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COURSE OF LECTURES ON VENEREAL AFFECTIONS

DELIVERED

AT THE HOPITAL DU MIDI, PARIS.

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Translated and arranged by Daniel McCarthy, Esq.,
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LECTURE XV.

June 30, 1843.

Extraordinary case of a Jewish child infected by the operation of circumcision—Peculiarities of chancre arising from its seat—Chancres on different parts of the penis; in the urethra; in the female; in unusual situations—Prognosis of chancre: first, with regard to its local consequences; secondly, with regard to the chance of bubo; thirdly, with regard to the chance of secondary symptoms—Aphorisms on this point—Period at which all fear may cease.

GENTLEMEN,—Before we resume the history of chancre, I cannot refrain from mentioning to you a case which was confided to my care but yesterday, and which is highly important to us at the present moment, as it bears on several points we have already examined together.

A Jew child, aged two months, was brought to my house with an indurated chancre of the prepuce, enlarged glands in the groins, and a general eruption of syphilitic papules all over the body. The parents stated that the infant had been circumcised a week after his birth at the synagogue, according to the rites of their creed, that the wound had festered, and became gradually *harder and harder at its base*, and that the eruption first broke out three weeks after the operation.

This interesting case, in which general syphilis developed itself fully, in the same manner, and nearly within the same period, as in the adult, was further important with regard to the difficulty of ascertaining the exact mode of infection. Hereditary syphilis is altogether out of the question, the child still presenting the primary ulcers—first cause of all the mischief. Where is that ulcer seated? On the very part where a wound has been inflicted. Three modes of inoculation of this wound can alone be admitted: 1, The knife or razor used may have been previously employed on a chancrous subject, and, being imperfectly cleaned, have become the cause of inoculation. 2, The dressing applied to the wound may possibly have been also soiled with inoculable matter, and thus changed a simple wound into a chancre. 3, The practice of sucking the wound—an important part of the Hebraic ceremony—may have caused the transformation of the incision into a sore—if the rabbin was affected with chancre of the mouth. Now,

the persons to whom this duty is confided, are not by far the highest of their caste, but a sort of upper servants of the temple, who are not at all above suspicion. It is impossible, however, without more accurate data, to solve the question in an absolute manner. I will only add, as a fact not to be forgotten, that the nurse has suckled the infant ever since its birth, and has, notwithstanding, remained in a perfect state of health.

We now turn to the consideration of the peculiarities of chancre relative to its seat.

Chancre may occupy the prepuce or the glans penis. Primary ulcer of the prepuce mostly affects its limbus or orifice. Here the physical condition of the part, so liable to lacerations and fissure during coitus, explains at once the frequency of the sore at this point, and its special fissure-like shape.

Seated further back under the prepuce, chancre easily excites a degree of tumefaction, the results of which are accidental phimosis and symptoms of balanitis. The presence of chancre may, however, be recognised by the circumscribed seat of the pain, which is diffused around the corona glandis in balanitis; by the nature of the discharge, thick and creamy in balanitis, thin and sanious when arising from chancre.

A gentleman of Versailles was affected with complete induration of the prepuce, with total incapacity to draw it back; the surgeon's diagnosis was malignant disease, and I was called in, merely as an operator, to remove the obnoxious prepuce, which I did.

Six weeks afterwards a most perfect syphilitic eruption occurred, which both explained the rapid cure of the wound made after excision of the supposed cancer, and fully exposed its true nature.

Chancre of the mucous surface of the prepuce not unfrequently determines abscess of the cellular tissue, and a perforation of the prepuce through which the glands may protrude.

When the foreskin can be reflected, so as to uncover the glans, chancre is usually found at its base, and is very common also at the meatus, where it is sometimes visible in part, but where it can occasionally be seen only when the lips of the meatus are held open.

Perhaps the most frequent seat of chancre is the frenum, from its great tendency to tear during erection and sexual intercourse. The frenum is often perforated transversely, and a bridge left, containing the artery, which is ulcerated only by the ulterior progress of the sore.

The inguinal fold, the skin of the penis, that of the abdomen, as you have lately had various opportunities of convincing yourselves, enjoy no immunity from chancre; but in the last named region the tendency of the ulcer to cover itself with a scab is a frequent source of error.

On true mucous membrane, the humid state of the

surface prevents altogether the formation of a crust and on the lips you will find the sores concealed under a sort of "mezzo termine" secretion, something between liquid and crusty matter—viz., a pseudo-membranous substance, with a tendency towards desiccation.

I will add to the foregoing some remarks on the seat of chancre in each sex.

In the male, any part of the urethra, from the meatus to the bladder, may become affected with chancrous ulceration. Inoculation of various blenorhoid discharges have proved the assertion to be true on the living, and ocular inspection has demonstrated it on the dead subject.

When treating of gonorrhœa, we mentioned the chief symptoms of urethral chancre; we said that the incubation is supposed to be longer in gonorrhœa virulenta than in simple urethritis, and we showed that no such thing as incubation really exists in either one or the other, but that the discharge from urethral chancre is so trifling as not to be perceived for several days—hence, the general error. We mentioned the sanious, rusty hue of the secretion, nor did we omit to speak of the pain experienced by the patient in the *circumscribed* extent of the chancre, either during the introduction of a catheter, or the passing of urine. When the sore is not far removed from the meatus, it may also sometimes be seen, either by simply separating the lips of the meatus, or by the use of the "speculum urethræ" of Ségalas. As to the "smell" of the discharge, it is of no use or advantage whatever for the discrimination of its nature.

The orifice is the part of the urethra most commonly affected with chancre; the occurrence is rarer and rarer as the deeper parts of the urethra are investigated.

All the signs of urethral chancre enumerated above can give only a probability of its existence; a positive certainty can be acquired only by successful inoculation.

In the female, the fourchette, the vulva, the caruncle, the præputium clitoridis, are the most common seats of primary ulcers. Chancre may occupy the os uteri, but is rare in the cavity of the neck or body of the womb. It is rare also in the vagina.

Perhaps more frequently than in the male does chancre exist in the female urethra. I shall say nothing further in vindication of the all important use of the speculum in such diseases.

In both sexes the anus may be the seat of primary disease, chiefly on its anterior aspect. It may easily be confounded with simple fissure—a mistake committed not very long since by a distinguished professor of clinical surgery, who incised the sphincter, and gave rise to an immense chancre, which I had the trouble of curing.† * * * *

Prognosis of Chancre.

This must be considered under a threefold aspect:

- 1, The local injury which the sore itself may produce.
- 2, The chances of bubo.
- 3, The effects of chancre on the constitution.

† We omit many passages relating to cases which, thank Heaven, English practitioners need not trouble themselves about. They are far more curious than instructive or delicate. The learned professor says, *inter alia*, "I have attended one of our great poets—a man of unruly imagination(!)—for chancre of the 'pharynx,' which I tested by inoculation."—Eps.

1. *Local Prognosis.*—As far as the sore is concerned, its spontaneous cure is now demonstrated to be possible; the most severe local forms of ulcers are undoubtedly the phagedenic and gangrenous varieties. You may, however, perceive that, when the chancre meets aponeurotic or fibrous structures, it is occasionally limited thereby in its further progress, as in the last patient of our second ward, who had a phagedenic and gangrenous sore of the glans, which was limited by the tissue which separates the corpus cavernosum from the glans.

The unlimited period during which the phagedenic and diphtheritic chancre may last, makes it also a very formidable ulcer. Even though its size may be limited to a small space, yet the prognosis must be very guarded as to its duration.

Indurated sore has no tendency to enlargement; it is seldom painful: hence, as far as local disorder is concerned, the prognosis is favorable.

2. *With reference to Bubo.*—Enlargement of the inguinal glands may exist in all, or almost all, chancres; it is, however, rare to see them swelled to a considerable size in the phagedenic gangrenous chancre.

With simple chancre bubo is frequent, and its supuration very common.

Tumefied lymphatic ganglions accompany almost all indurated chancres, but I have never known them to suppurate.

Suppurating bubo is most frequent in man from ulcers of the frenum, and in females from sores of the vicinity of the meatus; and as chancres in women are more usually observed at the fourchette, the less frequent occurrence of bubo in one sex than in the other is at once explained.

I have never seen bubo occur from an inoculation practised by myself; not that the artificial sore is incapable of producing it, but merely because the seat which I choose for the operation—viz., the inner part of the middle of the thigh—appears, from the anatomical distribution of its lymphatics, to be less subject to the accident. Cases of inoculation performed by others are adduced, wherein bubo occurred, either from neglect in destroying the sores, or, more probably, from simultaneous sores of the genitals. These facts have been brought forward, as objections to the method of inoculation, by a person who ought to be the very last to make such an objection, inasmuch as his favorite theory is, that bubo may exist without chancre, and be the first symptomatic manifestation of syphilis. How, then, we will ask, can he be certain that the bubo he observed in a case of inoculation was due to the operation, and not to some previous infection?

Bubo may be observed to occur at any period of the existence of chancre. I have seen it occur six months after the beginning of the sore of the genitals, which had never been healed during that time. I have met with it at the close of the second year of a phagedenic ulcer, which had deeply furrowed one groin, descended to the neighbourhood of the anus, and invaded the opposite sciatic region, where some lymphatics of the hitherto healthy groin, becoming implicated, gave rise to inguinal chancrous abscess.

Canterisation of chancre does not always prevent bubo, but it may, at any rate, be disculpated from the charge of producing it, as bubo occurs far oftener

in cases where the original chancre has undergone no cauterisation than in opposite circumstances. In this respect my opinion is in direct contradiction with that of Bell. The cases he adduces to prove the sinister influence of cauterisation are utterly without value; he neither mentions the period of the chancre at which the operation was performed, its previous duration, its seat, nor any one of the important points, without which his arguments are inadequate to support his position. It is, moreover, quite clear that the longer a patient is allowed to carry an ulcer, secreting inoculable pus, the more will he be exposed to special irritation of the inguinal glands. On the other hand, the sooner the ulcer is *destroyed*, let it be by caustics or otherwise, the more will the chances of escape from bubo increase in number.

There is a celebrated case of Van Swieten, adduced to prove that cauterisation of chancre may cause secondary syphilis; you shall judge of it. "A man is affected with chancre during THREE MONTHS; at the expiration of that period it is cauterised with nitrate of silver, and *three days* afterwards secondary syphilis appears!"

I will not dismiss the subject without stating that I have had frequent opportunities of convincing myself, from inspection, that the hard string felt on the dorsum of the penis, in cases of chancre, is not formed by a tumefied vein, as the name given to the symptom, "dorsal phlebitis," would imply, but by an inflamed and distended lymphatic, from which I have frequently succeeded in extracting inoculable matter.

The circumstance of a patient with chancre being placed under the influence of mercury, has no value whatever in the prognosis of chancre with reference to bubo.

3. *Prognosis of Chancre, with reference to the Probabilities of Secondary Infection.*—As to the probable occurrence of secondary syphilis, I can positively bring forward the following propositions as the result of my experience:—

1. Primary ulcer is the indispensable precedent of secondary syphilis; without chancre there can be no general infection, except in the rare case of hereditary disease.

2. Simple, non-indurated chancre, and gangrenous chancre, are very seldom, and only in exceptional cases, followed by secondary syphilis.

3. Indurated chancre gives *always* rise to constitutional infection.

4. The seat of chancre does not in the least degree influence the production of secondary symptoms. Provided the chancre be indurated, secondary disorder is as common and as constant after sores of the mouth, hand, nose, or foot, as after chancres of the penis.

5. The size of a chancre, the number of sores a patient is affected with, do not increase his chances of general infection, always provided none be indurated.

6. If the primary ulcer be destroyed during the six first days of its existence, no secondary symptoms will follow.

7. Six months having elapsed after the cure of a chancre (no mercury having been exhibited) without the appearance of any secondary eruption, all fear of constitutional symptoms may be laid aside.

A CASE
OF
MALIGNANT DISEASE OF THE OS UTERI,
COEXISTING WITH PREGNANCY, AND TERMINATING
FATALLY HALF AN HOUR AFTER DELIVERY.
WITH REMARKS.

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(Continued from page 33.)

Cases in which the Natural Powers have not been able to effect Delivery, but in which this has been effected by Artificial Means, compatible with the Life of the Child.

Madame La Chapelle, in her "Pratique des Accouchemens," vol. iii, pp. 371—7, gives three cases, of which the following are abstracts:—

CASE I.—Catherine D., a tall, thin woman, aged thirty-four, was pregnant for the sixth time. All her labors had been very easy. Two years intervened between the fifth and sixth pregnancy, the commencement of which was attended with moral suffering. She had hæmorrhage from the uterus from two months before to six months after conception, when it was checked by repeated venesection. It reappeared, however, often in the eighth month. During the last three weeks of the ninth month she had slight pains, and a rather abundant discharge of water. On the 6th of May, 1819, she had more active pains, and the discharge of some drops of blood. The uterine orifice was very irregular, and was surrounded by four or five hard, smooth, irregularly disposed tumors, the largest of which was backwards. These tumors, which were separated by healthy but very narrow intervals, were slightly moveable on each other. The neck of the uterus had not undergone the usual changes, but was two inches long. It was not so hard, and more uniform on its mucous surface than at the orifice. The head presented. The pains hung about her during the 6th, 7th, and 8th, when great feverishness and depression showed themselves. Baths, half baths, and enemata, were used, and on the evening of the 8th stronger pains came on, and threw the patient into a state of anxiety, paleness, and very alarming oppression; she was covered with sweat; the pulse was frequent and contracted. An ethereal draught was given. The neck of the uterus was now only an inch long, and softer, and the tumors more moveable and distant from each other. Afterwards the internal orifice of the cervix dilated, and the membranes began to protrude. On the morning of the 9th the os uteri was dilated to the diameter of two inches, the tumors being posteriorly, some irregularities only anteriorly. The abdomen was painful, and there was vomiting of green matter; she was pale and feeble. A draught containing wine was given. At three o'clock the membranes were artificially ruptured; the waters were discharged, but the pains were feeble, and the head remained stationary. At four o'clock the forceps were applied on the sides of the pelvis, the tumefaction of the scalp preventing an exact diagnosis of the position of the head. The extraction was easy; the child was dead, and its integuments abraded at many points. There was moderate hæmorrhage after the expulsion of the placenta, which was stopped by con-