Medical Memoranda

Traumatic Perforation of the Bladder

An unusual case of traumatic rupture of the bladder in a man suffering from schistosomiasis in South Central Africa is described below.

CASE HISTORY

A male African, judged to be about 65-70 years of age, was brought in dead to the Gwelo Native Hospital on July 2, 1948. The relatives stated that the man had died at his kraal the previous afternoon. Four days before his death, while coming out of a native hut, he had collided with another native who was entering, and the latter's head had struck the old man in the abdomen. During the four days before his death he had complained of abdominal pain and had vomited once or twice. The other natives had not brought him to hospital.

Post-mortem Examination.—At 10 a.m. on July 3 a post-mortem examination was carried out. As it was the cold season and rigor mortis was beginning to pass off, it was estimated that he had died 36 to 48 hours previously. There was no bruising of the abdomen or any other sign of injury. The presence of some vomitus in the mouth was noted. On opening the abdomen the peritoneal sac was seen to be full of a dark-brown fluid which smelt like urine. There were flakes of pus covering the coils of the small intestine, and several loops of these were adherent. The stomach, spleen, liver, gall-bladder, and small and large intestines were removed, and apart from distension and inflammation of the bowel no abnormality was detected. Examination of the bladder *in situ* revealed a hole in the fundus about the size of a sixpence. The bladder was empty. The edges of the hole were ulcerated and sloughing. The bladder was carefully removed and opened. The prostate (median lobe) was seen to be much enlarged, and the mucosa of the bladder had the granular appearance and ulcerated areas seen in extensive schistosomiasis. The kidneys and ureters were removed, but they showed no naked-eye pathology.

Histology.—A snipping of mucosa close to the hole in the bladder was examined microscopically by teasing out the preparation in water on a slide. The mucosa was seen to be packed with terminal-spined ova (*Schistosoma haematobium*). Section of a portion of the ulcerated edge of the vesical perforation showed the presence of *S. haematobium* ova in large numbers in the mucosal layer and some leucocytic infiltration of the deeper muscular layers.

COMMENT

From the above findings it was concluded that in the presence of a distended bladder, presumably in part due to the enlarged prostate gland, the blow on the abdomen had caused rupture to take place through the most advanced area of schistosomal destruction. The resulting extravasation of urine caused a generalized peritonitis, ending in death from the toxæmia.

This case is described for two reasons. First, enlargement of the prostate gland is not a common condition in the Africans of Southern Rhodesia, presumably because of their death at a somewhat early age. Secondly, although the presence of schistosomal infection is extremely common in the South Central African native (Gelfand and Ross), I can find no evidence in the literature of a previous traumatic rupture of the bladder through such an area.

Although this native must have been suffering considerable pain during the four days previous to his death, he was not admitted to hospital, which was in the near vicinity of the accident. This may have been due to a disinclination of the other natives to reveal the accident, but may be an example of the remarkable stoicism of the native in the

presence of severe pain. The relatives definitely stated that in the first two days of his illness the old man was working in the fields.

Grateful thanks are due to Dr. G. R. Ross, Acting Secretary for Health, Southern Rhodesia, for permission to publish this case.

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REFERENCE

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A Case of Femoral Appendicitis

A rare complication of femoral hernia occurs when its sole content is the vermiform appendix. An example of this is considered worth recording.

CASE REPORT

The patient, a woman aged 55, was seen at a gynaecological out-patient clinic on Oct. 8, 1947. Three weeks previously she had developed a feeling of heaviness at the "bottom of the stomach." Five days later she noticed a lump in the right groin, and shortly afterwards she began before micturition to feel slight pain, which persisted. Her history was otherwise negative.

On examination the internal group of superficial inguinal glands in the right groin were found to be tender and inflamed. There was slight inflammation of the urethra, and a few sub-epithelial haemorrhages were present in the vestibule. The glands were treated by local applications for a week, and on re-examination on Oct. 15 the acute infection had settled. The hard irregular lump had persisted, and the glands were slightly movable, discrete, and hard. No femoral hernia was palpable, and arrangements were made to remove a gland for biopsy.

On Oct. 17 the patient was operated on under local analgesia. Dissection revealed a lobulated fatty mass with two normal lymphatic glands perched on its surface: the mass extended towards the femoral ring. The sac was opened and was found to contain turbid fluid surrounding a purple pre-gangrenous vermiform appendix. The appendix was removed and the stump allowed to retract into the abdomen. The inguinal canal was then opened, and the femoral sac was transposed above the inguinal ligament, where it was excised. One stitch between inguinal ligament and pectineus fascia was adequate for the repair of the small femoral ring. Closure of the aponeurosis and skin was then effected without drainage.

No pathological examination was considered necessary either for the glands, which were macroscopically normal, or for the appendix. Convalescence was uneventful.

DISCUSSION

In 1731 De Garengot recorded the first operation for hernial appendicitis, and in 1785 Hevin gave the first detailed description of operation for femoral appendicitis. Ryan (1937) published three cases of femoral appendicitis, Watson (1938) collected 217 cases, two cases were recorded by Seley (1941) and one by Knapp and Claps (1944), bringing the total number of published cases of this condition to 223.

The most unusual case recorded is that of Johnstone (1934). In his case auto-appendicectomy occurred, and was followed by survival of the separated appendix owing to the acquisition of a new blood supply from the wall of the hernial sac.

Battle (1899) has recorded a case of appendicitis in a femoral hernia associated with inflammation of the overlying glands, and this is the only case found in the literature similar to the present one.

The sustaining interest of femoral appendicitis would seem to be, first, that it is so rarely diagnosed pre-operatively, and, secondly, the difficulty in making a precise

diagnosis even when the possibility of its occurrence has been remembered. Taking the present case as an example, the data on which an accurate diagnosis could be based were quite inadequate; it was not even possible to be sure that a femoral hernia coexisted with the inguinal glands. Furthermore, even when a hernia is obvious, the differential diagnosis of femoral appendicitis is most difficult. One must exclude omental hernia, partial enterocoele, adenitis, strangulated epiploic appendix, prehernial lipoma, intestinal diverticula in hernia, and reducible and irreducible hernia of the intestine, bladder, and other viscera. It seems obvious that in most instances this condition is destined to remain an accidental finding during herniotomy.

I am indebted to Dr. C. E. B. Rickards, honorary gynaecologist, Warrington Infirmary, for permission to publish this case.

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An Interesting Case of Epilepsy

The following case is worth reporting because of several unusual features. It also emphasizes one of the pitfalls of psychiatric practice and closely links up neurology and psychiatry.

CASE HISTORY

A male aged 30 was transferred to us from a hospital in the Midlands where he had been suffering from partial aphonia, difficulty in swallowing, and attacks of partial unconsciousness for several months.

History of Present Illness.—His first fit occurred at the age of 17, while he was at his fiancée's house. There was no recurrence until soon after marriage, at the age of 21. During these attacks he threw his arms and legs about, and after a severe attack found it difficult to walk. After being turned down by several medical boards he was finally accepted by the Army, but about three weeks later, while waiting to go overseas, he had one of his fits. On account of this he was invalided out.

He continued to have four or more fits daily for several months after his discharge. Gradually the fits became less frequent and their nature changed to what the patient's relatives described as "blackouts," in which his head suddenly dropped on his right shoulder, he appeared to lose consciousness for about two minutes, and then suddenly recovered. During these attacks he bit his tongue if no precautions were taken. In neither these "blackouts" nor the fits was he ever incontinent.

Early in 1947 he developed a progressive impediment in his speech and had difficulty in swallowing both liquids and solids. This led to his admission to the Midlands hospital, where, after some months' treatment, a psychiatrist was consulted. He came to the conclusion that the patient's condition was "in many ways a regression to infantile behaviour. It would appear that the epileptic element in his condition has receded and been largely replaced by hysterical regression." On account of the frequent fits the patient had been unable to work for four years. There was no history of epilepsy in his family and nothing significant in his early medical history.

Condition on Admission.—A well-nourished young man. Because of tonic spasm of the masseters the patient could not open his mouth wide and could only lisp like a child. There was continuous dribbling of saliva owing to difficulty in swallowing. There were no other physical signs.

Investigations.—Wassermann negative. Total R.B.C. 5 million, Hb 100%, C.I.=0.9.

Progress.—While under observation in the ward he had several fits, both when awake and when asleep. Fits could also be easily induced by hypnotic suggestion, and clinically there was no difference between spontaneous and induced fits. Each fit began with the typical epileptic cry, followed by tonic contraction of facial muscles and loss of consciousness for one to two minutes. At the same time the head dropped to the right side. During the attack the plantar reflex was extensor on both sides. Cyanosis of the face varied—sometimes it was marked, at other times it was slight or absent. During a demonstration it was possible to induce by post-hypnotic suggestion a series of these fits in rapid succession when the patient was standing but supported on either side. There was difficulty in obtaining the E.E.G. record owing to the number of fits, the tracing being "grossly abnormal; high amplitude slow rhythms between attacks, definite evidence of epilepsy." Next day he had fits almost every 10 minutes—a total of about 132 fits in 24 hours—although he was receiving phenobarbitone gr. 1 (65 mg.) t.d.s., and epanutin (soluble phenytoin) gr. 1½ (0.1 g.) b.d. Although lucid in the intervals, he was unable to open his mouth; the muscles of his neck and nasopharynx also appeared to be in spasm, as it was difficult to pass a feeding-tube. In order to control the fits he was given paraldehyde dr. 8 (28 ml.) per rectum, but he rejected a good deal of this. However, phenobarbitone sodium, 1 ml. intramuscularly, and "amytal," gr. 3¼ (0.25 g.) intravenously, caused sufficient relaxation of the pharyngo-oesophageal muscles to enable him to swallow. He was then given phenobarbitone gr. 2 (0.13 g.) t.d.s. and epanutin gr. 3 (0.2 g.) b.d., which reduced the fits to 23 in 24 hours. In spite of these large doses of phenobarbitone and epanutin he had 17 fits next day. He was then seen by a neurologist, who considered there was an approximation to status epilepticus. During the next 24 hours the patient had only seven fits, although there was considerable tonic spasm of the jaw muscles. Next day (26th day after admission) he had no fits, but the dribbling continued. The E.E.G. showed "great abnormality of the cortical rhythms from all areas of the head, possibly more so on the left side. Diffuse 3 c/s and 5/6 c/s rhythm, little alpha rhythm seen; 3 c/s rhythms often occurring in bursts of high amplitude. Blocking by visual stimuli poor." From that day he had no spontaneous fits and suggestion failed to induce them (although there was no change in his domestic circumstances). The increased salivation, however, did not respond to any treatment and persisted for several days. An E.E.G. performed just before his discharge from hospital showed: "Generalized abnormality of 5–6 c/s rhythms. Still some 3 c/s rhythms present, but not having the high amplitude of the previous recordings. Some alpha rhythm seen of 8 c/s, blocked by visual stimuli. No single focus of abnormality seen. Record greatly improved." On discharge from hospital he was able to start work, and was later reported to be still employed.

DISCUSSION

There is no doubt that this was a genuine case of epilepsy involving specially the face and the pharyngo-oesophageal region. Psychogenic causes were apparently sufficient to initiate the attacks, thus lending support to the concept of hystero-epilepsy. Fits which were clinically indistinguishable from epileptic attacks could also be induced by hypnotic suggestion, though they could not be controlled by suggestion. The E.E.G. records showed that the induced fits were identical with epileptic fits. The response to phenobarbitone and epanutin was also significant.

SUMMARY

A case of epilepsy involving the face and pharyngo-oesophageal region is described. The fits were initiated by psychogenic causes.

Thanks are due to the medical superintendent for permission to publish the case-notes.

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