# Original Communications.

## THE CAUSE OF HEPATIC ABSCESS.

By

Surgeon-General MOORE, C. I. E.

The percentage of hepatic abscess to total cases treated in the Jamsetji Hospital, Bombay, during the past three years was ·62. In the Gocaldass Hospital it was ·54. In the European General Hospital it was ·66. I have been induced to refer to the subject in consequence of the statement made by Dr. Harley in his work on liver diseases that "natives of hot climates, whose mode of life is entirely different to that of Europeans, are not one whit more liable to be affected with abscess of the liver than any man residing in Great Britain." We in India know this to be erroneous, for, although natives may not be so liable to hepatic abscess as Europeans, they are, nevertheless, not exempt from this tropical malady to nearly the extent to which Dr. Harley supposes them.

Dr. Harley attributes hepatic abscess amongst Europeans to "gluttony and intemperance or to the habitual over-indulgence in rich food and strong drinks," so "that it is impossible all the hydrocarbons admitted to the circulation can be used up, which, coupled with the inactive mode of life followed by the majority of English residents, produce the liver diseases of India." With this sweeping statement I do not agree. Doubtless, many Anglo-Indians do eat, drink, and sleep too much, which, as Macnamara long since demonstrated, tends to induce fatty liver and hepatic abscess. But as *we* all know the habits of life of Europeans in India have, during recent years, changed considerably for the better, and the charges of a general habitual over-indulgence in rich food and strong drinks, or of an inactive mode of life, are unfounded. It is a known fact that Europeans in the West Indies do not suffer from liver disease to nearly the same extent as Europeans in the East; among soldiers whose habits of life are much the same in all parts of the globe, four times as many suffer from hepatic abscess in the Eastern commands as in the Western commands. While the return from the semi-tropical Mediterranean stations do not show an increase of hepatic abscess *pari passu* with an increase of heat. For these reasons Parkes questioned whether heat *per se* had anything to do with the prevalence of hepatic abscess. The occurrence of hepatic abscess among men of the most temperate habits in every respect shows that it is not always the consequence of "gluttony and intemperance."

I believe the principal, if not the only, exciting cause is *chill*, resulting in robust subjects in preceding congestive or inflammatory conditions, and in anæmic subjects probably leading to hepatic embolism, as the first steps towards abscess. The cutaneous surface is, in India, as in other hot climates, rendered very susceptible to impressions from cold by the heat which induces undue excitation, and consequent cutaneous debility. But in India there appears to be greater atmospheric vicissitude than in other hot climates. On the coast districts there are the diurnal variations caused by the sea-breeze, the land-wind, and a stagnant calm. In land, during the greater part of the year, there is the early morning fall of temperature, and especially in the northerly districts the enormous differences between the day and night, and between the hot and cold weather. Then there is the reckless manner in which persons, after spasmodic exertion, expose themselves to be chilled. We scarcely require "gluttony and intemperance" and an "inactive mode of life" to account for Indian liver disease.

## ABSTRACT OF CLINICAL LECTURE ON GONORRHŒA.

By Surgeon-Major E. LAWRIE,

*Officiating Residency Surgeon, Hyderabad, and Superintendent, Medical School.*

The following remarks were made in the course of a lecture on two cases admitted into hospital with gonorrhœal rheumatism:—

Gonorrhœa is a complaint which is often lightly regarded by medical men and their patients. In reality, it is not only a formidable disease, but is a fruitful source of misery and life-long unhappiness; and for this reason it is necessary to impress on you the principles on which it should be treated. It is characterised by specific inflammation of the urethra, attended by secondary non-specific inflammations, and later on by blood-poisoning, which shows itself in a peculiar form of rheumatism. There are consequently three indications for treatment: The first is to arrest the specific inflammation, the second to prevent extension of inflammation directly or indirectly to neighbouring parts, and the third to prevent blood-poisoning. The latter indication, however, will never arise if the two former are properly attended to. The objects in view in treating gonorrhœa are therefore: (1) To destroy the specific virus of the affection, and (2) to prevent inflammations. With regard to the first it is now known that the virus of gonorrhœa consists of a micrococcus, which is readily destroyed by weak solutions of corrosive sublimate. And in the second place, Dr. Spender, of Bath, has lately called attention to the fact that local inflammations may be prevented or arrested by frequently repeated small doses of antimony. The treatment founded upon these principles will be best illustrated by a short description of a case, which has recently occurred in my practice. One of the

first patients I was called to see after my arrival here was a young Indian gentleman, who had contracted gonorrhœa a week previously. I found him very ill, with fever, a profuse discharge of pus from the urethra, the penis and prepuce greatly inflamed, the inguinal glands on both sides tender and enlarged, and he was suffering from uneasiness in the perinæum and exquisite pain during micturition, and could not sleep more than an hour at a time on account of chordee. He was ordered two leeches to the penis, and two to each groin: fifteen minims of vinum antimoniale in an ounce of water every two hours: and a urethral injection of corrosive sublimate of the strength of one part to fifteen thousand parts of water. He was told to use the injection as hot as he could bear it every hour, and shown how to make it reach every part of the canal. Before he had followed these directions forty-eight hours, he was relieved of all the most distressing symptoms. He slept for eight hours the same night without chordee, and when I saw him next day the scalding during micturition, and threatened inflammation in neighbouring parts, had almost disappeared. The treatment was continued for a week, the strength of the injection being gradually increased to one part in five thousand, and the doses of antimony given at longer intervals. He was then ordered to use the injection three or four times a day, and to take the antimony three times a day, and was quite well in another fortnight. I saw him a month afterwards, and by passing a catheter into the bladder ascertained that his urethra was normal throughout. I could mention other cases to you quite as successful as this, but it is unnecessary. Enough experience has been gained to show that this plan of treatment is immensely superior to those that were in fashion until recently. Under the old treatment, by astringent injections and the internal administration of copaiba and cubebs, gonorrhœa persisted for months and even years, was followed by serious complications, and often ended in stricture. If the principles I have brought to your notice are attended to, the disease does not last more than a few weeks, and terminates in complete recovery.

In short, corrosive sublimate and antimony may be regarded as little less than specifics for gonorrhœa, and I find it difficult to avoid overstepping the limits of moderate language in advocating their use. It only remains to be added that urethral injections ought always to be used hot instead of, as is usual, cold. Apart from their beneficial action, the effects of hot injections are so soothing and grateful to the patient that he at once acquires confidence in you, without which it is useless to expect that he will carry out your orders with implicit obedience.

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## A STATISTICAL REVIEW OF 108 CASES OF GLAUCOMA.

By Surgeon-Major E. F. Drake-Bockman, F.R.C.S.
*Superintendent of the Eye Infirmary, Madras.*

This paper records statistically the history of 73 persons who suffered from glaucoma, in 35 of whom both eyes were affected, thus making a total number of 108 eyes.

I have classified the cases under the heads of acute and chronic glaucoma. Both classes also include cases in which glaucomatous symptoms appeared suddenly or insiduously upon some previously existing local disease of the eyeball itself, or upon some pre-existing bodily state, or other cause remote from the affected eyeball. I have, therefore, divided each class into two subdivisions, *viz.*, into "primary" and secondary" glaucoma. Arranging the numbers, therefore according to this plan, we obtain the following result:—

Table I.
Acute Glaucoma.

| | |
|---|---|
| *Primary Glaucoma—* | |
| Nervous causes | 4 |
| Injuries | 4 |
| Fever | 2 |
| Native operation | 2 |
| Atropine | 1 |
| Rheumatism | 1 |
| Unknown causes | 15 |
| Co-existing cataract | 15 |
| Total | 44 |
| *Secondary Glaucoma—* | |
| Irido-choroiditis | 1 |
| Grand total | 45 |

Table II.
Chronic Glaucoma.

| | |
|---|---|
| *Primary Glaucoma—* | |
| Metrorrhagia | 2 |
| Nervous | 2 |
| Alcohol | 2 |
| Unknown causes | 55 |
| Total | 61 |
| *Secondary Glaucoma—* | |
| Irido-choroiditis | 2 |
| Grand total | 63 |

Under the subdivision "primary," I have placed all those cases in which it was difficult to discover a cause either from the patient's previous history, or from any evidence in the eye itself, those in whom mental distress was pronounced, those in whom vision was impaired by co-existing cataract, those who had suffered from fever, &c., as may be seen in the table above. Under the second class of "secondary" glaucoma, I have placed all those cases in which a pre-existing cause was found in the eyeball itself, as iritis.

Among the former, acute glaucoma supervened in 44 cases, and the number of days which elapsed in each case before the patient applied for relief was as follows:—

Table III.

| | 2 days | 3 | 4 | 5 | 6 | 7 | 8 | 10 | 12 | 14 | 20 | 25 | 4 weeks. | 6 weeks. | Unknown time | Total. |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| *Primary.* | | | | | | | | | | | | | | | | |
| Unknown cause | 1 | 0 | 1 | 0 | 1 | 1 | 1 | 2 | 0 | 1 | 3 | 0 | 0 | 0 | 4 | 15 |
| Cataract | 0 | 5 | 1 | 2 | 0 | 0 | 0 | 4 | 1 | 0 | 0 | 0 | 0 | 0 | 2 | 15 |
| Nervous causes | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 2 | 4 |
| Injuries | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 1 | 1 | 0 | 0 | 4 |
| Fever | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 0 | 2 |
| Native operation | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 2 |
| Atropine | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| Rheumatism | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 1 |
| *Secondary.* | | | | | | | | | | | | | | | | |
| Irido-choroiditis | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 1 |
| Total | 1 | 5 | 2 | 2 | 2 | 2 | 1 | 6 | 1 | 4 | 4 | 1 | 2 | 2 | 10 | 45 |