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COURSE OF LECTURES ON VENEREAL AFFECTIONS DELIVERED AT THE HOPITAL DU MIDI, PARIS.

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LECTURE XII.

June 13, 1843.

Part II.—*Syphilitic Affections.*

Action of syphilitic poison—Primary symptoms—Propagation of primary symptoms—Question of incubation—Chancres by inoculation—Forms of chancre; phagadenic, diphtheric, gangrenous—Causes producing distinctive forms.

GENTLEMEN,—The action of syphilitic poison may be immediate or "primary;" or it may follow at a later period, when it is called "constitutional."

The immediate or primary results of the cause are characterised by the circumstance of their furnishing *inoculable* matter, and by their inability of being transmitted in any manner but by contagion.

Primary symptoms I call *direct*, when they occur in the very spot where contact with inoculable matter previously took place; such is chancre, the true primary symptom, the constant and necessary origin of all the forms of syphilis, without any exception.

I call *successive* (*accidents successifs*) those symptoms which originate in the former and are produced by the contact with or the absorption by the lymphatics of their secretion. Such, for instance, is an accidental inoculation in the vicinity of a chancre—such is a bubo, caused by the absorption of chancrous pus into the lymphatics, and producing inflammation and suppuration of the first ganglion on its passage.

The syphilitic virus may, after producing its primary effects, invade the whole system, and "constitutional" lues is the result. Here, again, we find two groups—viz., the *secondary* and *tertiary* symptoms.

In neither can inoculation succeed. The first group, or *secondary symptoms*, is observed on the *skin* and *mucous membranes*. The tertiary, on the contrary, occupy the *cellular*, *fibrous*, or *bony* structures of the human body.

We must also add that secondary symptoms are transmissible in hereditary descent, whereas parents affected with tertiary syphilis do not hand down to their offspring the disease in any of its ordinary forms, but only a marked tendency to scrofula. Is it to this cause we are to attribute the gradual but rapid increase of scrofulous affections in all civilised countries?

Propagation and Progress of Primary Sores.

When by artificial inoculation a particle of inoculable matter is introduced under the epidermis, the first phenomena which appear depend on mere local irritation, and might be the result of the excitement

of the dermis from any stimulus whatever. The punctured spot becomes in a few hours red, and slightly sensitive; but after these first symptoms, in which nothing specific is manifest, a tumefied papule forms, and is shortly followed by the appearance of a vesicle at its point. The contents of the vesicle become opaline and purulent, and a true pustule is developed, similar in all respects to a pustule of ecthyma, and presenting occasionally an umbilicated depression in its centre. All these various periods scarcely require three days for their complete evolution; if the pustule is not arrested in its future progress, its size increases considerably, and large bullæ may be obtained. Around the pustule may be noticed an inflammatory areola, of a dark red hue, extending at most two or three lines from the pustule, which breaks naturally. Its secretion rapidly dries up, forming a stratified crust. Should the pustule be opened with a stiletto or a conductor, underneath will be found a small circular ulcer, seldom exceeding a line in diameter, perforating the skin completely, down to the cellular structure, and constantly presenting a greyish fundus covered with adhesive plastic lymph, which likewise extends to the inner face of its sharp edges.

The first circumstance which strikes the surgeon in the mechanism of the above phenomena is the total absence of anything like incubation. From the moment the pus is introduced the morbid action begins without interval, and proceeds without interruption, until it is completed. The only reasonable explanation which can be given of the common error on this subject is, that patients perceive the chancre, in general, only when it is formed, and consequently assert that a week, or more, has elapsed between sexual intercourse and the first appearance of the sore—i. e., before it has been noticed; but to all reflecting minds it must appear evident that the incipient stage of a sore is not *ulceration*, but that any sore, no matter what may have been its origin or its nature, has arisen from the breaking of a pre-existing pustule. Why, then, we will ask, should chancre alone of all sores escape this common law?

In one instance, indeed, error might be easy, and incubation admitted with some appearance of reason. Inoculable matter deposited upon tissues which have neither been excoriated or wounded, and which are covered with a thick epithelium, may remain in contact with them for several days without causing the specific sore to appear; the fact is readily accounted for. The pus first acts as a common irritant; an excoriation is formed, and the poison remaining in apposition with the unprotected dermis, then only produces its constant effects.

The further progress of the ulcer is acute, subacute, or chronic.

Two distinct periods may be noticed in the sore.

The first, during which it retains its inoculable properties, and has no tendency to cicatrization. In the second, the chancre ceases to be inoculable, granulates, and heals.

During the first period the ulcer is covered with a yellowish layer of adhesive lymph. The surrounding areola assumes the purple color mentioned by Hunter, and the chancre, retaining always its character of inoculability, may be modified by the constitution of the patient so as to assume the indurated form, or a gangrenous, or again, a phagedenic nature. The ulcer then remains stationary for some time.

This *specific period* has no absolute limits of duration. I have seen one last for seven years, and still inoculate by accident on the patient's finger at the end of that time. The usual duration is, however, from one to two or three months.

The second period of chancre is that in which its specific nature being neutralised, its inoculation is no longer possible. Its yellow color is replaced by a pink hue, and its plastic exudations by granulations. The areola gradually disappears, and the sore has, like simple ulcers, no other tendency but to heal. The cicatrix, in general, proceeds from the circumference to the centre, or by insulated spots of desiccation.

In some cases the cicatrix persists; in others it disappears altogether, leaving no trace whatever of the previous chancre.

Such, Gentlemen, is from beginning to end the history of the inoculated sore. You will find that it is in all respects similar to that which is the result of impure sexual intercourse.

I have now given you a rough sketch of the history of the inoculated chancre. It is the prototype of that sore which most commonly results from sexual intercourse; but that sketch would be most incomplete if I did not mention immediately afterwards those deviations from the original form which various circumstances may produce, and which, influencing either the first appearances, the ulterior progress, or the cicatrization of chancre, have caused in science considerable confusion and a degree of obscurity, to be dispelled only by long continued and serious observation.

Deviations from the Common Incipient Stages of Chancre.

The incipient stage, the first appearance of chancre, is, in my opinion, commonly a pustule. This assertion has met with a decided negative from M. Gibert, who admits it only in cases of artificial inoculation. We need only mention here the dangerous tendencies of such a doctrine, in consequence of which a patient presenting a pustule on the genitals would, from this single circumstance, be pronounced by M. Gibert (if consistent with himself) not affected with chancre, a diagnosis to which the subsequent progress of the disease might in many instances oppose a flat contradiction. Cases of this kind I hope I shall, ere long, have many opportunities of showing you in the wards. But a pustule is not in every instance the first manifestation of chancre. I have occasionally seen chancre originate in an abscess, and you may witness illustrations of the assertion whenever the virulent pus, passing from an ulcer to the neighbouring cellular tissue, produces there an excitement which inevitably terminates in circumscribed suppuration. The pus is eva-

uated with the lancet, or the abscess naturally bursts, and the sore, consequent upon such opening, offers all the characteristics of true chancre.

In most chancres observed in the hospital another origin exists. The ulcer begins by a tear or a wound of the genitals, produced during coitus, and inoculated on the spot.

Deviations during the Progress of Chancre.

A wound of the same extent, made with the same instrument, and on the same tissues, will, on different patients assume different aspects—in one becoming gangrenous, suppurating abundantly in a second, whilst it heals kindly in a third. The same remark applies perfectly to chancre—hence its several varieties.

1. *Superficial Chancre.*—The inoculable matter generally destroys the skin or mucous membranes with which it is placed in contact. It may, and does, however, occasionally happen that an *erosion*, “presenting none of the Hunterian appearances,” differing in no one character from superficial erosions, secretes inoculable pus, and is a real chancre, thus explaining without difficulty those rare instances which have been mentioned of secondary syphilis consequent upon external gonorrhœa, or blennorrhoid discharges.

2. *Phagedenic Chancre.*—The expression “phagedenic” may, to a certain extent, be applied to all ulcers whatever; the denomination is, however, limited to those sores, which, in consequence of a general predisposition, seem to have no other tendency but to increase their surface beyond the degree of ulceration warranted by the amount of original local damage.

Phagedenic primary ulcer usually increases in all directions, without losing its circular shape. Several sores may unite to form a large one.

A. *Phagedenic and Gangrenous.*—Phagedenic chancre may become gangrenous from the excessive degree of local inflammation. It is known under the denomination of “black slough” in England, where it appears more common than in France, a circumstance to which I would call the attention of temperance societies, as it is perhaps due to the introduction of French wines and spirits.

Seriously, habitual intemperance, more particularly in elderly people, exposes them to phagedenic chancre in a striking manner. Also great heat and dressings of an irritant nature. In a great many instances mercurial ointment, the very worst of local applications to a chancre, seems to have caused it.

The progress of the ulcer is very rapid, and the destruction of the part on which gangrene has settled inevitable. More or less deformity must, therefore, follow its cicatrization; but this complication is more than redeemed by this fact, that gangrene neutralises the virus, and the patients are hardly ever affected after it with constitutional syphilis.

B. *Phagedenic and Diphtheritic.*—This is the most severe of all the forms of primary ulcers; I have seen it last for seven years without interruption. We have at the present moment three cases in the wards, which have lasted nine, ten, and eighteen months. The sore is characterised by a pultaceous secretion of adhesive lymph, which either covers the whole surface or is diffused over it in islets. The fundus is often cedematous; the edges raised, irregular, jagged, and serrated. A purple areola spreads over the adjoining skin, and

the sore increased in size by the successive ulceration of depending parts. The pain is great and the ulcer very irritable. Secondary symptoms follow rarely this variety of chancre, but from its gradual draughts upon the system the constitution is soon impoverished and the patient frequently sinks under colliquative diarrhoea, due to extensive ulceration of the colon. The causes which most contribute to produce this form of phagadema are youth, a lymphatic temperament, the depressing influence of cold and damp weather, also damp houses, bad food, or pre-existing organic disease, and a bad state of the digestive organs. I have observed that the antiplastic action of mercurials has a very great influence on its production. It is more common in women than in men.

The progress is sometimes slow, but the sore may put on various aspects, in consequence of the particular state of the constitution. In scrofulous patients the ulcer is longer stationary, and the complication of tubercular disease of the lungs is far from uncommon. In herpetic subjects the skin of the whole body is irritable, and particularly so in the neighbourhood of the chancre where herpes and eczema frequently appear.

Scorbutic subjects present at the same time hæmorrhagic stains of the skin or the gums, and the sore itself bleeds very freely, presenting at the same time a dark brown or even black color. In those patients, ulcers of the large intestine are decidedly the most formidable complication, and I am inclined to believe that many of those intestinal erosions have their origin in a hæmorrhagic state of the submucous cellular tissue of the intestine, leading to softening, and terminated by erosion.

The sore may also put on the cancerous appearance, when the base will become hard, the lancinating pains appear, the peculiar aspect of scirrhus encephaloid tumors shew itself, and the other signs of a cancerous diathesis become manifest.

PRACTICAL REMARKS

UPON INJURIES TO THE IRIS, AND ON ARTIFICIAL PUPIL.

By J. B. ESTLIN, F.L.S.

Read at the Anniversary Meeting of the Provincial Medical and Surgical Association, held at Leeds, August 3, 1843.

TO DR. STREETEN, ONE OF THE EDITORS OF THE
PROVINCIAL MEDICAL JOURNAL.

MY DEAR SIR,—The paper read at the late meeting, at Leeds, upon "Injuries to the Iris," &c., was intended for a *vivâ voce* communication, and is scarcely in a form appropriate to the pages of the Journal; still, as you were present at the reading of the "Remarks," and think they may interest some of our members who were not at Leeds, I cannot but cheerfully comply with your request to forward the copy to you for publication.

I am,

Yours faithfully,

J. B. ESTLIN.

Bristol, August 12, 1843.

From the multitude of books that issue every year from the medical press, and especially from the num-

ber and variety of periodicals devoted to medical literature, that are now in existence, it would be reasonable to infer that the profession had access to every valuable fact and theory that existed in the experience or the minds of the practitioners of our art; but I believe such a conclusion would be very deficient in truth. I am inclined to the opinion that we could well afford to substitute for much of our written law the oral traditions of our older practitioners, would they but allow their stores of information to be opened to us.

I can never look upon a collected number of medical men who have been in practice from ten to twenty years, without thinking what a mass of valuable knowledge exists among them, quite inaccessible to the most industrious student, with an unlimited range of medical libraries, and certain of going out of the world with its possessors! There is no individual among us who could not impart some useful facts and observations to his brethren, and in bearing my own portion of blameworthiness for not having communicated more freely of the little I may possess, I must share in the reasonable grounds of exculpation to be found in the full engagement of time during an active career of medical practice; a fear of appearing before the public unworthily—a shrinking from the chance of being numbered among those who contribute more words than ideas to the various repositories of science, and, perhaps, sometimes a too unfavorable appreciation of the value of what he may have the power of communicating.

These remarks have naturally arisen from reflecting upon such meetings as those of this Association, and are by no means intended as introductory to anything of importance that I have now to offer, but, as our meetings are very favorable opportunities for bringing forward practical remarks of too limited and too insignificant a kind to be deserving of a more durable medium of record, I am induced on the present occasion to request the attention of the members to a few practical observations upon injuries to the iris and artificial pupil.

Thirty years of experience in rather an extensive field of observation have strongly impressed upon my mind the remarkable power of the iris to bear injuries without destructive inflammation to that membrane, or to other textures of the eye. The highly vascular and nervous structure of the iris would lead to the expectation, *a priori*, that no injury could be inflicted upon it without giving rise to serious and disorganising inflammation, but I have seen almost every possible kind of violence done to it with no more important consequence than such as the direct mechanical injury, produced at the moment of the accident, has occasioned. These accidents consist of lacerations of this membrane, cuts, punctures, separation from its attachments, together with protrusion through wounds of the cornea and sclerótica, and through openings occasioned by perforating ulcers of the cornea, in nearly all of which herniæ of the iris, the prolapsed portion becomes united to the wounded part.

As a type of the sort of injury the iris will meet with without becoming seriously inflamed, I will state the following:—

A young man, while turning iron, was struck on the