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Observations on Liv.52

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I have much pleasure in reporting the results of trials with Liv.52 (The Himalaya Drug Co.) – a drug, which I have found very useful in liver derangements. When I say liver derangements I refer to liver disorders from the most severe dysfunctions to the minor degrees of liver upsets, so peculiar to young children, which are accompanied by bad taste, poor appetite, pale stools and coated tongue.

During the course of the last 15 months I had in all six cases of cirrhosis of the liver referred to me for treatment and hospitalisation, some of them as incurables to be nursed till they passed away. Three of these were very advanced cases of cirrhosis with a history of several tappings. These were the start hopeless and I shall dispose of them without much further information, as two of them died after a fortnight. The third of these cases left the hospital after a month and a half of treatment with Liv.52 with some improvement which was quite unexpected by the patient. She had to attend to some important and pressing matters concerning her property at her native place and she decided to take advantage of this improvement to undertake the long journey. This case could have been followed, if she were in Bombay, with more intensive and prolonged treatment and she would certainly have proved a very fine test for this drug. However for purposes of record, one has to count the above three cases as unsuccessful.

The next three cases will be described in detail. These, as far as I can see, have improved remarkably with this drug. They are all surviving so and are able to attend to their ordinary duties. These three cases were put on Liv.52 after every other treatment had been tried in other hospitals and found useless and were getting worse. Two of these cases were well-established cirrhosis of the liver of alcoholic origin and the third was of severe hepatic insufficiency passing on to cholaemia following an operation on the gall bladder. All these three patients were comparatively young.

Case 1 (Cholecystectomy):
Patient aged 42, cook by profession, no alcoholic history, complained of attacks of pain in the upper abdomen for the last three years, associated with flatulence after food, nausea and occasional vomiting. He had two severe attacks of biliary colic. Clinical examination revealed features of well-established cholecystitis. X-ray showed stones in the gall bladder; general condition was good. Apparently he was a good operative risk as liver function tests were normal (Thymol turbidity and cephalin cholesterol flocculation test).

Patient was operated under general anaesthesia, induced by pentothal followed by gas, oxygen and ether. The gall bladder was removed and the common bile duct opened, thoroughly explored but no stones were found in it. Three stones were found in the gall bladder. The common bile duct was then closed and internal biliary drainage was established by opening up the second part of the duodenum, identifying the duodenal papillae, which were slit up for about 1½ cm. The common bile duct was thus given a larger opening and kept patent by a button-hole stitch right round the enlarged orifice. The abdomen was closed with a rubber catheter in the hepatorenal fossa. The liver appeared normal in size, colour and feel; no other pathology was noted in the upper abdomen.

The usual post-operative treatment for gall-bladder operative was given. There were some bilestains on the dressings for four days after which the catheter was removed. On the fourth day, patient

began to vomit which became gradually more persistent and intense. There was no improvement with gastric lavage or intravenous drips of glucose, vitamin C etc. On the 7th day, patient became jaundiced, but vomiting improved. The jaundice continued and became more intense. From the 12th to the 16th day, his condition was extremely grave. All this time the patient was afebrile. He now began to have a range of temperature from 100°-101°F with slight shivering from time to time followed by icy cold seats. Blood pressure fell to 90/50 mm Hg and vomiting recurred. During all this time intense treatment for liver insufficiency was given e.g. glucose drips with vitamin C, vitamin K and protein hydrolysate by the vein.

It became evident that the patient was passing on to severe liver insufficiency and cholaemia. He was deeply comatose. At this stage we abandoned all treatment and switched over to Liv.52. However, we kept up his nutrition with intravenous drip and protein hydrolysate. From the 3rd day onwards improvement set in; vomiting came under control, mental condition cleared up, blood pressure rose to 110 mm of Hg and jaundice gradually cleared up and within a fortnight he could sit up and take nourishment by mouth. Improvement continued steadily till he was discharged 45 days after operation with only a slight tinge of jaundice and after having lost 30 lbs in weight. He is now quite fit and has regained his former weight.

Case 2

Patient aged 35, taxi driver by profession, South Indian non-vegetarian was brought to me from a public hospital in a severe degree of anaemia following repeated attacks of haematemesis with a history of being tapped once in the same hospital and six pints of fluid withdrawn. He has an alcoholic history of 12 years, and during the last three years very heavy indulging in country liquor.

On admission, patient's general condition was very low. RBC and haemoglobin count were less than 30%. The abdomen was distended with a moderate quantity of fluid, liver was tender but not palpable. Patient had temperature off and on. He was also troubled with early morning vomiting and while even in hospital he was shipping alcohol stealthily. On the 6th day of admission he had an attack of vomiting blood which stopped spontaneously.

He was first put under a psychiatrist who tapered off his alcohol and got him off it completely within a fortnight. At the end of it he had a mild attack of haemorrhage again. He was tapped and 4 pints of fluid were withdrawn. He was immediately put on a course of Liv.52 without any other treatment except glucose and vitamin C orally and by injection. He was also given three blood transfusions. He was hospitalised for three months during which time he gradually improved, regained his normal weight and colour and was found fit enough to be discharged. There was no fluid in the abdomen; liver was not tender and his haemoglobin rose to 80%.

At home he began to indulge in alcohol and six months later he was readmitted after two attacks of haematemesis. The liver was tender but no fluid was detected in the abdomen. He was immediately put on Liv.52, glucose and vitamins and the psychiatrist helped him to get over the habit of alcohol. After two months he was discharged fit but returned again with another attack of haematemesis. This time he had not indulged in his old habit of alcohol and this was confirmed by his wife and relatives. He was discharged after 15 days of treatment. He has now settled down in his native place and is doing well. I receive regular reports from him. He is advised to continue Liv.52 for a fortnight at a stretch every month.

Case 3

Patient aged 45, bootlegger by profession for the last 4 years. He had a heavy alcoholic history of 12 years and is diabetic for the last 18 years. He was in a city hospital for two months without any benefit, and discharged as incurable. His main symptoms were frequent attacks of haematemesis; the abdomen was distended with fluid and he had pain in the liver region. He was tapped several

times. He brought with him copies of all records of investigations such as blood sugar, liver function tests, plasma proteins etc., which showed that he was a clear case of cirrhosis of the liver.

He was immediately put on Liv.52, insulin, intravenous glucose with vitamin C and ferrous iron for his anaemia. As his massive haemorrhages continued even during the two weeks of treatment, we decided to give him a last chance by doing a triple ligation of his gastric, splenic and hepatic arteries, an operation which was getting a reputation for treatment of cirrhosis. He was prepared with 3 blood transfusions.

We opened the abdomen by an upper middleline incision and succeeded in typing the gastric artery but while searching for the splenic, the anaesthetist found himself in difficulty, the patient being fat and very anaemic; he warned us to close up. The operation though very incomplete had the benefit of stopping his haematemesis once for all but it could not possibly have had any influence on the liver.

The patient had a very stormy recovery from the operation. After 3 months' stay in the hospital he improved well enough, without any recurrence of haematemesis or ascites, to be discharged. This man never went back to his alcoholic habits and his word can be relied upon. Though not completely restored to normal health, as he is still diabetic, he is able to get about and has returned to his original profession of motor driving. He has regained his weight and colour, the liver is just palpable and occasionally becomes painful and tender. He has developed a certain amount of obesity about the abdomen but even after careful observation and exploratory tapping we could not detect any fluid. He is on Liv.52 for over a year – 15 days treatment with a break of 15 days. The progress is very satisfactory compared to the state in which he was discharged from the public hospital. He is still under observation.

CONCLUSIONS

I have recorded here in detail three cases of the most severe hepatic damage which were apparently beyond our usual means of treatment and which have been restored to health by Liv.52. I am aware this is too small a number to make a convincing impression but the results so far obtained hold a gleam of hope for a disease for which we have very little treatment to offer. To many of my medical colleagues I have suggested the use of this drug for the treatment of infective hepatitis and some of them have reported that they have found the drug very useful. I am still keeping my mind open about this drug and hope to continue my trials on cases of cirrhosis of the liver that I get.

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