HYSTERIA FROM A SURGICAL STAND-POINT.[1]

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HYSTERIA is usually considered to be strictly within the province of the neurologist or the general practitioner, but surgeons meet with it in many forms, and, should they fail to recognize it, will frequently be guilty of grave errors in diagnosis and prognosis.

Hysterical symptoms frequently appear as a post-operative complication, and when unrecognized may lead to unnecessary anxiety. A rise of temperature is not a part of the clinical history of hysteria, but we may have a post-operative rise of temperature in an hysterical patient, which cannot be accounted for in any other way than by calling it a neurotic temperature. I recently performed a curettement upon an hysterical patient who developed mild delirium and a temperature of 102.8° F. on the second day. She reminded me that some three years previously, when I had performed a trivial operation upon her, she had had fever which had been relieved by injecting medicine into her arm. I ordered the nurse to administer an eighth of a grain of morphine hypodermically, and in two hours her temperature had disappeared. We have doubtless all been worried over a temperature of this character following a laparotomy.

Persistent hiccough after the administration of an anæsthetic is sometimes purely hysterical. I remember one instance in which this symptom was so persistent that I began to fear for my patient's life, when I ascertained that

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her father had hiccoughed for three days before he died, and that she had always feared that she might die the same way. She was given the positive assurance that her condition was so entirely different from her father's that she could not possibly die in that manner, and an enema containing assafœtida was administered, which gave prompt relief.

Persistent cough or emesis following an operation may be purely hysterical.

I once operated upon a splendid specimen of physical manhood who suffered from aphonia for some days afterwards, which I was at a loss to explain, until I learned that he had suffered from a similar attack immediately after some business reverses. Every laparotomist should be on guard against phantom tumors.

When a neurotic female presents herself for surgical treatment, and the subjective symptoms are out of all proportion to the objective, we should be upon our guard, for operations under these circumstances are seldom of more than temporary benefit. These patients frequently derive a morbid pleasure from operations, and are perfectly willing to submit to the most dangerous surgical proceedings, when, by careful observation, the surgeon may satisfy himself that their sufferings are purely imaginary. Such patients should go to the Osteopaths or Christian Scientists, and add to their list of marvellous cures rather than fall into the hands of unscrupulous, would-be surgeons.

I recently saw a woman who had had her "rectal pockets" slit up and her ovaries removed, and who had called me, expecting to submit to an operation for appendicitis. Her abdomen was rigid all over, and she complained of exquisite tenderness upon pressure over the right inguinal region, but her temperature and pulse were normal. She had all the symptoms of hysteria minor, and seemed quite disappointed when informed that she did not have appendicitis and did not need an operation.

Hysterical hyperæsthesia, anæsthesia, paresis, or seemingly complete paralysis may be so mingled with real patho-

logic conditions as to mislead the most skilful diagnostician. I have found Patrick's suggestion with reference to the rapid shifting of the border of the affected area in hysterical hyperæsthesia or anæsthesia a very valuable aid in diagnosis. (Gould's "Year Book," 1897, p. 805). If the hyperæsthetic area be outlined and lightly marked, and another examination be made a few minutes later, the outline will have changed.

It is in joint and spine ailments that the surgeon is most likely to meet with hysteria, and it is of so frequent occurrence here, and ofttimes so closely resembles real disease, that he must ever be on his guard lest he mistake the shadow for the substance. Sometimes the hysterical joint-affections so closely resemble tubercular joints as to deceive very good diagnosticians, but ordinarily one needs but to know that there is such a malady as an hysterical joint to be able to recognize it.

The hysterical joint usually, but not always, follows an injury. There may be slight atrophy, but it will only be such as is due to non-use or bandaging of the limb, and should not be mistaken for the marked atrophy accompanying tuberculosis. In hysteria there is no local rise of temperature, but it may be subnormal. There is no marked swelling, although there may be slight puffiness about the joint. There is marked restriction of motion in hysteria, but it differs very materially from that so characteristic of tuberculosis. It varies from one minute to another, and may temporarily disappear when the patient's attention is directed to something else. The muscular spasm is very different from that of tuberculosis. It is more marked, and is voluntary in character.

An hysterical joint is usually deformed. The deformity is apt to be a flexion, more marked than in real disease. In some joints, for example the hip, the deformity may be greatly exaggerated and different from what would be expected from disease.

In making a diagnosis the age and sex are to be borne

in mind, hysteria being more common in young women, although it may develop at any age and in either sex. When convulsions or other hysterical symptoms are present they may be helpful to the diagnostician, but it is quite possible for an hysterical person to have a tubercular joint. I have one case of hip-joint disease under treatment at the present time, in which the hysterical symptoms cause the friends more anxiety and me more trouble than does the tuberculosis.

An hysterical joint occurs, as a rule, in an hysterical patient. The pain is not that of an inflamed joint, but is an hyperæsthesia. The deformity may resemble very closely that of tuberculosis, but there is a difference. The symptoms are all exaggerated, and the whole condition gives the experienced examiner the impression that the patient is playing a part.

The prognosis is good, for while some cases are very persistent, they eventually recover. It is said that a hysterical contraction may become permanent, owing to organic changes brought about by the prolonged abnormal position, but such a condition has never come under my observation. Were it not that some very able observers have reported this condition, I should think that an error in diagnosis had been made, for in numerous instances, where a joint had been flexed for a long time, I have seen such speedy relief as to preclude all possibility of the presence of any organic change. The miracles performed by various pretenders are doubtless of this character.

Hysterical patients, fortunately, are very susceptible to suggestion, and what one does for them is not so important as it is to insist that whatever is done will cure them. I have obtained the best results from administering an anæsthetic, reducing the deformity, or rather, allowing it to reduce itself, holding the limb in proper position for a short time, and insisting that a cure had been wrought, and that the patient is able to walk. Very little of the anæsthetic is necessary, as they yield to it very quickly.

It is questionable if a cutting operation is ever necessary for the relief of an hysterical deformity. Tenotomy is a very safe procedure, and it may be justifiable in an extreme case. I believe, however, that the operation helps through suggestion rather than by relieving contracture. Cases reported in which organic changes are said to have taken place in the spinal cord following hysterical contractions should not be classed as hysterical cases, as they are evidently cases of organic disease, and if hysteria be present at all, it is merely a coincidence.

It is comparatively easy to make a diagnosis of an hysterical spine, because the deformity does not resemble that of disease, and the patient complains of extreme pain and sensitiveness at the seat of deformity, which does not obtain in real disease.

Since comparatively little has been written upon this interesting topic, I will give briefly the history of a few selected cases, illustrating hysteria as met with by the surgeon.

CASE I.—A young woman from North Dakota, referred to me by Dr. Hall, of Minneapolis. She was eighteen years old, fair-haired, blue-eyed, red-cheeked, well-developed, and healthy-looking. She gave a history of having had a fall some months before, injuring her hip, from which she had been lame ever since. Upon examination I found the right hip flexed and adducted to a marked degree, just as one would expect to find it in a dislocation upon the dorsum. Upon manipulation, a distinct slipping, as of the head of the femur upon the dorsum of the ilium, could be felt and heard. The temperature was 100° F., and the patient complained of great sensitiveness of the joint. There was slight atrophy of the affected limb. The thigh could not be abducted or extended to the normal limit, and the patient complained bitterly of efforts in that direction. She had been to a local osteopath, who had pulled her leg both literally and metaphorically.

My diagnosis at this time, based upon the history as I understood it, and upon the temperature, atrophy, and deformity, was traumatic subluxation of the hip, with a subacute synovitis,

due to the violent manipulation of the quack. Owing to the large amount of adipose about the patient's hips it was impossible to decide whether the trochanter was above Nélaton's line or not. I applied a long extension splint, which seemed to hold the limb in proper position and to relieve pain. After a couple of weeks the temperature had disappeared, and the patient seemed to be doing so well that I allowed her to go to her Dakota home, wearing the splint. For three months reports from the family and physicians were very favorable. At the end of four months came the report that she was very much worse; that the brace no longer prevented the hip from slipping, and that the knee was flexed and rigid. The family physician reported that she had hysterical convulsions. My suspicions were at once aroused, and I advised the patient to come to Minneapolis, to the Northwestern Hospital, immediately, which she did.

I found the hip the same as when I had first examined her, save that there was less tenderness and no rise of temperature. The knee was flexed to a right angle and perfectly rigid. It was perfectly normal in appearance and without local heat, although the patient complained of great tenderness in it. I at once made a diagnosis of an hysterical knee, with a strong suspicion that the whole trouble was hysterical. I announced to the hospital internes my intention of performing a miracle, and ordered them to chloroform the patient. As soon as a few whiffs of the anæsthetic were taken, the contracted muscles began to relax, and the limb fell into its normal position, with nothing but its own weight to aid it. Both joints were normal. A plaster cast was applied from the toes to the umbilicus, and the patient was assured, upon regaining consciousness, that she had been cured. At the end of a week the case was removed and the patient told to walk, which she did, and she has been able to walk ever since.

What deceived me at first was the rise of temperature and decided slipping of the joint, together with the understanding I had that she had been unable to walk since the accident. I have since learned that she had walked for some time after the accident. This patient shortly afterwards developed a curvature of the spine, which differed in appearance from any curvature due to disease, which improved

very rapidly under very strong—and consequently painful—shocks from a static machine. This patient can cause a click in that hip at will, which can be heard and felt. I have placed my hand upon the trochanter, with the patient standing, and tried to make out just what happened. She throws her weight upon the limb and suddenly rotates the femur forward, causing the tendons of the glutæus minimus, pyriformis, and obturator internus to slip over the top of the trochanter with a snap. Dr. Shaffer, in his paper on "The Hysterical Element in Orthopædic Surgery," has given a very satisfactory explanation of the knee-click, but I have never heard the hip-click explained, and offer the above explanation, which, after careful study, I believe to be correct. The temperature she had when I first saw her was probably due to an inflammation of the bursæ under these tendons.

The prompt relief afforded by treatment in this case is, of course, conclusive evidence of the correctness of my diagnosis.

Another characteristic point is the small amount of anæsthetic required to relax the spasm, for while it is possible to relax the spasm due to tuberculosis, it requires profound anæsthesia.

CASE II.—In May, 1897, I was called by Dr. J. T. Moore, of Minneapolis, to see a young woman from the southern part of the State, who claimed to be a great sufferer, and who had come to the city to have an abdominal tumor removed. About two years ago she was examined by a local physician, who told her that she had a tumor in her abdomen, which he proposed to remove. She came to Minneapolis at that time and was examined by Dr. Moore, who told her that he could find no tumor, and advised her to go home. Since that time she has written several times to the doctor, telling him of her great suffering. Once within that time her home physician has written, stating that the tumor was growing quite rapidly, and that he feared it would soon become inoperable.

In appearance the patient was as healthy a nineteen-year-old girl as you could find in a day's journey. In trying to get a his-

tory, about all I could elicit was that two years ago she had been told that she had an abdominal tumor, and that she had been a great sufferer ever since.

Upon examination we found the pelvic organs perfectly normal. When we undertook to palpate the abdomen she complained of the great pain it caused her. After a little, however, her rigid abdomen relaxed, and we could feel a large solid mass just below the umbilicus, which we soon found to be the spinal column. We then found that there was marked lordosis, and that the lumbar spine was several inches from the table when she laid upon her back. We then had her stripped, when she showed the characteristic gait and deformity of a double congenital dislocation of the hip. Both trochanters were fully two inches above Nélaton's line, and the lumbar spine was so arched forward that it could readily be felt through the abdominal wall. This girl has a decided tumor in her abdomen, but one that causes no pain, and one that few would care to operate upon. Her pain is clearly in her mind, and she probably would never have had it had she not been told that she had a tumor, for that same tumor had been there for seventeen years without causing her the least pain. She was not at all pleased with our diagnosis and prognosis, and was decidedly disappointed when we sent her home without an operation.

CASE III.—I was recently called by Dr. Emily Fifield, of Minneapolis, to see a patient, about fifty years old, who stated that she had been a great sufferer all her life, and that for many years her uterus had been paining her so much that she had finally made up her mind to have it removed. She stated that she had had her cervix "fixed up" some time before by a Boston physician, but without benefit. She was very emphatic in her statement that she would not submit to anything short of a vaginal hysterectomy. She was so exquisitely sensitive that a satisfactory examination could not be made. We finally persuaded her, however, that she did not need so grave an operation as an hysterectomy to relieve her suffering, and gained her consent to do what we might deem advisable after examination under an anæsthetic. She was sent to the Northwestern Hospital, where an anæsthetic was administered, and upon examination we found that she had no uterus. The enterprising Boston gynæcologist who had "fixed her cervix" had evidently removed

that organ without saying anything to the patient about it. Her vagina was packed with iodoform gauze, and she was assured, upon regaining consciousness, that her uterus would cause her no more pain.

CASE IV.—Last month I was called by Dr. P. M. Holl, of Minneapolis, to see a patient of his, who had met with an accident to her knee some months before, and had been unable to walk since. At the time of the accident, the doctor stated, he found a small wound over the patella, caused by the point of a nail. He dressed it properly and obtained prompt union, but the patient complained of great suffering. When I was called, the doctor stated that he could see nothing wrong with the knee, but that his patient was very nervous and complained of pain. Upon examination I found the whole limb slightly atrophied. There was no swelling, but when I made pressure upon any part of the knee the patient complained of pain. When she was busily engaged in conversation, however, she did not notice pressure. She would not bend the knee, or allow it to be bent, but I had no difficulty in bending it when her mind was upon something else. This was an hysterical joint, pure and simple. The atrophy was due to the bandaging of the limb.

The patient was ordered to apply a domestic remedy that had been strongly recommended by her mother, and was directed to begin to walk after a certain number of days. We stated very positively that she would be able to walk quite well in three weeks. In four weeks she was perfectly well.

It is well to remember that it is not safe to make the time allotted for recovery too short in a case of this kind, lest our prediction may not come true, and the power of our suggestions be greatly diminished.

CASE V.—The patient, a female, nineteen years of age, came to the Northwestern Hospital from the southern part of the State. She had been confined to bed for about three months by severe pain in her back and hips. Upon examination I found exaggerated reflexes and great sensitiveness in both lower limbs. There seemed to be restriction of motion in both hips, but not of the kind met with in hip-joint disease. She stated that her limbs had grown very much smaller during her illness. She said she could not walk on account of the slipping of her hip-joints. When asked to stand, she could only do so when supported by

two nurses. By placing the hands over the trochanters a peculiar slipping could be felt in both hips, and her joints looked as if they were dislocated, but the trochanters did not rise above Nélaton's line. The restriction of motion and deformity did not resemble very closely any disease or deformity with which I am familiar. I had my suspicions, but, for fear of making a mistake, I requested Dr. Jones, a neurologist, to examine her, to exclude, if possible, a spinal cord lesion. Dr. Jones pronounced the case one of hysteria, and she was treated accordingly, and in a few weeks went home perfectly well. The slipping in this case was exactly like that in Case I, and was undoubtedly caused in the same manner. The slipping and snapping of those joints and the position the patient assumed when required to stand excited the sympathy of all the nurses, and had already deceived a number of competent medical men.

CASE VI.—Quite recently Dr. Ames, of Minneapolis, referred a maiden lady of uncertain age to me for an examination and opinion. She stated that there was something alive in her abdomen; that she wanted it cut out; that, after eating a meal, she could feel "him" crawl up from the lower part of the abdomen to her stomach, and, after eating what he wanted, he would return. Upon a careful examination I found a floating kidney and hæmorrhoids, and advised her that, if these were properly cared for, her dyspepsia would probably be cured. The last report from this case was that "he" was making regular trips up and down her abdomen at least three times a day, and that she believed that her only salvation was in a laparotomy.