Common Symptoms of Disease in Adults

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Preface

This book is based on a course of lectures given twice yearly for twenty years at Charing Cross Hospital. Lectures are best prepared with the subject, not the audience, in mind. Although these lectures were given to students on the introductory course in medicine, they differ little from lectures given to final year students, general practitioners and doctors preparing for the Membership.

It has often been emphasized, especially in text books, that common things occur most commonly. No apology is made for often giving in this book undue prominence to rare diseases. This is done with a clear conscience for a number of reasons. Firstly, an understanding of some uncommon diseases gives a deeper understanding of medicine as a whole, and may throw light on the commoner disorders which are often related to the rare. Secondly, if you are going to be an enthusiastic student of medicine all your life, the uncommon disease which you are able to diagnose will give you lasting intellectual satisfaction. Thirdly, it is no consolation to the relatives of your late patient to know that death occurred from a rare disease. Some diseases may be rare only because they are not often recognized. What is rare today may be common tomorrow. Whether or not lecturers and text books emphasize that common diseases occur most commonly, this is the one thing that experience will certainly teach.

When a single author covers a wide field in medicine, there is a danger of undue emphasis on the subjects with which he has been particularly concerned during his career. I have failed to resist the temptation to mention some of my own original contributions to medicine, but have tried to avoid exaggerating their importance. The subjects to which I refer include printers' asthma, bradycardiac angina, pre-clinical hypothyroidism, panic states in left ventricular failure, the prolonged ankle reflex in anorexia nervosa, gangrene due to carbon monoxide

poisoning and mesothelioma due to tiny exposure to asbestos.

Repetition in a book of this nature is difficult to avoid and may be helpful. The child who knows that $2 \times 4 = 8$ may fail to answer when asked what 4×2 equals. The student class may be told that hypertension can be associated with renal and endocrine disease. The hypertension in Cushing's syndrome can be emphasized. Yet later, when asked about the findings in Cushing's syndrome, hypertension will not be mentioned if this one fact has been purposely omitted in describing this condition.

I am grateful to colleagues at Charing Cross Hospital and fellow examiners in Conjoint medicine who have been pestered by me for advice. My friends and colleagues, Dr. 'Tiny' Maini at Charing Cross Hospital and Dr. Howard Travers at Wembley Hospital, each read half of the book. I am indebted to them both for all the trouble they have taken and their constructive criticism. My thanks are due to my wife and family, including my son-in-law, Dr. Richard Savage, for their help and encouragement. My secretary, Mrs. Pauline Carr, has typed out the book from a mixture of dictated notes and tapes. Her speed and skill, combined with her humour and patience, made enjoyable the whole job of writing the book. Finally, it gives me pleasure to acknowledge the help and encouragement of my publishers during the book's gestation.

Contents

The mode of onset of symptoms

A diagnosis may be made from the mode of onset of a symptom and the course an illness takes, when the most recent and expensive tests are unhelpful or positively misleading. Disaster often follows reliance on complicated investigations as a substitute for skilled history taking.

The onset of symptoms may be:

(1) Sudden.
(2) Rapid.
(3) Insidious.

The importance of the speed of onset of symptoms is illustrated by the patient presenting with severe headache and neck stiffness. A sudden onset suggests subarachnoid haemorrhage, a rapid onset suggests a pyogenic meningitis and an insidious onset suggests tuberculous meningitis.

Sudden onset of symptoms

A patient will often incorrectly state that the onset was sudden when a symptom came on rapidly. There are only two classes of disease which present suddenly.

(A) Mechanical defects in which the symptoms are usually non-repetitive.

(B) Abnormal electrical discharges in which the onset is sudden and the symptoms repetitive. This group includes nerve root lesions, the paroxysmal tachycardias and epilepsy. Nerve root lesions cause such symptoms as lightning pains in tabes dorsalis, vertigo, trigeminal neuralgia and the pains before and after herpes zoster.

(*A*) *Mechanical defects*

If a symptom starts suddenly, the patient should be able to say

exactly what he was doing at the moment of onset. Two medical students at Charing Cross Hospital were practising their chosen sport in their room, and both had a spontaneous pneumothorax. One was a 'butterfly' swimmer who was lying on the floor stretching his arms at the end of a stroke when seized with the pain, the other a high-jumper who was limbering-up and throwing his leg up to his trunk. The hockey-player turns in anger to see who has struck him across the calf from behind, when he ruptures some muscle fibres. In addition to mechanical defects, such as the ruptured berry aneurysm, the spontaneous pneumothorax and the torn muscle already mentioned, diseases of sudden onset include dissecting aneurysms of the aorta, ruptured or perforated viscera, any infarction due to thrombosis, haemorrhage or embolus and the effects of trauma. Unfortunately, torsion of the testicle may occur at night, so that the mode of onset is lost in sleep. Errors of diagnosis should not be made when the history of a sudden onset of pain and swelling is obtained. The onset of an infective orchitis is never sudden.

Although it is only a mechanical defect or disease associated with an abnormal electrical discharge that can ever cause a sudden onset of illness, the converse is not true, i.e. a mechanical defect can appear to come on slowly. In the latter event, a careful history usually shows that the onset was sudden followed by further episodes also of a sudden nature, but the whole natural history of the illness is roughly interpreted as gradual and progressive. These mechanical defects which arise insidiously include cases of arterial thrombosis and stenosis in contrast to arterial rupture and embolism. Partial or complete occlusion of an internal carotid artery, or stenosis of the basilar artery, give rise to intermittent signs and symptoms. Teleologically, the blood supply to the brain is so important that it needs the design of the circle of Willis to ensure an adequate blood supply if the flow through one channel is diminished. The sabre-toothed tiger might tear out one carotid in its leap for the throat, but arteriosclerosis, rarely confined to a single vessel, is the scourge today. An onset which also appears to be gradual, but usually consists of sudden repetitive incidents, is seen with a

slowly leaking viscus, such as the stomach, when a gastric ulcer is walled off by omentum or gut as it perforates.

The way in which a sudden onset of a symptom points to the correct diagnosis is shown by the following example.

A butcher with fever, joint pains, a heart murmur and past history of rheumatic fever, was thought to have a recurrence of rheumatic fever. One finger had become suddenly painful when lifting his chopper to cut some meat. He thought that his finger had been injured in some way by the handle, and the significance of this incident was not appreciated by the doctor. The painful finger was due to an embolism and the diagnosis subacute bacterial endocarditis.

When one can fairly say that the onset of a symptom is sudden, it is often possible to distinguish degrees of suddenness. Thus strokes due to thrombosis, haemorrhage or embolism usually come on suddenly, but the absolute suddenness of the embolus is in contrast with the less abrupt onset seen in a cerebral haemorrhage and the variable onset in thrombosis as already described.

One of the most difficult differential diagnoses lies between stroke and cerebral tumour in a patient whose blood pressure is found to be raised. Hypertension, whether benign or malignant, is usually of unknown aetiology. The small group, which is secondary to some other condition, is subdivided into:

(i) Renal disease.
(ii) Endocrine disease.
(iii) Coarctation of the aorta.
(iv) A miscellaneous group in which the hypertension is mainly significant, in that it leads to diagnostic errors. This miscellaneous group includes:
  (a) Raised intracranial pressure due to cerebral haemorrhage, subarachnoid haemorrhage and cerebral tumour.
  (b) Congestive heart failure, as in mitral stenosis.
  (c) Polyarteritis nodosa.

When hypertension is due to increased intracranial pressure (iv,a), it may be misleadingly assumed that the high blood

pressure is the cause of the cerebral lesion rather than the result of it. In these circumstances, a berry aneurysm or a cerebral tumour may fail to be diagnosed. Symptoms from a cerebral tumour come on suddenly if there has been bleeding in the tumour, but usually there is a long preceding insidious onset of symptoms.

It is often forgotten that a raised blood pressure may be the result of heart failure (iv,b) as well as the cause. No murmur may be heard when heart failure is due to mitral stenosis and the failure attributed to hypertension. The murmur will re-appear when treatment of the failure increases the blood flow through the narrowed valve.

The sudden onset of symptoms due to infarction from a blocked or burst vessel, is not so abrupt as when the mechanical defect more directly causes the symptoms. An example is the difference in onset between a cardiac infarction and a dissecting aneurysm (see section on **Chest pain**).

(*B*) *Abnormal electrical discharges*

Abnormal electrical discharges occur in the following conditions:

(i) Nerve root lesions.
(ii) Paroxysmal tachycardias.
(iii) Epilepsy.

(*i*) *Nerve root lesions.* Symptoms begin suddenly when due to a nerve lesion, and are then transient and repetitive. Vertigo always comes on suddenly. If associated with tinnitus and deafness, it is due to a peripheral lesion affecting either the eighth nerve or the labyrinth itself. If the vertigo occurs alone, the lesion arises in the brain stem, where the vestibular and auditory pathways have separated (see section on **Vertigo**). Failure to obtain the history of onset in trigeminal neuralgia, with the absolute suddenness of onset and cessation of the pain, like a needle being thrust into the flesh, still leads to mis-diagnosis and useless tooth extractions. The lightning pains of tabes dorsalis which vary with the weather are often attributed to rheumatism, and, here again, the history would reveal the abrupt onset and cessation of the pain (see

section on **Pain**). Tabetic crises, whether gastric, rectal or laryngeal, all come on with complete suddenness, as does the transient condition of unknown aetiology, proctalgia fugax. Doctors appear to be particularly prone to this condition, which usually occurs at night. The patient complains that he feels as if a red hot poker has been momentarily inserted up the back passage. A writer in a learned medical journal makes the suggestion that ice should be inserted into the rectum to relieve the pain. One can only suppose the refrigerator is kept beside the bed, with a compartment for making ice easily detached, and the shape of the cubes suitably modified for their unusual destination, ready to be inserted by the sleepy doctor in the moment or so that the pain is present.

(*ii*) *Paroxysmal tachycardias*. The diagnosis of paroxysmal tachycardia can only be made between the attacks by the history of onset and cessation of the palpitations. The onset is always sudden and the cessation abrupt. The diagnosis is made on this fact alone (see section on **Palpitations**).

(*iii*) *Epilepsy*. Epilepsy is a transient disturbance of cerebral function, associated with an abnormal electrical discharge. Syncope is a transient disturbance of consciousness due to cerebral ischaemia. The differential diagnosis of epilepsy and syncope can be difficult, and the onset in both is always sudden.

Rapid onset of symptoms

A rapid onset of symptoms is commonly seen in acute inflammatory disease. A rigor ushers in the illness if there is a rapid rise in body temperature, so that it will occur in lobar pneumonia, but uncommonly in bronchopneumonia and never in typhoid fever, where the onset is more gradual with a step-ladder rise in temperature over the first week (see section on **Fever**). There is an initial rigor when any virulent pyogenic organism causes a severe infection, such as bacillary dysentery or meningococcal meningitis. When the organism is not so virulent, as in Sonne dysentery, or when the infection is localized, as in gonococcal urethritis, a rigor may not occur at the onset. Infants will have convulsions in circumstances that

would produce a rigor in an adult, with the two exceptions of a urinary tract infection and malaria. It was therefore possible during an epidemic to diagnose bacillary dysentery in an infant presenting with a convulsions before there had been any bowel symptoms.

The causes of repeated rigors are listed in the section on **Fever.**

Other clinical signs, besides rigors, at the onset of an illness, although apparently trivial, may be of crucial diagnostic importance.

How an apparently unimportant herpes simplex was crucial in making the diagnosis of meningococcal septicaemia is described in the section on **Sore lips.** It is difficult to decide whether a symptom or a sign, such as a few spots, is important or just 'a red herring'. This is not a reference to such diagnostic lesions as rose spots in typhoid, Koplik spots in measles or palatal petechiae in glandular fever, and is illustrated by the following case.

A spotty young nurse complained of shortness of breath on exertion. There was no evidence of heart or lung disease, and her dyspnoea was due to an iron deficiency anaemia. It was some time before the significance of her acne vulgaris was appreciated as the indirect cause of her symptoms. She anointed herself liberally each day with an oestrogen cream, and had absorbed sufficient to cause menorrhagia and the subsequent iron deficiency anaemia.

A rapid onset with a predictable course suggests an acute bacterial infection, such as pneumonia, tonsillitis or bacillary dysentery. The outcome of the disease depends upon the virulence of the organism and the resistence of the host. An unpredictable course with spontaneous exacerbations and remissions suggests a so-called collagenosis. The exception to this rule occurs when a bacterial infection is partially walled-off, so that a state of 'cold war' exists with chronic changes punctuated by acute exacerbations. This is seen with sinus, gallbladder and urinary infections, diverticulitis and collections of pus anywhere, as in the pelvis, perinephric fat, under the diaphragm and in an interlobar fissure.

Insidious onset of symptoms

The course in malignant disease is inexorable and relentless in contrast to the remissions so often seen in chronic inflammatory diseases, such as tuberculosis, syphilis or chronic sepsis. Carcinoma of the head of the pancreas usually has an insidious onset without pain, whereas a stone in the common bile duct starts abruptly with excruciating colic. This rule is often broken with a carcinoma producing pain and a stone painless. Serial serum bilirubin estimations will show a steady rise in carcinoma of the pancreas, but will fluctuate with the stone. Although a steady progression is so characteristic of neoplastic disease, cerebral tumours produce more than their share of diagnostic pitfalls in this respect.

The sudden onset of a symptom narrows the cause down to a mechanical defect or disorder associated with an abnormal electrical discharge, but an insidious onset of disease makes diagnosis difficult. The slow, insidious onset is typically seen in endocrine disorders such as myxoedema and Simmonds' disease.

The general practitioner may miss the diagnosis of myxoedema because the onset is so gradual that the change in the patient is not noticed. The hospital doctor may miss the condition if a patient presents with some other disease to which the unrecognized myxoedema is incidental. In fact, patients with this disease commonly have no complaints. While lassitude, increasing torpor, dry skin and aversion to cold are typical symptoms of myxoedema, untreated cases are often seen in the street and particularly on the underground railway—that pathological museum of disease recognizable on inspection. The pale, creamy yellow skin like Jersey milk in its colour and its carotene content, the puffy face, markedly swollen round the eyes, the everted lips, like sausages almost bursting from too tight skins, the malar flush, dry, coarse skin and hair with scanty eyebrows, the unconcerned but not necessarily apathetic stare, should all form an unforgettable picture. It failed to do so in the case of a chief district nurse who presented with a triple diagnosis.

The nurse with a triple diagnosis

Newly-appointed to Wembley Hospital, I was seeing in the busy Out-Patients Department the chief district nurse for the first time concerning her diabetes. It appeared, glancing through her voluminous notes, that she had suffered intermittently from an iron deficiency anaemia that had always responded promptly to oral iron therapy. There was no history of menorrhagia, bleeding piles or a peptic ulcer. As in any patient with an unexplained anaemia, one wished to see her hair, but trying to get off her large district nurse hat had produced a paroxysm of rage. She had never been seen, day or night, without this head gear, despite two admissions to hospital in ten years for stabilization of her diabetes. She was considered an oddity by the nursing staff in the hospital and her colleagues in the district. After a great deal of cajolery, she was persuaded to remove her hat, and beneath was found a squamous cell carcinoma the size of a soup plate. This unfortunate woman would carry a number of hats with her in her car, and as one became blood-stained, she would change it. She was admitted to Charing Cross Hospital for deep X-ray therapy and subsequent skin grafting. One day while having lunch in the hospital, I overheard a house surgeon telling a colleague of an interesting and typical case of myxoedema which he had on his ward. As the tale unfolded, I was horrified to realize that he was describing the chief district nurse with the squamous cell carcinoma of the scalp. After treatment of her myxoedema and the fitting of a wig, she returned to her work as a chief district nurse, where she was literally unrecognizable.

The hospital residents dining table is a good place to hear about clinical material, and the case of the lousy man with one axillary hair acted as a redress for the missed myxoedema just described.

The lousy man with one axillary hair

A lousy vagabond was brought into Casualty. His unconscious state was vaguely attributed to exposure. His axillary and

pubic hair was purported to be normal, but a male nurse had been asked to shave the patient on arrival.

Presumably, like John the Baptist, he was preparing the way for one senior to himself, the resident doctor, who would wish to avoid contact with the lice.

On examination, the significant finding was one long hair in the right axilla. The male nurse who had dealt with the patient was then questioned about this one hair. The nurse explained, with the air of one whose duty it was to humour odd consultants, that he had found it unnecessary to shave the axillae as they were virtually hairless.

The patient's coma was due to Simmonds' disease, and responded to treatment. His so-called varicose ulcer was a gumma, and presumably tertiary syphilis was the cause of the Simmonds' disease.

The insidious onset and slow progress of Simmonds' disease due to a chromophobe adenoma is shown by a patient who was found to have optic atrophy in 1944, in retrospect seen to be due to his chromophobe adenoma, was diagnosed as Simmonds' disease in 1958 when presenting in coma and was blind but otherwise well on replacement therapy over twenty years after the onset of symptoms. The story of a third patient seen in coma due to Simmonds' disease ended unhappily.

The woman in coma

A woman aged thirty-five years was seen on a domiciliary visit one late September evening, when the first severe cold of the autumn abruptly ended an 'Indian summer'. The doctor, who was unable to accompany me, explained that the patient was probably hysterical. She had retired to bed and had not moved or spoken since her husband brought his mistress to join the household two days earlier. The door of the patient's house was opened by her son, an only child aged twelve. She had a difficult confinement with him, and was afterwards diagnosed as having myxoedema and given thyroid. A local clinic had found replacement therapy with thyroid unsatisfactory, as sufficient

hormone to control the 'myxoedema' had made her feel less well. The smooth, dry skin, finely wrinkled face and absence of axillary and pubic hair made the diagnosis of Simmonds' disease obvious. The recent emotional stress might have precipitated her coma. More likely, the cold spell had made the poikilothermic lady hypothermic. Menstruation re-started with replacement therapy in hospital, and her appearance changed from an old hag to an attractive woman, looking younger than her years. The husband dismissed his mistress, and took some temporary interest in his wife. The patient remained well for five years, but then developed a cold and stayed in bed. During this spell in bed, she ran out of replacement therapy which was supplied by her own doctor. She was found dead, presumably from adrenal insufficiency. A coroner's post mortem confirmed the diagnosis.

The importance of simple clinical observation is illustrated by a case of mushroom poisoning, reported in a famous medical journal. Extremely skilful treatment had saved the life of a nearly moribund man. An honest admission was made of the delay in diagnosis which caused the patient's deterioration. Every kind of esoteric test had been done, but there was no mention of the pulse rate. All students should know that mushroom poisoning must be considered in any patient with severe abdominal pain and a slow pulse presenting on a muggy September day.

Abdominal swelling

Abdominal swelling is more often a physical sign than a symptom of organic disease. When abdominal swelling is the main complaint, it is less likely to be due to organic disease than when it is a subsidiary symptom.

A patient may complain of abdominal pain, weight loss and anorexia for three months. He may admit on direct questioning to letting out his belt, despite his weight loss. This patient is likely to have a carcinoma with ascites.