LESSON XIV.

Clinical case—Initial Lesion on the lip—Simulating Epithelioma; also the mucous patch—Dark color of papular eruption on a quadroon—Roseola passing off in 48 hours—Malposition of Epitrochlean Gland—Ease with which enlarged glands sometimes escape discovery—Subsequent papular eruption—Occurrence of Iritis due to same cell accumulation as produces the papule—Treatment for all lesions in the active stage of Syphilis the same—New troubles not an evidence of relapse, but incidents *en route*—Treatment of Iritis—Persistence of the papular eruption Characteristics—Recurrence after disappearance, and in same spots formerly occupied—Continued recurrences—Significance of this—Question of marriage a difficult one in such cases—State of papular eruptions significant of changes previously effected in the skin where papules occupy spots of previous eruption, and suggestive of *non-contagious* stage.

CASE VII. *Initial lesion. Mucoid form, simulating a mucous patch. Large papulo-pustular eruption. Iritis—Acquired from woman with mucous patches and a miliary papular eruption.* A. W., chemist, 38, presented December, 1878, for an opinion as to the nature of a small superficial ulcer just inside the lower lip, near the right labial commisure. Patient had suffered occasionally with "cold sores" about the lips, and thought the trouble of that nature, until a medical friend suggested that it might be a commencing epithelial cancer, the result of excessive smoking, and ought to be shown to a surgeon. Two surgeons had examined the sore, one of whom was confident that it was an epithelioma; the other thought it doubtful, and suggested syphilis, and advised him to get another opinion. The lesion was nearly circular, and about as large as would be covered by the top of an ordinary lead pencil; its surface was slightly elevated, florid, granular, and covered with a grayish pellicle. The tissues on which it was situated were quite hard to the touch, for perhaps a quarter of an inch surrounding. But for this induration it could not have been distinguished from a typical mucous patch. Two slightly

enlarged lymphatic glands lying over the parotid were found; none at any other point. The patient denied ever having had syphilis, or any sexual connection for more than a year, but admitted kissing a female domestic in his family on several occasions. No other evidence of trouble was found. After much argument the gentleman at last consented to send the domestic for examination. She proved to be a very handsome quadroon, very simple, and evidently unaware of having any venereal disease. She admitted that she had had some sore-throat and a profuse leucorrhœa, but denied ever having had sexual intercourse; denied also having had any sores of any sort, except an occasional "canker" in the mouth. Examination revealed an extensive superficial irregular ulceration of the soft palate, bordered with the diphtheric deposit characteristic of the *syphilitic mucous patch*. She had also well-marked gland enlargements in all the usual localities, and a miliary papular eruption over the body. The papules were about the size of a large pin's head, in groups of 6 to 8 or 10, an inch or more apart, and appeared on the light coppery skin of the quadroon as of a deep purple color. At first claiming that she had always had these dark points, she finally confessed that they had appeared only two or three months previous, and also that she had had a single illicit connection some months before, but stoutly denied all knowledge of having had any local disease.

With this positive knowledge of syphilis and the strong circumstantial evidence which it afforded, there was but little room to doubt that the suspected epithelioma of the lip was an initial lesion of syphilis, acquired through contact with a mucous patch; the secretion of which, as well as all the secretions throughout the active stages of syphilis, being well known to possess the contagious property equally with the open initial lesion of syphilis.

Mr. W. was satisfied to commence a systematic mercurial course, as advised. Pil. duplex (hyd. mass. 2 grs.; ferri exsic 1 gr.) was taken steadily for about a month, at the rate of three per day, without any trouble of any

sort, except slight tendency to fluid passages from the bowels, which was readily corrected by a little paregoric. Having been instructed to watch carefully for any eruption, he called within a few days, with a slight mottling of the skin on back and abdomen, so indistinct, however, it was quite uncertain whether this was anything more than the natural spottiness which is not uncommon in cool weather. Gland enlargements in the cervical region were now distinctly made out; none in the inguinal or epitrochlean.

On the following day, by careful inspection, looking across the back, and also the abdomen, against a strong light, a pale eruption, slightly elevated in places, made it quite certain that it was the roseola, initiating the constitutional stage of syphilis. It passed off completely, however, very soon, for 48 hours afterwards it could not be certainly detected at any point.

It is worthy of note here, that another careful examination for an enlarged epitrochlean gland resulted in its discovery fully the size of a marrowfat pea, and situated *at least three inches above the epitrochlean space*, between the borders of the biceps and triceps muscles. The knowledge that such malposition is not very uncommon, and that quite large glands, having sometimes very loose attachments, will slip under the borders of muscle or fasciæ in such a way as to elude any but the most careful and persistent search, may occasionally be serviceable.

During the next few weeks nothing noteworthy, except congestion of the faucial mucous membrane, which at times was quite swollen and sensitive, but temporarily relieved by chlorate of potash gargle, and occasional spraying with a 40-gr. solution of argent. nit. Finally, two or three small superficial ulcers occurred on the tonsils, and at about the same time some redness and pain in the left eye, which had been quite weak for a day or two. Examination showed some conjunctivitis, the iris slightly discolored and duller than the opposite, and on closing and opening the lids quickly, with aid of a thumb on either eye, it was seen that the iris of the left eye was nearly immovable; and, as

if it were not sufficient to have discovered this well-marked example of a mild type of syphilitic iritis, it was also found that a scanty eruption of papules, some as large as silver three-cent piece, had developed on the back, arms and legs; not the least irritation announced their presence; they were rosy in color, slightly elevated, and quite insensitive to touch. The patient was very despondent from this combination of ills until assured that the trouble with the throat, the eye, and the integument, were simply evidences of the same papular eruption, modified by locality; an accumulation of cells which had caused a disturbance by their presence, chiefly mechanical, and which, with the aid of the treatment, would, in all probability, pass off in a short time without leaving any permanent trace. That they were not evidences that the treatment thus far pursued was unsuitable or inefficient; but that, in the necessity of avoiding damage to healthy structures, the process of destroying and eliminating this imperfect cell material, accumulated in the mucous membrane of the throat, in the iris, and in the skin, was a comparatively slow but a sure one. That nothing else was necessary but to go steadily on with the mercurial, in just that amount and frequency as could be borne without damage to the sound material and tissues in which they were imbedded. That these new troubles were not the evidence of a relapse or coming anew under the syphilitic influence, as manifested in the apparently arrested and transient roseola. They were simply *incidents*, adverse currents, or shoals, if you will, on the onward voyage towards recovery; that while many made this voyage with scarcely a ripple of discomfort from beginning to end, others met with varying obstructions and delays; but all eventually passed through, and few comparatively, if well guided to its termination, found themselves much the worse for the experience. The distillation of a couple of drops of a solution of atropine (2 grains to the ounce of distilled water) into the affected eye, had the almost immediate effect of demonstrating that slight adhesions of the iris to the anterior capsule of the lens had taken place,

irregularity in border of the iris becoming visible. This, however, soon gave way under a few repetitions of the atropine, at intervals of three or four hours, which also relieved the pain. The attack proved a very slight one, for no other treatment became necessary; and after continuing the dilatation by atropine for a couple of weeks, and simply avoiding a strong light, all evidences of the trouble had disappeared. The initial lesion and the induration, never extensive, had quite disappeared. The papular eruption remained, and although the mercurial was well borne, and an occasional sense of tenderness of the gums announced the limit of endurance of the remedy. At the end of another month it had not entirely lost its salience, although it had quite lost its reddish color and assumed a deep coppery hue. Occasional papules showed an exfoliation of the epidermis at their base, which condition, resulting from the interference with nutrition through the cell accumulation causing the papule, constitutes a valuable point in diagnosis. With a steady continuance of the treatment, however, the spots gradually disappeared, having continued (from the date of their appearance until they could no longer be detected) fully three months. Nothing then occurred to interrupt the favorable course of the trouble in this case—throat trouble having gradually faded out: the gland enlargements almost gone. After nearly a year, however, the treatment in the period having been faithfully pursued as initiated, small scaling papules appeared. These were flat, slightly thickened spots, rather than papules, about the size of a lead pencil top, with their silvery border of epidermal scales, when discovered, and, had it not been for previous history, could not have been distinguished from spots of simple psoriasis. There had been on each hand only a very few spots of the original papular eruption, say five or six, and had caused the chief discomfort of the patient at one time, as they constituted the only evidence of syphilis to a casual observer. On this account they had received quite a little local treatment by mild mercurial unguents, and with apparent success, as they passed off at least a month before those on the body. The

statement (which the patient made quite confidently) that these spots had returned *in the exact places occupied by the former eruption* was noted. Similar carefully-observed cases which had been met, where a return of such an eruption over three years (in one instance) after the original papular eruption, and in the same places, seemed to indicate that the later eruption might belong rather to the sequelæ of syphilis than to the evidences of the active contagious disease. And the treatment was changed from the simple mercurial to the combination of mercury, with the iodid. of potass. (Mist. biniodid. hydrarg., see page 259.) A few weeks of this treatment, added to ung. hydrarg. nit. and vaseline, equal parts, locally, caused entire disappearance of this, and after three months further treatment with the misturæ biniodid. (℥ three times a day), it was suspended from accidental causes for nearly a month, when the spots returned, and apparently *on the exact sites of the former spots*. Treatment resumed, with the addition of a fumigation thrice weekly, thirty grains of resublimed calomel, (this preparation, on account of its less irritant property, being preferred), and moderate inspiration of the vapor advised, if it could be borne without producing cough.

Again, within a few weeks, the spots disappeared, and, as the gums became slightly tender, the fumigation was omitted, continuing the "Misturæ Biniodid." alone. The patient then went on living very regularly, and taking his medicine as ordered, and with scrupulous care, as he was under engagement of marriage formed just previous to his inoculation, and desirous of hastening his recovery in every possible way. After six months of this treatment, in order to test his condition, he omitted his medicines and the spots returned in less than a fortnight. This was the only evidence of the syphilitic diathesis now remaining, for the throat had long since ceased to show any unusual engorgement, and the glands in all localities, while still distinguishable, were no longer characteristic. Another six months, making fully two years from the date of his inoculation, and the patient presented very worried, stating that while he

was quite well in every other respect, and had no trouble of any sort when he took his medicine, as soon as he left off treatment, the scaly spots would return on his hands, and *always in the same places*. He was very anxious for some definite time to be set when it would be safe for him to marry. It became necessary to advise this patient that, in the present state of knowledge in regard to such a relapsing eruption following syphilis, it was uncertain whether or not any contagious element was still associated with it; that the active stage of syphilis was one of steady progression, while the sequelæ were prone to relapses. That the repeated recurrence of the scaling spots on the same sites were significant rather of organic change in the vessels of nutrition in the affected integument than of an infecting material free in the blood; but inasmuch as there was not sufficient available experience to decide this point positively it would be necessary for him to postpone his marriage indefinitely, and go on with his treatment until the cessation of it, as tested from time to time, was not followed by a recurrence of the trouble. Then, according to best authorities, he should wait a full year, which, if passed without evidence of syphilitic trouble, he might venture to consider himself well, and marry. This patient is now two and one-half years from the date of inoculation, and has passed nearly three months without treatment or any return of trouble.

Remarks.—The occurrence of the syphilitic initial lesion on the lip is not very rare. In the foregoing case the contagion was undoubtedly direct, but this is the point, more than any other, where the initial lesion may be looked for as a result of mediate contagion, viz., contact as of the lips with any articles which have been in use by persons who have mucous patches on the lips or in the mouth or fauces. Hence, when syphilis is suspected, and the site of the initial lesion in doubt, this region should be examined with great care. The presence of enlarged lymphatic glands in the vicinity is of great value in clearing up a diagnosis, for *these are rarely, if ever, absent* in syphilis beyond the third or fourth week after inoculation, and may often be found at a much

earlier period. (For explanation of manner in which mucoid form of initial lesion is formed see page 108.)

Various modifications of the papular eruption of syphilis will be met, no two cases presenting exactly the same arrangement, locality, or degree of development. The miliary variety where the papules are about the size of a pin's head, sharply acuminated, and often into a little serous accumulation or a scale at the summit, and thickly and irregularly distributed, or in groups (like that described in the female associated in the foregoing case), or arranged in circles or figures of 8. Again, the papules may be large and flat in groups, or thickly and generally distributed, or sparsely (as in the above case of A. W.), but to a certain extent always symmetrical on either side of the median line of the body—a fact which characterizes the early papular eruption as contra-distinguished from that sometimes occurring in groups and unsymmetrically at a later period, as towards the end of the first year of infection, or subsequently. Papules may be associated with pustules; may all be more or less pustular; may even begin apparently as pustules; and thus a great variety of eruptions of a papular or papulo-pustular character may be met in the early period, say from the third to the sixth month after infection. The presence of such eruptions, whether we designate them after authorities by the size or shape of the papules, or according to their real or supposed resemblance to simple diseases of the skin, as the lichenoid, the lenticular, the scaling papular (syph. psoriasis), the annular (syph. lepra), or the acneiform, the variola form, the impetigo form, or the ecthyma form, we must nevertheless bear constantly in mind the fact that one and all, if of syphilitic origin, are the result of the localized accumulation of cell material, hastily generated through the syphilitic influence; taking the different forms through constitutional idiosyncrasies or dyscrasias, and, according to the late microscopic researches of Kohn, Auspitz, Virchow, Neuman, Baumler, always beginning in a papillæ cutis,* and that

* See Otis on "Physiology, Pathology, and Treatment of Syphilis:" Putnams, 1881, p. 33.

the treatment for all is the same, varied in degree only, to suit the constitutional peculiarities of each case. It is also proper to state that no eruption can be pronounced syphilitic from its *appearance* alone, but that, in order to warrant such opinion, gland enlargements must also be present more or less pronounced in the various localities where the superficial lymphatic glands are located, as in the cervical, inguinal, and epitrochlear regions. It will also be seldom that other evidences are not also present, one or more, such as congestion of the throat, ulceration of tonsils, mucous patches in the mouth, or between the toes, or at the anus. It is then evident that the form, color, size, or locality of an eruption is not the test as to its nature, but it must always be traced to a probable syphilitic origin before it is warrantable to pursue a systematic mercurial course. That, so traced, every variety of eruption of a papular, pustular, or vesicular character, or any combination of these forms occurring between the second and seventh months after a syphilitic inoculation may be said to have its cause in a localized cell accumulation beginning in a papilæ cutis. For the elimination of this, a gentle persistent mercurial treatment is indicated not only as the result of clinical experience, but from the fact that it is "*the remedy, par excellence, for inducing the fatty metamorphosis: through which alone the cell accumulations occurring during the acute stage of syphilis can be removed.*"

Papular eruptions, and their variations, in the early stage are sometimes slow in reaching their full development, varying usually several days and sometimes as many weeks, but there are apparently no relapses, the new accessions appearing always at new points. The so-called relapses coming on soon after the disappearance of the first crop of papules, coming as they usually do in groups, would seem to be due to the setting free of infectious material stored in temporarily obstructed lymphatic glands. In other cases where the eruption recurs at same points (as in present case,) this would seem to be due to changes in the skin from previous damage, and may ultimately have to be classed among

the *sequelæ* rather than among the manifestations of the active period of syphilis, or that in which a contagious element is still present in the blood and in the secretions of all lesions. Further observations on this point will be presented when considering the later periods of the disease.