

PORCHER (F. P.) of F. P. M. D. ab

[From Trans. S. C. Med. Assoc. May-;
Reprint in N. Orleans Med. & Surg.
Journal, June, 1889]

FIFTEEN CASES OF HYDROTHORAX—(SIXTH
SERIES.)

BY F. PEYRE PORCHER., M. D., CHARLESTON, S. C.



The preceding series were restricted to the consideration of cases in which paracentesis of the plural cavity, the lungs, or the pericardial sac was employed.

As I do not desire to record or describe the surgical procedures only, which are unimportant in comparison with the diagnosis and detection of the presence of fluid, I will include in this series every case where fluid was discovered, ante or post-mortem, during a service, it will be observed, of but a few months, and in only one division of a hospital of very limited capacity. This will demonstrate the unsuspected frequency of pleurisies with effusion in this country. A few cases treated at the same period by one or two of my colleagues are added.

From a consideration of the entire series (numbering 69 cases,) I am again compelled to say that the conclusion is forced upon us that throughout the country a vast number of cases escape detection and treatment, either medical or surgical. If this be true, the question arises whether such a conclusion is flattering to the profession as a body.

CASE I. Serous fluid degenerating into pus; paracentesis; introduction of drainage tube.

I. Morrison, colored, æt. 33, difficulty of breathing upon exercise, with dropsy of feet, legs and abdomen. The dullness extended above the nipple of right breast, and posteriorly to the same level; slight roughness of first sound at base of heart, but could not detect prolonged first sound over mitral, as reported by others who had examined him.

Diagnosis.—Fluid in right thoracic cavity.

The hypodermic needle having been introduced an inch below the point of the scapula, the presence of fluid was established.

It is stated as follows in hospital book: "June 1, patient aspirated, and two quarts of fluid of a vermilion color, removed by Dr. Porcher. Patient has been feeling better since the aspiration, and the act of respiration is much more easily performed."

After a time, as there was immobility of the unsound side, with no reverberation of voice, and hectic symptom, and an evening temperature of 100 degrees occurred, it was determined to repeat the aspiration. The needle was inserted at the ninth intercostal space at the back, four inches below the spine of the scapula, and about one quart of purulent, or sero-purulent fluid was removed.

July 16—Patient better, but the movement of fluid could be detected upon changing the position of his body. A trocar and canular was inserted, and two and a half quarts of purulent fluid withdrawn. The opening having been widened with a bistoury, a drainage tube was introduced and allowed to remain.

To show how successful may be the treatment of empyæmia, I insert the following from a recent journal:

"The question of the after treatment of empyæmia is one of great practical interest, and the experience of Prof. Hoelsti (*Rundschar*, 5 H. 1889) is well worth attention. Of the 27 cases operated on, only one died, and that from pulmonary and cardiac complications; three left the hospital with fistula, and the rest were cured. In all the cases operated on the pleural cavity was not washed out once. The main point to emphasize in every case was free drainage, which was best accomplished by the resection of a rib, preferably the sixth, and to avoid the mistake of removing drainage tubes too soon."

CASE II. S. Camoens, colored, female, æt. 50; entered June 19, 1888. Extremities dropsical, absence of respiration and dullness at base of right lung, corresponding dullness at base posteriorly and also in front of left lung. There was no decided pain in the chest, or abnormal sounds upon auscultation. She had been ill for months before admission, and died June 21.

Autopsy: Cheesy matter under sternum; pericardial sac adherent to heart, and degenerated, with a purulent abscess; tubercular deposits upon ensiform cartilage; heart extremely fatty; fluid in right pleural sac compressing the right lung upon the spinal column; fluid also in left cavity.

Cause: Former pleurisy and pericarditis, followed by

inflammatory exudation. This woman must have suffered from the presence of intrathoracic fluid long before her admission, and doubtless it should have been detected and removed.

CASE III. Illustrating unusual difficulty in diagnosis of intrathoracic fluid:

Cæsar Brown, colored, æt 59, admitted July, 1888. There was no fever, slight swelling of the feet, but no albumen in the urine. He was tapped with the hypodermic needle on the right and left side to test for the presence of fluid, because, although there was some vocal resonance and no fever, there was impaired respiration, and partial dullness at base of lungs, anteriorly, posteriorly and laterally.

His liver was greatly enlarged, and the spleen also—or at least the left lobe of the liver gave dullness over the splenic region.

He was carefully examined, July 18, with a diagnosis of cirrhosis of liver, and fibroid phthisis with intrathoracic fluid. No satisfactory respiratory murmur was found in any part of his chest—only sub-dullness; so that the exploratory tapping was justifiable. Prof. Guitéras agrees as to the cirrhosis, and, notwithstanding negative results, is of the opinion also that fluid does exist in the thorax.

CASE IV. M. Townsend, æt. 40, colored, admitted July 8, with the diagnosis: "Fluid in pericardium and dilatation of the heart; the dullness over this organ being five to six inches in area."

Death occurred a week after admission, without treatment. It was intended to use hot baths and hypodermic injections of pilocarpin whilst in the baths, which had proved very efficient in our hands in other cases of dropsy from disease of the heart. The post-mortem revealed the correctness of the above diagnosis; some fluid also being found in the right thoracic cavity.

CASE V. Leonora Bell, colored, æt 45. Fluid in chest and ectopia cordis; heart displaced to the right, two inches beyond the sternum. Sick four months before admission; œdema and pain of left breast; both hands swollen; slight general anasarca; no signs of valvular disease.

Diagnosis: "Left chest up to clavicle filled with fluid." Several friends, Drs. Ogier, M. Michel, E. Ravenel, Legaré,

and the house physicians being present, paracentesis was practiced in the left sub-auxiliary region, between the sixth and seventh spaces, and a quart of light serous fluid was removed.

Patient died during my absence, August 17. At the autopsy, fluid was found in all the cavities; left lung atrophied to half a finger's width, and as usual pressed back upon the spinal column; costal pleura tuberculous. [*Note*: Fluid should have been removed oftener and more thoroughly.]

CASE VI. Saw case with Dr. Guitéras, 1888, with fluid in thoracic cavity; not aspirated.

CASE VII. Treated by Dr. P. G. DeSaussure, 1888; also with fluid in cavity of chest.

CASE VIII. Miss S., white, seen with Dr. Grimké, æt 30; complete dullness over left thorax. Used hypodermic needle without success, as the tube was too fine to admit the exit of pus, which subsequently escaped in large quantity from a rupture through the bronchial tube.

CASE IX. B. Collins, colored, æt. 40, admitted July 20. From notes by house physician as follows: "Complained of pain in right side with difficulty of breathing. Said she had had an attack of pleurisy three weeks before. On percussion, dullness was found over right lung up to one inch of clavicle. Auscultation showed absence of respiration on the same side, and a friction sound discernible; some bulging out of chest."

Diagnosis: Pleuritic effusion. July 22, the needle of the aspirator was introduced three inches to the right of the right nipple, between the fifth and sixth ribs, and fully 3½ pints of a pale-straw-colored fluid withdrawn. Patient showed signs of faintness at the termination of the operation, and an ounce of whiskey was given. As the operation proceeded there was gradual relief from the dyspnoea.

July 23. On percussion, found resonance extending to one inch below the nipple; there was no vocal resonance upon auscultation. A blister was applied to the back below the right scapula. Patient rested well last night for the first time in three weeks.

July 24. Ordered syr. ferri iodidi, t. i. d., and spirits, ℥iii daily.

Aug. 1. Right lung above nipple has partially resumed its functions; the pains from which she had suffered were greatly relieved by blisters.

CASE X. I. B., æt. 30, 1888; pleuritic effusion; had spitting of blood; much emaciated; loud complementary respiration under clavicles, explained by the subsequent discovery of fluid. The dullness exists above the line of the liver and extends as high as the nipple in front of the right lung; so conclude there is pleuritic effusion—the result of a pleuro-pneumonia.

CASE XI. J. Smalls, colored, æt. 40; admitted February 5; died a few days after admission, which the autopsy will explain, as follows: "Extensive lesions of the thoracic organs; cavity filled with fluid, and plastic lymph coagulated; lungs compressed against the spinal columns and atrophied; pericardial sac also filled with light, serous fluid. There was an abscess of the liver and the spleen was engorged." [Note—This case should have been earlier detected and treated, either medically or surgically.]

CASE XII. C. Davis, colored, æt. 30; admitted February, 1889, during a partial service by the writer of a few weeks.

Full plethoric habit, dropsical, with difficulty of breathing; *no albumen in urine*; feet infiltrated with fluid—forming blebs, and serum exuding. A friend who was invited to examine him gave the opinion that the chief trouble was from disease of the heart. My own diagnosis was infiltration of the lungs and dilatation of the heart, with fluid in the thoracic cavity. Death occurred in a few days.

Autopsy, March 2, 1889:—Pericardial sac contained fluid; left pleura so strongly adherent that lung cannot be removed without tearing. Lung dark, infiltrated with serous fluid, which pours from it upon pressure. Fluid in right cavity also. Right lung more spongy and resonant, but with some engorgement of middle and lower lobes, resembling hepatization, but with much serous juice exuding. Lungs in a desperate condition. Heart dilated; liver very large; kidneys somewhat large; capsules adherent, but with no material lesion or change; spleen adherent to diaphragm.

Cause of death:—Result of acute pneumonia and plurisy, with inflammation extending to the organs under the

diaphragm, which had also passed through stages of severe acute inflammation.

CASE XIII.—P. Drake, colored, *æt.* 21; admitted under Dr. Guitéras, Oct. 21, 1888, with tubercular peritonitis and hydrothorax. Was treated for three months with no improvement. Died in January.

CASE XIV.—J. Leonard, white marine, *æt.* 30; admitted Jan. 28, 1889, under Dr. Guitéras, with right pleural cavity completely filled with serum up to within two inches of the clavicle; was treated with potash iodide and syrup of the iodide of iron, and chest painted with tincture of iodine. Patient left on way to good recovery; fluid diminishing.

CASE XV.—S. Selby, white, male, *æt.* 40; was treated in hospital for some time. Upon a *post mortem* examination the left pleural cavity was found full of a sero-fibrinous fluid. The three last cases were reported to me by Dr. Folk, one of the house physicians.

CASE XVI.—This case is reported on account of its puzzling nature, there being complete dullness on percussion, yet an entire absence of fluid:

John Elmore, *æt.* 28, had had pneumonia and typhoid fever a year ago, in Columbia, under Dr. Pope. There was complete dullness over left chest, without cough or respiratory sounds, and no expansion upon breathing, but complementary active expansion of the right.

Diagnosis:—Absence of fluid. Cause of dullness: tuberculosis, or fibroid phthisis, with contraction of chest walls, which were flattened. Patient does not complain of chest or heart, but came in with an injured foot; and the condition of the lungs was discovered by us only upon careful examination; found also a prolonged, aortic obstructive first sound at base of heart, swallowing up the second sound; can hear both first and second sounds at the apex, to the right of the nipple and below it. He did not complain of his chest.

