老周的肝

揚影

「喂！老周，昨晚是否多喝了兩杯呀？」大夫拿着病歷咕，以一副老不正經的口吻問他。

老周，現年五十歲，江蘇人，未婚，退伍後一直在我工作的醫院裏當工友，是個健壯的慈祥老人，他並無甚麼不良嗜好，只是愛摸摸酒杯底，喝其三、五兩而已。平時他並沒有甚麼頑疾，可是今次他卻眞的遇上麻煩了……。

他沒精打采的樣子，搖了搖頭，跟著强笑了一下，說：「老了，不中用了。」大夫聽罷，摸摸他發燙的額頭，頓時改變了剛才輕浮的態度，嚴肅地拿起聽筒，一邊像哄小孩般詢問病情，一邊在他身上摸索，試圖找出一些蛛絲馬跡，去拯救這無助的老人。可是，故事的發展，並沒有那麼簡單。

八月廿日，大夫替他做了一個肝功能檢查，BUN 12mg％，Uric acid 7·1mg％，GOT／GPT 31／22，Cholesterol 181mg％ ，結果顯示他的肝並無甚麼不妥。而血液中白血球數則升高至16700／mm^3，N：L＝82：16，於是大夫便給予抗生素治療。八月廿二日，胸部X光顯示無異常。經過三天的抗生素治療後，老周的病況並無好轉，體溫升至38·8°C，並感到上腹不適（無血便或腹瀉），身體衰弱，在同事友好的勸導下，於是住院

作更進一步的檢查。

八月廿三日，亦卽是住院的第一天，體格檢查顯示，老周的體格發育健全，神智清醒，精神略帶倦怠，皮膚正常無疹亦無血管瘤，眼無黃疸但稍呈貧血，頸部正常無淋巴腫大，心肺正常，腹部扁平柔軟無壓痛點，肝脾不大，四肢正常。跟着又做了一個肝功能檢查，Bilirubin 一分鐘 0.11 mg%，Total 0.24 mg%，A/G 4.2/3.1，C.C.F.(-)，T.T.T. 1 unit，SGOT/SGPT 32/25，Alkaline phosphatase 5.04 units，Mucoprotein 250 mg%。在抗生素和一般的治療下，除低熱外，老周的病都在好轉中。翌日，Widal test 顯示正常。但八月廿五日，發現 E.S.R. 高達 48mm/hr，WBC 15150，N：L＝75：23；此時，老周的上腹再度感到不適。九月八日，肝功能檢查顯示 SGOT/SGPT 34/28，Alk-p-tase 7.83 units，Mucoprotein 169 mg%，γ-feto protein(-)；此時，大夫開始給予 Choroquine 及 Dehydroemetine 治療。九月九日 ^{99m}Tc-S，Colloid liver-spleen Scintigraphy 顯示：Space-occupying lesion in the liver. Positive liver scintigram is nonspecific for primary or secondary neoplasm in the liver, liver abscess and liver cyst as well as calcified hematoma or granuloma etc. 同時血液檢查結果，血色素 12.8，WBC 11200/mm^3，N：L＝82：12。以後數天血色素分別爲 13、14.4，WBC 分別爲 10200/mm^3、15900/mm^3，N：L＝63：33、N：L＝64：32，Alk-p-tase 14.49，Mucoprotein 135mg%。九月廿六日，Celiac Angiogram：Cancer of Pancreas body and tail with liver metastasis was highly suspected from the aortographic study. 九月廿八日會診外科，意見是 Chemotherapy for Palliative effect.

當時，由於一連串的檢查與及長期煩悶的病床生活，老周再也抵受不住了，他慈祥的臉孔變得暴躁，壯健的體魄變得衰弱。每當醫院的同事走過，他都不厭其煩地屢次詢問病情，何時可以出院。唉！可憐的老周啊！照目前情況顯示，試問誰會那麼鐵石心腸忍心告訴你呢！在千篇一律的答覆下，他常常自言自語地說：「到底是什麼玩意嘛！爲何沒有人願意告訴我呢？」他的處境，正如一個等候着宣判的犯人，眞不好受，但他怎樣也想不到，他的人生旅程似乎快要到達終點了。

出乎意料之外，在使用抗阿米巴蟲藥物治療後的第七天，他的體溫已回復正常，上腹亦不再疼痛了。十月十日肝功能顯示 GOT/GPT 28/25，Alk-p-tase 5·14，Mucoprotein 84 mg%。十月十一日 ^{99m}Tc-S Colloid liver and spleen scinti-photography 顯示：The liver is return to normal in its size. Superficial suprahilar lesion in the liver that is shrunken with fibrosis formation. In addition, the spleen is normal in appearance. Impression："LIVER ABSCESS, RCOVERED."

隨後，再給予 Carbarson 治療十天，老周出院了。翌晨，看到他輕鬆愉快地抹杯子，在同事悄悄地告訴他死裏逃生的經過後，嚇呆了，沈思了片刻，皺紋交錯的臉上突然露出了一絲刼後餘生的歡笑，聳了聳肩頭，說：「唉！人生如夢，生死尤如一線之間，嘿！」

阿米巴膿瘍是由 Endamoeba histolytica 所引起的，常見的症狀包括持續性發燒、寒顫、肝部酸痛、體重減輕、噁心、嘔吐、肝腫大、白血球增多等。此病在世界各地都有發現，而且有 10% 是由有症狀的腸道阿米巴病併發而來的，不過沒有先發的腸道阿米巴膿瘍的病例更多，大多爲發生於右葉的單發膿瘍。阿米巴肝膿瘍患者的大便和乙形結腸內視鏡檢查，是很少找到 Endamoeba histolytica。因此只要臨床表現像阿米巴肝膿瘍，而且 Indirect hemagglutination test，IHA 陽性時，就應投以抗阿米巴治療（卽 Emetine Chloroquine），往往很快獲得緩解，且可使大多數病例不必借重外科引流。

GERMAN MEASLES

Steve Chang

German measles is an acute infectious disease of childhood characterized by minimal or absent prodromal symptoms. A 3-day rash, enlargement and tenderness of the retroauricular, suboccipital and posterior cervical lymph nodes. It is usually a self-limiting disease with rare complication, however.

Etiology

German measles is caused by a specific virus that has been shown to be present in the blood and nasopharyngeal secretions of patients with the disease. Under the electron microscope, this virus is revealed to be a moderately large virus, spherical in shape, having a central nucleoid 30 nm. in diameter, within an envelope of 60 to 70 nm. wide. It is a RNA virus which is quite sensitive to heat, to extremes of pH, and to a variety of chemical agents.

Clinical Manifestations

German measles is spread usually by droplet infection or contact with secretion from the patient's nose or throat. It can also be transmitted by blood transfusion from the patient with this disease. The incubation period for German measles is generally 14 to 21 days. The typical course is illustrated in Fig. I.

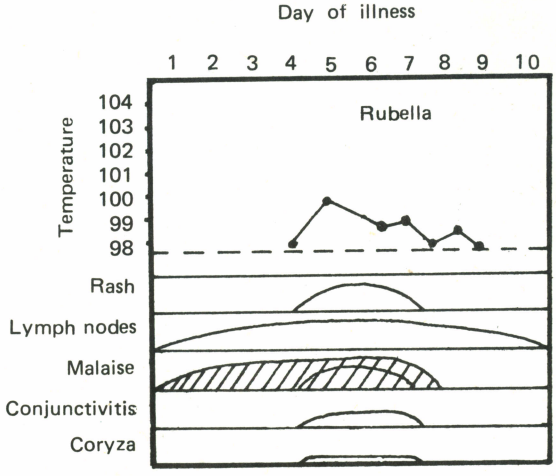

Fig. I. Schematic diagram illustrating typical course of rubella in children and adults. Lymph nodes begin to enlarge 3 to 4 days before rash. Prodromal symptoms (malaise) are minimal in children (shaded area). In adults there may be a 3- to 4-day prodrome (hatched area). Conjunctivitis and coryza, if present, are usually minimal and accompany the rash.

(1) Lymph node involvement

Dr. Green pointed out that (Fig. II) the lymph node enlargement may begin as early as 7 days before the onset of rash. And the nodes most commonly involved are the retroauricular, suboccipital and posterior cervical lymph nodes. No other disease causes the tender enlargement of all these nodes to the same extent that German measles does. The tenderness of nodes subside within a day or two, but the palpable enlargement may persist for several weeks or more. As indicated in Fig. III, Dr. Krugman stated that the extent of the lymphadenopathy may be extremely variable, and occasionally it may even be absent.

(2) Exanthem

The rash, particularly in children, may be the first obvious indication of illness. It appears first on the face and then spreads downward rapidly to the neck, trunk and extremities within 24 hours. Then, it begins to fade in the same direction at about the third day after the rash appears. The rash may resemble the rash of measles on the first day and scarlet the second day, then disappears on the third day. The rash is rarely persisted more than 5 days. However, there is about 25% of German measles without a rash.

(3) Fever and blood picture

A typical temperature course is illu-

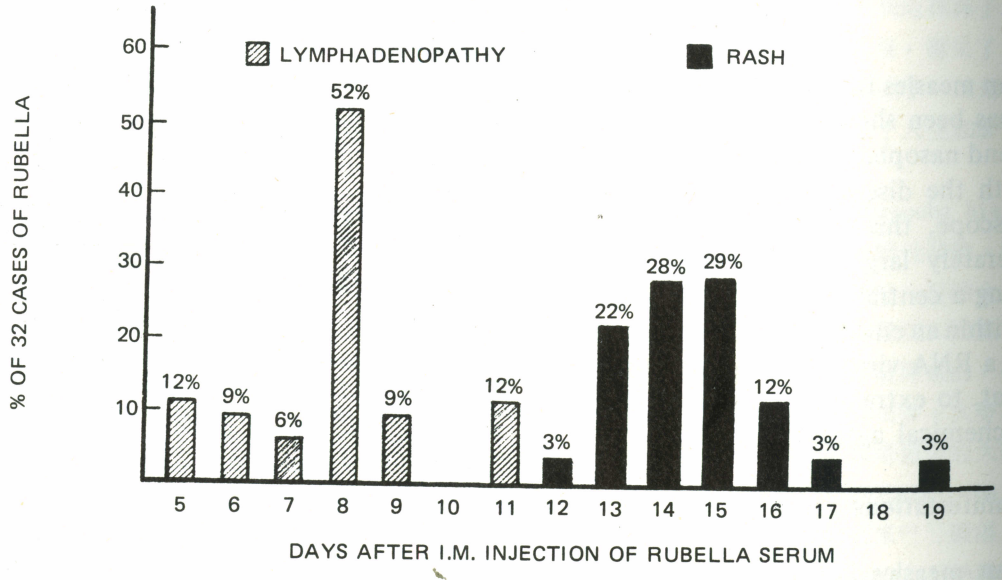

Fig. II. Time of onset of lymphadenopathy and rash in thirty-two cases of experimentally transmitted rubella. Note appearance of lymphadenopathy 5 to 7 days before onset of rash. (From Green: Am. J. Dis. Child. 110:348, 1965.)

strated in Fig. I. Experimentally induced rubella (See Fig. III) reveals the fever is usually normal or just slightly elevated.

Generally, the white blood cell count tends to be low, as indicated in Fig. III. However, the white blood cell count may be normal.

Diagnosis

(1) Confirmatory clinical factors.

A diagnosis of rubella is suggested by the appearance of a macucopapular eruption beginning on the face, progressing rapidly downward to the trunk and extremities, and subsiding within 3 days. Prodromal symptoms are minimal or absent, fever is low grade or absent, and lymphadenopathy precedes the appearance of the rash. A history of exposure, if available, is helpful.

(2) Detection of causative agent.

As indicated in Fig. IV, rubella virus may be recovered from the pharynx as early as 7 days before the onset of rash and as late as 14 days after the onset of rash. In contrast, viremia that is present before the onset of rash is rarely observed after the onset of rash.

(3) Serologic tests

The pattern of appearance and per-

*Fig. III. Clinical aspects of experimental rubella in children**

Patient	*Maximum temperature (F.)*	*Rash*	*Lymph node enlargement*	*Leukopenia*
C. R.	100.4	+	++	0
J. G.	101.6	0	+	0
P. K.	100.8	0	++	++
N. K.	99.6	++	+	++
E. T.	101.6	+++	+++	0
K. L.	100.4	++	+	+
J. S.	99.0	++	+	0
S. E.	99.4	++	0	0
G. O.	99.8	++	++	0
C. N.	99.4	+++	+++	-
P. A.	99.6	+++	++	-
T. B.	99.2	+	+	-
M. I.	99.4	++	+++	-

* From Krugman, and Ward,: J. Pediatr. 44:489, 1954.
Key: +, mild; ++, moderate; +++, marked; 0, none; -, not done.

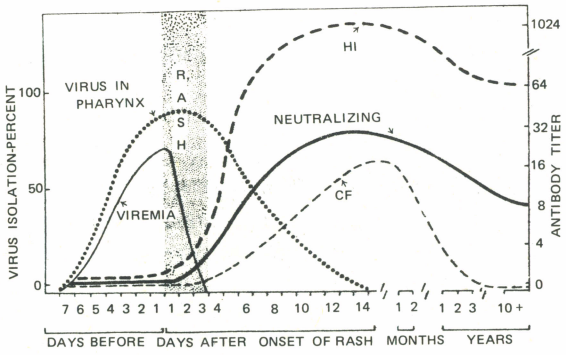

Fig. IV. Natural history of postnatal rubella. Pattern of virus excretion and antibody response. (Modified from Cooper, and Krugman,: Arch. Ophthal 77:434, 1967.)

sistence of rubella virus ——Neutralizing, Complement-Fixing (C.F.), and Hemagglutination-Inhibition (H.I.) antibody is shown in Fig. IV. Antibody is usually detectable by the third day of rash, and peak levels are reached about one month later. C.F. antibody may be short lived, declining to nondetectable levels within a year or more after infection. Neutralizing and H.I. antibodies usually persist for life. The H.I. antibody test has the advantages of high sensitivity and speed with which results are obtained; results are available within 24 hours. A serologic diagnosis is possible if acute and convalescent-phase serum specimens are obtained. The acute phase serum should be obtained as early as possible after the onset of rash, convalescent-phase serum should be collected 2 to 4 weeks later. Evidence of a fourfold or greater rise in rubella antibody titer is indicative of a recent infection.

Complications

Complications are rarely seen after the attack of German measles. However, during epidemic, the following complications have been reported.

(1) Arthritis

Joint involvement in adolescents and adults with German measles are much more common than children. It usually develops just as the rash fades on the second and third day of illness, and usually clear spontaneously within 5 to 10 days.

(2) Encephalitis

This complication is extremely rare, its incidence is about 1:6000 cases of rubella. Complete recovery is generally the rule, but fatalities have been reported. Electroencephalo graphic abnormalities, however, are relatively common and persistent. Generally, if the patient survives, the intellect is usually unaffected.

(3) Purpura

Thrombocytopenic as well as nonthrombocytopenic purpura may, in rare instances, complicate rubella. In some reports, the clinical manifestation have included one or more of the following disorders : cutaneous hemorrhages, epistaxis, bleeding gums, hematuria, bleeding from the intestinal tract, and, rarely, cerebral hemorrhage. Most patients become symptom-free within 2 weeks.

Prognosis

The prognosis is almost uniformly excellent. Rubella is one of the most benign of all infectious diseases in children.

Immunity

(1) Active immunity

One attack of rubella is generally followed by permanent immunity. Many of the so called second attack represent errors in diagnosis. Active immunity is induced by infection after natural or artificial exposure. As indicated in Fig. IV, rubella neutralizing antibody may persist for many years after infection.

(2) Passive immunity

Neutralizing antibodies for rubella are present in gamma globulin and in convalescent-phase serum. Rubella is rarely observed in the early months of life because of transplacentally acquired immunity.

Treatment

Treatment of rubella is usually symptomatic, because rubella is a self-limiting disease.

Congenital German Measles

If a pregnant woman contracts rubella during her early gestation, the risk of congenital rubella occurring in the infant is about 20%. The newborn infant may be born with the following congenital abnormalities : intrauterine growth retardation, eye defects, cardiac defects, deafness, thrombocytopenic purpura, cerebral defects, hepatitis, bone lesions, pneumonia, and hepatomegaly. Many of the infants continue to excrete the virus for the first 12 to 18 months of life (Fig. V)

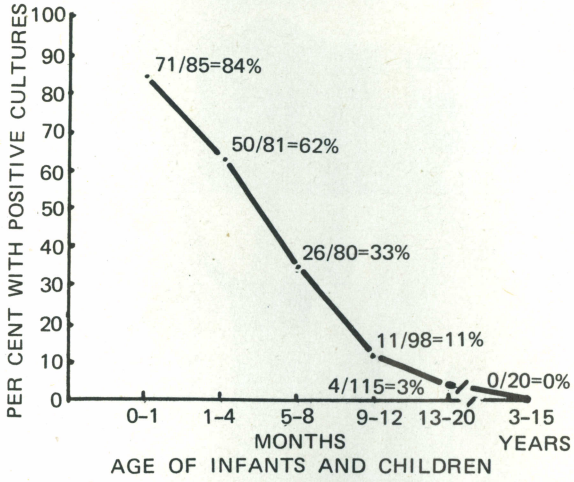

Fig. V. Incidence of rubella virus excretion by age in infants with congenital rubella. (From Cooper, L. Z., and Krugman, S.: Arch. Ophthalmol. 77:434, 1967.)

Therefore, preventive measures are utmost importance to protect the fetus. It is important for girls to be exposed and contract the disease before the childbearing age. Pregnant women, especially early in pregnancy, but also during the entire gestational period, should avoid exposure to rubella, regardless of the history of the disease during childhood.