

Tropical liver abscess

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Hepatic & Perihepatic Inflammation Abscess

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See following		Perihepatic Hepatic abscess		

The term "hepatic abscess" is loosely used to cover all abscesses in or around the liver. ~~It is seen in the~~ following account ^{however} Perihepatic abscess is chiefly dealt with & it is ~~worth~~ that disease in particular that I ~~have~~ wish to illustrate further to limit the ~~to the differentiation between the two~~

subject for the purpose of this article ~~and~~ it is with ~~perihepatitis~~ ~~perihepatic~~ ~~of the~~ abscess of the dome of the liver I propose to deal. Abscess of the dome of the liver has occurred within the last ^{few} months in four cases in my practice. The cases were treated in my ^{Private} Hospital. The Peak, Hong Kong & the notes & observations were accurately taken & kept. The results of treatment were: 2 Recovered 2 died. In both of the fatal cases, ^{was allowed} ~~to die~~ a most mortem. ~~Thereby verified the diagnosis~~. The chief difficulty in Perihepatic ~~of the dome~~ is to ~~diagnose~~ is the diagnosis. ^(3 out of the four) all the cases ^{imputed} ~~to~~ for treatment were undiagnosed & a reference to previous case ^{with} my own practice I am convinced ^{was after} ~~that~~ were Perihepatic of the dome which I failed to recognize.

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The two practical points I wish to elucidate are first the diagnosis secondly the treatment. The diagnosis of perichepatitis of the dome is fraught with difficulty. It is plain that the only possible conditions which can be mistaken ^(pleurisy with effusion pleurisy pericarditis) for perichepatitis is congestion of the right base of the right lung. This seems all too simple & the diagnosis of perichepatitis ^{pericarditis} between such conditions ^{conditions} of the dome of the liver should be very ^{all too} simple. When however I state that all the cases presented ^{it does not seem evident of it, simply} which came to me for consultation were undiagnosed, ^{they were} men experienced in tropical disease before I saw them and in only one instance was the disease suspected. The very fact of the disease being suspected ^{the} the diagnosis strengthens the opinion I have formed as to the difficulty of diagnosis. We find the hint that such ^{conditions} conditions may be the cause of the symptoms of the diagnosis recognition of the actual seat of disease is usually abundant and easy; but not so with apparently with ^{pericarditis} perichepatitis of the dome of the liver. Even with the idea present in our mind, with the aid of temperature charts, the history, & all the accessories by				

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2. Capt B.	27 years in China, ^{with} at sea since 14.			
3. J. B.	27 years in Formosa, China.			
4. G. B.	97 years in Shanghai, China.			
The previous histories vary. 1. Ice-tollen for ^{ten} years previously, lived fully, dysentery, fissure of Rectum. 2.				
1. Ice-tollen ten years 1879-1889. previously lived fully, dysentery, fissure of Rectum.				
2. Lived fully. no previous illness.				
3. Lived moderately. Fever. Had an abscess of ^{the} liver which pointed in the ^{right} ^{hypochondrium} ^{into} the ^{peritoneum} ^{into} the ^{intestine} .				
4. Lived very fully. Fever. Had an ^{abscess} ^{of} the ^{liver} ^{which} ^{pointed} ^{into} the ^{peritoneum} ^{into} the ^{intestine} .				
Ages 51. (2) 30 (3) 26. 439.				
Previous history Illness (1) Fissure for 20 years cured Jan 1890.				
Dysentery slight 27 years before				
Operated on for piles 1870.				
Influenza prevalent 1850. had fever after.				
2. A few days, self attack had completed in some cases.				
3. Had Formosa fever liver abscess opened in the ^{right} ^{hypochondrium} Jan 1891.				
4. Had liver abscess opened in ^{right} ^{hypochondrium} Sept 1890.				
Existing Cause or antecedy patient.				
1. Influenza.				
2. Cholera in summer years.				
3. Previous liver abscess.				
4. " " - returning the patient.				

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The situation of the disease. The time of the liver is the seat of the disease from cause just mentioned examination. It is the commencement of the trouble is between the layers of the coronary ligament of the liver. Therefore it does not commence as a ~~peritonitis~~ peritonitis, but in the space described by Renton between the diaphragm & the liver. The space in this neighbourhood is the pathway of the lymphatics from the liver to the diaphragm & the sternum of the diaphragm are really channels for the conveyance of fluid from there to the pleura. That the ^{lymphatic channels} ~~diaphragm~~ ^{with the diaphragm} convey the fluid better when ~~distended~~ ^{distended} is known from the original experiment of the Becking house when he showed the ^{central tendons of} diaphragm of a rabbit. I saw a red ring of water with passing through it. So it is in the latest stage that the fluid ~~is~~ ^{is} known from the ~~diaphragm~~ ^{diaphragm} as it is known from ~~anyway~~ ^{of the symptoms} the symptoms, it is believed for ~~the~~ ^{the} of experiment in pathology.

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The determining cause of ~~abscess~~ inflammation
 & abscess attacking the liver has to be accounted
 for. To my knowledge such ~~has~~ an attempt
 has not been made. I have formed a belief based
 on clinical & anatomical foundations. With simple
 hepatitis a large of jaundice is usually noticed
 bile appearing in the urine & elsewhere. In ~~these~~ ^{chronic}
~~abscess~~ ^{in hepatitis abscess} I have never seen jaundice in any shape.
 In the ~~abscess~~ ^{abscess} & abscess the in fact the opposite
 condition obtains: pale stools, light colored urine
 & clear conjunctiva. The explanation of these
 seems to be that the ~~the abscess maintains~~ ^{the abscess maintains} allows of
 the escape of bile. The connection between the
 biliary & ~~the~~ lymphatic capillaries with the
 evidence is such that even Heale was led to assume
 that the lymphatic not the so-called biliary
 elements had to do with the formation of bile.
 The liver is usually bile stained at times very decidedly,
 so although it is incontestable that biliary degeneration
 does not take place within the intestine, still a quantity
 of it must find its exit by the ~~portal system~~ ^{portal system} ~~system~~ ^{system}

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The anatomical conditions of the liver as regards the relations of the fine ~~ducts~~ ^{channels} ~~liver~~ ~~passage~~ ^{recapillaries} & the lymphatics are such that a ready ~~for~~ passage of one to the other either by transudation or by rupture or slight pressure can readily take place. Not an increase of pressure taking place from engorgement or inflammation ~~would~~ ^{could} instantly ~~in~~ flow of bile toward lymphatics which ~~to~~ would in all probability lead to inflammation of ~~it~~ & even to abscess of the connective tissue in a ~~around~~ the liver.

The lymphatics from the surface of the liver find their way to the Thoracic duct by way of the diaphragm. The channel by which they are conducted being the connective tissue between the layers of the coronary ligament of the liver. Here, in this ligament, are found also biliary ducts & secretory apparatus, but that they determine or are the formation of pus ~~seems~~ ^{is not to be supposed}. It seems to be probable & probable therefore that the presence of peritonitis abscess of the dome is in the lymphatics of the tissue between the layers of the coronary ligament of the liver.

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liver is not recognizable by the rough estimate we are able to form ^{as to the position of the} liver border. ~~along the right margin~~. The very variable extent to which the liver extends from beneath the right rib cartilages is such that any difference up to less than 1 inch in extent is of accuracy in diagnosis. But the depression ^{even} of ^{are} each from a collection of pus ^{along the upper border} of the liver means ~~that~~ that a considerable amount has collected so that for ^{exact} diagnostic purposes the anterior border of the liver is of but little value. That there is an increase in the prominence of the liver border toward the abdomen ^{in such collection} is certain & is of value combined with other ^{signs} symptoms ~~the~~ but by itself it is of no diagnostic value. It is along the upper limit of the liver area we have to examine for signs of the presence of inflammation & purulent collection & then ~~we~~ ^{in peritonitis} of the dome is so deeply seated that the ~~diagnosis~~ ^{examination} requires the hands touching & well considered.

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Proceeding with the physical examination of the chest we notice 1. By inspection, ~~that~~ the chest ~~looks~~ ^{appears} ~~normal~~ presents ~~an aspect~~ ^{an aspect} of fulness in the region of the lower ~~intercostal~~ ^{intercostal} space, ~~which~~ ^{which} is not affected by the breathing ~~movement~~ ^{movement} as in the normal state. There is a ~~rehearsed~~ ^{rehearsed} ex-
pansion of the ~~chest~~ ^{chest} wall in the lower ~~right~~ ^{right} portion of the ~~right~~ ^{right} side. 2. By Palpation local fremitus is diminished or only ~~markedly~~ ^{markedly} pressure upon the ~~border~~ ^{border} of the lower lobe of left lung. 3. Percussion

(a) nipple line

Normal pulmonary resonance ceases at the nipple & impaired resonance continues for one inch below ~~where~~ ^{where} the note becoming ~~deeper~~ ^{deeper} slightly ~~reduced~~ ^{reduced} & shortened; below the fifth rib ~~the~~ ^{the} note is ~~quite~~ ^{quite} dull.

(b). In the axillary line. The normal percussion note ~~can~~ ^{is} only to met with within highest point of the axilla. The impaired resonance for short distance below that ~~but~~ ^{but} when the dull note is met with at a higher level than in the nipple line. The outline ^{of fulness} ~~is~~ ^{is} ~~seen~~ ^{seen} ~~from~~ ^{from} the base of the xiphoid cartilage upwards. ~~the~~ ^{the} ~~to~~ ^{to} assume a new note

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(c) in the scapular line. The dull area ^{is} is in the early stage the normal pulmonary resonance continues to the usual limit the 70th rib. so that there is mapped out a sudden drop B at the upper limit as in the diagram. in the <u>late</u> stage. as if the patient has been long in bed. the dip is much less marked the dullness being conducted across the scapular lower angle 15th rib space.				
4. Auscultation. In the lower right chest the auscultatory sounds are muffled in the & around the area of dullness. Away above, the dullness compensatory breath sounds are the rule, & if the area abscess has attained large size, the compensatory breath sounds are audible even in the left & deeply below. In the dull area commencing from below upwards the following are the signs met with ^{with the stethoscope} (a) the ^{the} <u>scapular line</u>. respiratory ^{sounds} are audible at the upper limit of in the area of impaired resonance. close to the sternum a few patches of fine dry crepitation. without without tubular breathing indicating a mild adenoma of the posterior of the lung. (b) In the axillary area				

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a blowing expiration indicative of lung consolidation by pressure occurs along the upper limit of the dullness. ~~Below~~ At the base of the chest of ~~broken~~ emphysematous. Above this & reaching upwards is rather a curical form is a mixed sound, a slight blowing expiration but with ~~it is a distinct~~ what at first strikes one as a wavy jerking or coffee beater sound. Some observation however will depose that this sound is not dependent on pleural or pulmonary conditions. They are too distant for pleural sounds & at the upper limit of the harsh where they are met with they can be heard independent of any blowing expiration or other pulmonary condition of mixed expiration. They are ~~an~~ ^{almost} constant ~~but~~ ^{at any rate} sufficiently so to be utilized for diagnostic purposes. They are caused by a peritoneal friction & can be heard as high as the apex of the chest in case of mixed sounds.

Liver

Whilst engaged at the performance of a Post-mortem examination, on a death from suicide, upon a Chinese prisoner in the Hongkong Gaol, my attention was drawn to a marked alteration of the anatomical outline of the liver.

On careful inspection I found the condition to be:-
(1) an atrophy of the right side, and (2) an hypertrophy of the left side of the liver.

I use the word "side" advisedly, as the subsequent account will explain.

Right Side. The upper surface was attached by a tough thickened, fibrous band, in diameter $1\frac{1}{2}$ inches, and $\frac{3}{4}$ of an inch in breadth, to the under surface of the diaphragm.

The band was so strong and firm that no amount of pulling upon it could tear it through.

The liver, over its right area, was of a dull mottled red colour; the connective tissue of its capsule, and its peritoneal covering, seemed increased in quantity, and the whole of the right side was reduced in bulk to one third of its natural size.

Investigating this anomaly further, I found, on cutting into the liver, that the centre of the right side was occupied by a dense mass of fibrous tissue, leading upwards towards the diaphragmatic adhesion, and sending radiating bands outwards towards the thickened capsule.

It was easy to see what had happened, viz., that the right side of the liver was the seat of an old abscess cavity, which had burst upwards through the diaphragm. The track of the pus could be readily followed through the adherent pleura to the nearest ~~lung~~ bronchus.

large

Interesting as this was, as showing a spontaneous cure, it was doubly so when one's attention was directed to the left side of the liver.

Left Side. Over the left area of the liver the peritoneum was glistening, bright, and no trace of any capsule could be seen. The colour was a bright liver hue. The bulk was seemingly many times more than the normal, and of such dimensions that the right side appeared a mere appendage.

The whole of the left ^{lobe} side was thus enlarged, and not only so, (and here is the crux of this anatomical notice), but the Lobulus Quadratus, Caudatus, and Spigelii were included in the hypertrophic area. That is to say, a part of the liver to the right of the Longitudinal Fissure was involved in the hypertrophy, and it was that part along the under side of which the above-mentioned lobes extended. The appearance of the minor lobes was so extraordinary, that it was impossible to throw the liver aside with a mere passing glance; the Lobulus Spigelii especially projecting downwards from the liver substance like a huge tongue.

The liver was

The liver was thus divided into two sides, a right and a left, which did not correspond to the division into right and left lobes; hence I used the word side to avoid complication: later on I may use the word halves for reasons to be explained.

The junction of the atrophied and hypertrophied areas was very distinctly marked, and it extended in a slightly wavy line from the posterior to the anterior border of the liver. Behind, it commenced to the right of the lobulus caudatus, and ran forwards almost in antero-posterior diameter, ending to the right of the lobulus quadratus- in fact, just above the middle line of the fundus of the gall-bladder.

This seemingly unnatural division caused me to speculate as to the real ~~cause~~ reason for such an apparent anomaly, and with the following results.

Experiments to determine the Real Area of the Right and Left Lobes of the Liver, respectively.

Reflecting upon the conditions met with so pronouncedly in the pathological specimen above described, I came to the conclusion that the blood supply of the liver might be the cause.

Accordingly, I gauged the size of the vessels leaving the healthy liver, both in man and animals. I found little or no difference in the calibre of the primary branches of the Portal Vein, of the two primary branches of the Hepatic Artery, or in the size of the two converging Hepatic Bile-ducts.

Further, the fact of every vessel- the Portal Vein, the Hepatic Artery, and the Bile-ducts- entering or leaving the liver as two vessels, gave further food for reflection. Were these vessels, after they entered the liver, independent of each other? If they were, then we have a couple of livers, placed alongside of one another, but as distinct as the right and left kidney. The juxta-position of the two lobes would then be a developmental, and not a functional development. The kidneys occasionally coalesce to form a single horse-shoe shaped organ, and this abnormal fusion of the two organs may be the normal condition of the two livers. If this be the case, its truth must be determined by analysis, and not by mere naked-eye inspection.

To settle the question thus raised in my mind, I injected:-

(a) different coloured fluids, first into the right, and then into the left branch, of the portal vein.

No intermingling of the fluids took place, but the different coloured areas met at a line drawn antero-posteriorly from above the centre of the gall-bladder, backwards to the right of the lobulus caudatus. Now this line was that met with in the pathological specimen above described.

(b) Next injected the branches of the Hepatic Artery

dissection

Necessity

Open wound of liver

with different coloured fluids in another liver, and found the areas similar to the areas presided over by the branches of the Portal Vein; namely, a wavy, antero-posterior line extending from the liver above the fundus of the gall-bladder backwards to the right of the lobulus caudatus.

(c) In a third liver, I injected the right branch of the Portal Vein with a blue-coloured fluid, and the left branch of the Hepatic Artery with a red fluid, and found the coloured vessels approached each other, but did not intermingle- they did not, in fact, cross the bridge of wavy outline above mentioned.

(d) I treated the right and left Hepatic Ducts in the same manner, injecting each with a different coloured fluid, and found they approached each other in the liver, along the same line.

These injection experiments led me to the conclusion that :-

1st. The branches of the Portal Vein supply each a definite area, and do not commingle.

2nd. The branches of the Hepatic Artery in like manner preside over a distinct area.

3rd. The Bile-ducts drain each their special region, without regard to each other.

4th. That the areas supplied by the right and left branches of these vessels correspond: that is to say, the right vein drains the same area as does the right artery and duct, and the left vein, artery and duct act in like manner in their own area.

(f) A further experiment was the division of the liver along the wavy line mentioned, and weighing the resulting pieces. These proved to be equal, thus apportioning the liver into a right and left half.

preside
over

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radiating bands, outwards towards the thickened capsule. It was easy to see ~~that~~ what had happened viz: that the right side of the liver was the seat of an old abscess cavity which had burst upwards through the diaphragm. The track of the pus could be readily followed through the adherent pleura to the nearest big bronchus. Interesting as this was, as showing a spontaneous cure, it was doubly interesting when one's attention was directed to the left side of the liver.

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Aug 20. 1894

S.B.S.F.

Whilst engaged at the performance of a Post mortem examination, on a death from suicide upon a Chinese prisoner in the Goal Hong Kong, my attention was drawn to a marked alteration of the anatomical outline of the liver. On careful inspection I found the condition to be: An atrophy of the Right side, an hypertrophy of the left side of the Liver. I use the word 'side' advisedly as the subsequent account will ~~show~~ explain.

Right side. The upper surface was attached by a tough, thickened, fibrous band, in diameter $1\frac{1}{2}$ inches, and

This short statement of the
 developmental condition of
 the liver bears out the idea of
 a double organ. In fact the
^{apparent} only non-paired vessel met
 with is the hepatic vein ~~and~~
~~a careful investigation would~~
~~no doubt~~ ^{and} in the human being.
 at any rate, the limitation
 of its drainage area is beyond
 the possibility of anatomical
 settlement; ~~that is its function~~
~~is its nature to affect the~~
~~to affect the activity a hyper-~~
~~trophy of the liver halves.~~
 Clinically ~~the~~ the fact of a
 double organ is of the greatest

interest & importance.

The Right Portal vein may be
choked by a thrombus; may be
the ^{selected} ~~route of~~ tract by which
dysenteric poison or debris reaches
the liver. The right side of the
liver may suffer most of all
by exclusion of the left. ~~The~~ ^{Cancer}
affects one ~~to be~~ half of the liver
one to the peculiar exclusion
of the other. ~~The same~~ I Text
books on the liver seem with
such reference.

Harley at page 100 in his text
book discusses of the liver with.

The hypertrophy of one lobe
is dependent upon ~~activity of the~~
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of development of a hepatitis
giving an abscess ~~the~~ in the right
lobe a gradual increasing bulk
of the left lobe has led me to the
belief again & again that it
was the left lobe itself which
was the seat of disease; whereas
the real state of things is that
the functional inactivity of the
right ~~lobe~~ ^{half} induces an increase
& increasing hypertrophy of the
left. The increasing bulk of the
left, noticeable from day
to day, ^{is} generally considered
to be a mechanical descent of the
entire organ owing to the accumu-
lation of pus within a abscess the
liver

if it be not actually mistaken
for an increase dependent upon
the presence of pus in the left
half only. That there is not
may be diagnosed ~~by the~~

- 1) Because there is little or no
tenderness on the swelling
- 2) That the ^{left} inner edge & surface
~~are normal~~ ^{to} have the
natural feel & outline.
- 3) That no ^{perforated} fistula can be ~~felt~~
be heard on the left ^{half}, whereas
on the right & it can be
heard ~~on the~~ ^{every} through the
chest wall.
- 4) That post mortem evidence
reveals, if it is looked for, the
true ^{relative} state of the ~~indication~~ of the
liver, an autopsy of the ~~body~~
divides in question.

COLLEGE OF MEDICINE FOR CHINESE.

HONGKONG.

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In the Indian Medical Gazette of May 5th 1898, Surgeon-Capt. W.J. Buchanan M.D., I.M.S. discuss the etiology of liver abscess in a manner which must recommend itself to all those who have considered the subject earnestly and dispassionately.

In lecturing and writing upon this subject I have for some years past insisted upon the fact that the term tropical abscess of the liver groups under one heading different species of a disease which have little to associate them except the fact that they all contain pus and that they are found somewhere in the neighbourhood of the right hypochondria. It has been the endeavour of physicians both ancient and modern to make their liver-abscess patients confess that dysentery at some previous part of their clinical history. Any acknowledgement of an intestinal flux, whatever its nature may have been, is considered sufficient and the way in which the patient is helped and encouraged to believe that he might have had real dysentery is scarcely worthy of men striving after truth. The colic and diarrhoea induced by a piece of shell fish or unripe apple lasting until a dose of castor oil sweeps it away have been known to serve as evidence of previous dysentery by those pledged to the dysenteric origin of liver-abscess. Many hold that the *Amoeba coli* having strayed to the liver is the cause of liver-abscess, and were the results of this belief followed out to their scientific fulness, it should

be the struggle of the physician as it is of some surgeons with the appendix vermiformis to treat the amoeba coli as some surgeons do the vermiform appendix by anticipating the disease, and eradicating a healthy natural state which might in mere wantonness cause future trouble. And yet even the most advanced believers in the amoeba confess that 40 per cent of the cases of liver abscess cannot be accounted thereby.

Because the amoeba coli is found in liver pus need it be assumed that this piece of protoplasm is the primary cause of the ailment. I have found the amoeba coli in the pus that ran away from an opening in the chest connected with a liver abscess that burst upwards, two months after the onset of the disease. The expectoration from the bronchus in a case of hepatic abscess which burst upwards through a bronchus contained amoeba coli during the whole time of convalescence? The amoeba coli of not an abnormal product and can be found not only in liver discharge but in any inflammatory connection with the peritoneal lining, and ready to proceed beyond it as occasion offers.

I have reported cases of liver abscess that have developed in patients who had never set foot in the tropics until six weeks previous to the attack, and who never had been out of England or had dysentery.

I have also reported cases of dysentery and liver abscess that supervened after a chill where no dysentery played a part. Chill is the great cause of liver abscess. As the lung and bronchial tubes in temperate climates register

the fact that abnormal exposure to cold has proved more than h
the individual could stand, in the tropics the liver is the
organ that has to bear the burden and if it is incompetent to
adapt itself to the altered environment, the fact is made
evident through the symptoms of liver abnormalities. If farther
proof is need it is ready to hand, and the oft repeated tale
that liver abscess are much rarer in the West Indies and in
the Straits Settlements than elsewhere helps to prove that
exposure to cold is the fons et origo mali. The countries
just named the West Indies and the Strats Settlements, to which
might be added several others in the same latitude are Equator
ial in their climate. The temperature even in the island of
Jamaica, which lies some 17 degrees to the north of the equa
tor has an equable climate which classes it as equatorial. The
variations of temperature in the Equatorial belt are very
slight and chills are comparatively rare. Even in the higher
altitudes of Jamaica although the temperture is cool the

Liver



ACCESSION NUMBER

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PRESS MARK

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