

HYSTERIA IN ITS RELATIONS TO THE UPPER AIR TRACT AND TO THE EAR.*

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Translated by

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This excellent monograph of eighty pages covers the field of hysteria in its relation to the nose, throat and ear in a very thorough-going manner, although the reader is several times referred to other works for the more complete elucidation of certain points.

The author devotes the first ten or a dozen pages to remarks on hysteria in general, and throughout the work there are scattered many pages of speculation and theorizing as to the nature and action of this disease. Want of space, if nothing else, would prevent our entering into this subject, and this abstract will be held strictly to the points enumerated in the title. The first of the local hysterical phenomena to be noted are the various sensory disturbances throughout the region in question. These may take the form of hypesthesia, anesthesia, hyperesthesia or paresthesia. The diminished sensibility of the mucous membranes of the pharynx may exhibit all degrees up to complete anesthesia. It is generally associated in hysterical subjects with various anesthetics of the skin. It may be unilateral, corresponding to a similar skin condition. Morphia and cocaine habitués usually pass through a period of hypesthesia of the pharyngeal membranes, which, however, disappears with the abandonment of the drug.

A more commonly observed form of hysterical disturbance is that of hyperesthesia. One of the best tests of the sensory condition of the mucous membranes is the ordinary rhinological or laryngological examination. Some are so very sensitive that even a movement toward such a procedure results in active gagging and choking. Oftentimes catheterization of the tube, even though accomplished without difficulty, will be followed by a profuse secretion of tears and of watery nasal mucus, which may be prolonged through several days, associated with paroxysms of sneezing and a stinging, burning sensation. Of course, we should bear in mind that, to a certain extent, this might result from a physiological re-

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flex, but it is the intense and extensive reaction that forms the reflex neurosis. Paresthesia, which the author rather grimly calls the élite of hysterical sensory disturbances, gives rise to spontaneous sensations of pain. It has many forms and may affect all parts of our field of observation. Those cases where prolonged and intense pain follows what are ordinarily painless operations are apt to be of this nature. Hysterical otalgia is well known. Hysterical rhinalgia is also common, although not much has been written about it. It is usually located in the nasal bones and a careful examination may fail to find anything abnormal. The author recommends in certain of these cases the use of the "apparent cautery," that is, the electrode is first brought to a glow so that the patient may see it. It is then allowed to cool, is carried into the nostril and while held free in the cavity, touching no structure, the current is again turned on. This is preferably done without cocaine, in order that the patient may feel the heat and be convinced that an operation is being done.

Hysterical sore throat very commonly follows some operation in that region. Thus the removal of an adenoid or a tonsillotomy is sometimes followed by pain which lasts for years. Hysterical laryngeal pain is most frequently met with in those persons who depend peculiarly upon that organ for carrying on their occupation. For this reason we must exercise great care not to confound this condition with that of commencing exhaustion. The most noticeable difference is that hysterical pain may come on at any time, while the pain that accompanies overwork of the larynx is most apt to occur immediately after some unusual demand on its activity. Of course, if the larynx is not given its needed rest, there soon follow physical changes which will enable us to distinguish between the two troubles without difficulty. Hysterical laryngalgia may be increased during phonation so that the patient dreads to speak, and soon gets to having fears of all sorts of dread diseases, such as cancer, syphilis and tuberculosis. Among singers, actors and speakers there is a wide-spread belief in a condition known as laryngeal catarrh, which is nothing more than hysterical laryngalgia and has nothing in common with laryngeal exhaustion.

From hysterical pain we pass to the consideration of paresthesia proper. This consists generally, not in a feeling of soreness, as in the pharynx, but in a sense of painful pressure. This feeling of oppression may be either fixed or movable, and constitutes the well-known *globus hystericus*. These hysterical sensations of pressure may be attributed to all regions of the upper-air tract; the

nasal cavities, the frontal or maxillary sinus, the naso-pharynx, the oro-pharynx, the larynx, the trachea, or the ear. In the latter situation the patient complains of a feeling as though the ear were closed by a valve. No effect on the hearing is produced, however.

A hitherto undescribed hysterical affection is the sensation of nasal obstruction. This is apt to occur after adenoid operations. The patient returns to the operator after a longer or shorter period and complains that the growth has returned. A careful examination reveals the fact that the passages are perfectly clear, and yet the nasal respiration is gradually lost and the patient breathes and talks with his palate tightly drawn up against the pharyngeal wall. This generally occurs in nervous, ill-nourished children, where we might expect hysteria. The treatment is simple. After satisfying ourselves that the passage is actually clear, the finger is passed up behind the velum palati and the latter is stretched forward slightly. The patient is told that as soon as the trouble recurs the same treatment will be repeated. A cure generally follows.

Another variety of hysterical paresthesia is the feeling of foreign bodies in the passages. These may be described as of all shapes and forms. It is the commonest of experiences to have a patient come to the office demanding relief from some foreign body, "high up in the nose," "far back in the throat," or in the ear. Insects in the ear and fish bones in the throat are two very common forms of hysterical delusion. In this connection we should not lose sight of the fact that many hysterical persons do actually introduce foreign bodies into the nose and ear. Treatment for all these cases must be mental. If the patient is intelligent the real state of things may be clearly stated to him, and an appeal made that he use his will power and common sense in overcoming the delusion.

We come now to the hysterical disturbances of the sense of smell. Anosmia is the least frequent form of trouble, but may be most obstinate and unyielding. It may be periodical in its appearance. Thus it may be present during menstruation and at no other time.

Hyperosmia and parosmia are far more important troubles. Hyperosmia may be general or confined to certain limits. Thus the author states that he has a patient who cannot endure the odor of peppermint during her menstrual period, although at other times it is indifferent to her. The olfactory hyperesthesia may play an important part in social and family relations. We know that everyone has his own peculiar personal odor. Now in a case of hysterical hyperosmia, if the one affected were to take a dislike to the

odor of husband or wife most unpleasant consequences might follow. A case is cited from the author's own practice where the woman was affected with nausea to the point of vomiting by the near approach of her husband. This woman was also especially susceptible to the odor of certain plants.

In dealing with hysterical acoustic anesthesia the author adopts Gradenigo's definition. "Anesthesia in hysteria consists in a loss of the ability to synthesize impressions, or the process whereby the mind renders a sensory impression concrete by means of images." Thus is explained how a patient is subjected to the continued mastery of an idea or of an injury, the real effects of which are long past. In these cases we must beware of two sources of error. One the hysterical radiation of symptoms, "the blinding veil which covers all those cases where there is present a peripheral disturbance of the conducting apparatus, but which does not cause the anesthesia;" the other is true simulation.

True hysterical deafness may be temporary, may come and go with almost lightning-like rapidity, or it may be continuous.

We now come to the consideration of secretory disturbances. Of these the author is inclined to think that only one, viz., hydrorrhea nasalis, is possibly of hysterical origin. In these cases an enormous quantity of fluid may be excreted—several litres a day. The treatment is unsatisfactory.

Vaso-motor neuroses comes next. They may appear as angio-paralytic or as vaso-constrictor affections. To the first class belong those hyperemic and infiltrated conditions of the skin, nose, eyelids and sometimes the cheeks. This condition may also obtain in the mucous membrane of the throat and larynx. One of the most troublesome affections of this sort, is the swelling of the cavernous structures of the turbinal bodies. This condition may lead to serious general debility in hysterical patients and to secretory reflexes of the mucous membranes and the lachrymal glands.

Among the vaso-motor disturbances are to be considered those hemorrhages which are described as periodical or vicarious. The whole subject is little understood, but it is known that, in many hysterical cases, the hemorrhage is not vicarious; and, indeed, may be brought on at a given time by suggestion.

Another form of hysterical disturbance is the production of vertigo by irritation of the membranes, particularly of the ear. Hardened serumen, instrumentation (catheterism, etc.) may produce it. Here also should be mentioned the various degrees and forms of phonophobia, fear of sound. The most active hysterical seizures

may result from noises. Another curiosity is the *audation colorée* where the patient, upon hearing certain tones or notes, will at the same time have the impression of a certain color. Here, too, may be mentioned the cases of laryngeal vertigo (Charcot). This condition is not clearly understood and its study is rendered still more difficult by reason of its resemblance to syncope, laryngea and the laryngeal crises of tubes.

We now come to the consideration of motor hysterical disturbances. The aural muscles may be the seat of almost continuous action. A convulsive tick affecting the muscles of the face is common. Convulsive action of the tubal muscles may under favorable circumstances be seen by posterior rhinoscopy. The mouth of the tube is expanded and then closed with the result of producing a snapping or ticking noise in the ear. It may, however, produce merely a roaring or buzzing sound. This condition is most apt to be present where other abnormal conditions of the pharynx or nasopharynx prevail. Hysteria may affect all of the respiratory muscles, or any one of them. The *alæ nasi* are frequently the seat of irregular convulsive movements. Attacks of hysterical sneezing and coughing are common. Several forms of this purely nervous cough are described, and the treatment recommended is a sort of pulmonary gymnastics. This consists of deep-drawn breaths which are held in the chest for a certain time.

Nervous asthma next claims our attention. Of course, it is very difficult to say when a case of asthma is purely nervous, yet there are many cases presenting some slight substratum of physical change, which are nevertheless largely nervous in their origin. Another reflex neurosis is a sudden contraction of all the respiratory muscles—singultus. In these asthmatic cases the practitioner is warned to abstain from any long-continued series of cauterizations or any other irritating treatment. The result of such measures being frequently to leave the patient in a worse condition than before, so far as the asthma is concerned.

Hysterical spasm of the larynx is one of the gravest affections with which we have to deal. It sometimes ends in death and is always distressing. It will be present at intervals for years. Observations are also on record which tend to show the existence of a tracheal spasm. Here the smooth muscular fibres of the posterior tracheal wall are thrown into activity, and by their contraction form a ridge along the interior of the trachea, which produces dyspnea.

The author next considers those motor disturbances which affect phonation. First, spastic dysphonia, which consists of a spasmodic

contraction of the laryngeal muscles just as the patient is about to speak. This may occur in all degrees of severity, from a mere disturbance in speaking up to spastic aphonia.

The spasm may so completely close the glottis that not only phonation but respiration also is interfered with; requiring the use of chloroform, ether or cocaine to relax the muscles. Where these do not effect a cure, tracheotomy must be resorted to. Michael has given us a means whereby this spastic aphonia may at once be distinguished from anterior paresis. This is the application of upward pressure to the cricoid. Inasmuch as this pressure effects the movement which would be accomplished by the anterior muscles, the phonation is improved if they are at fault; whereas in spastic aphonia such pressure only increases the trouble.

Another form of hysterical motor disturbance is the swallowing of air. The patient feels a constant inclination to swallow. This being yielded to, the stomach soon becomes inflated with air. The patient in many instances is able to throw this off and the whole performance commences anew.

The last subject taken up by the author is that form of motor disturbance affecting the voice. Before entering upon the consideration of aphonia he draws attention to a form of paresis of the soft palate which has never been described. It occurs in nervous children and generally follows removal of adenoids. Some time after the operation (four to six weeks) the child is brought back with the statement that he speaks through the nose worse than ever. A careful examination shows that the passages are perfectly free, and yet the nasal voice is certainly present, although it may be intermittent, the child at times speaking in a perfectly free and clear voice. Flatau says that at first he was inclined to think that this paresis was due to some injury received during the operation. He, however, noticed that this condition appeared in children who had shown other evidence of nervous irritability. He therefore abandoned all treatment except a sort of vocal gymnastics, and generally thereby effected a cure, although slowly.

Hysterical aphonia may exhibit many different phases. One patient may simply lose the power of speaking aloud, but may still be able to whisper; another will be unable to make the slightest sound—hysterical mutism. All the laryngeal muscles may be affected or only a single pair. Among the causes may be mentioned sudden emotional disturbances. Local diseases also may bring on an attack of this sort, where no such effect would be produced if the patient were not of an hysterical temperament. Hysterical mutism

is to be regarded as a grave affection, for it may persist for weeks and months. This absolute idleness of the muscles of phonation may result in nutritional changes which render abortive all attempts at restoring their functional activity. The author recommends in these cases a system of proper breathing, with efforts at accomplishing phonation. Many cases have been cured simply by using the laryngeal mirror, particularly if this manipulation is new to them. The use of "apparent cauterization" is again recommended in these cases. In old cases, irritation by the probe and the electric current is advised.
