ACUTE AND CHRONIC HEPATITIS

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Diffuse hepatitis or mild jaundice is produced in ninety-five per cent of the cases by either the hepato-cellular or destructive type of liver disease. We are of the opinion that there exists a subclinical form of hepatitis where jaundice is not a feature and where the symptoms are of a purely subjective nature. This we will discuss later in the paper. Somewhat similar to this syndrome is a condition of hepatitis which has followed an attack of jaundice *but with the symptoms persisting long after the jaundice has disappeared.* This syndrome has been discussed by others. In hepato-cellular jaundice there are several predisposing factors which are of importance. The first of these is malnutrition. It appears that marked depletion of the glycogen reserve increases the case with which the liver cells become damaged. It also has been shown that diet deficient in protein makes the liver more susceptible *to this damage and vitamin B fractions* if deficient also contribute to hepatic disease.

Other factors of a general nature are anoxaemia resulting from chronic congestive heart failure, thyroid disease, and indirectly allergy if the patient be sensitive. This increases the damaging effects of the drug which ordinarily would not be important.

Considerable confusion exists as to the causal factors of catarrhal jaundice and we know that it may be produced by transfusion, inoculations or the eating of infected meat.

From a symptomatic standpoint the typical case usually runs the normal period of from a few days to a week and the symptoms experienced during this time are of a simple, toxic variety such as lack of appetite, headaches, malaise, occasional vomiting, coated tongue and bad taste in the mouth. When jaundice appears its duration and seriousness are subject to considerable variations and the determination of the serum bilirubin concentration furnishes the only reliable methods of measuring the degree of icterus. From a physical examination standpoint the liver increases appreciably in size, then decreases as improvement sets in and parenthetically it might be remarked that aminoacids therapy intravenously quite regularly results in marked decrease in size of the liver.

From a differential diagnostic standpoint it is essential to eliminate jaundice of an obstructive nature which is best done by the use of alkaline phosphatase test. Also, to eliminate the use of such toxic drugs as cinchophen, *the arsenical sulphanilamides and gold.* Glandular fever, or infectious mononeucliosis sometimes causes jaundice, but it is eliminated by the blood changes and the heterophile antibody reaction. There should be no difficulty in confusing cirrhosis for, if jaundice is present, it is a late fatal symptom.

The various liver function tests such as the hippuric acid test, prothrombin, and bromsulphathalein would all be positive.

Liver function tests: The most satisfactory liver function test is the hippuric acid test. This test postulates that a normal adult subject after receiving six grams of sodium benzoate by mouth excretes as hippuric acid in four hours an equivalent amount of benzoic acid of three to four grams. If excretion is below these limits hepatic insufficiency is indicated provided renal function is normal and the volume of urine adequate. If a patient has nitrogenous retention this test is unsatisfactory. This test cannot successfully differentiate between obstructive and toxic jaundice and we prefer the alkaline serum phosphatase here which is high in obstructive jaundice, however, if in this test hippuric acid is employed with other tests such as the urobilinogen, the prothrombin response, it may be useful. In haemolytic jaundice the hippuric acid synthesis is normal, therefore we argue that if a normal hippuric acid output is obtained in the presence of moderate jaundice and haemolytic jaundice can be ruled out by other tests it appears fairly definite that the icterus may be due to mechanical obstruction. Quick sums up this test as follows: Hippuric acid tests call upon the metabolic processes of the liver which is our chief concern. The icteric index supplies information which the hippuric acid test cannot be expected to yield. The flocculation tests depend on the disturbances in the globulin of the blood and the bromsulphathalein test reflects the state of the reticulo-endothelio system of the liver which plays no part in the synthesis of hippuric acid.

Perhaps the most delicate test according to present concept is the thymol turbidity or flocculation test. We have not had a large experience with this test but it seems to be positive when the other tests fail to give us information. In their evalnation of this test Neff states "The positive thymol flocculation test is of significance as evidence of existence of hepatic disturbance when other hepatic tests were within normal range. This is indicated by the fact that positive thymol flocculation tests were associated with clinical symptoms in a group of three cases and did not become negative until almost complete clinical recovery had occurred.

The Cephalon-cholesterol flocculation tests quite widely used in some clinics today is related chiefly to active injuries of the hepatic polygonal cells according to Hanger.

Treatment: Liver damage of whichever type responds in a greater or lesser extent to treatment directed at diet. I refer to adequate carbohydrate and therefore proper supplies of glycogen within the liver. Usually, three or four hundred grams of carbohydrate daily are to be taken. This can be supplied by the addition of soft drinks, hard candy, honey, sugar or lactose to the diet. If this is too much by mouth it may be given by vein in selected cases. Protein requirements are of the greatest importance and servings of gelatine, skimmed milk, cottage cheese and meat such as hamburg steak are of importance. Recently, it has been shown that the amino acid methionine is of great use in protecting the liver against toxic action. Inasmuch as

milk and eggs contain large quantities of this they should be given but the milk should be skimmed, to avoid fat. Fat-containing foods in general should be interdicted in the acute stage because there is no bile to make its digestion possible and because fat deposits in the liver inhibit hepatic recovery.

Drugs like Decholin and related types which act as stimulants physiologically to liver activities are contraindicated. This is because the organ requires rest and not stimulation.

From a homoeopathic standpoint we should be aided by considering the causal factors of the hepatitis as well as that particular drug's ability to produce jaundice. Diarrhoea if a prominent symptom, particularly if gushing and offensive Podophyllum is suitable. It has an elective affinity for the duodenum, liver and for such states as are apt to come on in hot weather and are aggravated particularly in the morning. It is especially suitable in pediatric practice, but subjectively the grinding of the teeth together with dentition difficulties are often concomitant symptoms. Hydrastis is frequently indicated if the jaundice is not too intense and evidence of a catarrhal state exists elsewhere. The type of patient is of an old, easily tired individual who complains of great debility. The taste is bitter and the tongue often shows the imprint of the teeth as in mercury or feels scalded with aphthous lesions. Stringy mucus appears in the upper respiratory tract and is often present in the lower bowel as evidenced by the mucus in the stool. Its objective symptom of *complete loss of appetite*, so prominent wherever hepatitis is present is well met by Hydrastis. The tonic effects of this drug combine with Nux and China are well known to many of you as a general tonic.

Myrica cerifera has long been used by us for states of extreme jaundice. In a sensitive subject this drug will produce jaundice on proving but in a recent proving we noticed more symptoms relating to the stomach than anywhere else. A definite gastritis was produced, the gastric emptying time increased, acidity was increased, mucus and cellular contents of the stomach increased, and in the duodenal drainage the cellular elements were all of greater magnitude. This would seem to show that Myrica should be prescribed in those cases of jaundice whose actiology was an acute gastrointestinal upset which incidentally is a frequent cause. Objectively, the provers showed a marked loss of appetite and the usual symptoms of headache and malaise. Thus, symptomatically and from a laboratory standpoint Myrica rates high in a hepato-cellular hepatitis.

In more chronic forms of liver enlargement, probably a preclinical cirrhosis Magnesia muriatica comes in. Much bloating of the abdomen and a general state of constipation aggravated by milk are seen. The usual lack of appetite, eructations, gas together with tongue symptoms which feels as if burnt or scalded are noted.

As a last thought I would like to speak of what may be called subclinical hepatitis. Here there is no jaundice but abnormal liver functions are evident on subjective and objective examinations. From a laboratory standpoint there may be a positive thymol or deficient hippuric acid test. Most

reliance is placed on clinical evaluation. My opinion the absolute criteria of impaired liver action is anorexia. This is most important, sometimes it is the only symptom. If this keeps on, weakness, giddiness, headache follow naturally. In another class, such cases have as their chief complaint headaches, oftentimes with dizzy spells. Successful therapy depends on proper diagnosis and a migraine will have to be excluded, which usually can be done because this disease is characterized by vomiting, is cyclic and symptoms of flickering and shimmering before the eyes. The indurative headache of fibrositis has also to be eliminated. This is frequently not recognized and is diagnosed by the suggestive signs of neck stiffness and induration on palpation of the back of the neck, at times with palpable nodules there. The patient will confess that massage helps or that manipulation relieves temporarily. Aetiologically, it may be brought on by psychosomatic influences and is not unusually a local manifestation of a generalized primary fibrositis. If these two causes of headache are eliminated we may proceed to outline treatment of a subclinical form.

In general I have found simple restrictions sufficient. Eliminate whole milk, but skimmed milk may be used, eliminate cream, gravy, condiments, mayonnaise and of course rich desserts. Meats recommended are lamb, tongue, chicken, well done roast beef, other proteins such as cottage cheese, not cream cheese which contains about 60 per cent fat. There should be a rest period before meals. A mild type of table water is recommended but it may not be necessary in districts outside of Philadelphia.

My remedies vary a good deal depending on symptoms. Euonyminum, Iris versicolor, Nux and Pulsatilla, Mercurius seem to lead. Euonymin has a wide field of usefulness and its symptoms are typically 'bilious'. Where a physician unacquainted with this drug would probably give a cholangiectic substance like decholin or caroid and bile salts, the homocopaths employ Euonymin IX. Taken to excess it may produce a crampy diarrhoea in which case one instead of three tablets daily are used.

Mercurius indications are well known to you. A mercurius case is aggravated from weather changes, he has a continually moist skin and characteristic indented tongue and aetiology which seems to point to the G. I. tract.

Iris versicolor is the great burner, burning of the mouth, stomach and even the lower bowel and rectum. More often indicated for migraine however than hepatitis.

Nux and Pulsatilla indications are commonplace to you all. These two polychrests are indeed a precious gift to the practical homoeopath.

I have made no mention of Chelidonium, Dioscorea, Calcarea carb., Mag. phos. and other drugs which come in so well in jaundice due to the obstructive causes as this would take us far afield of the topic assigned.

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