A Lecture ON SOME UNUSUAL MANIFESTATIONS OF SYPHILIS IN THE UPPER AIR PASSAGES.

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GENTLEMEN,—There is no more trite expression than the ever-reiterated designation of syphilis as "protean" in its manifestations, yet it would be hard, I venture to say, to point to any affection in which we have voluntarily bound ourselves to more rigid formalism than in our notions regarding the classification and the treatment of the various stages of that disease. It is an axiom religiously believed in, that we must distinguish between primary, secondary, and tertiary manifestations, separated from one another by certain limitations of time, which are, after all, purely conventional, and when we have decided upon registering an individual case as coming within one of these categories, we again feel it to be our duty to prescribe mercury for the first and second of these stages and iodide of potassium for the third. A convention of this kind could of course not have arisen if experience had not taught us that on the whole it answered practical requirements, and far be it from me to shake well-founded belief in the results of such practical experience. From time to time, however, it is well to be reminded that exceptions occur to almost every rule, and that to insist too rigidly upon convention is not wise. Many years ago I published under a title¹ similar to the one given to this lecture some instances of rare manifestations of syphilis in the upper air passages, which did not fit into the generally adopted scheme, and having recently had within a comparatively short time the opportunity of seeing a further number of such unusual cases, I avail myself of this opportunity to bring them before the notice of the profession. As they all have occurred in private practice, I shall, for obvious reasons, not give any particulars which could lead to identification of the patients, and for the same reasons shall not mention the names of the practitioners who were good enough to send me the patients or were otherwise concerned in the management of the cases themselves.

1. *Precocious Tertiary Syphilis of Throat and Tongue of Malignant Type.*

A gentleman was sent to me by his medical adviser with a letter from which I abstract the following statements: A year ago the patient got a hard chancre. It had only just appeared when his doctor saw him. He put him on full doses of mercury at once. None of the ordinary secondary symptoms ever appeared, but the patient got a tremendously swelled throat and tongue, and was badly salivated, ropes of saliva pouring out of his mouth. The soft palate became oedematous, the tonsils, on each of which a large ulcer appeared, almost met in the middle, and the patient was very ill generally. The medical attendant considered the phenomena as mercurial. Mercury being left off, the ulceration gradually improved, the salivation diminished, and the patient went away to recoup, but returned with his throat again deeply ulcerated.

In consultation with a specialist the affection was considered to be of the nature of secondary syphilis; a return to mercury was advised and practised, with the result that the ulceration, as on the first occasion, grew rapidly worse, and the patient became very ill. Mercury was again abandoned, and the patient was treated with "ordinary throat applications." Temporary improvement occurred, but a month or so afterwards fresh ulceration broke out in the throat. On renewed consultation mercury was again advocated and used, with exactly the same result as previously, namely, that the ulceration immediately became much worse, and that the patient was again very ill. Mercury being discontinued, he very slowly and gradually recovered, and was then sent to a

great authority on syphilis who, it was stated, took an intermediate view between syphilis and mercurial ulceration, and considered the former to belong to the phagedaenic type. He advised the use of iodide of potassium, which, however, the patient was "unable to take in ordinary doses." All this information was given in a letter, the tone of which was perfectly despairing; the writer, who obviously took the greatest possible interest in his patient, had evidently on each occasion, when, either on his own initiative or following the advice of his consultants, he had tried antisyphilitic remedies, particularly mercury, been so much frightened by the extreme violence of the resulting local symptoms and their bad effect upon the general health of his patient, that he had become firmly convinced that the ulceration was of an exclusively mercurial character, and although he laid the case with the greatest fairness before me, it was quite obvious that his own conviction had become so firmly established that no arguments would easily shake it.

The patient was a pale, unhealthy-looking man, evidently in pain, whose speech was guttural and indistinct, his frequent endeavours at swallowing the saliva, which was constantly produced in large quantities, being accompanied by signs of great distress.

On examination, I found the following condition: There was extensive scarring owing to destructive ulceration of the mucous membrane of the palate and fauces, resulting in adhesions, on the one hand between the soft palate and the posterior wall of the throat, and on the other, of the pillars of the fauces with the sides of the tongue. The uvula was entirely destroyed, and there were two perforations—a larger one above, a smaller one below—in the middle line, the larger one of which represented the only communication between the nasopharyngeal and oral cavity. The tongue showed evidence of old ulceration and was fissured; the epiglottis was partially thickened, more particularly on the right side, and on this part, as well as on the sides of the fauces, there was still some active superficial ulceration. The interior of the larynx was free. There was no disease in the nose, the cervical glands were hardly enlarged at all, and there was no skin eruption.

From the appearance described there was no doubt in my mind that the affection was of a purely syphilitic character, tertiary in nature, although appearing at an unusually early time, and revealing a most unusual idiosyncrasy on the part of the patient against antisyphilitic remedies, particularly against mercury. I wrote in this sense to the patient's medical adviser, and mentioned in anticipation of the natural objection that the throat affection had occurred at a time much prior to the usual occurrence of tertiary symptoms, that I had in 1882 described in the *Lancet* a case in which gummata developed in the larynx within the first year from the primary infection, and that I had on the same occasion quoted a case of Mauriac's, in which as early as two and a half months after the primary infection an evolution of gummata took place, and a statement of Zeissl's that he had seen a nodular syphilide four months after the primary infection. At the same time I proposed that the patient should be sent to Aix-la-Chapelle with the primary object of eliciting the opinion of one of the authorities of that place as to the differential diagnosis between mercurialism and syphilis, and, in second line, of the patient's being treated there for syphilis in the event of the opinion being in favour of the manifestations being specific. This advice was adopted.

The opinion of the physician at Aix-la-Chapelle, taken quite independently of me, entirely coincided with my own. He considered the case one of precocious malignant tertiary syphilis, two instances of which affecting the nose he had previously observed himself. He at first tried to treat the patient with iodine preparations, and made four injections of 25 per cent. iodine, each containing $\frac{1}{2}$ oz. of the drug, this remedy being chosen because, in the experience of my friend at Aix, this form of iodine is equally mild and efficacious. The result was no more successful than had been the mercury and iodine treatment at home. On the day after the last injection the patient got a painful swelling of the tongue. The tongue itself, as well as the soft palate, became covered with a dirty yellowish deposit in the area where previously simple erosions had been present. This condition got

daily worse, and ultimately the entire affected region of mucous membrane became changed into a mass of rather deep and intensely painful ulcers, the general health at the same time deteriorating rapidly. The ulcers were painted with a 10 per cent. solution of nitric acid. Under this treatment they became cleaner, but showed no tendency to heal. From this result of the iodine treatment the Aix physician became even more convinced than he had been before that he had to deal with a case of malignant syphilis, as in such cases in his experience the inefficiency of mercury and iodine preparations is quite characteristic. The present case additionally, he stated, belonged to a rare variety which he had previously observed, and which is characterized by a tuberculin-like effect of iodine preparations. In such cases the reaction, which ordinarily is quite insignificant, manifests itself by a furious inflammation. This very reaction, in his opinion, made it even more certain that we had to deal with a case of lues, inasmuch as, although mercury may produce ulcerative lesions, such have never been observed under the administration of iodine preparations, often though they be administered, to non-syphilitic persons.

Acting upon this opinion Zittmann's sarsaparilla decoction was prescribed for the patient with immediate and brilliant results. For twenty-six days he daily took in the morning 7 oz. of the stronger Zittmann's decoction, and in the evening 7 oz. of the weaker decoction. This was followed for ten days by Kobert's* sarsaparilla decoction, and finally he took the two Zittmann preparations for another fortnight. Under this treatment his general health improved from day to day, the ulcers cicatrized in the most desirable manner, and ultimately were replaced by a solid scar. The patient's articulation became much more distinct, he could eat without difficulty and pain, and during the whole time hardly ever suffered from diarrhoea. He was discharged with the advice to take Kobert's decoction for another fortnight, and afterwards to discontinue for a time all treatment. When I saw him on his return I found a most pleasing improvement; a dense cicatrix united the remnants of the soft palate with the lateral wall of the pharynx down to the level of the epiglottis. In its midst there was one sharp-cut perforation, and the uvula, as already stated, had completely perished. There was no active ulceration in the pharynx and the larynx was normal. The patient's general appearance and articulation were infinitely better than before he went to Aix. Since then, so far as I know, he has remained perfectly well.

2. Tertiary Syphilis of Larynx and Trachea followed by Isolated Tertiary Syphilis of the Nasopharyngeal Cavity.

A married lady was brought to me on account of gradually increasing loss of voice and dyspnoea, which had come on, it was stated, during the preceding ten days, after a bronchial catarrh. The patient complained of loss of voice and some slight difficulty in swallowing, but, curiously enough, did not attach any importance to the difficulty in breathing, although this was clearly manifested by distinct stridor even during quiet respiration. Tuberculosis had been suspected on account of the laryngeal appearances to be described presently, but two examinations of the sputum made by the Clinical Research Association had failed to disclose any bacilli. There was no history whatever of syphilis.

On examination of the almost aphonic patient it was seen that the left half of the larynx was fixed, and that the left vocal cord, which was distinctly oedematous, was bent outwards in its posterior part. The right vocal cord, which was quite white, moved normally. A long way down into the trachea it was seen that from the walls of the tube on both sides reddish projections extended into the interior, those on the left side projecting more than those on the right. The calibre of the tube was thereby narrowed to such a narrow split that it was surprising

that the patient had not got even greater dyspnoea. The larynx made no respiratory excursions. There was tenderness on pressure over the front part of the cricoid cartilage. On examination of the chest the tracheal stridor was found to be conducted all over the chest, and nothing else could be heard. There was no skin eruption.

In spite of the absence of a syphilitic history I diagnosed gummatous infiltration of the larynx and trachea, and sent the patient at once to a home, where she was put to bed with a Leiter's tube round her neck, whilst iodide of potassium in 10-gr. doses and liquor hydrarg. perchloridi in 1-drachm doses three times a day were prescribed for her. It was explained to her and her husband that tracheotomy might become necessary, unless the disease quickly yielded to the treatment prescribed. Fortunately, already on the next day the stridor had somewhat diminished, the patient having passed a good night. From the second day onwards mercurial inunctions according to Zeissl's plan were instituted. This consists, as I have described in the *Lancet*, 1882, in the following: "Twenty grains of mercury ointment were daily rubbed into various parts. On the first day the ointment was applied to the skin of the neck over the larynx, second day to the inner surfaces of both upper arms, third day to the inner surfaces of both thighs, fourth day to the inner surfaces of both forearms, fifth day to the inner surfaces of both calves, sixth day to the skin over both loins, seventh day to the skin of the back." This series is to be repeated four times in the same order, each series being preceded and followed by a warm bath, and astringent gargles being used as a matter of course during the whole time.

Under this treatment both the subjective and objective symptoms described rapidly disappeared, and six days after the first consultation practically no trace of the previous serious illness could be detected in either larynx or trachea. The patient went home, but was urgently admonished to continue the inunction treatment for another month. Whether this advice was strictly followed I am unable to say. At any rate, hardly three months later the patient began to suffer from sudden deafness and suppurative otitis media in both ears. At the same time an obstruction to breathing existed, which was located between the nose and throat, and a large ulcerating swelling, evidently of gummatous nature, was found to cover the vault of the pharynx and the upper part of its posterior wall. These manifestations again quickly yielded to mercury and iodide of potassium. In view, however, of the fact that twice within a short time gummata had formed in such dangerous situations, I strongly advised the patient to go to Aix-la-Chapelle, in order to be radically cured, if possible. The patient followed my advice, was energetically treated with inunctions and at the same time with injections of iodine, whilst local applications of nitrate of silver were made in the pharynx and nasopharynx to promote quicker healing. Under this treatment complete recovery ensued. The patient six months afterwards once more went to Aix-la-Chapelle to undergo a short inunction treatment as a prophylactic, and has ever since remained perfectly well.

3. Early Fibroid Infiltration of Pharynx and Larynx in a Case of Obstinate Recurring Secondary Syphilis.

The patient was a gentleman, who had been very liable to tonsillitis and pharyngitis for many years. Some years previously he had a hard chancre in the urethral orifice and hard glands in the groins. Hydrargyrum cum creta was given in 1-gr. doses three times daily for four months, under which treatment the chancre and inguinal glands soon disappeared. Hardly any secondary rash occurred, but about six months after the primary infection his throat began to trouble him, his voice became hoarse, and he had difficulty in swallowing. He was then sent to me, and I found a characteristic mucous patch on his right tonsil, whilst the corresponding region on the left tonsil looked suspicious. In the larynx there was marked diffused general thickening of the epiglottis and of the arytaenoid cartilages, and the vocal cords were congested. The aspect of the larynx was such that, without the history of syphilis, one would have thought rather of the pseudo-oedematous swelling often ushering in laryngeal tuberculosis than of syphilis, but the fact that a characteristic pharyngeal affection existed at the same time, and that, further, the laryngeal swelling was of a much more dusky colour than is usually seen in laryngeal tubercu-

* The formula of this preparation is the following: Place 1 kg. of sarsa root in coarse powder in a closed vessel with 4 kg. of distilled water, and set aside for three hours, occasionally stirring; heat and keep boiling for one hour, then press out. Repeat this once more. Evaporate the combined decoctions until there remains 1 litre (quart), mix well with an equal volume of alcohol (90 per cent.), wash out the residue with boiling alcohol (90 per cent.) $\frac{1}{2}$ litre, strain through flannel and filter, evaporate to $\frac{1}{2}$ litre or less. Establish the quantity of parilli and sarsaponia according to the method of v. Schulz-Christophson, and adjust the strength of the finished product either by evaporating or by adding distilled water, so that it shall contain 2 per cent. of the above glycosides.

losis, militated against the tuberculous theory. In addition, on careful examination of the lungs no evidence of tuberculous disease was found, and the absence of constitutional symptoms, except some emaciation which was admitted, seemed to point in the same direction. All the same, the possibility of a combination of syphilis and tuberculosis was not lost sight of. From the very first, however, I inclined rather to the belief that this was a case of syphilis pure and simple, appearing in the larynx in the somewhat unusual form of early general fibroid thickening, than a combination of syphilis and tuberculosis.

The weight and temperature of the patient were registered carefully for a while, and his sputum was repeatedly examined for tubercle bacilli. The results were perfectly negative, and the idea of the presence of a combination between tuberculosis and syphilis could therefore be entirely abandoned.

Whilst the syphilitic phenomena in the pharynx were of such a fleeting character that they varied almost from day to day, the aspect of the larynx remained for a time stationary, in spite of continued treatment by oral administrations of mercury, and the patient ultimately decided to go to Aix-la-Chapelle. There he underwent energetic mercurial inunction treatment, with the result that the general infiltration of the larynx very much decreased, and he returned greatly improved. Shortly afterwards, however, fresh mucous patches appeared in the pharynx, a roseolar eruption broke out on his skin, and so considerable an increase of the infiltration of the larynx was noted that I feel sure that nobody seeing the patient then for the first time would have doubted that the condition represented the infiltration stage of laryngeal tuberculosis. He complained of pain in the shin bones, occipital headache, and a general feeling of malaise. Together with these phenomena syphilophobia of a marked type developed. He commenced to take note of the smallest objective and subjective symptoms in his case, and became greatly depressed. Renewed physical and bacteriological examinations not having afforded the least evidence of the existence of tuberculosis, Kobert's sarsaparilla decoction was given, but without effecting any improvement. The patient's syphilophobia had by that time increased to such a degree that it became extremely difficult to manage the case. At last iodide of potassium was tried, which I had so far fought shy of, because in view of the already existing infiltration of the larynx I had feared that possibly it might produce laryngeal oedema. Its effects, however, were very pleasing. The infiltration materially decreased, the skin eruption disappeared, the difficulty in swallowing, which previous to the administration of the iodide had returned with increased severity, quite vanished, and the patient's voice, which at that time was very hoarse, became natural again. At the same time his general health very much improved, he became more hopeful, and matters at last took a more favourable turn. Quite recently I have heard that under the continuation of liberal doses of iodides his throat symptoms were kept in abeyance as long as he was under observation, but that until the very end he continued to be very nervous about himself, and was always on the look-out for every little adverse symptom.

4. *Tertiary Syphilis of the Larynx manifested particularly by Periodical Inflammation, with production of Ephemeral Papillomatous Excrescences.*

A gentleman consulted me on account of persistent hoarseness, from which he had suffered for a long time. He at once stated that thirteen years previously he had had a hard chancre, and had since then frequently suffered from cutaneous eruptions and ulceration of the tongue. On examination nothing wrong could be detected on the skin, on the tongue, in the mouth, or in the pharynx, but there was considerable thickening, inflammation, and ulceration of the epiglottis, the free edge of which showed several deeply-cut ulcers. The mucous membrane over the arytaenoid cartilages also was greatly inflamed and thickened. The movements of the left arytaenoid were deficient. The vocal cords were changed into two rounded cylindric bodies, but were not ulcerated.

As there could be no doubt that the patient was suffering from syphilitic disease of the larynx of a serious type, and as he had repeatedly and for a long time taken

mercurial preparations by the mouth without obtaining a cure, I advised him to start at once for Aix-la-Chapelle in order to undergo a thorough inunction treatment. He followed my advice, with the result that a very considerable general improvement took place; the vocal cords lost their roller-like appearance, and appeared merely slightly congested when he returned, and the thickening about the left arytaenoid cartilage became much diminished, although its movements were not entirely regained. After his return he took for some time hydrargyrum oxydulatum tannicum (5 gr. daily) in the form of pills. Unfortunately, however, the improvement was not of long duration. About fifteen months after his return I saw him again, when he spoke with an extremely thick voice, and there was occasional inspiratory stridor. He had had several apparently rather severe choking fits. On examination the epiglottis was seen to be considerably more thickened than it had been, and the outward movements of both vocal cords, particularly of the left, were very deficient. There was also some fresh ulceration on the epiglottis, and the general thickening of the mucous membrane over the arytaenoids had increased. I was afraid that the case would turn into one of those serious instances of general fibroid syphilitic laryngitis in which often ultimately tracheotomy and the constant wearing of a tube become necessary, and strongly advised that he should immediately return to Aix and go again through a thorough inunction treatment. To this he agreed.

The report from Aix was this time not so satisfactory as after his first visit. The patient during his stay contracted acute bronchitis after which the infiltration of the epiglottis increased to nearly double its former size. Although some improvement of this condition took place when the bronchitis subsided, the epiglottis remained much more thickened than it had been previously. The arytaenoid cartilages diminished in size under the influence of the mercurial inunctions, but now for the first time nodular excrescences made their appearance upon the vocal cords. Before leaving Aix the patient was advised to take sarsaparilla decoction for some time after his return.

When I saw him after his arrival here the appearances were even less favourable than I should have anticipated from the Aix report. The epiglottis itself was less swollen than I had ever seen it, and there was no trace of active ulceration. The mucous membrane over the arytaenoids, however, was still much thickened, and considerable swelling was seen in the front parts of the ventricular bands, so much so that at first sight it looked as if these parts had actually grown together. There was also a great deal of irregular nodular fibroid thickening of the left vocal cord and in the interarytaenoid fold, as well as of the posterior part of the right vocal cord. Curiously enough, there was no dyspnoea, but the voice was certainly not so good as it had been the previous winter. On examination of the chest nothing wrong could be detected.

From this time onward the disease changed its character in the most remarkable manner. Whilst previously its manifestations had been mostly of the nature of apparently fibroid, deep-seated infiltration, and to some extent of ulceration, these phenomena for a considerable time receded, and were indeed at times conspicuous by almost complete absence. Their place, however, was unfortunately taken by a periodical sprouting of irregular pale excrescences, occasionally condylomatous, but more frequently papillomatous, in shape, which arose sometimes more slowly, sometimes with almost incredible rapidity, from almost any part of the interior of the larynx, but most frequently from the vocal cords themselves, from the interarytaenoid fold, and from the ventricular bands. After having been in existence for variable lengths of time, they then always completely disappeared, sometimes spontaneously, sometimes under the influence of antisyphilitic treatment, either gradually or quickly, just as they had made their appearance. In fact, the aspect of the larynx varied at different times like the figures of a kaleidoscope, and unless I had had the privilege of following these changes up myself, I should not have considered it possible that such grave alterations, as I repeatedly had the opportunity of observing, could be followed by such an almost complete restitution of normal conditions. I need hardly say that the subjective symptoms corresponded with the objective ones. Whilst during those periods when the larynx was

filled almost completely with excrescences the voice was extremely hoarse or even almost aphonic, and the respiration noisy and stridulous, in the free intervals there was hardly any hoarseness and the breathing was quite free. These ups and downs were of course attended with a good deal of anxiety and excitement. Several times tracheotomy seemed to be almost immediately required, and more than once I was greatly tempted to remove part, or the whole, of the obstructing masses by intralaryngeal operations. What induced me to withhold my hand was the ever repeated observation that the growths after all always disappeared either spontaneously, or, more frequently, under the direct influence of constitutional treatment; and what prevented me particularly from having recourse to intralaryngeal instrumentation was the consideration that syphilitic scars, as is well known, have a great tendency to extreme contraction. For this reason I was afraid that wounds produced by intralaryngeal removal of the excrescences might lead to lasting stenosis.

Several years passed with such fluctuations as those described. The patient frequently went to Aix, and was each time very considerably benefited, although unfortunately never lastingly cured. Yet there never seemed to be any tendency towards the establishment of irreparable grave changes in the larynx, and never during the time that he was under my care did syphilitic manifestations occur in any other part of the body. In a report which I sent to my friend at Aix several years after the patient had been under my observation I find the following note: "I am surprised beyond measure at the enormous improvement which has recently taken place in the condition of the larynx. The swelling of the epiglottis and of the arytaenoid cartilages, the mobility of the vocal cords, and the shape of the latter are so astonishingly improved, that, with all my previous experience, I have never seen such a change for the better as has taken place in this case; and, indeed, I should have considered such an improvement impossible to occur after so much apparently organic infiltration, if I had not seen it with my own eyes. Quite corresponding with this objective improvement the voice, when I saw him a few weeks ago, was marvellously better."

Unfortunately, again, this improvement was not destined to last long. At Aix fresh excrescences appeared on the vocal cords with such astounding rapidity that tracheotomy at one time was considered unavoidable, and I was requested to hold myself in readiness to perform it. Again, however, a sudden improvement—almost overnight—occurred, and the operation could again be postponed.

At that time the patient sought other aid, and for a time I lost sight of him. Later on I was informed that a few months after his last visit to Aix a fresh aggravation took place, and that at last tracheotomy had to be performed under circumstances of great distress, the stenosis having attained an extreme degree before relief was given. The patient then underwent a long series of intralaryngeal operations, partly of a cutting, partly of a caustic, nature, in the course of which a very large quantity of new growths were stated to have been removed. Throughout all that time he had to wear his cannula on account of the still existing stenosis. Recently he returned to me, when I took the following notes:

Crico-tracheotomy has been performed. The patient is still wearing his tube, although it is corked up. The epiglottis is slightly thickened and a little irregular, but not markedly so. The left cord stands almost motionless near the middle line, and is only very slightly abducted during forced inspiration. There is considerable adhesion between its anterior third and that of the right vocal cord. The latter is clotted together with the right ventricular band into one reddish mass. The right arytaenoid cartilage is very little abducted in inspiration. The chink of the glottis is reduced to a very narrow, irregular gap in the posterior part of the organ, through which occasionally the shining silver cannula can be seen. The voice is reduced to an absolutely toneless whisper. No active disease can be seen at present in the larynx, and it is stated that for about a year's time no active manifestations of syphilis have made their appearance. Tracheoscopic examination does not reveal any mischief below the level of the vocal cords.

The patient was very anxious to get rid of his tube. His present medical adviser, however, very properly seemed to hesitate on account of the risk of sudden obstruction of the narrow glottis in the event of an acute

catarrh. I strongly supported this cautious attitude in view of both the existing stenosis and the possibility of further attacks of the disease itself, and suggested that under all circumstances before an attempt were made to lastingly remove the tube, the adhesions in the front part of the larynx should be split with a cutting dilator, and for a long time dilating tubes, such as Schroetter's, should be introduced into the larynx with a view of further and sufficiently enlarging the calibre of the glottic aperture. At the same time I stated that I considered it possible that the voice might become a little stronger when the adhesions had been divided, although of course restoration of natural voice could hardly ever be hoped for.

REMARKS.

The four cases just narrated well illustrate, I think, the thesis from which I started, that is, that whilst ordinarily it is easy enough to follow the established canons with regard to the diagnosis and treatment of manifestations of syphilis in the upper air passages, yet cases occur in which it is imperative not to be fettered by rigid formulas, and to judge anomalous instances on their own merits only, and not on the strength of general rules. Apart from enforcing this general lesson, each of the four cases offers some important points for consideration. In the first case it is the occurrence of severe tertiary lesions so shortly after the primary infection, and the uselessness, not merely, but the direct deleteriousness of the recognized antispecifics, which confer a particular interest upon it. As to the precocious occurrence of tertiary symptoms, this is, as already stated, although a rare, yet a by no means unheard-of occurrence. Much more exceptional is the damaging effect exercised upon syphilitic lesions by both mercurial and iodine preparations. So tangibly serious were the effects of mercury in this case, that there is little room for wonder that the distinguished practitioner who sent the patient to me for an opinion became firmly convinced that the phenomena seen by him were actually due to mercurial poisoning, a view to which he even now adheres. My reasons for thinking otherwise are the following:

First, we all are familiar with the effects of mercurial poisoning when appearing in the throat; we know the stomatitis, the profuse ptialism, the ulceration of the interior of the cheeks, the fungosity of the gums, and the decay of the teeth; but I am not aware that ever a case has been described in which conditions such as those observed in this case—destructive ulceration of the mucous membrane of the palate and fauces, loss of the uvula, perforation of the hard and soft palate, extensive ulceration of the tongue, extensive cicatricial adhesions—have ever been observed as a result of mercurial poisoning.

Secondly, as already stated, it is of great importance that damaging influence was exercised upon the process, not only by mercurial but also by iodine preparations, and here it is particularly noteworthy, as insisted upon by the physician at Aix-la-Chapelle, that actual ulceration followed the administration of iodine, whether administered by the mouth or by subcutaneous injections, a result never produced in ordinary cases of idiosyncrasy against iodine preparations. However violent the symptoms of iodism may be—I have seen several very instructive instances of the kind—active ulceration has never been amongst them.

Thirdly, it is particularly important that twice in this case, before the patient came and saw me, active ulceration had made its reappearance spontaneously a long time after mercury had been discontinued.

Fourthly and lastly, the condition left behind after the period of ulceration is so absolutely characteristic of the ravages of tertiary syphilis, that I feel sure that every experienced observer who were to see the patient now for the first time would, without a second's hesitation, declare that the lesions were due to tertiary syphilis.

I therefore feel perfectly justified in bringing the case under your notice as an instance of malignant, precocious tertiary syphilis, and in recommending to you in similar cases not to persist with the administration of mercury and iodides, but to have recourse to sarsaparilla in the form of Zittmann's and Kobert's decoctions.

The second case—the one in which tertiary syphilis of the larynx, and especially of the trachea, was followed by isolated syphilis of the nasopharyngeal cavity—offers a

good illustration of the truth of the, if somewhat cynical, yet excellent, advice: "Whenever you have to do with a particularly obscure case, think of syphilis as a possible cause." Here was a married lady of unimpeachable antecedents and without the least history of syphilis, who at a mature age suddenly developed the serious symptoms described. It is the absence of the syphilitic history to which I would particularly draw your attention, and from which I would again deduce the lesson, which I have been endeavouring to enforce on more than one previous occasion—namely, to trust to the evidence of your own eyes rather than to the absence of a characteristic history. From what has come under my own notice on a good many occasions, I think it is desirable that this necessity should periodically be emphasized. At the same time, I would take the opportunity of urging the need of the utmost caution, when dealing with such cases, to guard against any imprudent expression of opinion as to the nature of the case you have to deal with. In no class of cases are tact and diplomacy more required than when dealing with syphilis in married people, and the attendant should always remember that a single incautious remark of his may for ever destroy the happiness of a family. When remembering the incidents of the case now under consideration, the necessity of such a warning is very deeply impressed upon me. Quite apart from these points, the case is also remarkable for the fact that one not very common localization of tertiary syphilis—namely, gummatous infiltration of the trachea—was followed within a very short time by an even rarer one—namely, the formation of a gumma in the nasopharyngeal cavity.

In the third case two points deserve special attention—namely, first, the occurrence of extensive infiltration of the larynx shortly after infection, and at a time when the ordinary phenomena of the second stage, namely, roseola on the skin and mucous patches in the pharynx, were still present; and, secondly, the terrible syphilophobia to which the patient became a victim after repeated recurrences of the disease. With regard to the first point, I would say that in my own opinion this was a case in which secondary and tertiary symptoms intermixed—an occurrence the possibility of which ought always to be kept in mind. Ordinarily, in secondary syphilis of the larynx the phenomena are simply those of erythema; more rarely do we meet with formation of condylomata and with actual superficial ulceration. I have never previously seen so extensive an infiltration of the larynx take place in genuine secondary syphilis, nor am I aware that such has ever been described. Another reason why I am inclined to look upon the laryngeal phenomena observed in this case as belonging to the tertiary period is the failure of mercury to prevent recurrence of the symptoms, whilst the disease, as long as the patient was under observation, was kept under control by iodine preparations. I am sorry I cannot say what ultimately became of the patient, my endeavours to trace him having failed. Whilst one could not help sympathizing greatly with the poor man in his recurring tribulations, the syphilophobia which he developed ultimately became almost as trying to his medical advisers as to himself. In such cases the medical attendant must not merely be an adviser of the body, but also of the soul. Some unfortunate syphilophobes fall into a condition of melancholy, others become quite frenzied, and not merely threaten but are actually apt to commit suicide. Under such circumstances it is the duty and the privilege of the medical adviser to maintain courage, to cheer up, and to always hold out the hope of ultimate and lasting recovery. A despondent attitude on the part of the medical attendant is the surest way to drive the patient into utter despair.

The last case is, without exception, the most unusual instance of syphilis in the upper air passages which I have ever met. I have made it a point to look through literature with a view of discovering whether ever a similar case had been described, but have not found one. Whatever the causes were which repeatedly produced new growths—which almost completely filled the patient's larynx, then made them disappear, leaving the organ but little disfigured, and then again and again produced fresh crops, to be followed by similar disappearance—I am quite unable to say. Nor can I explain, in view of the long interval before the patient's last visit, in pre-

cisely what manner the present condition of his larynx has come about.

In conclusion, gentlemen, let me say that the simple narrative I have given illustrates, I think, better than any elaborate commentaries how little one single form of antisyphilitic treatment can claim to be universally successful in all cases. In the great majority of my own cases of syphilis of the upper air passages methodical inunction treatment has been most successful, and I trust this more than any other method. Yet you have heard that in 2 out of these 4 cases it failed. The therapeutic lesson to be derived from the experiences gained in these 4 cases, it seems to me, is that as in diagnosis so in the treatment of syphilis, it must be our aim to individualize when the ordinary canons show themselves insufficient to cope with the particular case, and not to insist on preconceived notions of any kind.

REFERENCE.

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THE REALITY OF ENTEROSPASM AND ITS MIMICRY OF APPENDICITIS.

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I BELIEVE it must be allowed that the appendix is sometimes excised unnecessarily, or, to put it in terms of absolute truth, there are certainly patients whose symptoms are the same after as before this operation. It is now a common practice to excise the appendix, almost as a precautionary measure, with greater freedom and on more slender evidence of disease than was the case a few years ago. The evidence which is considered sufficient to justify excision often amounts to nothing more than pain and perhaps tenderness in the right iliac fossa. The absence of evidence of any peritoneal infection and the fact that no definite febrile attack has ever been observed are not considered of sufficient importance to justify delay. In the main I believe this practice is right. But it must be confessed that in many instances of this kind the diagnosis is guesswork, and I think there can be no doubt that in some cases the excised appendix is innocent. There must be risk of mistake when a diagnosis must needs be based not on physical signs but on such variable features as the character and locality of pain. Putting on one side the rare cases where there has been patent error and confusion with biliary or renal colic, movable kidney, or disease of the uterine appendages, we are left with a more numerous class of patient, in whom, though none of these other troubles are present, the symptoms for which the appendix has been excised continue unaltered after that operation. If these disappointed patients are studied, it is difficult to come to any other conclusion than that their disorder is functional and has no basis of structural change in intestine or elsewhere. It would save trouble if they could be recognized before rather than after excision of the appendix, and an attempt to define them may so find an excuse.

Functional disorders of the stomach receive some slight attention in our textbooks, but similar conditions of the intestine are as a rule unnoticed. The student completes his fifth year with the impression that the intestine is a lowly tube of mean function, and that consequently it is hardy and uninfluenced by defective states of other organs. He couples it up mentally with pictures of gross matters such as hernia, obstruction, and carcinoma. If he subsequently holds a resident appointment, he may become aware that there is a nervous side to intestinal disease. But intestinal neuroses diminish in frequency as we descend the social scale, and he may pass six months in a hospital and meet with no example of the kind. As a rule, he learns in years of private practice that there is much abdominal pain which has no name and does not kill.

The known functions of the intestine are motor, sensory, secretory, and absorptive. If a functional disorder is defined as being a quantitative or qualitative alteration in one or more of those functions, not dependent on any