

A HUNDRED YEARS AGO

Extracted from a 1921 issue of *The Practitioner*

PLEURISY: THE DOCTOR'S DILEMMA

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IT IS ALWAYS WORTHWHILE to see whether the fluid you remove in pleurisy is albuminous or not. All ordinary pleuritic effusion fluid is albuminous, but hydatid fluid is not. I can tell a very dramatic story in that connection.

The case of the doctor's wife

A doctor's wife had fluid in her chest. She was seen by another doctor in the same town, who aspirated her chest and did not notice whether the fluid contained albumen. Fearing that it was a tuberculous case, he sent her away for six months. She was not benefited.

She passed through London on her way back – and I was asked to see her. I put a needle into the chest and aspirated fluid containing no albumen. She was operated on, and hydatids were evacuated from the chest.

Unfortunately, just after the operation, a yellow fog set in over London, lasting three or four days, and that killed her. Nevertheless, if we had known six months earlier that the fluid was hydatid, and not tuberculous, it is quite likely that the woman's life would have been saved.

**“‘Are those the hydatids?’ I said.
‘Yes,’ the house physician answered.
‘Well,’ I said, ‘how do you think
they got through the needle?’
‘Upon my word,’ he replied,
‘I never thought of that’”**

The house physician and the hydatid cysts

A ridiculous instance once happened to me with respect to diagnosis of hydatid fluid by a physician.

When I lived just outside the hospital, the house-physician came round to me to say that he had aspirated a chest as I had told him to do, and that it contained hydatid fluid.

‘How do you know?’ I asked him. ‘Why,’ he said, ‘I can see hydatid cysts.’

We went across, and he showed me the fluid, and floating about in it were the usual rounded coagulated masses of albumen, some of them nearly as big as an egg. ‘Are those the hydatids?’ I said. ‘Yes,’ the house physician answered. ‘Well,’ I said, ‘how do you think they got through the needle?’ ‘Upon my word,’ he replied, ‘I never thought of that’.

Large effusions and the position of the heart

The amount of fluid effused may be very large indeed, and where it all gets tucked away is difficult to imagine. Anything over 100 fluid ounces must displace the heart a good deal, and that is a dangerous condition. Cases of excessive pleuritic effusion have been known to die suddenly, therefore empty the

chest as soon as the case is seen and let the fluid out slowly. The heart is much hampered in its action by being pushed over.

During the last few days I have seen a man distressed with fluid in the chest, and the heart pushed over to the right. Yet on aspirating him we got only 15 fluid ounces out, but I think we got all there was, for after aspirating that amount the heart was back in the normal position.

Locating empyema

Seventy-five per cent of all empyemata are pneumococcal. It is often not easy to diagnose where the empyema is. You may frequently needle the chest without coming across it.

On calling on my surgical friends to do the operation, they have had the greatest difficulty in finding it, and have had to make many punctures, and they knew where the needle went in originally. In one case, twenty punctures had to be made before the spot was hit.

The smallest empyema I have ever found contained only ½ oz of pus. The chances of finding that with several square inches of thick pleura are very small. One sign of value is local tenderness. I am inclined to attribute the greatest importance to the plan of putting the needle in where the patient says it hurts most when you press the chest.

Another reason why it is difficult to find empyemata is frequently because they occur in parts where you could hardly hope to find them by putting in the needle. They may be between the diaphragm and the base of the lung, or between the lobes of the lung, or between the pericardium and the lung; or, again, they sometimes occur underneath the scapula where you cannot reach them with the needle. (However, often we might have missed it in a common position; that is between the outer surface of the lung and the wall of the chest.)

If you suspect an empyema is in one of these out-of-the-way positions, let me implore you not to push the needle in to try and find it. The needle must traverse the lung before it reaches the pus, but then as the needle is withdrawn the lung will be infected by drops of pus exuding from it. I have seen a whole row of little pulmonary abscesses due to this cause.

Some people think they can cure empyemata by aspirating the chest only. I have tried aspirating the chest for pus, and have never known it to succeed. The pus will re-collect.

With regard to cases supposed to show cures, in all probability the patient subsequently has coughed up his empyema and has got well. I have seen over 30 cases in which patients have got well after coughing up the empyema.



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