DIURNAL VARIATION IN BODY WENGHT IN TUBERCULOUS PATIENTS.

The following observations were made on the body weight of patients attending Stepney Green Tuberculosis Dispensary during the time that I was acting Medical Officer.

The patients were weighed at each attendance between 2 and 4 in the afternoon. I made it a practice to call up 10 or 12 for re-examination next morning at 10 a.m. when they were again weighed. The weighing was done by the porter who was very keen on his work and after careful observation, I can trust his records.

I noticed that in the majority of cases there was a fall in the morning weight as compared with the previous afternoon. It varied from $\frac{1}{4}$ lb. to as much as 4 lbs.

The patients being of a poor class have no extensive wardrobe and the difference was unlikely to be due to a change in the clothing. To eliminate this possible factor, however, the patients were instructed to wear exactly the same clothes in the morning as they wore in the afternoon. The fall in weight continued to be recorded.

Careful questioning and observation showed that changes in sleep or diet could not be the cause of this variation.

The patients were unable to have any alteration in diet, and in every case reported sleep as usual.

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ProQuest LLC. 789 East Eisenhower Parkway P.O. Box 1346 Ann Arbor, MI 48106 – 1346 Out of a total of 962 recorded weights I found that 146 showed no variation, 205 showed an increase, and 611 showed a decrease. The average increase was .77 lb. The average decrease was 1.03 lb.

The patients attending the Dispensary are divided into positive cases, including Pulmonary and Glandular cases of Tuberculosis, and suspect cases. The majority of the observations were made on women and children, because men and youths attended only in the evening and were unable to sacrifice a morning's work to attend the Dispensary.

Taking only the positive cases who showed an increasea total of 55, the average increase is .6 lb., while the suspect cases showing an increase total 150, give an average increase of .8 lb.

Taking only the positive cases who showed a decrease, a total of 177, the average decrease is 1.6 lb., as against the decrease of 434 suspect cases averaging .8 lb.

From these figures one concludes that a tuberculous patient will record a greater fall in weight in the morning as compared with the afternoon weight than a person who is merely a suspect. Also that where an increase is recorded in a positive case that increase is likely to be less than an increase in a suspect case.

From observation I can say that the more serious and advanced the disease the greater the variation in weight recorded.

The probability of a decrease occurring as against an increase is 3 to 1.

Grouping the cases according to age the average decrease is instructive.

| | | Age. | Number of | consecutive | decreases. | Average decrease. |
|----|------|-------------|-----------|-------------|------------|-------------------|
| 1. | From | 3 to 8 yrs. | • | 20 | | .8 lb. |
| 2. | From | 9 to 16 " | | 20 | | .9 lb. |
| 3. | From | 17 to 24# | · | 20 | | 1.7 lb. |
| 4. | From | 25 years | | 20 | | 1.5 lb. |

This table includes positive and suspect cases. It is reasonable to infer from it that the decrease will be proportional to the body weight of the patient.

Taking the individual patients the variation practically even after a period of days. remains constant, and alters according as the pathological condition improves or grows worse. Thus one woman who came to the Dispensary as a suspect case on subsequent re-examination recorded decreases 1 lb. 1 lb. 1 lb. 1 lb. before she was diagnosed as a positive case. On the other hand, a boy who was strongly suspect and improved under treatment recorded decreases 1 lb. 1 lb. and in two later examinations Another woman improving under treatment his weight was even. changed the decrease into an increase thus, 12 lb. decrease, In a girl a 1 lb. decrease, 1 lb. increase, 1 lb. increase. positive case of Pulmonary Tuberculosis, but quiescent, the

decrease was invariably the same, namely, ½ lb.

The cause of this variation is obscure. It has been recognised that loss of weight accompanies, and is to a great extent, proportional to, the increased temperature found in tuberculous patients. But in the case of children who had apyrexia and were increasing in weight, this diurnal variation persisted. Nor can it be accounted for by temporary upset of the alimentary system. The influence of the nervous system can also be set aside, because forty per cent. at least of the patients were Jews who are most susceptible as regards "nerves" and their degree of variation is not increased over that of purely English stock.

Without unduly emphasizing the point, my observations lead me to conclude:

- 1. Tuberculous patients tend to have a diurnal variation in body weight.
 - 2. Of those showing such variation, 75% show a decrease.
- 3. The decrease is greatest from the age of 20 to 24 years and is proportional to the severity of the infection.

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Stepney Dispensary

FOR THE

Prevention of Consumption

The patient is requested to return to the Dispensary every Monday, Tuesday, Thursday and Friday.

Once Weekly,
Once a Fortnight,
Once Monthly,

till further notice, and thereafter report progress at least once in three months.

N.B.—On second visit, a small specimen of expectoration should be brought in the bottle provided for the purpose.

The Green Prescription Form must be brought on each visit to the Dispensary.

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Dulness on percussion over left lower lobe with good air entry. No added sounds. Temperature 101. 2.

Three years before he had suffered from "wet pleurisy" of the left lung and had been "tapped" twice. After an illness of ten weeks he recovered. No history of other illness. He had appeared to be in normal health that morning and had not recently complained of feeling ill. Never addicted to alcoholic excess.

One sister had died of Pulmonary Tuberculosis.

As it appeared to be a case of Cerebral Harmorrhage, he was put to bed and 1 minim Croton oil administered.

24 hours later he regained consciousness. Temp. 99.6.

pulse 90. Respiration 25 per minute. There was now no stertor.

Flaccidity of left side of face and right arm and right leg
had gone. Both knee jerks exaggerated. Plantar reflexes
normal. Pupils equal and reacted to light and accommodation.

No abnormality of sensation. Heart and lungs as before. His
bladder and bowels had acted. He was ordered to remain in bed.

Next day he was very restless. Temp. 100. 2. Pulse 100. He complained of frontal headaches. At night he became delirious and required gr. ½ Morphia hydrochlor. hypodermically, to quieten him.

On Wednesday 23rd Nov. he complained of pain in both lower limbs. Plantar reflexes were now extensor in type.

An occasional crepitation which cleared on coughing was to be heard at the left base. Temp. 100. p. 94.

On Thursday there was a definite Kernig's sign. The pupils were now dilated and reacted sluggishly to light.

Lumbar puncture was performed and 5 oz. fluid removed.

On Friday definite Optic Neuritis could be made out and there was tenderness on palpation at the back of the neck.

Temperature 101°.4. pulse 108.

On Saturday head retraction set in. The abdomen was now scaphoid. He seemed unable to recognise anyone and was in a state of muttering delirium, whence he could be aroused only for a minute or two and could answer questions. The optic

neuritis was now more marked.

On Sunday the temp. rose to 104°.6., pulse 140. He was absolutely unconscious and lay in characteristic position on his side with head fully retracted and knees drawn up. He had to be fed through a tube.

He gradually sank and died on Wednesday 30th Nov.
No post mortem was allowed.

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Q. H., girl age 8 years, sailed from Glasgow on Saturday 16th April, 1910 on S.S. Athenia on which I was Ship Surgeon. She was travelling with her grandparents to join her parents in Canada.

My attention was drawn to her on Monday 18th April because of excessive sea -sickness. The passage so far had been rather rough. She looked very ill and wretched and on the verge of collapse. The grandmother stated that the girl had taken no nourishment since leaving Glasgow; that she had vomited constantly since leaving the Clyde and that water even could not be retained in the stomach. The bowels had acted freely. The temperature was 96.08. pulse 128 regular but thready. Heart and lungs normal. She was put to bed with hot water bottles and a rectal feed of 30 min. Brandy, eggs and milk to 6 oz. administered every 4 hours.

On Tuesday 19th April she was no better. Vomiting continued. She complained of severe vertical headache. Pupils equal and active. As she looked very ill, I had her removed into Ship's Hospital. Temperature and pulse as before. Kernig's sign was now present.

On closely questioning the grandmother she acknowledged that for a week before sailing the child had not been herself, but the grandmother attributed this to the excitement natural to a child about to make such a long voyage to meet her parents. I recalled then that a girl had been carried in a

woman's arms on board the boat at Glasgow. When the Board of Trade Medical Inspector of Emigrants asked why the girl was not walking the answer given was that the child was too tired to walk, as she had been travelling for 24 hours in the train from the North of Scotland.

According to the grandparents, the family history was good.

On Thursday the temperature had risen to 99°.2. pulse 100. Vomiting had ceased. The child looked better but there was distinct head retraction. Plantar reflex extensor.

On Friday a slight extensor strabismus was manifest in the right eye. Head retraction more marked. Temp. 99°.6. No vomiting. She was now able to take milk by mouth and to retain it. She refused to take solid food.

On Saturday strabismus was more marked and she lay in a typical meningeal position with head retracted and knees drawn up and resented interference. She rambled in her speech and did not seem to recognise her grandmother. There was obvious loss of flesh.

On Sunday at Quebec the Canadian Port Medical Officer came on board. After satisfying him that the case was not one of Typhoid Fever, the child was removed to Jeffrey Hospital where she died a week later. The Hospital authorities diagnosed the case as Tuberculous Meningitis. No post mortem was allowed.

John Gardiner, age 6 years, residing with his parents in Andrie, after being, as his mother said, "unlike himself" for three or four days, on 9th June 1913 complained of headaches and was put to bed. I saw him the same day. He was a well nourished child, with delicate features. He had a hectic flush with circumoral pallor. Temperature 102°.4 pulse 128. Respiration 26. There was no rash and tongue was clean. Nothing abnormal could be found in heart, lungs or abdomen. Knee jerks brisk, plantar reflex normal.

His parents informed me that although he had never had a serious illness, he had always been regarded as delicate, and had frequently required medical attention for slight ailments such as colds and headaches. The family history was good.

There had been no movement of the bowels for over 24 hours. I prescribed a purgative and Aspirin gr. V.

On 10th June the temperature had fallen a degree but he still complained of headache and was very restless. The bowels had acted--normal stools which I saw. He now refused all food. Nothing abnormal to be found in heart, lungs or abdomen. Aspirin was continued gr. V. t.i.d.

The following day the temperature had fallen to 99°.8

pulse 96. His eyes stared straight in front and he seemed to take no notice of anyone but his mother. She informed me that he had taken about 10 oz. of milk that morning and had vomited it half an hour later and had continued to vomit clear

fluid for about 2 hours. There was still no rash and the bowels were acting well. No physical signs of disease to be otherwise detected. The abdomen was soft and nothing abnormal to be palpated.

Later that day I was called in because the child had had a convulsive seizure lasting 15 minutes. When I saw him he appeared sleepy, but the temperature was now 100°.2.

Next day the right eye showed a slight degree of external strabismus. Kernig's sign was present in both lower limbs. Lumbar puncture was performed and 5 oz. fluid which came out with more than normal rapidity was removed. It was neutral in reaction, thickened on standing, not sufficiently to be called coagulation, and gave a positive reaction to the tests for sugar and albumen. Microscopically it contained many small lymphocytes. Temp. 102°.4, pulse 128.

On the 13th June head retraction was present. Examination of the fundi was attempted but the child was too fractious and the effort had to be desisted from. Lungs were still clear of abnormal physical signs.

A day later the knees were drawn up to the abdomen and head retraction was more marked. He lay on his side in a comatose condition. Pupils dilated, face Tlushed. Temp.103°.8 pulse 140 and inegular. There was a marked Tache cerébrale. He could take only fluid nourishment through a sick cup. This comatose condition with high temperature lasted for four days when he began to resent interference and on occasion would lie

on his back. Temp. fell to 1010.6.

Two days later he returned to his comatose condition lying on his side with head retracted and legs drawn up and temperature rose again to 103°. This lasted for 3 days.

Then the temperature began again to fall. Kernig's sign began to be less marked, the rigidity of the muscles at the back of the neck became less. He lay more and more in a natural position and displayed a better appetite and more interest in his surroundings. At the end of a fortnight the temperature was 99°.2, pulse 100. There was no head retraction, knee jerks exaggerated, plantar reflex normal. There was still some external strabismus in the right eye. He was inclined to be fractious and easily upset.

He was allowed up on 10th July and continued to progress. When I saw him a year later there was no strabismus and the parents assured me that he was in every way normal.

Brayton, was admitted to Cumberland Infirmary, Carlisle, on 8th October, 1912.

Three weeks before admission patient was confined and delivered of a healthy male child with instrumental aid. A week later she began to be feverish and to have pain in epigastrium. Lochiae and uterine conditions normal. The feverishness and pain grew worse and her doctor sent her into hospital.

On admission temperature 100°.2, pulse 120. Nothing abnormal was discoverable in chest, abdomen or pelvis. Left border of Cardiac dulness $2\frac{1}{2}$ inches from mid sternum. Patient was a well nourished, well developed healthy woman with no record of previous illness. I discovered that the heart was being displaced gradually to the right with disappearance of the apex beat. The left lobe of the liver was pushed down, and on 10th October I made out left border cardiac dulness $1\frac{3}{4}$ " from mid sternum, with slight dulness and diminished respiration at the bases of both lungs. On 11th needle exploration revealed clear fluid in left base only. Later that day Hippocratic anvil sound could be made out in front in the 4th left intercostal space. Sub-phrenic abscess was dia-

gnosed and operation arranged for.

On 12th October Mr. Norman MacLaren F.R.C.S. operated. A long exploring needle was inserted in 10th space below angle of left scapula, pushed through the pleural cavity and diaphragm and blood and pus found. The needle was left in position and a portion of the rib beneath removed. The pleura was opened and stitched to diaphragm. The diaphragm was then opened and pus found in a small cavity under the diaphragm to the amount of $\frac{3}{4}$ oz. Nothing could be found to account for this. Drainage tube inserted and wound closed. Three days later the drainage tube was removed. Patient made an uninterrupted recovery and left the hospital well, on 2nd November, 1912.

Whether this abscess had a connection with, or was a consequence of her confinement could not be determined.

William Armstrong, age 47, printer - 25, Margery St., Carlisle, was admitted into Cumberland Infirmary, Carlisle under Dr. Bird on 2nd January, 1912.

Four weeks previously he experienced sudden acute pain of a stabbing character on the right side exacerbated on deep inspiration and movement; beginning at the level of the right scapular angle and running along to the nipple line. Except for this pain and accompanying loss of appetits he felt well. The pain gradually changed in character and a week before

admission it became continuous and gnawing and more easily exacerbated by deep inspiration and movement. There was no cough or sputum. He began to vomit clear fluid not related to meals and he took to bed. He was treated for Wet Pleurisy, and not responding to treatment was sent to hospital.

For 30 years patient had been subject to attacks of dyspepsia. Apart from this he had always been healthy. Parents both dead - causes unknown to patient. 6 children alive and well.

On admission patient looked pale, emaciated and in generally poor condition.

(Left border 4. inches
(to left of mid sternum
Circulatory system: Cardiac dulness (Right border, mid sternum.
(Upper border, 4th rib
(upper border.

Apex beat in 5th interspace, palpable and barely visible.

No thrills, cardiac sounds feeble, but pure and regular.

Mitral and pulmonic second sounds both accentuated.

Pulse weak, arteries thickened.

Pulmonary System:

Chest expansion 14. Diminished movement at right base.

Intercestal spaces fuller at right base than left, but
not bulging.

Percussion note impaired at both apices, more marked at right than left. Absolute dulness over right lung

in front from middle of 3rd interspace, in the axilla from the 4th rib, at the back on a level with 6th dorsal spine.

At right apex on auscultation the breath sounds were weak with prolonged expiration and a crepitant note heard at end of forced inspiration. Respiratory murmur only faintly audible at right base with almost no vocal resonance. Left lung normal.

Alimentary System: Teeth bad and foul. Tongue furred.

Abdominal muscles rigid, especially above umbilious.

Right rectus more rigid than left and tender on pressure to right of epigastrium and also close to 9th and 10th ribs. Owing to the rigidity of the muscles nothing could be palpated in the abdomen.

Succussion present. Grea of

tympanicity as shown in sketch. Lungdolmen

Liver dulness area cannot be

accurately delineated owing to

dulness at pulmonary base

and rigidity of rectus.

Splenic dulness slightly enlarged.

On rectal examination prostate enlarged.

An exploring needle was inserted and a syringeful of turbid fluid was removed from right pleural cavity.

Microscopic examination showed abundant small lymphocytes, with an amorphous deposit of unknown earlity. No pus.

Rigid recti.

4.1.12. Blood examination H \hat{p} . 75% Red cells 4,000,000. Leucocytes 47,000. Liver edge was felt 2" below costal margin.

Patient was seen by the surgeon, Dr. Ramsay, who recommended operation.

5.1.22. Dr. Ramsay aspirated the fluid and removed 43 oz. of greyish fluid with a faecal odour. An incision was made below the costal margin posteriorly and drainage tube inserted.

The patient bore operation well but gradually sank and died on 11th January.

A postmortem examination showed a bottonhole perforation of the great colon at the hepatic flexure. It had indurated edges and was evidently of old standing. The colon contents had worked their way up behind and over the liver and ruptured the diaphragm which was very thin on the right side. No other ulcers present in stomach, bowel or colon. Liver showed slight fibrosis. Spleen soft and pulpy.

