HYSTERICAL HIP.

By W. H. OGILVIE.

I HAVE been asked by the Editor of the *Post-Graduate Journal* to discuss a case shown at one of the F.R.C.S. courses, choosing for preference one over which the candidates had made mistakes. From this point of view I have selected a girl with an hysterical hip who attended on April 19. Only one of the candidates to whom I showed this case diagnosed it correctly, and his success was due less to clinical acumen than to previous acquaintance with the patient, who had been under his care in one of the many hospitals to which she had been admitted. I cannot blame any of the others for their failure, since I myself was completely deceived on the first occasion that she attended my out-patients at Guy's, but an examination of the reasons for our failure should be of value to all of us.

The patient was a girl aged 18, a stage dancer. About a year ago she slipped and fell awkwardly during a performance. Since that date she has complained of pain, chiefly in the left hip, but also in the right hip and both knees. She

History. has spent most of this year in various hospitals, where different diagnoses have been made, but the condition has been usually considered tuberculous. However, the external cartilage has been removed at different times from both knees.

She was a nice-looking, plump, fair-haired girl, perfectly frank and straightforward, and obviously at peace with the world. On examination of the joints, when she was lying on a couch, no deformity could be noticed, but very little move-

Examination ment in any direction could be obtained in either hip or knee. The muscles immediately went into spasm and she complained of great pain. Voluntary movements of the limbs could not be carried out, or only over a very small range and then not against resistance. The contours of the hips, and the bony points around the joints were normal, and there was no fluid in either knee. The tape measure showed that there was no wasting of thighs or calves, and no shortening. Knee-jerks, ankle-jerks, and plantar reflexes were normal. Her mode of progression was very awkward, the chief features of the gait being that she held the left leg stiff and in full eversion, and at each step lurched her whole body over on to the left hip.

The reasons why the men all diagnosed this case wrong were, first a too ready acceptance of the history and symptoms; and second, an insufficient analysis and checking of the physical signs. The girl, as I have said, was charmingly

The Importance of Obtaining Correct History. frank and might have been a village milkmaid; it was very hard to disbelieve her. But the hysteric is not a malingerer or attempting to deceive; her disease is absolutely genuine in her mind, and because she has replaced her real and tangible troubles with a good copper-bottomed imaginary ailment, she is entirely happy. There were several things in the history that were suspicious. Pain in a joint is invariably accompanied by wasting in the muscles controlling it; where there is no wasting, the pain is either slight or imaginary. Evidence of constant use of a limb, full development of the muscles, or callosities on the hands or feet, is proof that it cannot be painful. Then a disease involving both hips and knees is almost unknown. It is quite impossible in tuberculosis, excessively rare in gonorrhœa, and in rheumatoid arthritis, without any of the

upper limb joints being involved, equally improbable. When the joints are also of normal appearance the diagnosis of hysteria is almost certain. Then any surgeon knows the rarity of a lesion of the external cartilage ; when both have been removed in a patient under 20, we are facing a condition so unlikely as to be suspicious.

Most of the candidates told me that the left leg was short. This was because they expected shortening, and interpreted the gross errors that are inherent in the ordinary methods of measurement to fit their diagnosis. The textbooks of surgical diagnosis lay down methods of measuring for shortening which every orthopaedic surgeon knows to be very inaccurate. They depend upon the identification of bony points that are vague and deeply placed, and marking these points upon the skin, which can move to any extent

**Common
Errors in
Measuring
Shortening
of Lower
Extremity.**

over them. The internal malleolus is sharply defined, the anterior superior spine less so ; the tip of the great trochanter is very vaguely felt through the ilio-tibial band, and the ischial tuberosity equally indefinite. Of all orthodox methods Nélaton's line, especially when drawn in a fat patient, is the most useless ; it no more necessarily crosses the tip of the trochanter than a line drawn from north to south pole passes through Greenwich. Bryant's triangle is more sensible but, because the subcutaneous points, though felt, cannot be marked with any certainty, it is only reliable to within about $\frac{3}{4}$ in. Measurements of length taken from the anterior superior spine to the internal malleolus are only approximately correct if the pelvis is level and the limbs in identical position. If both limbs are movable, better methods are available. If the diseased hip is adducted, the method is of no value, because the sound one cannot be put in a comparable position. If the diseased hip is abducted, it is the only possible method, but since it contains three errors, the location of the bony points, and the line taken by the tape measure between them, it must not be taken as accurate within more than $\frac{3}{4}$ in.

No method of measurement is entirely accurate, but the best approximations are obtained by realizing that, while a mark or the end of a tape measure placed on the skin over a bony prominence may differ by $\frac{1}{2}$ in. from one similarly placed on the opposite side, the fingers of the surgeon can be placed on exactly corresponding points.

To measure shortening, when both hips are movable, the patient should stand and the surgeon sit opposite her with his eyes on a level with the pelvis. The fingers are laid on the outer side of the hips and the thumbs pressed against the anterior superior spine, the sense of touch indicating when they correspond exactly. Books, papers, or wood blocks are then placed under the foot of the short leg, till the thumbs, gauged by horizontal lines on the panelling or doors, are exactly level. The thickness of the raising block then gives the shortening to within $\frac{1}{8}$ in. If the patient cannot stand the thumbs are again placed on the spine, and a ruler is laid across them. An imaginary line is drawn at right angles to the centre of this plane, and the feet are placed touching each other so that the line passes between them. Direct measurement from one malleolus to the other again gives the shortening very accurately.

**The More
Accurate
Method of
Diagnosis in
Shortening.**

The level of the trochanter is best gauged by standing above the patient, with the thumbs pressed against the anterior superior spines and the tips of the index fingers against the trochanters. The position of the marking digits will be exactly comparable on the two sides. An inch measure is laid on the abdomen, and the surgeon estimates the distance from spine to trochanter on each side by comparison of the distance from thumb to index with the markings on the measure.

Again the men failed to notice that many of the observations they made could be used to check others previously made, and prove their falsity. When this girl was lying down, the hip movements were extremely restricted, and the hip was slightly adducted. When she walked she lurched right over, and it was obvious that the hip-joint was moving over a wide range and into nearly full abduction. Lying down the muscles were in spasm; walking, the gait spoke of a flail or paralytic hip. A lurching gait indicates an inefficient gluteus medius, either because it is paralysed, as in poliomyelitis, or because its leverage is gone, as in congenital dislocation of the hip. When Trendelenburg's test was applied in this patient (standing on one leg), the right side of the pelvis was instinctively raised, showing that the hip abductors on the left were normal. Other muscles could be cross-checked in similar manner. Thus, when asked to extend the hip there was no contraction of gluteus maximus; but if laid on her face and told to raise her head, it contracted normally.

The treatment belongs to psychotherapy. Our friend, having reached Guy's, patronizes many departments and comes back from each with a fresh splint. I am, however, averse from removing these gadgets, as I do not wish to do anything to prejudice the curative treatment that will be undertaken when she is admitted to the medical wards under my colleague Dr. Gillespie.

SOME REMARKS ON THE ROUTINE OF EXAMINATION OF A PATIENT.

BY DAVID LEVI, M.S., F.R.C.S.

MORE store is laid by the majority of the Examiners at the Fellowship Examination upon a correct physical examination and the *logical* marshalling of facts so gleaned than upon a spot diagnosis which is often nothing more than a guess. Patients at the examination hall fall into two groups. In the first group the diagnosis is obscure and a routine examination of the patient must be made. Many of the "long" cases may be so classed. The "short" cases often fall into the second group, the group in which the diagnosis is obvious. The object of the examination of these patients should be to confirm rapidly the preformed impression and the examination should then resolve itself into a search for the common complications that may be associated with the lesion found.

Recently a patient with a tumour in the neck was shown to candidates at the London Temperance Hospital. Most men diagnosed an adenoma of the thyroid. Many could not, however, when asked, say whether it was solid or cystic, and a still greater number were unable to say whether there were toxic signs present or not. If the patient seen, however, falls into the second group and the diagnosis is not obvious to the candidate, many men fail—because of the haphazard, happy-go-lucky way in which they examine the patient—before they have even been asked a single question by the examiner. A patient should be examined in a routine logical manner. Each part of one's examination of the patient should be carried out rapidly, but in a *logical orderly* sequence. For example, when shown the patient with the tumour of the neck, many candidates