

On the treatment of so-called epileptiform neuralgia, or the so-called incurable facial tic / by W.J. Walsham.

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ON
THE TREATMENT OF EPILEPTIFORM NEURALGIA,
OR THE SO-CALLED INCURABLE FACIAL TIC.

BY W. J. WALSHAM, F.R.C.S.,

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“ALTHOUGH,” says Trousseau,¹ “epileptiform neuralgia from its nature must be considered as an almost incurable affection, I have always felt it a duty to combat it by therapeutic means. . . . Of all the therapeutic agents that I have tried, and I have tried a great number with the utmost perseverance, opium is the one that has given me the least disappointment. But remember this, gentlemen, that opium in the treatment of epileptiform neuralgia must be given in large doses.” And in large doses indeed did Trousseau give it—ten, twenty, or even thirty grains daily were in some cases found barely sufficient to relieve the pain; one patient took as much as four hundred grains a day, and spent 1,200 francs during one year alone in the purchase of the drug. Here is a choice of evils! Either to bear, as best one may, the agony of this terrible malady, or to be reduced to the pitiable condition of an opium or morphia *habitué*.

Since Trousseau published his admirable but discouraging lecture on epileptiform neuralgia a new field for the relief of pain has been opened to us; and nerve-stretching, if it cannot cure the affection, can give the sufferer the prospect of months or years of immunity from it.

During the last few years I have had a series of six cases of

¹ *Clinique Médicale de l'Hôtel-Dieu de Paris*, Paris, 1868, pp. 155-161.

this interesting form of neuralgia under my care, but it is not my intention to relate them in detail, as, although in none of them has there as yet been any return of the pain, I do not wish to publish them until a sufficient time has elapsed to show whether the, at present, apparent cure proves permanent. It is merely desired here to call attention to a method of treatment which, although it may not permanently cure, has at any rate already given to these patients many months and, to some, years of freedom from their suffering.

As the disease is a somewhat rare one, it may be well, before passing to the treatment, to say a few words on the symptoms. The terms epileptiform neuralgia and incurable tic are, to say the least, unfortunate ones, inasmuch as the former implies that the affection is a form of epilepsy, which it is not, and the latter that it is incurable, which I think cannot now be affirmed of it. The terms, however, are here retained as those by which it is best known.

The disease is characterised by neuralgic paroxysms occurring in one or more branches of the fifth nerve, and is always, as far as I know, confined to one side only of the face. The pain as a rule is not constant, or, if so, is increased during the characteristic paroxysms. These seldom last more than half a minute at a time. In one of my patients they were said to last half an hour; but they seemed to be rather a series of paroxysms following in quick succession than a single prolonged one. The pain almost invariably begins at one spot, that is, in one branch of the nerve, thence centrally spreads along that branch, and is radiated to the other branches of that division; or it may be transmitted to a second or even to a third division of the fifth. A paroxysm may be determined by very various causes—speaking, eating, washing the face, a draught of cold air, a sudden noise, pressure on a certain spot, a fly settling on the beard—in short, anything even of the most trifling nature. During a paroxysm the action of the patient is characteristic. He rubs the part violently, or grasps his head between his hands, stamps upon the floor, or paces hurriedly about the room, convulsively clutches at anything within his grasp, or throws himself upon his couch or bed and writhes in agony. The pain is variously described by the patients as

agonising, "like a bundle of red-hot wires being driven into the face, and then twisted in all directions," "like the seizing of all the teeth at once with dental forceps and rocking them to and fro," "like crushing the part in a vice," or "stabbing it in a thousand places at once with bradawls or sharp needles." A paroxysm comes on whilst the patient is describing his symptoms. He breaks off in the middle of a sentence or even a word, to undergo his torture; the muscles of his face may visibly twitch, his conjunctivæ become suffused, a tear perhaps trickles over his cheek. Suddenly the attack ceases, and with a sigh of relief he resumes the history of his sufferings. A second paroxysm may not occur for half an hour, even though the irritation which produced the first is repeated; but more frequently there will be two or three during the next ten minutes. The number of paroxysms during the twenty-four hours varies greatly; they may occur during the day only, but more frequently during both night and day. Sometimes there may not be more than twenty or thirty in the twenty-four hours; at other times there may be two or three or even more every half-hour. They vary at different times in the year and are usually worse in the spring. When severe, they make the patient's life almost unbearable, preventing sleep and rendering the taking of food, which invariably brings them on, a dreaded evil.

The treatment may be divided into the Medical and Surgical. Of the former little need be said. Nearly every drug in the Pharmacopœia has, at one time or another, been tried with but little success. Opium in large doses, as given by Trousseau, undoubtedly relieves the pain for a time; but little permanent benefit can be expected from it, and the remedy, if remedy it can be called, would appear almost worse than the disease. Aconitia, given internally, has been strongly advised by Gubler as a specific. I tried it in two cases but was disappointed. In one patient, the pulse under its use became intermittent every third beat, and it had to be relinquished after a few doses. In neither was any benefit apparent. Among the surgical measures may be mentioned neurotomy or division of the nerve, neurectomy or cutting a piece out of the nerve, nerve-stretching, removal of one of the ganglia connected

with the fifth, the application of the actual cautery, the introduction of hot needles into the supra-orbital, infra-orbital, or mental canal. Of the last-mentioned method of treatment I have had no practical experience, and the accounts I have heard of it are not encouraging. The actual cautery was employed in one of the cases before it came under my care, and seemed to give some relief for a few hours after each application, but no more. That merely temporary benefit is obtained by division of the nerve is well known; and even after a piece has been cut out the pain has soon returned. In three of my patients one or other of these operations on several occasions had been previously performed, but with the most evanescent relief, the pain returning as severe as before in a few days. Nerve-stretching on the other hand has been attended with the most happy results. In the first patient with this disease who came under my care I stretched the infra-orbital nerve; the neuralgia was of ten years' duration, and for two years of this time the patient had been actually bedridden, as the pain was beyond endurance when she attempted to get up. All medical remedies had been tried and failed. The operation was performed in February, 1879. She was completely relieved, and when last heard of three years afterwards by my friend Mr. Anderson, who sent her to me, she expressed herself as having been cured. The second patient, a man thirty-two years old, who had been an out-patient of Dr. Lauder Brunton's, had had the neuralgia for nine years. He had formerly been in good circumstances, but in consequence of his pain had been rendered unfit for any mental exertion and had gradually lost his business. The neuralgia was confined to the regions supplied by the auriculo-temporal and inferior dental nerves. He had consulted many of the most eminent physicians in London and Paris, and various homœopaths, medical rubbers, and electricians, and had had the inferior dental and mental nerves divided by Messrs. Tomes and Durham. In April, 1883, I stretched the auriculo-temporal nerve, and a week later the inferior dental from within the mouth. The relief from pain was complete; he has had none since, and is now again making headway in his business. The third patient, sixty years old, had suffered for eight years. The pain was confined principally to the inferior dental nerve. I stretched this in May, 1883. Since then he

has had no pain except some slight twinges in the infra-orbital nerve (none in the inferior dental) for a few days in March, 1884, ten months subsequent to the operation, after having got wet through and taken a violent cold whilst following his occupation as a gardener. The fourth patient, a man fifty-six years old, had been in St. Bartholomew's Hospital for some time under the care of Dr. Church, and more lately as an out-patient under Dr. Lauder Brunton, to whom I was indebted for the case. He had suffered for five years. In November, 1883, I stretched the inferior dental and infra-orbital nerves, and he has remained well since. The fifth, a man seventy-three years old, had suffered for ten years with pain chiefly in the inferior dental. He had had the mental branch cut and stretched with little or no benefit at the National Hospital for Epilepsy. In March, 1884, I stretched the inferior dental from within the mouth; the patient, notwithstanding his age, had no bad symptom, and at present has had no return of his neuralgia.

In the sixth case a man, fifty-nine years old, had suffered for upwards of fourteen years. He had been under the care of several physicians, and had had the supra-orbital and infra-orbital stretched on various occasions. Looking to the success of the above cases I attempted to stretch these nerves again, but found, on cutting down upon them, that the tissues were so matted together, as the result of the previous operations, that it was impossible to isolate them. An aneurysm needle was passed under the cicatricial tissue in the situation of the nerves, and an endeavour made to stretch it, but it did not yield to any appreciable extent. The pain was as severe after the operation as ever. On more closely questioning him it was found that although he said the pain began in the cheek and darted upwards over the head, it really began in the gums in the region of the molar teeth, which had been previously extracted, *i.e.* in the posterior dental nerves, and shot upwards towards the back of the orbit. In January, 1883, I removed Meckel's ganglion and the whole of the superior maxillary nerve, after having forcibly stretched its proximal end, from the foramen rotundum to the spot where it emerges on the cheek. The patient had no bad symptom; he slept well the night after the operation, better than he had done for months; he was up and about the ward in a few days, and has had no pain since.

The results of the above cases, I think, speak for themselves, and require no further comment. I have given the briefest outline of them, for, as previously said, I intend publishing them in full when a longer time has elapsed. In the meantime, when last heard of, the patients had been relieved for periods of three years, fourteen months, thirteen months, six months, three months, and five months, and even should the neuralgia again return, these many months of respite should alone compensate for the few days' confinement necessitated by the operation.

A few words on the methods of stretching the inferior dental and auriculo-temporal nerve. The operations for stretching the supra- and infra-orbital are too well known to call for any remarks. The inferior dental has been exposed in various ways:¹ (1) by division of the cheek, through its entire thickness, at a spot corresponding with the anterior edge of the ramus of the jaw, without dividing the mucous membrane; (2) by division of the cheek at a spot corresponding with the sigmoid notch; (3) by division of the soft parts over the posterior border of the ramus of the jaw in a direction from behind and below, inwards and upwards; (4) by removal of a portion of the angle of the jaw; (5) by trephining the ramus after division of the soft parts just above the commencement of the inferior dental canal; (6) from within the mouth. The last method of exposure was the one used for stretching the nerve in the above cases, and although I worked it out in the dissecting room—not knowing that it had been already employed—I found, on looking up the subject, that it would appear to have been first resorted to by Paravicini. Its superiority over the other methods cannot, I venture to think, be questioned. No scar is left externally, and if the anatomy of the parts be borne in mind, the operation should not be attended with much, if any, difficulty. The mouth having been opened by a gag, an incision through the mucous membrane only is made from the last molar tooth in the upper jaw to the last molar tooth in the lower. The finger is now introduced into the wound and insinuated between the ascending ramus of the jaw and the internal pterygoid muscle. The small spur-like projection of bone at the entrance of the inferior dental canal is next felt for, and serves as a guide to the nerve. An aneurysm

¹ *Wiener medizinische Wochenschrift*, March 31, 1874, and *London Medical Record*, 1874, p. 275.

needle with a very short curve is now passed and hooked round the nerve, which can be then drawn visibly into the entrance of the wound. There are no important structures with the exception of the inferior dental artery and gustatory nerve in the near neighbourhood. The latter is best avoided by remembering that whilst the inferior dental nerve passes into the bone the gustatory continues its course between the bone and the muscle, and is anterior and a little internal in its relative position to the inferior dental. Should the artery be wounded it will probably be torn rather than cut, and therefore not likely to bleed; were it to do so it is doubtful whether it could be tied, as the wound is deep and will barely admit the finger. There was no hæmorrhage in any of the above-related cases, but had there been I should have endeavoured to staunch it by plugging.

The internal lateral ligament which is inserted into the spur-like process of bone, follows somewhat the same course as the nerve, and may readily be mistaken for it. To avoid it the point of the aneurism needle should be made to hitch in the entrance of the canal, and thence swept upwards, backwards, and outwards around the nerve, keeping the point close to the bone. As the parts can hardly be seen the sense of touch must be trusted to as our guide. The wound, if the operation is neatly done, is small, and heals kindly and in a few days.

I am not aware that the auriculo-temporal nerve has been hitherto stretched; but I have found a case recorded by Dr. McGraw,¹ in which the nerve was divided. The best guide to the nerve is the temporal artery. An incision about an inch long should be made parallel and immediately posterior to the artery, beginning just above the zygoma. Having carefully exposed the artery the nerve will be discovered just below and posterior to it. The nerve being of small size the dissection must be done neatly, or it will not be found.

Meckel's ganglion I removed by the operation which is known as Carnochan's. A description of this operation will be found in the *Proceedings of the Royal Medico-Chirurgical Society* (vol. i. No. 5, New Series) by Mr. Chavasse, and in the discussion that followed his paper an account of some modifications which I suggested might be desirable to make in its performance.

¹ *Detroit Medical Journal*, November, 1877.