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retaining approximately its normal relation to the diaphragm, and that the impulse found to the right is that of the right auricle, the apex lying behind the sternum. Clinical and post-mortem evidence is adduced in support of both contentions; there is, unfortunately, nothing in the present case to indicate the anatomical condition with certainty. There is general agreement as to the causes of displacement to the right in acquired cases. The causes given include increased pressure in the left pleural cavity, owing to the presence of fluid or air, and tumours to the left of the heart; phthisis, cirrhosis, and old pleurisy of the right lung can also cause the displacement, owing in part to contraction of pleuro-pericardial adhesions. With removal of the cause of increased intrapleural pressure, the heart may return to its normal position, but traction by pleuro-pericardial adhesions causes permanent and the most extreme degrees of displacement.

NOTES ON A CASE OF ACUTE YELLOW ATROPHY OF THE LIVER, WITH REMARKS ON THE ETIOLOGY AND TREATMENT OF THE DISEASE.

By MAJOR C. B. LAWSON.

Royal Army Medical Corps.

Patient.—Driver A. R., R.F.A. Was admitted on February 9th, 1903, apparently suffering from a mild attack of catarrhal jaundice. On February 18th, 1903, he developed mental symptoms, and was transferred to a special ward. He came under my charge on February 25th, 1903. He was slightly jaundiced, his skin being lemon-colour and conjunctive faintly yellow. Urine slightly bilious; it did not give a very typical “play of colours” with Gmelin’s test. No albuminuria. A few gonococci.

Alimentary System.—Tongue slightly furred, yellowish-white; teeth good; no aural sepsis. Liver and spleen tender, but not enlarged. Stools white and scybalous.

Circulatory and Respiratory Systems.—Normal.

Nervous System.—He looks dull, half asleep, in fact, in a state of mental torpor, but he can be roused into sufficient intelligence to answer questions relating to his case. Pupils regular, react both to light and accommodation; no nystagmus; superficial and deep reflexes normal. Organic reflexes, incontinence of urine and faeces at times.

Blood Examination.—Showed a polynuclear leucocytosis. No malarial parasites.

Temperature.—102° F. on admission, then normal until three days before death, when it rose to 103° F.

Pulse.—Slow, 56, regular, low tension; the same on both sides; artery not thickened.
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He has had syphilis and gonorrhoea. There is a history of intemperance.

March 4th, 1903.—He has become slightly delirious. Has vomited curdled milk and passed some unaltered blood in his stools and urine.

March 8th, 1903.—More vomiting of undigested milk and also some bile, followed by a good deal of collapse.

March 9th, 1903.—Vomiting continues and consists of food, mucus, and bile.

March 12th, 1903.—No vomiting now. About 6.30 p.m. his temperature was 103° F., and he was tepid-sponged, but with little beneficial result. He was seen by Lieutenant-Colonel Whitehead, R.A.M.C., who suggested acute yellow atrophy of the liver as a diagnosis. The liver dulness was four inches in the mammary line. Leucin but no tyrosin in his urine.

March 13th, 1903.—Liver dulness rapidly decreasing; only half an inch in mammary line this morning. Both hepatic and splenic regions are tender. Temperature, 103·6° F. He had a convulsive seizure at 8 a.m., and became semi-comatose. Pulse rate has risen from 52 to 124. He was tepid-sponged. Evening temperature, normal; pulse, however, still rapid, but regular and of low tension. Case diagnosed acute yellow atrophy of liver.

March 14th, 1903.—No liver dulness anteriorly and three inches in mid-axillary line. Leucin and gonococci still in his urine; also some blood. Vomiting of mucus and bile still continues. At 6 p.m. his temperature rose to 101° F., coma deepened, pulse became almost uncountable, and he died at 9.30 p.m.

Treatment.—Purely symptomatic; careful feeding and nursing.

Post-mortem Examination.—Thirty-six hours after death. Body fairly nourished. Skin, bile-stained a greenish-yellow. Rigor-mortis present in trunk and extremities, but passing off from neck. Post-mortem lividity marked on posterior aspect of body. Abdomen—Liver weighed 2 lbs. 7 ozs., flattened, capsule wrinkled, and surface presents purplish and yellowish-brown, almost circular areas, about two inches in diameter, which were very friable; the organ also shows fatty degeneration; it feels tough to the knife. Similar coloured areas and fatty changes found on section. Gall-bladder shrunked and almost empty; contents liquid bile; Spleen, 11 ozs., congested and easily friable. Kidneys, normal. Pancreas, bile stained. Large and small intestines normal.

Thorax.—Right lung, 1 lb. 13 ozs., showed patches of congestion. Left lung, 1 lb. 9 ozs., was in a similar condition. Heart, 12 ozs., valves, substance, and great vessels normal.

Head.—Superficial cerebral and cerebellar vessels engorged; puncta cruenta well marked.

Microscopical examination of the liver.—Capsule thickened; cells of parenchyma atrophied; purplish and yellowish areas consisted of masses
of pigment, and granular and fatty debris. Leucin was also found in some of the sections, but no tyrosin. Bile ducts empty. Atrophic changes most marked in purplish areas.

Special points.—Impossibility of diagnosis in the early stage from a case of simple catarrhal jaundice. Almost afebrile course. The sudden and marked alteration in the pulse rate, slow at first as in ordinary jaundice, then greatly increased as the disease approached its fatal termination. The long duration of the case. Polynuclear leucocytes. Leucin being found without tyrosin.

General remarks on the disease.—The hemorrhages and splenic enlargement point to its being of the nature of an infectious disease or a toxemia; so far, however, no specific micro-organism has been reported.

As regards its etiology, it may possibly be due to some toxic action on the liver cells, the resisting power of which has been lowered by syphilis and alcoholism, conditions nearly always associated with the disease.

Treatment.—Hitherto this has been purely symptomatic, but judging from the beneficial results that the intravenous and subcutaneous injections of saline fluid have produced in the toxemic condition of yellow fever and post-operative (especially abdominal) acute yellow atrophy of liver, they should be tried in this very fatal disease.

Perhaps an antitoxin will be some day forthcoming.

NOTES, MAINLY POST-MORTEM, ON A CASE OF ANTHRAX IN A SOLDIER.

By Captain L. W. Harrison,
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Private C., aged 28, 3rd Hussars, reported "sick" at the Station Hospital, Sialkot, at 6 p.m., on July 17, 1905, complaining of "fever," with headache and vomiting, of three days' duration. He was seen by Major R. N. Buist, R.A.M.C. His temperature was 103.6° F., but no other objective signs of disease were visible. A sample of blood for microscopical examination was taken from the finger, which was found to contain nothing of diagnostic importance. During the night the temperature dropped to 102° F.; he complained very much of pain in the head, but was never delirious. He could not tolerate the ice-bag to his head, and vomited everything given, including water. At 5.30 a.m. on the following day he was given some water by the orderly, and spoke quite sensibly. At 5.45 a.m. he died.

Post-mortem examination four hours after death.—Post-mortem rigidity and hypostatic congestion well marked. The blood was fluid in all the veins. Pericardial sac contained a little clear fluid. Heart weighed thirteen and a half ounces; no sign of valvular disease. Lungs, right, nineteen ounces; left, seventeen ounces, congested. Spleen weighed