

## SYPHILITIC ULCER OF THE STOMACH

REPORT OF A CASE EXAMINED HISTOLOGICALLY

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In view of the fact that the impression prevails in some quarters that syphilitic ulcer of the stomach is a rather rare condition, and since, in spite of the assertions of others, that it is fairly common, comparatively few cases are reported in the literature, the following case would seem to be of some scientific interest:

A negro laborer, aged 50, complained of pain in the stomach after eating. The family history was negative, except that the wife had had one late miscarriage. The personal history was negative for any trouble bearing on the present illness. There had been no stomach trouble before the onset of the present illness. The patient denied lues but admitted gonorrhoea.

The present illness began three months before admission with a sharp pain in the upper epigastrium, radiating to the right side, appearing from one-half to one hour after meals, being fairly constant in appearance, but varying in intensity. It was never severe enough to become a definite colic. Acids appeared to increase the pain. The patient thought that he had lost some weight, the amount of which was not known, but probably about 20 pounds.

Physical examination revealed nothing abnormal except tenderness on pressure over the epigastrium, especially just to the right of the midline. Examination of the blood showed a slight anemia (4,300,000 reds; hemoglobin 65), but nothing else of interest. The Noguchi test for syphilis was positive.

Stomach analysis after an Ewald meal showed an absence of free hydrochloric acid, a total acidity of 25, occult blood and lactic acid and Oppler-Boas bacilli. Microscopic examination of the empty stomach contents, removed by means of a Jutte duodenal tube, revealed nothing abnormal. The tube passed through the pylorus with some little difficulty (1 hour), but as soon as it had become engaged in the pylorus, an interesting change in the microscopic appearance of the contents was noted. Numerous pus cells, with a mixture of red blood cells were noted, along with a large number of cylindrical and globular gastric epithelial cells, giving a very different picture under the microscope from that obtained in the first stomach contents removed. The duodenal contents were normal cytologically and chemically.

The patient was placed in bed, and on specific treatment (mercury and potassium iodid), for two weeks. At the end of this time, there was no demonstrable improvement in his condition. The pain was as bad as before. He was afraid to eat on account of the discomfort. At this time it was noted that the administration of hydrochloric acid after meals seemed to increase the pain.

In view of the absence of any improvement in the gastric or general condition of the patient after two weeks of anti-luetic treatment, it was deemed advisable to perform an exploratory laparotomy on the suspicion of the presence of a malignant condition. At operation, a marked annular thickening was made out, encircling the first part of the pyloric region. There was a general enlargement of the pyloric lymph-nodes. Also, several large mesenteric lymph-nodes were observed. Several of the pyloric nodes were as large as Lima beans. A resection of the pylorus was done. The specimen removed at operation showed an annular, apparently active ulcer, almost completely encircling the first part of the pylorus. The submucosa appeared to be most involved. The edges of the ulcer were undermined and soft. The floor was smooth. At one extreme end there appeared to be an attempt at healing. Microscopically, the picture was one of degeneration, chiefly of the submucosa, but affecting also the muscular layers to some extent, with a marked periarteritis of all the arterioles. The mononuclear elements played almost the entire part in the periarteritis.

At the point where the attempt at healing was suspected, there was an evident growth of new connective tissue. The large lymph-nodes showed a simple hyperplasia.

The patient made a good recovery from the operation, received a dose of salvarsan and a thorough mercurial treatment, and was as well as ever when last heard from, about eight months after the operation. The histologic specimens were submitted to several competent pathologists and all agreed that the picture was that of a syphilitic periarteritis. No spirochetes could be demonstrated in the sections.

In a search of the literature, I was able to find only one case reported which resembled the foregoing in all respects, even to the resection of the stomach and to the histologic appearance of the lesions. This was reported by Hayem<sup>1</sup> in a man of 60, on whom a resection was done on the suspicion of malignancy, which condition was suggested by the stomach analyses, as it was by the stomach analyses reported above.

It will perhaps be well to state that since this case, I have been very suspicious of all ulcer cases which have fallen into my hands, and although I have seen two since then in which there were positive Wassermann reactions, I have seen no benefit to either from the administration of mercury and potassium iodid, and, in one case, of salvarsan.

I wish to thank Dr. R. W. Knox, chief surgeon of the Southern Pacific Lines, on whose service the case was observed, for permission to publish this report, and also Dr. Martha A. Wood, who prepared the histologic specimens.

## BREAKAGE AND REMOVAL OF EUSTACHIAN APPLICATOR

G. W. STIMSON, M.D., PITTSBURGH

Recognizing the truth of the statement that it is by our mistakes as well as by our successes that we profit, I wish to submit the following short report of an unexpected and unforeseen accident that occurred to me a short time ago:

A woman, aged 20 (a private patient), refined and of a highly nervous temperament, complained of fulness, tinnitus and some impairment of hearing, etc., in her left ear. The diagnosis was tubotympanic catarrh. In order to shrink the mucous membrane of the eustachian tube so that I could get a blast of air freely into the middle ear or pass a eustachian bougie, a Yankauer's eustachian applicator tipped with cotton soaked in a mixture of cocain and epinephrin was passed well into the tube. When this was removed it was discovered that the distal end had broken off, consisting of the cotton tip and an inch of the twisted wire applicator.

Thinking, or rather hoping, that it might have dropped into the pharynx, I made an attempt to pass a gentle blast of air through the tube. No sound could be heard, however, through the ausculting tube, the occlusion being apparently complete. In the hope that the end might be protruding enough from the mouth of the tube to permit its being grasped with forceps and removed, I carefully inspected the eustachian opening with the aid of the Holmes nasopharyngoscope, but there was no sign of the applicator. It then occurred to me to pass another dry cotton-tipped applicator, twirl it around with my thumb and forefinger and withdraw it. This was done and at the first trial, to my gratification, the dry cotton engaged the broken end of the wire and together with its cotton tip it was withdrawn through the catheter.

During the short interval required the patient was blissfully unconscious of what had occurred (which was particularly pleasing on account of her temperament), and only when she inadvertently caught sight of the dangling end did she unconcernedly remark, "Oh, did the cotton come off?"

While I had used Yankauer's eustachian applicators hundreds of times I had never had the slightest trouble in any

1. Hayem: *Maladies de l'estomac*.

way, and when I sought for a reason I found that before the sterilization of the applicator (which had been used once or twice before) by boiling, the cotton had been burned off, and this had taken the temper out of the wire and made it brittle, although it had withstood the pull that I always make to test whether or not the cotton is perfectly and securely applied. Of course, this should never be done; the cotton should be removed by laying the applicator flat on a glass-top table and scraping it off with a knife or some semisharp instrument.

In a conversation a few days ago, Dr. Yankauer told me that I was the second who had recited to him an occurrence of this sort. I hope that if this accident, which might readily prove most embarrassing, should befall another, he may find in the foregoing report some helpful suggestions and profit.

#### PROSTATIC ABSCESS OPENED THROUGH THE CYSTO-URETHROSCOPE WITH THE HIGH-FREQUENCY SPARK

ABE NELKEN, M.D., NEW ORLEANS

Abscess of the prostate is one of the less frequent complications of gonorrhoeal invasion of the posterior urethra. In fully 75 per cent. of the cases, the abscess points toward the urethra, usually causing complete retention of urine and requiring regular catheterization until such time as spontaneous rupture into the urethra occurs. This is usually from seven to ten days after the onset of retention, but I have seen cases that have gone as long as three weeks before being relieved by the abscess discharging into the urethra. Operative interference is rarely justified in these cases, for incision of the abscess either through the perineum or through the urethra by perineal incision is a comparatively radical procedure when it is remembered that it is the rule for such abscesses to rupture into the urethra if given time. The simpler procedure of draining through the rectum, save perhaps in cases about to rupture into that organ, is bad surgical practice for obvious reasons.

I have recently opened a prostatic abscess by means of high-frequency cauterization through the Buerger cysto-urethroscope, and the procedure was so simple and caused the patient so little discomfort that I believe the report may be of interest:

E. L., negro, aged 26, applied at the Touro outclinic for relief because he had been unable to urinate for the past two days. There had been gonorrhoea of four weeks' duration. The bladder contained 16 ounces of slightly cloudy urine. Patient returned next day still suffering from retention. Sixteen ounces of urine were again withdrawn. Through the cysto-urethroscope, the posterior urethra was inspected. The mucosa was found to be much injected. Just behind and slightly to the right of the colliculus, distinct bulging could be seen. The flexible electrode was pushed against this bulging area and a rather mild current applied. In thirty seconds there was seen through the instrument a puff, resembling exactly a powder explosion, the field of the instrument rapidly clouded, and I knew that I had opened the abscess. The patient experienced no pain at any stage of the proceedings, which did not last more than five minutes in all. He has been emptying the bladder without difficulty since.

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**The Physician's Life.**—The study of medicine is an entrancing subject; its practice require an array of virtues whose mere contemplation staggers the mind. One must meet violence with gentleness, ingratitude with equanimity, insult with fortitude, slander with silence. The physician's life is a daily exemplification of the golden rule. The very sensitiveness that inspires sympathy with pain and misery is a weapon in the hands of ignorance and malice wherewith they deal dreadful wounds, wounds which must be endured silently. Resentment can have no place in the physician's mind. Equanimity must be maintained in the face of misapprehension and abuse.—Gadsden (Ala.) *Times-News*.

## Special Article

### PRACTICAL PHARMACOLOGY\*

(Continued from page 341)

#### IV

#### A. STIMULANTS: 2. MEDULLARY—ATROPIN GROUP—(Continued)

##### LOBELIA

The action of lobelia is practically that of its alkaloid, lobelin, which resembles nicotin closely in its preparation and actions.

Tobacco was used formerly in a great variety of conditions, but owing to its careless use and the great toxicity of its alkaloid, many accidents resulted, and it fell into disuse in therapeutics. If the drug which has been studied more frequently should now be considered of little value, it is difficult to explain the advantages to be derived from lobelia. Lobelia itself is no longer used as an emetic as it was formerly. It would seem that physicians are loath to give up a drug which has been so long in use.

Those who wish a detailed description of lobelia, or lobelin, are referred to the larger text-books of pharmacology, for its actions are very complex. The peripheral actions of lobelin, like those of nicotin, may be summarized as consisting of stimulation of the ganglia of the sympathetic and parasympathetic systems throughout the body after small doses, followed by depression or paralysis of these ganglia with large doses. It will thus be seen that lobelin acts on the organs innervated by the sympathetic and parasympathetic systems in opposite directions, depending on the dose, and the complex nature of its effects may be appreciated when one remembers that the actions of these two sets of nerves are commonly antagonistic.

Stimulation and depression of the ganglia induce the same effect on the organ supplied as stimulation and depression of the nerve endings; hence lobelin combines in itself the peripheral actions of a number of drugs including atropin, pilocarpin, epinephrin and others. In addition to these actions it stimulates and later depresses various parts of the central nervous system.

The emetic action, for which lobelia was formerly used, points toward the medullary centers as the seat of this stimulation, and it also stimulates the vagus, vasomotor and respiratory centers.

The action on the vagus ganglia results in cardiac slowing, which is augmented by the stimulation of the vagus center, but this is soon followed by an increased heart-rate due to the depression of the ganglia. The rise of blood-pressure of peripheral origin is also augmented by the central actions.

Lobelia is not used for these effects, and it is now sought to avoid more than slight stimulation of the vomiting center, because dangerous collapse is frequent with large doses.

The treatment of poisoning is symptomatic, severe poisoning with lobelia being rare since its use as an emetic has been abandoned.

Nicotin is excreted by the kidneys in part, and the same is probably true of lobelin.

\*This is the fourth of a series of articles on useful drugs—on practical pharmacology for the general practitioner. As soon as completed, these articles, elaborated by additional subjects, will be published in book form.