LETTSONIAN LECTURES

ON

SOME MOOT POINTS IN THE NATURAL HISTORY OF SYPHILIS.

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LECTURE II.

The Relationship of Tertiaries to Secondaries.—Nerve-Affections, which are Symmetrical, Central, and Aggressive.—The Position of Rupia and of Psoriasis Pulmaris.—Syphilitic Lupus.—Periostitis.—Other Maladies often considered Tertiary really of Early Occurrence.—Influence of Mercury as an Antidote.—Recurrence after Long Treatment.—Conclusions.

MR. PRESIDENT AND GENTLEMEN,—In our former lecture we glanced at some questions which are still matters of debate in reference to the primary phenomena of syphilis, and I now purpose to take up certain similar topics which concern its later stages. First and most important amongst these, we shall have to consider the relationship between what are known as the secondary phenomena and those which come later and are named tertiary. The older doctrines taught that there exists between these an essential difference of kind and of tendency, and that certain forms of disease can be named as "secondary," and certain others as "tertiary." Thus it has been supposed that the viscera and nervous system suffer in the tertiary period only, and that there is at this latter stage a general tendency to ulceration, and to extension deeply, which is not observed in the secondary one. What has been named a "gumma," has been supposed to be characteristic of the tertiary stage. Opinions have, however, been gradually changing respecting several, if not all, of these points. Cases have been recognised in which the various conditions referred to were met with so early in the disease, and in such close combinations with each other, that the only explanation seemed to be that the disease had run an unusually rapid course, and had reached its last stage before it had well finished its first. By degrees we are, however, arriving at another interpretation of such facts, and are beginning to see that the old classifications of the phenomena cannot hold their ground, and that we must seek for other characters by which to distinguish the secondary and tertiary stages. Not, indeed, that the old observations were wholly wrong; this would be exceedingly improbable, and its mere assertion would very properly lead to much mistrust of any modern conclusion which might seek to supplant them. Speaking loosely and in a general way, it is still true that visceral affections, gummata, deep ulceration, and periostitis, belong to the tertiary stage; it is only when these facts are brought forward as if they were constant, and sufficient in themselves to form the basis of classification, that we are compelled to make protest.

Permit me to illustrate what I mean by the citation of a case. A young man, aged 21, too young, let me note, for it to be likely that he had ever had syphilis before, was admitted into the London Hospital under my colleague, Dr. Langdon Down. He had still the remains of a hard chancre on him, and he was covered by a papular rash, which was ulcerating in places. The date which he assigned to the beginning of the affection was only four months previously. He died suddenly and unexpectedly. The necropsy showed gummata in both testicles, in the spleen, and in the heart, death having been caused by the softening and ulceration of the latter.

Here, then, we have conditions, which are usually counted tertiary, occurring before the primary ones have had time to disappear. If the case were one without companions, we might put it aside; but it is not so, the fact being that it is very exceptional only in the circumstance that the patient died, and thus afforded an opportunity for the demonstration of conditions which are probably present but unsuspected in many others.

I have myself known another case in which a young man, not fairly over the secondary state of syphilis, died of diffuse gumma of the

heart. Large gummata in viscera are common enough in syphilitic infants, who, at the same time, still present the ordinary forms of secondary eruption. In the adult, it is an every-day occurrence to observe symptoms implying periostitis, transitory disease of various parts of the nervous system, or even visceral affections, during the secondary period. It is not so much in the special location, or even the character of the morbid changes, as in their tendencies that we observe a difference between them and the lesions of the tertiary stage. The gummata of the early period are small and numerous; those of the later one are large, and often few in number, or even single. Those of the early period easily disappear, either spontaneously or under mild specific treatment, whilst those of the tertiary stage persist, and grow indefinitely unless adequately met. Hence it may easily happen that the indications of internal disease in the secondary stage may often pass unnoticed, whilst those of the later one rarely escape discovery. We may argue this point in more detail in reference to two special symptoms which, as they occur in parts open to inspection, are not liable to the fallacy just mentioned. I refer to rupia and periostitis.

The Position of Rupia and of Psoriasis Palmaris.—It has been customary to claim rupia as definitely a tertiary symptom. This, I contend, is quite a mistake. It almost invariably begins within a year of the chancre, and often much earlier; and, if met with later, it is almost always in cases in which it has resisted treatment and lasted for long. The mistake as to its proper position has arisen from a too easy acceptance of the dogma, that everything that ulcerates is necessarily tertiary. But such is not the fact; ulceration, even to the extent of phagedæna may happen not only in the secondary, but even in the primary stage.

It would be beyond the scope of the present lecture, if I were to attempt to produce proof by the citation of cases that rupia does really occur in the early periods of syphilis. Such proof could easily be brought forward did time permit, but I must leave it for clinical observers to test the assertion for themselves. It is needful, however, to say a few words as to what is meant by rupia, and as to the conditions under which, chiefly, this peculiar and rare form of eruption does occur. We must not confound, under the name of rupia, all conditions attended by ulceration and scab; for this would allow the inclusion of certain lupoid affections which do certainly, as a rule, come much later. By rupia, we mean an eruption consisting of many distinct sores, which begin as bullæ, and tend to the production of conical crusts. There is ulceration of the skin beneath, but it is seldom deep, and there is a certain amount of infiltration, but never much. The face and limbs are its usual sites. Its sores are always round, unless two or more have become confluent, and it leaves round scars. The very fact that it is usually symmetrical, sufficiently denotes its position as one of the secondary phenomena; but, although I claim that such is its place, it is to be clearly admitted that it is never one of the earliest. Usually, I think, the ulcerating forms of eruption, of which rupia is one and ecthyma another, occur after a certain amount of treatment, and after the first eruptions, which were erythematous or papular, have quite disappeared. Often there has been an interval of good health, and all treatment has been laid aside. Sometimes, however, a papular eruption is converted into an ulcerating or rupial one apparently by too vigorous treatment. Sometimes the rupia happens apparently as a consequence of neglect of treatment. Very often, a peculiarity in the diathesis of the patient has been implied, by the fact that his chancre inflamed and ulcerated. Thus a scar-leaving eruption often follows a scar-leaving chancre.

The belief that the occurrence of rupia, or other ulcerating eruption, makes it desirable to avoid mercury and use only iodide of potassium, is, I think, fast losing its hold. Although, unquestionably, mercury does sometimes disagree in such cases, we know that it is chiefly a question of dose and mode of use, and that when these are well arranged it will almost always cure.

Rupia, as a rule, is not seriginous; it does not creep at its edges; its crusts, when typical, are always circular. The shilling-like scars which it leaves are well known. There is, however, another and an allied condition, possibly sometimes a direct consequence, in which the morbid process is allied to lupus. In this the round form of the sore is lost, for the inflammation spreads at its edges by local infection, and allows healing in the centre. Thus a horseshoe form is assumed; or it may be that large irregular patches, with crescentic edges, become involved. This disease may last indefinitely unless carefully treated, and often does extend over several years. It seldom, I think, originates *de novo*, as a genuine tertiary, years after the secondary symptoms have all disappeared, but is more commonly a sort of continuation of an imperfectly-treated eruption of early date; it ceases to be a generalised eruption, is no longer arranged

with any tendency to symmetry, and it is often more amenable to local than to internal treatment. In all these features, it denotes a sort of transition position.

Syphilitic Lupus.—It may here be convenient to discuss briefly the moot question as to whether there is such a disease as syphilitic lupus. Our answer to such question must depend upon the definition of our terms. That there are syphilitic inflammations of the skin which affect by preference the parts most frequently attacked by lupus, which spread at their edges just as lupus does, which, like it, leave scars, and which, even to those most experienced, present throughout features which render it very difficult to decide whether the condition is common lupus, or due to syphilis, everyone will admit. These diseases, of which we have as great a variety as we have of lupus itself, are to be cured by specific treatment; and in this they differ *to toto* from common lupus. I fail to see that any clinical convenience is served by refusing to call these affections syphilitic lupus, using the term in the same sense that we speak of syphilitic psoriasis and syphilitic lichen. They are the syphilitic imitations of the typical malady. The most acute and rapidly destructive of these is what has been termed erosive lupus, an almost phagedenic affection, which usually attacks the nose, and which is more frequently seen in inherited than in acquired syphilis. Good examples of it are, however, occasionally seen in the acquired disease, and always, I think, at a distance of more than a year, and usually of several, after the primary disease. From this acute affection downwards, we have the most varying degrees of severity in syphilitic lupus. As a rule, all lupoid affections rank as tertiary; and it would scarcely be too bold a generalisation to say that all the tertiary affections of the skin are of a lupoid character. I mean by this that all are serpiginous, all unsymmetrically arranged, and that all leave scars. We have done with rosacea, psoriasis, lichen, and even with rupia; and if the skin at this stage suffer at all, it will from a tubercular affection which creeps at its edges, persists indefinitely unless cured by treatment, and leaves scars. It is, in fact, a serpiginous gumma of the skin. This generalisation is a most important one, as giving us a clue to the character of the affections of the deeper parts (hidden from view) which occur in this stage. They, like lupus, may be serpiginous, the cell-growth tending to infect the edge of the patch, and thus cause persistent spreading. Such a pathological hypothesis would well explain what we witness in such affections as ophthalmoplegia externa, in which we find indications of slowly spreading central disorganisation, and corresponding external paralysis, the process often going on for years. The same remark applies to locomotor ataxy, if it be admitted that it is sometimes of specific origin.

Periostitis.—Having thus discussed the relationship of the different forms of skin-disease to the different stages of syphilis, we must next try how matters stand as regards the bones. It will be asked, Are not all nodes necessarily tertiary? If by a node we mean a local periosteal swelling, most certainly they are not. Periostitis is a very common phenomenon in the secondary stage, as denoted by what is called syphilitic rheumatism, osteocopic pains, and sometimes by local swellings of considerable size. In some cases, the periosteal pains of secondary syphilis are very severe indeed, and now and then we observe swellings on the skull or tibiae which might rival those of the later stages. It is quite true that the periostitis of the tertiary period differs much in its tendencies from that of the secondary; it is more lasting, more apt, on the one hand, to end in softening, and, on the other, in permanent sclerosis. It is in these differences of tendency, however, that we distinguish the two in the different stages; not in the tissue which is attacked. Permit me to note that the differing tendency of periostitis is very marked, also, in congenital syphilis. Young infants, whilst suffering from secondary eruptions, often suffer, also, from multiple periostitis on the skull-bones, and also on those of the limbs. It is, however, at this stage, for the most part, a transitory and easily curable process; whereas, eight or ten years later, another form may be expected which will produce much more conspicuous and more lasting lesions.

Other Maladies which are considered Tertiary, often of Early Occurrence.—I might mention many other lesions of different tissues which have usually been counted as tertiary, but which as a matter of fact occur most frequently in the earlier periods. Thus, for instance, the nervous system is very often attacked within the first year, or even within the first six or eight months. Neuro-retinitis, a condition which is easily demonstrable by the ophthalmoscope, almost always occurs early. It is to be distinguished, I need hardly say, from the neuritis which is restricted to the papilla, and attended by what is known as the choked disc, and which is usually symptomatic of an intracranial gumma. Fournier has described lesions of sensation attended with defective perception of pain, which are, he says, very

common in the secondary stage. Attacks of paraplegia and the cerebral paralyses, which result from disease of arteries, also occur, I am sure, much earlier in the course of the disease than they are usually supposed to, and often well within the secondary stage. When that terrible form of inflammation of the internal ear, which leads to absolute deafness, occurs, it is always about in the same stage of the malady as the inflammation of the eye; that is, in the second half of the first year. Less severe and more transitory attacks, affecting the ear, and attended by deafness and giddiness, resembling what is known as Menière's disease, are also not very uncommon at this stage. Although the results of choroiditis disseminata are often not recognised until a later period, yet the primary attack almost always occurs within the first eighteen months; and it sometimes happens to the ophthalmic surgeon to be able to demonstrate at this stage, with beautiful distinctness, the existence of multiple gummata in this structure. From such demonstrations, we may infer the kind of changes which may happen at the same stage in other tissues of the same order; such, for instance, as the pia mater.

Before leaving this topic, we may suitably recollect that many of the diseases which I have just mentioned would probably occur much earlier in the evolution of constitutional syphilis, and would be recognised much more definitely as belonging to the secondary stage, were it not for the almost constant employment of antidotal specifics. The effect of mercury, when it does not absolutely cure, is usually to delay and retard. In many cases, the patient remains free from symptoms so long as he continues the drug, but experiences an outbreak within a few weeks or a few months after suspending its use. It seems to be quite easy, if mercury be begun on account of the primary sore, and well antecedent to the appearance of any secondary symptoms, to entirely prevent the development of the latter. I have witnessed this prevention over and over again; and it appears to be the rule, rather than the exception, that no secondaries should appear. The immunity, however, not unfrequently lasts only so long as the drug is continued, and within a few weeks after its omission, even when the course has been one of six or eight months, a rash on the skin will show itself. Thus it may easily be the fact that inflammations of the eye and ear, and of other parts of the nervous system, which occur, in the natural course of things, later than skin-affections, may be yet further retarded by treatment, and may sometimes appear almost to encroach upon the tertiary period, although definitely belonging to the secondary.

If what I have said has carried with it the lesson which has been intended, I think we shall have arrived at a clear perception, that it is quite impossible to classify secondary and tertiary symptoms into two groups, with reference to the tissues which are attacked. These words are to be used rather as applicable to distinct periods of time; and we must thoroughly understand that there is no lesion whatever which may not happen, and no tissue which may not be attacked, during the secondary stage. I really cannot think of any definite exceptions to this sweeping statement. Many things are omitted in the tertiary stage which are common in the secondary; but few, indeed, are the conditions met with in the tertiary which have not found their representatives in its predecessor. This fact supplies, I think, important evidence in favour of the belief that the tertiary symptoms stand in relation to the secondary, often in the place of relapses; that is, of a recrudescence of morbid process in tissues which had been damaged at a former period. Everything that is tertiary is local, in a sense which is not true of any of the secondary phenomena. Thus we find that the tendency to symmetry, so definite and universal in the early stages, diminishes as we advance in the chronology of the attack. With the exception of certain maladies affecting the nervous system, concerning which there is as yet much debate as to whether they are syphilitic or not, we may say that nothing in the tertiary stage is ever bilateral, excepting by accident. For clinical convenience, it may seem well to recognise an intermediate period, during which, in many patients, there is an absolute abeyance of all symptoms, and which may last over several, or even many years. If symptoms should occur after a prolonged period of immunity, they are always definitely of the tertiary class, and almost always non-symmetrical, and if on external parts, they are remarkably amenable to local treatment only. In many persons, however, this intermediate period is not one of absolute immunity, but is occupied by the display of conditions which partake in character of both stages. We may perhaps, for convenience sake, say arbitrarily that the secondary stage ends with the second year, and that about this period the disease ceases to be capable of spreading by contagion, or of being transmitted to offspring. In very many patients the secondary stage, as defined by these criteria, ends with the end of the first year, whilst, in a few exceptional cases, it may be protracted beyond the end of the second.

Perhaps I could not adduce better illustrations of the difference between the secondary and tertiary affections of the same parts, than by reminding you of what happens in the case of the palm of the hand and of the tongue. In the secondary stage, and simultaneously with the general eruption of the skin, the palm of the hand often suffers from psoriasis. It is always both palms which are affected, not one only; and there are usually in each a number of separate patches, which, although of various sizes, are alike in being circular, and covered with broken-up epidermis. Most obviously, such symmetrical and multiple affections are due to blood-infection. This form of secondary palmar psoriasis is generally cured very easily by the use of mercury; it vanishes when the rest of the skin-eruption leaves, and it seldom returns in the same form. If, at a later period, the palm be affected, it will probably be by a single patch of considerable size, which has a spreading edge, and which affects one hand only. The hand most likely to be attacked is that which the patient irritates most, whether by the use of tools in his employment, or by carrying an umbrella or walking-stick. The later the affection occurs, the more definite will be the characters just mentioned. The condition may be cured by the internal use of mercury, but it will often be found to yield more quickly to the local employment either of that drug or of iodoform. Almost precisely similar statements are true as regards the tongue; it is liable, in the secondary stage, to an eruption over its whole surface and sides, of scattered spots, which are part and parcel of the general eruption. These pass away under constitutional treatment, but are very likely to be followed, at a later period, under the influence of local irritation, such as that produced by sharp teeth, hot tobacco-smoke, or by various articles of food, by the development of persisting sores or abrasions, usually not symmetrical, and which are more definitely under the influence of local than of internal treatment.

All these facts, I may repeat, favour that view of tertiary symptoms which regards them as being, for the most part, the sequelæ and consequences of the secondary ones, and which assigns to them, as a rule, certain more or less definite exciting causes, for the help of which there is no necessity in the secondary period. The exciting causes to which reference has just been made are not necessarily local ones, although most frequently such. A patient who has had syphilis is to be regarded as having all his tissues damaged, their power to repair interfered with, and their liability to take on processes of chronic inflammation, ending in atrophy or sclerosis, definitely increased. He is less well fitted for the wear of life in every sense. If his tongue or his palm be subjected to local irritation, they will inflame; and the inflammation once begun, will very likely persist and become chronic. So also with his nervous system. If he be exposed to great heat, he is more liable to sunstroke than others. If he be subjected to mental strain or excitement, he may get general paralysis of the insane; or if his spinal cord be exposed to unusual fatigue, locomotor ataxy may be the result. It is in this way that I would try to explain the frequently occurring apparent connection between syphilis and some of these obscure and aggressive forms of disease of the nervous system. The nature of that connection, nay, even the fact of its existence, are certainly amongst the moot points in the natural history of syphilis. Everyone admits that locomotor ataxy, for instance, is very frequently met with in those who have been the subjects of syphilis. Those who are specialists in the latter disease see so much of it in this connection, that they almost invariably arrive at the conclusion that it most certainly occupies a very important place amongst its causes. At the head of those holding this belief is M. Alfred Fournier, of Paris; and, unless I am misinformed, Professor Charcot holds a similar opinion with scarcely less confidence. Yet in England we find observers, such as Dr. Buzzard and Dr. Vivian Poore, expressing, after careful consideration of the facts, great doubts as to there being any bond of association whatever. Dr. Buzzard, in particular, doubts the fact, upon which Fournier and Charcot have built with some confidence—the beneficial result of specific treatment.

For myself, I may confess that the number of cases of apparent connection which I have seen has been so great, and the seeming influence of specific treatment so frequently marked, that I cannot resist the conclusion that a previous attack of syphilis plays, at any rate, a very important part as a predisposing cause. There is a cognate malady, ophthalmoplegia externa, in which central changes, at first inflammatory and then atrophic, cause paralysis of the external muscles of both eyeballs. Now, it curiously happens respecting this affection, that in almost all the cases on record there was a clear history of preceding syphilis, and, in some, very definite results were obtained from specifics. The paralysis of single muscles of the eye, or of single nerves, as, for instance, the third or sixth, which are of frequent occurrence, and which not unfrequently precede ataxy, in

former days, before this symptomatic significance came to be observed, used invariably to be considered as syphilitic, and were as constantly cured by iodide of potassium. It is difficult to avoid the conclusion that the more widespread changes which produce ataxy, and of which these are only a part, are due to the same cause. I have no wish, however, as already stated, to claim for syphilis in respect to any of these a more important share than that of a predisponent.

Influence of Mercury as an Antidote.—Amongst the questions which may fairly be considered as moot points in the natural history of syphilis, we may count those which concern its relation to the specifics used in its treatment. The claim of mercury to rank as an antidote to the virus of syphilis, has, I think, been much strengthened by the results of recent experience, and it is one of extreme importance in reference to a very important department of general pathology and therapeutics. In connection with it, we may suitably bear in mind the great repute which weak solutions of corrosive sublimate have recently obtained in the prevention of septic processes in wounds. In former times, when mercury was given in large doses and allowed to produce violent effects, and when of necessity its administration was frequently interrupted, the development of constitutional symptoms in some form or other was so constant, that much hesitation was felt by all as to the use of such a word as "antidote." Of late years, we have got into the habit of using only small doses, and giving them over very long periods, carefully taking every precaution against the necessity for interrupting them. I will ask permission to state briefly my own rules of practice, and the impressions which I have formed as to results. As those impressions have been formed for many years chiefly in private practice, and amongst patients concerning whom I have often had opportunities for obtaining information over long periods, I am in a position to speak with much more confidence as to results than would otherwise have been the case. The remedy which I have used almost exclusively has been the grey powder, and the dose usually not more than a single grain. This dose I have given from three to six times in the course of twenty-four hours, according to circumstances, and seldom for a shorter course than six months in the first instance. If this dose be given to a patient with an indurated sore, but in whom, as yet, no secondary symptoms have appeared, the result will usually be that none will occur. If the rash have already made its appearance before the treatment is commenced, as a rule it quickly fades; and so long as the patient continues the remedy he remains free. The exceptions to completeness of freedom concern chiefly the month and throat.

It is very seldom indeed that there is any difficulty in keeping the skin perfectly clear. In the tonsils, and sometimes in other parts of the lining membrane of the mouth, sores will occasionally form; and, although these are in a general way amenable to an increase of the dose, and to the local use of the drug (as a black-wash gargle), it is to be admitted that there do occur occasionally cases in which it is difficult to be sure that the supposed remedy does not aggravate the disease. In a large majority of cases, however, in which, beginning at an early period, the patient is put under a six months' course; during the last four of this period, he is absolutely without symptoms and apparently in excellent health. If, however, at the end of this time, the remedy be stopped, in many cases a very remarkable proof of its antidotal efficacy will occur. We shall find that it was it, and it alone, which had held the poison in inactivity. For, in spite of the long period of absolute quiescence, an outbreak of symptoms will occur within a few weeks of its suspension. This outbreak is usually a very mild one, but is, nevertheless, very definite, and it is general. It usually takes the form of an erythematous or lichenoid eruption, occurring chiefly on the trunk, and is not often attended by sore-throat or other symptoms. Although it may now and then be papular, I have never seen it approach in severity the eruptions which we often see in cases which have not been treated. In more than one case, I have known this eruption which comes after the suspension of mercury mistaken for scarlatina. It is always, I believe, very easily amenable to mercury, disappearing in the course of a few days, or at most a week or two, and seldom recurring. There is, however, another very peculiar eruption which sometimes persists for a long time, and recurs over and over again. I have been in the habit of speaking of this as the "after-bath eruption." It is a very trivial affair, and consists chiefly in the appearance of a number of faintly marked erythematous rings, which are seen only on sudden exposure of the body to cold, as on first getting out of bed, and especially after the use of the morning bath. Nine out of ten patients notice them only under the latter condition, and they generally fade away almost completely after a few hours. These rings are seen most frequently on the arms, but sometimes on the trunk and thighs. They are unquestionably

syphilitic, and the liability to them usually ceases on recurrence to mercurial treatment. They are seldom or never attended by other manifestations of the disease.

Respecting the results of treatment in general, I believe I may with truth assert that I have never, in any single case of late years, seen a severe eruption on the skin develop itself after a mercurial course of the kind indicated had been commenced. It is a fact, then, that the remedy manifests antidotal power in that it can not only remove, but anticipate and prevent, by far the most conspicuous manifestations of the disease. I cannot make so strong an assertion respecting some other of the symptoms of the later part of the secondary stage. I have seen iritis, and neuro-retinitis, occur occasionally, with even some severity, in cases which had been well treated; and, in very exceptional instances, I have witnessed disease of the arteries of the brain. In a large majority of cases, however, a six months' course of small doses appears to be adequate to the complete and permanent cure of the disease. No relapses occur, and the patient remains afterwards in excellent health.

We may admit that it is a question which must be left open for future accumulations of evidence, whether the antidotal repression of the secondary stage is influential in preventing the development after a long interval of tertiary symptoms. That it does not do so always, is abundantly proved. I cannot but believe, however, that it does exercise a very powerful influence in that direction, and that the diminishing frequency and severity of tertiary disease in modern times is largely due to better regulated treatment. It is often matter of remark that those who do suffer seriously after long intervals, are those in whom the early symptoms were exceptionally slight, and treatment in consequence not persevered with, or almost wholly omitted.

In urging the antidotal efficacy of mercury as a fact in the natural history of syphilis, I have not in the least wished to claim superiority for the special mode of administration which I have mentioned. I do not doubt in the least that the advocates of other methods, such as those by inunction or by the vapour-bath, can produce just as good results. The essential point seems to be that the treatment should be very long continued, or, if not, that short courses should be repeated without waiting for symptoms. The method which I have advocated is simply one of the most convenient.

It is a question of some interest whether syphilis has any tendency to develop itself by, so to speak, a series of successive waves. It is certain that we do observe periods of very sudden and acute outbreak, and that these sometimes follow after others of complete quiescence. Such facts are especially noted during the development of the secondary phenomena; but it happens, every now and then, at much later periods, that a patient who has been well for years suddenly has new symptoms occur, not only in one, but in several different parts of the body at once. This is, however, infinitely more rare than are the sudden and acute recurrences of symptoms which we often witness during the first year of the disease. The fallacy which besets our observations on this point is the one which meets us at all turns in our attempts to study the natural history of syphilis; it is this, that the phenomena may be connected with the intermittent employment of antidotal treatment. The worst cases of *rupia* which we see occur usually under these conditions, the patient having been cured of a first and much milder outbreak of eruption, and then, after an interval of some months, becoming the subject of a more severe one.

There is a very severe form of *rupia*, in which the ulcerations coalesce over large surfaces, and the crusts thus lose the typical limpet-shell form. Of this I have seen but very few examples, and the two which have made the most impression on my memory were almost exactly alike. The violence and the suddenness of the second outbreak were, in each case, most marked. The first occurred to me at the London Hospital, nearly twenty years ago, in the person of a young man named K. I had treated him for a mild attack of secondary symptoms with the usual papular eruptions, and he had got, apparently, quite well. He desisted from treatment, and I lost sight of him for some months. At the end of this time, he came back with a vesicular and bullous eruption just beginning on his face. In conformity with the opinion of those days that mercury ought to be avoided for such eruptions, I gave him the iodide of potassium. The eruption blazed up with extraordinary quickness, and in the course of a week his whole face was covered with crusts; there were many also on his limbs. He became extremely ill, was confined to bed for several months, and was so much emaciated that we thought he would die. At first a mixed treatment of iodide of potassium and mercury was used, and for a while it seemed powerless. Ultimately, under the influence of mercury alone, the man recovered, but with a

lamentable amount of scarring. Almost the whole of his face was involved in scars, and his lower eyelids were displaced downwards.

The exact counterpart of this case came under my observation not long ago. A young gentleman of fortune suffered from primary disease at Christmas 1884. He had a sore, which was both exceedingly hard and deeply ulcerated. This sore healed under the influence of full doses of bichloride of mercury, leaving a deep depressed scar in the glans. In April, after about three months' treatment, it was laid aside, as the patient appeared in excellent health, and had had neither rash nor sore-throat. Through the summer he remained well, but towards the end of September what he described as a slight red rash, which lasted only a few days, occurred on the chest. So far as is known, no specific treatment was used for this. No sooner had it faded, however, than some blisters appeared about his lips, and, spreading with great rapidity, in the course of ten days or a fortnight covered his whole face and neck. At the same time, others appeared on the buttocks, and a week or two later all over his limbs. The trunk, with the exception of the buttocks, remained free. The bullæ became confluent, and large heaped-up crusts, covering areas as large as the palm of the hand, were formed. The ulceration was deep, and on the back of one hand the tendons were exposed. For nearly a month, the disease continued to develop, in spite of the use of specifics. The patient was confined to bed, and was in the most loathsome condition. He became exceedingly emaciated. The treatment under which he finally recovered was the use of the bichloride of mercury in doses of one-eighth of a grain with five grains of iodide of potassium, the sores being dressed very liberally with a weak nitrate of mercury ointment. When I saw him in the early part of December, he was still confined to the house, though not to his bed. His face, with the exception of two small patches, one in the middle of each cheek, was wholly involved in scar. The lower lids were everted, and dragged down to the utmost possible extent. The *alæ nasi* were destroyed, and the contraction of the scar around his lips had everted the prolabia, and so fixed his mouth that he could with difficulty open it. The cicatrization of the skin of his cheeks had so much contracted them that it made the mucous membrane bulge between his teeth, so that he bit his cheeks in eating. The scars left on his neck, shoulders, arms, and hands were very peculiar; few of them were quite round, but all were abruptly margined, and in many cases it was clear that they resulted from a confluent group of bullæ. Most of them were slightly raised, and looked as if they were in an early stage of keloid; but I was assured that their thickness was diminishing, and not increasing. Most of them were of a deep purple colour, but a few were quite pale. The scars on the legs were purple, almost to blackness. The buttocks were covered by a great number of little button-like scars, and on these parts there were no large ones. The healing was complete on all parts, with the exception of two or three spots on the legs. The symmetry in the arrangement of the scars was almost absolute.

Several important points are to be noted in this case. First, the disease, which had fallen with such great severity on the skin, had entirely avoided the mucous membrane. There had never been any sore-throat, nor, with the exception of a slight soreness of the gums from the mercury, any sores in the mouth. Secondly, the location of the eruption was on the limbs and face only. If we count the scapular regions as belonging to the upper extremities, and the buttocks to the lower ones, there was not a single spot on the trunk. Thirdly, the arrangement of the eruption was more like that of psoriasis than of a syphilide. Thus there were large livid scars on the tips of the elbows and fronts of the knees, and on the backs of the hands; whilst the fronts of the arms and the palms were exempt. Fourthly, the scalp had been throughout absolutely free. Fifthly, the subsidence of the eruption on all parts under the influence of mercury had been most definite and complete, although in the first instance this drug, which was begun early, had seemed to exert no influence in preventing the outbreak.

Let us for a moment contrast such cases as the two which I have just adduced with some mentioned a little earlier, in which very mild eruptions appeared on the disuse of mercury after the prolonged use of small doses. Under the latter conditions, the eruption, although of common occurrence, is never severe. After short courses, especially if attended by salivation and sudden complete stoppage of treatment, these severe recurrences are not, I think, very rare. They suggest the inference that the poison is in some way retarded in its development by the antidote, but that it is not destroyed, and that it possesses the power, after a rest, of still displaying its utmost rigour.

Conclusion.—And now, Mr. President and Gentlemen, in conclu-

sion, allow me to recapitulate. I have urged that many of the phenomena of syphilis usually counted as tertiary really occur, as a rule, in its early periods, and that there is no structure in the body which may not be attacked in the secondary stage. As instances of this fact, I have mentioned rupia, periostitis, and diseases of the viscera and of the nervous system. If my argument holds good, we must regard the terms secondary and tertiary as applicable to different periods of time, and not to different phenomena. At the same time, it has been fully admitted that syphilitic processes do display different tendencies in relation to the stage in which they occur. The position assigned to the tertiary symptoms has been that of late relapses of morbid processes, in tissues previously damaged. In this way it has been suggested that syphilis may occupy an important part in predisposing to such maladies as locomotor ataxy, without actually causing them. Lastly, the relation of mercury to the natural evolution of syphilis has been discussed, and I have tried to claim for it the position of an antidote to the virus, asserting that not only can it cause symptoms to disappear, but, if used early enough, will entirely prevent them.

"ON A CONDITION OF THE INNER SURFACE OF THE UTERUS, AFTER THE BIRTH OF THE FŒTUS, OF PRACTICAL IMPORTANCE."

By J. BRAXTON HICKS, M.D., F.R.S.,
Consulting Physician-Accoucheur to Guy's Hospital, etc.

THE above was the title of a short paper of mine read at the meeting of the British Medical Association at Cardiff last year. It was published on October 10th, 1885. This heading is repeated by Mr. J. Stuart Nairne, of Glasgow, in the JOURNAL of January 16th. And then he says, "I am very glad this condition has attracted the notice of such an eminent physician, but I would have been still better pleased if he had given a little credit to some small observations of my own on the same subject."

In answer to this I would say at once that, to be thought capable of omitting knowingly to give a co-worker due credit, is a source of pain to me. My explanation of my omission is simple but twofold; 1, we are talking of different conditions; 2, I have never seen the remarks made by either Mr. Nairne, or Dr. Napier.

1. I am talking of a condition of the whole internal surface of the uterus, while Drs. Nairne and Napier are speaking of the area of placental insertion (serotina); this they describe after uterine contraction as now "about a couple of inches in length and breadth." In one of my cases, I specially observed that it was outside the area of the placenta before its removal. But, supposing we were describing actually the same condition, then the second part of my answer is, first, that I have to-day consulted the *Glasgow Medical Journal* of 1884, and can find no account of Mr. Nairne's paper, nor any discussion thereon in reference to this question, neither in the report of the Glasgow Southern Medical Society for March, 1884, nor in the April number of the Journal, nor in any other volume thereabouts, neither could I find any report in the Edinburgh journals of these meetings. The only allusion I can find in this remote south is one by Mr. Nairne on Dr. K. N. Macdonald's case in this JOURNAL. This came out in May, and was overlooked by me, doubtless because the heading was "How to Prevent Septicæmia in Cases of Morbidly Adherent Placenta." My paper had been projected long before, and I should have quickly noticed anything bearing on the subject; but, as I say above, the conditions are different, as can be seen by comparing the papers. I therefore must repeat the last paragraph of my short paper. "I am not aware of any one having noticed or pointed out the peculiarity before, though I can hardly think it could have escaped observation; but, in the excitement of the moment, the danger of mistaking the lining of the uterus for adherent placenta is undeniable, and this must be my excuse for occupying your time."

ROYAL EAR HOSPITAL.—It was stated in the report presented by Drs. Pritchard and Matheson at the annual general meeting of the Royal Ear Hospital, Frith Street, Soho, that during 1885 there were 7,796 out-patient attendances, at which 2,463 separate cases received careful treatment. Forty-four patients were admitted into the in-patient wards, all serious cases, and mostly children. This new department was reported to be a very great success, although it had considerably added to the expenditure. The financial condition of the hospital was shown to be far from satisfactory, as there was a considerable falling off in the donations and subscriptions. Funds are urgently needed to prevent a reduction in the number of beds.

ON THE SURGERY OF THE LATE EXPEDITION TO SUAKIN.

Read before the Surgical Section of the Academy of Medicine in Ireland.

By R. F. TOBIN, F.R.C.S.I.,

Assistant Surgeon, St. Vincent's Hospital, Dublin; late Assistant Professor of Surgery, Army Medical School, and Field-Surgeon to the Suakin Expeditionary Force.

DURING the late military operations at Suakin, it was my good fortune to occupy the position of Field-Surgeon; and, although I have nothing very new or important to communicate, it may be that it will interest you to hear from an eye-witness the surgical history of that brief campaign. The appointment, styled Field-Surgeon, is one new in our army, it is one that has not yet been recognised by the supreme authorities, and the duties of which are not defined in the army medical regulations. (The subject is treated of in Mr. Longmore's work on *Gun-shot Injuries*, pp. 438, 439.) Let me, therefore, say a few words about it. Perhaps I shall best convey to you the nature of the appointment, by pointing out the conditions that call for its existence. If I do so by uttering a truism in connection with an acknowledged fact, I hope I shall offend no one. That skill in the practice of operative surgery, especially of antiseptic surgery, can only be obtained by practice, is a truism. That in times of peace the ordinary duties of an army medical officer give few opportunities for such practice, is an acknowledged fact. When, therefore, on the breaking out of war, medical officers sent out from various stations are called upon to take charge of wounded, it seems right to put at their disposal, for the purpose of consultation, etc., some one whose hand, to use a familiar phrase, is "in" at surgery. Men skilled in surgery will be glad of such an assistant; men whose training has been limited to operating on the dead body, will be steadied and encouraged by the presence of such a one in their first operations on the living. Men, on the other hand, who from any cause are reluctant to operate, will ask him to undertake for them whatever operations fall to their lot.

The operating tent at Suakin was a large double pole tent, of a pattern in use in India. To the poles were hung irrigators, and to the walls all round were stitched calico bags, filled with ready-made Lister's dressings of various sizes, salicylic, boracic, and iodoform wool, lint, bandages, and other surgical appliances. The floor of the tent was kept sprinkled with carbolic acid solution.

There were carried into the base hospital at Suakin, 129 wounded non-commissioned officers and men. The officers were, as a rule, taken direct to the hospital-ships; and, as I did not see much of them, I do not include them in my statistics or remarks. The official returns classify the 129 wounds as follows.

Regions of the Body Wounded.	Admissions with Wounds.		
	Total Wounded.	Projectile or Weapon by which Wounds were Inflicted.	
		Rifle-Shot.	Sword or Spear.
Wounds of the Head	6	2	4
" " Face	6	4	2
" " Neck	5	3	2
" " Chest	11	8	3
" " Abdomen	3	2	1
" " Back and spine	13	9	4
" " Urinary organs	2	2	—
" " Upper extremity	32	20	12
" " Lower extremity	51	43	8
Total	129	93	36

N.B.—The Royal Marines are included in this return.

Of the 129 who were wounded, 124 recovered. The five deaths occurred as follows: one from a perforating wound of lung and liver, one from a similar wound of abdomen, with perforation of the intestines; three from wounds of the lower extremities. Two of these latter wounds were fractures of the femur in the neighbourhood of the hip-joint, a class of wound which has never, under the most favourable conditions, furnished a less mortality than 70 per cent., and one of the two was complicated with other injuries that