duce girdle ulcers is duplicated by the annular type of intestinal carcinoma. In both, the long circularly disposed muscular lymphatic plexus is involved. The chains of lymph nodes affected follow the same anatomical course in carcinoma as in the other diseases mentioned. Undermining of the mucosa in amebiasis is duplicated by one type of carcinoma in which the neoplastic process starts at one point in the mucosa, spreads through the submucosal lymphatic plexus and appears on the mucous membrane at some distal point.

MISCELLANEOUS FORMS OF INTESTINAL ULCERATION

Syphilis—Acquired Syphilis rarely involves the intestinal tract in regions other than the rectum. At the latter site, one may see an occasional primary lesion, but more frequently there appear gummata in the submucosa above the internal sphincter. There is a form of luetic proctitis characterized by ulceration and hyperplasia of the rectal mucosa with a tendency to fistula occurrence and abscess formation. Perivascular, round-cell infiltration, however, commonly is not seen. The congenital type of syphilitic intestinal involvement is more common. Primarily it arises as miliary gummata in the submucosa and the muscularis. Coalescence of gummata occurs early. There is a strong tendency to stricture formation in syphilis of the rectum as fibrosis results. Such stricture appears as tough, fibrous, narrowing of the bowel lumen (“hose pipe-gut”), a form of stenosis rarely observed when carcinoma is present. Diagnosis of this may be established by means of the history, the absence of anemia and cachexia, the relatively scant bleeding, absence of metastases, the duration and character of the tumor and by serologic tests of the blood-serum and the spinal fluid. Anti-syphilitic medication not only may “provoke” a latent positive complement-fixation test but alter the conformation or extent of the bowel lesion. It has been claimed that certain malignancies may be associated with positive blood-sera Wassermann tests; we know of none in which spinal fluid reactions, cell-counts, etc., mimic those of lues.

Balantidiosis—Balantidium coli, a ciliate infusorium, infests the intestinal tract of the hog and through food and water contamination, may produce ulcers in the intestinal tract of man. The lesions are limited to the colon but the parasites have been found in the mesocolic lymph nodes.

Dysentery of a type other than those above described has been noted by Araf in Bithuriasis infestation and in malaria. Stercoral ulcers and ulcers produced by chemical injury or vitamin deficiency (pellagra), and those associated with aninitation here require no special description. Their origins are either quite obvious or the diagnosis is made after the other types of organic lesion have been ruled out. Lymphogranuloma inguinale deserves mention with respect to females because of the occasional secondary involvement of the rectal wall. Such lesions are possible because of the lymphatic drainage from the vulva to the nodes surrounding the lower rectum. In such complication, post-inflammatory rectal stricture may occur. A history of contact infection, the observation of fused inguinal lymph nodes and a positive Frei test establish the diagnosis.

Finally, the writer has seen ulceration of the rectal mucosa in association with agranulocytic angina.

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INSANITY EQUIVALENTS AND THE GASTRO-ENTEROLOGIST

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ONE of the most troublesome and puzzling problems with which gastro-enterologists have to deal is that of the patient who comes complaining of some digestive disturbance, but who, on closer questioning, or after one or two unsuccessful operations, admits that the trouble is really a feeling of overwhelming fatigue, and an inability to face people, and to stand up to the day’s work and its annoyances.

Once these facts are clear we may think that the remainder of the treatment will be plain sailing, and that all we will have to do is to apply some psychotherapy and give the patient a prolonged rest-cure. But soon it becomes apparent that the rest-cure is not doing any good, and then, when we observe the patient more closely, we discover that she cannot rest. (It is usually a “she”.) There is never any let-down, and I often tell such a woman that when idle, she works harder than I do, and has more right than I have to be worn out at the end of the day. Her mind is always seething; she cannot leave her problems alone, and even in the middle of the night, after taking two or three sleeping tablets, she cannot shut off the flow of tumultuous thoughts. Worse yet, she spends energy riotously on little things which are disregarded or promptly dismissed by a saner person. Even pleasures are entered into so keenly and with so much anticipation and fear of possible disappointment that they wear the patient out. Terrible fears also may come on her: that the right diagnosis has not yet been made, and that some serious disease like cancer is gnawing at her vitals, fear for the health of children or mother or husband, or fear of financial troubles or the loss of the husband’s love.

Every little problem of life tends to assume gigantic proportions and even small decisions are hard to make. Breaks in the day’s routine are particularly exhaust-
ing. Women patients wrestle with trifling problems of conscience; they worry because they see that their behavior is driving the husband out of the home or they daily settle and then reopen the question of getting a divorce. Furthermore, with the great increase in the irritability of the nervous system, all sorts of annoyances which ordinarily would not have much effect become unbearable. Noises from many sources seem to pound in on the brain until the patient fears she is about to lose her mind.

Often, because sufficient time is not spent in talking to the patient, physicians fail to recognize or to understand these handicaps which lie in the way of recovery. The physician who does pay some attention to the psychic side of the problem generally inquires for some cause of worry in the home or in business life. He asks about the sexual compatibility of husband and wife and he asks about finances. If he fails to unearth anything wrong about home or office, often he is stumped, and he cannot imagine why the patient should be so badly prostrated.

THE BREAKDOWN WITHOUT APPARENT CAUSE

In other cases, and those are the most puzzling and the most interesting to me, even a skilled and pernickacious questioner will fail to unearth any adequate cause for the nervous breakdown. It is in just these cases that we must, I believe, go searching for the cause in the family history. Unless we do this, we are prone, when the rest-cure fails, to assume that the diagnosis of nervousness must have been wrong; and especially when there is a new flare-up of symptoms, or when the patient is found to have an afternoon temperature of 99.5° F., we decide that there must be some hidden, organic cause for the disease. Much laboratory and roentgenologic work is then repeated; perhaps the basal metabolic rate is found to be —15, and some thyroid extract is tried. If the patients are women, some ovarian extract next may be injected, and finally there will be much vague talk about the suprarenal glands and the hypophysis. In the end, hoping against hope that something pathologic and removable can be found in the abdomen, the patient is operated on again. Perhaps she is encouraged and improved for two or three months, and then she sinks still further into the slough of despond.

SOME IMPORTANT SYMPTOMS

I have the feeling that many of these poor patients would have been spared that extra operation if the physician had only asked two or three questions which are seldom thought of when the history is being taken. I never find answers to these questions in the histories which are taken by able young medical graduates, and yet, to me, the information that can be obtained often is most enlightening. I always want to know how long it is since the patient worked, because so often I am put on my guard when I learn that a man who complains of a little flatulence and abdominal distress, the sort of thing that would probably be ignored by most of us, has sat idle at home for months or years. The next question is: Why has he not worked? And the usual answer is that on many days he has waked feeling so discouraged and miserable, or with such a strange feeling in his head, that he could not face the world, or he dared not work because he so dreaded to assume responsibility.

The last of the three important questions, and the one that gives a most helpful insight into the mental and nervous status of the patient is, "Can you read a short article in a magazine?" Many of these people cannot. First, they have lost their interest in everything; second, they cannot hold their attention or use their eyes long enough to finish an article. It always seems to me that any person whose nervous system shows this degree of disorganization should never have put on him the additional insult of an operation, if this can possibly be avoided. I have seen several cases in which even so slight an operation as tonsillectomy or the removal of a few teeth sent such a patient "over the edge" into a serious mental breakdown.

BIG CHARACTER-CHANGES OFTEN MISSED

In many cases, it is most important that the physician note that the patient has undergone a marked change in character. A man who has been active and prosperous in business, cheerful and friendly and interested in many things, will give up work; he will become irritable and solitary and will lose interest in all of his old enterprises and hobbies. Any able internist hearing this story would know immediately that serious damage of some kind had taken place in the brain; the tragedy is that the patient rarely volunteers this important information, and it never occurs to him to consult a psychiatrist. He generally goes to a gastroenterologist with the complaint that the abdomen is uncomfortable, and with the conviction that if the functions of his colon could be restored to normal he would be well.

There is some excuse for the city consultant when he fails to see that the complete stranger sitting before him is a changeling with an injured brain; what is harder for me to understand is how a family doctor, who has watched the mental change taking place, so often fails to realize its tremendous significance. Like the patient, he ordinarily looks on it as secondary to some hypothetic disease in the abdomen.

THE PSYCHOPATHIC PATIENT

Many patients doubtless would be spared useless and hurtful operations if only the medical adviser would first get in touch with the family and learn that the man or woman who seemed rational and sensible for an hour at the office came home and wept and raised Cain. How helpful it would be sometimes if the physician were to learn that the patient had always been a problem and a source of expense to his relatives; that he had never stuck to anything, and that those who know him best always had blamed his troubles on what they call his "foolishness."

I do not mean to infer that all our nervous patients are psychopathic or unpleasant or wrong-headed; many are not. Some are lovely people, and others have a most attractive side which they show to strangers and, for a while, perhaps, to the physician. But many are the times that I have been shocked and astounded on coming on the Mr. Hyde face of a feminine Dr. Jekyll for whom I had come to have considerable liking and admiration.

PRESENT-DAY MEDICAL PRACTICE IN THE HANDLING OF NERVOUS PATIENTS

In the place where I work, I see so many patients with this type of disease and so many who have been thoroughly studied and treated by able internists throughout the country, that I have an unusual opportunity to see how the average American physician looks on these problems. What strikes me is, that