Case 4.—Chancre of the Left Tonsil. Mr. E., aged 59, was brought to me by his physician on May 14, 1894, on account of a very general maculo-papular eruption covering the body and extremities.

He had been suffering for four weeks from very severe general pains in the neck and back, and also aching of the bones all over. This had been considered rheumatic or neuralgic by his physician, and he had had plasters in various places and treatment with the Turkish bath, Rochelle salts, quinin, colchicum, etc. He had also complained of soreness of the throat much of the time, and a cough. Four or five days before his visit, an eruption began on the forehead which had increased rapidly up to the time of his visit, when it had become very general. There could be no mistaking the maculo-papular syphilid which he presented, which extended over his bald head, upon the trunk and limbs, even on the palms.

In searching for the source of infection, examination of the genital region showed no trace of a primary lesion, and it was learned that he had had no connection for a year. Nor was there any sign of a chancre, past or present, on any other external part of the body, nor had he had any sore.

He had had, however, trouble on the left side of the throat, with swelling beneath the left jaw, which latter had, however, about disappeared at the time of the visit. There was not very much to be seen in the throat except a dull redness of the left tonsil, with a little superficial ulceration. There was no record made as to hardness, and the facts regarding this have escaped me. But from a total absence of any other possible site of infection, and from the amount of trouble he had had on the left side of the throat, with the adenopathy beneath the jaw on that side, I have no doubt whatever that the infection took place in that locality. Among the fifteen cases of chancre of the tonsil, which I recently reported,[1] the tonsillar lesion was relatively insignificant in some instances, as we know it often to be in the genital region and elsewhere; although it may often produce large tonsillar lesions, giving rise to much trouble and pain, this is not at all necessary to secure infection, and it is well known that chancre within the cavity of the mouth, especially in children, may very frequently be overlooked, until other signs of syphilitic infection call attention to their presence.

All the localities represented in these cases have been repeatedly observed to be the seat of syphilitic infection. Few realize, however, with what relatively great frequency the point of entry of the syphilitic poison is in the region of the mouth and throat. Thus, in my recent study of the subject,[2] out of a total of 9,058 extra-genital chancres, I found records of no less than 307 cases of chancre of the tonsils; there were also 264 cases where the location of the chancre was "deep oral and nasal;" and in 734 cases it was recorded as in the "buccal cavity." These, together with 157 cases on the tongue and 42 on the gums, make no less than 1,504 cases where infection took place within the cavity of the mouth, or over 16.5 per cent. of the entire number analyzed. Adding these to 1,810 cases of chancre of the lip, there collected, we have a total of 3,314 cases or 36.5 per cent. in which infection occurred in the region of the mouth. With this very great relative frequency in this locality, it is well to be on the lookout for instances where the poison has been here introduced.

In addition to the four cases here detailed, where the site of non-venereal infection was definitely known, several other cases have been observed in my private practice where there was every reason to believe that the disease was thus acquired, but where even careful investigation failed to demonstrate with sufficient certainty for report the exact location of the primary sore; some of these have been very interesting and puzzling, but need hardly be detailed here. This is quite exclusive of instances of marital or hereditary syphilis of which a number have also been under observation.

[1] Transactions Medical Society, State of New York, 1893.
[2] Syphilis in the Innocent (Syphilis Insontium), Bailey & Fairchild, N. Y. 1894.

Including the four cases above narrated, of extra-genital chancre, no less than 120 instances of this form of infection have come under my personal observation and care. The histories of 116 of them are given in the recent work referred to on "Syphilis in the Innocent." For those who may not have seen the list, I will present it here in full, in order to illustrate the frequency with which other portions of the body than the genital region may become the seat of the initial lesion of syphilis. These instances occurred among something over 2,000 cases of syphilis seen in various forms and states; the extra-genital infection being demonstrated in about 6 per cent. of all the cases seen.

PERSONAL CASES OF EXTRA-GENITAL CHANCRES.

Location.	Male.	Female.	Total.
Chancre of the lip	20	31	51
" " tonsil	9	7	16
" " finger	14	2	16
" " breast		8	8
" " tongue	3	3	6
" " cheek	5	1	6
" " eyelid	3	1	4
" " chin	3	1	4
" " hand	1	1	2
" " nose	1	1	2
" " ear	1		1
" " temple		1	1
" " neck		1	1
" " forearm	1		1
" " sacral region	1		1
Total	62	58	120

Of these 120 cases it will be seen that the males are slightly in the preponderance, which is rather contrary to the common belief. I think, however, that these figures, although small, probably show the correct proportion; as a rule, the patients with syphilis have come on account of the eruptions present some time during the course of the disease, or because of the local sore present, which is commonly supposed to be a skin lesion. Therefore, both the proportion of extra-genital chancres, and the relation of the sexes are more likely to be correct than in an experience drawn from venereal practice alone, where many of the extra-genital sores would not present themselves.

The cases here narrated, and those represented in the table also, show how careful we should be when having to do with syphilis in a patient, not to necessarily charge the individual with wrong doing, for the disease is much more frequently acquired innocently than is commonly thought. Among the cases of syphilis presenting themselves in my private and public practice, about 6 per cent., or one person in sixteen or seventeen had received the disease through extra-genital infection; when we come to include the cases of marital and hereditary syphilis it is quite probable that over 10, perhaps 15 per cent. of all cases acquire the disease quite innocently of all sexual transgressions.

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ULCERATIVE SYPHILID OF THE PHARYNX.

Read in the Section on Dermatology and Syphilography, at the Forty-sixth Annual Meeting of the American Medical Association, at Baltimore, Md., May 7-10, 1895.

BY A. RAVOGLI, M.D.
CINCINNATI, OHIO.

Syphilis attacks the pharynx like any other organ, and cases have been reported in which the initial lesion was found in the upper pharynx, the infection

being communicated by means of the Eustachian catheter. In the secondary stage syphilis attacks the pharynx as a result of a specific erythema, which from the soft palate and the tonsils spreads to the surface, and sometimes it produces a catarrhal inflammation without characteristic specific symptoms. Mucous patches which we so frequently meet with on the tonsils, faucial pillars and soft palate, very rarely are found on the wall of the pharynx. Zeissler never saw a mucous patch on the pharynx, and in my experience I do not remember to have seen mucous patches on this region.

Ulcerative syphilid affects the pharynx at an advanced secondary period. As the affection is not a common one, I find it worthy to be submitted to your attention.

In a large number of syphilitic patients in my practice I find only four cases of this peculiar lesion recorded. All four were men and all used to drink alcoholic liquors and chew tobacco.

The affection began at the time when the patients were in apparent good health, two to three years after the infectious chancre had first appeared. Feverish reaction, and an intense pain in the act of deglutition and in the articulation of words were constant symptoms in each case. The lesion consisted of an inflammatory prominence, of the size of a dime, dark red, which soon showed ulceration in the middle. The center of the ulcer, like a crater, was deep and covered with a yellow diphtheroid detritus; the edges, brown-red, were sharply cut and elevated above the surface of the mucous membrane, and were surrounded by an inflammatory halo. Recovery took place with a whitish superficial scar, which remains always perceptible.

Case 1.—J. S., 25 years old, butcher by trade, man of a splendid physical constitution, had hard chancre on the internal surface of the prepuce in February, 1885. In May of the same year had a papular eruption accompanied by mucous plaques of the mouth and of the anus. He was subjected to intramuscular injections of sublimate 1 per cent. After twenty injections every symptom had entirely disappeared. He was in good health, had no syphilitic symptoms, and refused further treatment. On March 19, 1886, came again to consult me for sore throat and fever, which he thought due to a cold. He was somewhat emaciated. A superficial examination of his throat did not reveal any specific lesion of the soft palate, the tonsils were normal, but the posterior wall of the pharynx looked very red. As speaking was difficult and the voice had a nasal tone, I subjected him to a rhinoscopic examination. On the upper portion of the pharynx behind the velum palati, I found an ulcer of the size of a five cent piece deeply and sharply cut in the mucous membrane, covered with a yellow diphtheroid detritus with elevated swollen edges, surrounded by an inflammatory halo. The diagnosis was not difficult, knowing the preceding history. A mixed treatment of inunctions with mercurial ointment and large doses of potass. iodid, combined with local applications of peroxid of hydrogen for cleansing the surface and then blowing powdered iodoform, soon brought about recovery.

Case 2.—M. P., Italian laborer, 37 years old, good constitution, used to smoke pipes and drink whisky, came to my clinic on July 15, 1893. He complained of excessive pain in attempting to swallow anything, had some remittent fever and was wasting away rapidly. The man had been under my treatment nearly one year before for papular syphilid, which yielded easily to fifteen intramuscular injections of sublimate 1 per cent. There remained a stubborn sternal neuralgia, and for this he took iodid of potassium, followed by pills of protoiodid. The patient was well, and I did not see him any more until said date, nearly one year after the first treatment.

At present the patient is very pale, of sallow hue, emaciated; a few enlarged glands can be found on the cervical region as evidence of the past trouble. No mucous patches in the mouth, none on the throat, which is scarcely red. By the aid of the tongue depressor a vivid redness can be seen at the base of the pharynx, which surrounded a round ulcer the size of a quarter of a dollar. The edges of the ulcer were sharply cut, inflamed, elevated on the surface of the mucous membrane, the hollow of the sore showed a yellow diphtheroid appearance, discharging purulent matter. The patient was treated with mercurial inunctions and iodid of potassium in large doses. Locally the ulcer was washed with peroxid of hydrogen and covered with iodoform powder. In twenty days the ulcer had completely healed up and the patient was discharged.

Case 3.—W. F. F., a young man 27 years of age, barkeeper by occupation, of good and sound constitution, has always enjoyed good health. In April, 1892, he called on me with a syphilitic roseola. The initial lesion of syphilis was found on the second phalanx of the thumb of the right hand on the internal side. It was an ulceration half cicatrized on an indurated base. The epitrochlear gland of that side was hard and swollen. The patient received twenty intramuscular injections of sublimate 1 per cent. and on the ulcer emplastrum hydrargyri was daily applied. In a short time the roseola had completely disappeared and the ulcer of the thumb thoroughly cicatrized. The patient was discharged, with the advice to take two pills a day of protoiodid hydrarg. for two months longer.

In January 1893, he came again with a pustular syphilid. A few ectymatous ulcerations were scattered on the scalp and on the face. He was subjected to another course of treatment, and when better was not seen again.

The patient kept on in his occupation and used to drink a good deal of whisky and to smoke. On August 1893, he came to my office complaining with difficulty of speaking and swallowing. He had fever and was greatly emaciated. Pushing down the tongue with the depressor a round ulcer could be seen on the base of the pharynx of the size of a quarter of a dollar, surrounded by an inflammatory halo, with swollen edges, sloping down to a yellow grayish bottom. A mixed general treatment was begun, and local washing with peroxid of hydrogen and dressing with iodoform powder in short time brought about recovery.

Case 4.—In my hospital service, T. P., on February 18, 1895, was admitted with one of the same ulcers on his pharynx. He had acquired syphilis nearly three years before, and had been treated in the same institution. He had high fever and experienced great difficulty in swallowing.

This man like the others had been used to drink liquors and was in the habit of chewing tobacco.

The treatment, general and local, was like that of the other cases and in three weeks the ulcer was perfectly cicatrized and the patient left the hospital.

In the literature on syphilis of the pharynx there is not much said about this kind of lesions. Seifert[1] speaks of ulcerations, hard chancres, mucous patches of the tonsils and palate, but does not speak much of the pharynx. In the same way J. N. Mackenzie—"Syphilis of the Upper Air Passages"—speaks of secondary lesions of the pharynx as a result of lesions of the surrounding parts, mentions tertiary lesions, but nothing definite on this affection.

In my opinion, I find this ulcerative syphilid of the pharynx to be rather a rare one, considering that in a large number of syphilitic patients only four showed this affection. All the four cases were in men, and I never met with this affection in women.

I find this affection of great importance for the diagnosis, for the possibility of being exchanged with ulcerations of diphtheritic or of any other origin.

I do not consider the affection as a true tertiary lesion, but only as a late secondary ulceration. From the habits of the four patients I should come to the conclusion that the use of alcoholic liquors and chewing tobacco has a great deal to do with the production of this ulcerative affection. The irritation produced on the inferior portion of the pharynx by the passage of the alcohol and of the saliva saturated with the irritant tobacco juice is sufficient cause to excite a syphilitic inflammatory affection resulting in ulceration.

The affection is very painful, prevents the patient

[1] Syphilis der oberen Luftwege. Deutsche Med. Wochensch., 1893.

from eating, and in all the cases was accompanied with fever.

The ulcer heals up readily when with a general antisyphilitic treatment a local antiseptic medication is used. A superficial, whitish scar is the result of this ulcerous syphilid, which remains always perceptible on the mucous membrane. I have never seen deep scars resulting from this affection, like those from the true gumma of the pharynx, which may result in a stricture and impairment of the function of the organ.

The coexistence of fever with this affection and the stormy inflammatory symptoms cause me to place it rather among the secondary symptoms of syphilis than among the tertiary. In the tertiary affections we see more tendency to a slow process of hypertrophy, as it is in the production of gumma, while in all secondary lesions we see a tendency to inflammation.

The local irritation as mentioned above, from the use of tobacco and alcohol, is the most effective factor in producing this peculiar ulcerative lesion of the pharynx.

LUPUS TREATED BY GALVANISM.

(ILLUSTRATED BY PHOTOGRAHS.)

Read in the Section on Dermatology and Syphilography, at the Forty-sixth Annual Meeting of the American Medical Association, at Baltimore, Md., May 7–10, 1895.

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So much has been said concerning the various forms of lupus that I refrain from speaking of it from any other than a personal point of view. I would refrain from speaking of any other treatment than is herein mentioned, especially as I presented a paper to the Pan-American Congress upon the extirpation of lupus tissue.

It is conceded that constitutional treatment avails nothing in this disease, and I think that I am safe in saying that caustics and the curette are of little use unless carried to the extreme.

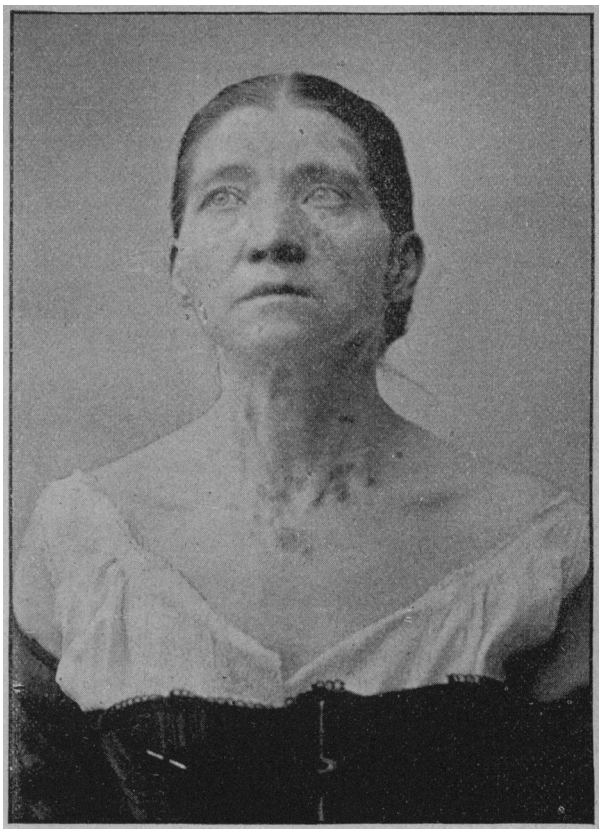
I wish now merely to report one of several cases in which I have used the galvanic needle with the greatest satisfaction. There is, however, one great objection to its use—that is the length of time required—but as the treatment is not imperative, the disease being exceedingly slow in its progress, I do not think that good results should be sacrificed for the want of time.

The length of time required to destroy a given area affected with lupus, depends upon the degree of tolerance on the part of the patient.

However, if the patient is an adult, or even a child, the amount of galvanism used may be almost without limitation, if a small amount of cocain has been previously injected within and about the affected area. In this way the tissue may be destroyed more rapidly.

Where there are several lesions to be treated, the effects of cocain in any one will pass off before it is necessary to inject another. In this way the length of time of a sitting may be indefinite, and the amount of cocain practically disregarded, if the amount used in any one lesion is not more than absolutely necessary to produce anesthesia.

As stated on a previous occasion, an operator should accustom himself to the use of but one kind of cocain, and he should familiarize himself with the



Mrs. M., white, aged 51, born in Ireland, mother of several healthy children. Lupus erythematosus began at the age of 30 on the face and neck. Treated for years for syphilis without result. Twenty-two lesions treated by galvanic needle, with twenty-one cured, not having returned in eighteen months; twelve excised with knife; three returned and were afterward treated by galvanic needle and did not return.