HERPES PROGENITALIS.

Accidents:	
lymphangitis	None save in mixed cases.
bubo	None save in mixed cases.
phagedena	None save in mixed cases.
gangrene	None.
Systemic results	None.
Influence of treatment	Local treatment effective in two or three days; general treatment required only for neurotic and gouty states in recurrent cases.

Treatment.—The management of the general condition of the subject of chancroid is usually simple. The recumbent position is required in all severe or threatening cases, especially when complications exist. In the simpler cases no internal remedies are indicated; in others a tonic regimen is urgently required, including a generous diet and the use of the ferruginous tonics, among which, in this connection, the potassio-tartrate of iron has long been especially esteemed. Mercury and the compounds of iodine are in unmixed cases actually harmful, and should not be employed.

The local treatment of chancroid is usually pursued on one of two lines, the one occasionally supplementing the other: The first is by antiseptic dressings; the second aims at obliteration of the lesion by surgical or chemical measures.

Antiseptic treatment is always indicated, and in the end is probably the most satisfactory for the majority of all cases. By this method the sore, as soon as its character is fully determined, is washed frequently with lotions containing either boric acid, carbolic acid, or corrosive sublimate—the first in saturated solution, the second in the strength of 1 part to 50, the third in the

OTHER LOCAL DISORDERS OF THE SKIN AND MUCOUS MEMBRANE.

Accidents:	
lymphangitis	None save in epithelioma of advanced grade.
bubo	Occurs in severe scabies and eczema (adenopathy of sympathy).
phagedena	Only in grave epithelioma.
gangrene	Only in complicated and grave epithelioma.
Systemic results	None save cachexia in grave epithelioma.
Influence of treatment	Local treatment usually effective promptly in balanitis, verruca, some of the eczemas, and some of the epitheliomata; psoriasis often obstinate.

strength of 1 part to 1000 or 2000. The first named is preferred, and, when it is possible to immerse the entire organ, should be employed as a continuous local hot bath of the temperature most grateful to the patient. When employed intermittently, the immersions or washings should be made as often and for a space of time as long as practicable. Mercurial and carbolized fluids are better employed as lotions.

At the outset all crusts should be removed and the pus washed away in warm water with the aid of soap, after which, so far as possible, the pultaceous floor of the ulcer should be cleansed. The surface may then be sprayed with peroxide of hydrogen, or with water to which has been added, in the cup of the atomizer, from 10 to 15 drops of iodized phenol:

℞. Acid. carbolic., ʒj;
Iodin. tinct., f ʒss;
Glycerin.,
Spts. vin. rect., āā. f ʒij;
Aq. dest., ad ℥j.—M.
Sig. For external use only, diluted.

After the washing either a dry or a wet dressing may

be employed. The former answers well for most cases, the ulcer, when dried, being well dusted with either europhen, iodol, aristol, boric or salicylic acid, or hydronaphthol. The three first usually answer well; the fourth and fifth named are sometimes productive of pain when applied over a very sensitive sore, and hence should often be reduced with starch, talc, or bismuth. Hydronaphthol is usually mixed with fuller's earth 1 part of the former to 50 or 100 parts of the latter. Iodoform is chiefly valuable as a local narcotic, but it is highly objectionable on account of its odor. It may be ordered for patients confined to the room for a brief time, when it is not necessary to conceal the character of the disorder from others visiting the apartment. The deodorized preparations of iodoform are not preferable to the other powders named above, which have no specially disagreeable odor. Calomel, pure or mixed with equal parts of the subnitrate of bismuth, is useful as a resort where other preparations do not answer well. In fact, many patients exhibit an idiosyncrasy with respect to these local applications. After the antiseptic treatment of the sore wet dressings are employed by laying a pledget of lint moistened with antiseptic astringent, sedative, or even stimulating solutions. To the class of preparations first named belong those employed in the lotions already described; to the second class belong solutions of sulphate of copper and sulphate of zinc, 10 to 20 per cent. strength; to the third class, solutions of cocaine, morphia, and lead (often added to ingredients suggested for other lotions), as well as the black and yellow washes; in the class last named are included alcoholic lotions, embracing the aromatic wine, popular with the French.

The destruction of the chancroid is wrought by the aid of the actual cautery (Pacquelin knife, galvano-cauterization apparatus, hot iron), and by chemical agents, including nitric and pure carbolic acid, zinc chloride, caustic potash, cupric sulphate, and the nitrate of silver. The last is, however, ineffective for complete destructive action, and is chiefly useful as a stimulating application to sluggish lesions, for which purpose it is admirably adapted. Gaylord recently advised a 40 per cent. formaline solution. All destruction of chancroids by these methods should be accomplished with strict antiseptic precautions.

The operative procedures by the instruments of the surgeon are curetting the sore itself and the neighboring tissue, and excision of the part, with attempts at securing union—such immediate union as is possible after the surgical excision of simple lesions of moderate size. Both methods require the strictest observance of antiseptic precautions, and both, in the best of hands, have been followed by infection of the resulting wound, as also by the development of syphilis in cases where the diagnosis was not well established.

The objections to the destruction of chancroids by each and all of these severe measures are not to be lightly set aside. They may briefly be summarized as follows: (1) These destructive procedures obscure and aggravate the existing local disorder. It is in many cases difficult, if not impossible, at the date when destruction is practised, to make certain that the case is not one of mixed infection; and, without question, initial scleroses thus treated are apt to exhibit excessive induration at the base of the sore. No practitioner can be assured that a chancroid will not be complicated with syphilis

until about one month has elapsed after the first appearance of the lesion; hence all destructive procedures undertaken during the first month of the existence of a chancroid may be disastrous to an on-coming syphilis. (2) Many of these operations, even when performed with the utmost care and repeated, utterly fail of accomplishing the end in view. The sore, instead of becoming converted into a simple ulcer, the desired issue in all attempts of this class, becomes an ugly and intractable lesion, persisting unaccountably, often without exhibition of classical symptoms of chancroid, the despair of the inexperienced and the horror of the patient after the suffering undergone in the heroic and ineffectual treatment to which he has been subjected.

On a careful survey of the field, it seems probable that destructive treatment of chancroids will before long follow in the wake of the now practically abandoned attempts to annihilate the syphilitic chancre.

Continuous Immersion.—There is no treatment of the threatening or actually destructive chancroid comparable in value with the local or general continuous water-bath. Its value depends upon the fact that the pathogenic microbes of the disease lose their vitality at a high temperature which is tolerable by the body. The patient, when the part upon which the sore is seated can be immersed, spends the greater part of the wakeful hours of the day with his ulcer wholly submerged in water as hot as can be tolerated; at times boric acid may with advantage be added to the bath. In other cases it is much easier to employ the sitz-bath, in which the patient partially reclines with the entire ano-genital region immersed, the water of all such baths being maintained at a high temperature by the aid of supplies

from a source of heat. The patient leaves the bath only for the purpose of evacuating the bladder and bowel. In all grave cases both the night and the day are spent in the water, the patient being, of course, under the constant supervision of a trained nurse. The most formidable of the phagedenic, sloughing, and gangrenous lesions with destruction of tissue are thus readily and even brilliantly converted into healthy ulcers which speedily assume the phases of repair, if effective constitutional treatment of the patient, with proper food and tonics, be at the same time secured.

All ointments are contraindicated in chancroids in a toxic condition, seeing that the germ of the disease finds a suitable culture-field in these greasy applications even when they are medicated. There are but a few indications for their employment; one is when the lint overlying the dry or wet dressing adheres so firmly to the part, in consequence of the discharges which leak through, that when the dressing is removed there is bleeding from the edge or floor of the ulcer. Another exception relates to chancroids of the urethra: in these cases the lint may be spread with carbolated vaseline—not in contact with the sore itself, but merely to facilitate removal of the dressings.

Treatment of Complications.—Urethral chancroids may generally be exposed by the aid of an ear-speculum or a pair of urethral forceps, after which the treatment of the sores may be practised as in the case of those existing in other regions. Pledgets of lint smeared with petroleum jelly and medicated with one of the powders already named may be inserted in the urethra. Urinating with the penis immersed in hot water is of great service in relieving the pain of micturition, and aids in

securing repair of the ulcer. The black and yellow washes, pure or dilute, may subsequently be applied.

Chancroids complicated with phimosis, the sore being so imprisoned that it cannot be exposed within the sac of the prepuce, are usually the source of alarm to the patient and anxiety to the physician, but the real danger in any case is much less than is generally believed. With the aid of careful syringing of the sac through the preputial orifice, sufficient cleanliness of the surface of the sore may usually be secured to ensure repair for most cases, especially as lotions may be employed about the integument of the tumid and often reddened and empurpled prepuce, serving to still further reduce the inflammatory symptoms. In other cases, however, the chancroid becomes threatening, and exposes the patient to the danger of a slough forming, after the fall of which the glans escapes through a species of button-hole through the swollen and distorted prepuce—a rare accident. In these and other severe cases resort must be had to operative procedures. A serious objection, however, is the danger of auto-infection of the wound inflicted by the surgeon. As a rule, therefore, it is wise to reserve operative interference for cases of emergency.

Circumcision of the prepuce, or incision either over the dorsum or on one side or another of the prepuce (as advocated by Taylor), may be practised in these emergency cases; but the surgeon will always do well to remember that in the best of hands and with every precaution infection in these cases has occurred repeatedly.

The operative treatment of the bubo of chancroid is gradually receding into the class of reservations advocated in the management of the sore itself. Early surgical treatment of these complications, once indiscriminately advocated for all cases, has at last given place to a more judicial waiting for the evolution of the malady to the point where intervention is inevitable.

The abortive treatment of the bubo includes rest in the recumbent position (which is perhaps the best of all measures having this end in view); hot fomentations with boric acid; cathartics and a restricted diet; the local application of leeches; and applications with a view to a resolvent effect, such as the tincture of iodine, mercurial ointment (1 part to 10 of lanolin), belladonna ointment, and salves containing the salts of iodine, as, for example, the compound iodine ointment. Pressure by a spica bandage and by the application of bags filled with hot shot is also of value. The common treatment by painting with tincture of iodine is by most experts practically abandoned as useless. The internal remedies employed, such as sulphide of calcium and mercury, are of little, if any, value.

Injection of chancroidal buboes has been practised with hot solutions of boric acid, bichloride and benzoate of mercury, and carbolic acid. Dangerous results have followed some of these injections, and those containing the mercuric benzoate have in cases been found ineffective.

The operative treatment of bubo is by free incision, all antiseptic precautions being strictly observed, with excision of all glands wholly or partially implicated in the morbid process, subsequent curetting of the surface, and careful washing with hot borated solutions. The subsequent dressings are with iodoform gauze. These operations, when carefully practised, are followed by exceedingly satisfactory results, the bubo being speedily converted into a healthy ulcer.

As the resulting scar is, however, both deep and indelible, and ever afterward points unmistakably to the nature of the original disorder, efforts are constantly being made to rob these procedures of some of their surgical severity. With special care many surgeons in private practice now succeed in penetrating the abscess-cavity of the gland with a fine bistoury or a large aspirator needle. The evacuation of the contents by squeezing is followed by injection of a hot borated solution or, as White suggests, of iodoform ointment. Aspiration of the abscess with subsequent injection of hot borated water often suffices, without the production of a serious scar.

DISORDERS NOT INVARIABLY VENEREAL.

BALANITIS AND BALANO-POSTHITIS.

BALANITIS is an inflammation of the mucous membrane covering the glans penis. It is usually accompanied by more or less inflammation of the prepuce (posthitis).

Etiology.—Balanitis frequently complicates gonorrhœa and chancre, but it may occur independently of these affections, and may be non-venereal in origin. It is caused by mechanical or chemical irritation of the mucous membrane, and it most frequently results from retention beneath a long prepuce of gonorrhœal or other pus or of irritating vaginal or other secretions. Neglect to cleanse the parts, permitting the normal secretions to decompose and become irritating, may be a sufficient cause.

Symptoms.—In the beginning of the inflammation the surface of the glans is slightly reddened and is covered with a thin, creamy layer of mucus and pus. The redness rapidly becomes more intense, the discharge thicker and more profuse. As a result of maceration the epithelium is destroyed in patches, leaving irregularly outlined excoriations; these excoriations are usually superficial, but they may become quite deep and simulate the early stage of chancroid. The inner surface of the prepuce usually participates in the process, thus