℞. Potass. iodid.,
Aquæ, āā q. s.

Commencing at five drops, largely diluted, after eating, go on until the symptoms yield, or the remedy disagrees.

*Quantity of Iodide which may be required.*—There is practically no limit to the proper dose of the iodide of potassium, except an improvement of the symptoms. A taste may produce iodism in some cases, in others the symptoms fail to yield until enormous doses have been reached. An old patient, whose mouth, fauces, and nose, formed one vast, ulcerated cavity, a hospital case, who was accustomed to enter the Charity Hospital, stay till he was nearly well, and then leave until the progress of his disease forced him back—this man took daily for eleven days, having been rapidly run up to this amount, two ounces (nine hundred and sixty grains) in the twenty-four hours. He developed only a few scattered pustules of acne, but, after eleven days, when the destructive disease in the throat had been stayed, the stomach began to suffer, and the dose was decreased. His throat went on improving under the diminished dose. It is not uncommon to see patients, with open, advancing ulceration, who have been taking perhaps twenty-grain doses of iodide of potassium for weeks without benefit, in whom another five or ten grains added to the dose clears the ulcer, arrests its progress, and induces rapid cicatrization. Hence the rule: in all cases where the diagnosis is certain, of a late, tertiary, syphilitic symptom requiring iodide of potassium, continue increasing the dose until the symptom yields, or the patient will bear no more. The advantage of hygiene in connection with the administration of the iodides is illustrated by Case L.

### DURATION OF TREATMENT.

Treatment of syphilis, according to the experience of the authors, should last at the very least two years—one year with mercurials, one year with mixed treatment—and this in cases which show only the mild lesions of glandular engorgement, a few papules or roseolar patches, mucous and scaly patches in the mouth, and sore-throat. To this class belong nearly all cases treated steadily and conscientiously, continuously from the first. It is the rare exception to find such patients showing bad symptoms during their treatment, or developing serious lesions afterward. In other words, those cases do badly most often which are irregularly and spasmodically treated, and those cases are most apt to be prolonged and obstinate, and indeed to crop out in severe lesions at late date after chancre, which have not followed a continuous, persistent, prolonged, mild mercurial course at the start.

Hence there are two classes of cases to be discussed:

1. The patient who comes with syphilitic chancre.
2. The patient who comes with a late, obstinate form of disease, after perhaps years of apparent health.



1. *The patient who comes with chancre* should be gently urged with a suitable mercurial, until his "dose" is found. His "course" should now be based upon a dose a little lower than this, which should be continued steadily, until some reason to change appears. Should an eruption crop out, the remedy is changed and slightly pushed and maintained steadily, inunction being added, until the eruption has disappeared. Tonic and hygienic measures are observed throughout. In bad cases, with frequent outcrops, this mercurial course may be prolonged eighteen months, twelve may be sufficient. Where tertiary symptoms appear early, the iodide of potassium must be added to the mercurial.

After this, mixed treatment is commenced, and is to be continued one year, eighteen months, or more, until at least six months have passed after the appearance of any symptom due to syphilis. Then the patient should be put for a while upon a tonic, and finally allowed to give up treatment.

This is the treatment by extinction, and although it is impossible to say of any given patient that he will never have a relapse after having faithfully followed it, still it is so rare as to be almost phenomenal, when a case so treated develops any very serious lesions due to syphilis, later on in life. What symptoms do appear, if any, generally yield promptly to the mixed treatment, while it is rare for extensive, pure, gummy lesions to develop.

2. *Where the patient first comes for treatment with serious or obstinate disease which has come on at a late period after chancre*, there will be found to blame, either: 1. The gouty constitution. 2. The scrofulous diathesis. 3. Intemperance, excess, or misery—in short, bad hygiene; or, 4. A short mercurial treatment, at first, perhaps, carried to salivation, which, in the treatment by extinction, is always to be avoided.

The proper course to pursue with such a case is to adopt a treatment suited to the lesion, mixed or iodide alone, and to use it, aided by hygiene, until the lesion has disappeared, then to commence a course of mixed treatment, and continue it mildly for a year or more, watching for relapse; finally, to terminate with a mild, pure mercurial course, extending over six months or a year at least. This seems to be the most beneficial course, but in old, obstinate cases it will not always prevent subsequent outbreaks. In such cases the main reliance is in tonics, hygiene, and the symptomatic treatment of the outbreaks. It must be remembered that mercury has power, more or less marked, over all shades and dates of syphilis. It is useful in the tertiary stage, although undoubtedly not so useful as in the secondary.

# CHAPTER VI.

## *SYPHILIS OF SKIN AND MUCOUS MEMBRANES.*

Syphilides, Secondary and Tertiary.—The Secondary Syphilides.—Concomitant Symptoms on Mucous Membranes.

THE SYPHILIDES are those manifestations of general syphilis found upon the cutaneous envelope. There are two groups, the secondary and the tertiary.

Those occurring in secondary syphilis are:

| | |
|---|---|
| 1. Roseola; | 5. Bullous syphilide; |
| 2. Papular syphilide; | 6. Vesicular syphilide; |
| 3. General pustular syphilide; | 7. Squamous syphilide; |
| 4. Pigmentary syphilide; | 8. Tubercular syphilide. |

With these occur on the mucous membranes:

| | |
|---|---|
| 1. Erythematous patches; | 3. Mucous patches; |
| 2. Ulcers; | 4. Scaly patches. |

These are all general eruptions, except the pigmentary and scaly syphilides, and they belong to the group called secondary, about in the order in which they are given. Thus the roseola and papular syphilide always appear early; the tubercular and scaly syphilide always late. The former require mercury alone for their removal; the latter demand a mixed treatment, a combination of the iodide of potassium with mercury, to insure the most prompt and effective action.

The syphilides which belong to the tertiary stage of the disease are:

| | |
|---|---|
| 1. Ecthyma; | 4. Tertiary ulcerations; |
| 2. Rupia; | 5. Gummy tumor. |
| 3. Groups of pustules; | |

With these occur on the mucous membranes:

| | |
|---|---|
| 1. Mucous patches; | 3. Deep chronic ulcers; |
| 2. Scaly patches; | 4. Destructive gummy ulcerations. |

These (tertiary) affections, it will be noticed, are none of them generalized. They all occur in patches. They will be considered later. The concomitant symptoms of the group are affections of the bones, of the larynx, of the internal organs, and nervous syphilis.

### SECONDARY SYPHILIDES.

1. ROSEOLA.—This is an erythema, or simple redness, occurring in small, flat patches or blotches of irregularly crescentic or circular form and slightly indented margins, each blotch varying from the size of a split-pea to that of a copper penny. Occasionally the blotches become confluent. Instead of being flat, the patches of eruptions may be raised above the level of the surrounding skin by the presence of minute papillæ upon the reddened area. The patches of roseola resemble exactly what would be an exaggeration of the mottling (marbling) of the integument, which any fair-skinned individual may observe faintly upon his own person by exposing the abdomen to cold air for a few moments. This erythema is the lesion proper, but, following the rule of polymorphism in syphilitic eruptions, it is customary to find other lesions besides the erythema, such as pustules leaving scabs in the hair, and pustules and papules elsewhere, scattered through the eruption, especially about the head and face. The patches of erythema at first disappear entirely upon pressure; but, where the eruption has been intense or of long duration, a faint, tawny, yellowish-brown stain is left after pressure (pigmentation), which indeed outlasts the eruption and is removed only by time. A small amount of fine desquamation attends the disappearance of the eruption in well-marked cases.



This exanthem is usually the first to appear after chancre, generally at about six weeks, sometimes three weeks, occasionally after several months, but rarely after the fourth. Its advent usually coincides with the secondary engorgement of the lymphatic glands. It often comes on slowly, and may never be observed by the patient until his attention is attracted to it by his physician, or it may be called out rapidly by the heat of a bath, by a cold, or other exciting cause. If the patient have had no syphilitic fever, he is less likely to have noticed the eruption. When it comes on slowly, the chest and flanks are first invaded, and an inspection of these surfaces with the light shining obliquely across them will reveal sometimes the beginnings of a roseola, as yet invisible to casual inspection. In rapid cases twenty-four hours are sufficient to cover the whole body with the eruption, including even a few blotches on the palms and soles. In perhaps the majority of cases the eruption is confined to those portions of the skin covered by clothing, the hands and face escaping, or being so faintly marked as not to attract attention.

When roseola comes on early, it lasts from one to six weeks; when, however, it first appears some months after chancre, it usually lasts several months. Treatment greatly influences its duration. Relapse occasionally occurs.

*Diagnosis.*—Patients with syphilophobia are apt to mistake the natural marbling of the skin produced by cold for syphilitic roseola. Heat causes this marbling to disappear. Non-specific roseola is attended by some positive febrile symptoms, often by nausea, disappearing when the eruption comes out. The latter runs a rapid course. It is more frankly inflammatory than the syphilitic roseola, and occurs chiefly in

children. Copaibal roseola is frankly inflammatory, usually itches, sometimes excessively. The history shows the ingestion of copaiba (of which the urine smells), and abstinence from the balsam effects a speedy cure. Urticaria occurs in raised patches, and itches greatly. The concomitant symptoms distinguish measles. The non-inflammatory character of syphilitic roseola, its lack of itching, and the accompanying indolent engorgement of the lymphatic glands, render its diagnosis easy. When itching is complained of with syphilitic roseola, pediculi, urticaria, or some accidental eruptions are to be suspected. (*See* Case XLIX.)

General treatment alone is required.

2. Papular Syphilide.—This eruption may follow a roseola, or a roseola may be transformed into a papular eruption, or the latter may be the first eruptive outbreak observed after chancre. The papules constituting the initial lesion may be miliary in form (like those seen on the spots of roseola), in which case they are often early surmounted by a minute vesicle. The papule is often larger, but acuminated, or it may be broad and flattened (this is a common form), about the size and shape of a split-pea (lenticular); or, finally, this last form of papule is sometimes greatly exaggerated, reaching the size of a penny. The type varieties, then, of papule in the earlier general papular syphilide are two, the acuminated and the flat. The general characteristics of the eruption are the same in each. The papular syphilide is superficial and precocious.

The color at first is rosy, but soon darkens to the purplish hue of syphilis. Pressure removes the color at first, but later some pigmentation occurs, and then pressure is no longer effective. This final tawny coloration often outlasts all prominence of the papule. Desquamation sets in early. Fine scales become detached, especially around the base of each papule, forming a sort of little ruffled border of white. Biett considered this circular desquamation of the base of the papule of great diagnostic value. It occurs, however, occasionally, in the case of large non-syphilitic papules. Sometimes the desquamation is so considerable over closely-grouped broad papules, that a diagnosis with squamous syphilide becomes difficult. One form of papular syphilide is peculiar: Broad flat papules appear, scattered irregularly, especially seen about the face, forehead, and neck, and on the scalp. Each papule is covered by a thin, yellowish, superficial scale, like a scab, raised at the borders, and distinctly depressed centrally. The raised edge is sometimes distended by a slight amount of serum, the whole looking like a flattened, partly-desiccated bulla. Sometimes each lesion is surrounded by a reddened (livid) areola. Shortly the large superficial scale becomes detached, the papule pales, flattens, disappears, and leaves no scar.

The papular syphilide, though general, is usually most marked at the back of the neck, on the forehead, back, and flanks. There is no pain or itching with this eruption. Scabs in the hair are likely to



coincide with it, and the indolent, engorged, post-cervical and epitrochlear ganglions are rarely absent. The eruption may come before the third week from chancre, or after the fourth month. Its duration is from three to eight weeks, it may be prolonged for months by the recurrence of successive crops of papules.

*Diagnosis.*—A papular syphilide is liable to be confounded with two eruptions only. (1.) When the acuminated papules are few, and scattered about the temples, and over the forehead, they greatly resemble a form of acne seen in middle age upon rheumatic subjects. The syphilitic eruption may be usually distinguished by a certain amount of pigmentation around the older papules, a feature not observed in acne. (2.) The flat papules, few in number, livid in color, and attended by no itching, situated over the backs of the hands, wrists, forearms, and sometimes extensively over the body, and constituting one of the forms of lichen planus seen on rheumatic subjects, are very liable to be mistaken for syphilitic lesions. The patches, however, are more irregular in shape and size, and often present a slight umbilication (without desquamation) at some period of their course, which, together with the history and lack of concomitant phenomena, serves to distinguish this affection from a syphilide. With the papular syphilide are apt to coexist scabs in the hair, engorged ganglia, perhaps patches of erythema and pustules occasionally, and pretty certainly mucous patches, erythema or ulceration of some mucous membrane, especially that of the fauces. Small, circular reddened spots on the palms and soles are also a very constant accompaniment of a generalized papular syphilide. These are attempts at papulation aborted by the thickened epithelium. They appear as circular depressions, reddened centrally and partly deprived of epithelium, which latter is undermined at the edge of each depression as a whitened, fringed circle. Several of them may usually be found on each palm. An exactly similar condition is sometimes seen on the palm after an attack of lichen urticatus of the extremities. The severe itching attending the latter eruption insures against error of diagnosis. This affection of the palms is sometimes described as syphilitic psoriasis. It is more justly an aborted papular syphilide, or results from previous small patches of erythema. It may be found when there is no other syphilitic eruption upon the surface. Its appearance is characteristic, almost pathognomonic of syphilis. Iritis sometimes accompanies a severe outbreak of syphilitic papules.

*Treatment.*—A general papular eruption requires only general treatment. When the papules are conspicuous upon the face or hands, their disappearance may often be greatly hastened by local applications. Any mercurial ointment is useful, rubbed into the papules. Ungt. hydrarg., red oxide of mercury ointment, and dilute citrine-ointment (ʒ j–ij to the ℥ j), are all efficacious, but the most prompt results are obtained from one of the following:

| | | |
|---|---|---|
| ℞. | Hydrarg. ammoniat., | ʒ ss.–ʒ j. |
| M. | Cerat. benzoat., | ℥ j. |

Or—

| | | |
|---|---|---|
| ℞. | Hydrarg. oxid. flav., | gr. xx to ʒ j. |
| M. | Cerat. benzoat., | ℥ j. |

and perhaps best of all the five-per-cent. oleate of mercury applied nightly. The white ointment, on account of its color, may be used for the face, the yellow for the palms—the oleate for either.

These local mercurial applications are useful in all the dry syphilides, and (mitigated) in the ulcerated forms of disease as well.

3. General Pustular Syphilide.—There are three varieties of generalized pustular syphilide belonging to secondary syphilis:

(*a.*) Superficial pustules complicating other lesions.
(*b.*) General syphilitic acne.
(*c.*) Superficial ecthyma.

(*a.*) *Superficial Pustular Syphilide.*—With a roseola, or papular syphilide, or occurring alone, there may be some superficial pustules scattered on the scalp, or along the forehead, or about the upper lip, at the base of the nose, at the labial commissures, or, indifferently, over any part of the body, more or less thickly. The pustules are small, superficial, ephemeral, without any hardened or elevated base; they often run together and dry up, forming scabs—brown, rough, uneven—like those seen in impetigo. The patches always tend toward a circular arrangement. Instead of drying up under the scabs, slight ulceration may take place, with, not infrequently, vegetation of the surface by the excessive growth of granular tissue. This feature is especially noticeable at the angles of the lips, or around the base of the alæ of the nose. Indeed, any moist, ulcerated surface may granulate, the feature being an epi-phenomenon, and not essentially a characteristic of syphilis. Occasionally, in syphilis about the labio-nasal furrows, the lips, and chin, minute, dry, irregular, papular prominences occur in rows and segments of circles where there has been no previous moist surface. These warty excrescences rarely get larger than the head of a pin; they are of a dead gray color, sometimes pigmented. They last several weeks, then dry up and disappear without leaving any cicatrix. Hardy has described the eruption as "syphilide granuleuse."

There is nothing about the slight pustular eruption above described characteristic of syphilis, except the pigmentation of the skin in the brown areola which forms about the scabs, and the tawny, vinous-red color of the skin left after the fall of the latter. A very faint, central depression marks the spot of the pustule, and from this central depression the clearing up of the pigmentation begins, progressing centrifugally. The eruption may relapse, several crops appearing successively, especially on the scalp.

(*b.*) *General Syphilitic Acne.*—This eruption occurs scattered over the scalp, face, and the extremities, the lower rather than the upper, or it may cover the whole body. Each pustule is distinct, and out of most of them grows a hair. They are not prominent, usually small, often but little larger than a grain of millet, occasionally quite large. Each separate pustule rests on a reddened base, which itself never suppurates, the pustule being superficial. Each pustule grows slowly, taking from two to three weeks to develop and break, and then the fluid hardens into a dry scab. The hard base of the pustule has meantime been getting brown, and becoming surrounded by a copper-colored areola. When the scab falls, the elevation constituting the base of the original pustule remains as a papule, with a faint central depression. This papule becomes gradually absorbed, leaving a purplish, pigmented discoloration, which is very slow to disappear. Sometimes a slight, superficial ulceration remains. This is followed by a minute, round, white, depressed cicatrix, very different from the puckered scar of ordinary acne.



General syphilitic acne rarely appears before six months after chancre, being later than the superficial pustular syphilide, and earlier than the superficial ecthyma. It may appear very early, indeed as the first eruption, but it is believed to indicate a bad form of syphilis, especially if accompanied by iritis.

Syphilitic acne lasts ordinarily about two months, but this limit may be greatly prolonged by successive crops of eruptions.

*Diagnosis.*—The coppery areola distinguishes syphilitic acne from other varieties, but where the eruption appears late, and is confined to the forehead, temples, and face, it is sometimes hard to distinguish it from the simple acne occurring late in life on gouty subjects.

(*c.*) *Superficial Ecthyma.*—This eruption is constituted by reddened patches upon which pustules develop. The latter may be umbilicated, much resembling variolous pustules. The pustules vary in size from that of a pea to (occasionally) nearly an inch in diameter. They are round, either scattered or collected into groups, in which latter case they may run together (confluent). The pus is thick, often bloody, and there is a dark-red areola (afterward coppery) around each pustule. The pustules do not repose on a hardened base. The crust is rough, dark brown, with a greenish shade, and underneath it there is ulceration. The latter heals under the scab, leaving a slight cicatrix (often pitted, like the scar of vaccinia), which for many months retains its purple, coppery color, gradually whitening from the centre.

Syphilitic superficial ecthyma is found anywhere on the body, often on the scalp. It occurs in bad cases of syphilis, especially where cachexia comes on early. It rarely appears before about the close of a year from chancre, and may be delayed a couple of years or more. On the other hand, it occasionally comes on as the first eruption, within some weeks after chancre, accompanied by early cachexia, not yielding readily to treatment, and often followed by extensive ulcerations.

*Diagnosis.*—When febrile symptoms accompany the outbreak of syphilitic ecthyma, as they sometimes do, and the pustules are umbilicated, the disease is not uncommonly mistaken for variola—an error to be avoided by a study of the history of the case, the course of the eruption, and the absence of other symptoms of variola. Cachectic ecthyma may be confounded with the syphilitic. The former appears in children and the aged, chiefly on the legs, is more purulent, more inflammatory, less or not at all pigmented, and has no accompanying history of syphilis.

The superficial ecthyma of secondary syphilis differs from the so-called ecthyma of tertiary syphilis, in that the latter has an elevated, hard, empurpled base, ulcerates deeply, leaves a considerable, depressed scar (not pitted); is, in short, a gummy infiltration of the skin, ulcerating superficially. All the pustular syphilides have the common characters of lack of pain and itching, and the presence of the areola, first of vinous-red, then of copper-color, from the pigment.

*Treatment* is general. Locally very mild mercurial applications are serviceable.

4. Pigmentary Syphilide.—This syphilide has been described by Hardy.[1] It appears between the fourth and twelfth month. It consists of a coffee-colored pigmentation of the skin, without elevation of the surface and without desquamation. The size of the spots varies from that of a silver five-cent piece to a quarter of a dollar. The borders of each spot are irregular, many of the patches run into each other. The intervening skin seems whiter than normal.

This eruption occurs chiefly at the sides of the neck, perhaps extending down over the breast. It may be found elsewhere. Lymphatic patients, with white, fine skin, chiefly women, are subject to it.

*Diagnosis.*—In pityriasis versicolcr there are desquamation, itching, and the parasite constituting the affection may be readily demonstrated by the microscope. Freckles are smaller and more generally distributed, never confined to the neck.

*Remarks.*—This eruption is sometimes, possibly always, simply a pigmentation left behind by a roseola. It is often very faint, so that it can only be seen by viewing the neck sidewise with the light shining across it. It is found in some patients who deny any previous eruption upon the site occupied by the pigmentation. It may last one or two months or indefinitely, and is entirely uninfluenced by treatment. It is rarely detected by the patient, and is of little importance, except as an additional means of diagnosis in obscure cases, since it only occurs on syphilitic patients.

5. Bullous Syphilide.—A syphilitic pemphigus upon adults has been observed in a few cases (Bassereau, Zeissl) occurring among the secondary symptoms, confined to the palms, soles, backs of the fingers,

[1] "Leçons sur la Scrofule et les Scrofulides et sur la Syphilis et les Syphilides," Paris, 1864, p. 175.



and bends of the elbows, and relievable by mercurials internally. This eruption, so common in inherited syphilis, is of the utmost rarity in adults.

6. Vesicular Syphilide.—This is a rare form of syphilitic eruption. There are three varieties:

(*a.*) Varicelloid syphilide;
(*b.*) Syphilitic eczema;
(*c.*) Syphilitic herpes.

(*a.*) *Varicelloid Syphilide.*—This form comes early if at all, before the sixth month after chancre. Small, red, perhaps slightly elevated spots appear as large as a pea. Upon these arise one or more pointed, round, or umbilicated vesicles, surrounded at their base by a dark-red areola afterward becoming brown. The contents of the vesicles quickly become purulent and dry up into a greenish-brown, adherent crust. This scab falls in about a fortnight, leaving a purplish discoloration, which slowly disappears. There are usually but few spots of eruption, scattered over the face, limbs, and body. Successive crops of vesicles may prolong the eruption for several months, and ordinarily some other early syphilide coexists with it.

*Diagnosis.*—When there is considerable syphilitic fever, there is danger of confounding this eruption with varioloid. This may be avoided by observing the color of the patches, the areola around them, the course of the affection, and concomitant symptoms.

(*b.*) *Syphilitic Eczema.*—This is a vesicular eruption, not very common, appearing chiefly on the trunk and extremities, rarely on the face. The vesicles are small and acuminated, scattered or united into patches. When scattered, each vesicle is surrounded by the characteristic areola; when in groups, the surface from which they spring is of a vinous-red, which coloration extends slightly beyond the border of the patch. The vesicles behave in two different manners. After remaining a while translucent, they may dry up, the liquid being reabsorbed; slight desquamation follows, the brown areola pales and no scar is left: or the vesicles become purulent, break, and little darkish scabs form (isolated and not confluent as in eczema); the scabs separate slowly and the brown stain disappears, leaving no scar. The eruption, in itself slow, is made more chronic by relapse.

*Diagnosis.*—In ordinary eczema the vesicles are small, ephemeral, and break quickly, leaving an oozing surface or a confluent scab. The eruption itches, and there is no coppery areola.

(*c.*) *Syphilitic Herpes.*—The patches of syphilitic herpes are situated on a base of specific color. The vesicles are of different sizes, from a grain of millet to a pea. They are arranged in irregular groups or describe circles or segments of circles. The vesicles last about a week, are succeeded by little scabs or by a fine desquamation. After these disappear, the color pales and no scar is left. Successive crops of eruption are the rule.