STEATORRHOEA*

A Case Report

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Mrs G., aged 36, was a housewife and mother of two children. She grew up in an unhappy home in which the parents not only treated each other badly, but also showed a minimum of love and care towards their children. The sister of the patient developed asthma, psoriasis, and hay-fever, and became very neurotic. At the age of sixteen Mrs G. suddenly developed severe diarrhoea (approximately 12 to 18 stools daily) containing blood and fatty offensive material. She was admitted to hospital for investigation. A barium meal showed no abnormality. Sigmoidoscopy confirmed the diagnosis of ulcerative colitis. The patient recovered and received no treatment.

She remained well until the age of 22, when, following her arrival to live alone in London and the death of her father, she developed a similar diarrhoea. This time the illness was more severe and associated with hysterical paralysis of the legs. She was again admitted into hospital and fully investigated. Sigmoidoscopy again showed changes in the bowel compatible with the diagnosis of ulcerative colitis. Mrs G. was discharged with instructions to avoid roughage and dietary excesses.

The patient continued to work in London as an actress, living an unsatisfactory and unstable life. She married rather against her will, and was at first unhappy. This was associated with a further attack of diarrhoea, for which she had no treatment. Two years later the family emigrated to Canada, where two children were born. Diarrhoea of increasing severity occurred with each pregnancy and eventually led to faecal incontinence. Mrs G. lost weight, and was unable to attend social functions or go out shopping. She was very ashamed and unhappy, receiving little sympathy from her husband. Again the family moved, but the diarrhoea became so disabling (60 stools daily) that the patient reluctantly visited a doctor. She was treated with steroid drugs, and this was moderately successful.

When Mrs G. returned to England, two years ago, with her

*One of the successful essays submitted for the Public Welfare Foundation Undergraduate Prize, 1961.

husband and children, she was suffering from intractable diarrhoea (yellow-green, offensive, blood-stained stools) and hysterical palpitations. She spent most of the day and night in the lavatory, and was unable to go out of the house. She was ashamed, unhappy, and hurt by the ridicule of her children. The patient was seen by a general practitioner who prescribed treatment with phenobarbitone. In Easter 1960, she was admitted into hospital, collapsed and dehydrated, following a bout of severe diarrhoea. Treatment consisted of investigation, sedation, and salazopyrin. She was discharged after two weeks still with some mild intestinal hurry.

Mrs. G. then attended her present general practitioner giving the above history. He accepted this as genuine, especially in view of the results of previous investigation, and prescribed treatment for the colitis and the malabsorption syndrome. She was given prednisolone, calcium and vitamin supplements, and became much better. Despite this, the stools were still loose and fatty, and as the practitioner was not altogether content with the presentation of the case, he decided to obtain specialist opinion at the end of three months of the above therapy.

She remained reasonably well for two months but then developed glycosuria. The local laboratory performed a glucose tolerance test confirming severe diabetes mellitus. Because of her refusal to leave the children, as well as her dependance on the practitioner, she was treated at home by insulin injection given by him and the district nurse. She was weaned of prednisolone and kept on a special carbohydrate diet. The severity of the diabetes then diminished. In a letter to a distinguished gastro-enterologist, the general practitioner asked about the possibility of colectomy, and the need for special investigations to exclude any other disease as the cause of the symptoms. He also stated that the family circumstances warranted as little interference as possible with regard to investigations or admission to hospital.

The specialist saw Mrs G. and suggested that the condition was a steatorrhoea, and that it could be investigated by tests as an outpatient. These tests were:

Plain x-ray of the abdomen
Barium meal and follow through
A three-day fat excretion test

The abnormalities noted were firstly, an enlarged head of the pancreas; secondly, an S-shaped duodenum due to distortion by the pancreas; and thirdly, stools showing excessive fat and faecal nitrogen. There was no evidence of the typical " lead piping " seen in ulcerative colitis, nor were there any pathological changes in the mucosa visible on sigmoidoscopy.

The patient was then treated with pancreatin granules, three

times daily with meals, and she improved greatly. The stools became well-formed, occurring twice daily, and there was a general improvement in health. The diagnosis suggested by the specialist, following this response to pancreatin, was " chronic pancreatitis associated with colitis ".

At present Mrs G. is well and happy. The diabetes has cleared up and is regarded as having been due to the steroid therapy. She is being treated, at present, with pancreatin and vitamin supplements.

Social Aspects

These can be viewed in retrospect since successful treatment has eliminated the major social difficulties. The main factors can be subdivided into two parts.

(i) *The effect of the illness on the patient herself*

From the history, both familial and personal, there is definite evidence of a neurotic and immature personality. The condition has produced emotional distress in the past, expressed by shame, depression, unhappiness, anxiety, and an indifference to her family (self-preoccupation) which must have exacerbated the steatorrhoea. There is no doubt that Mrs G. has shown considerable courage and optimism in the face of such a disability.

(ii) *The effect of the illness upon the husband and children*

Mr G. is a man unable to sympathize with ill people, and this may have hurt his sensitive wife. On the other hand he was relatively impervious to his close contact with someone who was incontinent of faeces, both day and night, as well as unable to look after the children properly. It is to his credit that he remained with her and maintained, as far as possible, a husband-wife relationship.

The children, fortunately, have suffered little, since Mrs G. strove manfully throughout her illness to look after them. Prior to successful therapy, they were beginning to understand the strange behaviour of their mother, and realize that it was abnormal. If this had continued it might have had significant mental and social effects on them.

Since the improvement in Mrs G.'s condition, her family relationships, both close and casual, have improved. She is now able to perform the normal functions of a mother without shame or fear of the unexpected.

The Role of the General Practitioner—An Appreciation

Diagnosis

History and examination
The acquisition of the patient's confidence
An understanding of the emotional and organic symptoms
Reference to hospital and specialist, or local laboratory

Management

Reassurance
Maintenance of diet and drugs
Regular supervision
Explanation of the implications and prognosis to husband and wife
Advice on the practical aspects of steatorrhoea

The list above indicates the extent of the practitioner's participation in diagnosis and management in this case.

The first doctor to see Mrs G. on her arrival in England fell into the trap of regarding her illness as mainly emotional, and this is quite understandable on the basis of her history of diarrhoea precipitated by social problems, an unhappy childhood, and the incidents of hysterical symptoms. The hospital into which she was later admitted in a collapsed state also committed the same error.

This lady presented a difficult problem to her present general practitioner. He was quite prepared to accept the diagnosis of ulcerative colitis (which had already been thoroughly investigated in three hospitals) with a distinct psychological element. The importance of the latter in the aetiology of her illness was enhanced by her emotional history and immaturity.

It must be remembered that the more mature the disease, the easier the diagnosis becomes for an objective observer, and this obviously was a factor in the practitioner's ability to assess this patient correctly. Dr O. (the practitioner concerned) expected this lady, after such a long history of illness, to be apathetic, resigned, depressed, and disinterested, for in his experience this was often the end result of unsuccessful treatment of ulcerative colitis. Instead he found her eager to undergo further investigation for the complete cure was, for her, still a possibility. This attitude, together with an atypical history (the lack of severe bleeding per rectum throughout the illness) aroused his suspicions.

Instead of dismissing these discrepancies, Dr O. decided rightly, to refer the patient for specialist opinion, but first treated her for a trial period with steroid drugs, to observe her response generally and obtain her confidence. When steroid diabetes occurred, the practitioner, realizing the patient's need for reassurance and confidence, as well as her reluctance to part from the children, treated her at home with insulin injections instead of in hospital. This meant that he had daily contact with her. This was important at the time, for the question of colectomy had been raised both by the patient and Dr O. In addition, she was becoming quite dependent upon him. When, eventually, the diagnosis was reached after specialist

opinion, and the treatment instituted, the practitioner had to reduce this dependance and allow her to return to normal family life.

In this case, the doctor has avoided the pitfall of " psychosomatic disease ", and has managed the patient adeptly with regard to her emotional state, by home treatment and outpatient investigation. He has been instrumental in restoring good health as well as avoiding the possible chance of a severe abdominal operation or undesirable long-term steroid therapy.

Comment

The problem of steatorrhoea is becoming more important in general practice. This is partly due to the increasing numbers of people undergoing gastro-intestinal surgery and presenting with this condition postoperatively. It is also probably true that the advances in technical diagnosis and therapy have led to a greater awareness throughout the profession of the pathology, aetiology, and presentation of steatorrhoea.

The general practitioner must be able to recognize those cases requiring fuller investigation and specialist opinion, as well as the principle that in taking over an old case, one does not necessarily take over an old diagnosis, for there is no doubt that much of the burden of diagnosis and management lies upon his shoulders.

Summary

A lady, 36 years of age, presents a history of 20 years fatty diarrhoea precipitated, at intervals, by emotional crises. The diagnosis of ulcerative colitis was made throughout this period, during which there was either no treatment, or steroid therapy. The latter produced some improvement, but initiated steroid diabetes. The opinion of an eminent gastro-enterologist, following a request from her general practitioner, suggested a diagnosis of chronic pancreatitis associated with colitis. The patient is now being treated with pancreatin and is very well.

Summer Diarrhoea in a General Practice. A. H. W. BRENAN, M.R.C.S., L.R.C.P., *The Practitioner* (May 1962), **188**, 669.

Thirty patients complaining of diarrhoea seen in general practice were investigated bacteriologically, and three of them were found to be infected with Salmonellae and seven with *Shigella sonnei*. All patients were treated with sulphamagna, and in all cases the symptoms cleared quickly, though two of the salmonella-infected patients continued to excrete the pathogen.