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

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LECTURE XIX.

July 22, 1843.

Constitutional syphilis—The syphilitic diathesis—Its concurrence with induration of the chancre—Hereditary syphilis—Causes which bring the syphilitic diathesis into active operation—Prenatal symptoms—Enlargement of the posterior cervical glands—Secondary and tertiary symptoms—Prognosis—Varieties—Syphilitic roseola.

GENTLEMEN,—No individual enjoys an immunity from primary symptoms; wherever chancre is inoculated, there does it occur. This assertion, inoculation with the lancet has demonstrated beyond all contradiction. It is not so with constitutional syphilis. Here a peculiar condition of the system is necessary for the infection; and the first sign we have of this morbid aptitude is the induration of the primary ulcer.

According to M. Chomel (*Pathologie Générale*, p. 42), one constitutional infection predisposes to a second. This assertion, perfectly correct when applied to gonorrhœa, I conceive to be erroneous as regards constitutional syphilis. Within the whole range of my experience, I do not recollect one single case in which indurated chancre has recurred in the same subject, or wherein a fresh infection has again brought on the same train of secondary symptoms. Relapse is, however, a most frequent occurrence, and must be carefully distinguished from the manifestations of a fresh infection; indeed, your diagnosis in this matter will be powerfully assisted by this circumstance, that the older the infection the deeper will be its seat, so that you can hardly confound the symptoms of relapse of an old infection with the characters of a fresh one. So frequent is relapse in syphilis, that it may be fairly questioned whether the syphilitic diathesis once established can ever afterwards be completely eradicated. Syphilis appears to me one of those affections which, like small-pox, occur generally but once in the same individual.

The lymphatics do not seem to be the immediate channels for the introduction of the poison into the system; for we find the virulent matter still inoculable so long as it has not abandoned the lymphatics. But once introduced into the venous system, it loses its inoculable properties, and I am tempted to consider the venous and lymphatic inoculations demonstrated by Fohman in the lymphatic glands, as the true agents of syphilitic absorption.

I conceive that the matter is not absorbed in the state of true pus, as Hunter supposed; if his theory on this point was correct, it is clear that the number and extent of the chancres would considerably increase the chances of secondary infection, and we find that they bear no ratio whatever to each other.

Were I permitted to hazard a hypothesis, which seems to acquire a certain degree of value when the peculiar mode of development of syphilis is reflected upon, I would say that the poison acts, when mixed with the blood, as a kind of ferment, requiring some extraneous cause to urge it into action.

The fœtus, enclosed in its mother's womb, may be infected, if the blood, from which it derives its chief nutriment, be tainted by syphilis. But we may find in the fœtus, as well as in the adult, peculiar idiosyncracies, which are not susceptible of syphilitic absorption, and the child may thus escape free, from what would at first appear an inevitable cause of infection. Thus, a father's or a mother's constitution may predominate in the child, and, according as one or the other does or does not enjoy the privilege of escaping constitutional contamination, the child may or may not be affected.

In my opinion, with the exception of hereditary symptoms, secondary syphilis is always caused by a chancre. I have often seen children nursed by women affected with secondary symptoms, who have not become affected; I have seen at least as many, and have at present several cases under my care, of children diseased whose nurses remain perfectly healthy.

When indurated chancre exists, a true syphilitic diathesis is established, and accidental circumstances are alone necessary to bring about its manifestation.

The interval which separates indurated chancre from secondary symptoms may truly be considered as an incubation, during which a ferment mixed with the blood (*syphilis larvée*, Baglivi), and circulating with it, modifies its composition in such a manner as to render it in some measure unfit for a proper nutrition, on one hand, and on the other—under the influence of circumstances which have no action on the healthy individual—to give rise to a series of symptoms, which have received the collective name of secondary syphilis. This interval of incubation is shorter in the child and the female than in the male adult. It lasts from three or four weeks to as many months in general, the average being six weeks. A sudden change in the external temperature, the excitement caused by alcoholic stimulants, or even local causes, a warm or cold bath, the action of a short pipe on the lips, neglect of cleanliness, diet of an exciting nature, the exercise of riding,—such are the most frequent determining causes of the first outbreak of secondary symptoms.

Mercury, administered for the cure of primary sores,

may prevent altogether the establishment of the diathesis; once this peculiar state of the system in existence, mercury may again interfere with or postpone its manifestation. Should the secondary symptoms have already broken out, mercury will cause them to disappear; but the syphilitic diathesis once established, can *never*, in my opinion, be destroyed.

Premonitory Symptoms.

A change in the complexion, dryness of the hair, rheumatic pains in the extremity of the long bones, violent nervous headache, particularly in the anterior regions of the cranium, frequently a slight degree of febrile excitement, such are the symptoms which usually usher in a syphilitic eruption.

The aspect of precocious senility has been, by all observers, mentioned as accompanying in general constitutional syphilis of infants.

In early eruptions, one symptom is so frequent as to be almost pathognomonic; and, strange to say, it has never attracted the notice of practitioners, before I mentioned it in my annotations to the French translation of Hunter. It is the enlargement of the lymphatic glands, seated in the posterior cervical region, on either side of the mesial line.

These prodromic symptoms are not, however, *constant*. They may fail; but, from this period forwards, you will find syphilis proceeding with such admirable regularity that any one syphilitic symptom being given, the date of the primary infection may, almost with certainty, be stated.

I recognise two series of constitutional symptoms; the first, the earliest, manifesting itself seldom later than the sixth month, or earlier than the second week, after infection, generally, as I before stated, during the second month. It affects the skin and mucous membrane; its symptoms are neither inoculable nor contagious. I have denominated them "secondary."

The second series of constitutional symptoms I call "tertiary." Here the cellular tissue, fibrous or bony structures, are affected. Six months always intervene, at least, between the primary accident and these deep-seated affections.

Although such an occurrence is anything but common, yet the primary sore, the first cause of all the subsequent mischief, may outlive its usual period, and coexist with advanced secondary or even tertiary disease; nay, it may even be found after these have disappeared—a circumstance which completely overthrows the prognosis formerly introduced into syphilis, and according to which the primary symptoms were looked upon as of trifling importance; the secondary as more serious, and those we call tertiary were looked upon as the most severe. At the present day, on the contrary, with the assistance of mercury and the hydriodate of potash, the surgeon may always be certain of mastering any given symptom; indeed, the deeper the symptom, the *more readily* will it yield, whereas he cannot, with any degree of certainty, answer for the duration of a phagedonic sore.

Secondary syphilis is always a chronic disease, and its diagnosis is generally easy. It rests chiefly upon two points—1, the antecedent history of the primary infection; and 2, the physical characters of the secondary symptom itself. In one symptom alone can a positive diagnosis be made without any refer-

ence to the primary infection; that is the mucous papula, the appearance of which is so characteristic as to leave no doubt whatever of the nature of the case.

The action of mercury is, it is true, a powerful touchstone, but one which cannot be *exclusively* depended upon, mercury curing many affections quite independent of syphilis.

Mercurialis says, however, with some foundation of truth, that those affections which yield to *no other* treatment, but give readily way before mercury, may be considered as syphilitic.

The prognosis of secondary disease should be exceedingly reserved and guarded, inasmuch as the practitioner can hardly ever calculate upon a complete and *lasting* cure. The symptoms disappear, but relapse is a common rule.

Secondary Symptoms analysed.

My friend, Mr. Carmichael, of Dublin, holds that several syphilitic poisons exist, producing each a distinct primary symptom, the consequence of which is also a distinct secondary manifestation corresponding to each of the primary accidents. This opinion it is impossible for me to concur in; as I have in many instances noticed, after *one* sore, *all* the forms of secondary infection. These forms depend, therefore, not on the peculiar variety of the primary symptoms, but upon the idiosyncrasy of each individual patient.

The first manifestation of secondary syphilis belongs to the order of exanthemata.

Syphilitic roseola, generally observed during the first three or four months which follow the primary sore, is characterised by superficial, confluent, red maculæ, disappearing under pressure in the incipient stage, and unaccompanied by any true papular elevations.

For several months may this eruption persist in the state of simple maculæ, but they may also spontaneously disappear in a much shorter time, in which case the exanthema almost inevitably returns. The abdomen and base of the chest are its usual seat, and seldom the face.

This eruption is not, in my opinion, a distinct form of cutaneous syphilis. It is the beginning, the incipient stage of all its forms, however deep, and as such does not perhaps deserve a separate description.

It resembles closely common roseola and measles, from which it may, however, be readily distinguished by the absence of fever and of itching, the long duration of the syphilitic eruption, the enlargement of cervical glands, the pre-existence and frequently the co-existence of indurated chancre, and lastly the rare occurrence of desquamation.

The prognosis of this eruption, as a local affection, is comparatively light. We shall pursue in our next lecture the history of the other forms of secondary syphilis on the skin.