Hospital Reports.

A CASE OF HEPATIC ABSCESS—OPERATION—RECOVERY.

UNDER CARE OF DR. LACHLAN M'FARLANE, IN TORONTO GENERAL HOSPITAL.

(Reported by L. F. Barker, M.B., House Surgeon.)

Considering the comparative rarity of abscess of the liver in individuals who have never lived in a tropical climate, together with the fact that abscesses so occurring are, as a rule, secondary to dysentery, a brief description of the following case may be of interest:

E. B., æt. 46, born in England, admitted to Toronto General Hospital, Dec. 17th, 1890, under care of Dr. McFarlane. He had lived in England 24 years, since then in Canada; occuptions various, farming, railroading, hotel-keeping, etc.; always reckless and dissipated; often exposed to cold and wet. He has never been farther south than Boston, he has never had dysentery; has taken alcohol to excess; nine years ago he had dropsy of peritoneum, the abdomen was of immense size, and it was tapped once. Family history, negative. After admission, the patient was deprived of stimulants, and continued delirious up to Jan. 7th, 1891. The temperature varied from 99° to 103.5° at this time, without obvious cause. This condition continuing, pus formation was suspected, and careful physical examinations made repeatedly. Finally bulging in right side below ribs was noticed, and by Feb. 10th this swelling extended as low down as the umbilicus; complete dulness on percussion existed over the enlargement. The tumor moved with respiratory movements, but not freely. One of Dieulafoy's aspirating needles, being introduced, discovered pus. There existed, in addition, probably cirrhosis of liver, some pulmonary emphysema, and slight cardiac hypertrophy. Mentally, patient was weak; sometimes talked to himself. (The above notes have been epitomized from the clinical history of the case taken by Mr. S. D. Day).

On Feb. 11th, 1891, at 3.30 p.m., Dr. McFarlane operated as follows:—The patient was prepared in the usual way for abdominal section. Chloroform narcosis; an incision 7½ cm. long was made below the margin of the ribs and parallel to them. The liver was found adherent to the abdominal wall. A free opening was made into the parenchyma of the organ; about one litre of yellowish-white pus was evacuated. Two drainage tubes were passed to the bottom of the wound after thorough irrigation with a hot solution of boric acid, 1-20. The skin edges were approximated by silk sutures; a large dressing of bichloride gauze and absorbent cotton was applied.

Progress of Case.—Considerable hemorrhage occurred through the night. The dressing was changed at 12 p.m. The cavity was washed out with hot boric acid solution, and dressing, as before, applied. Feb. 14th: the dressing was changed for the fourth time. Discharge now greenish-yellow. Feb. 15th: On changing the dressing one found very little pus, but abundance of bile and mucus. In the drainage tube a gall-stone was found weighing 1½ grains. Feb. 16th: Drainage tubes removed. Cavity packed with iodoform gauze. Feb. 20th: Wound has been dressed daily since the 16th. Since that time the patient has been taking syrup of the iodide of iron and cod liver oil, with nutritious diet. The temperature has been natural since the operation. Feb. 21st: To-day the patient developed facial erysipelas and was removed to the isolation wards. March 4th: Erysipelas gone. The wound granulating nicely; discharge diminishing. March 17th: The wound is healed. General strength improved. Patient will soon be discharged.

Remarks on the Case.—Examination of the pus collected in a sterilized tube revealed numerous groups of staphylococci. Smear cover-glass preparations stained in the Hospital Clinical Laboratory with Gram's method showed as many as twenty of the grape-like bunches in one field (Leitz syst. 7, ocular No. 4). No cultures were made. The cocci stained well with Loeffler's alkaline blue.

Since the patient had never suffered from dysentery, and had never travelled in tropical regions, one necessarily would be somewhat puzzled in deciding upon the exact infection-atrium. The finding of the gall-stone, however, clears up the case. This body, becoming impacted in a bile-duct, had led to ulceration and necrosis from pressure, together with decomposition of the retained bile, the micro-organisms ascending through the common duct from the interior of the intestine.