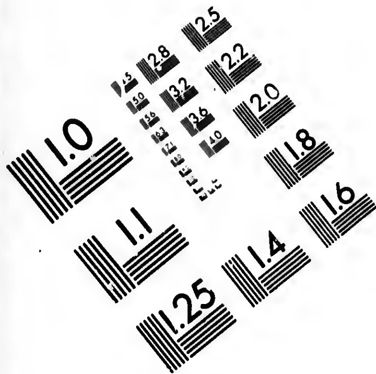

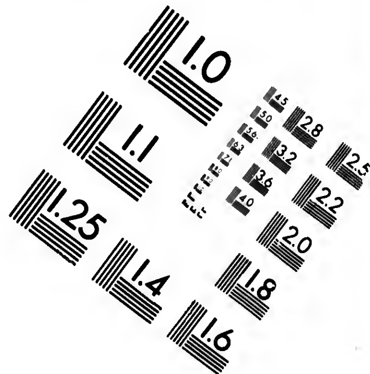

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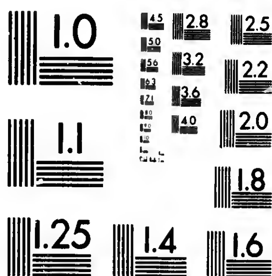

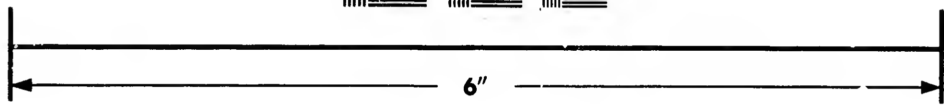

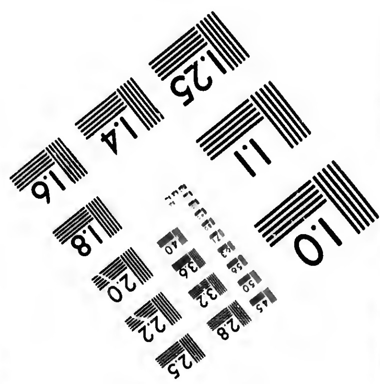

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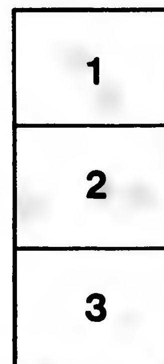
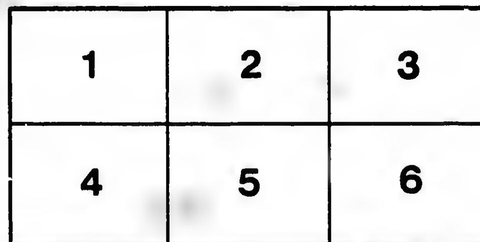




AMŒBIC ABSCESS OF THE LIVER

BY

F. G. FINLEY, M.B. (Lon.), and M.D., (McGill).

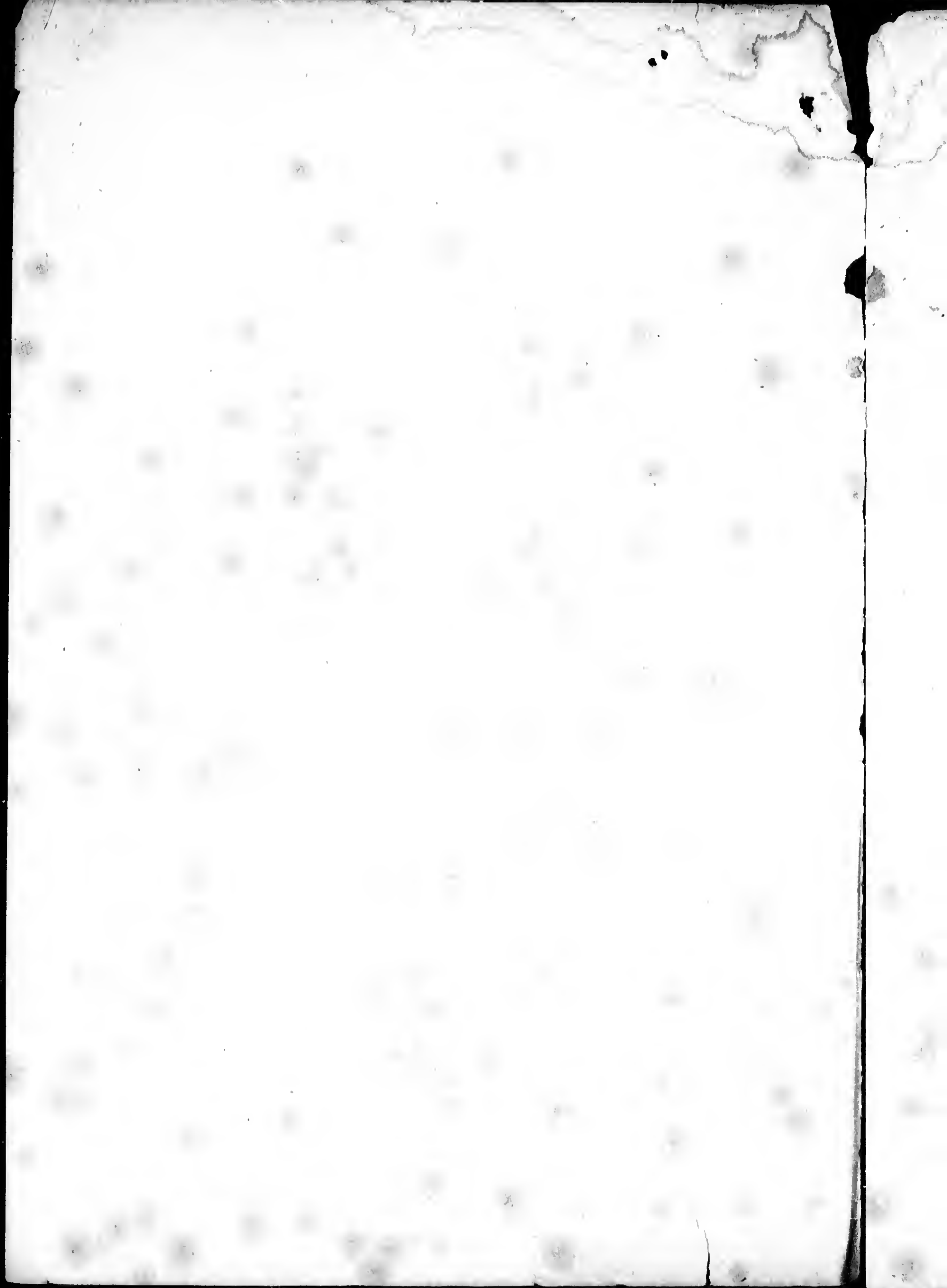
Lecturer in Medicine, McGill University, and Physician to Mont. General Hospital.

AND

J. G. ADAMI, M.D.,

Professor of Pathology, McGill University, Pathologist to Montreal General Hospital.

(*Reprinted from the Montreal Medical Journal, April,* 1894.)



AMŒBIC ABSCESS OF THE LIVER.*

BY F. G. FINLEY, M.B., (Lon.) M.D.,
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AND
J. G. ADAMI, M.A., M.D.,
Professor of Pathology in McGill University, Pathologist to Mont. General Hospital.

The patient, a negro, æt. 37, was admitted to hospital upon January 31st, 1894, complaining of pain in the right side and weakness. The chief facts relating to his medical history were that he had lived for eleven years in Texas, that he had acted as cook on a vessel trading between Quebec and South America, and that he had also spent some time in Australia. He had never suffered from diarrhœa for more than a day or two at a time, and had never had dysentery. He had, however, two febrile illnesses, each lasting about three months, some years previously.

The present illness began a month previous to admission with febrile symptoms and diarrhœa. Some pain in the right side and weakness, together with nausea and vomiting were also present, but he had not taken to bed before his admission to hospital.

On examination the temperature was 101$\frac{4}{5}$, the tongue was coated ; there was no jaundice.

The intercostal spaces over the liver were full, and there was marked tenderness in the right epigastric region. Hepatic dulness began at the 5th rib, extending down for about 6 inches. Posteriorly there was dulness from the angle of the scapula downwards. Friction could be detected over the right infra-mammary region. The abdomen was otherwise normal. The urine was of a deep sherry color, 42 ozs. in 24 hours ; it contained no bile, albumen or sugar.

During the ten days that the patient was under observation the temperature remained almost constantly at 102, and there were no chills or sweats. The hepatic dulness during this period rose to the 3rd rib, and pus was withdrawn by the

* Read before the Medico-Chirurgical Society, February 23rd, 1894.

aspirator. Upon February 12th, Dr. Bell, after preliminary aspiration, opened the abscess posteriorly in the 9th space and resected the rib, allowing about 50 oz. of pus to escape. The patient did fairly well for some days, but sank rather rapidly and died upon February 18th, six days after the operation. Numerous actively moving amœbæ were found in the pus, together with much debris and a few leucocytes and red blood corpuscles.

The stools were examined for amœbæ during life with a negative result.

It is unnecessary to give all the details of the autopsy which was performed upon the day of death. Suffice to say that upon external examination there could be seen a wound in the ninth interspace and posterior axillary line in the right side ; this led through the region of the resected ninth rib to the liver, and from it could be expressed whitish necrosed tissue together with some pus.

Upon opening the thorax the right lung was found firmly adherent over all its surface, and greatly contracted and diminished in size. The adhesions were firm and close. It was found that the incision into the right lobe of the liver had passed through the diaphragm, but in consequence of the firm nature of the adhesions between diaphragm and costal wall, the pleural cavity presented no signs of acute recent disease, and had apparently been in no wise disturbed by the passage across of the contents of the hepatic abscess. The liver, which weighed 2650 grm , was greatly enlarged, both upwards and downwards. It extended three finger breadths below the costal margin ; was of a fawn colour, and presented here and there upon the upper surface of the lobes frequent small white patches—necroses or abscesses—averaging 2 mm in diameter. The falciform ligament was well to the left of the ensiform cartilage, the right lobe being especially enlarged. In the substance of the right portion of the right lobe was a large abscess, with thick necrosed walls and irregular and shreddy internal surface. This extended from the under surface of the organ to within 2 cm. of the upper and outer surface of the lobe ; its breadth from side to

side was 12 cm., and from above downwards it was 15 cm. (6 inches) across. Throughout the rest of the right lobe there were scattered a few other secondary abscesses; the largest of these was 15 mm. in diameter.

The intestines were markedly congested. In the jejunum were a few subcutaneous hæmorrhages. Upon examination of the large intestine no signs could be made out of any dysenteric lesions. Close to the ileo-cæcal valve was a small whitish patch, which gave rise to the suspicion that there was a cicatrix, but upon closer examination the most that could be discovered was that here the mucous membrane was softened and thin, with no ulcerous or old inflammatory conditions. Here, then, as not unfrequently occurs, the amœbic abscesses of the liver were present without any indication of dysenteric intestinal lesions, either during life or at the autopsy. It is to be noted, however, that the hepatic flexure of the colon was in close contact with, and, in fact, adherent to that portion of the under surface of the right lobe of the liver, which was undergoing necrosis.

Beyond that the heart presented the condition of early pericarditis, and that the kidneys showed some acute parenchymatous nephritis, the condition of the other organs does not call for remark.

Stained sections of the liver and slough showed the presence of amœbæ; these were best shown by staining with methyl-blue and were faintly stained by hæmatoxylin. In the abscess cavity and its walls were numerous masses of streptococci. These were evidently of secondary growth, for the abscess contents were singularly free from pus cells, being mainly formed of broken down cheesy matter. Microscopic examination of the walls of the colon showed no evidence of necrosis.

In this case, therefore, the presence of fever, of hepatic enlargement, pain and tenderness, suggested the presence of purulent inflammation in the neighbourhood of the liver. That this was so was confirmed by the result of aspiration. Whether the abscess was sub-diaphragmatic or in the liver substance was determined by the discovery of the amœbæ in the removed

fluid. These indicated clearly that the origin of the disease was in the liver itself.

The failure to find amœbæ in the fæces was explained at the autopsy by the absence of any dysenteric ulcers or necrosis in the colon.

This case gains an additional interest from the fact that so far as we know, it is the first recorded in Canada in which the amœbæ coli have been demonstrated in an hepatic abscess, if not in the living body generally.