PROVINCIAL MEDICAL JOURNAL

And Retrospect of the Medical Sciences.

No. 142.]

LONDON, SATURDAY, JUNE 17, 1843.

PRICE SIXPENCE.
[Stamped Edition Sevenpence.

COURSE OF LECTURES ON VENEREAL AFFECTIONS

DELIVERED

AT THE HOPITAL DU MIDI, PARIS.

By Dr. PHILIP RICORD.

Translated and arranged by Daniel M'Carthy, Esq.,
Interne of the Hospitals of Paris.

LECTURE VI.

April 29, 1843.

Treatment of balanitis—Local depletion—Caution in the application of leeches—Influence of position—Propriety of operating for the removal of phymosis—Inutility of copaiba, cubeb, &c.—Urethritis, or true gonorrhœa—Five forms of the disease, as modified by locality—Prenatal symptoms—Stage of suppuration—Declining stage—Signs of stricture—Complications and accidents—Retention and incontinence of urine—Hæmorrhage—Abscess—Bubo—Abortive treatment—Injections—Copaiba.

GENTLEMEN,—To resume the subject began at our last meeting, it now becomes necessary that I should bring before you the chief rules according to which I conceive the treatment of external gonorrhœa should be conducted.

If the inflammation be very violent, you will find the application of leeches to the inguinal regions sufficient to subdue it, without resorting to the lancet, which may, however, be called for by the great intensity of the symptoms in persons of very plethoric habit. But in no case should leeches be applied to any part of the penis itself; I have seen diffused suppuration and gangrene consequent upon the neglect of this precept.

Whenever the surgeon has reason to suspect the presence of chancre, the patient must be impressed with the necessity of isolating the leech-bites from any possible contact with the suppuration. Some eighteen or twenty years ago a young practitioner, ignorant of the dangers of such contact, omitted recommending his patient to protect with care thirty leech-bites existing in the groin. The result was that each wound was changed into a rebellious ulcer, which extended over the entire groin, and gave no small trouble and uneasiness to the above-mentioned practitioner, who was no other than the professor who now addresses you.

Experience has taught me that emollient lotions, frequently resorted to in similar cases, are the very worst applications which can be made, and tend only to produce on the internal surface of the prepuce a plentiful crop of cauliflower excrescences. The best wash, and that which acts in the most rapid manner, whatever be the degree of activity of the complaint, is, without doubt, a slightly astringent solution of nitrate

of silver. That which I employ, and from which I have seen most benefit derived, is the following:—

Nitrate of silver, 2 grammes;

Distilled water, 200 grammes;

or equal to about five grains of the former to an ounce of the latter. The lotion should be employed three or four times a day, alternating with a poppy injection. The application of lunar caustic to the part is attended with more pain, but with equally satisfactory results.

The influence of *position* on all inflamed organs has likewise shown the advantage of keeping the penis in an elevated situation, with an appropriate bandage.

Benefit will also be derived from the exhibition of five or six grains of camphor daily, to obviate erection.

An important question connected with the treatment of this variety of disease refers to the propriety of operating for phymosis in cases of external gonorrhœa, during the suppurative or ulcerative stage of the malady. It was formerly a rule with surgeons in this country that, whenever phymosis existed, the glans penis should be laid bare by means of an incision, in order to expose and inspect the diseased parts. This precept has been broken through of late years with advantage, and the directly opposite practice is adopted by all those who have experience in syphilitic diseases.

For my part, I operate only when the incision is rendered indispensable by threatened gangrene, and my reason is, that if chancres do exist, concealed by phymosis, the operation will be followed by the chancrous transformation of the whole extent of the wound made by the surgeon. Besides, in many instances the phymosis is only a temporary state, induced by the inflammatory swelling, which will, on subsiding, permit a proper degree of freedom to the membranous appendage of the penis. If, on the contrary, a congenital impossibility of exposing the glans exist, the inflammation must, in the first instance, be subdued, and then the knife may safely be employed to remove the deformity. This practice was constantly followed by one of our great authorities on syphilis in France, Cullerier (nephew), and it is that which I constantly adhere to, and which I would recommend to all those who have at heart the welfare of their patients, and the interest of their own reputation.

Vegetations, cauliflower excrescences may exist, and render the operation indispensable. You have seen me, a few days since, operate on a patient of this kind, who left us but yesterday, perfectly cured. The vegetations had existed for nearly twelve months, and gradually increased, so as to render retroflexion of the prepuce impossible. When the man entered the hospital, you noticed the distension of the prepuce, and the incipient gangrene of the skin. Under

such conditions, the only course left was an operation. The dorsal region of the prepuce was incised on the mesial line, and also the inferior region, so as to form two lateral wings or flaps, which were removed with the numerous vegetations which flourished on their mucous surface. The glans was then carved out from amidst the forest of excrescences which had compressed it for months, and considerably reduced its size. The pain was, it is true, intense, but the hæmorrhage was trifling, and the operation successful. The patient left us cured twelve days after it was practised.

I will not dismiss the treatment of external gonorrhœa without adverting to a plan which you will find answer to perfection in almost every case of inflammation of the mucous membranes. Observation has already shown to you, Gentlemen, that the contact of two inflamed surfaces tends to prolong the duration of disease. This general remark holds good for the prepuce, and a very rapid cure may be obtained, in simple cases, by the mere interposition of dry lint between the surfaces, assisted with the nitrate of silver wash, or even with lotions of cold water. I need not add, that if secondary symptoms coexist with external gonorrhœa, a mercurial treatment will be advisable.

As to the exhibition of anti-blenorrhagic drugs—such as cubebs, turpentine, or balsam of copaiba—it is worse than useless in balanoposthitis; it is absurd.

Urethritis—True Gonorrhœa.

Absence of the prepuce—a favorable disposition, as far as external gonorrhœa is concerned—renders, on the contrary, easier and more frequent the inflammation of the urethra.

Hypospadias I consider also as a deformity which makes its bearer more subject to gonorrhœa, from the width of the opening, through which urine and spermatic fluid are excreted. Some two years since I had in my wards a patient affected with hypospadias in front of the scrotum, who was also affected with phymosis. The fistular passage was the result of a ligature placed during infancy around the penis, to prevent unconscious emission of urine during the night. The opening had some twenty years' standing when I saw it for the first time, and the patient was affected with gonorrhœa; but the point towards which I desire particularly to direct your attention is, that the blenorrhagic discharge began in the *abnormal opening* of the urethra, and extended at a later period to the natural meatus. It is not uninteresting to observe that, during erection of the penis, the hypospadiac opening stood out in relief. This patient was operated upon subsequently by me, and the fistular passage cured by a new method, which the Institute of France has been pleased to honor with a gold medal.

The large diameter of the meatus permitting an easier introduction of leucorrhœal or irritant matter, also predisposes to gonorrhœa. Do not consider this observation, Gentlemen, as one of slight importance. It has, in my opinion, a strong practical bearing. It will explain to you why we cautiously avoid incising an apparently much too small meatus, except when the introduction of large instruments for the extraction of calculi, or the treatment of strictures, renders such an operation indispensable.

Coitus causes, during erection, the lips of the penis to open, from the lateral pressure exercised on the base of the glans, and, therefore, the predisposing influence of erection must not pass unnoticed.

Many patients conceive that when connexion has not been altogether completed, gonorrhœa is impossible. Experience shows the contrary proposition to be true, inasmuch as ejaculation, acting as a sort of injection from the mouth of the seminal ducts forwards, carries away with it irritants deposited in the urethra.

With regard to the seat of gonorrhœa, we may establish five degrees of the disease. In the first it occupies the balanic region; this is the most frequent. In the second it invades also the spongy portion of the urethra up to the bulb; with the third it extends to the membranous or muscular portion; in the fourth the prostatic region is affected; and a fifth degree may be found in the extension of the inflammation to the bladder itself.

Four spots of the urethra, when the complaint affects corresponding portions of the duct, form centres of morbid action, and give rise to particular symptoms, which permit the attentive observer to diagnose exactly the inflamed portions of the urethra. We shall enumerate—1, the fossa navicularis; 2, the bulb; 3, the prostate gland; 4, the neck of the bladder.

Premonitory Symptoms.

Increased sexual desire, and the sin of Onan, frequently announce the invasion of gonorrhœa. It is also preceded by a sense of titillation about the fossa navicularis, which Professor Richerand has not inaptly termed “a hermaphrodite sensation, partaking equally of pleasure and of pain.”

The first symptoms of the disease generally show themselves after a full meal. They are a sense of heat and tension, especially during a kind of sub-erection, induced, in all probability, by the commencing inflammation, and also slight scalding in micturition. The urine appears to the patient much warmer than usual, and its excretion is accompanied with a stinging, which seems concentrated about the fossa navicularis.

This peculiar pain can be explained by the concentration of the urine; and this fact tallies with the circumstance already mentioned, that its first appearance is after a full meal. Also the natural sensibility of the urethra is modified by the disease, to such a degree that it becomes acutely sensitive to the passage of urine over its surface; and the rigidity caused by inflammation renders distension painful, so that the scalding may be ascribed to three causes—concentration of urine, modification of irritability, and inflammatory rigidity of the duct.

You will find that, in order to render the pain as slight as possible, gonorrhœal patients excrete their urine very slowly, and thus avoid at least one of the causes of this inconvenient symptom.

The tumefaction of the mucous membrane may of itself produce dysuria, a frequent companion of the inflammatory stage.

The discharge may appear spontaneously, or run only on pressure, in patients with a narrow meatus. In general the *abundance* of morbid secretion is in proportion to the length of time which has elapsed

since the last excretion of urine. It is not, therefore, to be wondered at if the discharge be more copious in the morning, the repose of the night having allowed it to accumulate in the urethra.

Let us now examine the characteristic feature of the disease in the various regions of the urinary duct.

Gonorrhœa of the Balanic Region.

The glans penis is more tense, the meatus injected, its lips puffed out, and surrounded by a red areola. The balanic urethra, in a state of inflammation, is of middling hardness. This induration does not occupy one spot or one side in particular, but feels like a tight drawn, round cord, extending through the glans. The pain is limited to the balanic region, but tension of inguinal glands, and *inflammatory* abscess of the inguinal regions, accompany it oftener than the other varieties of blenorhagia.

Gonorrhœa of the Spongy Region.

The discharge is more abundant than in the preceding form, and pressure of a more distant region is necessary to bring it out. Erection is more frequent and painful. Should there exist no cellular inflammation around the duct, the erect state of the organ is accompanied with tension and straining, but the penis remains straight; if, on the contrary, periurethral inflammation complicates the disorder, the urethra, coagulated, as it were, becomes incapable of yielding to the dilatations and increase of length of the cavernous bodies, the pain becomes intense in proportion with the forcible distension of the parts, and the penis is obliged to assume a curved form, whence the name of "chordee" given to this symptom, which is not to be considered in the light of a special complaint, but as a mere extension of disease to adjoining structures.

Gonorrhœa of Membranous or Muscular Regions.

The pain is here specially seated in perindio; a sense of crany extending even to the testes, difficulty and occasional impossibility of the emission of urine, without the assistance of the catheter, chordee, and the *perineal* stretching which it causes, characterise this variety of the disorder.

Gonorrhœa of Prostatic Region.

The pain is deeper, and occupies the anus and front of the rectum. Venereal appetites are sometimes increased, pollutions frequent, and erections numerous. The seminal losses, at first attended with pleasure, become, from the straining of chordee, and distension of urethra by ejaculation, even more excruciating than micturition. Lacerations in the mucous membrane cause the seminal fluid to be mixed with blood. Cramps in the scrotum, and painful, oscillating, cremasteric contractions, increase the severity of this form of gonorrhœa. Vesical tenesmus, frequent, unsuccessful, and imperious attempts to empty the bladder, clearly show the deep seat occupied by the affection.

The inflammation may extend to the bladder itself, but here ends the demesne of special pathology. Our subject is sufficiently long to warrant our leaving aside the description of diseases, interesting in themselves, but connected only in a remote manner with the subject of these lectures.

Declining Period of Gonorrhœa.

Here the discharge is the chief symptom. The pain, if not altogether removed, is remarkably dimi-

nished. The color of the running is of a clearer tint, and occasionally puts on the bright yellow color of a canary bird's tail. Erection may remain uneasy, the urethra requiring some time to resume its natural elasticity. The remaining symptoms now and then obstinately persist in a state of *statu quo*, and constitute the

"Chronic State."

A drop of muco-purulent discharge appears at the meatus every morning, and forms what the French call "suintiment," "goutte militaire," and the British writers term "gleet." Any region of the urethra may be the seat of the disease, but the prostatic most frequently. With some patients the only symptom is the agglutination of the lips of the meatus in the morning; with others a running exists of a milky, opaline hue. And here, Gentlemen, I feel it necessary to warn you of a circumstance which tends not a little to prolong the secretion. Most people, being much preoccupied and anxious in their minds from the presence of this discharge, examine themselves almost at each moment, and have no rest until repeated pressure has brought forward a drop of fluid from the urethra. Now, of itself, such pressure would be sufficient to keep up a running, which, left to its own course, might have a tendency to disappear.

Illusory signs of *stricture* are common at this period, and occasion much fear and uneasiness to the patients. The presence of thick secretion in the duct, causing temporary agglutination of the opposite walls, may divide the jet of urine, so as to give it a forked appearance, or occasion it to assume a cork-screw shape. Also the loss of tone, which the urethra must inevitably experience from chronic inflammation, does not permit the duct to rid itself, after vesical contraction has ceased, of the last drops of urine, which flow into the trousers; also pollutions, not attended by any pleasurable sensations, occur from the prolonged excitement of the prostatic region. Thus, an inattentive observer may be imposed upon by these three circumstances; but the error cannot be of long duration, if the history of the case and characters of these symptoms be properly investigated.

Complications and Accidents.

Spasmodic dysuria, from inflammation of the membranous region, is not uncommon.

Retention of urine may also arise from the momentary obliteration of the duct, caused by tumefaction of the membrane. This troublesome complication may, it is true, accompany balanic urethritis, or even other parts, but it is chiefly observed in combination with inflammation of the spongy regions, where the bulb and peno-scrotal angle easily permit the formation of an obstacle to the passage of urine. We should not omit mentioning, as a frequent cause of retention, inflammatory swelling of the prostate.

Incontinence of urine should be mentioned as a possible complication of gonorrhœa.

Hæmorrhage may, from mere sanguineous congestion, be exhaled from the membrane, but it more commonly results from rupture of chordee during erection, or coitus, or again, from that absurd habit of the lower orders in this country, in consequence of which the penis affected with chordee is placed on a solid table, and the arch it forms broken down by a

smart blow on the dorsal region, thus rupturing forcibly the urethra, and procuring immoderate hæmorrhage.

Abscess from inflammation of the peri-urethral cellular structures is not by any means rare. Urethritis of the balanic region occasions abscess about the frænum. Should gonorrhœa occupy the spongy region, the abscess will most commonly be observed in the peno-scrotal angle, and frequently, as well as the former, be followed by urinary fistula. After perforations of this kind, Wedkind believes the patients are liable to constitutional syphilis. The remark is so far founded in truth, that chancre of the urethra may, as we have shown, corrode the duct, perforate it, and invade the cutaneous surface. A fact of this kind, in which inoculation powerfully assisted the diagnosis, is at the present moment under observation in our second ward.

The abscess seated in the phrenic region, opened, perforation of the urethra was the consequence, and the opening put on a decided aspect. Inoculation was practised, and its results were negative. The sore resulting from the spontaneous ulceration of the abscess assumed almost immediately a healthy appearance, and granulations have appeared.

Another case I will draw your attention to; it is that of the last patient of our first ward. A perineal tumor, seated on the left side of the urethra, arose from the extension of gonorrhœal inflammation. The tumor softened, was incised, and, five days after incision, urine passed through the cutaneous opening of the abscess. At present, if you examine the case, you will find the tumor has invaded the right side, and extended, probably, from Cowper's left glandule to the adjacent cellular tissue.

In the membranous region, Cowper's glands appear to have a greater tendency to suppurate, and we will observe, as a singular fact, that the left glandule is oftener affected than the right, following thereby the same rule as epididymitis, which you know, Gentlemen, is more often met with on the left than the right side.

If the seat of gonorrhœa be the prostatic region, the prostate itself becomes the centre of an abscess, which frequently terminates by fistula in perineo.

Bubo in gonorrhœa is a comparatively rare accident; but that form of inflammation commonly producing it is balanic urethritis.

As to epididymitis and strictures, they are too important complications to be mentioned in a cursory manner; we shall advert to them in a lecture especially devoted to that purpose.

Abortive Treatment of Gonorrhœa.

We shall begin by laying down as an invariable rule that the abortive treatment should in every case be attempted, when the disease is not complicated by phlegmonous inflammation of the structures surrounding the urethra.

The dangers supposed to attend this treatment are imaginary. Experience has shown to us, in the clearest manner, that strictures, feared by many from the effects of this treatment, are, on the contrary, more common after discharges, which vain fears have prevented from being arrested, and that, in fact, they are to be attributed solely to the persistency of the

inflammation, and not to the means employed to arrest its progress.

This treatment is applicable to all periods of gonorrhœa, when acute inflammation does not attend them. Should subacute inflammation be present, provided it be unaccompanied with pain, even though the affection may have had a long previous existence, the treatment employed as an abortive of the incipient stage may still be employed with perfect safety, and with every chance of success.

The best local remedy, and that which shall be first noticed, is injection. Far from being the cause of those accidents it has been so often accused of producing, it constitutes their best prophylaxis.

Cold water injections may occasionally be successful, but the results cannot be altogether relied upon. Bell employed sulphate of zinc. In my opinion, nitrate of silver is almost a specific in the inflammation of mucous membranes. The strength of the solution differs with practitioners. Mr. Carmichael, of Dublin, was the first to recommend strong solutions of ten, twelve, or twenty grains of nitrate of silver to the ounce of distilled water, injected morning and evening. Before my friend Mr. C. published the results of his observations on this subject, I had tried the method; but, although my cases were not so fortunate as those of Mr. C., yet I found it impossible to draw any inference unfavorable to this mode of injection, because the cases in which it was exhibited were not properly discriminated. Until the year 1841, I remained satisfied that small doses, a quarter of a grain to the ounce, were quite as efficient as larger doses.

My opinion has, however, been slightly changed in this respect. I prescribe at present *one injection* a-day, with a ten-grain solution, and this proportion seems to me more beneficial than any former injection.

But, as this little operation is one which requires some nicety in its execution, as it is one which frequently fails, merely because the patient performs it badly, I must request permission to give you some practical hints on the subject.

A glass syringe is far preferable to a metallic one, for chemical reasons easily understood. Do not, however, Gentlemen, tell your patients that your preference for glass is founded upon the decomposition of the pewter syringe by the injection; this would, no doubt, alarm many, and they would instantly refuse injecting into their urethræ such pernicious stuff. Tell them, on the contrary, that the metallic syringe decomposes the injection, and take my word for it they will be perfectly satisfied.

The instrument commonly employed contains about an ounce of fluid. This quantity should not be injected at one time; half is sufficient.

The patient should sit on the edge of a chair, and the injection be permitted to pass over the whole of the duct. Pressure is recommended by some, at two or three inches from the meatus, with a view of preventing the liquid to pass into a portion of the urethra, which they suppose to remain always healthy. Both the theoretical notion and its practical consequence are to be rejected. I have explained to you that, in many cases, gonorrhœa extends beyond the bulb, and consequently the injection should be placed, by all

means, in direct contact with the inflamed part. On the other hand, should urethritis be limited to the distal orifice, the injection running over healthy mucous membrane can do it no possible injury; hence we may regard pressure as unnecessary.

For the same reason I reprobate perineal pressure made by the arm of a chair, or by a truss. The fear of the entrance of the injected fluid into the bladder I am not in the least intimidated by, as, in the first place, such entrance appears to me next to impossible; and, in the second, supposing even the injection to enter that viscus by chance, it would prove utterly harmless, being instantaneously decomposed by contact with the urine.

I conceive, on the contrary, the precautions recommended on these occasions prevent the injections from being properly made use of, by inspiring the patient with a dread of imaginary evils.

The axis of the syringe should, as much as possible, be parallel with that of the urethra, and, if at all oblique, should be inclined rather towards the inferior wall of the canal, the lacunæ of Morgani, in the balanic region, being strictly confined to the upper surface.

The index and thumb of the left hand should press the lips of the meatus against the syringe, so as to prevent the return of the liquid, while the right hand propels slowly and steadily, without violence, the liquid into the urethra, where it should be retained half a minute. Occasionally no pain follows the injection. In other cases it lasts a quarter of an hour after; in some few it remains for several hours, and sometimes appears only on the first emission of urine.

The secretion becomes sero-sanguineous, and now and then bloody, at the same time the excretion of urine is difficult; but this symptom is of short duration. We must not omit to state that, in most cases, the muco-purulent discharge increases in quantity for a certain time after the irritant injection.

You plainly perceive, Gentlemen, that all these possible consequences should be mentioned to the patients, in order they may not consider as fresh complications, induced by your treatment, what may, on the contrary, be looked upon as proof of the favorable action of the remedy.

How many injections should be employed? The object of this treatment being to substitute an artificial inflammation for the previous gonorrhœa, one injection may not suffice to accomplish this end, and a second, or even a third, may become necessary. At this period, when the symptoms enumerated above have taken place, the surgeon has created a new affection, which might, perhaps, disappear spontaneously by the suspension of the means employed to produce it, but which will be easily subdued in a shorter period, by the injection, three times a-day, of the following solution, which was first mentioned to me by my friend Mr. Evans, of London:—

Rose water, eight ounces;

Sulphate of zinc, sub-acetate of lead, of each seventeen grains.

Thus the disease is generally arrested in a time varying from two to eight days. Should the discharge return after having ceased several days, the local treatment must be begun anew, with the nitrate of silver, as before.

It has been proposed to carry a stick of nitrate of silver over the inflamed surface. This is easy enough when the disease is limited to the neighbourhood of the meatus, but, when it has a deeper seat, cauterisation with Lallemand's instrument might, it is true, be followed by good effects; but these are not sufficiently certain to warrant an operation which alarms the patient in no slight degree.

Injections alone might, I feel convinced, achieve the cure of blenorragia, but their efficacy is more than doubled by the internal exhibition of special anti-blenorrhagic drugs, such as

Copaiba.

The action of this medicine is threefold—1, it may influence the constitution from absorption into the system; 2, it may act as a revulsive; 3, its action may be purely local, being placed, through the agency of the urine, in direct contact with the inflamed urethra.

The first mode of action is that of all balsamic substances, which exert a divided and almost specific action on mucous membrane.

The revulsive influence of copaiba may be limited to the stomach, and manifested by sickness and vomiting, in which case it is of no advantage whatever, and its use must be abandoned.

On the intestines revulsive action is more beneficial. When purging is induced, the urethral discharge is often found to disappear; but do not rely on this apparent cure, for, the moment diarrhœa ceases, the running returns. Some persons are, on the contrary, rendered costive by the drug, and in these no revulsive action takes place. Should enteritis be excited by the excessive use of copaiba, gonorrhœa is found to persist, and even to acquire fresh vigor by it.

But the local action on the genito-urinary organs I deem to be the specific influence of copaiba. Stimulated by the balsamum, the kidneys secrete more fluid, and this is modified in its chemical properties, so as to acquire a nature highly favorable to the rapid termination of blenorragia. The local action of the urine, thus modified by copaiba, is so remarkable that I purpose injecting it again into the urethra after excretion, in order to obtain an increase of the benefit which already accrues to the patient from the liquid passing once over the membrane.

My conviction of the local influence of copaiba in gonorrhœa is not only founded on theory, but also on facts. I will close this lecture with the following case, which illustrates my opinion:—"The hypospadiac patient, whose history I have adverted to at the commencement of this lecture, and who presented a double discharge, one from the meatus, and the other from the fistulous opening of the urethra, was put under the influence of copaiba. The discharge from the hypospadiac opening, through which all the urine passed (not a drop coming from the meatus), was *rapidly arrested*, whereas, in the distal orifice of the urethra, the gonorrhœa *persisted*, and was cured only by subsequent injections."