1938), and the early chemotherapy with sulphapyridine reduces the possibility of involvement of the posterior urethra and its related structures. In addition, it is still important to enlist the co-operation of the patient in avoiding any form of sexual excitement and in carrying out the detailed instructions with regard to the taking of the tablets. These measures, combined with thorough tests of cure and a detailed clinical and bacteriological examination of the urethra and the associated structures following upon clinical cure, can do much to reduce the incidence of late relapse.

Conclusions and Summary

The differentiation between late relapse and reinfection may on occasion present real difficulty. It is evident, however, from a careful analysis of a personal series of cases of urethritis treated with sulphapyridine, that late relapse may occur in a proportion of such cases. The incidence found in the present series was 3.7 per cent., and it seems that the unusually high rate of late relapse reported by Cokkinis and McElligott has not been the experience of other venereologists.

While the clinical picture may vary widely in this condition the cause of the recurrence of signs and symptoms is often to be found in a closed focus of infection situated in the various glandular structures which normally communicate with the urethra.

The prophylaxis of late relapse is described: the successful treatment of the condition is usually dependent on the discovery and eradication of such closed foci by local measures.

The wider appreciation of these conclusions is required for a deeper understanding of the epidemiological problem presented by late relapse in gonorrhoea.

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The annual medical report of the King Edward VII Sanatorium, Midhurst, now in its thirty-third year, is full as usual of statistical tables. The number of patients discharged during the year, leaving out readmissions and a certain number who were in the sanatorium for less than nine weeks, was 174, and of these 55 per cent. were discharged with the disease arrested and just below 25 per cent. were discharged much improved. In the course of the last fourteen years artificial pneumothorax has been attempted in 280 cases, of which 220 were successful. Attention is drawn to the apparently small number of pneumothoraces induced in the sanatorium (only nineteen during the year under review); the reason is that owing to the long waiting list many cases have their treatment started before admission. The after-history of 327 patients who had had gold treatment in previous years shows that 229 are known to be alive. Only twenty-nine were treated with sanocrysin during the year under review, and of these fourteen ceased the treatment owing to various complications. The drug is considered dangerous enough to be stopped at the first appearance of complications, and if stopped for any reason it is never again administered to the same patient. In the surgical department 120 major operations were carried out, principally thoracoplasty and thoracoscopy and division of adhesions.

TREATMENT OF SPASMODIC TORTICOLLIS BY PSYCHOTHERAPY

BY

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The following series of cases seems to be worthy of record because the recent literature contains few instances of treatment of spasmodic torticollis by psychotherapy.

Since Brissaud first urged the importance of mental infantilism in the *ticeur* most authorities have considered that some cases of spasmodic torticollis have a neurotic or psychopathic factor. This is particularly stressed by Finney and Hughson (1925), Brain (1928), and Frazier (1930). Yaskin (1935) after an extensive survey of the literature concludes: "There are but few cases in which an organic brain lesion is proven. These were associated principally with encephalitis or torsion spasm, and the torticollis merely formed part of the clinical picture. In some of these surgery is reported to have been of benefit. For the majority the organic origin of spasmodic torticollis is unproven. Nevertheless a number benefited by removal of septic foci and surgical interference. The rest probably have a psychogenic origin, and so every case should receive the benefit of modern psychotherapy before surgery is attempted." Turning to the application of psychotherapy, Meige and Feindel (1907) refer to cases treated by re-education, gymnastics, and persuasion. The relative failure of such methods is understandable, as they do not reach the fundamental causes. In fact, physical exercises often seem to become bound up with the patient's symptom, and to fix attention upon it still further. Schaller (1913) records two cases treated by psychotherapy with benefit. Clark (1912, 1914, 1917) describes five cases, four of which recovered; the fifth had had spastic ataxia since childhood, but the torticollis developed later as the result of psychological strain. Clark draws the conclusion that in spasmodic torticollis there is a mental infantilism, with persistence of a childish pattern of reaction, emotional instability, and frequently obsessive thinking. The underlying factor is held to be an abnormal infantile sexual attachment resulting in unconscious conflict, which may express itself in motor or psychic restlessness, or both. Three of Clark's cases had had various forms of treatment without benefit before psychotherapy was begun; in one instance surgical division of the spinal accessory nerve had also been performed without benefit. Yaskin (1935) gives a detailed account of a case which showed faulty psychosexual development, with varying anxiety as the fundamental cause. Partial resolution of the underlying conflict brought recovery.

The cases here presented are confined to those in which muscular spasm was of the spinal accessory distribution and in which there were no other neurological signs and no history of rheumatism. The spasm had assumed a compulsive character and had been of long duration. The case histories are much abbreviated.

Case I

A single woman aged 37 first attended the clinic on November 11, 1937, complaining of twitching and turning of her head to the right.

Clinical Examination.—The patient's face was turned to the right with her chin upwards. There was spasm of the left sterno-mastoid muscle, but no pain or spasm of other muscles.

She could steady her head by placing a hand upon her chin. Full examination showed no abnormality in other systems. The symptom had been present since 1932, and had come on suddenly while she was in good health. She had attended her panel doctor. Radiographs showed no abnormality. Diathermy, electrical treatment, and massage had produced no improvement. She had been off work since the onset except for a few periods of one or two weeks.

Previous History.—The patient was the youngest of eight children and had always been the darling of her parents, who spoiled and pampered her. Between 14 and 16 years of age she became afraid to go out into the street alone and had been excessively shy in company. Analysis showed this to be associated with pubertal sexual anxiety and fears of leaving the security of childhood for the uncertainty of adult life. Following this she became attached to her parents more than ever, and was regarded as delicate. In 1929 her mother had a stroke, with resulting left hemiplegia. In 1930 her father died from bronchitis and pericarditis, and within the year her mother died. The patient continued to live with her sister and two brothers. They were unsympathetic to her and she felt alone, missing the affection of her parents. She had been courting with a boy friend for two years, and after her parents' death he began to press her to get married. She feared all sexual advances and the responsibilities of married life. In 1932 while at work she felt her head turn to the right: "My head seemed to turn away from my work." She had heard people say that girls were likely to die from the same complaint as their mother. She feared that her symptom was a form of stroke which was progressive and would leave her paralysed. Now that she was ill her sister and brothers were more sympathetic and looked after her with tenderness. Her symptom also made marriage impossible.

Results and Comments.—Superficial analysis associated with suggestion and relaxation secured complete relief from the symptom. She returned to work and became more mature in her outlook, more co-operative and independent. Her symptom symbolized her previous attitude of turning away from sex, life, and responsibility.

Case II

A married woman aged 41 first attended the clinic on March 9, 1938, complaining of uncontrollable jerking and turning of her head to the left.

Clinical Examination.—The patient's face was turned upwards and to the left. There was a coarse tremor of the head and spasm of the right sterno-mastoid muscle only. She could bring her head level by holding the chin, but a coarse lateral tremor remained; the head returned to its previous position immediately on release. There was a dull aching pain in the neck, shoulder, and arm on the right side. Full examination showed no abnormality in other systems. The symptom began suddenly four months previously while she was sitting at home knitting. She attended her own doctor immediately. Medicinal and electrical treatment were tried and gave no relief; x-ray examination showed no abnormality.

Previous History.—The patient was the only girl, and the youngest of three children. She had always been her father's favourite and was very much attached to him. There were no previous illnesses or neurotic symptoms. Sixteen years ago she was married, and two years later had one child. Her sexual life was satisfactory. Two years after her marriage her mother died following a stroke. Seven years ago her father became ill with heart disease. He lived alone in the next street, and she had to divide her time between nursing him and looking after her own home. She began to find this a burden: whichever house she was in she thought she ought to be at the other, feeling that she was neglecting her duty. She became increasingly irritable and unhappy. She resented having to look after her father, but felt this to be a wicked thought. During this period she gave up all her friends and interests. One year ago her father died. She was very much upset at his death, and later, when she began to take up her former interests and make social contacts, she felt she could

not meet or mix with people: "I wanted to hide my face or turn away from them." Analysis showed marked guilt for her father's death. She was afraid she had neglected him; she thought that if she had been more considerate he might have lived and that she was therefore responsible for his death. These ideas were repressed, but she felt she could not look people in the face. Her head began to tremble when she conversed and she had to steady it with her hand. She became more and more self-conscious about this, until one day, while knitting, she began to think about her father and immediately felt her head turn to the left. With the onset of the symptom she experienced relief from her anxiety.

Results and Comments.—Analysis associated with suggestion and relaxation secured complete freedom from symptoms, and she was able to take up her former interests and make social contacts. Her symptom represented her desire to turn away from people because of the repressed guilt for her father's death.

Case III

A married woman aged 44 first attended the clinic on November 18, 1937, complaining of uncontrollable jerking of her head to the left.

Clinical Examination.—There were gross spasmodic movements of the head to the left, with the face turned upwards and to the right. Marked spasm of all the muscles of the left side of the neck, especially the left sterno-mastoid and trapezius, was observed. The jerking movements tended to make her stagger as she walked. All tendon reflexes were exaggerated, but no abnormality was found in the other systems. A radiograph of the neck was normal. The symptoms had begun gradually two years previously and had become progressively worse. Electrical treatment had been given without improvement.

Previous History.—The patient was the youngest of fifteen children, of whom seven were still living. One brother had developed "nerve trouble" during the war: "His face drops down on to his right shoulder and he cannot hold it up." His symptoms caused him to be invalided out of the Army, and they had persisted. Another brother had a pronounced stutter. Her mother had had a very unhappy married life and the early home environment was unstable. The patient married in 1913, and a year later her husband had enlisted. While in the Army he became neurotic and addicted to alcohol, and had done no work since. During and after the war the patient kept a public-house, but this was ruined by her husband and had to be given up five years ago. Since then they had been living on her husband's pension and the charity of relations. Her sexual life had been unsatisfactory, as since the war her husband had had ejaculatio praecox. She therefore had had no children, although she had longed for them. The onset of her symptoms coincided with the menopause. Menstruation stopped suddenly and she was anxious because she had no floodings: "I think it must all have gone to my head and neck." Her symptoms served to throw more responsibility on her husband, who has had to do all the housework. Since the onset she had become much more intolerant of her husband and continually grumbled about him.

Results and Comments.—Full analysis was impossible owing to irregular attendance and lack of co-operation. Relaxation and suggestion brought slight relief, but the symptoms were still present when the patient discharged herself. The psychological background and the symbolic nature of her symptoms were nevertheless evident.

Case IV

A married woman aged 26 first attended the clinic on January 6, 1937, complaining of her head turning to the right.

Clinical Examination.—The patient's head was turned to the right. She could voluntarily turn it forwards when asked to do so, but was unable to keep it there unless she held it with her hand. There was no pain and no spasm of any muscles

except the sterno-mastoid. No other physical abnormalities were present.

The symptom came on gradually three years previously while she was engaged. She first felt she could not face people and must look away. This difficulty became gradually worse until her head was turned to the right all the time, making her still more sensitive about meeting people. She married, thinking this would help her to get better, but was unable to go away on her honeymoon, so she and her husband have continued to live with her parents. She had a baby, and again hoped this would help her. From the fourth month of pregnancy until the child was 3 months old she had considerable relief from symptoms, but later they returned worse than before. She looked after the child and helped in the home, but was too self-conscious to go out alone, and would only venture out a short distance accompanied by her mother.

Previous History.—She was an only child and had been brought up very strictly; no sexual instruction was given nor was the subject ever referred to. At the age of 4 she went into her mother's bedroom and saw her mother standing naked. She was horrified at the sight of her mother's pubic hair, thinking it was some terrible abnormality, and rushed from the room feeling that she had seen something she ought not to have seen. The incident was completely repressed, but from then on she became very particular to keep her body entirely covered. At the age of 12 to 13 she noticed her own pubic hair developing. She was afraid of this, but did not know why. She felt that she was different from other girls, but dared neither to ask anyone nor to try and find out if her fears were justified. She kept it all to herself as a "terrible secret," but led a fairly normal life. Analysis showed a repressed fear that she had inherited a horrible abnormality from her mother. When she became engaged she was very anxious because she thought that when married her secret would be discovered. She became more conscious of a difference from other women and gradually began to feel she could not face other people. Her head seemed to be pulled to the right, and as the wryneck became more established her anxiety diminished. After marriage she was completely frigid and was terrified by intercourse: frequently an acute spasm of her neck would come on and prevent it. Her temporary improvement coincided with the period when coitus was impossible because of pregnancy.

Results and Comments.—Analysis produced freedom from symptoms. She became able to go out alone, was free from embarrassment in company, and her sexual life became normal. Her symptom symbolized her attitude of turning away from her sexual role as a woman.

Conclusions

It is a most striking feature that, although the psychogenic origin of spasmodic torticollis has so long been recognized, there was such an extended history of the condition in these cases before they were referred for psychotherapy. In three of them it had been present for from two to five years. Much inconvenience had been entailed and much valuable time wasted by previous methods of treatment, which in two cases had been prolonged in spite of the patient showing no response. As long ago as 1907 Janet wrote in reference to hysteria: "Do not count the number of arms cut off, of muscles of the neck incised for cricks, of bones broken for mere cramps, of bellies cut open for phantom tumours, and especially of women made barren for pretended ovarian tumours." It is regrettable that even now psychotherapy should have been considered for these patients only as a last resort, instead of being advised as soon as they came under medical observation. Belief in physical instead of psychotherapeutic lines of treatment for conditions in which the psychogenic origin is well recognized dies hard.

In three of these cases there was a period of mild generalized anxiety, which came on first but subsided

when the torticollis became established. The symbolic nature of the symptom seems to be significant. The patients each had some factor which they felt they could not face or from which they felt compelled to turn away. This bears out the importance Halliday (1937) gives to the symbolic significance of symptoms in his studies of the psychological factors in rheumatism. The more carefully we study the cases the more we see that the symptom is not an isolated factor but the response of an inadequately adjusted personality to a period of particular stress. Our task is to discover what real satisfaction lies behind the symptom. Our efforts to correct the condition must therefore be directed not to the torticollis alone, nor simply to a disclosure of its genesis, but to a fundamental attempt to readjust the personality to life.

Summary

The literature of spasmodic torticollis is reviewed and the psychogenic factors are stressed.

Four cases treated by psychotherapy are recorded; three of these recovered.

The importance of early psychological investigation is demonstrated.

I wish to thank Dr. T. Wishart Davidson, medical superintendent of the City Mental Hospital, Leicester, for permission to publish the cases.

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MULTIPLE EMBOLI TREATED SURGICALLY

BY

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The following case is reported because it is felt that some of the principles illustrated in the treatment may well be applicable to the surgery of the vascular system in war.

The patient, a young unmarried woman of 27, was admitted to the surgical wards of the Toronto General Hospital on April 12, 1939. Her physician had seen her a few hours before and thought that she was suffering from acute appendicitis. She had wakened the previous evening with abdominal pains and vomiting. The pain seemed to be localized in the right lower quadrant. When she was seen on admission she was somewhat cyanosed and her heart was fibrillating at 170. It was then learned that she had had chorea at the age of 12 and that her doctor had been giving her digitalis at intervals for three years. It was obvious that she had mitral stenosis, and that this was the cause of the fibrillation. When her abdomen was examined she was found to have definite tenderness in the right iliac fossa, but no rigidity. The rectal examination was negative: there was no blood. The leucocyte count was 18,500. Her urinary examination was negative and her temperature 99.6°. It was felt that she might have a small mesenteric occlusion from an embolus, so she was watched carefully. Her pain and nausea subsided in twenty-four hours and she felt much better. Digitalis therapy was initiated.

On April 17, five days later, when the weekly ward round was in progress, the nurse called attention to this patient, who