MODERN MYSTICISM

The psychology of insanity, the psychologic interpretation of the symptoms, is one thing, psychoanalysis is another. The psychology of insanity is a legitimate field of inquiry, though from the very nature of the subject its results must be largely speculative. Psychoanalysis, on the other hand, is a cult, a creed, the disciples of which constitute a sect. To be admitted to its brotherhood, it is merely necessary that the novice should be converted to the faith, not that he should be convinced by scientific proof; for none such is possible. If the convert claims that he has found psychoanalysis followed by cures, he places himself side by side with those who claim cures by means of hypnotism, divine healing, Christian Science and like procedures.

Psychoanalysis is an outcome of the general mystic tendency of the modern world. Occultism and symbolism in art, music, literature and the drama—cubism, futurism, modernism, the problem play—are all expressions of this tendency. On what basis are we to explain such phenomena? Factors which influence the social condition, the mode of living, of great masses of people, all have to do with this psychopathic tendency. Among them we may enumerate the strain of modern living, the strain of the adaptation required by rapid rise in social level with its unaccustomed demands and new dissipations, the strain of the struggle of those who have not yet achieved their goal, and to this we should add the lateness of marriage and the difficulties of living a normal, a physiologic, a complete life. Under these circumstances the less stable and weaker minds lose their moorings. That which is old and has perhaps been acquired slowly, with difficulty and at great cost is forgotten. Truth is rejected for no other reason than that it is old.² New things are accepted for no other reason than that they are new. There is an abandonment of all previous standards. The mind is unhinged and takes refuge in mysticism. The real gives place to the unreal, the beautiful to the unbeautiful, the wholesome facts of life to the morbid untruths of disease; actual experiences are belied by pathologic illusions; the evidences of the senses are replaced by the phantasms of exhaustion. To the jaded and blasé psychopathic patient, to the chronic hysteric, psychasthenic, hypochondriac or what not, to the patient who has tried all sorts of procedures, psychoanalysis presents something new, something interesting, something pruriently exciting.

Of course, such a procedure must have its vogue; indeed, it bids fair to acquire, as have other mystic methods, an epidemic character. That physicians are found not unwilling to profit by the material advantages of such an epidemic is both sad and true, though happily the members of this sect form as yet but a very small percentage of the general body of physicians. Indeed, very few prominent names appear among its votaries. Just at present two, perhaps, are especially in the limelight, Bleuler and Jung. The case of Bleuler, because of the position which he holds at Zurich, is particularly to be regretted. In so profoundly neuropathic an affection as dementia praecox, he gives to psychoanalysis the first, if not the only, place in treatment. Further, as Hoche points out, he is responsible for the fact that in Switzerland to-day ministers are practicing psychoanalysis among their flocks, and women school-

teachers among their pupils! As regards Jung, the world cannot but look on his recent explanations, apologies and "sublimations" as in the nature of a retreat, a retreat which began last summer at the International Medical Congress in London, and which, though adroit, is none the less a retreat, the end of which is merely a matter of time.³

The prophecy can with safety be ventured that psychoanalysis will in due course pass away, will in due course be a matter of history and it will then take its place side by side with other mystic practices, such as animal magnetism, mesmerism, braidism, hypnotism, metallothrapy, Perkinsism, Dowieism, Eddyism, Worcesterism, divine healing, New Thought, the Bergeon treatment of tuberculosis, hanging in locomotor ataxia, and other weird procedures that have time and again swept the earth in epidemic form.

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RUPTURE OF THE INTESTINE

WITH SPECIAL REFERENCE TO ITS EARLY
DIAGNOSIS

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Rupture of the intestine, variously designated "sub-parietal," "subcutaneous," "traumatic," "rupture produced by blunt force," "rupture without external wound," "concealed," etc., relies for its great interest on the distinguishing characteristic of its happening without penetration of the abdominal parietes; on the high mortality attending such injuries, varying among different reporters from 58 to 92 per cent. in cases with operation, and on the comparative rarity of its occurrence. During a ten-year period, according to Campbell¹, only eight cases occurred in 13,060 surgical admissions to the Montreal General Hospital, which is favored with a large emergency service.

The manner in which this injury occurs may be by one of three methods, in the following order of frequency:

1. Compression of the intestine between the vulnenerating force and the vertebral column or pelvis. This is most likely to take place in that portion of intestine hanging down in the pelvis.
2. Violent oscillation of the fluid contents of a loop of kinked intestine, resulting in its bursting. This is most apt to occur in that portion of the intestinal tract which is endowed with a long mesentery.

3. A laceration of the intestine at its mesenteric attachment by being carried beyond the range of its normal mobility. Those portions of intestine which possess a short mesentery are most prone to this insult.

If the damage is consequent on compression, the perforation may be anywhere and have any form and any size; whereas, if it has been produced by oscillation, the perforation will be found at the point of least resistance, namely, opposite the mesenteric attachment, and is usually round and small. The victims of this accident are to be found among those exposed to violence, chiefly young men, though occasionally active young girls are the sufferers.

2. "A rejection of everything old because it is old is mischievous in its tendency. It is a spirit of literary licentiousness which seeks a reputation for genius and originality by thinking as no one has ever thought before, courting singularity for the sake of notoriety."—John Ludlow, provost, University of Pennsylvania, 1834-1853.

3. See also the first number of the Psychoanalytic Review.
1. Campbell: Ann. Surg., 1905, xlii, 601.

Disease of the bowel wall, intestinal adhesions and hernia are the recognized predisposing causes of rupture. The immediate causes are: blows on the abdomen from flying pieces of lumber, a man's fist, the kick of a horse or man, or a club in the hands of an assailant; lifting heavy objects, etc. Most of these causes, it will be observed, are of the sudden type, the impact occurring before the abdominal muscles have an opportunity to contract, catching them "off their guard," and so it happens that the rupture is usually directly underneath the spot where the blow was received.

REPORT OF CASES

CASE 1.—*Recovery*.—Mr. S., miner, aged 27, arrived at the hospital two hours after having fallen a distance of 20 feet in a mine, striking the abdomen on a plank that was interposed between the timbers of the shaft. A few scratches on the head and right arm were the only visible marks of injury. The patient complained of slight pain in the abdomen, but remarked that he felt better than he did an hour before. Right-sided rigidity was marked; the pulse was 80, the urine clear, and there was no vomiting. An hour later, the rigidity and pain continuing, the patient was operated on through a median incision. An opening was found in the lower ileum admitting the tip of the index-finger, from which liquid feces were slowly flowing. The opening was closed with a double purse-string suture, the abdomen carefully sponged, and a drain to the pelvis inserted. Recovery was uneventful.

CASE 2.—*Death*.—Mr. D., teamster, aged 30, was seen fifty hours after having been kicked by a horse in the left abdomen. For the history of this case I am indebted to Dr. J. A. Jeannotte, who, like myself, was called late to the case. Immediately after the accident the patient had rigidity, suffered some pain and presented only slight tenderness. Obstipation was present for the first thirty hours; then an enema brought away some feces and flatus. At the time I saw him he had all the classic symptoms of peritonitis, including copremesis. The pulse was 150, the temperature subnormal. One peculiar feature which I had never before encountered and which I am unable to explain was that the lower half of the abdomen was distended while the upper half was retracted. The only external sign of injury was a superficial wounding of the skin, consisting of parallel linear scratches on the right side of the abdomen just below the level of the umbilicus. These resembled the scratching of a child's face from falling on a gravel walk. There was no ecchymosis or discoloration. A diagnosis of rupture of the intestine as the cause of the general peritonitis was made, and immediate operation performed in the face of almost certain failure. Salt solution subcutaneously and medicinal stimulation were begun synchronously with the operation. A large median incision gave entry to the abdomen, which was full of pus and feces. Many recent adhesions were present, and lymph was plastered everywhere from the bottom of the pelvis to the diaphragm. Two perforations were found in the ileum opposite the mesentery, about a foot apart; the lower one 2 feet from the ileocecal valve; this was ragged, would admit one's thumb and poured forth liquid intestinal contents, whereas the upper opening was smaller, admitting only the tip of the little finger and was plugged with herniated mucous membrane. The openings were closed and the operation concluded as speedily as cleansing and abundant drainage would permit. The patient died on the perambulator before reaching the ward.

CASE 3.—*Death*.—Mr. P., miner, aged 30, was seen in consultation with Dr. A. J. McDonald at 2 p. m., July 29. July 28 at 5 p. m., he was in a runaway accident, as a result of which he was thrown from the wagon, which was overturned, falling on the patient's abdomen. He walked unaided a square and a half to a hospital, and, as he complained of severe pain, morphin was administered. Enemas were given without result. There had been no vomiting and no singultus, and yet when I saw the patient for the first time twenty-one hours post trauma he was dying of peritonitis, without even

the slightest evidence of injury to the abdominal parietes. Because of the rapidity with which he was advancing toward a fatal termination, a diagnosis of rupture high up in the intestinal canal was unhesitatingly made. He died three hours later. A necropsy was performed at 6 p. m. which disclosed a plastic peritonitis including the diaphragm, and the abdominal cavity full of fluid. On the convex aspect of the jejunum 6 inches from its origin, a rupture was found admitting one's thumb, with mucous membrane pouting.

CASE 4.—*Recovery*.—J. F., boy, aged 8, referred by Dr. J. A. Jeannotte, to whom the patient was sent from a neighboring town, on the evening of August 29, while fording a creek, fell, striking his abdomen against a stone. He complained greatly of right-sided abdominal pain and was put to bed, where he remained until sent to Leadville. Meanwhile cathartics were administered and the bowels moved, but no relief was obtained. He arrived at the hospital the night of September 11. Examination showed pulse 104, temperature 99.6, and a mass filling the right iliac fossa. A diagnosis of appendix abscess was made and operation immediately performed. A Kammerer incision came down on the abscess, which was evacuated. When the wall of the abscess was torn through there was disclosed a ragged perforation the size of a 25-cent piece in the convex aspect of the cecum. This was closed, and a normal postcecal appendix dug out of the adhesions with some difficulty, it being necessary to strip it out beginning at its base. Drainage was introduced to the inner side of the cecum, to the outer side of the colon and to the pelvis. Recovery being complete, the patient was discharged October 8. The fortunate termination of this case, despite the poor treatment inaugurated, should not lead us astray, for we have no reason to expect recovery to follow such neglect, whereas we have every reason to expect death promptly to ensue.

NECESSITY OF EARLY OPERATION

In the comparatively few cases with successful operation reported, the operations were performed within a few hours of the injury, and in most of them the presence of collapse, loss of liver dulness, fluid in the abdomen, distention, etc., that is, the absolute indications of surgical intervention, appeared very early. Not always, however, are the symptoms so importunate. Frequently they are very insidious in their onset. At times the patient *seems* to recover from the immediate effects of the accident, but subsequently develops signs of peritonitis. I say *seems* to recover from the immediate effects of the accident, but this is only apparent, not real, for as will be shown presently, so serious an injury to the intestine cannot pass symptomless, despite the fact that not a few cases are found in the literature, either with operation late or going to necropsy with the remark that no symptom of intra-abdominal lesion presented until the second or third day. More likely the milder symptoms were present but unperceived.

There is no doubt that the high mortality incident to this condition, which all statistics so far compiled exemplify, is to be sought apart from the general consideration of surgical technic, for we may justly claim a very lofty and gratifying technic in all abdominal operations. Neither can it be ascribed to the peculiar character of the intestinal lesion itself, as we have often in gunshot wounds of the bowel more numerous and more damaging injuries and yet a greater proportion of recoveries following operative interference. The reason is that we attack the gunshot cases promptly, while, on the contrary, we too often hesitate in these cases, awaiting classical symptoms which announce the gravest complication, thus passing the time of maximum safety by an avoidable and perilous delay.

A very satisfactory percentage of recoveries may be expected if we will enhance our diagnostic acumen, develop a keener sense of comprehension, a prompt recognition of certain initiatory signs and a ready interpretation of the significance of those early manifestations. It is not to our credit that Nature has occasion to call so vainly for assistance. That she is signaling for help is indubitable, and I am convinced that it is not a cipher message either. Clearly then it is our duty to apprehend the signal and to render efficient aid with prompt and timely operations.

Given a case in which a person has been kicked by a horse, has fallen on a blunt object striking the abdomen, has been run over by the wheel of a wagon or has sustained some other typical mishap consequent on which a rupture of the intestine has ensued, and I know of no better method of procedure to insure the patient's death than to wait for reaction to take place, giving morphin as soon as pain manifests itself in order effectually to mask developing symptoms of importance; to await the exhibition of the absolute signs of rupture, namely, vomiting, costal respiration, tympany, distention, loss of liver dulness, generalized tenderness, declining temperature, high pulse-rate, the higher the better, and above all the hippocratic facies, and then to operate, when death may confidently be anticipated either on the table or very soon thereafter.

SYMPTOMS OF INTESTINAL RUPTURE

A detailed consideration of the symptoms is worthy of attention:

Shock varies from very slight to the most profound. In some cases there is no deepening of the little shock that slowly succeeded the accident, while in others the shock swiftly increases with a rising pulse and a declining temperature; this divergence of the pulse and temperature is always a grave symptom. The absence of shock is inexpressive.

Vomiting is common though not constant. The more persistent the vomiting the more consequential is the sign. This symptom is due to the irritation of the peritoneum by the effusion of intestinal contents, and occasionally comes on early, though not infrequently it is long delayed, more especially if the intestinal contents are expelled directly into the pelvic basin.

Obstipation is very common in these cases, though often a slight amount of fecal matter may be voided from the lower bowel following an enema, as is seen in some cases of intestinal obstruction. This symptom loses some of its value, as we have a similar picture in traumatic or paralytic ileus. Moreover, in a suspected case the means essential to establish the existence of this symptom would not with propriety be pursued.

Frequent urination has been observed, and results from peritoneal inflammation in the paracystic region. It is a rare and a late symptom.

Pain is usually intense, localized or general. At times it is localized to the umbilical region or lower abdomen, rarely over the seat of injury, though more often it is generalized. Pain arises from peritoneal irritation, and hence is a constant symptom though varying in intensity; it appears early and continues unabated. It is deprived of some of its worth in this as in other conditions, by reason of the variable degree of pain endured by different persons before complaint is made.

The pulse is usually slow at first, gradually and steadily rising, though cases are on record in which a normal pulse was displayed for several hours post

trauma. An increasing pulse-rate is a valuable indication, but it is to be remembered that it may not be initiated until late, at which time it is indicative of peritoneal absorption.

The respiration is said to be characteristic, of thoracic type and shallow. This I have not observed, surely not early enough to be of value. Should it be present it would be very significant, but its absence is insignificant.

The temperature is but slightly elevated within several hours, and as is well known results from toxic absorption, thus being of necessity a tardy symptom and not available for early diagnosis.

Formerly much stress was laid on the facial expression, but inasmuch as the peritonitis needs to be far advanced before the patient looks bad, this symptom is valueless except that its presence usually signifies impending death.

Loss of liver dulness, dependent as it is on the presence of gas in the abdomen, occurs usually as a late sign; so late that it is of trifling value. Furthermore, it may be simulated by a marked meteorism.

Abnormal areas of dulness consequent on hemorrhage may be present. This is more likely to occur if the intestine is torn from its mesentery, thus favoring hemorrhage from a large branch of one of the mesenteric arteries, or it may result from a concomitant rupture of the liver or spleen. Otherwise the symptom would be tardy, and then too might be due to effusion and plastic lymph. Should it appear early it would doubtless be accompanied by other unmistakable signs, so that its worth as an early symptom is inconsiderable.

Rigidity of the abdominal muscles is one of the most constant symptoms. It is almost, if not quite, impossible to conceive of a lack of effort by Nature to protect the subjacent structures in so serious an injury, unless prevented by intense shock, unconsciousness or profound alcoholism. It follows, therefore, that it is an invaluable sign in a suspected case, and should it continue for a few hours constitutes alone sufficient evidence on which to base a diagnosis of probable rupture, and to indicate surgical intervention. It is not subordinate in importance to any other symptom.

Local tenderness is of great value if one be able to eliminate superficial injury sufficient to explain the sensitiveness, and happily, there often is slight or no injury to the overlying structures. Besides, the tenderness rapidly increases in severity and in area.

WHEN IS OPERATION WARRANTED?

The longer the time since the accident and the more numerous and the more marked the symptoms, the easier the diagnosis and the greater the security felt in such diagnosis; and conversely, the shorter the time since the accident, the fewer the symptoms, and these perhaps not very evident, the greater the difficulty of diagnosis. But it is just at this early period when the symptoms are often slight and the conclusion most difficult that the important decision should be made if we are to reduce the mortality-rate to its legitimate rank. As has been mentioned, many of the symptoms declare themselves late, and when they do appear do not herald the rupture itself, but proclaim the complicating peritonitis which procrastination has made possible. The only disparity of opinion arises relative to the diagnosis; or more accurately, the disagreement is in regard to what minimum symptoms justify operation. Once the diagnosis is made, we are all agreed that the importance of prompt and expeditious operation cannot be overemphasized.

The history of the case may now and then be misleading, for it might be assumed that the vulnerating force was insufficient to produce rupture, and yet a rupture be present. This is the more likely to happen in the case of hernia with contents, in which event even a slight blow over the hernia could produce rupture of the intestine by reason of its being closely confined with no opportunity of hasty escape. Nevertheless, the history is obviously of primary importance. Frequently no external sign of injury such as bruise, laceration or abrasion of the skin exists, so that the amount of injury to the abdominal wall gives not the slightest indication of the degree of visceral damage. Further, any injury to the abdomen may be associated with grave damage to the intestine.

Few of the other serious conditions are likely to be confounded with traumatic rupture of the bowel. Intra-abdominal hemorrhage may for a time simulate this condition, but one would expect to find the signs of hemorrhage most marked, namely, air-hunger, anemia, blanched skin, thirst, restlessness, faintness, free fluid in the abdomen, etc. Of course, both conditions may be coexistent. Nevertheless, the differentiation between these two conditions is not of the utmost importance as the treatment is prompt surgical intervention in both, and a surgical diagnosis is sufficient in such cases; in fact, much valuable time may be wasted by an effort at too refined discrimination. Take, for example, a man who has been kicked by a horse but has not sustained a serious intra-abdominal lesion. What occurs? He is knocked down or thrown a few feet, the "breath is knocked out of him," he is pale, has a weak pulse, is dyspneic and looks distressed; he may even vomit; but within a little while he recovers his color, his pulse becomes normal, his respiration is easy and he looks and feels well. In other words, he recovers his usual feeling of well-being in a short time with a subsidence of all symptoms. Take, on the other hand, one who under the same circumstances has sustained a rupture of the intestine. Some of the symptoms disappear, but some of the more important incipient symptoms endure; he does not feel much better even after two or three hours; the symptoms do not disappear, though they usually subside somewhat. That is to say, we have a persistence of the initial symptoms, particularly rigidity and pain, though the pain may be slight. *This persistence of the initial symptoms with the history is sufficient to warrant operation.*

To discover the early signs and in order to detect their continuance, which is so momentous, these patients require the most observant supervision during the early hours following injury. The presence then of rigidity with pain or tenderness leads to a diagnosis of probable rupture and is sufficient to defend the propriety of exploration. Finally, the danger of an infrequent needless operation is a nullity contrasted to the frolic with death by delaying surgical intervention in the case of rupture.

Varieties of Authors.—It may be said that there are three kinds of authors. First come those who write without thinking. They write from a full memory, from reminiscences, it may be, even straight from other people's books. This class is the most numerous. Then come those who do their thinking whilst they are writing. They think in order to write, and there is no lack of them. Last of all come those authors who think before they begin to write. They are rare.—Schopenhauer.

DUODENAL TOXEMIA FOLLOWING RUPTURE OF THE DUODENUM

WITH REMARKS ON EXTRAPERITONEAL RUPTURE AND A
REPORT OF TWO CASES *

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That a toxemia other than bacterial is a factor in the mortality of extraperitoneal rupture of the duodenum, an observation of two cases has convinced me. The fact that there was something different from the ordinary type of death from peritonitis was evident. The notes on the history sheets were made independently, and it was only later that the similarity of the observations was appreciated. The picture was especially emphasized in the second case in which the following statement was made evidently as a summary before the history was filed:

The appearance of the patient was almost suggestive of delirium tremens or more of an active toxemia. There were no positive signs of peritonitis, no vomiting and the bowels moved freely. The patient presented the appearance of death from toxemia other than bacterial.

The well-known observations and studies of Maury,¹ Matthews² and others give emphatic support to this assumption. Whether the toxin comes from the secretion of the mucous membrane of the duodenum or from the bile which has not been rendered harmless by dilution and colloidal suspension or from the pancreatic juice may be open to discussion. In relation to possible death from pancreatic secretion it may be said that in only two cases, one of my own and one other, have I been able to find a fat necrosis, although Richter³ has proved experimentally that a perforation of the duodenum may give rise to a fat necrosis. Wilms has drawn attention to the fact that high intestinal obstruction produces death with extreme rapidity and suggests that the patients succumb to toxic absorption resulting from decomposition of stomach and intestinal contents—an assumption that, it would seem to me, lacks clinical or experimental support.

In both of my cases the post-mortem confirmed the belief that there was not a peritonitis sufficient to cause death. The second patient did not vomit after the operation, his bowels moved freely, and yet death supervened at the end of fifty hours. The case histories are appended.

A study of the literature served to emphasize the high mortality in rupture of the duodenum. In the ninety-four cases studied there have been only seven recoveries. This may be partly explained by the toxemia complicating this condition as noted above; but a considerable part must be attributed to the failure of diagnosis and to the inability of the surgeon to suture these ruptures by exposure after Kocher's method. I experienced the same difficulty in the first case, but in my second I fell on the method I have described elsewhere, by which the duodenum was mobilized through an incision in the

* Read before the Western Surgical Association, St. Louis, Dec. 20, 1913.

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2. Matthews, S. A.: One of the Functions of the Duodenum. *THE JOURNAL A. M. A.*, July 23, 1910, p. 293.

3. Richter, H. M.: Perforating Duodenal Ulcer with Fat Necrosis. *Quart. Bull. of Northwestern Univ. Med. School*, xii, 131.