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To

W. H. Bowling M. D.
Professor of the practice of Medicine
in the University of Nashville
This Dissertation
Is dedicated as a tribute of respect
for his high professional attainments,
and as a mark of gratitude for
his valuable instructions

By The
Author.
The Diagnosis of Diseases

The diagnosis of diseases is unquestionably the most important office of the physician, and the first duty he has to perform in visiting the sick. The term is generally applied in two senses, first, that of determining the nature of the disease by the symptoms; secondly, that of distinguishing one disease from another by comparing the symptoms. Notwithstanding science has thrown much light upon this subject, I have learned from limited experience that the young physician often finds the path dark and difficult; yet it is his beacon light; without it, his progress will be uncertain both in treating disease and securing a name among the people as a scientific physician. Were it not for the latter proposition, he might often satisfy himself with some hope of success to treat symptoms without a special regard to the
name of the disease. But, after an examination of the patient, this question immediately comes up, with great solicitude on the part of the patient and friends; and if he is unable to give a satisfactory reply, he may be censured. But, by an artful evasion of this question, at the first visit, he may avoid facing difficulties, for the disease may turn out to be different from what his first diagnosis revealed, and then he might be induced to avoid himself of that popular error, with the vulgar many; and say the disease had "run into another disease." Bee to adopt the wise old maxim, "Know we are right, then go ahead."

The sources of diagnosis are too numerous to give a special notice of each, such as morbid alterations of the various functions, of the face, tongue, attitude,
facial expression, seat, and character of pain, which constitute our most important means of diagnosis, together with the habits, constitution, hereditary predisposition, particular locality and climate. For as we are taught, and I think correctly, that man is very apt to take on a certain diathesis which is either, inherited from parentage or country, their habits of life, particular seasons etc. etc. cause the development of this diathesis.

This subject affording such an extensive field, I have chosen merely, to apply it in this dissertation to our fevers which constitute the most important class of disease that our physicians are called to treat, viz. - Pathologic Malarial, Infective and Phlogistic Fevers. Some of the varieties of each having come under my observation.
formed a limited acquaintance with them; but am free to confess, not familiar enough with them to recognize them readily, when called to see them, but from some beautiful descriptions I have heard of them; together with my former limited acquaintance, I hope for the future to be better able to recognize them.

Malaria fever claims the first attention, for this is a common fever in the locality where I have resided since my attention has been directed to the study of hygiene, not only here (Upper Georgia) but indeed in Middle Georgia, my former home.

It may be remarked as corroborating with the statements of writers and teachers, that we never had in either of these localities a case of Intermittent Fever unless contracted elsewhere and brought into our community, showing the fact that they are not common.
to the same localities. Though as already
alluded, my attention was called to two
cases of intermittent fever contracted abroad.
The only cases I once saw in our "hill country"
as it is generally termed; but the same
cannot be said of typhoid fever, for it
is often wandering amidst our hills, without
any traceable cause, for it seems to have
no respect for persons, often attacks persons
of the most cleanly habits and occupations.
The disease is generally not very recognizable
at the beginning. As described, the patient at
first makes very little complaint, says he
feels weak, shivers, hot, which is generally per-
sisting, he tells the physician, he thinks all
what is necessary is to sweat him. I have seen
cases that had been tried by all the sweating
tea that could be thought of by patient or
friends and still the physician will find
the
patient complaining of a hot, dry skin.
Not sick but not well is a very significant term in this disease—very descriptive.

Pain in the heart, though sometimes absent, I noted a case recently, where the cerebro-spinal manifestations were all absent at the beginning and for a week after slight rigors, which generally occur at the beginning. There was no observable phenomenon differing from that of health except hot, dry skin, slight acceleration of the pulse, little alteration in the tongue, and muscular inactivity. Delirium came on in the second week and continued for a week, but patient recovered. Though we have no very diagnostic symptoms at the beginning, but where the aforementioned symptoms exist, we many suspect some lurking danger. We have been recently reminded of this diagnosis.
the symptoms, one of which I have noticed particularly. First, hoarseness, and then a "muffled" cough, which was always present and hence some mistake this diagnosis for typhoid pneumonia. The character of the sputum, or of any other sputum, without the absence of other signs of typhoid pneumonia will enable us to distinguish this complication. Other signs are rather a characteristic in this disease; I saw a case where this sign, together with subcutaneous lymphatics, lead to the greatest permanency. impressions that the patient was attacked with typhoid fever, of course. Some other symptoms had passed, but not a very diagnostic. In this case there occurred in about two or three days after I saw the patient severe
Spasms, case terminated in death. I failed to state the crisis in which I first saw the patient, there was copious hemorrhage from the bowels.

The rose - colored, eruptions and Scurfiness which occur in this disease, are said to be valuable diagnostic. Signs in this fever, notwithstanding they make their appearance at such a late period that we may have formed an opinion as to the kind of fever with which we have to deal, they will confirm us in our diagnosis. The duration of the fever is another diagnostic, particularly when the case is called typhoid fever and guides to treatment or gets well very soon, we know the case was not typhoid fever. I have been practitioners who take great advantage in pronouncing such fevers typhoid fever. I have been differently advised - been taught that this is a self-limited disease, and have so contended.
The next fever that claims our attention in this connection is that of malarial fever. Here the locality will assist us in diagnosis, as a general rule. These are confined to malarial districts and dependant upon a specific poison, malaria, producing a variety of fevers, viz., Simple Intermittent, Inflammatory Intermittent, Malignant Intermittent, Simple Remittent, and Inflammatory Remittent.

Simple Intermittent is considered the true type of all malarial fevers, and the general diagnostic belonging to this class of fever—that is, the paroxysms, are too well marked to require other symptoms to enable us to distinguish this form. We have distinct sensations of cold, hot, and sweating stages, occurring at intervals of twenty-four, forty-eight, and seventy-two hours.
Inflammatory, Intermittent—Sweating stage more imperfect—interval not so well marked
Skin remains hot—pulse full. Quinino Said to be a valuable diagnostic agent—confirms
the diagnosis. Should we be unable to determine it, Simple Intermittent or Inflam-
matory Intermittent. After giving it in
proper dose, and it fails as an antidote
indicates the existence of something besides
malarial poison. Then look out for inflam-
mation. Some organ will be able to make com-
plaint. If the liver—pain in the case of the
Shoulder—yellow tinge of the skin. Stomach
pain in the epigastrium, increased respira-
movements of the diaphragm, together with vom-
ing—great pain produced by
Successions or lowering the head. But the
Spleen being more liable to become inflamed
and less apt to make complaint—apt to be
The seat of inflammation—sometimes detectable by percussion and manipulation over the region of the spleen.

Malignant, Intermittent. Difficult of diagnosis from the fact that no two cases resemble each other. Coexistence of heat and cold—rose—ears—fingers—little or no pulse, in fine when we meet with a case differing from any other disease—patient probably had other varieties of malaria: fever, we may suspect danger of this fearful form, very important that we be able to recognize it.

Simple Remittent.—In this form the fever does not entirely go off. Slight exacerbations towards evening—Patient may need at night—may be slight chill in the morning—Delirium consisting—yellow skin and eyes—Vague asthenic weakness. Soon inflammation of some organ is set up.
and we have. Inflammatory. Remittent characterized by continued fever. As this state often mistaken for typhoid fever. Having set out with the characteristics of a malarial fever, dependent upon malarial poison for its production—typhoid fever being produced by a different poison, will be sufficient evidence to form a correct diagnosis in regard to these diseases, in the absence of other signs.
Of the remittent fevers, we have only three varieties that claim attention, viz., Small Pox, Measles and Scarletina.
In these fevers, we have the usual phenomena in the initial fever belonging to fevers in general, such as rigor, heat of skin, accentuation of the pulse, pain in the head, back and limbs; nothing particular to distinguish them from other febrile affections.
The occurrence of the eruption will reveal the character of the fever—its distinguishable variety from the other period of incubation-duration of the fever and the character of the eruption, will constitute our chief means of diagnosis.

Smallpox has for its period of incubation usually twelve days, fever two days.

Measles-incubation period two days-fever three days. Scarlatina seven days from the introduction of the poison to the efflorescent stage—including one day of active fever or twenty-four hours. Character of the eruption in each present signs differing: notwithstanding they were in such harmonious association among the ancients, up to the time of the great Sydenham, who first successfully pointed out these differences.
The eruption is described in Small Pox to consist of minute red points which first make their appearance on the face. Then the neck—breast, etc. Next these red points or pimples are converted into vesicles—eroded every where except the middle which is held mechanically down by a small ligamentous fiber which is finally destroyed and thus the vesicle rises up in the middle and becomes pointed. The vesicle contains a fluid or lymph which is clear, which becoming more opaque forms pus, this vesicle is then termed a pustule.

Measles. Here the eruption is more rapid. It may first be seen behind the ears—nape of the neck—forehead, breast—descending spots become confluent—skin presents very rough surface—rash assumes a brick dust color,—no two spots the same size.
In scarlatina the rash is much order more in measles, minute red spots forming patches more diffused than in measles, but not confluent; not attended with roughness and elevation of the skin—greater tenderness of the skin; besides the emulsion. Other signs may be added—there is greater fever in scarlatina, there is sore throat in scarlatina, whilst, there is no sore throat in measles. Said to be greater tendency to delirium in scarlatina. Cough is seldom absent in measles. These fevers also being contagious, and capable of propagating themselves, their prevalence in the country of the one or the other will attest us in distinguishing the variety. The next fevers that call attention, and by no means of the least importance to a Southern Practitioner are very properly termed Jndrologic fevers, I shall only call attention to three of this class, viz.
Bronchitis, Pneumonia and Pleurisy. These fevers are dependent upon the same cause for their production, and have symptoms greatly resembling each other, hence there is more or less difficulty in their diagnosis. We are truly indebted to the celebrated Laennec for his great discovery which has thrown so much light upon the subject of diagnosis; the subject would have certainly remained in great obscurity, more particularly in the fevers now to be considered, had it not have been for his discovery of Auscultation. They are common in the fall, winter, and spring months. Our country is subject to such vicissitudes, that few are free from the febrile diathesis, and according to any observation, these fevers are met with oftener than any other class of fevers, hence their importance.
Bronchitis, usually commences as common Catarh—a inflammation attended, with increased discharge, of the Schneiderian membrane lining the nose and the Sinuses communicating with it—fever, hurried respiration, irritation about the larynx and trachea. Cough at first dry and harsh—soon a glairy mucous expectorated, soon becoming viscid, yellowish, sometimes streaked with blood. The mucous membrane of the Bronchial tubes being inflamed, sounds are produced in respiration differing from the healthy Sounds; first the dry sound—also the sonorous, which soonjoins to the other mucous. Sometimes the interior murmur ceases, from the obstruction of air into the air cells, at this stage might be mistaken for pneumatic efforts of coughing, removing this ob-
...
-Direction the vesicular murmur soon returns. There is always clearness on percussion in this disease which is a good diagnostic sign.

Pneumonia. The natural signs will of necessity distinguish this fever. Here the inflammation is in the substance of the lungs first a sense of stricture and some oppression about the chest, pain in some part of the chest, rather obscure, some difficulty in respiration. The reflexion of the term is pathognomonic—first frosty becoming very tenacious, as smoky a rusty, brick dust. Color: Physical signs more reliable, more particularly in the absence of the more marked natural signs. I have observed one or two cases in my limited experience where nearly all the prominent natural signs were absent, such as—
Cough, expectoration etc. Here the physical signs are of great value. The crepitation sound is considered to be pathognomonic. Sound said to resemble the rubbing of a lock of coarse hair between the finger and thumb. This cracking sound heard in the lower portion of the lungs is caused by the separation of the walls of the air cells partially agglutinated. The plastic tracheal or successive bursting of minute bubbles of the bronchial secretion which occurs in this disease, as the air passes through the minute tubules into the air cells. If the stage of hepatisation comes on this crepitation sound ceases—no vesicular—malignant—dullness on percussion. If the case runs on the third stage—gray—hepatization—separation—characterized by fulmin.
juice expiration. If favorable termination is to take place the vesicular murmur returns.

Pleurisy—In pleurisy we have inflammation of a serous membrane. There are certain characteristics besides fever the pain as in all serous membranes severe and lancinating—situated in this case in the side—aggravated by inspiration and coughing—cough harsh.—Inflammation no sooner established, than we have evaporation of serous lymphah and the surfaces become adherent or are separated by the effusion of serum. Characterized by the following signs. First. The friction sound may be heard—produced by the rubbing together the dry inflamed surfaces of the pleura— if adhesion.
takes place this sound ceases, or if there is an effusion of serum the sound also is entirely stopped, and this effusion may be detected, by percussion—of very excessive, the walls of the chest will be pressed out—sometimes change in the position of the heart, vesicular murmur weakened etc.