees of the scale, and possibly friction with the tongue (?) are to be suspected.

In comatose patients and in infancy the temperature is best taken by rectum. In others we must be sure that the lips do not remain open during the test, so as to reduce the temperature of the mouth.

1. *Fever, i.e.*, a temperature above 99.5° F., in adults has much

more diagnostic value than in infancy and childhood. In the latter it is often impossible to make out any pathological condition to account for a fever. After childhood the vast majority of fevers are found to be due to:

- (a) Infectious disease or inflammation of any type.
- (b) Toxæmia without infection—a much less common and less satisfactory explanation.
- (c) Disturbance of heat regulation—as in sunstroke, after the use of atropine, and in nervous excitement, *e.g.*, just after entering a hospital.¹

For such causes we search when the thermometer indicates fever.

Types of fever often referred to are:

(a) "*Continued fever,*" one which does not return to normal at any period in the twenty-four hours, as in many cases of typhoid, pneumonia, and tuberculosis.

(b) "*Intermittent,*" "*hectic,*" or "*septic*" fever, one which disappears once or more in twenty-four hours, as in double tertian malaria and septic fevers of various types (including mixed infections in tuberculosis).

A fever which disappears suddenly and permanently is said to end by "*crisis,*" while one which gradually passes off in the course of several days ends by "*lysis.*"

2. *Subnormal temperature* is often seen in wasting disease (cancer), nephritis, uncompensated heart disease, and myxœdema. It is rarely of diagnostic value, but is a rough measure of the degree of prostration.

3. *Chills* (due usually to a *sudden* rise in temperature) are seen chiefly in:

- (a) Sepsis of any type.
- (b) Malaria.
- (c) Onset of acute infections.
- (d) "Nervous" states.

After the passage of a catheter, after or during labor, and after

¹The latter event may also reduce (temporarily) a high fever to normal or below it.

infusion of saline solution, a chill is often seen, but not easily explained.

True chill, with shivering and chattering teeth, is distinguished from *chilliness* without any shivering. Chilliness is far less significant and often goes without fever; true chill rarely does.

The cause of true chills can usually be determined by blood examination (leucocytosis, malarial parasites) and by the general physical examination.

CHAPTER II.

THE HEAD AND FACE; THE NECK.

THE HEAD AND FACE.

ALMOST all that we can learn about the manifestations of disease on the head and face is to be learned by the use of our eyes, by *inspection*, as the term is. Other methods—percussion, *x*-ray, palpation—yield but little. I shall begin at the top.



FIG. 1.—Hydrocephalus.

I. THE CRANIAL VAULT.

1. *The Shape and Size of the Cranium.*

The shape and size of the cranium concern us, especially in children.

(a) *Abnormally small* crania (microcephalia) are apt to mean idiocy, especially if the sutures are closed.

(b) An *abnormally large head* is seen in *hydrocephalus* (see Fig. 1), associated with enormous "open" areas uncovered by bone and a peculiar downward inclination of the eyes, which are partly covered by the eyelids and show a white margin above the iris. This condition is to be distinguished from the