Medical Memoranda

A Case of Pseudocyesis

A woman of 41 complained of "peculiar feelings" in the abdomen, pain in the breasts, and morning sickness. She had not menstruated for eight months. The abdomen "felt tight," and she said it was much larger than usual. Two successive pregnancy tests were negative, and she was shown the results; her comment was: "I question the tests. They may be wrong. I think it's an eight-months pregnancy." The sensations in her abdomen were described as "like a mouse."

She had married in 1947, and was most eager to have a child. No contraceptives were employed, yet she did not conceive. In 1953 her husband had an accident and went to hospital. This was the first separation in seven years of marriage; the patient was very disturbed by it, and very glad when he was discharged. "It was marvellous. Felt different. More response at intercourse." From this time forward, she had breast pains, felt sick in the mornings, noticed veins on the breasts, with some discharge, and thought herself heavier and bigger in the abdomen. She was quite convinced that these signs indicated a pregnancy. The urinary gonadotrophins were considerably raised.

About a week after her attendance at the clinic she experienced abdominal pain and had a bout of diarrhoea. "I felt something had burst, something to do with the baby." She felt better, and had more energy. The abdomen was "still fat, but not so hard. I felt the baby did start and now it's finished. Something passed away." Six weeks later she said: "I'm better now. I was certain about the pregnancy, but am satisfied now it wasn't." Her own explanation of the episode was: "Perhaps the shock of the accident altered the glands."

The intercourse with her husband which occurred after his discharge from hospital was more gratifying, and more intensely experienced, than it had ever been, and the patient then felt that at long last a child would be conceived. Her later history seems to show that the desire to conceive, if it is strong enough, can produce the subjective sensations of pregnancy, and some objective physical signs as well, even an alteration in endocrine balance. Her belief in the pregnancy remained unshaken by the negative tests, and persisted until the attack of diarrhoea, which signified to her that the "foetus" had been passed out.

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Acute Osteomyelitis of the Maxilla in Infancy with Cavernous Sinus Thrombosis

Acute osteomyelitis of the superior maxilla in infancy is more common than is generally believed, although only 21 cases have been described in the English and American literature since 1928. The usual aetiological agent is *Staphylococcus aureus*, penicillin-resistant strains of which have been encountered with increasing frequency of late, especially in hospitals and maternity units (Gairdner, 1954). Treatment with penicillin, although it has been successful in the past (Jacoby and Sagorin, 1945; Haworth, 1947; Macbeth, 1951), may therefore no longer be effective. McCash and Rowe (1953) have already reported two cases of osteomyelitis of the superior maxilla in 4-weeks-old infants caused by penicillin-resistant strains of *Staph. aureus*; in these cases there was further deterioration in the clinical condition after starting penicillin treatment. Both cases required surgical intervention and then eventually responded to treatment with chlortetracycline and streptomycin.

A case of osteomyelitis of the maxilla caused by penicillin-resistant strains of *Staph. aureus* and complicated by

cavernous sinus thrombosis is described below. This patient received penicillin for four days before the antibiotic was changed to chlortetracycline and streptomycin, to which the organisms isolated from the pus were sensitive *in vitro*. By this time, however, the infection had spread to the cavernous sinus.

CASE REPORT

The patient, the elder of twins, was born in hospital by breech delivery. Her birth weight was 5 lb. 9 oz. (2.5 kg.). She developed a "mild right-sided ophthalmia" on the third day of life. This was successfully treated with oral sulphadimidine, and she was discharged home aged 17 days. Four days after discharge she presented with swelling of the left side of the face associated with general fretfulness. Cellulitis was diagnosed and treatment with benzathine penicillin ("penidural") by mouth was begun (1,200,000 units daily in four divided doses). There was no improvement, and three days later she was admitted to hospital.

On admission there was an inflammatory swelling involving the left side of the face, nose, and hard palate. Pus was discharging from the gum margin in the left canine region. A diagnosis of osteomyelitis of the maxilla was made.

Crystalline penicillin, 2,000,000 units, was administered intramuscularly in divided doses during the next 24 hours, but the temperature continued to rise and the child vomited frequently. Both eyelids became progressively more oedematous, accompanied by increasing bilateral proptosis. Cultures from the pus grew two separate strains of *Staph. aureus*, resistant to penicillin but sensitive to streptomycin in both instances, and in one also to chlortetracycline and chloramphenicol. The treatment was therefore changed to oral chlortetracycline, 150 mg., and intramuscular streptomycin, 200 mg. daily in divided doses. This was continued for three weeks. Although the swelling of the face receded, and the amount of discharge of pus into the mouth decreased, the ocular signs became more pronounced, indicating thrombosis of the cavernous sinus. Gross oedema of both eyelids was present, with marked bilateral proptosis, diminution of the ocular movements, engorgement of the retinal veins, and slight bulging of the fontanelle.

Treatment with intravenous heparin was instituted as follows: A continuous intravenous drip infusion was begun and 500 units of heparin injected as an initial dose, followed by 250 units after four hours; the total amount given four-hourly was increased by 250 units each time. Thus after 48 hours the dose injected was 2,000 units and the treatment with heparin was discontinued. The clotting-time was estimated twice daily, and at the end of treatment was 13 minutes. The swelling of the eyelids disappeared during the period of heparin administration, but some bilateral proptosis and thrombosis of the right supraorbital vein persisted for another eight days.

After this the progress towards recovery appeared to be satisfactory until, three weeks after the onset of initial symptoms, the oedema of the right eyelids and right-sided ocular proptosis recurred. This was accompanied by a rise in temperature. The antibiotic treatment was changed from chlortetracycline to chloramphenicol, 350 mg. daily in divided doses for two weeks. As anticoagulant, oral phenylindanedione ("dindevan") was used instead of heparin, 20-30 mg. daily in two divided doses being given for 10 days. This dose was effective in maintaining the prothrombin index in the region of 50%. The response to treatment was good. The temperature became normal after 24 hours, the oedema disappeared after 24 hours, and the proptosis of the right eye receded after a week.

Three weeks later proptosis in the left eye recurred. This was followed after four days by an area of inflammation below the inner canthus of the left eye. Another course of phenylindanedione was given for 17 days together with chlortetracycline, of which 250 mg. daily, in divided doses, was administered for three weeks. The inflammatory lesion resolved. The patient was discharged fit and well two months after admission.