CLINICAL REMARKS ON PSEUDO-PERITONITIS AND EPILEPSY IN HYSTERIA.

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THE paper which I am about to read this evening will be devoted mainly to the narratives of two cases which came into the hospital within a few days of one another, which presented so many points in common that, even up to the time of their dismissal, I regarded them as being cases of the same kind, but of which later developments proved, I think, pretty clearly that while my diagnosis with respect to one was correct, my diagnosis with respect to the other was altogether erroneous. I propose, in the first instance, to give an account of each case during its first sojourn in the hospital; in the second instance, to trace the subsequent history of each; and, in the third instance, to discuss the phenomena of the case in respect of which I was mistaken.

E. W., a married woman, aged 28, was admitted under my care on November 10th, 1888. Though supposed to be delicate, her only serious illness previous to the present one, was apparently the result of a miscarriage three years ago. The symptoms she presented then were much like those of the present illness, were attributed by her medical attendant to inflammation of the womb, and kept her confined to bed for nine months. A year later she was delivered of a still-born child at term.

Her present illness came on suddenly three days before admission, with general pain and tenderness in the abdomen, and was attributed by her husband to her having had to get up frequently in the night to attend upon him on account of an accident from the results of which he was suffering. She had complained of pain and tenderness in the belly ever since, with sickness and diarrhoea, and some difficulty in micturition. The catamenia appeared on the day of admission.

She was a fairly well-nourished woman, with an expression of great distress, complaining of pain and tenderness in the belly, and difficulty in passing water. She lay on her back with her knees drawn up, breathing irregularly and shallowly at the rate of eighteen in the minute, and with the intercostal muscles only. The tongue was dry and coated, and there were sordes on the teeth and lips. Her abdomen was somewhat swollen, tense, and with rigid parietes, and very tender. The pain occupied no particular spot, the tenderness was general. There was no dull area or evidence of tumour, and no sign of the presence of fluid. The lungs and heart were healthy; urine clear, acid, 1020, free from albumen. Examination *per vaginam* showed fixation of the uterus, and a little roughness about the os. Pulse 118, temperature varying during the day from 101° to 101.8°.

During the next five days her symptoms presented no great change. Her pain was less, and her bowels were confined owing, doubtless, to periodical exhibition of morphine; but her abdomen continued more or less hard and generally tense. She lay on her back with her knees drawn up and inactive diaphragm. She was occasionally sick, and occasionally suffered from hiccup; her tongue remained coated; her pulse ranged from 80 to 112, and her temperature from 99° to 101.2°. Then she began to improve; her sickness and hiccup ceased; her abdomen got softer and less tender; her temperature fell to the normal; her bowels, after an enema, became somewhat loose, her tongue cleaned, and desire for food returned. But as the abdomen became generally softer and less tender, a lump was detected in the right iliac fossa, which had never previously been recognised, and of which there could be little doubt that it indicated the presence of typhlitis.

She remained in the hospital down to December 12th, and, during the latter part of her stay, her temperature was generally normal or sub-normal, though occasionally rising to 99°. She improved steadily in health, and although, owing to the increasing flaccidity of the abdomen, the lump in the iliac fossa became more and more apparent for a time, it had almost entirely disappeared

at the date of her discharge, and was wholly free from tenderness or pain. When she left the hospital she appeared, as far as her general health was concerned, to be quite well.

This was regarded from the beginning as a case of peritonitis, and was treated as such. But the cause was not recognised until the peritonitic symptoms were subsiding, when the discovery of a lump in the caecal region rendered it probable that it was ovarian or caecal mischief; the latter view was adopted. The case was interesting in the fact that the symptoms of general peritonitis were not preceded by any local symptoms.

The second case is as follows: B. G., a girl aged 19, was admitted on November 15th, 1888 (five days after the admission of the former patient). Four years previously, after a fright, she had been attacked with fits, said to be "cataleptic." She had about 100 during the first month, then they diminished in frequency; and latterly she had been almost entirely free from them. She had been under treatment at times at the National Hospital for the Paralyzed and Epileptic, where her fits were said to have been regarded as hystero-epileptic. In the previous May she had had an illness which lasted for six weeks, during which she brought up a little blood from time to time, and was supposed to be consumptive. The catamenia came on two days before the beginning of the present illness. On the 12th (three days before admission), being at the time in good health, she sneezed while lifting a bedstead, and was attacked with sudden pain across the upper half of the abdomen; and she fell down across the bed on her stomach, where she lay unable to move on account of the severity of her pain. She was removed to bed, where she continued in severe pain and prostrate until the day of admission. During the greater part of this time she did not vomit, and had no difficulty in micturition; the bowels were unrelieved. On the 15th, prior to admission, she became suddenly much worse, and retching for the first time came on.

The patient was well nourished, had an anxious and distressed expression, and complained of general abdominal pain. She lay on her back with her knees drawn up; the abdomen distended and tense, and extremely tender on pressure; and the breathing almost wholly thoracic. There was no dullness to be detected, nor was there any evidence of tumour or of fluid effusion. Nothing abnormal was detected either *per vaginam* or *per rectum*. There was no reason to suspect the presence of intrathoracic disease. Tongue dry, thinly coated; pulse 124; temperature 99°.

November 16th. She had been frequently sick between 4 and 9 A.M. this morning. Her face was flushed, and her look still anxious. Her general condition and symptoms had undergone no material alteration, but she still retched at times, while her tongue had become moister, her pulse had fallen to 104, and her temperature to 97.6°. Her respirations were 22. She continued in much the same condition during the remainder of the day; her temperature remained normal; she was occasionally sick, and her water had to be drawn off. She remained on the whole (but with occasional intervals of amendment or aggravation) in much the same state as on admission down to the 22nd. During the whole of this time her abdomen was swollen, tense, generally painful, and extremely tender; she lay on her back, and her respiration was almost entirely thoracic; she continued very sick; her bowels were unrelieved, and her water had to be removed by catheter. Her pulse varied from 92 to 120, and her temperature was usually normal or subnormal, but on the 17th ranged generally between 99° and 100.4°. She was treated at first with the periodical subcutaneous injection of morphine, but latterly opium was given by the mouth.

On the 17th, twelve leeches, followed by poultices, were applied to the abdomen with much temporary relief; subsequently an ice-bag was applied, also with apparent benefit.

About the 22nd her abdominal pain and tenderness began to subside, she lost her sickness, she recovered the power of passing her water, and she began to take milk and other fluid foods without difficulty. On the 23rd the bowels were relieved for the first time by means of an enema. On the evening of the 22nd an ill-defined lump, or rather area of resistance, was observed above the right groin; and this was still detectable for several days subsequently. But there was no definite tumour, and the tenderness was no greater there than elsewhere.

By the 27th the abdomen had recovered its healthy condition, and no lump whatever could be felt in it. Her bowels were relieved by enemata; she took food well, and was, in fact, convalescent. She was discharged well on December 8th.

I need scarcely say, perhaps, that this case, like the other, was

regarded as a case of peritonitis; and that the detection of an ill-defined lump in the neighbourhood of the cæcum, so soon as the general tenderness had subsided and the abdominal walls had become flaccid, led me to believe that in this case, as in the other, the peritonitis had been induced by disease of the vermiform appendage.

If nothing more had occurred, I should have regarded the two cases as absolutely identical, and should have stored them up in my memory as typical examples of peritonitis secondary to disease of the cæcum, but coming on antecedently to any symptoms referable to the cæcum.

On June 2nd, 1889 (about six months after her dismissal), E. W. was again received into the hospital. It appeared that in the interval she had had two recurrences of peritonitic symptoms; one soon after leaving the hospital, and one towards the end of March. Her present attack began on May 25th. On admission she presented the characteristic symptoms of peritonitis: anxious look, dorsal decubitus; tense, tender, and painful abdomen; thoracic respiration, vomiting, retention of urine, and constipation. The tenderness was greatest in the lower part of the right side, and there was distinct sense of resistance there. Her pulse varied from 84 to 120, and her temperature from 100° on coming in to 105° at midnight. It is sufficient for me to say that the patient went on badly, and died five days after admission, on June 7th. Although nominally under my care, I did not happen to see her on this occasion, and am, therefore, not responsible for her treatment. But I gather that for the first two or three days she seemed to be improving with treatment, and her temperature fell; but that after that collapse set in rather rapidly, and an operation, which might have been of service at the beginning, was then deemed inadvisable.

Necropsy.—The peritoneum presented many old adhesions, the result of former peritonitis. There were also slight evidences of general recent peritonitis. In the pelvis and right iliac fossa the parts were bound together by a considerable quantity of buttery lymph; in the former situation a few small collections of pus were observed; in the latter there was no pus, but the cæcum and small intestines were welded into a mass. The vermiform appendage was thickened and ulcerated, and presented a small perforation, but no concretion could be found. The right ovary formed a thick-walled cyst the size of a hen's egg; the left (about the same size) presented several cysts filled with caseous matter. There was no important disease of any other organ.

The correctness of the original diagnosis in this case was thus unfortunately confirmed.

I will now return to the case of B. G. She had left the hospital apparently well on December 8th. About a month later, on January 10th, 1889, she was brought back late in the evening. Unfortunately, the history of her case during this month has been lost or mislaid; but I believe she had remained well until a day or two before admission, when she had been seized with recurrence of her abdominal symptoms, and shortly afterwards with fits, such as she had been liable to for some years. These fits, though occurring at other times, had always been liable to come on during the menstrual period. She had now been menstruating for two days.

After being warded she lay on her back, with the legs extended. Her cheeks were flushed, her eyes half closed; her breathing was shallow, thoracic, irregular, and jerky, and about 32 in the minute. She was continually retching, but only brought up a small quantity of brownish offensive fluid. The tongue was coated but moist. The abdomen was much distended and excessively tender; it was universally resonant. Every now and then she ceased breathing for a few seconds, becoming first rigid and then slightly convulsed, and unconscious. Each fit lasted only a few seconds. Pulse 92, temperature 98°. She was ordered fifteen leeches to the abdomen and a morphine injection.

January 11th. She passed a bad night, had many slight fits, complained of much pain and tenderness in the belly, and was constantly vomiting. As she retained nothing, she was ordered to be fed with nutrient enemata. There was still pain, tenderness, and distension of the belly, and sickness. Her pulse was 112, weak; her respirations about 40, shallow, explosive, and irregular; her urine had a specific gravity of 1022, was alkaline, phosphatic, and free from albumen. Her temperature in the early morning was only 95°, but it rose later in the day to 98.6°.

From this date until the 17th she continued, on the whole, without much change or any obvious improvement. She suffered from frequent fits, coming on irregularly night and day, and often

in groups of two or three; her abdomen remained swollen, painful, and tender; she frequently vomited, and had to be fed almost entirely with nutrient enemata; her tongue remained coated; her respirations were variable in frequency, and mainly thoracic; her pulse ranged from 72 to 130; her urine had to be removed by catheter, and continued free from albumen; her bowels remained unrelieved, and the temperature varied generally between 97.2° and 98.8°. On the afternoon of the 16th, however, it rose to 100.2°, and it reached 101.4° at midnight; the next day it rose to 102°. During the last day or two of this time she was taking milk in small quantities and at frequent intervals.

On the 18th, although the temperature rose to 100°, she was much better; she could lie on either side, she had no sickness, and she was able to take food freely and to retain it. The fits continued.

After this, all symptoms supposed to indicate the presence of peritonitis subsided, and nothing arose to confirm the suspicion, formerly entertained, that her peritonitic symptoms had any relation to typhilitis. The fits, however, continued. These varied in severity, but were all of them apparently epileptic. They came on either without warning, with a sense of faintness, or with twitching of some of the muscles of the hand and arm. They were occasionally ushered in with a plaintive cry, once with three cries. During the beginning of a fit respiration ceased for some seconds, and she generally got livid in the face; she presented tonic convulsion of the face, head and neck, and limbs, the chin was generally thrown over towards the left, and the eyes turned strongly in the same direction and upwards; her arms got stiff, sometimes extended, sometimes flexed on the chest, sometimes one or other being drawn up slowly towards the head, with the thumbs thrown across the palms, and the fingers more or less firmly closed upon them. The legs also became rigid. Clonic convulsions of more or less severity followed, with noisy respiration; and occasionally she bit her lip in this stage, and occasionally passed her water. The pupils remained small and active; the conjunctivæ rarely, if ever, became wholly insensitive. The fits lasted from one to about five minutes, and as they were passing away, the patient perspired profusely, and exaggeration of tendon reflexes, and generally ankle and patellar cloni were observed. The convulsive symptoms varied a good deal in their seat of onset, and in their distribution in different fits. To the best of my belief they were epileptic, and I think I am justified in saying that Dr. Hughlings Jackson, who occasionally at this time visited my wards with me, and saw the patient in two or three of her fits, admitted that, although perhaps they were not typical epileptic fits, still they were essentially epileptic.

On February 5th it was noted for the first time, after one of her fits, that there was impaired sensation all down the right side of the body. This observation led to a more careful examination of the condition of the patient's sensory functions.

On the 8th it was ascertained that she was suffering from imperfect right hemianæsthesia. Sensation was blunted on that side. Although she could feel anywhere on the affected side; she had no sense of pain on being pricked with a pin. Her taste was defective on the same side, so that she could not taste with the right half of the tongue either sugar, salt, tartrate of potash or quinine. Her colour vision was also imperfect.

On the 9th a more careful examination was made. Light touches with the blunt end of a penholder were not perceived on the right side; the prick of a pin was not felt as pain; a cold or hot spatula gave the impression of cold or heat; but when of the temperature of the blood it was not felt. On again testing her vision it was found that the visual field of the left eye was much contracted. The field for white was included for the most part within the 30° circle, that for blue wholly within the 10° circle; and that for green occupied little more than a mere point in the very centre. In the right eye, on the other hand, the field for white was included within the 10° circle, and colour was not recognised even at the centre.

On the 12th the field of the right eye for white had become considerably enlarged, and red could be distinguished within the 10° circle.

She remained in the hospital until April 24th, at which time it was noted that, although she still suffered from fits, these had diminished in frequency; that she was anæsthetic throughout the right side, excepting about the face; that there had been no return of abdominal symptoms; and that her general health had greatly improved.

She was admitted for the third time on May 11th, 1889. She

stated that she had had pains in the abdomen off and on ever since she left, and that she had had only three fits. On the evening of the 9th she had crab for tea; and in the night woke up in severe pain. The pain was general over the abdomen, but worse on the left side, and had a "dragging" character. The abdomen became swollen and tender. The bowels had not been relieved since the 7th, and she had not passed water since the pain came on.

On admission (about noon) the patient was writhing in apparently great agony, groaning, and frequently retching. The legs were drawn up, and respiration was entirely thoracic. The abdomen was much and uniformly distended, and extremely tender to the touch, especially in the left iliac region. She was examined under chloroform, and had a fit while it was being administered, but nothing unnatural was discovered in the abdomen. Tongue dry; pulse 75, full; temperature 100°. She was anæsthetic throughout the whole of the right side. Water removed by catheter.

The next day (the 11th) she was much better. Her tongue was moister, her temperature was normal, and she passed water voluntarily. She had lost her sickness, and her abdomen was less swollen and less tender, and her breathing was more abdominal than it had been. The bowels had not been open since admission, and she had some headache. She improved rapidly; her bowels were moved by an enema on the 14th; and on the 15th she was discharged well, excepting that her anæsthesia continued. She had two fits while in the hospital.

On November 13th, 1889, she was admitted for the fourth time. She had continued to have fits at the rate of three or four a week ever since she left; but she applied for admission on account of violent jerky movements of the limbs, head, and trunk, and stammering, which had come on about a month previously. She looked fairly well, had no abdominal pains, and no anæsthesia. She presented irregular violent clonic movements coming on from time to time, and implicating her trunk and limbs. The muscles of the eyes and the respiratory muscles were not affected. The tongue twitched violently when protruded, and her lips partook in its movements. She had much hesitation in speech, and some stammering. She improved under treatment; and left apparently cured on the 17th. She had three fits while in the hospital.

The above two cases interested me very much at the time when they came in the hospital together, for they both appeared to me to be cases of peritonitis coming on in young fairly healthy women without obvious cause, but in which (from the results of former experience) I thought it not unlikely that the peritonitis was due either to perforative disease of the vermiform appendage, or to some ovarian mischief. The further progress of the former case during its first residence in the hospital confirmed my suspicions, and the further progress of the latter also I thought pointed, though not so conclusively, in the same direction; and, as I have already said, if I had never heard anything more of the patients, their cases would have been pigeon-holed in my memory as examples of the same pathological conditions. The unfortunate result of the former case put the exact nature of it out of the region of controversy. In regard to it, I can only say now that I wish I could have persuaded the patient to have an operation performed when she was first under my care, or that an operation had been thought advisable during her later fatal illness. I do not quote the case as one which we can look back on with much sense of satisfaction, but it has been outside the scope of my paper to enter into details concerning it, and I have not, therefore, given the grounds which determined those who watched over it to refrain from operative procedure.

When the second patient came into the hospital for the second time, I was still under the impression that she was suffering from peritonitis, and treated her accordingly. But the threatening abdominal symptoms soon passed away, and the epileptic fits which had accompanied the other symptoms from the beginning became the prominent feature in her case. Of course, it was quite possible that a person liable to epileptic fits should also suffer from typhilitis. But when, in the course of her case, it was discovered, almost by accident, that she had hemianæsthesia, and further examination showed that there was loss of taste on the same side of the mouth, and optical phenomena which are common as a feature of hysteria, a different explanation of her various maladies naturally presented itself for consideration.

That she was distinctly hysterical was further shown when, at a later period, she came under treatment for spasmodic muscular movements, and for stammering. I came to the conclusion, after

reconsidering the facts of her case, that all her attacks suggestive of the presence of peritonitis were really hysterical, and of the nature of the more localised abdominal pains and tenderness which are common in hysteria; and that she had never had any abdominal inflammation at all—a conclusion which seemed to me fortified by the facts that there was no discoverable starting point for the successive attacks; that the temperature, with few exceptions, was normal or subnormal; and that on the third occasion her symptoms, though beginning with equal severity, subsided without special treatment in the course of three or four days. Were the fits also hysterical? The convenient term "hystero-epilepsy" as their designation, of course, suggests itself. The fits were certainly not hysterical in the ordinary sense of the word. They were often ushered in with a cry, the patient's breath ceased for a time, there were tonic convulsions, followed by characteristic clonic convulsions, she lost consciousness absolutely during their presence, and she occasionally bit her lips or tongue, and passed her water.

It must not be forgotten that patients suffering from epilepsy not infrequently present symptoms indistinguishable from those of hysteria, and that the use of the term hystero-epilepsy of epileptiform fits occurring in hysterical patients does not settle the true nature of such fits. I incline to the belief that the fits were epileptic. There is room for difference of opinion with respect both to the nature of the abdominal affection and of the epileptic fits, and with this remark I conclude my paper, and leave the subject to be discussed.

REMARKS ON SCLEREMA & ŒDEMA NEONATORUM.

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SCLEREMA and œdema of the newborn infant are affections concerning which great confusion reigns not only in the minds of medical men, but also in a majority of the textbooks devoted to the description of the diseases of infancy and childhood. It is my wish in this communication in the first place to show the manner in which this confusion has arisen, and, secondly, to demonstrate that the two diseases are pathologically quite distinct from each other. I shall first give brief clinical notes of two cases which occurred at the Edinburgh Maternity Hospital three winters ago and which were examples, the one of sclerema, and the other of œdema neonatorum.

Case of Sclerema Neonatorum.—On December 27th, 1885, an unmarried woman of 19 years of age was delivered at the Edinburgh Maternity Hospital of a premature male infant. The mother was a primipara, and was in apparently perfectly good health. The labour was not a long one, the first stage lasting 12 hours, the second half an hour, and the third ten minutes. The vertex presented in the O.D.P. position. The child was small; it weighed only 4lbs. 12ozs., and had a length of 18 inches. The placenta, which was normal, weighed 1lb. 3ozs., and the cord was 23 inches in length. The child, at the time of birth, had a premature appearance, and its breathing was with difficulty established, and, even when established, was shallow and weak. On the second day after birth it was noticed that the skin on the thighs, back, and buttocks, was hard and tense, and had a dirty yellowish appearance. Pressure with the finger did not cause any pitting of the skin. The child took the breast very badly, and the cry was weak and whining. The scleremic condition of the skin had, on the third day, spread to the neck, chest, and limbs, and was indeed almost universal. The body of the child felt cold to the touch, resembling the sensation given by contact with a half frozen corpse. The child died on the evening of the third day after birth. Through the kindness of Professor A. R. Simpson I was enabled to make a *post-mortem* examination of this, and of the following case, and to the conditions found at the necropsies I shall again return.

Case of Œdema Neonatorum.—On January 4th, 1886, a married