CASE OF IMPACTED GALL STONES IN CYSTIC DUCT: OPERATION: RECOVERY.

By CLAUD F. FOTHERGILL, M.B., B.C.CANTAB.

THE following case was so atypical, and presented a train of symptoms so unlike one's expectations, that I think it sufficiently interesting to record.

A lady aged 24, married three years, no children, one miscarriage, gave a history of frequent so-called "bilious attacks," dating from the age of 12, when she had an attack of jaundice. The attacks consisted of headache, nausea, and some vomiting, and usually lasted a day, occurring at intervals of several months.

In August, 1909, she was seized with what seemed to her to be a bilious attack of unusual severity. At the time of onset she was on a trip to Norway, and happened to be in harbour. In addition to the usual symptoms there was abdominal pain, mostly in the upper portion of the abdomen. The ship's surgeon diagnosed the condition as "gastritis." The attack passed off in a day, but the patient felt very sore in the abdomen for the next three days.

In September, 1909, she had another attack much the same as the last and treated herself. I was first called to her on December 13th, 1909. An attack had started at 6 a.m., accompanied with headache and diarrhoea; she was vomiting bile-coloured material at frequent intervals and had moderately severe abdominal pain, worst around McBurney's spot, but there was also pain along the costal margin on both sides. The abdomen moved freely in respiration, there was no hyperaesthesia or anaesthesia; no tumour or thickening could be felt. The appendicular region was distinctly painful on pressure. The pulse and temperature were both normal.

Next morning, after the vomiting had ceased and the patient had become distinctly better, I arrived at the diagnosis of intermittent appendicitis, partly from the previous history but chiefly as the pain was worst in McBurney's area, although most other symptoms and physical signs were absent. She rapidly recovered, and I recommended an exploratory operation with a view to locating the trouble and probable removal of the appendix in the quiescent period, believing that further attacks were all but inevitable.

My advice, however, was not followed, and on the morning of April 18th, 1910, another attack occurred. At 11 a.m. the patient was almost incessantly vomiting muco-bilious material, without any trace of blood; there was considerable abdominal pain, quite acute around McBurney's spot on deep palpation. The pain was also severe on the left side, and she complained of pain in the back. She had no pain radiating into the shoulder, arm, or leg. The abdomen moved quite freely in respiration and appeared rather empty. There was no hyperaesthesia. The temperature was 98° and pulse 74.

At 5 p.m. her condition in spite of starvation remained much the same, with frequent vomiting.

At 9 p.m. I called Dr. C. M. Pennefather in consultation. He diagnosed "acute gastritis;" a soap enema was ordered and an opiate.

The vomiting ceased about 3 a.m. on April 19th, and the pain became decidedly better. On palpation it was worst one inch above and two inches external to the umbilicus on the right side. The left side was free from pain, even on deep palpation. She had five hours' sleep during the night, and at 11 a.m. on April 20th there was no pain except on deep palpation (in the same situation as on the previous day).

At 9 p.m. I was sent for urgently, and found the vomiting had restarted at 5 p.m., and was more frequent than before. Since 5 p.m. there had been frequent micturition, but no blood in the urine. The pain in the abdomen at the time of my arrival was so acute at McBurney's spot that I injected a grain of morphine hypodermically, having decided on immediate operation.

Operation.

Mr. R. P. Rowlands very kindly came down after midnight, and decided on an exploratory operation. The incision was made through the sheath of the right rectus, and we found the cause of the trouble to be a gall bladder tightly distended with muco-purulent fluid, and much enlarged, containing three large faceted gall stones, and two more (in all five) so tightly impacted in the cystic duct that the one was only removed whole with extreme difficulty, and the other had to be removed piecemeal with even greater difficulty. The gall bladder and cystic duct were involved in many adhesions. The incision into the gall bladder was closed, with a rubber tube sewn in with catgut as drain, and the bladder sewn to the anterior abdominal wall, the whole being carefully packed off with gauze.

The gauze was removed on the third day, the tube came out on the fourth, and the biliary fistula had completely closed by May 2nd (less than twelve days), and the patient made a straightforward recovery afterwards.

The interesting features of the case were: (1) Absence of positive symptoms and physical signs, and there was nothing which could be honestly styled biliary colic until a short time before the operation. (2) The difficulty of diagnosis between a simple acute gastritis, appendicitis, biliary colic, and in a lesser degree renal colic. (3) The

pulse never rose above 90, nor the temperature above 100°.

(4) Are some of the so-called "bilious attacks" to which a good many women are prone (and fewer men), really due to gall stones?

A CASE OF DERMATITIS ARTEFACTA, AND ITS SEQUEL.

By R. O. ADAMSON, M.D.,

GLASGOW.

DR. NORMAN WALKER'S interesting paper in the JOURNAL of June 18th recalls to me the only case of the kind that, so far as I know, I have met with, and its brief recital may interest some of your readers. The patient developed at a later period further factitious illnesses, which I shall also shortly refer to. As such cases bring mortification and worry to all concerned, by no means excepting the medical attendant, and as every practitioner may meet with an example, they are of some importance. Needless to say, a prompt diagnosis is amply rewarded; but, as Dr. Walker points out, it is one thing to diagnose the cause, another thing to prove it.

My patient was a young lady of more than usually attractive appearance, in whom I had detected, in a professional acquaintance of some years, nothing that might have suggested the morbid tendencies she came to exhibit.

STAGE I.

Her illness began with the unexplained development of some patches of "weeping eczema" on her face. It may be that the first patch was genuine. However that may be, there continued to appear on the cheeks, forehead, nose, neck, arms, and, later, thighs and legs, areas of the same type of cutaneous disorder, despite incessant treatment, and often these areas appeared in places covered with dressings and bandages.

The crop never failed for many months, sometimes better, sometimes worse. In the earliest stage of a patch there was an acute erythematous flush, like a scorch, which rapidly became moist, suppurated, and eventually healed by "crust." Their shape was often square, or linear, sometimes round. This linear element was an important clue in the final diagnosis. There was no difficulty in getting any one diseased area to heal, though it sometimes promptly relapsed. The feature of the illness was the endless succession of diseased areas; their number and situations, and the necessary—as it seemed—applications, kept the patient a prisoner in the house for many months, unrepresentable to her friends, almost in isolation. This was borne, on her part, with remarkable patience.

I need not detail the consternation of the family or the worry sustained by myself. I confess that the idea of the complaint being factitious never occurred to me. Those who have met with such cases for the first time may understand this want of imagination. I was also, I must say, supported in my sympathy for my patient by a skin specialist, who diagnosed "dermatitis herpetiformis." Naturally, no good resulted, and I was absolutely sure that, whatever it was, it was not that. In time the lady went to a well-known spa for treatment, and two, if not three, doctors saw her and treated her, with no benefit. Again the diagnosis of dermatitis herpetiformis was made, why, I cannot say, as the condition did not seem to me to bear any resemblance to that disease.

Finally, after many months, I regret to say, the whole story was laid before a well-known dermatologist, who, after hearing and seeing all, promptly diagnosed dermatitis artefacta. I felt he was right, and will not detail my own reflections.

And now for the sequel, to bear out what Dr. Walker says as to the trouble these can give and the tact needed. The attitude of the family was frankly unbelieving. The patient was not, of course, told anything, and treatment was continued as before. A nurse was sent into the house, to be with the patient all day, to sleep in her room at night, and her instructions from me were to detect the artifice. In two weeks nothing had been detected, numerous fresh areas of disease had developed, often under most carefully applied bandages, and the nurse, an excellent one, and all on my side at first, became convinced we were entirely on the wrong track. I was surrounded with an atmosphere of distrust and