CHAPTER II.

PECULIARITIES DEPENDENT UPON THE SEAT OF CHANCROIDS.

The seat of a chancroid often modifies the symptoms and necessitates changes in the treatment.

Chancroids upon the Integument of the Penis.—The majority of venereal ulcerations following suspicious connection, and seated upon the integument of the penis, are chancres and not chancroids; why, I do not know; but it behooves the surgeon to look sharply to his diagnosis with ulcers in this region. The rule is far from being invariable, for I have met with many cases of simple chancres situated between the preputial orifice and the root of the penis and even upon the pubes. Chancroids upon the integument of the penis often originate in a follicle, and when first noticed resemble a pustule or small abscess (*follicular chancroids*, see p. 386). Not unfrequently they extend to the loose cellular tissue, and undermine the skin around a small external opening, through which the pus can be made to well up on pressure. The mobility of the integument over the concealed chancroidal cavity interferes with cicatrization and prolongs the duration of the ulcer. The cavity, first thoroughly cleansed of matter, should be cauterized by means of a sliver of wood (as a lucifer match) dipped in strong nitric acid; or sometimes it becomes necessary to enlarge the external opening even at the risk of inoculation of the edges of the wound. The ulcer having been thoroughly exposed and freely cauterized, should be kept moist by the application of wet lint, a layer of oiled silk, and a retentive bandage, in the manner previously indicated.

Chancroids of the Frænum.—Chancroids of the frænum are especially painful, persistent, and exposed to hæmorrhage. They may commence either upon the free margin or at the base of the bridle. In the former case a rent or fissure, the result of violence during coitus, has probably been inoculated; and the resultant chancroid gradually eats away the whole bridle, and hollows out a narrow longitudinal groove upon the under surface of the glans, giving great annoyance, long persisting, and resisting ordinary modes of treatment. Again, they may proceed from chancroids in the neighborhood, which exhibit a remarkable tendency to involve the bridle, if situated near it. In this case the base of the frænum is first attacked and often becomes perforated from side to side; the chancroidal opening gradually enlarges, extends to the free margin, and, as in the former case, probably destroys the whole bridle. The frænum is

copiously supplied with blood and exceedingly sensitive; hence, ulcers of this part are very liable to bleed and give rise to much suffering. Their persistency and destructive tendency are due to the frequent rupture of the longitudinal fibres of the frænum, occasioned by the constant motion to which it is exposed, in walking, handling the penis during micturition, in erections, etc. Minute rents are thus caused in the sore, which become inoculated and increase its depth; and ulcerative action goes on until the whole bridle is destroyed, including the portion buried in the under surface of the glans; and hence the fossa already referred to. Occasionally they extend to the urethra and give rise to a urinary fistula. In the treatment of these ulcers, the patient should be directed to avoid all motion of the part which will stretch the frænum; the glans should not be uncovered except to dress the sore, and even then no further than is absolutely necessary to insert the dressing. If the chancroid threaten to destroy the whole bridle, time will be gained by accomplishing the same at once by means of caustic. When perforation has taken place, the remaining portion of the bridle should be divided with scissors, and the raw surfaces freely cauterized. The flow of blood in this operation is often troublesome, and should be avoided by previously passing a double ligature through the opening and tying a thread at either extremity of the frænum, all of which should be removed. Diday heats one blade of a dull pair of scissors over a spirit-lamp, and passing the opposite cold blade through the opening to serve as a support, thus divides the frænum by the actual cautery.[1] The galvano-caustic wire would seem well adapted to this purpose.

Sub-preputial Chancroids.—These are almost always multiple; they suppurate freely and are quite destructive in their tendency. Three conditions of the prepuce may obtain:

1. This envelope may be so large as to be readily retracted.
2. The prepuce may be naturally tight, or it may be œdematous from attendant inflammation, so that the sores are with difficulty exposed, and the attempt occasions rents in their surface, and considerable pain to the patient.
3. There may be complete phimosis, either congenital or supervening as a complication of the disease.

In the last case, the sores are more effectually "concealed" than if situated within the urethra or vagina, and, indeed, cannot be exposed at all except by an operation. The discharge which collects in the balano-preputial fold before escaping from the orifice may usually be distinguished from that of balanitis. It is of a different color and less homogeneous, and is often streaked with blood and mingled with organic detritus. The exact situation of the ulcers may sometimes be detected by palpation, whenever the inflammation of the surrounding

[1] Du chancre primitif du frein de la verge; Gaz. hebd. de méd., Par., Oct. 19, 1855, p. 749.

tissues is sufficient to convey the impression of hardness to the fingers applied to the external surface of the prepuce, and also by the pain excited by pressure.

Chancroids are apt to appear upon the margin of the preputial orifice in consequence of successive inoculation from the discharge of those within, and they present a few peculiarities worthy of notice. Thus they are often *exulcerous*, or superficial, their floor being nearly or quite on a level with the surrounding integument, a fact which has been attributed to the constant irritation to which they are subjected from the sub-preputial discharge and the urine. The same cause frequently occasions a fictitious induration of their base, so that they may be mistaken for true chancres. They sometimes appear as rents or fissures in consequence of their occupying the folds of the orifice; and they are then, as it were, doubled upon themselves, so that two portions of their surface are in apposition. Any attempt to destroy them by cauterization will fail, so long as the ulcers beneath the prepuce remain open and secrete inoculable pus.

Sub-preputial chancroids are especially exposed to become complicated with balanitis, abscesses between the two layers of the prepuce, phagedæna and gangrene. Several neighboring ulcerations may unite and form a large sore, which may result in the destruction of more or less of the glans, or, by extending along the furrow at its base, nearly enucleate this organ.

The treatment varies according to the presence or absence of phimosis. When the prepuce can be kept retracted *without becoming œdematous*, and incurring danger of paraphimosis, the ulcers may be cauterized and dressed like chancroids upon the external integument of the penis. They will thus heal much more readily than if the prepuce be kept forward.

In cases of partial phimosis, in which retraction of the prepuce can be effected only with pain and violence, it is better to allow it to remain forward and treat the ulcers as if the phimosis were complete. Destructive cauterization is here, of course, impossible, and attention to cleanliness, the use of astringent lotions, and in cases attended with inflammation, hot hip-baths and rest are the only means of relief. The balano-preputial fold should be thoroughly cleansed with injections of tepid water, repeated from three to six times a day, according to the copiousness of the discharge, by means of a syringe with a nozzle long enough to reach the base of the glans. An astringent, or slightly caustic lotion, may afterwards be thrown in; one of the best for the purpose is a solution of nitrate of silver, from five to ten grains to the ounce of water. This application is not contra-indicated even by the presence of inflammation, since its effect is found to be sedative. Abscesses occurring between the layers of the prepuce must be opened.

The reader is referred to Chaps. III. and IV., of Part I. of this work, for a fuller account of the treatment of balanitis and phimosis complicating the chancroid.

Sub-preputial chancroids, especially when accompanied by chancroids of the preputial orifice, are often followed by such an amount of permanent contraction of the prepuce as to render exposure of the glans difficult or impossible. In these cases it is better, after the sores have healed, to resort to circumcision, otherwise the abnormal condition of the parts is a constant source of annoyance, interfering with cleanliness and exposing to repeated attacks of balanitis and herpes.

Urethral Chancroids.—Chancroids are not unfrequently met with at the meatus, occupying either a portion or the whole of the margin of this orifice, and they occasionally occur within the fossa navicularis, which is richly supplied with follicles whose mouths afford ready entrance to the poison. In this manner a number of small follicular chancroids may arise in the fossa, which, in consequence of the ulceration of the intervening walls, subsequently form a sore of considerable size, and this has been known to extend into the subcutaneous cellular tissue and undermine the integument of the penis even up to the pubes (Zeissl).

I have never met with chancroids in any deeper portion of the canal, and the possibility of their existence is doubted by most authorities of the present day, including Zeissl. Ricord,[1] indeed, presented to the Academy of Medicine, of Paris, two specimens of ulcers affecting the deeper portions of the urethra, and even the bladder, of which he has given plates in his *Atlas*, and in his *Notes to Hunter on Venereal*. These he believed to be chancroids, on the ground that he had successfully inoculated the secretion coming from the patient's urethra before death. With our present knowledge, we cannot now regard this proof as conclusive; and, even at the meeting of the Academy referred to, a number of the members present expressed their belief that the ulcerations were tubercular. We conclude that the existence of urethral and vesical chancroids, except at or near the meatus urinarius, is not proven. A case of tuberculosis of the urethra, simulating urethral chancre, was published by Emanuel Soloweitschick in the *Archiv für Derm. und Syph.*, vol. ii., p. 1.

Any lesion confined to the lips of the meatus is of course visible to the unassisted eye. For exploration of the fossa navicularis, Toynbee's ear-specula may be used, the uniform calibre of which permits of their introduction for about an inch, and, if the patient be placed in direct sunlight, or reflected light be used, an excellent view of the lining membrane for this distance may be obtained. Any short endoscopic tube will, of course, answer the same purpose. Dr. T. Skeene, of Brooklyn, has recently invented one (Fig. 113) which has some advantages.

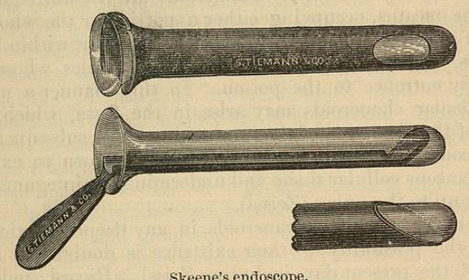
No special treatment, other than that described in the previous chapter, is required. The dressing, with perhaps a thread attached

[1] Bull. Acad. de Méd., 1838, t. ii., p. 506.

to facilitate its withdrawal, should be renewed after each act of micturition. If contact of the urine be painful, this may partially be relieved by holding the penis in a glassful of warm water during the act.

These ulcerations may eat away the lips on either side, finally leaving the urethral opening funnel-form in shape. Still more frequently a stricture at or near the meatus is formed during the process of cicatrization. To prevent this a pledget of lint, or a piece of a

FIG. 113.



Skeene's endoscope.

bougie about an inch long, smeared with some ointment, and retained in place by an appropriate bandage, should be kept in the canal while the sore is healing. Even with this precaution, "slitting the meatus" will often be required subsequently.

CHANCROIDS OF THE FEMALE GENITAL ORGANS.—Upon the external and integumental surface of the labia majora, chancroids often assume the appearance of pustules or abscesses, in consequence of the virus having inoculated the internal surface of one or more of the follicles (follicular chancroids); and there is frequently more or less œdema of the subcutaneous cellular tissue, as evinced by the swelling and hardness of the labia. When the pustule breaks, the underlying ulcer, if exposed to the air, becomes covered with a scab and resembles ecthyma.

Chancroids are also common on other portions of the vulva; on the internal surface of the labia majora, where they occasion pain and difficulty in walking; on the labia minora; and in the neighborhood of the clitoris and meatus. Their base is engorged from the irritation of the urine and vaginal discharges, which likewise renders them difficult of cure. Those situated at the meatus often penetrate the urethra for some distance, giving the orifice an infundibuliform shape, or, by destroying the posterior wall of the canal, throw its opening backwards into the vagina. When attacked by phagedæna, as not unfrequently happens, the loss of tissue may result in great deformity and inconvenience.

Vulvar chancroids are, however, much more common at the fourchette than elsewhere, partly in consequence of its dependent position, where contagious secretions gravitate, and partly owing to the rents and abrasions to which it is exposed in sexual intercourse, and to its being neglected in the ordinary attentions to cleanliness. They have been attributed to inoculation of discharges from the deeper parts of the vagina, and have consequently been regarded as affording a strong probability of the existence of chancroids upon the os uteri. These ulcers often assume the form of fissures, like chancroids of the preputial orifice and of the anus, and for the same reason.

Examination of the vulva and lower part of the vagina is greatly facilitated by passing one finger up the anus and pressing the recto-vaginal wall forwards.

Chancroids often occupy the interspaces between the caruncles, where they may readily be overlooked unless carefully sought for. In the lower portion of the vagina, chancroids are generally irregular in their outline, and often invade the walls of this passage for a certain distance internally, and the vulva externally. Among low prostitutes especially, they may open a communication with the rectum, forming fistulæ which are difficult or impossible to close after the healing of the sore. I am informed by my friend, Dr. Emmet, that the ordinary operation for recto-vaginal fistulæ, when such fistulæ were due to venereal ulcerations, has always failed, even in his skilful hands. As we ascend the vagina, chancroids are less frequently met with. They are least uncommon in the lower third, and are exceedingly rare in the upper two-thirds.

They are often seen on the cervix uteri, but their occurrence even here is a rarity. Among 332 cases of venereal sores of the female genital organs, including both chancroids and true chancres, observed by Klink,[1] eight were situated on the cervix and one on the deeper portion of the vagina. Klink remarks that French authorities regard their existence upon the cervix as much more frequent than do the German; while, on the other hand, the French look upon a chancroid of the upper part of the vagina as an extreme rarity, yet the Germans think it not of such *very* uncommon occurrence. He, although a German, thinks the French are in the right.

It has been observed, as might be expected *a priori*, that in chancres on the cervix, the contagion was often derived from a man having a sore situated on the glans penis, and especially at the meatus.

These ulcers upon the cervix may be single or multiple. They may occupy one or both lips of the os, or involve a large portion of the cervix. They occasion little or no pain. Similar sores are usually present at the vulva. They are commonly accompanied by catarrhal inflammation of the vagina, often by inflammation of the womb. They are prone to take on phagedenic action and destroy a portion or the whole of the cervix; in one case mentioned by Bernutz[2] pelvic

[1] Vrtljschr. f. Dermat., Wien, 1876, p. 542.
[2] Traité des mal. de l'utérus, t. ii, p. 117.

peritonitis was induced. They may extend into the cervical canal, and, according to Desprès,[1] even into the uterine cavity. When seated upon the margin of the os externum, their cicatrization results in a firm stricture of this orifice.

Can a chancroid exist so far within the cervical canal as not to be visible and not to present any evidence of its presence upon vaginal examination with a speculum? It can, if we may credit the following case:

"In March, 1840, a woman from the neighborhood of Arles, aged 22, and remarkably beautiful in form and appearance, was thoroughly examined in the usual manner, by Prof. Lallemand, and no symptom of venereal disease discovered. This examination was made at the request of an officer who complained that she had infected him; and several similar complaints being subsequently made by others, she was sent to the police station, where she was again examined by M. Delmas in the presence of a considerable number of students. The neck of the uterus still appeared healthy, but on pressing it with the speculum, it discharged a muco-purulent fluid, which was inoculated in four places upon the patient's thigh, *with the effect of producing four well-marked chancroids.*"[2]

We shall see hereafter when considering the true chancre, that one of its most prominent symptoms, viz., induration of its base, which is almost always present in men, is often poorly marked or even absent in women. It may hence be inferred that the exact diagnosis of venereal ulcers in women, as to whether they are chancroids or chancres, is frequently difficult or even impossible, unless indicated by the condition of the inguinal ganglia or the occurrence of secondary symptoms at the usual period. This difficulty is increased when the sore is situated upon the cervix, since the normal consistency of this part is so great as readily to mask to the touch any induration, especially of the parchment form, of the base of the ulcer.

The treatment of chancroids of the female genital organs does not differ materially from that already laid down. The application of the speculum to venereal diseases, introduced by Ricord, has rendered these ulcers nearly as accessible as if situated upon the external integument. Almost the only modifications required in the treatment are due to the difficulty of maintaining and changing with sufficient frequency the local dressing, and to the danger in certain regions of resorting to destructive cauterization.

With chancroids about the vulva the stronger caustics may be used with the same freedom and the same benefit as in the male sex. It requires no little care and attention to keep the dressing in such immediate contact with the sore as to be of any service, but this may still be accomplished by means of a T bandage, or by the ingenious contrivance, with regard to which women beyond the age of puberty

[1] Traité iconographique de l'ulcération et des ulcères du col de l'utérus, Paris, 1876.

[2] J. Soc. de méd. prat. de Montpel., 1845; and Gaz. méd. de Paris, 1845, p. 670.

need no instruction. Here, as elsewhere upon the female genital organs, the dressing soon becomes soaked with the natural or abnormal secretion of the parts, and requires more frequent changing than in the male.

With chancroids situated upon the walls of the vagina, destructive cauterization should be used with great caution, for fear of opening communication with the rectum, urethra, or bladder, or in the deeper portion of this passage, of inducing peritonitis. This objection does not apply to chancroids of the cervix, which may be thoroughly cauterized through a speculum. If the patient can be seen often enough, the sore may be isolated and its secretion absorbed by the insertion of a tampon of lint either dry or medicated; but this requires a visit at least once in twenty-four hours, and may, therefore, be impracticable in private practice. The best substitute is the *frequent* use by the patient herself of copious vaginal injections, either disinfectant or astringent, as a solution of carbolic acid, nitrate of silver, alum, tannin, etc.

Chronic Chancroid of Prostitutes.—Among public women, especially those of the lowest class, there is a form of chancroid which is often seen in our public hospitals, and which is entitled to be regarded as a variety of the simple chancre. Examples of it are always to be found in the venereal wards of Charity Hospital, Blackwell's Island. It was first noticed by MM. Boys de Loury and Costilhes,[1] and more recently by Rollet,[2] of Lyons, who speaks of it under the head of phagedæna, and whose description I shall chiefly follow.

"Chronic chancroids may be seated upon any portion of the genital organs, but especially at the posterior commissure of the labia majora. There is also another point where they are very frequent, viz., at the entrance of the vagina, on either side of the urethra, in the furrow external to this canal. These ulcers often acquire a considerable size, less, however, than serpiginous chancroids, whose progress is always more rapid. In most cases, no difference can be recognized between the appearance of a chronic chancroid and a chancroid of the ordinary type; but it is found on inquiry that the ulceration has persisted for an unusually long time, and that it is indolent—a character, however, which must not be regarded as belonging exclusively to this variety, since an acute chancroid, occupying the mucous membrane of the vagina, is often free from pain. Yet we find women with chronic chancroids of the genital organs, either multiple or of large extent, the existence of which they do not even suspect, since they experience no inconvenience from them.

"There is rarely any inflammation, but usually an infiltration of the surrounding tissues. The surface of the ulcer is of a pale color, and often covered with a somewhat firm secretion, beneath which the tissues are also hardened; hence the name given them by M. Sperino

[1] Des ulcérations chroniques, ou chancres chroniques des parties génitales de la femme. Paris, 1845.

[2] Traité des mal. vén., Paris, 1865, p. 186.

of *callous and chronic vulvo-vaginal chancres*. This variety is usually met with in women from thirty to forty years of age, who are debilitated, of a pallid complexion, and exhausted by their excesses."

M. Rollet thinks, with reason, that other affections than chancroids have been included under this name; for instance, that a mere rent in a debilitated subject may terminate in a chronic ulcer under the irritation of filth, contact of the urine and vaginal secretion, and frequent indulgence in sexual intercourse.

The callous condition of the surrounding tissues has appeared to me to be the greatest obstacle in the way of their cure. I have treated them successfully at Charity Hospital, when their situation, as in the furrow between the nates, permitted, by putting the patient under the influence of ether, excising the hardened and hypertrophied masses of tissue, and freely applying the actual cautery to the fresh wound as well as to the surface of the ulcer. But there are other cases at the above-named institution, in which the situation of the sore at the entrance of the vagina does not admit of such heroic treatment, and in which the patients make their appearance from time to time during a period of years, leaving the hospital whenever they are somewhat improved, and returning when their condition is again so aggravated that they cannot carry on their trade. In many such cases, powdering the surface of the ulcer several times a day with iodoform or with the persulphate of iron (Monsel's salt) will be found to have an excellent effect.

Hypertrophy following Chancroids of the Female Genital Organs.—Hypertrophy, especially of the labia majora, is frequently seen in women who have been the subjects of venereal ulcerations, and is regarded by Gosselin (*Arch. gén. de méd.*, Dec., 1854, p. 684) as so exclusively the effect of chancroids, that its presence is sufficient to justify the conclusion that a woman has been thus diseased. We see the same effect in the thickening of the prepuce in the male following sub-preputial chancroids, to which I have already referred.

Chancroids of the Anus and Rectum.—Chancroids of the anus and rectum may occur in either sex from unnatural coitus, but are more frequent in women owing to the facility with which these parts are soiled with the secretion of sores situated upon the vulva. When seated upon the margin of the anus, they may readily be mistaken for fissures. They are best exposed in women by passing a finger into the vagina and pressing the vagino-rectal fold out through the anus. They are attended by much pain, especially during the passage of the fæces, which should always be rendered liquid before going to stool by a mucilaginous injection. It is sometimes advisable after clearing out the bowels, to thoroughly cauterize the sore, and to confine the patient to bed and a low diet, and administer opiates for the purpose of preventing any further stools until cicatrization has taken place.

M. Tardieu[1] calls attention to the fact that in cases of the communication of chancroids (and the same is true of chancres) in unnatural intercourse, the ulcer is usually found upon the same side in both of the guilty parties—upon the right or left side of the penis in the one, and upon the corresponding side of the rectum in the other. This, of course, is the reverse of what holds good in natural coitus, in which a sore upon one side of the penis or vulva is most apt to be inoculated upon the opposite side of the other sex.

Chancroids of the folds of the anus, even when cured—as virulent ulcers—may terminate in fissures, which are still difficult to heal, in consequence of the frequent passage of the fæces, and the spasmodic contraction of the sphincter ani. In such cases the only certain means of relief is to be found in the well-known forcible dilatation or rupture of the sphincter, employed in ordinary cases of fissure of the anus.

Rollet advises repeated cauterization of the fissure with nitrate of silver, and a dressing of the following ointment:

R. Glycerinæ, ℥j	38
Amyli, ℥ss	15
Zinci Oxidi, ʒij	8

This treatment may possibly succeed in mild cases.

Chancroids of the anus and rectum not unfrequently escape observation from the natural reluctance of patients, especially women, to have this part of the body examined; and, indeed, the surgeon himself is often content with an inspection of the external orifice of the alimentary canal, when a digital examination would reveal the presence of a chancroid in the rectum. Chancroids in this situation often take on phagedenic action and open a communication with the vagina.[2]

[1] Étude médico-légale sur les attentats aux mœurs, 1867, p. 206.

[2] Des chancres phagédéniques du rectum, par le Dr. A. Després, Arch. gén. de méd., mars, 1863.