ESSAY

ON A SERIES OF SIX CASES OBSERVED AND TREATED IN DISPENSARY PRACTICE, 1939.

For the ROLLESTON (Sir HUMPHREY) PRIZE.

By
Introduction.

During the Spring vacation of this year when I had to complete the usual term of residence in the midwifery hostel, I took over the home-patient practice of the Royal Dispensary and during three weeks was called to see over fifty cases, of all ages and with a variety of diseases. From these I have selected the six most instructive cases, embracing nearly every system in the body, varying in age from nine months to sixty-seven years, and terminating some happily after a few days others fatally after weeks.

The descriptions which follow are not intended to present cumbersome records of exactitude; rather do they attempt to draw picture-portraits of each case in an endeavour to bring out the salient features and to convey the special problems which each presented at that time.

Dispensary practice is far removed from hospital work in several important respects. Firstly there is a great preponderance of children's ailments and seldom are there cases of such severity as to require hospital attention. Secondly at the first visit to the patient one has a very limited time within which to grasp the essentials of history, carry out the appropriate examinations both for positive and differential diagnoses, and think out the most suitable treatment.
As an hospital trained student I found some difficulty at first in convincing myself that my rapid inquiries and examinations had exhausted all the possibilities, but it was not long before this confidence was thrust on me partly as a result of a little experience and partly as a result of a feeling of responsibility which no amount of ward-visiting can give. Another beneficial result of this feeling of responsibility was the fact that I was forced to take daily active interest in the progress of my patients; I could not diagnose a case of heart failure, say to myself that she should have digitalis and leave everything at that; no! I had to be sure that the diagnosis was unchallengeable, I had to write out the required prescription, give detailed instructions as to its use and watch carefully every day to see the effects and avoid the mishaps. In this way every case assumed an importance and an interest which hospital cases seldom do.

With regard to the treatment meted out, there is nothing exceptional to note in advance except to express satisfaction of the apparently great success which 'Dagenan' had in a case of broncho-pneumonia complicating whooping-cough. This same drug was also tried for chronic cystitis and again gave an apparently rapid cure.

One difficulty in dispensary practice is ensuring that even simple treatment is being honestly carried out; it
is very disheartening and annoying to find that, as is related in case 4., the patient is surreptitiously and deliberately neglecting advice.

Finally, before going on to the individual cases, I should like to re-emphasise that all these cases are to be thought of as set in the atmosphere and background of the home, disturbed and anxious as the result of the illness, and eagerly waiting for words of hope and confidence. Even this short series of cases did not allow of this assurance being always forthcoming; in addition the problem of deciding whether it is necessary to send the patient to hospital for further examination is no easy one to solve, torn as one is between the two desires of making perfectly sure of the diagnosis and of avoiding unnecessary, complicated examinations if simple clinical methods will suffice.

Not as a result of it, the boy had been observed to be secretly crying but, when questioned, he had denied having cried and denied having pain in any part of his body.

His previous illnesses included his hip disease and a mild attack of diphtheria following which he was known to have been a diphtheria carrier. On going into
Case 1.

T. D., male, age 9.

This boy's mother gave the history that, two days previously (Wednesday), on coming home from school, the patient did not seem as active as usual and refused to take his tea. Since, previous to this, the boy had always had a good appetite the mother sensed that something was wrong and put the child to bed, but deferred calling in advice until Saturday morning. During this period the boy had taken very little food, save fluids; he had been constipated, and had wanted to be left alone. On the Saturday morning his mother had broken the news to him that he had to go into Hospital on the following Monday for an operation on his right hip which had, some years previously, been treated conservatively in the City Hospital as a tuberculous hip. Following this announcement, although in the mother's opinion not as a result of it, the boy had been observed to be secretly crying but, when questioned, he had denied having cried and denied having pain in any part of his body.

His previous illnesses included his hip disease and a mild attack of diphtheria following which he was known to have been a diphtheria carrier. On going into
the child's bedroom, I first of all noticed that the room was darkened by a half-drawn blind and that the child himself was lying with his face turned away from the window. On the mother's intimation: "Here's the Doctor to see you, Tom," the boy made no response so that the mother had to repeat the statement and coax the boy to turn round. He looked sleepy and tired and gave the feeble smile of one who was not interested in his surroundings. His cheeks were flushed, yet the surrounding skin showed that peculiar, smooth, velvety pallor which one so often sees in many tuberculous patients. He had strabismus but, according to the mother, this had been present since babyhood. The pupils were dilated.

While these observations were being made, the temperature had been taken and showed a rise to 101.8 F. The pulse was running at 110 per minute. His throat was examined and showed slightly enlarged tonsils from which a very little pus was expressed. The throat was not inflamed nor was it sore, and there was no sign of membrane. The tongue was dry and covered with a thin white film. There were no Koplik spots on the cheek. The body was examined for rash but there was none. At
it/
inadvisable to jump too quickly to this conclusion.

2. Pneumonia; especially of the apical type. But the slow rate of breathing and the absence of even the slightest impairment in the breath sounds made this diagnosis unlikely.

3. Scarlet Fever; the child had been exposed to infection and had never had the disease, but against this stood the absence of either enanthem or exanthem after two days history of illness.

4. Diphtheria; the child had been a known carrier and there was slight white spots on the tonsils, but there was no sore throat.

5. Constipation; which is well-known to produce pyrexia and general ill-health in children.

Of these possibilities meningitis was most in favour and hence, having to my own satisfaction excluded conditions requiring immediate specific treatment, I prescribed that the child be given a teaspoonful of Epsom Salts in Water, and encouraged to drink.

On the evening of the same day the case was revisited with the view to confirming the physical signs of meningitis, and to exclude finally the other possibilities mentioned. A motion had been passed, the temperature and pulse were about the same as before, the child was even drowsier than in the morning, and there were still none
of the signs suggestive of pneumonia, scarlatina or diphtheria.

Having diagnosed tuberculous meningitis and knowing that only symptomatic treatment was necessary until the fatal termination, I advised that the child be sent into Hospital and, at the mother's request, he was sent to the Western General Hospital.

I followed up the case with interest and a brief description will complete the story. On his arrival at the Hospital, my findings of neck rigidity and Kernig's sign were not confirmed and the condition of the tonsils gave rise to the suspicion of diphtheria, whereupon the patient was immediately isolated in the City Hospital. There two successive throat swabs were taken, the first of which was reported as positive, but the second as negative. Five days later a lumbar puncture was performed and it showed a clear fluid under pressure which, on standing, gave a fibrin clot and on examination showed slight lymphocytosis. Protein increased to 200 Mg. %; chlorides reduced to 595 Mg. % (the normal being 700 Mg. % by this method). The Glucose was not estimated.

After ten days a fatal issue ensued. During the period in Hospital the only striking features of the
the case were the drowsiness of the patient and the variability of the temperature which came back to normal for a few days preceding a marked rise to about 104 °F. before death.

The following anti-spasmodic prescription was prescribed:

- Calomel. .......... 4 gr. 4
- Belladonna. ...... min. 2½
- Quin. .......... min. 10
- Aries. ........... 4 gr. 4
- Mint. mitis. ....... ca. 2

A teaspoonful every 4 hours.

The parents were visited daily and his condition remained stationary for three days. On the fourth day he looked more ill than before and it was reported
Case 2.

G. W., male, age 2.

On being summoned to this patient, I got a history that the child had had whooping cough for a fortnight, and that the spasms were now very severe, especially at night, and were followed by vomiting. The child had a temperature of 100.2 °F. He looked worn out and exhausted. Examination of the chest revealed slight hyper-resonance and rhonchi could be heard at the bases after the child coughed. Though the child did not whoop in my presence, the mother was emphatic that there was a definite whoop after the night coughing. The following anti-spasmodic prescription was given:

\[ \text{Rx.}\]
\[\text{Pot. Brom. } \quad \ldots \quad \text{gr. 4.}\]
\[\text{Tinc. Belladonna. } \quad \ldots \quad \text{min. } 2\frac{1}{2}\,\text{.}\]
\[\text{Syr. Tolu. } \quad \ldots \quad \text{min. 10.}\]
\[\text{Aquam ad. } \quad \ldots \quad \text{dr. 1.}\]
\[\text{Fit. Mist. mitte } \quad \ldots \quad \text{oz. 4.}\]

\[\text{Sig. 1 teaspoonful every 4 hours.}\]

The child was visited daily and his condition remained stationary for three days. On the fourth day he looked more ill than before and it was reported
reported/
that he had not slept well on the previous night. His temperature had risen to 102.2 °F. and his chest showed rhonchi all over with patchy areas of diminished resonance at both sides of the lower chest. This was taken as a sign that the complication of bronchitis and broncho-pneumonia had supervened, and M.&B. 693 was prescribed in the following doses: half a tablet to be taken immediately, another half in four hours' time, and thereafter a quarter of a tablet every four hours till ordered to stop. The anti-spasmodic mixture was discontinued and in its place was given the expectorant mixture as follows:

\[
\text{Rx.} \\
\begin{align*}
\text{Ammon. Carb.} & \quad \ldots \ldots \quad \text{gr.} \quad 2. \\
\text{Tinc. Ipecac.} & \quad \ldots \ldots \quad \text{min.} \quad 3. \\
\text{Inf. Senega.} & \quad \ldots \ldots \quad \text{dr.} \quad 1. \\
\text{Aqu. Chlorof.} & \quad \ldots \ldots \quad \text{ad dr.} \quad 2. \\
\text{Fit. Mist.} & \quad \ldots \quad \text{mitte oz.} \quad 4. \\
\text{Sig. 1 dessert spoonful to be taken t.i.d.}
\end{align*}
\]

On the following day it was reported that the child had spent a relatively sleepless night, but had brought up about a cupful of yellowish green sputum. His temperature had fallen to 97.8 °F. His chest was
was still noisy, but he looked very tired and sleepy and had refused food. The mother was again instructed not to lift the child from the bed, to keep the windows open, to give plenty of fruit juice and sugar, and the following prescription was given to ensure that the child slept at nights:

\[\text{RX.}\]

\begin{align*}
&\text{Pot. Brom.} \quad \text{gr. 5.} \\
&\text{Chloral Hydrate} \quad \text{gr. 5.} \\
&\text{Syr. Auranti} \quad \text{min. 15.} \\
&Aquam \quad \text{ad dr. 2.} \\
&\text{Fit mist. Mitte oz. 2.} \\
\text{Sig: one dessert-spoonful to be taken at night.}
\end{align*}

On the following day the child was reported to have spent a good night's sleep of ten hours; he looked a little more lively but the physical signs in his chest were unaltered.

This state of affairs continued for another three days after which the child showed marked improvement in his behaviour although the signs in his chest still persisted.

The M&B '693' tablets were stopped on the fifth day from their first administration so that the child had taken seven tablets in that period.
The child's appetite was improving and he was given milk foods, fine fish and lightly boiled eggs, which he relished eagerly. The expectorant mixture was continued and the mother was shown how to induce good postural coughing.

For another four days a fair amount of purulent sputum was expectorated after which the signs in the chest quickly disappeared, the sputum lessened and finally was absent.

The expectorant mixture was stopped and a general tonic was prescribed in the form of:-

\[ R_x \]

Ol. Morrhuai c. Malt.
Mitte oz 8.

Sig: one dessert-spoonful three times a day.

The mother was instructed to take the child out into the park daily and to feed him up on nutritious foods. After only one week's convalescence the boy was once more bright and lively, simply overflowing with vim and devilment, and no relics of his illness could be detected in his chest, whereupon he was discharged.
Case 3.

A.D., female, age 11.

This patient had had malaise and loss of appetite for one day followed by diarrhoea which necessitated her using the bedpan about 40 times a day. The stools were yellowish, watery and latterly tinged with red. She had a temperature of 101.2° F.; her face was flushed and her pulse rate 98 per minute. Her abdomen was slightly tumid and she complained of slight general tenderness on pressure over it and of colicky pain. An examination of her skin, respiratory and cardiovascular systems revealed nothing abnormal and her tongue was clean. Thereupon a specimen of stool was ordered and the following prescription was given:-

\[ \text{Rx: Paraff. liquid. } \text{5. Kaolin. (B.P.)} \]

\[ \text{Mitte oz. 4.} \]

\[ \text{Sig: one teaspoonful every three hours.} \]

At the same time a diet of boiled water and boiled milk was advised.

Two days later the number of motions was reduced to five per day and after a further three days the diarrhoea had completely cleared up.

In the meantime the stool had been sent away for bacteriological examination and it was reported that the causative organism was B. Dysenteriae Sonne.
The interest of this case lies in the fact that the source of infection was provisionally put down to a public bath, since the history offered no other very plausible explanation. Then during the following week I was called to visit three other cases of dysentery, two of which had also visited the same baths and the third was the brother of one of these latter cases. All of these cases presented similar manifestations to the one just described and all were successfully treated on the same lines.
Case 4.

J.W., male, age 11.

This patient complained of pains in both ankle joints and gave a history of several previous attacks of joint pains which had necessitated his being absent from school. On examination, the joints complained of gave full movement, and excessive manipulation did not cause pain when the child's attention was distracted. He had no rise of temperature but his pulse was running at ninety per minute when the child was resting. His heart was not enlarged but there was a mitral systolic murmur and a faint pre-systolic one. During the whole examination the child was remarkably taciturn but occasionally made grimaces and smiles without any obvious cause. This prompted an inquiry into his previous behaviour and drew out the following interesting points; the boy was not very fond of school and had several times been absent from school on account of pains in his joints. He also was subject to fits of temper when he would order visitors out of the house, brandish pokers etc., and fight with members of the family including his mother; no amount of bullying could quieten him although he was amenable to gentle persuasion from his father. Between these fits he was very quiet but often cried or laughed when there was no occasion to do so. When he was allowed outside
outside

he always got into mischief by climbing into forbidden places and by molesting other boys who in consequence set upon him whenever he appeared in the street. As a result he was constantly kept indoors except when he went to school. For some years he had been under the supervision of psychological experts attached to the school medical service, but no improvement had been noticed. The mother also said on further questioning that when the boy was on holiday in the country where he could get freedom from molestation his behaviour improved remarkably and he was "a different laddie". She gave no history of acute rheumatism but mentioned that, as a young child, he had fallen on his head and "never been the same since".

From this information I came to the conclusion that the boy was feigning pain in the ankles in order to avoid going to school which he disliked, presumably from his previous experience. I judged from his grimaces, his heart sounds, and his history, that he was suffering from mild chorea, and that quite possibly he had had genuine joint pain. Consequently he was ordered to go to bed flat on his back and the following prescription was given:

\[ \text{Rx.} \quad \text{Calcium Aspirin} \quad \text{gr. 10.} \]
\[ \text{Lactose} \quad \text{q.s.} \]
Sig. 1 tab. to be taken four hourly.

However, at subsequent visits, it was evident that this treatment was being disregarded despite repeated advice and, as an alternative, it was recommended that the boy should be given a prolonged holiday with his country aunt.

This case illustrates the difficulties which are encountered in mild cases who do not present from the patient's point of view a sufficient degree of illness to warrant restrictive treatment. It also brings out the difficulty of attributing correct value to history of trauma. But there is no doubt that there were two conditions present both of which required adequate treatment, for the recrudescence of joint pains would indicate that the rheumatic infection is still active and requires careful supervision in order to avoid subsequent crippling of the patient's activities from both joint and cardiac disability. Also there can be no doubt that the psychological make-up of this patient, if it continues in its present path, will undoubtedly bring him into conflict with society and thereby render him an ineffective citizen.
Case 5.

W. MCK., male, age 67.

This patient gave as his sole complaint that he noticed blood in his urine for two days, and beyond this there was no other abnormality at all. The following negative findings are worth mentioning: no increased frequency, no dysuria, no difficulty in starting the act, no noticeable change in the quantity, and no pain or pressure above the pubis. His pulse rate and pulse pressure were normal for his age, as also were his heart and his lungs, save for a little emphysema. Consequently a specimen of urine was taken away for examination which showed that microscopically there were numerous red cells, pus cells, and a string of epithelial cells. The specimen was stained and the said string of cells was seen to consist of a layer of connective tissue stroma covered by big square epithelial cells whose protoplasm stained purple with Leishmann's. There was no albumin; no casts; and the urine was acid to litmus.

The urinary examination suggested infection of the bladder, but in a man of this age painless haematuria demands more extensive investigation, in order to exclude growths. Further, the finding of the abnormally staining epithelial cells suggested that the condition might probably be an infected papilloma of the bladder; carcinoma of the prostate had also to be excluded.
A second visit was paid on the following day and on rectal examination the prostate was felt to be of normal size and consistency. Also the urine contained no naked-eye evidence of blood and both chemical and microscopical examination confirmed this. The patient had been abroad with the British Army in India and South Africa and the possibility of Bilharziasis had to be thought of, but examination of the two specimens of urine and of a third bloodless specimen on the following day failed to reveal any eggs of Bilharzia.

Thus, although a diagnosis of cystitis was made from the urinary findings, yet it was considered advisable to enlist the aid of a urologist. However, his report showed that there were no papillomata in the bladder, and that the only abnormal finding was slight reddening of the base of the bladder near the internal urethral orifice and he suggested a diagnosis of chronic cystitis. The patient was given the following prescription:

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Rx.
Pot. Sit. ......................... gr. 30.
Sod. Bicarb. ..................... gr. 15.
Liquor Ammon. Acet. ........... oz. $\frac{1}{2}$.
Fit. Mist. mitte ............... oz. 8.
Sig. 1 tablespoonful in water q.i.d.
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This was combined with M.& B. 693, which was given in doses of 2 tablets to begin with, 2 in four hours' time, and thereafter 1 every four hours and 2 at bedtime; i.e. 6 tablets per day which was continued for five days, and then stopped. On this treatment the urine quickly turned alkaline and after five days no pus cells were found on three successive days, and the patient was considered cured.

A search was then made for the cause. The throat and mouth were examined and found to be normal. The incisor teeth were present, top and bottom. The child resented having its mouth examined but at the time no particular significance was attached to this. Next the abdomen and chest were examined with particular reference to intussusception, appendicitis, hernia and pneumonia, but nothing abnormal could be detected.

The ears were examined and pressure was applied to the mastoid, but although the child screamed when I pressed on the mastoid yet when the mother did so it remained quiet. Renal ear trouble was discounted.
Case 6.

J.G., male, age 9 months.

I was called to see this child late one afternoon on the verbal report that it was in a precarious position. On arriving at the house I found the child perfectly quiet and looking apparently well. The history, however, was that, during the afternoon, the child had been very fretful and was crying a lot; he had vomited twice and was refusing food. He had no diarrhoea and his last stool was normal. The temperature was raised to 100.6°F. The pulse rate was 112 per minute and respirations were 22 per minute.

A search was then made for the cause. The throat and mouth were examined and found to be normal. The incisor teeth were present, top and bottom. The child resented having its mouth examined but at the time no particular significance was attached to this. Next the abdomen and chest were examined with particular reference to intussusception, appendicitis, hernia and pneumonia, but nothing abnormal could be detected.

The ears were examined and pressure was applied to the mastoids, but although the child screamed when I pressed on the mastoids yet when the mother did so it remained quiet. Hence ear trouble was discounted.
The child's buttocks and penis were examined for signs of irritation but the parts were dry and healthy. There were no loose pins which could cause trouble. In short, the problem to be solved was why a previously healthy child should quite suddenly in the course of an afternoon become fevered, fretful, and sick.

Frankly I was puzzled and in an attempt to get some inspiration I stood back and gazed at the child as a whole and then it was that I became aware of the fact that the child was clenching its teeth. Thereupon the probable diagnosis dawned, namely "teething", so a prescription was given for Acetyl Salicylic acid in 2½ gr. tablets, which were given to the child four times a day. This treatment seemed to give a little ease in so far as the child slept well at night and stopped vomiting, but it was not until two days later that all the symptoms cleared up and the tiny tips of the first milk molars were visible through the gum.

This case illustrates the difficulties encountered in dealing with babies who cannot tell by words where they are sore, with the result that one has to depend a great deal on careful observation. A further complication which was brought out in this case is the fact that tests for pain on pressure can be very
very/

misleading since the child screams not because of any pain but solely on account of being touched by a strange hand. Thirdly, the relative minuteness of these little mites demands a certain amount of finesse in examination while there always exists a subconscious fear that a serious condition will escape detection at first. Hence this case merits inclusion if only to demonstrate how extremely labile is the young child's health and how difficult it can be to come to a sure diagnosis.