MENTAL SYMPTOMS IN AURICULAR FLUTTER.

BY

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THE following case is of interest from the point of view of the relation between the mental symptoms and the physical state.

A business man of middle age had for years lived a "high-pressure" life, had smoked heavily, and had been a steady drinker. A friend stated that for some weeks he had had occasional "heart" attacks and had complained of giddiness when crossing roads. On one occasion he had collapsed on climbing some stairs and was taken to a hospital, where he was detained for a few hours before being sent home. He had then stayed in bed for three weeks. Two days before he came under observation he had attempted to resume his work, but returned home early and could not say where he had gone or what he had been doing. He appeared not to recognize his friends, and kept anxiously inquiring as to the state of his affairs.

When first seen he walked with difficulty and appeared to be extremely confused, replied to questions in monosyllables and was quite unable to give any account of his symptoms. His pulse was rapid but regular, about 140 a minute, and the cardiac dullness was a little increased. The pupils were not quite equal and reacted a little sluggishly to light, but the consensual reflex and the reaction on convergence were normal. There were no labial, lingual, or digital tremors, and the tendon and cutaneous reflexes were normal.

On the following day he was perfectly clear and well orientated and could give a good account of himself except for the period of the five preceding days, which seemed to him to be almost a blank but for a great fear that he was about to die. He stated that he had been subject to fainting attacks for about a year, and that he had been ordered to lead a quiet abstemious life and to restrict his diet. He had lost weight in consequence and had felt much better in health, while the fainting attacks had become less frequent and less severe. Latterly, however, he had felt faint even when confined to bed. Tincture of digitalis was now prescribed, but appeared to have little effect, as the pulse rate continued to vary between 130 and 160. He remained clear in mind, but was often anxious and worried and had bad dreams at night.

I am indebted to Dr. C. F. T. East for the reports on the electro-cardiograms. The first report was as follows:

"The case is one of auricular flutter. The auricular rate is 360 and the ventricular 180 a minute. There is therefore 2:1 heart block. There is preponderating hypertrophy of the left ventricle."

The patient was now given Nativelle's digitalin subcutaneously in doses of 1/600 grain thrice daily. He improved considerably and became much less restless, but continued to feel faint at times. The pulse rate was still high and became irregular. The report on the electro-cardiogram was:

"The rhythm is now irregular and the intervals between the ventricular complexes are quite dissimilar. There is variation in the ventricular complexes. The regular sequence of P waves is not seen in this graph as was the case before. Instead there are a number of coarse deflections occurring irregularly. In some cases there is still somewhat of a resemblance to flutter in the P waves. The condition is now one of coarse fibrillation of the auricles somewhat transitional in type between true flutter and complete fibrillation. Preponderating hypertrophy of the left ventricle is well marked. This change may be the result of digitalis medication."

The injections of digitalin were now omitted and the pulse fell from 120 to 72. The next electro-cardiogram showed

"regular rate of about 72 a minute with very slight sinus arrhythmia. There is no delay in the conduction of impulses. Normal rhythm has now been restored and the impulse arises normally and pursues a normal course. The only abnormal feature is the preponderating hypertrophy of the left ventricle."

The patient appeared to be restored to complete health.

The pupils reacted normally in all respects, and mentally he was alert and clear and had lost his feelings of anxiety. There was a history of syphilis thirty years ago and his blood was found to give a +40 Wassermann reaction. It was not anticipated, however, that the cerebro-spinal fluid would show a similar reaction with a large excess of cells and protein. The patient was given a course of 16 grams of tryparsamide, but the blood remained +40 while the cerebro-spinal fluid was +20 with 15 cells per cubic millimetre, 50 mg. of protein per cent., and a paretic Lange reaction of 5555543210. The patient has been at work for several months, and when seen recently did not show any physical signs beyond slight enlargement of the left ventricle.

Although dizziness and complete loss of consciousness are not uncommon features in auricular flutter, mental confusion of several days' duration is unusual. The mental picture of this case was extremely suggestive of general paralysis, except that the symptoms disappeared as the condition of the heart improved. Visceral hallucinations such as have been described by Head were absent.

Intensive treatment with digitalin caused the vicious circle to be broken and converted the flutter into fibrillation, which in turn was followed by a normal rhythm when the drug was discontinued.

PANNICULITIS: ITS SIGNS AND TREATMENT.

BY

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PANNICULITIS can be correctly defined as a chronic interstitial inflammation of the fibrous tissue, the peripheral nerves, and blood vessels in the panniculus adiposus. Stockman¹ prefers the somewhat lengthy term "chronic subcutaneous fibrosis," but Professor Salin had previously denominated the affection panniculitis, and most probably this concise term will be permanently adopted. The condition is quite common, and is not infrequently associated with fibrosis; indeed, it may be regarded as a superficial form of fibrositis, although it can be easily distinguished from the latter affection.

Unquestionably infection plays a part in the causation of some cases. There is generally a history of gastro-intestinal disturbance for months or years, which I regard as the predisposing cause in the majority of cases, and the exciting cause is usually a series of slight chills—not severe enough to confine the patient to bed. Although this affection occurs frequently in patients with neurotic symptoms, the question arises whether the panniculitis is not the cause of the neurosis. In a certain number of cases there are no symptoms referable to the nervous system. This fact must be emphasized, because the opinion is held that panniculitis is always associated with symptoms of neurosis.

There is a good deal of confusion regarding the signs of this affection. The description of the physical signs given by some writers is misleading. For example, one observer² describes hard nodular masses varying in size from a bean to a walnut; another³ mentions that nodules were found running down among the branches of the brachial plexus; and a third⁴ states that patchy areas of panniculitis give rise to thickening, and even tumours of a fibro-fatty nature. A nodule means a knot, knob, or lump. If this be the accepted meaning of the term, I have not met with a nodule in any case of uncomplicated panniculitis, and I have seen 86 cases during the last two years. Although it probably consists of pannicular deposits among the masses of subcutaneous fat, I exclude Dercum's disease from consideration, chiefly because it is not common, and the treatment of adiposis dolorosa is somewhat different from that of simple panniculitis.

Panniculitis occurs in small circumscribed patches, from about one to two inches in diameter. The seats of election are the supramammary regions in the female, the upper intercostal muscles (the left side being most frequently

affected, and, if both sides are attacked, the left is generally the worse), the costal margins, the abdomen, and over the fascia lata. Very occasionally patches may be found in other localities, but, apart from the fascia lata, as a rule they are confined to the trunk. Stockman's description of the microscopical appearance is as follows:

"The fibrous tissue is found to be thicker and denser than normal with numerous fibroblasts; the small nerve twigs running through it are in a condition of interstitial inflammation, and the small blood vessels show periarteritis and endoarteritis."

These observations upon the morbid histology of a patch established panniculitis as a distinct entity and explain the character of the physical signs. There is not much to be felt. The sensitive areas are generally smooth; when they are uneven they give the impression of a conglomeration of small shot-like particles. If pressure is applied perpendicularly to the surface the tenderness is slight, but if applied from the circumference of the patch it is most marked. A patch is evidently an aggregation of smaller ones. When the patch is disappearing under massage it splits up into its component parts. The contour of these can be made out, and before they finally disappear they feel like small pin-heads. On picking up the skin and subcutaneous tissue over a patch between the fingers, it feels firmer and less elastic than normal tissues. If the sensitive area is compared with a healthy portion, the practitioner will soon acquire the tactile discrimination necessary to diagnose this affection.

The implication of the nerves produces the symptoms, which are aching pain in the affected part, tingling, stiffness after exertion, numbness, muscular lassitude, and often a distinct loss of energy. Sometimes in early cases the patient is not conscious of any discomfort until the patch (or patches) is manipulated during an examination. The characteristic sign is the exquisite tenderness on picking up the sensitive part between the fingers.

Errors of diagnosis are not uncommon: for example, a case of left intercostal panniculitis was mistaken for angina; a patch over the right costal margin for cholecystitis, and another over McBurney's point for appendicitis. It is comparatively easy to distinguish between a hyperaesthetic skin area and a patch of panniculitis. In the former a slight stroking of the skin produces tenderness; whereas in the latter lateral pressure causes more or less severe pain.

TREATMENT.

The first essential is to improve the digestion. Over-eating or dietetic errors are usually the cause of alimentary irregularity. Secondly, to impress upon the patient the advisability of guarding against chills. If there is any septic focus it should be immediately dealt with. The fundamental principle of removing the cause, if possible, applies with special force to panniculitis. If the pain is severe, or interferes with sleep, a cachet consisting of magistral, pyramidon, and caffeine citrate may be given occasionally; otherwise drug treatment, apart from a digestive aid, is of doubtful value. The best treatment for this affection is skilled massage, given preferably by one who has obtained the Swedish diploma. I generally begin treatment with mild electric massage (d'Arsonval) and then go on to dry massage. In very sensitive ladies the masseuse uses a cream consisting of menthol, methyl salicyl, and cremor rosae. It takes a few weeks before the patches completely disappear. About once or twice a week it is sometimes advisable to substitute for dry massage a massage douche to improve the general health. Dry massage may become somewhat irksome, and a douche is always pleasurable. The vacuum tube (d'Arsonval) has a soothing effect upon the tender area, but the remedy to promote absorption of the effused inflammatory products is massage skilfully given—at first tentatively, and as the tenderness diminishes more vigorously.

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CONGENITAL MEGACOLON WITH ABSENCE OF VAGINA.

BY

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EXTREME constipation and distension of the abdomen present at birth as in the following case without organic obstruction, but with hypertrophied, dilated, and elongated sigmoid colon, are typical of the condition first adequately described by Hirschsprung.

M., a girl now aged 18, the second of eight children, was the only one born with abnormalities. The mother ascribes the daughter's defects to conception having occurred at a time of great distress caused by her first daughter's death from meningitis.

M. suffered from extreme constipation from birth—the midwife had to use aperients and enemata to get away the first motion, which was scybalous, and a doctor had to be consulted. The abdomen became greatly distended. When 5 years old colostomy—in the mid-line below the umbilicus—was performed by another surgeon, and then, for six years, injections had to be used three or four times a week and the bowels were only opened naturally per anum about once in three months. The mother says she could not afford a colostomy apparatus and by the time her daughter was 11 years old begged for something to be done.

On August 10th, 1917, I excised the faecal fistula with an enormously hypertrophied and dilated sigmoid colon. End-to-end anastomosis was done, and a tube passed through the anastomosis and stitched to the anus (Lane's technique). The large bowel not removed seemed almost normal in size but to have thick walls. Since then the bowels have acted naturally; the abdomen is not distended; there is no incisional hernia. The girl earns her living as a shop assistant.

Since she reached the age of 16 there have been mild attacks of abdominal discomfort, sometimes with vomiting, about every three weeks, but as menstruation did not appear she again came under my charge. No trace of vagina or of uterus could be found, even after deep incision into the perineum. The urethra is normal; the rectum roomy and unobstructed, and the secondary sexual characters, though backward, are definitely feminine. If she insists on getting married at some future date it is proposed to fashion from a segment of the ileum a substitute for the missing vagina (Baldwin's operation).

In the textbooks cases like this are not sufficiently separated from those with organic obstruction—for example, of 100 cases collected by Mummery organic obstruction was found in 23. The same authority says: "Curiously enough associated congenital abnormalities are apparently not common." Of his 100 mixed cases, only 15 presented some other congenital abnormality—in 10 abnormality of the anus; in 2 stricture of the colon; in 2 deaf-mutism; in 1 imbecility. Such abnormalities are nothing like so striking as those here recorded.

In another condition where hypertrophy of muscle is present at birth—congenital hypertrophic pyloric stenosis—there is also but rarely found an association with other congenital abnormalities (for example, club-foot). These two conditions—apparently closely comparable—were both first properly described by Hirschsprung. It seems idle to guess why, how, or when such defects arise. At any rate, we can summarily dismiss many of the hypotheses put forward to explain congenital megacolon, because they fail to take into account such facts as the absence of organic obstruction, the presence sometimes at birth of distension of the abdomen, as well as hypertrophy and dilatation of the colon, and the not rare extension of the dilatation right down to the anal canal, and because they do not throw the origin back far enough.

Probably at the present time the help of the sympathetic nervous system would be invoked: a "sympathetic block" might account for achalasia or for a zone of reversed peristalsis or of want of peristalsis, but it is very doubtful whether any neuro-muscular defect could produce hypertrophy even if it caused spasm. We can produce deformed starfish at will by shaking, needling, or otherwise interfering with the segmenting ovum. So in attempting to explain congenital deformities in the human species we can go right back to the egg stage—some "impression" on the ovum might result in an abnormal trophic control (nervous or chemical), with the result of overformation of muscle. At any rate, in the present case the mother was on safer ground than is usual in placing her "maternal impression" at the time of conception.