PROVINCIAL MEDICAL & SURGICAL JOURNAL.

No. 10.--Vol. I.]

LONDON, SATURDAY, DEC. 4, 1841-2.

PRICE SIXPENCE.
[Stamped Edition Sevenpence.

CLINICAL

OBSERVATIONS UPON SYPHILIS.

DELIVERED AT ST. GEORGE'S HOSPITAL,

By Sir B. C. BRODIE, Bart.

The communication of disease from one person to another, is effected in two ways; it may result from the poisonous matter of an unhealthy surface being brought into contact with a healthy one; or by the floating effluvia in the atmosphere passing over from an unhealthy person to a healthy one. It is in this latter way that scarlatina is propagated; and it is by both these means that the poisonous matter of small-pox is spread about. The disease of which I am now about to speak, syphilis, is propagated from one person to another, by the first method named—viz., by the contact of an unhealthy poison with a healthy surface.

Syphilis consists of two distinct stages of disease. The first stage is that in which the poison is communicated to the part, and affects it locally, and produces certain symptoms, which, in the practice of our art, we term primary symptoms. The second stage is where the constitution of the patient is affected, and produces certain symptoms which have received the name of secondary symptoms.

Primary Symptoms of Syphilis.—The first syphilitic symptom which attracts the patient's notice, is the presence of a small sore upon the part to which the poison has been applied; this part is most frequently upon the organs of generation, and this poisonous disease is almost always communicated from one person to another by means of sexual intercourse. This disease may, however, be produced by the application of the poison to any other part of the body. Syphilis generally shows itself in two or three days from the period of the impure connection. The precise period, however, may vary; it may not show itself until a fortnight has elapsed from the time of connection, and I am acquainted with a gentleman in whom it did not appear until eight weeks had elapsed. It is not every part of the organs of generation that is equally liable to imbibe with rapidity the syphilitic poison. Those parts which are covered with a thin skin are, of course, more liable to be affected than those parts which are covered by skin of a firmer and thicker texture. The part first affected may be situated on the outer surface of the penis, or the prepuce, or on some part of the glans penis, and this latter is the spot most commonly and frequently affected, in the first instance, and that part of it which is behind the corona glandis, and near the frænum, is that precise part in which the disease makes its first appearance. When you meet with a case of syphilis in the female, you will generally find the clitoris, the vestibule, the vagina, and labia, to be the parts most frequently affected with the earliest symptoms. In the male patient, in addition to the parts where this disease most frequently shews itself in the first instance, you may also meet with it on the surface of the urethra or the scrotum.

The primary sore of syphilis is termed a chancre. Now the appearance of a chancre varies very much, so that no one can tell, by merely seeing it, that it is a chancre. You will seldom have an opportunity of seeing it in its early stage, and when you do see it, you will generally find it situated in a corner below the corona glandis, and looking like a small pustule.

It may appear on any other part of the surrounding structure that may be torn, but the above situation is the one in which it is most frequently met with. You will sometimes meet with chancres having a flat and superficial aspect, like any common sore, without there being any hardness of the surrounding textures. Chancres may vary in number—there may be one or more. At first they give but little pain, and after a shorter or longer time the base of the sore becomes hard, and the edges of the sore also have a rough elevated edge, and separate and spread by sloughing shreds, and the sore becomes exquisitely painful. You will sometimes meet with chancres in which there is a great disposition to ulcerate, and to deposit lymph at the base; sometimes the ulceration is great in extent, and the deposit of lymph small in quantity, and sometimes the converse of this is the case. The pain attending a chancre varies; it is sometimes very great, and gives the patient great uneasiness and much anxiety. Occasionally you will meet with cases in which there is a sore on the broad surface of the glans penis, without any hardness of the edges or base, and with but little pain or disposition to spread, but becoming every day deeper and broader in extent; this kind of chancre I call a burrowing chancre.

You will thus perceive that these sores vary very much, both in their character and appearance; but though this be the case, I do not believe that they arise from differing species of the original disease. These sores are convertible into one another. A variety of circumstances may tend to alter their appearance, and these may be varied according to the constitution of the patient, the violence of the symptoms, the treatment of the disease, and the peculiar organization of the part in which the disease may be situated. A chancre situated on the penis or frænum differs in appearance from the differing organization of the parts in which it is situated.

Chancres may be considered as chronic sores, for they are very slow and indolent in their growth. But this character does not always belong to them, as there are some chancres which increase and spread very rapidly by ulceration, and these are termed phagadenic chancres; these generally make their first appearance on the coroma glandis, and spread in the course of the cellular membrane, between the skin of the penis and corpus cavernosum, but they may also spread in any other direction. These chancres are very painful ones, and in some of these cases mercury is injurious, whilst in others it is beneficial, although then it requires to be given in very large doses.

In addition to the varieties of chancre I have already spoken of, there are sloughing and gangrenous chancres. In the most common kind of these there is very great surrounding inflammation, with tumefaction and redness of the neighbouring parts; the surface of the chancre is covered by an ash-coloured slough, which extends, and as soon as one goes off, another comes on. In these cases the patient suffers great pain, and there is much constitutional disturbance, with frequent pulse, hot skin, white furred tongue, great loss of appetite, and attendant symptomatic fever. This sort of chancre most frequently occurs in those persons who have led an irregular life both before and after the chancre has made its appearance; sometimes in these cases a blood-vessel in the neighbourhood bursts, and does good by stop-

ping the sloughing process, and relieving the constitution. In such cases you will sometimes find that secondary symptoms follow, and sometimes they do not, as the sloughing completely destroys the parts which secrete the poison. There is another kind of sloughing chancre, where no tumefaction, and but little inflammatory action, exists; the surrounding parts become livid and black, and die, and the mortification extends, and very closely resembles that mortification of the toes arising from ossified arteries; there is not such a violent degree of pain in this as in the former species of chancre; there is likewise no fever; the pulse is small, quick, and irritable, without any heat of skin.

Where you meet with a chancre situated on the prepuce, lymph and serum may be effused into the cellular membrane of the prepuce in men, and of the labia in women. Where a chancre is situated beside the frænum, it eats through and destroys it; where it is situated below the frænum, it becomes very difficult to heal, as it is always torn open in order to be seen; where it is situated on the inner lining membrane of the urethra it is very painful, from the urine washing continually over it.

In those persons whose prepuce is long, a sebaceous matter is frequently secreted from the corona glandis, which irritates it, and a discharge comes on as a consequence, and ulcers may occur. These slight results are generally caused by uncleanness, and attention to cleanliness will generally cure them. You will sometimes meet with patients in whom an herpetic eruption occurs on the prepuce, and a little vesicle forms, which at first is filled with fluid, which soon thickens and becomes like pus. The cuticle and the fluid beneath it may desiccate, and a scab may form and drop off, and if it is left alone it will soon heal and terminate favourably.

Sores will sometimes occur on the corona glandis, which quickly increase in numbers, forming an ulcerated zone around the corona. Sometimes this will only extend half way round. You will also occasionally meet with an excavating ulcer, affecting the sebaceous glands of the corona glandis, which is very irritating and painful to the patient; it discharges freely, and is very difficult to cure. Mercury does harm in these cases, but secondary symptoms seldom follow. Sores will sometimes occur on the inner surface of the prepuce, and on the outer surface of the corona glandis; there are several of them; they are small, round, flat, superficial ulcers, with much surrounding inflammation; they are very painful and tender, and discharge freely. At first they appear to be covered by a thin white slough, but afterwards change their aspect to that of a clear irritating sore. These last sores cannot strictly be termed venereal, yet they depend upon and are caused by some peculiar secretion from the female vagina. They should be treated by keeping the patient quiet, and washing the affected parts frequently with a solution of sulphate of copper in the proportion of four grains of the sulphate to one ounce of water. The sores should not be bathed with this lotion as is so frequently the case, but it should be poured over them twice or three times daily.

Where the prepuce is long and narrow, a scaly eruption frequently occurs at the orifice at the prepuce, which becomes contracted and painful, and cracks; lymph is deposited in the cellular membrane, and the parts become consequently thickened in substance. These sores should not be mistaken for venereal sores; they may be cured by the application of the unguentum hydrargyri nitratis diluti, or the unguentum zinci.

Secondary symptoms of syphilis may sometimes occur on the parts of generation, and may be readily distinguished by a practised eye from those affections of which I spoke to you a while ago. Many circumstances may, and do, very often occur to modify the

peculiar character and appearance of a venereal sore. Many sores are met with which have no venereal appearance about them, and yet these will prove syphilitic, from having admitted the syphilitic poison; and if you should be at all in doubt in these cases, it will be quite right that you give your patient the full benefit of that doubt. You will frequently meet with chancres which have a hard basis, but you must remember that a chancre which is allowed to continue unchecked by remedial means will always have a hard basis. Yet, on the other hand, you will meet with venereal sores which are not chancres, and yet have a hard basis; and on the other hand, you may meet with true chancres which have not a hard basis. You may meet with cases in which there are sores on the prepuce or on the scrotum or about the eye, and which may become infiltrated with lymph, and thus hardened at the base.

The hard basis of a chancre is of a gristly induration, and this induration may be left behind, and remain after the chancre has healed; and where this is the case you may always correctly conclude that there is some venereal poison remaining in the constitution. If a chancre be situated within a long and narrow prepuce, it is at first drawn back, and the chancre may be seen, but serum and lymph are very soon effused, and the disease then becomes a phymosis. This prevents the prepuce from being drawn back, and consequently, the chancre from being seen, and the poisonous matter of the chancre causes inflammation, excoriation, and ulceration, and sometimes the opening in the prepuce becomes very small, and the matter collects so fast, that a sort of abscess forms. If this state of things goes on unchecked, the part which appears most tense ulcerates, and the matter escapes through it generally from the upper part of the prepuce. But the ulceration may go on, and the orifice become larger and increase in size until it is sufficiently large for the glans penis to push itself quite out. After the inflammation is over, the slight infiltration of serum that has occurred is absorbed, and the prepuce becomes as pliable as before; but if coagulated lymph has been effused, the prepuce is thickened and indurated, and this may not subside for some considerable time. Sometimes you will find that it is the extremity only of the prepuce that is thickened when the chancre has been situated near that spot. Where a chancre is situated under the surface of the prepuce, the latter will sometimes become attached to the glans penis by ulceration, and inflammatory adhesions will connect the outer surface of the glans to the inner surface of the prepuce; these may be either partial or extensive. Sometimes where there is phymosis, there is great ulceration of the glans, and a great portion of it may be eaten away; there may be little or no vestige of them left, and a narrow passage leads down to the orifice of the urethra, and when the cicatrix forms, it contracts the orifice of the urethra, and the patient is only able to void his urine by drops, and at last complete retention takes place. When the phymosis is of such an aggravated character that the glans cannot be uncovered, except with force, and cannot be returned back again over the corona glandis, the disease assumes the form of paraphimosis. This is caused by venous congestion in the glans, and the swelling and inflammation in the part may render it so tight as to impede the flow of arterial blood, and mortification may be the result; the prepuce behind the glans may give way, and the ulcerating surfaces may adhere, and the patient may have paraphimosis for life.

It would appear that the venereal virus passes through the absorbent vessels to the absorbent glands; and thus the absorbents on the dorsum of the penis may become tense, and feel like hard tight-stretched cords; this cord-like hardness may remain unaltered for a length of time, and then in some cases disappear. An abscess may form in one of these absorbent ves-

sels, which may burst, and a small ulcer may form. Absorbent glands are more liable to take on inflammatory action than absorbent vessels. When an absorbent gland inflames, it forms a bubo, and these buboes are generally situated in one of the absorbent glands below Poupart's ligament, and sometimes in the upper part of the groin, within the belly, but without the peritoneum. The bubo is generally situated on the same side of the body as the chancre; but this may vary. There is generally only one of the glands affected with venereal bubo; and this serves to distinguish it from a scrofulous or gonorrhœal bubo, or from a bubo caught from cold; it is very rare for the same patient to have two venereal buboes at one and the same time. A bubo generally makes its appearance at the space of about nine or ten days from the first appearance of the sore; sometimes when the sore is healing, and sometimes when it is healed. Buboes may be phlegmonous where the inflammation is acute, or indolent where the attendant inflammation is chronic. A phlegmonous bubo is very painful and tender; there is great redness of the parts around it, suppuration may take place; and an abscess may form, which bursts, and confines the patient to bed. A chronic bubo is also very painful and tender, but the patient is able to go on with his usual avocations; an abscess eventually forms in it which bursts. Whether the bubo be acute or chronic, there is always much discoloured purple skin over it; the abscess which forms is situated in the cellular membrane, between the gland and the skin, and at the bottom of the opened abscess is seen the diseased gland; the skin over the abscess is purple, and has much adipose substance attached to it, and blood-vessels carrying blood into it, and from this cause it soon recovers its normal vitality; sometimes, however, it becomes thin, and sloughs. When the abscess over a bubo bursts, it seldom heals directly; and if you introduce a probe, it is found burrowing under the skin; the sides are hard and callous, and the sinus is fistulous. Sometimes this fistulous sinus may arise from the matter getting out with difficulty, and this may prevent the healing of the abscess; or it may be prevented by the diseased gland being at the bottom of it, and irritating it as a foreign body would, if placed there; all that is to be done here is to allow of a free opening for the matter. Buboes sometimes ulcerate very much. When you are called in to a syphilitic case in a female, you will generally find the disease in a more forward state; but the general symptoms are the same as in the male subject. You will find the nymphæ and labiæ inflamed and swollen in the same manner as the prepuce is in the male; and they may likewise become hardened and thickened just in the same manner.

CASES
FROM THE EARLY NOTE BOOKS
OF THE LATE
SIR ASTLEY COOPER, BART.

Extracted with permission of Bransby B. Cooper, Esq., F.R.S.

No. XIV.

CASE OF CATARACT.

Miss —, of Yarmouth, aged twenty years, had been for some time blind from a cataract. In the year —, the cataract began to shift from its natural situation, and to pass into the anterior chamber of the eye. When I saw it, part of the diseased humour was placed in the pupil, the remainder being lodged in the anterior chamber, and resting against the inner part of the transparent cornea. Great pain and considerable inflammation had been brought on by this

change, and I thought it right to perform the operation of extracting the lens.

This was done without difficulty, as the incision was the only part of the operation required,—the cataract having already burst its capsule.

The cataract was firmly ossified. When struck against the vial, into which it was put, it made the same noise as a pebble would have done.

As I was fearful of great inflammation coming on, I applied a blister to the temple immediately after the operation.

On the fourth day after the operation, Miss — had little pain, and the inflammation was confined to the opaque cornea.

She did well.

CANCER CLITORIDIS.

Mrs. —, aged 49, had a cancerous tumour form on the nymphæ of the right side, which I removed. About three months afterwards the glans clitoridis became diseased in a similar manner, attended with occasional lancinating and burning pains.

It became necessary, on this account, to remove the clitoris, which I did. One vessel required to be secured.

The wound healed without any other inconvenience than that which the urine occasioned by the smarting it excited.

She was well in a few days.

HYDROCEPHALUS.

Sunday, July 17.—I opened the head of a child of Mr. —, which had died with symptoms of hydrocephalus.

Appearances. Five ounces of blood in the ventricles; vessels of the pia mater much less turgid than usual.

CLUBBED FOOT.

A child, who had a clubbed foot, was recommended to my care by Dr. Babington. I ordered for it two splints, both of them with a foot-piece,—to be lined with flannel, and kept together behind by two short tapes. With these I succeeded in curing the child.

DISLOCATION INTO THE AXILLA.

A woman, by a fall, dislocated the os humeri into the axilla.

An attempt was made to reduce it over the knee, which did not at first succeed, on account of the scapula remaining unfixed. When the hand was laid on the acromion, and that process was pressed gently backward, the bone slipped into its place.

INTROSUSCEPTION.

March 23d, 17.—Master —, aged three years and one month, was seized with pain in the abdomen, accompanied with sickness. Previous to this attack his bowels had been in a very irritable state.

On the third day he died, with symptoms of mortification in the bowels.

Dissection.—On opening the abdomen about four ounces of liquor peritonei were discharged.

The stomach was healthy.

The jejunum had two introsusceptions, unattended with inflammation.

The other small intestines appeared sound.

The colon on the left side was distended, as if with fæces,—but on the substance within being pressed, it was found to be unyielding. This sensation was