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