ON OPERATION IN SOME CASES OF TERTIARY SYPHILIS.

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It was with much regret that I found myself unable to be present in the Therapeutic Section at the discussion on syphilis published in the *BRITISH MEDICAL JOURNAL* of November 6th, for there was one point which I should have liked to have heard discussed, and which apparently was not alluded to, namely, the advisability of operative interference in some cases of obstinate tertiary syphilis. We all know that cases of tertiary syphilis sometimes occur which are extremely obstinate to treatment by iodides and mercury, in however large doses the former are administered; and, under suitable circumstances, I believe that a cure may be effected by operative intervention. I may cite two such cases, the first from memory as I cannot find my notes.

Some ten years ago a man, about 40 years of age, consulted me on account of an obstinate syphilitic ulceration of the cheek. The patient had acquired bad syphilis some years before, and for two or three years had suffered from a serpiginous ulceration of the cheek in front of the ear which was of a most obstinate character. He had been under careful anti-syphilitic treatment since its first appearance by men of the highest authority, and although the condition improved under treatment, no sooner was it left off than the trouble re-appeared. As I could not suggest anything better in the way of medicinal treatment, and as the trouble was limited (about the size of a florin), I suggested excision of the diseased tissue. This was performed, and the gap filled up by a plastic operation. The wound healed, and the disease had not re-occurred some years later when I last saw the patient. The tissue was examined microscopically, and simply showed inflammatory tissue, no trace of rodent ulcer or tuberculosis; but, indeed, from the history and clinical characters there could be no doubt as to its syphilitic nature.

The second case was that of a married woman, aged 44, who was admitted to the hospital on April 20th, 1896, with symmetrical ulcerated patches on the extensor surfaces of both forearms. The history of the trouble was that it began about a year previously, with swellings about the upper part of the forearms which were opened. At the same time she noticed a number of swellings over the extensor surfaces of both forearms, which became red and ulcerated and soon ran together into a raised brawny patch occupying the greater part of the extensor surfaces of both forearms, and covered with numerous ulcers. She was treated for some time at another hospital chiefly by boracic poultices without any improvement. In the autumn of 1895 she went to the country, also without any benefit. In February, 1896, she came under my care, and was ordered large doses of iodide of potassium and mercury, the iodide being increased up to 90 grains a day. Under this treatment improvement followed, a considerable portion of the ulcerated surfaces healed, and the patches became less prominent. After a time, however, the improvement ceased, ulceration began again, and, as she was suffering much pain in the arms, she was admitted to the hospital.

The patient was a weakly anæmic woman, who had been in indifferent health for some years. She stated that after marriage she had a healthy child, then a miscarriage, and then a living child who developed, shortly after birth, snuffles and rash; in fact, from her description there could be little doubt that the child suffered from congenital syphilis. No satisfactory history of syphilis could be obtained as regards herself, but since the miscarriage her health had been bad. On the extensor surfaces of each forearm was an extensive red, raised, brawny patch, practically symmetrical on both sides, extending from about 3 inches below the olecranon to about 2 inches above the wrist, and almost reaching the sides of the forearm. The surface of the patch was covered with numerous ulcers, and punched-out holes varying from a shilling to a florin in size, some circular, but many of them having run together into irregular forms. The patches were very tender. The case was shown to several authorities, who, with one exception (who thought it tuberculous) pronounced it to be tertiary syphilis. I may say with regard to this question of

tuberculosis, that there was no thin undermined skin around the ulcers, as is so characteristic of tuberculous disease. Iodides and mercury had a distinctly beneficial effect. Microscopical examination failed to show any tubercles, and animals inoculated with portions of the tissue remained well, and did not develop tuberculosis.

As she was incapacitated from work, and as it had not healed under anti-syphilitic treatment, I determined to excise the patch on one forearm in the first instance. This was done on the right side on April 25th, 1896. An incision being made all round the affected part and about half an inch beyond it, it was raised with the fat and fascia beneath, and removed. The extensor muscles were left exposed over the whole extent of the wound, which was then completely covered by skin grafts on Thiersch's method. All the grafts took, and the patient left the hospital on May 16th with the arm well. When she was admitted she was at once put on large doses of iodide of potassium, combined with drachm doses of liquor hydrarg. perchlor., and emplastrum hydrargyri was constantly applied to the left arm. Under this treatment the left arm improved markedly, the brawny swelling went down, and most of the ulcers healed. After her discharge the same treatment was continued, but very soon improvement ceased, her attendances became irregular, and in a short time the arm was as bad as before.

I readmitted her on November 24th, 1896. The left arm was in the condition previously described, and extremely painful; the right arm was perfectly healed, no tendency to recurrence and no imperfection in the movements of the fingers or hand. On November 25th a similar operation was performed on the left side as has just been described as regards the right. The grafts took well, and she was discharged on December 24th quite well, and has remained so since.

I remember, also, seeing half a tongue excised for an obstinate ulcer, which had resisted large doses of iodide of potassium, and was looked on as epithelioma, but which did not prove to be so on examination by the microscope, and in which I found another gummy in the substance of the tongue. The patient lived for several years, and had no further syphilitic disease of the tongue.

In tertiary syphilis affecting bones the possibility of doing good by operative interference is much greater and more frequent. In cases of gummatus bone disease with ulceration of the skin over it I have obtained healing without recurrence by thoroughly removing the affected soft parts and chiselling away the diseased bone just as one would treat a tuberculous disease, constitutional treatment being of course continued. One has only to look at a case of syphilitic necrosis, say of the frontal bone, to understand how slow must be the cure if it occurs at all by medicinal treatment alone. Not only is the sequestrum firmly fixed in parts and very slow in separating, but the bone around is extremely condensed and the circulation in the diseased area must be very imperfect. One can thus readily understand how by chiselling away the sequestrum, the diseased bone, and some of the condensed bone naturally without any intermission of the constitutional treatment healing may be greatly favoured. Apart from this form of bone disease I believe good might be done by operation in cases where there is much thickening of an individual bone with great pain where the effect of the iodide is only temporary, and where in order to be comfortable the patient has to go on taking iodides for an indefinite period. Such cases might quite well, I think, be treated in the same way as chronic peritonitis and osteitis due to other causes, namely, by cutting down on the bone, dissecting off the thickened periosteum, and freely chiselling away the affected bone.

In the opinion of many a gummy does not contain the syphilitic virus, and is some peculiar after-effect of the poison. My own belief is that when the virus of syphilis is discovered it will be found in gummata as well as in the earlier syphilitic lesions, though possibly altered in its characters, and no longer capable of causing a general disease. The general clinical history of gummata is not unlike that of tuberculosis, and gummata often remain localised for a long time, a patient with gummata in the leg, for example, often going on for a very considerable time without the appearance of disease elsewhere. Hence the local treat-

ment of gummata by removal in cases which will not yield to medicinal treatment, or where the patient cannot bear a thorough course of treatment, is no less worthy of consideration than the local treatment of tuberculous lesions. Iodides are admittedly only temporary remedies, and unless combined with mercurial treatment no permanent freedom is certain. Indeed, in some cases iodides alone seem to have the same disadvantage as was attributed to tuberculin, namely, that the virus is, so to speak, liberated, and after the cessation of the treatment leads to fresh lesions in the neighbourhood, and the removal of the local lesions may prevent the occurrence of further lesions in the vicinity, which rather seem to spread by local infection than by fresh deposit from the blood.

I do not, however, propose to enter into a disquisition on the natural history of the syphilitic virus, and merely wish to point out that in certain obstinate cases of tertiary syphilis of skin and bones much benefit may be gained from surgical intervention, with the view of removing the local lesion, as is done in the case of tuberculosis. I might suggest, also, that in very rapidly breaking down gummata, in parts where the result may be serious, as in the palate, thoroughly clearing out the gummata might be advantageously combined with vigorous antisyphilitic treatment, but this is merely a suggestion; I have never carried it out. I wish it also to be clearly understood that in mentioning this matter of operative interference I would in no way intermit vigorous general treatment, nor do I think that operation is necessary except in a limited number of cases.

MEMORANDA:

MEDICAL, SURGICAL, OBSTETRICAL, THERAPEUTICAL, PATHOLOGICAL, Etc.

TETANUS SUCCESSFULLY TREATED WITH ANTITOXIN.

On September 25th I was called to see a boy, A. F., aged 12, who complained of a pain in the back between the scapulae and some difficulty in stooping down. On making him jump from a chair to the floor he felt considerable pain, but was able to walk without any discomfort. I ordered him rest in bed. On seeing him the following day the pain had extended to the lumbar region, and I ascertained that about a week previously he had got a splinter of wood under the nail of his right thumb, which had been extracted at the time, and the wound was quite healed, and there was no pain whatever in the part. I, however, put on a carbolic poultice—1 to 20.

On September 27th the muscles of the neck, back, and lower extremities were quite rigid, with marked opisthotonos; the jaws could only be opened about a quarter of an inch, and the boy experienced the greatest difficulty and pain in swallowing.

I obtained some Tizzoni's antitetanus serum on the following morning. Before the first injection at 2.30 P.M. on September 28th the temperature was 100.3° F. I injected 35 grs., half the entire quantity at once (an adult dose) into the thighs and buttock. At 9.30 P.M. the temperature had risen to 102°, and a vesicular eruption had made its appearance in the region where the injections had been made.

The following morning the temperature was normal, and in the evening I injected 8 grs. more of the serum, and there was slight diminution of the symptoms.

On September 30th 8 grs. were again injected.

On October 1st the boy showed considerable improvement, suffering less pain, although at this time there was not much less muscular rigidity.

On October 2nd 8 grs. were again injected into the back; by this time the rash had almost covered the whole body, with the exception of the head and neck; it was specially well marked over the internal malleolus of each foot, and some of the vesicles in these parts were the size of a hazel nut. The arms were now more rigid, although the muscles of the trunk and legs showed marked relaxation, which steadily increased; and on October 4th, being the sixth day after the first injection, the boy was free from pain, and could swallow without difficulty and move himself round in bed.

On October 6th the patient complained of great pain in the adductor muscles of the right thigh, but without any rigidity, and this lasted for three days, but was relieved by counter-irritation.

Chloral was given in full doses from the onset of the disease, but before the injection of the antitoxin had little effect. The dried serum is not readily soluble in cold sterilised water unless reduced to a fine powder in a pestle and mortar, and then first made into a paste with a few drops of the given quantity of water.

The patient was able to be out of bed on October 21st completely free from the disease, and had it not been for the pain in the thigh would have been able to be up a week sooner.

This is the tenth case of tetanus which has come under my observation, and without exception each case has terminated fatally and in great suffering. This case I also considered hopeless, as also did Dr. Moorhead, who saw the case several times with me, and I can attribute recovery solely to the injection of the antitoxin.

Duns.

JOHN MCWATT, M.B. Edin.

COMPOUND TINCTURE OF BENZOIN IN ENTERIC FEVER.

LATELY I have had under my care several cases of enteric fever with excessive diarrhoea. I have in these cases tried a mixture of compound tincture of benzoin and water with marked success. I start by giving a dose of $\frac{1}{2}$ of the tincture every two hours, and if the diarrhoea does not decrease in twelve hours I then double the dose. In all the cases after twenty-four hours' administration I have found marked benefit, the diarrhoea decreases, the stools are not so offensive, and the temperature is decidedly lowered, and the patient feels very much more comfortable. I attribute the success in these cases to:

1. The internal antiseptic property of the drug.
 2. The mixture forming a protecting coat to the inflamed bowel.
 3. The antipyretic action of the drug.
- Spennymoor, Durham. JAMES C. POTTER, M.B., C.M.

HYSTERO-EPILEPSY WITH RAPIDLY FATAL ISSUE.
Miss O., aged 28, whose father and mother are alive and healthy, has one sister suffering from exophthalmic goitre, one brother subject to alcoholic excess which brings on epileptiform attacks, and another brother who suffers from glycosuria. Up to twelve months ago the patient had been considered strong and healthy, when she began to overdo herself with dancing, bicycling, etc. Two or three months ago she had a fright while out on her machine, nearly having an accident. Ever since she had been showing signs of hysteria, easily getting excited, and had had frequent attacks of laughing and crying with little or no cause. Menstruation had been painful and irregular for some months.

On July 31st, 1897, a very hot day, she overdid herself by playing tennis and going to a flower show, and went to bed very tired and sleepy.

Next morning (August 1st) when her sister came into her room to wake her, she found her very stupid and queer, and she became "stiff all over, and foamed at the mouth," and seemed to be unconscious. This lasted about half an hour. When I saw her a few minutes later, she was only dull and dazed, and complained of a headache, telling me she did not know what had happened to her. She had not bitten her tongue or passed urine in the attack, and there had been nothing of the nature of an epileptic cry at its commencement. Sensation, motion, and reflexes were normal. I prescribed bromides and rest in a dark room.

At 6 P.M. the same evening she again became unconscious, and at 6.45 P.M. I found her lying on her bed, somewhat rigid all over, and moaning continuously. She did not answer when spoken to, or even when shouted at. The conjunctival reflex was present but rather sluggish, the pupils were equal, fairly dilated, and reacted to light. The teeth were clenched, the tendon reflexes were normal, and there was no sign of paralysis anywhere. The pulse was 90, and the temperature 98.6°, and she had been sweating freely. She could swallow nothing. I applied cold effusion to the head and shoulders with no result. I then tried a fairly strong interrupted