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

approaching discredit. But it was clear that one nurse could not watch night and day, so trusting to the dermatologist and the conviction he had inspired, I insisted, as a last card, on the patient's removal to a nursing home, in which the lady's guardians, being fortunately reasonable people, at length acquiesced. There the patient was never left alone, night or day, and was never allowed to leave her room for any purpose, and the nurses knew well their duty; yet three days elapsed before a movement under the bedclothes led to the detection of the lady's hand holding most unsuspectingly a handkerchief, but in the handkerchief was a small ragged piece of pumice-stone! and thereupon this protracted case came quickly to a complete cure. I am ashamed to say that I understand no little "kudos" accrued to me from an indiscriminating public, which considered that at long last my patient efforts had restored a young lady's good looks and health.

STAGE II.

A year or two later this patient developed gastric pain, vomiting of blood, etc., and her guardians were much alarmed. Not to go into detail, I could detect nothing, and was conscious of some unreality in the matter; while the blood, of which there was plenty in evidence, had clearly not been in the stomach, despite its presence in vomited matter. For instance, it lay as a pinkish layer at the bottom of a vessel of vomited milk, and the milk was tinged pink. The patient's symptoms were clearly recounted, and her attitude seemed to be one of entire bonafides. What course my treatment would have run without my previous experience of her I know not, but after some days' careful observation I was certain her illness was feigned, and told her so, and there was an end of the matter. What her artifice was she did not disclose, nor, indeed, would she admit or confess anything, but her symptoms promptly ceased.

STAGE III.

Again, a year or more afterwards, she developed "obstruction of the bowels," that is, the bowels never moved, despite most drastic remedies administered before I was called in. Her guardians suspected nothing, and were much concerned about her condition. However, I presently told them that, in my opinion, the illness was feigned, and though they scouted the idea they promised me their help, and as far as they possibly could watched her night and day, and acted loyally to me, I believe, seeing that she took medicine and food, and so forth. The patient looked well, had no other symptoms, no distension, and enemata failed to produce any result. I ordered some pills which should have been cruelly effectual. These and other medicines she was seen to swallow. I cannot explain it, for I never obtained the information from her, but it is a fact that she was never known to have the bowels moved by those watching her for fully a month. Perhaps her friends weakened in the resolve to watch her constantly and everywhere. The patient, at any rate, never faltered in her statement that no action took place, and described her discomforts accordingly. I mention these facts to show the hopelessness of treating such patients at home, for the general public simply cannot realize this kind of case at all.

I was not disturbed about my patient, but sure that she was hoodwinking those around her, and to put an end to the farce I insisted on her going into a home, and again she was put under the care of two nurses, and strictly confined to her room. I wonder at her mental attitude in allowing herself to be taken so far to certain detection. She received in the home some active aperients of simple nature, and a full dietary, with a result as entirely satisfactory to me as it ought to have been ignominious to her. If it was, she did not show it. She was sent home immediately, cured, after an interview with me which I am hopeful was the means of keeping her well till now—that is, for several years. I regret I never examined the sensitiveness of her palate.

In other respects this patient is a bright and pleasant girl, and no one would, I think, suspect her of these "hysterical" tendencies. Of the many strange things met with in practice, I regard my experiences with this young lady as amongst the strangest.

Memoranda:

MEDICAL, SURGICAL, OBSTETRICAL.

SNUFFED POWDERS IN CORYZA EX FENO.

As Bristowe recited, the great Dr. Elliotson, in the earlier part of the last century, suggested the pollen of various grasses as the cause of "hay fever," and Mr. Blackley, himself a sufferer from that troublesome malady, published a book on the subject, in which after many researches and observations the conclusion is reached that Dr. Elliotson's suggestion is verified. Blackley thought that the local effects of the pollen were partly mechanical and partly chemical; to the eyes, conjunctivitis; to the nose, coryza; and to the bronchial tubes an irritative asthma.

As to coryza ex feno, may I suggest to my brethren a seasonable local medicament?

Of all iamatology, of all discourses on remedies for diseases, precise magistral formulae are the best for the busy medical practitioner. Here is a very useful one, of my devising and frequent using, and opportune at this time when grasses flower and susceptible persons suffer from their annual catarrh:

R. Pulv. pimentae bac. ... 3j
Ol. eucalypti ... miiij
Misce; fiat pulvis. To be used frequently as a snuff.

This mixture of allspice and eucalyptus carries not the intention of a sternutatory, ptarmic, or sneezer, but, rather, is an errhine, producing a substitutive discharge of healthy pituitary mucus, in which *materies morbi* are killed and washed away.

In the present preparation the pimento is a local stimulant and antiseptic, and the latter quality is accentuated by the co-operation of the eucalyptus.

Experto crede. Long ago I discovered allspice as a virtuous succedaneum for snuff of tobacco and as an excellent medium for the local exhibition of certain other medicaments.

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A CASE OF DIVERTICULUM OF THE UPPER PART OF THE BLADDER WITH A PATENT URACHUS.

Mrs. B., aged 33, mother of two children, was admitted to the Adelaide Hospital on March 1st, 1910. She complained of inflammation of the bladder, which gave her great pain on micturition, and obliged her to pass urine very often. She also complained of umbilical hernia. Her bladder trouble seems to have begun about four years ago during her first pregnancy, when she had some difficulty in micturition, and for a time passed most of her urine by the umbilicus. She has micturated naturally since the birth of her child, but the act has become increasingly painful. The urine now is alkaline, and contains pus.

She is a thin woman, with obvious asthmatic breathing. On examining the bladder the sound could be insinuated into a cavity at the top of the viscus, and it could then with some difficulty be got into a further passage, and appeared under the umbilical scar. The patient was anaesthetized, and an incision about 3 in. long was made in the middle line below the umbilicus. A broad band containing dilated veins, and having the appearance of a varicocele, was found adhering to the parietal peritoneum. In this band the dilated urachus was contained. The peritoneum was opened on either side, and the incision prolonged downwards to the pubis. When the bladder was exposed it was found to have a large diverticulum at the top, with the urachus attached to the apex. The appearance of the bladder, with its diverticulum, reminded me very much of an hour-glass stomach. The narrow neck between the diverticulum and the true bladder was clamped and divided, and then the urachus, together with the whole area of abdominal wall which comprised the umbilical bulging was removed. The opening in the bladder, which was about 2½ in. long, was then stitched up with a double row of catgut sutures, taking care not to penetrate the actual mucous membrane. A small drain was fixed in the lowest part of the bladder incision, so as to reduce to a minimum the risk of leakage.