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Hysteric Blindness and Pseudo-Meningitis, with Report of a Case Treated by Hypnotism.

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HYSTERIC BLINDNESS AND PSEUDO-MENINGITIS, WITH REPORT OF A CASE TREATED BY HYPNOTISM.

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Hysteric amblyopia with contracted visual field and dyschromatopsia is common, monocular amaurosis is less common and hysteric total blindness is rare. Gilles de la Tourette in his recent work[1] refers to only eight cases as already published, viz., Landouzy, two cases;[2] Briquet, three cases;[3] Marlowe,[4] Würdeman[5] and Levy,[6] each one case; and in looking up the references I find that the case of Würdeman is not a case in point, but one of hysteric deafness. To these I have been able to add fourteen more from the literature beside my own. Harlan[7] refers to a case cured by the application of an imaginary magnet and to another which occurred in the practice of Dr. Agnew. Jeaffreson,[8] two cases; Moore[9] mentions a case occurring in the practice of a colleague. Brown,[10] one case, although it is not reported as one of hysteric blindness; Buzzard,[11] one case; but it is not stated positively that the amaurosis was complete. Dujardin-Beaumetz and Abadie,[12] Thompson,[13] Mendel,[14] and

1 Traité de l'Hystérie. Paris, 1891.
2 Traité de l'Hystérie. Paris, 1846.
3 Traité de l'Hystérie Clin. et Thér. Paris, 1859.
4 N. Y. Med. Jour., Feb. 9, 1889.
5 Med. News, Feb. 14, 1891.
6 Ueber hyst. Amaurose. Inaug. Dissert. Berlin, 1890. Abstract in Neurolog. Centralb. Sept. 15, 1890.
7 Med. News, Jan. 11, 1890.
8 Lancet, April 13, 1889.
9 Internat. Clinics, II, second series, p. 315.
10 Northwestern Lancet, Oct. 15, 1890.
11 Diseases of Nerv. Syst., p. 91.
12 Soc. Méd. des Hôp. 1879.
13 Transactions Med. Ass'n Missouri. 1893, p. 166.
14 Deutsche Zeits. f. prakt. Med. 1874. No. 47.

Oppenheim,[15] each one case, the latter's patient having had thirteen attacks in ten years, one of them lasting a year and a half. Gowers[16] reports a case in which there were several transient attacks. I have included in this category two cases reported by Barkan,[17] although in each instance a careful examination revealed perception of light on one side. Since the foregoing was written Mitchell has reported a case.[18] A more extended search would possibly bring additional cases to light,especially from the older literature cases recorded as simulated blindness and malingering, for prior to the investigations of the French school these cases were not generally understood, and even now there are physicians who can not, or at least do not, distinguish between patients who see but who do not know it, and those who see but will not tell it. But in considering the cases we have only to remember that hysteric amaurosis is simply an hysteric anesthesia, produced by the same processes and amenable to the same laws as other hysteric anesthesiæ. There is no essential difference between monocular blindness with binocular vision and total anesthesia of the hand which still allows the patient to tie a bow beneath her chin with unimpaired dexterity. Some of the older cases of "reflex blindness" from slight injury of the eye or from irritation of the fifth nerve were doubtless hysteric.[19]

The diagnosis of hysteric blindness is usually not difficult if the physician simply bear in mind the possibility of its occurrence and have a fair knowledge of the symptomatology of hysteria. What may be called the negative symptoms are first to be considered. The pupils are ordinarily normal, the fundi oculi are normal as are also the cranial nerves; the corneal and lachrymal reflexes are present and the

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[15] Lehrbuch der Nervenk. Berlin, 1894.

[16] Diseases of Nerv. Syst. Vol. II, p. 165.

[17] Zwei Fälle von vollenständiger Erblindung in Folge von männlicher Hysterie. Heilung. Festschrift zum Fünf-und-zwanzig Jährigen Jubiläum des Vereins Deutscher Aerzte zu San Francisco. 1895.

[18] Med. News. Aug. 24 and 31, 1895.

[19] Vid. J. Santos Ferdandez, Amer. Jour. Med. Sciences, January, 1881.

interrupted galvanic current causes flashes of light as in a normal eye; but it must not be forgotten that exceptions have been noted to all these rules. In Mendel's case the pupils sometimes responded to light and sometimes were fixed; one of Harlan's cases had rigid pupils as did also that of Dujardin-Beaumetz and Abadie, and in Levy's and one of Barkan's cases they reacted sluggishly. In Levy's case also the corneal reflex was lost and the eyes turned upward and to the left, and in one of Jeaffreson's cases there was no light-reflex to the galvanic current. The fact that the blindness is not due to changes in the intra-ocular structures does not preclude the fortuitous presence of such changes; for instance, Gilles de la Tourette alludes to a case with syphilitic choroiditis. Hysteric strabismus, ptosis, facial paralysis and deviation of the tongue have been observed and there is nothing to exclude the possibility of any one of these complicating hysteric blindness. Donath,[20] in a case of hysteria under observation for four months, found that sometimes one pupil, sometimes the other did not respond to light and this was accompanied by paralysis of accommodation, but there was no amaurosis. S. Weir Mitchel[21] reports a peculiar instance of hysteric amblyopia almost reaching amaurosis in which the pupils reacted sluggishly and at times that of either eye only to light let fall upon the retina of the opposite eye. In making the diagnosis it is to be remembered that a lesion of the brain may cause total blindness with normal pupils and fundi if the focus of disease be bilateral, situated posterior to the corpora quadrigemina, and large enough to destroy the visual centers or cut the optic radiations on both sides; but a lesion of such magnitude whether due to hemorrhage, softening, inflammation, abscess or a new growth would cause other and marked concomitant symptoms, and therefore another necessary negative symptom of hysteric amaur-

[20] Deutsche Zeitsch. für Nervenh. Bd. II, p. 217.
[21] Med. News, Jan. 28, 1893.

osis would be the absence of other signs of such a lesion. The positive symptoms to be considered would be those of hysteria but I shall stop at the barest mention of the principal ones. Anesthesia, hyperesthesia, monoplegia, hemiplegia, paraplegia, contracture, tremor, chorea, stuttering and other affections of speech, disturbance of the special senses, convulsions and the general mental state, any of these bearing the characteristics known to belong to hysteria; vaso-motor phenomena, loss of pharyngeal reflex, and especially anesthesia of the conjunctiva and eyelids are to be mentioned and always sought for. The mode of onset might be of diagnostic worth; blindness coming on suddenly after great psychic disturbance or gradually as a concentric and increasing contraction of the field of vision with dyschromatopsia, or following an etiologic factor sufficient for auto-suggestion but inadequate to produce blindness otherwise, as a slight traumatism, atropin dropped into the eye or association with a blind person, would indicate the hysteric nature of the affection. But hysteric amaurosis may come on without ascertainable cause (possibly during the night) in a person who has never shown any signs of hysteria and who is found to bear none of the stigmata; that is, the case may be an example of primary, or initial, mono symptomatic hysteria. We must then depend entirely upon the negative signs and it is particularly in these cases that hypnotism may come to our aid in diagnosis as in treatment. Hysteric blindness is to be differentiated from that of exhaustion or anemia and if it follow an injury, especially in the vicinity of the eye, with profuse hemorrhage, the diagnosis might at first be difficult. Neither is the hysteric affection to be confused with the blindness of ophthalmic migraine, that is, migraine with marked disturbances of vision. These consist ordinarily of scintillating or central scotoma, amblyopia, or hemianopia not infrequently accompanied by disturbances of speech. There may also be visual hal-

lucinations or transient blindness. Charcot and Babinski[22] have attempted to show that this affection is sometimes hysteric but, however that may be, the blindness is totally distinct from hysteric blindness. We might have an hysteric ophthalmic migraine accompanied by an amaurosis that could not be called hysteric, and we might have an hysteric amaurosis following a migraine not in the least hysteric. The pathology of the two affections is entirely different. The one is of purely psychic origin, the other due to a disturbance, probably circulatory, of the visual centers. There is another psychic blindness that is to be distinguished from the hysteric, although the lines of division may blend in individual cases. This I am tempted to call the blindness of insanity and is simply a delusion entirely comparable to the ordinary delusions of the psychoses. These cases again shade off into those of photophobia, blepharospasm, etc., in which the patient fears the light, can scarcely open the eyes, may believe that he is blind but can see if he can be made to look.

Hysteric pseudo-meningitis, a knowledge of which we owe almost entirely to our French confrères, was first described as such in 1873 independently by Arnozan[23] and Saint-Ange,[24] although Briquet fifteen years previously had written of hysteric headache accompanied by chills, vomiting and sometimes fever. The principal later contributions have been by Dalché,[25] Chantemesse,[26] Macé,[27] Pitres,[28] Bardol,[29] and Brugère,[30] although a number of cases have been reported by other observers in France, Germany and England; none, so far as I know, in this country. I shall give here but the briefest résumé of the subject and pass rapidly to the report of my case which

22 Archives de Neurol., 1890. Vol. 20, p. 305.
23 Gaz. Méd. de Bordeaux. 1873, p. 250.
24 Ibid. 1873, p. 292.
25 Gaz. Méd. de Paris. Jan. 17, 1885.
26 Thèse de Paris, 1884, and Soc. Méd. des Hôpitaux, May 28, 1891.
27 Thèse de Paris. 1888.
28 Leçons sur l'Hyst. etc. 1891. Vol. I, p. 198.
29 Thèse de Paris, 1893, and Rev. Mens. des Mal. de l'Enf. XI, p. 296.
30 Thèse de Bordeaux. 1893.

is, I believe, unique in showing the combination of this symptom-complex with hysteric amaurosis.

Hysteria may present a clinical picture so similar to acute or subacute meningitis as, for a time, to make a correct diagnosis impossible. There may be constant headache, vomiting, retracted abdomen, rigidity of the spine, opisthotonos, double vision, great prostration and mental hebetude, delirium or somnolence, retention or incontinence of urine, convulsions, with fever and rapid or subnormal pulse. Furthermore, the vomiting of hysteria is like that of meningitis, spasmodic, projectile, generally without nausea or gastric pain. The fever of meningitis is ordinarily moderate and irregular or rapidly fluctuating; the same may be said of that of hysteria. In hysteric psuedo-meningitis temperatures of 101, 101.5, 101.8, 102.5 and 103.1 degrees F., have been observed and a pulse-rate as low as 48. The diagnosis must generally be made by means of other symptoms of hysteria (as indicated in connection with hysteric amaurosis) although in some cases the entire absence of fever and abnormality of the pulse indicate the character of the affection. In most instances a careful search has revealed hysteric stigmata. In Charcot's case a rythmic chorea at once gave the clew. In one of Guinon's cases it was the general conduct of the patient that indicated the nature of the malady. Occasionally only the sudden recovery of the patient has changed the diagnosis to hysteria. In one case Chantemesse demonstrated an inversion of the ratio of the urinary phosphates, such as was found by Gilles de la Tourette and Cathelineau[31] to be characteristic of an hysteric attack. As Gowers has pointed out, the strabismus of hysteria is nearly always convergent, of both eyes and spasmodic, while that of meningitis is paralytic and not equally convergent on both sides from the first. In the hysteric affection with pain in the head a hysterogenic zone may at times be found on the scalp. In a doubtful case

[31] La Nutrition dans l'Hystérie; Prog. Méd. 1890.

where the question of tubercular meningitis is to be considered the tuberculin test for tuberculosis might be tried or tapping the spinal canal with examination of the fluid for bacilli. The pupils are generally and the fundi oculi always normal, but these signs are of small negative value. The pulse in the hysteric affection may be rapid, normal or slow, but has never been observed to be irregular. Indeed as there is no pathognomonic symptom of meningitis and no one symptom is necessary to make the diagnosis, neither the presence nor absence of the disease can be affirmed from one symptom.

Case.—C. J., a Swedish servant girl, aged 30, was brought to the Policlinic Hospital, Monday, Oct. 26, 1894. The preceding Friday she had been taken with a severe pain in and above the left eye. The pain continued and she rapidly lost vision, first in the left eye, then in the right and when she entered the hospital she was totally blind. She was seen by the ophthalmologists, Drs. Coleburn, Mahoney and Wilder, who, finding no local trouble to account for the blindness, the following day referred her to me. I saw her, for a few minutes only, the same evening. Her pulse was 120, temperature 100 degrees F., tongue thickly coated; there was evidently marked prostration and considerable mental hebetude. When questioned she complained of extreme pain in the head, worse on the left side, especially in the frontal and temporal regions; the pain extended to the face, back of the neck and to a certain degree down the spine and there were some fugitive pains in the extremities. Marked tenderness to percussion was present all over the left side of the head and face except the inferior maxillary region, and to a lesser degree on the opposite side and along the upper spine. Cutaneous hyperesthesia was also marked, greatest where the pain was greatest but to some degree over the entire body. The head was not retracted but there was rigidity of all the extremities and the deep reflexes were abnormally brisk. The abdomen was not retracted but the patient was constipated and had vomited some. She was totally blind in both eyes. There was no perception of candle-light even as condensed by a two-inch lens, nor did the eyes follow the light or show, by other involuntary movement, recognition of the illumination. The fundi were normal, the pupils reacted promptly to light from all parts of the field and there were no ocular paralyses. Other cranial nerves were apparently normal except that she was totally deaf in the left ear. This deafness had come on since the beginning of the attack. As before stated, there was marked general weakness, but no localized paralysis

and no anesthesia was discovered. There had been no convulsions. Thoracic and abdominal viscera were normal except a small patch of broncho-vesicular breathing below and internal to the angle of the right scapula. She was menstruating and the pelvic viscera were not examined. The foregoing data were too conflicting to allow of a positive diagnosis at once and I made none. I think it will be allowed that with a temperature of 100 degrees F., pulse 120, excruciating headache, pain and rigidity back of the neck, vomiting, constipation, foul tongue, hyperesthesia and increased reflexes it looked much like cerebro-spinal meningitis. But this would not account for the blindness without other ocular trouble, nor for the deafness without involvement of the facial. A meningitis with an abscess in the occipital region might have been invoked to explain the symptoms but the abscess would have to be large enough to destroy the visual centers in both hemispheres or cut the optic radiations of both sides posterior to the corpora quadrigemina. But there was no discoverable source of infection and the blindness had come on within forty-eight hours, too quickly for the development of such an abscess. An ice-coil was ordered to the head and the next morning found the patient rather more comfortable but in much the same condi- as the previous evening. A more careful examination now showed that although she was deaf in the left ear and heard perfectly well with the right, yet when I spoke loudly into the left ear, the right remaining uncovered, she heard nothing. This was strong evidence, not of simulation, but of hysteria, and a prolonged search for stigmata finally revealed to the right of the sternum between the second and third ribs a spot of anesthesia about the size of a silver quarter. As I continued to examine and to try to accurately define this area it grew in extent until it reached the opposite side and up to the neck. I now felt reasonably sure of the diagnosis, or at least part of it, and as I had secured the attention of the patient by the examination of sensation, I immediately hypnotized her by simple suggestion. Fortunately, she was a good subject, although never hypnotized before, and in a few minutes suggestion had greatly ameliorated the pain and tenderness. The hypnosis with suggestion for the pain and tenderness was repeated in the evening with excellent results. The next morning she was quite comfortable and had a faint perception of light with the right eye. She was hypnotized and told that she could count fingers with this eye and on being awakened she was able to do so readily. A repetition of the treatment in the evening enabled her to read print. The left eye was still completely blind, but one sitting gave her perception of light, and the eye now followed the candle as it was moved about. The next morning she was given three sittings, one immediately after the other, enabling her in turn to count fingers, read print (left eye) and hear perfectly with the left ear.

She remained in the hospital about six weeks but the further history may be summarized. No very severe symptoms appeared, but she was troubled by a number of minor ailments, some of them very annoying. Aching pains in the back, abdomen, chest and extremities, anorexia, emesis, constipation, insomnia and once retention of urine for a day and a half, at the end of which time it was drawn, were some of the symptoms. They all came and went and varied in intensity without apparent cause, and were generally temporarily relieved by hypnotism, except the retention of urine and constipation. In connection with this case there are a few points that would seem, perhaps, to merit a more special mention.

Relation of the Headache to Loss of Sight.—Careful inquiry elicited the fact that the attack began as an ophthalmic migraine, that is, a severe headache with scintillating scotoma, or at least a play of lights and colors that she could not accurately describe; further, that about January, 1893, up to which time she had been perfectly well, she had a severe headache over and in the right eye, with impaired vision for a few days. About nine months before the present illness she had had a second and more severe attack on the left side, with complete blindness of the left eye lasting two or three weeks, and vision was still somewhat impaired when this last attack occurred, in which the pain distinctly preceded the visual trouble. Furthermore, during her stay in the hospital the most constant of her troubles was headache, and it invariably affected the visual function. When it was intense, as it was on one or two occasions, she would be unable to count fingers; if it were of moderate severity she would be unable to read ordinary print; when she had no headache her visual acuity was practically normal. The pain in the head was almost exclusively on the left side and it was as invariably the left eye which displayed the amblyopia. This difficulty in seeing could always be relieved by hypnotism, but what is of greater interest is the fact that

suggestion directed against the pain *alone* would improve the sight. Again, when the pain was rather severe she had in addition to more or less amblyopia, marked dyschromatopsia, green and blue being lost, with greatly contracted fields for red and white. Relieving the headache by suggestion, not a word being said about vision or colors, never failed to remove the dyschromatopsia and enlarge the previously contracted fields. With the amblyopia she had at times diplopia or polyopia monocularis, which was also banished by relieving the pain. All of this goes to support the modern doctrine that hysteric manifestations are of purely psychic origin and due to the development of a sub-conscious imperative conception, the "idée fixe subconsciente" of the French. I do not like the term, but it seems better than any current one to express the process in these cases.

The Fever.—As before noted, the girl had a temperature of 100 degrees F. when first seen, and during almost her entire stay in the hospital it remained elevated. It was generally about 99 degrees F., never exceeded 100 degrees F., but seldom fell to the normal. At the same time the pulse was somewhat accelerated. The question of hysteric fever has been a bone of contention among pathologists and clinicians for more than a hundred years (Pomme, 1760–1782) and although its existence would now seem to be an established fact, yet in these days of recognized multifarious infection it must be repugnant to most of us to make, in any particular instance, this diagnosis. I have been loath to do so in my case and can only say that no other cause could be discovered. There seemed to be no probability of a malarial element in the case, but she was given an active course of quinin and arsenic. Although she was at times constipated, yet the bowels received attention[32] and I think intestinal infection may be excluded. She

[32] I saw some years ago in consultation a case of hysteria in which the attending physician had made a diagnosis of meningitis, and in which the fever was doubtless due to intestinal intoxication.

coughed at times, but râles were never heard and the cough had all the characteristics of a nervous affection. No sputum could be obtained for examination. The small area behind where respiration was slightly bronchial in character remained unchanged weeks after her fever had left. In short, no source of infection was discovered. Her temperature, moreover, was irregular, rose and fell without any apparent cause and eventually disappeared rather suddenly.

The Relations of the Case to Hypnotism may be very briefly stated. The patient went to sleep promptly at the first attempt; but it should be added that a friend had been treated by hypnotism in Stockholm so it was not entirely unknown to her. It was an efficient diagnostic and therapeutic aid although the diagnosis might have been made without it and other treatment might have been equally effective, if less rapid, in producing the desired results. Although hypnotic suggestion was so effective the patient was never unconscious and afterwards could remember all that had been said to her. For instance, she recalled perfectly being told that she could feel nothing with her left arm, but did not know that I had thrust a pin into it. I tried once one variety of what has been called hypnotism at a distance, although in this case as, I think, in all others, it was an instance of simple suggestion. As before noted, she suffered from insomnia and one morning I told her—not during hypnosis—that at nine o'clock in the evening she should think of me, imagine me with her in my usual place, count nine, and that when she reached nine she would fall asleep, as I would put her to sleep from my home. She did as directed and it succeeded admirably.[33] She subsequently tried this a number of times of her own accord without avail. I also tried post-hypnotic suggestion; this several weeks after she had left the hospital. During hypnosis I raised her arm and told her it was rigid and would remain

[33] Needless to say I did not think of her at all and that the process was one of auto-hypnosis.

so after she should awake until I should give her permission to lower it. When awakened the arm remained above her head. At this juncture I was called from the room and on my return after a few moments I found her just as I had left her. After some conversation, I asked her what her hand was doing up there and she replied with a rather shame-faced expression, "you know well enough I can't put it down."

The patient one day, several weeks after having left the hospital, asked me if I was the doctor who told her at the time she was blind to make a face at him (I had done so to test the facial) and I then learned that that was the only incident of my first examination that she remembered, there having been, as stated, considerable mental hebetude. I hypnotized her and then with some urging she recalled most of the details of the examination, and what is of greater interest, could remember them after coming out of the hypnosis.

These seemingly umimportant details are cited to show that the most profound hypnosis is not necessary for effective suggestion.

Venetian Building.