CONCLUSIONS

In experimenting with the transplantation of a dog's kidney to the neck, the question of hydronephrosis may become of importance. The signs of a developing hydronephrosis are quite characteristic. They consist of an apparent enlargement of the kidney which has been secreting satisfactorily, as can be easily observed in the neck, and hypertrophy of the ureter, which is evidenced by a strong squirting of a stream of urine away from the dog.

DERMATITIS FACTITIA COMPLICATING
HYSTERICAL PARALYSIS *

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REPORT OF CASE

History.—Miss M. G., aged 28, unmarried, white, was referred by her physician to the Massachusetts General Hospital with a diagnosis of osteomyelitis because of pain and paralysis of the leg with a cutaneous lesion involving the foot and leg.

The present illness, as told by the patient, began eight years before when she and her cousin were "fooling" around with a male boarder at the cousin's home. As the patient was walking down the front steps, the man stretched out his foot, tripping her and causing her to fall three or four steps. She remained unconscious all night, and the next morning found that there was soreness in the left hip and sharp localized pain on attempted motion. She felt "sick all over" and was kept in bed for two weeks. Then on attempting to walk she experienced severe pain in the left hip. She felt determined to be up and around, however, and in order to lessen pain, held the left leg stiff and dragged it. The pain persisted and after a time she found that the leg was becoming rigid and could not be bent easily. About a year after the fall her physician applied a wire splint, which extended from the waist to the ankle and immobilized the entire left leg. This was worn continuously for two years, the pain being present only at times. Since wearing the splint she had never been able to walk without crutches, and the leg had been stiff at the knee and ankle and to some extent at the hip. During the previous year the pain had extended from the hip and now involved the entire leg. The pain was described as deep, sharp, and interfering with sleep. Cutaneous sensibility in the entire leg had been impaired almost from the beginning of the present illness.

About three years ago, the patient experienced a nervous breakdown, which her physician said was probably due to the monotony of sitting still and sewing. This began with increasing irritability and crying spells, which later developed into what was called "meningitis." This so-called meningitis came on gradually at first, with pain in the lower spine, which worked up to the head. The entire duration of this meningitis was about two years, the patient being confined to bed continuously for fifteen months. She had many convulsions, usually accompanied by unconsciousness and sometimes by opisthotonos, and she was catheterized frequently. She did not recall whether she had any fever, or any incontinence of urine or feces during convulsions. She never bit her tongue. Toward the latter part of her illness she had frequent severe abdominal pain directly after eating, followed by vomiting. She said that she had many "abscesses" up and down her spine. During those two years of "meningitis" almost daily hypodermic injections of morphin were given by her physicians, and for the latter five or six months sometimes twenty or thirty injections a day (!) both for the relief of pain and for spasms.

During the past ten months the patient had lived at a sanatorium in Maine where she went for the relief of morphin-

ism, and it was from there that she was sent to this hospital for the skin condition, pain in the leg, and vomiting. During the past three weeks she had vomited after nearly every meal.

According to the patient the skin eruption on the left foot, leg and thigh had been present for the past two or three months. Her description of its development is enlightening in view of our own findings:

"It began first on the big toe and looked like purple blotches. These spread over the foot and up the leg, usually purplish at first, sometimes red. Sometimes the blotches would persist for several days, and then little drops of blood would ooze out." The patient stated that on several occasions she had witnessed the drops of blood "ooze out." There was some soreness in the skin lesions, but no pain or itching.

The family history revealed that the mother had a nervous temperament, one paternal aunt had nervous attacks of choking and spasms, and the father had congenital nystagmus; otherwise it was negative.

The patient had had an appendectomy ten years previously; had always had occasional headaches; had had nystagmus since birth; had worn glasses for near-sightedness since the age of 9; had had transitory blurring of vision for ten years; had had double otitis media following measles five years previously; had worn upper and lower false teeth since the age of 18 because her teeth decayed; had had pleurisy during childhood; had always been constipated; had had attacks of vomiting ever since she could remember; had had irregular, painful and scanty menstruations, the last period occurring six months previously; had had nocturia for four or five years, and two years before had passed stones by the urethra accompanied by pain and hematuria; had had occasional fainting spells since childhood, and had never weighed over 100 pounds.

Examination.—The left leg was the interesting feature of the physical examination. The extremity was almost rigid in extension, only slight flexion was permitted at the hip because of pain; the knee allowed only the slightest possible movement, and the ankle was slightly movable. There was complete anesthesia to touch from the hip down; a pin prick, however, was perceived as a tactile sensation. The sensory disturbance was less marked on the posterior aspect of the leg.

Sense of position in the toes was completely lost. The knee jerk was not obtained, and the plantar reflex was sluggish. Reflexes elsewhere were normal. Over the dorsum of the foot, extending just beyond the base of the toes and upward over the medial, anterior and lateral aspects of the lower leg, also on the inner aspect of the heel, there were areas of vertical, parallel, short scratch marks, some with adherent crusts of dried blood. Over the foot, especially, there was a diffuse background of dull red or purplish discoloration, which, however, was absent higher on the leg. On the lateral aspect of the thigh there was a discrete area, the size of a half dollar, consisting of vertical parallel scratches without any discoloration.

The skin elsewhere was normal; there were no scars or other evidence of abscesses over the spine such as the patient described. There were no other neuromuscular disturbances except for the nystagmus, which was congenital, and paralysis of the external rectus muscle of the left eye, of uncertain duration. The remainder of the physical examination was essentially negative.

Roentgen-ray examination of the involved leg disclosed some atrophy of all the bones but no involvement of any of the joint surfaces. The systolic blood pressure was 155, diastolic 100. Temperature and respiration did not vary from normal. The pulse averaged 90. The urine showed a very slight trace of albumin, many white blood cells and epithelial cells, but no casts. The Wassermann reaction and the white count were not taken, but there is no reason to believe that they would have added any information of importance.

A steel phonograph needle was found in the patient's hand bag. On the point of the needle there was a small red

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stain, which was demonstrated both chemically and morphologically to be blood. When the stain was dissolved in physiologic sodium chlorid solution, hemin crystals were obtained, and red blood corpuscles could be seen under the microscope.

When confronted with our evidence the patient denied that the dermatitis had been self-inflicted. The facts, nevertheless, are interesting, especially the objective appearance of the skin with the obvious scratch marks, as contrasted with the patient's description of the development of the lesions.

Treatment and Result.—Our treatment consisted largely of psychotherapy, together with active exercise and passive movements. Dr. Robert F. Loeb, who had the immediate care of the patient during most of her nine days' residence in the hospital, explained in detail the nature of her disorder, and endeavored to rationalize it for her. We were unsuccessful in discovering any repressed emotion as a cause for the hysterical manifestations during the past eight years, but from the circumstances attending the onset, it is not improbable that the patient told us only part of the story. However, we did not insist on learning the details, but advised her to confide in some one who was sympathetic and who could be trusted whenever situations arose with which she was unable to cope. In spite of her "severe pain" we found it necessary to give chloral hydrate only once, and acetylsalicylic acid only on a few occasions. No treatment

undoubtedly has a neurotic predisposition as shown both by her family history and her past history. It is quite understandable how a mental conflict lodging in such a soil can produce the hysterical picture described.

The lesson to be drawn from the cutaneous lesions is that, first, the appearance of the lesion is more to be trusted than the history, and second, a lesion that is obviously artificial in appearance is probably artificial in etiology. Such self-inflicted injuries may be done to excite sympathy, to escape duty, to assist in winning damage suits, or occasionally, as is probable in this case, they may be done in a state of amnesia or semi-consciousness.

As illustrating that the neurologic condition described above is not rare, a companion case was recently discharged from this hospital relieved of a spastic paraplegia with anesthesia of over two years' duration. The history, examination, and treatment were essentially similar to the foregoing case, except that there were no cutaneous lesions. On entrance the patient was entirely unable even to stand; she did not feel the floor under her feet. After remaining in the hospital two months, she was able to walk unassisted,

Dermatitis factitia produced by a steel phonograph needle.

aside from cleanliness was needed for the skin lesions. The patient, herself, requested not to be given morphin. She seemed intelligent and desirous of getting well.

It is always gratifying to know that our measures have been successful. The patient was sent back to the sanatorium in Maine, and both she and her physician were told that there was no organic trouble and that she would recover complete use of her leg by following rational treatment—active exercise, passive movements, massage, and above all a proper mental attitude, realizing that her paralysis was due to functional inhibitions and that the skin lesion was self-inflicted, even though she herself may not have been actively conscious of the act. Two weeks later one of the nurses of this hospital received a letter from her, which reads in part: "I'm getting on fine—can get about my room without crutches, although I often lose my balance and my strength leaves me, but I shall persevere until I can do better."

COMMENT

This case illustrates a condition that is well recognized, but not as generally, apparently, as it should be. It brings out the contrast between treatment and mistreatment. In other words, a patient who has been an invalid, unable to walk without crutches for eight years, finds herself in the course of three weeks under rational treatment perfectly able to use her "paralyzed" leg and to walk without crutches. This patient

and sensation had returned. A few weeks after discharge a letter was received in which she stated that her improvement had continued, and that she could go up and down stairs and could walk almost as well as ever—and this after two years of invalidism, treated by her local physician for "incurable spinal trouble."

Striking the Source of Infection.—A knowledge of the physical conditions and the regulation of the personal hygiene of the individuals making up a unit or closely associated group is fundamental in all community health activities. It is the custom nowadays for a municipality or state to pass drastic laws regulating garbage disposal, the location of corrals and pig styes, the cleanliness of slaughterhouses, and the distribution of milk and foodstuffs. . . . While such laws may be rigidly enforced, a typhoid carrier, a victim of tuberculosis, or one who has a mild case of any one of the serious communicable diseases, may sow these diseases broadcast. One tuberculous person or typhoid carrier in a community may do as much harm to the individuals therein as lax enforcement or even nonrecognition of the laws pertaining to sanitation. It is not difficult to see the incongruousness of a regulation which requires the screening of foodstuffs and at the same time makes no provisions whatsoever for determining whether the person who prepares the food or distributes it is a typhoid carrier—John Sundwall, *Pub. Health Rep.*, Nov. 7, 1919.