DYSMENORRHOEA AS A CAUSE OF HYSTERO-EPILEPSY.

Read in the Section of Obstetric Medicine at the Annual Meeting of the British Medical Association in Worcester, August 1882.

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WHAT is meant by hystero-epilepsy? As yet authors are not agreed. Charcot says it is "hysteria, solely and always present, taking on it the semblance of epilepsy.....epilepsy being present only in the external manifestation, but not substantially existent;" in other words, epileptiform hysteria. But so little is at present known of the true nature of epilepsy, that one must be guided to a great extent by "external manifestation" in forming an opinion as to whether epilepsy be really present or not. For this reason, Charcot's definition appears to me unsatisfactory. Others regard hystero-epilepsy as simple epilepsy followed by hysteria; two separate affections, each distinct and independent. This occurrence is quite possible, but this should not be called hystero-epilepsy. Others regard it as a combination of hysteria and epilepsy, half hysteria and half epilepsy, a mixture of the two, a hybrid as it has been called. What I understand by hystero-epilepsy is epilepsy unmistakably present, but having an uterine or ovario-uterine origin.

The majority of the published cases of so-called hystero-epilepsy in France or America * I think we would regard as severe cases of hysteria only. In Richer's† typical cases, the epileptoid stage only lasts a few seconds, and is at once followed by wild hysterical convulsions. It is confusing and non-scientific to call hysteria, of however aggravated a character, by the name of hystero-epilepsy, when in reality there is no epilepsy in it. It would be best to drop the word epilepsy altogether and call the disease grand, or major hysteria, confining the term hystero-epilepsy to cases with marked epilepsy, combined or not with hysteria, but having an uterine or ovarian origin.

We know that epilepsy may arise from different causes—from the scarlet-fever poison, from dyspepsia, from local irritation, as worms, irritation from a tooth, a splinter of wood under the thumb-nail (Greenhow), and lastly the ovary. The uterus may also be added. It is in its connection with the last two, and because of its peculiar development, that epilepsy becomes hystero-epilepsy (from *hystéra*, the womb). And if the term were kept in this connection, I think it would simplify matters. Dr. Barnes and others have written on ovarian epilepsy, and it is in connection with the ovary that Charcot and Richer describe hystero-epilepsy; but the uterus is ignored altogether. Dr. Graily Hewitt, I believe, was the first to draw attention to flexions of the uterus as a common cause of convulsions, though he does not speak of them as epileptic in character. But I do not know of any one who regards dysmenorrhœa as a cause of epilepsy or hystero-epilepsy. The most recent works on epilepsy only casually hint at that disease first making its appearance in young girls with disturbed menstruation. Dr. Gowers, in his recent excellent work on epilepsy, refers in a single sentence to "retarded or absent menstruation" as an exciting cause, adding "the difficulty in determining the exact causal relationship between the two conditions is very great." Why the difficulty should be greater in this than in any other kind of peripheral irritation, I fail to see. Although Dr. Gowers does not recognise dysmenorrhœa or other abnormal condition of the uterus or its appendages as a cause of epilepsy, yet, when speaking of the statistics of the disease, he says that, "at infancy and puberty the excess of females (over males who suffer) is very great." Why it is so at infancy is not very clear, though, according to Dr. Gowers, heredity has something to do with it; but heredity affects both sexes more equally at puberty. This leaves menstruation and its troubles responsible for the great increase—one third more. After menstruation has ceased, males are more often afflicted with epilepsy than females.

The following I regard as a case of pure hystero-epilepsy. Mrs. P., aged 34, was of average height and rather spare build. There was no "nervous history" in herself or family. She had no convulsions when a child. She said that, shortly after marriage, she had three miscarriages, occurring within a few months of each other, and each time about three months gone. Since then, she had had more or less dysmenorrhœa, with scanty discharge. Her first fit commenced in July 1881, when she had three fits in one night. She had no more for ten days; then she had several. They then came on more and more frequently up to the time when I saw her in October, three months after her

first attack. I cannot describe the character of the earlier fits, whether they had more of the hysterical or of the epileptic in them; her friends say they were similar to what I saw, only less severe. Those which I saw were characteristic enough, some of them of great severity. They were preceded by an abdominal aura, immediately followed by loss of consciousness, tonic contraction of limbs, succeeded in a few seconds or minutes by clonic convulsions, especially of the right side. The fists were closed, the features contorted, with some foaming of the mouth, but no biting of the tongue. In some of the fits, there was slight opisthotonos. I have seen one fit succeed another every ten minutes, and before consciousness was restored; so that for an hour or more she was in the *status epilepticus*. A whiff of chloroform relieved the convulsions very quickly, but did not prevent their return. Strong doses of bromide of potassium and chloral kept them under. One day she must have had as many as thirty, and it was during the menstrual period that they occurred so frequently.

There was a history of a fall about twenty feet two years previously, for which she was admitted into St. George's Hospital; but no bad symptoms followed. When the fits began, she was told by a medical man that they were due to a tumour on the brain, resulting from the fall. But, judging from her symptoms, and from the fits becoming worse at her periods, that they were uterine, I examined her. There was no displacement of the uterus; the cervix was natural to the touch, only with a slight tapering; the os was small. On introducing the sound, the internal os offered more than usual obstruction. The depth of canal was normal.

On November 19th, the patient being put under chloroform, I introduced a double-bladed hysterotome up to, but not through, the internal os; and made a double incision. I then put in a small tangle-tent. Next day, the vaginal portion of the tent was moderately swollen; but traction on the string would not make it come away. Thinking the uterus was only grasping it tightly, I gave her some chloroform; but even then I had to use considerable force with polypus-forceps before I could get it away. The tent presented an hour-glass appearance, or like the cork from a wine-bottle, constricted in the middle by the internal os. The constricted portion was only double the diameter of an ordinary uterine sound, the ends being at least double that size. Forty-eight hours afterwards, a sharp attack of pelvi-peritonitis set in, which lasted a week; then she gradually recovered. She has had no more fits, the dysmenorrhœa having also quite disappeared; and she is now in good health. On April 5th, nearly five months after the operation, she had menorrhagia for three weeks, but no pain. Tincture of hamamelis checked it.

There are several points of interest in this case.

The fits had all the characters of epilepsy, except biting the tongue. This is no doubt an important symptom, but still not an invariable accompaniment of epilepsy. And though there was foaming of the mouth, it was not so marked as in most epileptics. Again, the slight tendency to opisthotonos is a characteristic of hysteria, and not of epilepsy. But, on the other hand, the loss of consciousness, the tonic succeeded by the clonic spasms, the absence of the so-called co-ordinate movements (throwing about the hands and arms, the purposive struggling, requiring half a dozen to hold the patient down), the sudden onset and short duration of the fits, the appearance of the patient, etc., are all characteristic of epilepsy. There was nothing violent or noisy about the patient, but a good deal of helplessness and exhaustion. Pressure on the left ovary, though painful, did not bring on a fit, nor cut one short. I did not take the temperature, which is said to rise in epileptics, but not in hysteria. The day after the fits, she complained of exhaustion and headache. She had no delusions, no globus hystericus. On the whole, then, the epileptic symptoms predominated.

There is no doubt as to the origin of the convulsions. Epilepsy due to centric or cerebral disease is a much more serious disease than that which is brought about by peripheral irritation; though the latter, when of long standing, may end in confirmed epilepsy, despite the removal of the cause. In my patient, the uterus alone was at fault, the cervical stenosis producing dysmenorrhœa, and the dysmenorrhœa the fits. This is evident from the great exacerbation of the fits menstruation; and the complete removal both of the fits and dysmenorrhœa by opening up the canal. The unyielding cartilaginous condition of the internal os is shown by the appearance of the tent. I think it would have been better to cut through the internal os in this case, though that is not usually recommended. It might have saved the inflammatory attack.

I have at present under treatment three other cases somewhat similar: one almost purely epileptic, of two years' standing, where the intelligence is beginning to suffer. In this case, there is ante-flexion, with dysmenorrhœa. Since wearing a Thomas's pessary, has had only one fit. The other

* Hystero-Epilepsy, by C. K. Mills, M.D. *American Journal of the Medical Sciences*. October 1881.

† *Etude Cliniques Sur l'Hystero-Epilepsie, ou Grande Hysterie*, pour le Dr. Paul Richer. Paris: 1881.

is also a case of antelexion, with dysmenorrhœa, the fits being epileptiform and slight. The third patient had antelexion, with dysmenorrhœa, with nine months of exaggerated hysteria, eclampsia, etc., but no epilepsy. An intra-uterine stem cured this woman. But it would occupy too much time to enter into these now.

Dr. BANTOCK (London) confirmed Mr. Dewar's observations that in many of the cases, of which Mr. Dewar's case was an example, relief was often quickly afforded by incision of the cervix, which he considered preferable to dilatation by means of sponge-tents.

Dr. THOMAS DUTTON (Siddlesham) wished to know if the ordinary treatment for epilepsy had been tried and failed. If so, he considered that they were cases of hysteria due to irritation of the uterus.

Dr. GRIGG (London) thought it was a mistake to call these cases epilepsy; they are instances of hysterical convulsions due to reflex irritation, to which any lowering of the general health conduces.

Dr. NESFIELD (Manchester) thought there were undoubtedly cases on the borderland between the two disorders, not unfrequently seen in children, and even in boys.

Mr. DEWAR, in reply, held that his case deserved to be called hysterio-epilepsy, more than those of Charcot and others, where there were absolutely no symptoms of epilepsy. Bromide of potassium relieved, but did not cure, his case. There was an unmistakable element of epilepsy, and, as the cause of the disorder was uterine, he considered the name he had given it justifiable. Biting the tongue was not a *sine quâ non* in epilepsy, which might be peripheral as well as central.

A SUCCESSFUL CASE OF TRANSFUSION OF BLOOD AFTER SEVERE POST PARTUM HÆMORRHAGE.

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THE case which I wish to bring before the notice of the Association is one of transfusion of defibrinated blood, for intense collapse following *post partum* hæmorrhage; and it presents a good example of the benefit that may follow this operation, even when apparently there seems but little probability of a successful issue.

On June 8th, 1881, Mr. Saberton of Ardwick was sent for to attend a patient (Mrs. S.), aged 22, in her second confinement. On reaching the house, he discovered that the child had been born and the placenta expelled at least ten minutes previously, and that the labour had not extended over more than a couple of hours. The condition of the patient was most critical; she lay in a pool of blood, her face deadly pale, and the pulse scarcely to be felt. Her abdomen was distended with an enlarged uterus, that reached almost to the ensiform cartilage. Not a moment was lost in firmly grasping the fundus uteri, and in resorting to the ordinary means of checking hæmorrhage, including the free administration of ergot; but no contraction ensued until the hand had been introduced into the interior of the uterus, and the clots which filled the uterus thoroughly removed; and these, when lifted into the chamber-utensil containing the placenta, completely filled that vessel. The uterine contraction was soon followed by dilatation, with a return of the hæmorrhage; and for an hour contractions and dilatations followed one another at short intervals, with repeated recurrence of hæmorrhage. During this time, pressure over the fundus was maintained, and occasionally the hand was reinserted into the cavity of the uterus, and the organ manipulated bimanually.

Mr. Saberton was now assisted by his partner, Mr. Gwatkin; and in the course of another half hour the hæmorrhage ceased, and the uterus remained firmly contracted. Notwithstanding this, the patient showed no signs of coming out of her collapsed condition; and both gentlemen saw that, if it were possible to save her life, it could only be by transfusion of blood. For this purpose I was sent for, and reached the house two hours after the labour, and half an hour after the arrest of the hæmorrhage.

I found the patient lying still and unconscious; her face and lips were blanched; her eyes had assumed that dull and lifeless appearance which only death, or its near approach, can produce. Respiration was scarcely perceptible, and the pulse could only at intervals be felt; her extremities were cold and clammy, but the uterus was firmly contracted. It is needless to say I had no hesitation in concurring with the opinion already expressed as to the necessity for transfusion, and placed in readiness Dr. Macdonnell's transfusion-apparatus. The husband of the patient cheerfully consented to supply the necessary blood, but her mother begged that she might be the donor; and to this request

we acceded, as the condition of her health was extremely good. The mother's age was forty-two; and it is worthy of record that her next menstrual period, which should have occurred two days later, did not on that occasion appear.

Whilst Mr. Gwatkin and I were performing venesection on the mother in an adjoining room, and before we had time to collect more than four ounces of blood, Mr. Saberton acquainted us that the patient was apparently lifeless. Accordingly, Mr. Gwatkin took charge of the defibrination, and I hurried back to the patient's bed-room to prepare her arm for the reception of the blood. The difficulty one had to contend with in finding a vein was very great, but at last one came into view; and, the skin over it being divided by transfixion at right angles to the course of the vessel, a probe was readily passed underneath the vein, so as to isolate it from the surrounding tissues. A small opening was now made in its walls, and the silver nozzle of the tube was introduced a short distance into its interior. The blood was now allowed to flow along the tube until it appeared at the opening in the side of the nozzle, whereby one knew that no air existed in the tube. The nozzle was then introduced further into the vein until the opening in its side was completely hidden from view; and the patient's arm, together with the apparatus, were elevated, in the hope that the blood would then be forced along by gravitation; but such was not the case, and it was necessary to aid in its propulsion by repeatedly compressing the dilated portion of the tube.

In from ten to twelve minutes, all the blood (nearly four ounces) was injected; and the patient's arm being bound up, we anxiously watched the results of the transfusion. Almost immediately, respiration became distinctly visible and audible, without the occurrence of any dyspnoea; the pulse at the same time returned to the wrist; and, in the course of a quarter of an hour, the insensibility gave way to consciousness, and she was able to recognise her friends. Her convalescence was steady and uncomplicated; and, within a month, she was able to walk out of doors.

In conclusion, I may remark how generally it happens that, in the cases of *post partum* hæmorrhage which would be most benefited by transfusion of blood, a transfusion-apparatus is not procurable until too late to be of service to the patient; and I cannot too strongly recommend a glass pipette with tube, such as the one I now produce (which is Macdonnell's apparatus made of portable form), should be constantly carried in the obstetric bag for sudden emergencies.

THE NON-REGISTRATION OF STILL-BIRTHS.—A very instructive case, in which the Solicitor to the Medical Defence Association prosecuted to conviction a person who had procured the burial of an illegitimate child by means of a forged certificate, in which the child was untruly stated to have been still-born, shows what a loop-hole is left to evil disposed persons for making away with their offspring, by the law, as it now stands, not requiring the registration of still-births, but merely the presentation of some sort of certificate by the undertaker to the cemetery authorities. In this case, the father of the child was summoned before Mr. Barstow at Clerkenwell, and charged with having wilfully forged a false certificate under the Births and Deaths Registration Act; also with having made a false declaration, and having unlawfully procured the burial of the body of the deceased child by means of such false declaration. To the first two charges the prisoner pleaded guilty, and the third was ultimately withdrawn. Mr. Pridham, for the prosecution, stated that the deceased was the illegitimate child of the defendant, and had been born on July 1st, a medical man being in attendance at the confinement. The child having died, the defendant, on July 3rd, handed to the undertaker what purported to be a certificate signed by a medical man (not the medical attendant) in the following terms:—"I certify that I have attended Mrs. Smith, and that the child was still-born. Given under my hand, Dr. Clift." The superintendent of the cemetery to which the body was taken, noticing the informal nature of the certificate, forwarded it to the Registrar-General, and as a result the body was exhumed and an inquest held, when it appeared that Dr. Clift had not attended the mother, and that the certificate was, as the defendant admitted, a forgery. Mr. Barstow inflicted a penalty of £5, or one month's imprisonment, on each of the two charges. The fines were not paid, and the defendant was therefore removed in custody. The forgery was so clumsy that it is hard to see how anyone could have been deceived by it; but, had the forger been less ambitious, and merely aimed at producing a fictitious certificate by an ignorant midwife, he would probably have succeeded in getting rid of the body of the child without any further trouble. It is not pleasant to think what facilities this state of things affords for wrong-doing to unprincipled persons, and the present case strengthens the argument in favour of the registration of still-births, which might very well be made compulsory concurrently with the better education and registration of midwives.