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19.

[Reprinted from the St. Paul Medical Journal, June, 1906.]

A CASE OF STERCORACEOUS VOMITING DUE TO EYESTRAIN.

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Violent and long continued attacks of stercoraceous vomiting in a fine and otherwise healthy boy of eleven years may lead the puzzled practitioner to despair, and to surgery which is the despair of medicine. An illustrative case of mine has a number of lessons:—

About two years ago a handsome, healthy, physically perfect lad, then aged nine years, began having daily attacks of dizziness, either in, or returning from school. He would come home and lie down saying, "I am going down in the elevator, Mama,"—alluding to the sinking feeling or giddiness he had once experienced in riding down an elevator. Soon these attacks continued for the rest of the day, and then kept up for whole days. Milder attacks or crises continued more or less frequent, but more severe crises began in the fall of 1905, and to the nausea without vomiting was now added terrible pain behind the eyeballs, headache, and intense and terrifying vomiting, finally degenerating into stercoraceous vomiting. This continuous intense and fecal vomiting or retching was in the last attacks kept up for 36 hours. Between these severe seizures there were periods of partial or complete relief from the headache, etc. At any time when the boy gets excited his face becomes pale, the lips blue, and his heart beats with great rapidity. He has generally a poor appetite for breakfast, has "heartburn", is a restless sleeper, and his eyes get "bloodshot", especially if he lies down in the evening. Careful inquiry elicited the fact that during the two summers of 1904 and 1905, and while not studying, the boy had none of the symptoms whatever. Dr. W. C. Cahall of Germantown referred the patient to me, suspecting, with a wise sagacity, that the eyes might be the cause of the symptoms.

Under cycloplegia I found the following errors of refraction:—

R. + Sph. 0.50 + Cyl. 0.25 ax. 75° = 20/20 slowly.

L. + Sph. 0.62 + Cyl. 0.25 ax. 75° = 20/20 slowly.

with 2° of exophoria.

With such axes of astigmatism there must be in a boy of this age an habitually tilted head and a lateral curvature of the spine either in a functional stage or proceeding to organic limitations of motion and elasticity. Upon exposing the back a functional curve, dorsal right, lumbar left, was found, as yet in its early stages, with limitation of elasticity of the lumbar vertebrae in bending to the left. I asked the mother to take the boy to Dr. H. Augustus Wilson, the orthopedic surgeon, to verify the diagnosis, and to institute orthopedic treatment if

any in his judgment should be required. This was not done and the immediate subsequent history has made the mother feel that this was unnecessary.

I ordered the following lenses in spectacles:

R. + Cyl. 0.25 ax. 75°
L. + Sph. 0.12 + Cyl. 0.25 ax. 75°

From the day the boy began using these lenses, with one slight exception,* he has not had any of the former distressing symptoms. He is changed as if by magic into a healthy and hearty boy, is increasing in weight, can now play ball, etc. The spinal curves are disappearing, and soon the back, I am sure, will be normal organically and functionally

This case is reported because of certain suggestions aroused by the details:

1. When a new truth begins to break upon unobserving and prejudice-governed minds, they at once repeat the old saying that "One swallow does not make a summer." The ornithology of the saying is almost as bad as its supposed medical significance. Because it is precisely the single case accurately and thoroughly scanned and well reported that may indeed be the forerunner of troops of migrant birds which make a long summer's work. In clinical study it is one plus one, again, and ever again repeated, that leads to the recognition of new pathogeneses and new therapeutics. Nothing has been more effective in hiding from attention and in hindering medical progress than the habit of smudging large numbers of clinical cases, probably poorly observed, into vague and useless generalizations, masses of foggy indefinitenesses that leave facts untouched and unexpressed. Disease is always individual, and the ignoring of these individual peculiarities by such words as "diathesis", "migraine", "neurasthenia", "epilepsy", and the like shows the groping of the unscientific mind among facts that have not been closely observed or clearly delimited. The fault of inaccurate vision and description seeks to hide itself, as well as the facts, with a magic carpet of meaningless nomenclature, useless theory, and mystifying generalization.

For this reason the detailed reports of individual cases should always form a goodly part of medical literature. Those text-books which deal only with the largest groupings of clinical facts by means of the most indistinctive and glittering generalizations, are of the least use to the earnest practitioner.

2. The only possible way such patients as this one can come to the oculist is through the reference of the general physician. How many general physicians would have suspected the possible ocular origin of the boy's affliction? Not one in all Europe, certainly, and probably few in the United States. Luckily at least one family physician was sufficiently alert-minded to do so. The common theory of the

*The boy had once some of the early and slight symptoms of an oncoming seizure but these passed away after he lay down a few minutes.

pathogenesis of persistent or pernicious vomiting of children needs revolutionizing.

3. The oculists of Europe, with two possible exceptions in England, would laugh outright at the "humbuggery" of such a tiny optical error being the cause of any disease whatever. Many of the famous or leading ophthalmologists in our own country would probably have said (as I daily hear reported) in such a case, "the child has no need of glasses," or "he has a slight astigmatism, but it is too little to bother with or to need correction." What would have been the subsequent history of this boy had he been advised by these men?

4. Only by means of cycloplegia could the exact nature of this error have been revealed. It was also discovered by means of the most delicate attention to the position of the head, and location of axes of astigmatism, etc

5. It is the slighter grades of astigmatism, when unsymmetric, (or coupled with anisometropia, also of low degree) which induces the most mischief, "Too slight astigmatism to need correction," is a proof of bungling, of prejudice, of unscience, of a cruel heartlessness towards patients.

6. The peculiarity of these axes tilts the head, and produces secondary spinal curvature and constrained (permanently innervated) muscles and ligaments of the back. Failure to examine and treat these incipient abnormalities, and learn their causes on the part of the regular profession, is directly breeding a host of quacks and their not altogether foolish adherents, and especially gives reason for the existence and blind success of osteopathy, mechano-neuralism, and such sorry weeds manured by our neglect.

7. The phenomena of "migraine", the "swoonings", "blind spells", "vomitings", "lapses", "sinkings", "fainting fits", "vertigos", "everything stopping", etc., usually present in patients with severe eyestrain, ally themselves in essential nature with those of the thousand types of epilepsy, big or little. If to this is added the functional strain of slightly curved spines or abnormal backs, we may have a potent cause of those severer and indirect effects of eyestrain we call "real" or "genuine" epilepsy. Every epileptic should have his eyes AND spine examined by experts in ophthalmology and orthopedics:—but not by those famed as expert, at least not until they have shown absence of "conservatism", and bigotry in science, and have exhibited some sympathy for their patients.