

Another point, not referred to in the books, to any extent, is the importance of keeping the lower bowel well emptied. There can be no better opportunity for the retention and reabsorption of bacilli and ptomaines than is found in an intestine abnormally distended and crowded with fecal matter and partially digested food. In nearly all cases of constipation in tuberculosis there is weakening of the muscular fibers of the intestine, retention in the descending and part of the transverse colon, and gas distension of the ascending tract. Aside from the ordinary sequela of chronic constipation, there is the additional danger of auto-infection from the bowel. We do not attach enough importance to this, self-evident though the proposition may seem.

The patient who is constantly expectorating tubercular matter will certainly receive more or less of it into the stomach with the act of deglutition. It is estimated that seven billion bacilli may be expectorated by one tubercular patient, in twenty-four hours. How many may pass from the upper air-passages into the digestive tract, can only be conjectured. The weak gastric digestion does not greatly change the activity of the bacilli nor the virulence of their ptomaines. These pass into the intestine, where absorption is one of the main functions. Is it an unreasonable proposition that this manner of auto-infection is one of the processes in tuberculosis?

While the sanitarian is doing all in his power to prevent infection from sources without, it is certainly the duty of the physician in charge to do all that he can to prevent and overcome infection from internal sources. Were it not for auto-infection, many of our cases of tuberculosis would be much more amenable to treatment. How often it has happened that a patient has done well for a time, under the ordinary treatment. There has been a gain in weight, strength and general appearance. Suddenly there was a change. Without any apparent cause there has been a return of the hectic, the night sweats and a loss of flesh. Oftentimes these symptoms have been accompanied by a diarrhea more or less persistent. Does not this suggest auto-infection? The very fact that impaired assimilation is so early a complication in tuberculosis is an evidence of the plausibility of this hypothesis. To me this deduction is something more than a mere hypothesis, it has all the authority of a recognized fact. If this part of the treatment is neglected and the lower bowel permitted to become a receptacle for the retention and absorption of material containing so much *materies morbi* as the tubercular sputum, then the physician must not be surprised if in spite of his efforts in other directions, his patient does badly.

I have elsewhere stated my belief in the theory that some of the good results credited to creosote, guaiacol and other remedies of this class, are due to their immediate action in the intestinal tract, either as germicides or in rendering the intestine uninhabitable for the bacillus and in counteracting the influence of the ptomaines. So strong is this belief that it has become my custom to order a high enema once or twice a week, so that the lower bowel may become well emptied and in as aseptic a condition as possible. With this practice, I feel that I can safely use much smaller doses of creosote, which is a decided gain in the medication. I have also found that often the afternoon fever is greatly diminished, but that it may return if the flushing is neglected—another evidence of its value.

If there is inertness of the small intestine, it is better to give laxatives than to neglect it. Often the peristalsis induced by the flushing of the lower bowel will

extend to the upper and be sufficient. Drastics should be avoided. A few drops of tinct. nucis vomicæ often acts well. There is no objection to a saline, but it should not be given before breakfast, as is too often the case. In the comparatively healthy individual it may be all right, and the theory that some of the salines promote the secretion of the gastric juice is a reasonable deduction from experiment in the laboratory, but the same conditions are not present in cases of lowered vitality and digestive function.

Sherican Lea has shown that in natural gastric digestion the conditions are favorable for the rapid absorption of soluble salts, but we are not dealing with natural gastric conditions. Besides, whatever of the salts remains unabsorbed must neutralize the hydrochloric acid to some extent. Where the alkalies, such as bicarbonate of soda, do produce a better gastric action when given near the time of eating, in cases of faulty gastric digestion, I believe that it is because of their reaction with the lactic and fatty acids. I have generally found that a mild saline at bed-time, with an enema in the morning, is sufficient. If, in addition, nux vomica or strychnia, as spoken of in the former part of this paper, is given, it will nearly always be enough.

I would again urge the importance of these two indications in tuberculosis—heart weakness and constipation. They are a part of the direct progress of the disease and, I believe, are complications of no little gravity. The attractive study of germ infection and specific medication should not lead us to neglect other conditions that play no little part in the tragedy of many a human life.

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### CHANCRE OF LIP IN A CHILD SEVEN MONTHS OLD, PROBABLY ACQUIRED THROUGH A FEEDING-BOTTLE.\*

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While extragenital chancres innocently acquired are not so very rare, instances of their recurrence at the early age of 7 months are seldom seen, and this is the youngest subject in whom I have seen it, among nearly two hundred cases of extragenital chancre which have come under my observation.

In earlier times, before the danger of infection was so well-recognized, instances of the innocent infection of children were very common, and literature is full of those<sup>1</sup> where children of all ages have been infected in the greatest variety of ways, indeed, where veritable epidemics of syphilis have arisen, having their origin in a child infected by nursing or otherwise. All are familiar with the various methods by which this has taken place: vaccination, circumcision, nursing, feeding in various ways, as well as by kissing and fondling, and also through various mediate objects. Among these feeding-bottles have occupied a not inconspicuous place in times past, and dozens of cases are on record, often in country towns and small places, where this has occurred. Happily these instances are very infrequent of late years.

The method by which this accident happens is easy to understand. In preparing the food in a feeding-

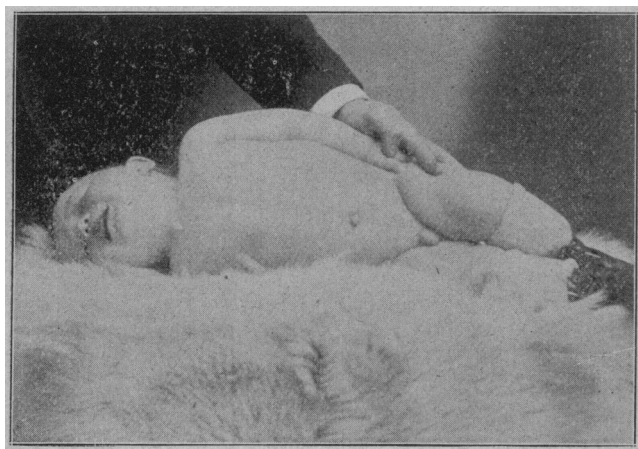
\*Presented to the Section on Cutaneous Medicine and Surgery, at the Fiftieth Annual Meeting of the American Medical Association, held at Columbus, Ohio, June 6-9, 1899.

<sup>1</sup> L. Duncan Bulkley: *Innocent Syphilis*. New York: 1894.

bottle it is not at all infrequent to see an attendant place the nipple to the lips, either as an example to the child, or to ascertain whether the prepared food is too hot or too cold, or properly sweetened, etc. The nipple is seldom washed after this, but is placed directly to the child's lips.

If now the individual doing this chances to have mucous patches on the lips or tongue, some of the sticky secretion from them is sure to adhere to the nipple; if there should be a chancre, which is infinitely less probable, the probability of infection is very much greater. It is well known that a very small amount of the virus is necessary for inoculation, and very brief contact has been known to transmit the disease, both directly and by mediate means. It is, therefore, very understandable how the infant taking the nipple, after it has been applied to infected lips, can with the slightest abrasion on the lips absorb the poison and acquire the disease, by means of a chancre developing in the place where the poison on the nipple was applied.

While this method was not clearly proven in the case to be mentioned, the probability seemed so strong that it is thought well to mention it. Diligent inquiry has been made by the physician who brought the child to my clinic, but thus far he has been unable to trace the person from whom the infection was acquired. The case was as follows:



Chancre of the upper lip.

W. W., aged 7 months, was brought to my clinic at the New York Skin and Cancer Hospital, by Dr. E. L. Cocks, on April 26, 1899. The mother came with the child. She was a large, well-developed woman, from Finland, and 24 years old. I believe this was her first child. Thorough examination of her, and also of the father, by Dr. Cocks, who is an old assistant of mine, revealed the absence of syphilis in both.

The child was a splendid specimen of health, large and robust, and but for the eruption, in perfect health, and it had always been in perfect health until the occurrence of the present trouble.

The history was that the mother had noticed the soreness of the upper lip on April 1, nearly four weeks before the visit. This had persisted and become more pronounced up to the date of the visit. When first seen by Dr. Cocks, a few days before I saw them, there was a raw, sore place a little to the right of the median line, about half an inch in either direction; there was enlargement of the submaxillary and ante-auricular glands of that side, with some general adenopathy, and already an almost universal macular eruption had appeared, more pronounced on the trunk. When the

child came to the clinic the eruption was in full bloom, and perfectly characteristic.

I did not notice the soreness of the lip at once, but recognizing the syphilitic nature of the eruption, and noting the superb health and development of the child, I remarked to the audience that it could hardly be a case of inherited syphilis, that we must look for the site of the infection, and that I felt confident that we should find an extragenital chancre present. The sore on the lip was promptly recognized as a chancre.

Chancres of the lip vary greatly in their appearance. While they will sometimes be very sharply defined, and present considerable hardness, they are not infrequently rather indefinite and illy defined, and with only a general boggy hardness; sometimes there will be quite a large area of raw surface, which may at times become covered with a crust; in other instances most of the surface is glazed over, with infiltrations beneath. In the present instance there was a raw, red, exuding surface, about half an inch in either direction, causing the lip to seem pouty, and with some slight crusting on either side. On palpation there was a distinct and well-defined hardness, rounded in outline. The adjacent glands were markedly enlarged. The condition of the lip, and also the eruption, are readily seen in the accompanying photograph, which was sent to me shortly afterward by Dr. Cocks.

Careful questioning of the mother failed to reveal any source of the infection. The child had been bottle-fed since two weeks after birth. It could not be found from whom the infection had occurred, but, as the father and mother were born in Finland, and as syphilis is very common there, it is more than likely that some one of her friends, who had now and then temporarily cared for the baby, had infected the nipple of the nursing-bottle, in the manner described. Dr. Cocks is still investigating, and writes that he hopes to trace the source of infection.

Syphilis from innocent causes is almost pandemic in certain parts of Russia and Finland, and is mostly transmitted in family life, and is seldom thought of as a venereal disease, as the cases thus acquired are very rare, compared to those acquired through family and friendly intercourse. Among the ignorant peasants few precautions are taken, and the disease is often untreated, and spreads readily and naturally. In this country there have been a few small epidemics from unrecognized cases of extragenital syphilis, but when once discovered the disease has been readily stamped out in such localities. But there are yet large numbers of syphilitics everywhere, and not at all infrequently I meet people who have very active mucous patches quite capable of communicating the disease where the patient seems quite unconscious of the danger to which he is submitting those around him. One can not be too cautious in regard to dangers from syphilis, and the greatest care should be exercised in instructing patients with the disease, especially when in an at all active stage, so that they may not communicate it to innocent victims, such as the little one whose case has been detailed.

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#### DISCUSSION.

DR. R. R. CAMPBELL, Chicago—The eruption, as shown in the picture, is a very typical one and the case is an interesting one throughout. I would like to ask the Doctor whether he noticed where the macular eruption roseola made its first appearance. In observing these cases in my clinic, at the Chicago Polyclinic, I have been interested in observing where it makes the initial appearance. In following up this point I have ob-

served few cases of syphilis. in the last eight years. in which the eruptions did not first appear about the umbilicus. I had one case of extragenital chancre on the lip of an adult, which was caused by the bite of a prostitute. I traced it to her and found her suffering with syphilis. The manifestation seemed to be secondary in character about the face, but when I looked at the abdomen it was more marked, showing older lesions. which had appeared first about the umbilicus. I would like to hear from other gentlemen as to whether they have ever noticed that point.

DR. A. E. CARRIER, Detroit, Mich.—The subject of extragenital chancre is very interesting. Why could not the disease in this case have been caught by kissing, as well as from the nipple from the nursing bottle? I have had two cases within a short time of chancre on the tonsil, and both were innocently acquired. One patient had been treated for diphtheria and had had four injections of antitoxin, and had been under the care of several physicians before she was sent to me. This case occurred from the patient kissing her affianced. The second one was probably contracted from infected instruments, as she had been treated locally for mild sore throat, from which she recovered completely, to be followed later by a chancre on the tonsil, and nine months later, when I first saw her, the body was covered with syphilitic lesions. I have seen so many cases of syphilis among nursing girls, who have come to my clinic for treatment, with mucous patches in the mouth, and lesions on the lips, that I wonder, when so many chancres are taken in this way, that so few cases of extragenital chancre occur.

DR. THOS. E. HOLLAND, Hot Springs, Ark.—Our patients come to us, and in many of them the histories of an original lesion are not traceable; but I have seen quite a number where it first appeared on the tonsils. I have not been able to explain it exactly, but I have a case just now, a short history of which may possibly be of some interest. The young man has a very bad case of eczema. He claimed to have contracted it in the war. Itching was excruciating. He was at Hot Springs for about six weeks, when, very much relieved, he went away, as he thought, about well. I did not think so. He had gone two weeks when he telegraphed me that the disease was appearing on his arms and he would like to come back. When he arrived he had an ulcer on his left tonsil, which was suspicious in appearance. The eczema was not troubling him as much as I anticipated. I watched the tonsil for four or five days, then an eruption broke out under the arms and over the body, a typical syphilitic eruption. That boy had been out from under my care only about two weeks, and for two months I saw him practically every day, and no other lesion appeared. The only one which existed prior to the breaking out of which I spoke was the ulcer on his left tonsil.

I can say that at least 5, and possibly 10 per cent. of the people who come under my observation for syphilis do not know or remember of an original lesion. I am unable to trace it or unable to assist them in calling to their minds the fact that they had a lesion at all.

The paper which the chairman read is a very interesting one, and there is no question that kissing, the nursing-bottle, and drinking cup as well are all prolific in their effects, so far as communicating syphilis is concerned. At Hot Springs every one is cautious with drinking vessels. Many of them are fearful of drinking out of the glasses, etc., and I instructed my people how to drink without exposing the mucous membranes of the mouth. There is no question in my mind that there is not enough attention paid to the selection of nurses for children. I think a great many children are affected by disease and careless nurses.

DR. A. H. BOWEN, Columbus, Ohio—With regard to extragenital chancres, I have had several interesting cases; two where the lesion occurred on the finger. One was on a dentist and the other on a physician. In the latter, before he found he was affected he had communicated it to his wife and both were suffering from it in severe form. In another case it was on the scrotum, 1½ inches from the root of the penis; in another, on the lip. In the latter I was unable to trace the source of infection. In regard to the location of macular eruptions, I always find them more marked and distinct on the abdomen than on other portions of the body.

DR. M. F. LEE, Columbus, Ohio—Three years ago I saw two patients with chancre of the lip. One was a young man, 23 or 24 years of age, who used a blow-pipe in his business, and he told me he had been poisoned by an acid solution it was dipped into. It struck me as being a typical chancre. I told him so and he was very much alarmed. As he went to go out he asked me to give him a drink—he almost fainted. Three or four hours afterward he came in with a nice-looking woman who had a chancre on the lip, an eruption of a very severe type of syphilis. She confessed to having kissed the young man, and she had been kissed by a professor in a college who had visited her some time before. These two people were treated—they were engaged. Some time afterward this woman brought a man to within a block of my office—I saw them—he came to the office and she went away. It was the professor.

I have seen one case of a chancre which was undoubtedly contracted by blowing powder in the throat. The patient had been treated by a throat specialist who used a bulb, and in that way carried the secretion from the mouth of one to the mouth of the other.

DR. D. L. PARKER, Detroit, Mich.—There is one point of view that impresses me. That is in regard to the nature of transmission of the poison. It seems to me that the view taken by the Doctor is most rational in the case presented. Infection must have been either by the nipple of the nursing bottle or by the direct act of kissing. I have seen a few cases of chancre of the lip. These are not generally diagnosed until they have been on the lip for some time. In these, in the household, where they use the same drinking cups, glasses, etc., I am surprised to find how very rarely the disease is transmitted. And it makes me think there must be associated with the transmission heat and moisture; that the cold water may have applied chilliness enough to the virus to cause it to be so inactive that it will not readily transmit. In other ways the moisture and heat are supplied, and in those cases it is more apt to be transmitted.

DR. FRANK WARNER, Columbus, Ohio—I did not hear the paper, but I gather from the drift of the discussion that the experience of these gentlemen is the experience of all physicians in practice, that is, that physicians are constantly running across patients infected with syphilis by exposures out of the ordinary. There is one case that I remember, in particular, of chancre on the lip of a female, supposed to have come from kissing; probably it did, for in the mouth in the male who kissed her were found mucous patches. I suppose that is the most frequent way chancre on the lip is acquired, but it may occur from common drinking cups, no doubt; and the plan suggested for drinking from public fountains by not bringing the cup into contact with the mucous surface is a valuable one, one which I learned fifteen years ago from Dr. Dunn, a physician in Cincinnati, who has since died. I remember having seen a chancre on the finger, which came from the examination of the vagina, on the surface of which was located a syphilitic disturbance, the exact stage of which I do not remember. In another case a chancre on the arm came from the bite of an infected patient. These cases only go to illustrate that any of these methods is capable of infecting a patient with syphilis; and I believe we should instruct the public more fully along this line.

DR. R. R. CAMPBELL, Chicago—Since speaking before four cases have been recalled to my mind, seen with Dr. Miller of Chicago. One was a street-car conductor, and the other a man from one of the best families of Chicago. The chancre was situated on the tonsil, the left in each case, and we could not trace any possible source of infection. In the case of the street-car conductor, particular attention was paid to the history, and we traced it down as carefully as possible. He was rooming with another man, and we thought possibly he had been using the pipe which the other used, but found there was no possible source of infection from that. In the other instance the patient was from one of the best families and Dr. Miller had had him under observation fully thirty years, and there never had been any syphilitic history in the family; he had never had anything of the kind as a boy or a young man, and this time came to see Dr. Miller with a chancre on his tonsil, followed by the evolution of typical syphilis. He said he had not used any smoking utensils which another had used, and the only possible means of infection, which we could reasonably suppose was that, as he was taking luncheon in

various restaurants, he had carried the virus back there by the use of table utensils, notwithstanding the fact that that may seem to be rather an unreasonable conclusion to arrive at in a case of chancre on the tonsil.

Case 3 was a male cook. In cutting a piece of steak he accidentally cut the middle finger of his left hand and at the point of injury, either from the knife or a dirty cloth that was used in dressing the wound, infection took place and an initial lesion developed nineteen days after. In following the case and searching for other possible sources of infection, not the slightest could be found. The subsequent evolutions of the disease followed the ordinary course.

Case 4, a traveling man, always shaved in a barber shop, and received at one sitting a cut on the chin, and in twenty-seven days thereafter what proved to be a chancre presented at the point of injury. The patient had not been exposed in the meantime, to any reasonable source of infection other than from the razor or towels that had been used, for in closely examining and questioning the barber employed I was satisfied he did not have and never had had syphilis. My diagnosis was confirmed by the subsequent evolutions of syphilis.

DR. THOS. E. HOLLAND, Hot Springs, Ark.—I would like to ask what constitutes a necessary condition to contract syphilis; in other words, how must the surface be prepared in order to absorb the virus? Must it be abraded or placed in a mucous membrane and allowed to remain a certain time, or, like vaccination, does it require an ulcer or sore place? I do not think you can take the virus and bind it on the unbroken skin for six hours and have any effect. It is a question whether you can do it on a mucous membrane. What must the condition of the lip be to take on syphilis? Is it necessary to have an abrasion in order to absorb the virus?

DR. L. D. BULKLEY, New York City.—I will answer the question as far as possible. I have seldom seen a case of chancre of the lip without some history of an abrasion, a bite, or "cold sore," etc. The other case, chancre of the tonsil, is most interesting. I reported fifteen unmistakable cases, with full histories, in one paper. The tonsil is necessarily abraded. I believe that if a person swallows a little bit of the virus, the pathogenic germ lodges in some crypt of the tonsil, and so produces the ulcer. In case of the penis, the pus germs are held under the foreskin, with the virus of syphilis, and can break the mucous membrane there and be the means of forcing the entrance. I do not believe that the virus of syphilis placed on the fully-developed, healthy epidermis would have the least effect, but it often enters through the abrasion of the epidermis. One physician came in the other day whose inoculation on the forefinger occurred nearly four months ago, dating back to a confinement. We traced it back as syphilitic. Almost four months after infection the eruption came out over his body. It is the longest duration I ever knew. There are cases on record up to five months, but these are very rare.

This child reported is the youngest one I ever saw with acquired syphilis. I have seen children down to 2 or 3 years old infected, but never saw one under 1 year old, before. There are almost none reported under one year old in recent literature.

In regard to kissing, it is so seldom that a child is kissed directly on the lips, that a chancre is not often acquired by them in that way. Nor is it often that chancre of the lips is acquired by kissing in home life; it is not sisters to whom men give chancres, but sweethearts.

Another unusual thing is observed in this case, in the location of the sore on the upper lip; three chancres out of four are on the lower lip; it is most rarely that we see them on the upper.

DR. R. R. CAMPBELL.—Did you ever observe, in regard to the location of chancre on the tonsil, whether they were most commonly on one side or the other?

DR. L. D. BULKLEY.—No they are almost equally divided. In regard to the matter of first development of the eruption, it does frequently come first on the body, not always as low as the umbilicus; but it is rather apt to be on the face fully as early. It is hard to say about that in regard to many of the cases that come to me, because in many instances they do not know of the absence until the eruption has appeared. In quite a large share of my cases the chancre has been found

only after considerable search. In one case, after the patient was stripped it was only after a long time that I was able to find the initial sore, which proved to be a typical chancre near the end of the coccyx, which he had gotten from a bathing suit.

## Therapeutics.

### Glycerin in Nephrolithiasis.

A. Hermann, in the *Medical Chronicle*, January, 1900, gives the following favorable figures in the treatment of 115 cases of this disease with glycerin. In 15 cases concretions were passed and improvement noted; in 25 cases there was improvement of the condition of patients without passage of concretions; in 46 cases glycerin had no effect.

Improvement noted in the above patients was along the following lines. Usually the dull boring pain in the back, which frequently accompanies the disease, was stopped, painful sensations along the ureters would disappear, and movements of the trunk, which had been avoided because painful, could be made without distress. Pain in the kidney region usually followed administration of the drug, but was not severe enough to require the use of narcotics. These generally ceased after a time. Urine voided after the use of glycerin was quite free from albumin, sugar, or blood, but contained much mucus and pus, especially where the disease was complicated by pyelitis. Urine passed after taking glycerin contains considerable quantities of the substance. He attributes the active qualities of glycerin to certain characteristics of the drug. The renal passages are lubricated, but he thinks it has no solvent chemical action, as concretions passed seemed just as hard and had quite as sharp points as those passed spontaneously.

The dose was kept within the limit of from one to four ounces, according to the weight and age of the patient. The amount given was dissolved in an equal quantity of water and administered once a day between two meals; it was repeated two or three times in intervals of several days. In a few cases with nervous patients, headache was complained of; diarrhea might rarely occur in people with disordered digestion, but these effects lasted but a few hours.

### Massage for Pyloric Constriction.

The *Semaine Méd.* calls attention to Dubard's suggestion that the pylorus responds much more promptly and effectively if the massage is commenced on the intestines and peristalsis started before the region of the pylorus is touched.

### Active Treatment vs. Expectation in Acute Gonorrhea.

The *Semaine Méd.* of January 27 quotes Steifon to the effect that in the military hospital at Warsaw, 233 soldiers with acute gonorrhea were treated with the urethral injections now in vogue, resulting in the cure of 48 per cent. in on average of twenty-eight days. A hundred other cases were treated exclusively with alkaline drinks, with 68 per cent. cured, the average forty-three days. The first method no doubt induces a more rapid cure but fails in a much larger number of cases. Local treatment, it adds, should be reserved for the chronic form.

### Obstinate Neuralgias of Obscure Origin.

Henry Posert, in the *Memphis Lancet*, February, 1900, describes treatment of some cases of obstinate or obscure neuralgia, which has sometimes proved beneficial. He finds in supra-orbital neuralgia that errors of refraction have no bearing, as they are seldom present, and if present, when corrected no relief is obtained. He also fails to find their cause in gouty or rheumatic diathesis or malarial intoxication. Quinin never relieves it. He has been successful in applying cold locally, giving hyoseyamin, aconite, cannabis indica, and caffeine internally. (See ¶ 167, p. 554.)

Cervico-occipital neuralgia may be limited to the great occipital or it may involve the four upper cervical nerves. The pain, which is often intense, is not relieved by antirheumatic or antineuralgic remedies.

Most dorsointereostal neuralgias follow la grippe or malaria, but occasionally one is found which can not be traced to debilitated conditions; these resist treatment for a long time. He finds that galvanism, quinin, salicylate of sodium combined