

Carthy.<sup>6</sup> Spencer Watson<sup>7</sup> reported a case of a nurse in attendance on a woman who gave birth to a syphilitic child. The sore could not be distinctly seen, on account of the swelling within the nostril. Severe pain, fever and mental depression was followed by the ordinary symptoms of secondary syphilis. The vehicle of infection in all probability, was the patient's own finger.

Intranasal inoculations occur most frequently in the lower and anterior part of the nasal septum, next in frequency on the ala, and then, as in the case I am about to report, on the inferior turbinated body. The location modifies the chancre's appearance. On the septum it displays a flat, reddish or greenish, fungiform mass with indurated circumference. The surrounding mucous membrane is, to a greater or less degree, swollen, and there flows from the oftentimes stenosed nostril, a bloody, fetid discharge. When the ala is involved the infiltration and induration often causes it to be of a cartilaginous consistency. When the inferior turbinated is primarily inoculated, the appearance resembles, mostly, a severe localized influenza, or a fibrinous or diphtheritic rhinitis. Usually the submaxillary, sublingual and preauricular glands early show marked indolent swelling.

Characteristic of this infection is an aggravated general febrile disturbance, malaise and depression of spirits. The chancre may be mistaken for an abscess of, or injury to, the septum; for a furuncle, to which for a time, it is not dissimilar; for vaccine inoculation; for tubercular ulceration; for malignant disease.

The existence of an ulcer in the nose with a peculiar hard base and granular surface, bleeding easily on touch and of limited extent, would suggest tuberculosis, malignant disease or syphilis. Tubercular ulceration occurs only as secondary to a pulmonary deposit and examination of the discharge would show characteristic bacilli. In malignant disease glandular enlargement is a late development, and the progress of the disease is liable to be accompanied by profuse epistaxes. In syphilis the chancre is followed shortly by characteristic secondary symptoms.

#### CASE REPORT.

*History.*—On Oct. 19, 1905, a surgeon in perfect health circumcised a patient, on whose prepuce was a large indurated chancre.

On December 16, nearly two months later, he first noticed stuffiness of the right nostril, and headache from brow across vertex to occiput. This was accompanied by malaise, anorexia, chilly sensations and constipation, a condition from which he never before had suffered. For a period of two weeks his temperature ranged from 100 to 100.2 F. He had worked very hard for a few weeks prior to December 16, and he attributed his condition to overwork and a grip-like attack. During Christmas week he visited his old home, but the rest did not improve his condition.

*Examination.*—I first saw him on Dec. 28, 1905. At that time I made the notation, "Superficial necrosis of the mucous membrane covering the anterior end of the right inferior turbinated body; the fibrinous membrane, when raised, revealed an ulcerating bleeding surface." Neither suprarenalin 1 to 1,000 nor 10 per cent. cocain solution caused any appreciable blanching or shrinking of the turbinated body. Lacrimation was present on the right side and one gland below the angle of the right jaw was enlarged and tender.

The condition resembled fibrinous rhinitis, but it was limited to the inferior turbinated body and there was no ichorous discharge from the nostril. The swelling practically occluded the nostril, which is narrow on account of septal deviation, the result of traumatism in childhood.

The treatment employed was a cleansing alkaline spray followed by sprays of peroxid of hydrogen and lime water.

*Course of Disease.*—On Jan. 8, 1906, eighty days after the probable inoculation, a macular rash appeared on the abdomen. Four days later, when I was shown the rash, I made a positive diagnosis of syphilis and was confirmed in this by Dr. Joseph Zeisler and Dr. T. Melville Hardie. The "lean-ham" macular and papular rash, more marked on his chest and abdomen, covered practically the whole body with the exception of the exposed portions of head and hands. There were papules at the base of the uvula, but no soreness or congestion of the fauces and no glandular enlargement or soreness excepting the before-mentioned submaxillary gland. Disappearance of the fibrinous membrane and healing of the ulceration took place under the simple sprays, before constitutional symptoms appeared. Coincident with the appearance of the rash, the headache ceased and the general feeling of well-being began.

On diagnosis of syphilis being made, inunctions of mercurial ointment, one dram, at bedtime were begun and after six rubbings all evidence of the disease had disappeared.

#### A CASE OF MULTIPLE CHANCRES.

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Cases of multiple chancres are rare. Chiefly because of their infrequency they are often unrecognized, and so the report of a single case, though adding nothing to the present-day knowledge of the subject, may call attention to the existence of a condition which might otherwise be overlooked. It is for this reason that I report the first case that, to my knowledge, has been treated in this section of the country.

*Patient.*—J. I. C., aged 22, presented a good family history.

*History.*—He had never been sick in his life except for an acne which bothered him but little, and for which he had done nothing. He first came under my care in August, 1904, when I treated him for a chronic form of gonorrhea. This, though stubborn, yielded after a time and the patient, after many tests, was discharged as cured. I did not see him again until August, 1905.

*Examination.*—On making an examination I found a purulent discharge about the urinary meatus, and a single, enlarged, painless, indurated, freely movable gland in the left inguinal region. The discharge, however, did not come from the meatus, but from beneath the prepuce, which was slightly swollen, tending to phimosis. On inserting a small, blunt probe several rough surfaces could be detected, and on questioning the patient I was somewhat surprised to learn that he had not had sexual intercourse for more than a month before noticing the discharge.

*Treatment.*—Realizing that with the existing phimosis local treatment would amount to little or nothing, I advised an incision through the dorsum of the prepuce to expose the glans and to aid in making topical applications. He consented, and on the following day, with local anesthesia—ethyl chlorid and a 2 per cent. solution of cocain—the incision was made, disclosing nine ulcers. Each lesion presented a typical picture. Their edges were sloping (cup shaped), they had a firm, cartilaginous, or woody feel. Their bases were covered with a thin, scanty, sero-purulent discharge which had no offensive odor. Each lesion was fully developed, separate and distinct. There was no tendency whatever to coalesce.

I was convinced that the picture before me was one of multiple chancres, and, realizing that all nine could be gotten rid of by a circumcision (all being located on the glandular surface of the prepuce), the primary incision was continued under cocain and a circumcision was done. The operation was followed by some little swelling and pain, but no more than would ordinarily occur after the performance of this operation on a perfectly healthy penis, the wound healing by first intention.

*Bacteriologic Examination.*—Smears from the nine lesions were made and examined for the bacillus of chancroid (bacillus of Ducrey) with negative results. Further tests were made

6. These *dé Paris*, 1844.

7. *Medical Times and Gazette*, 1881, vol. 1, p. 428.

to isolate the bacillus in culture tubes containing fresh blood, after the method of James Homer Wright of Harvard University, with negative results.

**Subsequent History.**—The patient was told of my suspicions and was instructed to report at my office for inspection when any of the lesions of the "active period," which were thoroughly explained to him, might put in an appearance. This he promised to do, but was compelled to leave the city and I did not see him again until Jan. 8, 1906, when he came to my office, not because he felt that his health was impaired, for he stated that he had not had an ache nor a pain since I had seen him last, but because he had returned to the city "and wanted me to examine him to satisfy myself that he was all right."

The skin presented nothing suspicious, the acne which he had had for the past five or six years was no better, nor was it any worse. There was no other form of eruption present. I found, however, that the post-occipital glands on both sides were much enlarged, as were also the cervical, axillary and inguinal glands. On examining the throat I found a bald patch in the roof of the mouth and two typical patches on both tonsils. They were oval, gray in color, moist, and looking as though silver nitrate had been applied; the whole faucial surface was engorged.

Not until I told the patient what I had discovered did he admit that his throat had bothered him for a day or two. I told him that in my opinion he had syphilis. Although having been acquainted at the time of performing the circumcision with my suspicions, the fact that he had suffered from no prodromes, or eruption (which he had been looking for) did not help to lessen the shock caused by my positive diagnosis.

Having to go to New Orleans he urged me to accompany him in order that I might give a detailed account of the case to Dr. Rudolph Matas, in whom he has the utmost confidence. This I willingly agreed to do. Dr. Matas listened attentively to the history, made a careful examination, and pronounced the case syphilis beyond a doubt. He was impressed, as I had been, with the mildness of the case, and attributed it to the fact that in performing the circumcision, nine points of infection were removed at once.

I believe, of course, that the chancre is a local manifestation of a constitutional disease, and that when it appears a large amount of the poison has already entered the system. This in no way opposes the duality theory, as I do not contend that the removal of the chancres would prevent chancroid from forming, for I believe, with Fournier, Cooper, von Zeissl, Taylor, Lydston and a host of others, that the poisons are not one and the same; nor do I believe for one instant that the removal of chancres will prevent the appearance of the active period (secondary stage) or the period of sequelæ, but I do contend that in this particular case their immediate and complete removal mitigated the attack.

In his excellent article on syphilis Lydston has this to say in favor of excision:

The excision of the chancre should be performed only after the induration has matured, that is, after it has attained full development, and remained in *statu quo* for some days, otherwise induration is apt to recur in the edges of the wound. By the excision we remove a constant focus of infection that is present so long as the induration lasts. We at once remove a large mass of syphilized cells that would otherwise only be removed by the slower process of fatty degeneration, absorption and elimination. We obviate the possibility of transmission of the disease to others by means of the initial lesion (a point sometimes of great importance in married persons); we lessen the danger of suppurating bubo in case the chancre should become inflamed or pus-infected; we remove a constant source of irritation and lessen the danger of phagedena and inflammation that might disable the patient.

I return to the narration of the case:

**Treatment.**—Principally for its rapidity of action and on account of the existing acne, I used the inunction plan of treatment, rubbing into the patient one dram of mercurial oint-

ment in one dram of lanolin every twenty-four hours, followed the next night by a warm bath with German green soap.

Dr. Matas suggested touching the mucus patches with pure carbolic acid, followed with alcohol or with a mixture of carbolic acid and iodine in equal parts. I used the pure carbolic and in eleven days from the time I started to make these applications not a trace of the patches on the tonsils could be seen. The bald patch in the roof of the mouth did not take kindly to this treatment and I changed to lunar caustic, putting the patient on a short, brisk course of potassium iodid, with good results. The iodid, however, made the acne worse, and after a week I stopped it and relied entirely on the inunction and the lunar caustic, with the result that at the present writing there is but one-sixteenth of an inch to heal. As a mouth wash and gargle the patient is using equal parts of an alkaline solution and a solution of peroxid of hydrogen five or six times a day; he also uses a chlorate of potash tooth paste after each meal.

He objected to the use of the curette, the best treatment I know of for acne; so I am using a sulphur ointment, and if the acne ever gets better the patient will wear a mercurialized shirt; the inunctions will be discontinued and the patient put on granules of protoiodid of mercury (each 0.01 gm.).

The plan I follow in giving these granules differs somewhat from the ordinary in that I do not reach the full physiologic action and then cut the dose in half, but, instead, when the patient reaches the limit, he is instructed to reduce the dose one granule a day until he has reached the original starting point, when he commences to increase the dose as before. It is astonishing how nicely this method agrees with the majority of patients. I have one who, following these directions, worked up to thirty-two granules a day before beginning to reduce his dose, and this without disturbing his digestion in the least.

Unless there are contraindications, I generally have my patients follow this plan of treatment for one year, when they are instructed to skip a month, taking a course of potassium iodid in the off month. In this way any mercury that is stored up in the tissues will be liberated, rendered active and eliminated. It is well to bear in mind the possibility of the injurious effects produced by the cumulative action of the drug.<sup>1</sup> I do not give the iodine simply and solely for its alterative effect, but because it is an established fact that the iodids alone are capable of effecting a cure in syphilis. That this view is correct is shown by the beneficial effects produced by potassium iodid in cases of late syphilis in which mercury has never been administered. Hassing<sup>2</sup> reports seventy cases of syphilis in which the patients were cured by potassium iodid alone without mercury at any stage. These experiments have since been frequently repeated by various observers, and by myself, with like results.

At the end of the second year the patient is again given a course of mercury for six months, during which time he again alternates; mercury one month, potassium iodid the next. Then I let him rest and watch for results. If all goes well, and all should go well if he has followed out directions, I discharge him, feeling reasonably sure that he can marry and beget healthy children. It goes without saying that the physician can not effect a cure alone; the patient must do his share, and the best advice that can be given to a syphilitic after he has been put in possession of all the facts concerned in his case is this: "To thine own self be true."

1. The text-books are notoriously deficient regarding the physiologic action of this drug and for the benefit of those who are looking for cause and effect and not a mere history of symptoms following large or small doses of mercury, I take pleasure in referring to the recent papers of S. V. Clevenger on the subject.

2. British and Foreign Medical Review, October, 1845.