EMERGENCIES IN GENERAL PRACTICE
ACUTE ANXIETY AND HYSTERIA

BY

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Anxiety is an abnormal emotion which resembles fear subjectively but differs from it in its persistence when the cause of the emotion is no longer apparent to the patient or appears inadequate to account for the symptoms experienced. It is abnormal by the criteria we apply to illness generally—namely, that the patient is called to bear an unreasonable amount of discomfort and is disabled to a varying degree in his work and in his capacity to maintain satisfactory social relationships. Thus the definition of the term excludes the normal or physiological response to the buffets of everyday life, and in practice there is no difficulty in distinguishing the two. A distinction must also be made between anxiety the symptom, which may colour a number of syndromes, and the anxiety state, which is a fairly clearly demarcated syndrome with anxiety as its principal symptom.

When anxiety is very severe it overflows into the muscular system, with the production of gross motor restlessness, and it is then termed "agitation." Agitation is always a symptom of an illness of a serious kind, and most patients referred urgently with a diagnosis of "acute anxiety state" are in fact suffering from a depression. Self-reproach and hopelessness about the future will usually be in evidence, and a depressive illness should always be suspected when symptoms of anxiety develop within a period of weeks without obvious external cause, and particularly when the patient is middle-aged or elderly. In younger patients acute anxiety or agitation may be the presenting symptom in schizophrenia, and the specific symptoms of that condition must be looked for. There may be paranoid ideas, woolliness or bizarreness of thought, or auditory hallucinations; and relatives may give a history of behaviour which has been unmistakably psychotic.

Symptoms of Anxiety

Whether anxiety develops as a primary symptom or as a reaction to another psychiatric illness altogether, it will produce bodily symptoms of a troublesome kind. Tension will develop in the voluntary musculature, notably in the front or back of the head and in the neck. Pain may come and go or the patient may find that because of one kind of discomfort or another his head is in his consciousness all day long. When muscle tension is severe and diffuse there is some reason to suppose that the massive central bombardment by proprioceptive impulses is responsible for the phobic attacks which afflict some patients from time to time. These are feelings of intense anxiety amounting to panic, and they are particularly likely to occur when free motor expression is denied by circumstances, as when travelling in a train or sitting in church. The attacks can be dispelled by deliberate relaxation of the musculature, but this will only be possible in a patient who has been taught how to go about it.

Other symptoms will result from the action of an excitable autonomic nervous system upon the viscera. It is wrong to look upon the symptoms of anxiety as being due predominantly to an overactive sympathetic, for in fact both divisions are working excessively and in a state of uncertain and fluctuating equilibrium. Thus the pulse will be labile but will not show a sustained change of rate. Constipation and diarrhoea may alternate with one another and the colour of the skin may alternate from pallor to flushing. It is the uncertain and variable behaviour of his organs which alarms the patient more than anything else and focuses his attention on one part, with the production of symptoms such as palpitations or epigastric discomfort.

Treatment

With two exceptions, a simple anxiety state will rarely call for emergency treatment. Occasionally a headache may prove intractable and severe enough for the doctor to be sent for, and headaches of this kind differ from "migraine" only in the absence of visual phenomena which have long been regarded as non-essential to the diagnosis. The treatment consists of a sedative such as sodium amylobarbitone in a dose of 3 gr. (0.2 g.), together with aspirin, 10 gr. (0.65 g.). There is no advantage in giving aspirin in larger doses than this, though of course it may be helpful to repeat the dose in an hour. The patient should lie down; when feasible, quiet and darkness will help in reducing the sensorial bombardment. The second condition for which the doctor's help may be sought is the panic attack, particularly when it occurs at night. What happens is that a very tense patient lies down and tries to keep still enough to go to sleep, and the denial of motor outlets provokes the attack. The immediate need in an anxiety attack is for a powerful and quickly acting hypnotic, and again sodium amylobarbitone is one of the more suitable, in doses of 3 to 6 gr. (0.2 to 0.4 g.) according to the severity of the attack and the weight of the patient.

When acute anxiety or agitation is combined with depression which is not itself slight or transient we are dealing with a dangerous combination. The depression makes life insupportable and the anxiety makes a solution an immediate necessity. The only possible solution to his problems may seem to be death, and the risk of suicide is great. It is at its height in the early morning, when symptoms are at their worst. If the patient's life appears to be in danger he should be placed under supervision, if necessary against his will, as quickly as possible. In the case of an ordinary patient the help of the duly authorized officer should be sought. He is a lay officer of the local health authority who has to decide for himself that the patient is mentally ill, and that by reason of this should be placed under restraint. Since the decision and the responsibility are the D.A.O.'s, the doctor should not be put out if the officer does not always follow his advice. In practice these officers discharge their duties with tact and helpfulness, and will not usually differ from a doctor who has taken reasonable care in his examination.

The patient will either be sent to an observation ward in a general hospital which has been recognized for the purpose, on what is called a "three-day order," or he will be sent straight to a mental hospital on an urgency order. In the case of a patient who is to be sent to a private hospital or licensed house the urgency order is used, but in this case the nearest relative will sign it and the services of the D.A.O. are not required. Any doctor may provide the medical certificate which goes with the order, though in practice it is usually filled in by a psychiatrist called out to see the case. The order forms may be obtained from any law stationer, and are self-explanatory. A diagnosis should not be included in the certificate, and non-technical language should be used. The doctor is well protected from vexatious litigation provided he acts in good faith and

exercises reasonable care. If the D.A.O. is expected it is sometimes unwise to give sedatives that may cover up the psychotic features which it is desired that he should see. The relatives should be warned in clear terms of the suicidal risk and the onus placed upon them of ensuring the patient's safety when that is a reasonable course to adopt. If sedation is imperative 6–9 gr. (0.4–0.6 g.) of sodium amylobarbitone can be given by mouth, or if the patient will not swallow, 5–10 ml. of paraldehyde intramuscularly is both safe and effective. Ampoules of 5 ml. of paraldehyde can be purchased in boxes of six, and do not deteriorate when carried in a bag over quite long periods.

Hysteria

Hysteria is a condition in which mental or physical symptoms not of organic origin are produced and maintained by motives which in some part, at least, are unconscious ones. If the motives involved are fully conscious we are, of course, then dealing with malingering. It has been customary to add to this definition the element of "real or fancied gain" which is to be derived from the symptoms. This gain is not always easily discerned, and certainly it may not be financial or material at all except in a very subordinate way. Thus in anorexia nervosa, which is more commonly hysterical than not, there is frequently no motive which makes any sense apart from a settled determination upon self-destruction, in which the patient is sometimes successful. The same applies to the strange hysterical self-mutilations which are sometimes encountered.

There are three notable features common to most hysterical reactions. First, there is the remarkable dissociation of mental and bodily functions from the main stream of living, which permits a patient weighing less than 5 stones (32 kg.) to sit cheerfully in bed quite unconcerned about the failure of her treatment, while another mentions casually that he "went blind yesterday and just hasn't seen a thing since." Such dissociation explains or perhaps merely reformulates the remarkable analgesias seen in some hysterical patients, and which are sometimes readily produced in hysterical personalities by hypnotists whether on the stage or in the consulting-room. The second characteristic lies in the suppressed emotion in hysterics, which may be liberated in a disconcerting way as a result of therapy which is a little too vigorous in its early stages. The third feature is a derivative of the second, and has been referred to as a tendency to "short circuit." A sudden liberation of pent-up emotion in the absence of cortical control may produce hysterical outbursts, hysterical delirium, or a hysterical fugue.

Hysteria should always be treated with caution until the reaction has been fully assessed and the diagnosis is secure. Apart from the problems set by a short-circuit, a hysterical reaction may conceal quite serious affective disorder. Involutional depressions quite often present with what look like hysterical syndromes, and a failure to recognize the underlying and more important condition may be serious. Hysterical reactions are liberated by organic disease much more often than is serious affective disorder, and while the diagnosis of hysteria may and should be made on its own symptoms and signs, a careful physical examination is required to exclude precipitation by organic diseases. Thus hysterical reactions often develop on top of disseminated sclerosis or complicate the disability left by a cerebral vascular accident.

Acute Somatic Hysteria

Paralysis of a limb or of one side of the body will not usually require emergency treatment, though the doctor may be pressed by the patient or relatives to see the case immediately. The patient will show positive signs of his disease, and in particular that remarkable unconcern which is known as *belle indifférence*. There may be a history of previous attacks and the precipitants of the present one may become evident when inquiry is made. There may be signs and symptoms of underlying anxiety—a history of sleeplessness, or a fine tremor of the hands. Physical disease of the nervous system is eliminated by showing its intactness even though equality of the deep reflexes is the most that can be shown in an uncooperative patient. Hysterical blindness shows the triad of a sudden onset, normal fundi, and normal pupillary reactions. Hysterical aphonia soon gives way to whispering, which is more convenient for the patient, and it may be observed to be selective and pitched so that it causes maximum irritation while permitting social or therapeutic exchanges.

If they are of recent onset, these conditions can usually be cleared up quickly with the aid of intravenous sodium amylobarbitone or thiopentone, which permits the discharge of suppressed emotion and the reception of suggestion while in a state of clouding. Equally good results may be obtained by some without the help of drugs at all, and this is preferable in general practice. A confidence born of having dealt successfully with similar cases before, mixed with an unprovocative aplomb, are the essential ingredients of such an approach. If this fails or for any reason is not tried, then it will suffice to treat the condition conservatively until psychiatric advice can be obtained.

Hysterical fits are sometimes confused with epilepsy though they differ in almost every particular. A hysterical fit does not show the characteristic tonic and clonic phase of epilepsy, and movements are haphazard or sometimes quasi-purposive. The tongue is not bitten, injury is seldom inflicted on the body, and incontinence is rare. The fits are circumscribed in time, and the short-term treatment lies in sedation pending investigation of the condition.

Hysterical Fugues

Fugues refer to wandering states for which the patient subsequently claims an amnesia. When the attack is unassociated with affective disorder such as depression, it is usually in the nature of a short-circuit reaction. Following some domestic upset perhaps, the patient will have a violent emotional scene and leave his house. It is virtually certain that such states of dissociation last only for a very short time, and that the main part of the fugue is not really so at all. A man arriving home three days late from his work may find loss of memory a good deal simpler as an explanation than the true one, both to his wife and to his employer. It is not always helpful to his affairs to be obsessionally preoccupied with the establishment of the truth, and it may be wise to be content with conveying silently, and with civility, one's conviction that he is a liar. The wanderings of depressives, which are sometimes regarded as hysterical, are in quite a different category. A depressed patient may wander for days in a state of preoccupation bordering on stupor and may have an amnesia subsequently which is to be ascribed to failure to register events. His behaviour during the journey will, on inquiry, lack the integration present in the hysteric. He will have had little or no food, and will show neglect of his person and clothing. Sometimes a friendly policeman will find him, and inquire whether he has lost his memory; this may suggest a reasonable explanation to the patient of what has happened. Some of these wanderings by depressives are begun with the intention of committing suicide when the necessary courage has been summoned or the necessary despair accumulated.

In the case of the hysteric, treatment can be undertaken with intravenous drugs, but in fact the amnesia can be unravelled in most cases without them. A firm conviction that the condition does not happen can be transmitted to the patient without much difficulty, and the problem is then resolved into the treatment of the underlying affective state if it is severe enough to require it.

Hysterical Stupor

Stupor is found, when it is found at all, in chronic and practised hysterics, and it can cause anxiety from the diagnostic point of view to the most experienced observer. The patient may lie flaccid and as if in coma, with a total absence of psychologically understandable responses to

stimuli as the usual definition of coma requires. It is called stupor rather than coma, because there is good evidence—usually retrospective—that awareness has not been suspended. Nevertheless the dissociation of function is so well established that there may be no response to pinches, sharp needles, or any other stimulus which it would be acceptable to apply. There is one common but not invariable sign which should be looked for since it gives the diagnosis, and that is a slight rapid fluttering of the eyelids. Most organic causes of coma can be excluded by an ordinary physical examination which may have to include catheterization and examination of the urine. The history of the last few hours will suffice to eliminate narcotic poisoning, epilepsy, and head injury, save in those few cases where no history at all is available. Fortunately in most hysterics there will be available a history of previous dissociative episodes, which will vary from the vague to a clearcut statement that the patient is just "having another of her trances."

A patient in a hysterical stupor is best left alone provided the diagnosis is clear, for the condition will usually resolve in a few hours or overnight. If there is any suspicion that barbiturates have been taken as a gesture additional to the stupor, then no risks should be taken and the stomach should be washed out, unless the dose taken is known with certainty to be innocuous.

Next article on Emergencies in General Practice.—"Treatment of Severe Haemoptysis," by Dr. F. H. Young.

THIRD EUROPEAN RHEUMATOLOGY CONGRESS

[FROM A SPECIAL CORRESPONDENT]

The third European Rheumatology Congress was held from June 13 to 17 at Scheveningen, in Holland, under the presidency of Dr. PEDRO BARCELO (Spain). Eight hundred delegates of the European League against Rheumatism attended, among whom were a number of rheumatologists from this country.

One of the main themes was the association of rheumatism and social medicine. Professor K. M. WALTHARD (Geneva), among others, described the services and plans for the future in Switzerland. A small survey had been carried out in one of the most rural Swiss valleys, where it was found that degenerative arthritis was extremely common. This was ascribed to the hard manual labour undertaken by the inhabitants.

Prognosis in Rheumatoid Arthritis

Professor NANA SWARTZ (Stockholm) presided over a session devoted to the evaluation of therapy, at which Dr. J. J. R. DUTHIE (Edinburgh) described the significant factors in reaching a prognosis in rheumatoid arthritis. He based his opinion on a follow-up study of 282 patients seen at an average of four years after discharge from hospital. Patients admitted to hospital within one year of onset had a much better prognosis than those admitted at a later stage. Functional capacity at follow-up deteriorated progressively the longer the duration of the disease before admission, and those patients in whom the disease ran a rapidly progressive course in the first year fared appreciably better in the long run than those in whom it started more insidiously. The importance of studies on the natural history of rheumatoid arthritis, particularly now that the necessity for evaluating new drugs has arisen, was admirably stressed in this paper.

During a session on connective tissue, with Professor F. COSTE (Paris) in the chair, Dr. L. E. GLYNN (Taplow) described studies suggesting that there is a widespread alteration in connective tissue in patients with rheumatic fever. There was increased permeability of their connective tissue, as shown by the delay in the reconstitution of the dermal barrier following an injection of hyaluronidase. Dr. G. ASBØE-HANSEN (Copenhagen) discussed the hormonal control of mesenchymal tissue. He had found that the individual elements of all connective tissue respond alike to the same hormones. In the course of a few hours endocrine secretions could alter the physicochemical balance and water-binding capacity of the tissues, and accumulation of mucopolysaccharides reduced tissue permeability. Thyroid hormone inhibited wound healing. The adrenal cortical hormones regulated the function of the mast cells: these cells, believed to be the source of ground-substance components, underwent changes such as degranulation and vacuolation, and their sulphur turnover was altered, while the release of hyaluronic acid, heparins, and histamine might also be affected; corticotrophin had the same effect. In patients with rheumatoid arthritis the mast cell count in the synovial tissue was increased, but this rise was inhibited by cortisone and corticotrophin.

Dr. W. S. C. COPEMAN (London) presided over a session devoted to papers on disk degeneration and osteoarthritis of the spine. Professor STEN FRIBERG (Stockholm) showed that the lower lumbar disks disintegrate earlier and to a greater extent that has previously been supposed, nor did a negative radiograph preclude even advanced disintegration. Deforming arthritis in the intervertebral joints occurred mainly at the level of the disk trouble which was found in 50% of patients with chronic lumbar pain. In a large series of such patients 20% reported an injury accepted for insurance compensation, 20% gave a history of minor strains such as lifting, and 60% had no obvious exciting cause.

The delegates were entertained by the Government of the Netherlands in the Hall of Knights at The Hague, and by the Corporation of Amsterdam at the Rijksmuseum following a trip on the canals.

The number of war pensioners fell by 30,882 to 900,141 during 1954, states the *Report on War Pensioners* published on June 28 (H.M.S.O., price 4s.). This is the first annual report under the arrangement by which the pensions are administered by the Ministry of Pensions and National Insurance, and the medical and surgical treatment by the Health Departments. At the end of 1954, 367,000 were receiving disablement pensions for the 1939 war, 273,335 for the 1914 war, and 38,700 for post-war service. 75,593 widows from the 1939 war received pensions, 91,986 from the 1914 war, and 86,364 received grants for their children. For the financial year ending March 31, 1954, £82,460,891 was spent on war pensions and allowances, and the increased rates which came into effect in February this year will raise the total cost by £15m. A second and final payment of £28 was made to British Far Eastern prisoners of war and civilian internees from the realization of Japanese assets in the U.K., and a share of the proceeds from the sale of the Burma–Siam railway was distributed among Servicemen prisoners. Medical boards examined 118,650 pensioners, but of the 1939 group 70% did not have their assessment altered. Full employment meant a drop in the use made of welfare services.