diarrhoea, without significant improvement in the contrast of the radiographic image.

Pain on Micturition.—A small number of patients complained of slight burning on passing urine on the morning after administration. Two had slight suprapubic discomfort, which suggested irritation of the bladder. None of these showed any sign of renal damage.

The manufacturers interested in pheniodol have since carried out further research into the dispensing of the drug. One firm (Glaxo Laboratories Ltd.) submitted samples of the drug in the form of sugar-coated granules. I carried out further tests, and found that the preparation was very satisfactory providing that the patient was asked not to chew or suck them. The granules readily dissolve in the intestinal juices.

Another firm (British Drug Houses Ltd.) has prepared the drug in the form of a fine powder which is readily suspended in water or milk. This preparation is also very satisfactory, though sometimes the patient mentions some slight burning in the mouth and throat; but this is readily relieved by a drink of water.

Comment

Since the introduction of cholecystography we have learnt a great deal about the behaviour of the gall-bladder in health and disease. Though numerous reports testify to its value many doctors still do not realize that reliable results can be obtained only by careful attention to technique and interpretation. Before giving any opaque material a preliminary radiograph should be taken, for failure to do so may result in faulty diagnosis. Unless definite gall-stones are revealed the examination should always be completed.*

The most reliable results are obtained by the intravenous method of administration, but this is seldom employed to-day on account of the liability of tetraiodophenolphthalein to cause unpleasant reactions, venous thrombosis, or sloughing of the tissues if any escapes from the vein. The oral method is simpler and the results are reliable in a large proportion of cases, but on account of the tendency of the sodium salt of tetraiodophenolphthalein to cause vomiting or diarrhoea the radiologist sometimes has difficulty in assessing whether enough of the drug has been absorbed. Rowden (1933) tried to avoid these difficulties by administering the drug in No. 3 gelatin capsules, which he himself filled so that the drug might be fresh. His procedure gives excellent results; but few people take the trouble to prepare the gelatin capsules, and most workers prefer to give the drug in fluid form. I hope that pheniodol will prove less troublesome and therefore more reliable, as I have tried to show in this paper.

Normal Cholecystography.—A dense well-filled gall-bladder shadow which is normal in size and shape and of uniform opacity and which contracts after a fatty meal to a much smaller size is almost always normal. Very occasionally gall-stones may be obscured by the density of the shadow and are revealed only by a film taken with the patient standing erect or by serial films of the emptying of the gall-bladder. More frequently, mistakes are made because the observer does not appreciate that the gall-bladder is seldom completely filled with the opaque medium, and so fails to realize that it is possible to report normal findings when a stone may be held in the ampulla of the gall-bladder or in Hartmann's pouch. Likewise it is generally assumed that stones in the cystic duct always cause no filling, whereas there may be several stones in the duct without impairment of filling, concentration, or emptying.

Faint Filling.—Even when technical standards are fully satisfied I doubt whether the opinion given by Graham and his associates (1925) can be upheld. They state that "the sensitiveness of cholecystography in revealing abnormalities of the gall-bladder is one of its most striking assets in the diagnosis of slight degrees of chronic cholecystitis"; or, in other words, slight degrees of chronic cholecystitis cause impairment of the ability of the gall-bladder to concentrate the drug. I believe that this view is incorrect, for I have seen two cases of chronic cholecystitis with gross inflammatory thickening of the walls of the gall-bladder which had shown no impairment of concentration of the drug. With the oral method, too many factors influence the absorption of the drug for us to state whether variations in its concentration in the gall-bladder are of functional significance, so that a faint filling should be

classified as normal unless it is shown to be constant at repeated examinations.

No Filling.—The most reliable sign of disease is no filling of the gall-bladder. In most cases this signifies either that the cystic duct is blocked by stone or mucus or that the gall-bladder is grossly diseased or full of stones. To be sure that there is no mistake the radiologist should check all factors influencing the absorption and elimination of the drug and should make certain that the films are properly centred and exposed. The test should never be conducted when the patient is jaundiced or when there are other clinical signs of hepatic insufficiency, for the medium is likely to induce further hepatic injury and the gall-bladder rarely fills. In less severe cases of liver disorder a satisfactory shadow is given if the gall-bladder is normal. There may be no filling if the patient is unable to absorb fats or if he has been on a fat-free diet for a long time.

In every case cholecystography should be followed by a barium meal to show whether the stomach empties naturally and to exclude any organic disorder which may affect the significance of the findings.

Conclusions and Summary

Pheniodol is a reliable peroral cholecystographic medium. Suitable preparations in doses of 3 to 6 g. give a shadow of the gall-bladder similar in density and filling to the best obtained with 4 g. of tetraiodophenolphthalein. It is less objectionable to take, and seldom causes vomiting. Diarrhoea occurs in some cases, but not more often than with tetraiodophenolphthalein.

An account is given of the interpretation of oral cholecystography in the light of present-day knowledge.

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A CASE OF CONVERSION HYSTERIA

BY

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We seldom see a case summary that shows in outline the actual course of a short and successful psycho-analytical treatment: a lot is said about psychotherapy in general, but very little about its methods and techniques. Here is such a case. I hope the technique explains itself. The actual conversion symptoms are unusual.

A. B., an insurance clerk aged 30, complained of increasing difficulty in drinking. He could drink water in the morning, though not easily. Later in the day fluid always "went the wrong way," and in consequence he dared not try to swallow. His trouble started four or five years previously, when he thoughtlessly bolted some iced lemonade at a dance and choked himself so severely that he was in a panic and waiters had to rush to his assistance. Fourteen days later, and after describing this incident to some friends, he was for the first time unable to swallow readily. The disability then got steadily worse. His medical student fiancée had recently expressed the opinion that he was suffering from a spasm of the throat and from an inferiority complex.

A. B. was a very tall, gracious, and immaculate young man with a fresh fair complexion, rather anxious blue eyes, and a very

prominent and large lower jaw. His test swallowing of air involved a big movement, but he performed it without difficulty. He pointed out, quite truthfully, that his palate was anaesthetic to a normally adequate stimulus. When he was given a glass of water he held it to his mouth, tilted it a lot, made much play with lip movements, got red in the face, and swallowed small quantities with much apparent effort.

True to type, there were other symptoms behind the presenting one. The patient readily volunteered that he "wanted to confess to fear"; he had struggled against it since the age of 11. Before that time he had been fearless, especially in fighting, which he used to enjoy. From kindergarten days he had always fought upon the assumption that he would win. But at 11 he was involved in two fierce fights in the school wash-house. In the first the other boy did not wish to fight but A. B. did. The enemy fought very pluckily, but A. B. worked himself into a "tremendous fury" and at the end the other boy was "a nasty sight." In the second fight A. B. early received a glancing blow on the face near the jaw. Suddenly he felt he must run away or he would be "knocked to pulp." He acted on the impulse, and since then had never been able to hurt anyone or to stand anything approaching a row. Later on, as an adult, unreasonable fear had become attached to car-driving, cliff-climbing, and other adventures in which he forced himself to accompany an "utterly fearless" fiancée. Above all, he feared the occurrence of a situation where honour demanded that he should fight—e.g., an insult offered to his young lady.

A. B.'s interests were connected with refined city life. He was sociable, friendly, and humorous, and a Sunday-school superintendent. He described himself as likely to be a "perfect curate," and this occupation he has since adopted. But into his developing ideas about people there had crept an observant but peculiar interest in physiognomy. In his own mind he classified people into two types according to the shape of their jaws. Men or women of one, which he called the "aggressive" (meaning successfully aggressive) or "leader" type, had vertical ascending ramus to their mandibles and receding lower jaws with the upper front teeth more prominent than the lower. He held that, in contrast, a backward-sloping vertical ramus, prominent lower jaw, and protruding lower teeth, together with a small mouth, "caused" a recessive weakness of character. This "non-leader" type, into which the patient himself exactly fitted, also had thin lips and a small and quiet swallow, as opposed to the large mouth, full lips, large and noisy swallow of "leaders, children, and natural people." His fiancée was in this favoured category.

School associations were taken first. They led A. B. to remember an earlier incident in the school wash-house. The school bully had been publicly ducked in front of a yelling crowd, and "nearly drowned." He had been frightened by the sight itself and by the "lynching atmosphere." By free association from this sight A. B. next recaptured early fears of asphyxia—e.g., when a cushion was held over his face as a child and in an attack of whooping-cough. He was an only child. His mother (of "leader" type) had clouted him, his father (a "non-leader") grumbled and drank, and there were constant difficulties between the parents throughout his upbringing. Some alarming fantasies of drunken men hitting women, while he stood by terrified and powerless to intervene, led him to the recollection of actual attacks of fury with his father for upsetting his mother and making her cry. He had wanted to hit him.

A return to considering his contemporary fears, and especially the question, "Why could he never attack?" led him suddenly to the conviction that he had always felt that a blow on his jaw would be fatal. "They'd catch me there. And my jaw is so thin!" The discovery that his cowardice was due to an *imagined* inferiority increased his assurance; and A. B. now began to develop the themes, "If Father had only trained me I'd have been able to take care of myself," and, "Fighting is not bad fun if you're built that way." With some difficulty he managed to face in imagination the possibility of "administering physical correction in an extreme case on behalf of a lady." Then, partly freed from fear of disaster and spurred to a just cause, he imagined himself weighing in more heavily. With increasing gusto he went through the motions of buffeting a foe, to the accompaniment of appropriate remarks from an imagined audience: "Bravo, sir! Nice uppercut!" In the midst of this exercise he suddenly became very excited and exclaimed that something was broken. He had hit his opponent right on the point of the jaw. Immediately he saw a conservatory in which his father sat with his mother upon his knee. It was a well-remembered photograph from the family album, with Mummy in her long skirts that he used to peep under and a blouse with bones in the neck, and Daddy tired and retiring, "like an undeveloped twig, with his kindness and temper, lack of discipline with me and heavy-handedness with her." He was surprised they were so intimate.

At this point in his treatment there was a considerable change in his contemporary attitudes. With awkward colleagues he now required prayer to maintain his calm. He spat out aggressive remarks and then prayed for humility. He was no longer afraid

of physical consequences: the issue now was between passion and restraining principle. In the following session he disposed of an imaginary aggressor against his fiancée with mixed feelings of hatred and liking of the undertaking. To his intense satisfaction a return blow on his own "Achilles heel," the jaw, did not seem to hurt him. Then came a second crucial analytic hour. Feeling that "honour would attach to it," and with some reassurance from me about the physical effects, he first slapped in the face a man who was insulting his fiancée, and then—"Oh! I hate doing this"—went for a burglar who was hitting his mother, smashed his head with a poker, and throttled him. While he was trying in vain to see "the real cause" of his anger, his mother's assailant changed into a drunken man. He struck at him wildly, pulled his hair, sobbed, and then hit him crash on the jaw, nose, and mouth. Asked to see the face of his adversary, he found he could not, because it had a "Guy Fawkes mask on." The scene was repeated by request, and this time the "blinding rage" was absent "unless he does something extreme, such as jump on her." Then, "Oh! I can get it against Father! Oh! don't make me do that! I hit him, smash him to pulp, there, where Mother had phlebitis when I was 24." He lay on the couch and sparrowed away in mid-air, while his exclamations reached a climax of excitement and tears.

The case did not require to be taken much further into "deep" analysis. At succeeding sessions A. B. discovered, behind his own aggressiveness, fears that his father would in his turn attack him. He imagined himself a baby and his father lurching against him "as if in a sudden impulse of anger." Again, as quite a young child he had got a fish-bone stuck in his throat, and his father had apparently held his head under the tap as a remedy ("He might go on and I'd be powerless to stop him"). In reliving the incident he felt frustrated, hopeless, then acquiescent. Besides thus being at once an object and a source of aggressiveness, his father was associated with the forbidding of all pleasure. He had emphasized every risk in life, deliberately those of hitting and drinking (e.g., from public fountains), and by unintentional implication all those attendant upon personal desires. Oral pleasures had always been valued highly by this patient. Beneath his resentments against his father was much love for him, with many happy memories. But his father had been inferior in character to his mother, and A. B., with his weak character, deceptive jaw, and erring mouth, resembled his father.

The first beneficial effects of recapturing his "death wish" against his father was that A. B. developed a new efficiency at squash rackets. But after tracing all his fears to his complicated relations with his father—resentment, jealousy, identification in type, and underlying love—he felt that he could swallow as well as hit, and that, at least in the latter pleasure, there were few restrictions to the indulgence of his adult desires. He thereupon drank water without difficulty; and shortly afterwards he drank beer readily enough at his pre-marital bachelor celebrations.

A short review of the differences between adult and childhood aims closed the analysis at the 40th session. A. B. threw off the legacy with which the inability of his real father to lead him and to forgive and discipline his passions had left him. He was able to meet his adult requirements through a revaluation of aim and a reliance upon that "something more than Father" which chimed with his religious convictions.

Medical Memoranda

An Unusual Diphtheria Infection

Diphtheria infection of the mouth, anus, and genitals is not common, and its occurrence as a complication of childbirth and the puerperium must be rare. Faucial diphtheria in the newborn appears to be even more unusual. Rolleston (1939) was able to collect 12 cases (including only one personal case) of faucial diphtheria in the first two months of life. A clinical sequence of those two rarities is herewith recorded.

CASE HISTORY

Mrs. A., aged 24, was admitted to Thornton Isolation Hospital at 1.30 a.m. on July 29, 1941; temperature 101° F., pulse 144, respirations 28. She was extremely exhausted and pale, and looked gravely ill. She had been in poor health for some time. About July 26 she began to have discomfort in the mouth, followed by difficulty in swallowing and discomfort at the anus on the 27th. She was confined on July 28. Examination revealed an extensive thick grey membrane firmly adherent to the floor of the mouth, extending from the root of the tongue forward to the edentulous lower gum and also lining the sulcus between the gum and lower lip. The throat was acutely inflamed but showed no membrane. The submaxillary and submental glands were severely swollen. The anus and an area within a 2-in. radius were acutely inflamed and covered with thin grey slough or membrane. The membrane could be easily removed with a swab, leaving a raw wound similar to a burn a few days old. On each side of the vulva in the sulcus between the labium majus