

Hutinel, P. HEREDITARY SYPHILIS AND DYSTROPHIES. [Archives de médecine des enfants, Jan., Feb., Mar., and Apr., 1920.]

Lesions dependent upon hereditary syphilis may be divided into two groups. The first group contains the specific alterations which are in general more localized if the malady is of long standing and more benign, and in which we find if not treponema at least the characteristic reactions which it has produced. In the second class we find nutrition difficulties, the *dystrophies*. The dystrophies have many different forms. Some are *local*, partial, sometimes highly circumscribed. Their nature often makes it possible to suspect syphilis; the majority of the stigmata of this disease may be found in this class. Usually they are multiple and their grouping is of such revealing nature that they often enable one if not to detect at least to suspect the existence of the infection. The main stigmata are the deformations of the skull, the nose, the teeth, alteration of the cornea, of the ear, of the testicles, etc. Others are made up of visceral scleroses. They have not all invariably got a specific character. They are the results of local lesions and are direct manifestations of the illness. Still others are *general*. They are characterized by nutritional difficulties, or difficulties in development which affect all the parts of the same apparatus (bones, articulations, nervous centers, genital apparatus, etc.) affect an important organ or some tissue (skin, blood, etc.). In these organs and tissues there are favored sections and the stigmata are not evenly distributed. Although they are at times isolated, more frequently they are grouped and associated and form true pathological entities.

They arise from specific lesions which attack the organs of nutrition, especially those which are localized in the endocrine glands (thyroid, hypophysis, suprarenals, pancreas, genital organs), but other organs (liver, kidneys, nervous centers, lungs, etc.) cannot be seriously altered without the organisms manifesting its infection. It is equally true that the organs governing nutrition when seriously affected are particularly inclined to reveal pronounced dystrophies. Thyroidal dystrophies, hypophyseal, suprarenal and genital dystrophies and pluriglandular syndromes accordingly hold an important place in this study. They do not appear as the immediate and direct result, but rather as the indirect and slow result of specific infection; they have no features individual to hereditary syphilis and may be brought about by other infectious and toxic processes; they may not accordingly be awarded specific treatment exclusively, but often require the intervention of opotherapy. To these two classes of dystrophies a third should be added which in specificity is still more distant from the second variety. These are the hereditary dystrophies. When the nutritional difficulties, imputable to glandular or organic lesions have been caused by hereditary syphilis or by some other morbid processes, they may be transmitted from parents to children. Thus it is that two or three successive generations may present indications of thyroidal or hypophyseal insuffi-

ciency. The special disease such as Basedow's disease is not so often transmitted, but rather an organic debility. A child whose mother has Basedow's disease is frequently a hypothyroid. In hereditary syphilitics of the second generation this dystrophic inheritance is more common than infectious heredity. Hereditary syphilis in affecting the organs of the new born modify them in function and in resistance. It is accordingly frequently met with at the outset of pronounced dystrophies in childhood (athrepsia, hypotrophy, rachitism, status lymphaticus, infantilism, etc.) but it is not always the only cause and it is not always easy to determine exactly the part that it played in the production of the dystrophy. As the dystrophies caused by hereditary syphilis draw away from their infectious origin, the importance of specific medication decreases gradually. Opothapeutic medication, on the other hand, is more and more needed as infection recedes. It is especially in cases where the dystrophies outlast the infection that these preparations give the best success, especially if hygienic precautions are not neglected. [Author's abstract.]

Barewald, C. L. HEREDITARY SYPHILIS. [Jl. Iowa State Med., Jan., 1920.]

About seventy-five per cent. of syphilitic mothers suffer abortion. Of the syphilitic children born alive, about seventy-five per cent. die in the first year of existence. Of all children born, one in every one hundred and fifty is found to be syphilitic. In all obstetrical wards the physician should have the Wassermann test performed as a routine measure. In private practice this procedure would also be advisable. Persons who have been cured of syphilis can procreate healthy children. Some syphilitic children are apparently healthy at birth, but usually there are certain indications which should not be overlooked. Some of these are obscure, others very apparent. The physicians should be inclined to suspect syphilis in weak children with high piped, strident voices, wheezy breathing, sero-purulent blood, streaked nasal discharges, impetigo neonatorum, purpura neonatorum, purpura hemorrhagica neonatorum, bullae on the palms of hands or on the soles of the feet. Exostosis and synovitis are pronounced indications. Slow and painful dentition, asymmetry in form, scantiness of hair, irregular features, enlargement of liver and spleen are all indications, but from the third to the sixth months evidence of hereditary syphilitic taint show themselves. Often in case where the hereditary taint is least suspected the Wassermann test and the administration of salvarsan and mercury will clear up the case.

The Wassermann test of blood not only in parents and children, but also in the apparently healthy as an eugenic measure is endorsed. [Author's abstract.]