

THE CONSIDERATION OF LATE HEREDITARY SYPHILIS.*

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On several occasions young girls from 5 to 18 years of age have been shown at meetings of the Chicago Dermatological Society, who presented undoubted lesions of tertiary syphilis, without a history of extragenital infection or previous eruptions of syphilis, and in whom none of the triad symptoms of hereditary syphilis was present. In the discussion of these cases it was apparent that a difference of opinion existed as to whether these were cases of extragenital infection or cases of long periods of latency in hereditary syphilis. The question which arose was: Can hereditary syphilis manifest itself for the first time some years after birth by the presence of such late lesions as occur in the acquired form, and with a total absence of triad symptoms?

That long periods of latency is one of the chief characteristics of acquired syphilis there can be no doubt, as we all have seen cases in which from ten to twenty years have elapsed from the time the disease was acquired to the time the tertiary symptoms appeared.

If long periods of latency may occur in the acquired form of syphilis, why may they not occur in hereditary syphilis? Syphilis is the same whether acquired by the individual himself directly, or transmitted to him by his parents at the time of conception. Such being the case, then we might expect to find long periods of latency in hereditary syphilis, and, if long periods of latency do not occur, then this form of the disease differs from ordinary or acquired syphilis.

While it often may be extremely difficult to establish the fact that children born of syphilitic parents and exhibiting late lesions may not have had other lesions early in life, still such cases are not infrequently met with. They must, however, be very carefully scrutinized, in order to avoid error. The ease with which one may be deceived in this matter is illustrated by the following cases: I have under observation at the present time several children who presented symptoms of hereditary or congenital syphilis at the time of birth, but who are entirely free from evidence of the disease at the present time. Were these children to be observed at the age of 20 years, and lesions of syphilis be found present, these children never having been informed by their parents or physician that they were born with the disease, would naturally give a negative history, and their cases readily be misconstrued or accepted as cases of acquired syphilis.

In establishing a diagnosis of hereditary syphilis, there are three points, known as the triad of syphilis, which have long been looked upon as of the greatest value. These are, namely, Hutchinson's teeth, interstitial keratitis, and a particular form of deafness. Let us consider these points in order:

TEETH.

Great stress has been laid on the diagnostic value of the Hutchinsonian teeth, but they in themselves are late manifestations of inherited taint, and can be accepted in no other sense. They are not present in the first or temporary teeth, but in the second or permanent

teeth, which do not appear until the fifth or sixth year, and are not always indicative of syphilis when present, as J. C. White¹ has reported a case of a boy who presented the central incisors notched from side to side, with the lateral incisors wanting, in whom the suspicion of syphilis was absolutely excluded. The other teeth were normal. The deformity followed a sudden and severe attack of cervical adenopathy. Again, the characteristic teeth are present in only a minority of those who are the subjects of inherited syphilis, and it is unquestionably true that teeth of perfect development may not infrequently be seen in the mouths of those who have suffered severely from inherited taint.

INTERSTITIAL KERATITIS.

This is perhaps the most frequent of Hutchinson's symptoms, and occurs usually between the ages of 6 and 15 years; but, unlike the Hutchinson teeth, it may appear as early as the second or third year of life. Fournier claims this symptom may be due to malnutrition, as well as to inherited syphilis, and no differentiation between these two etiologic factors can be made in the effects on the cornea.

LABYRINTHIAN OR CENTRAL DEAFNESS.

This syphilitic deafness, depending, possibly, on lesions of the auditory nerves, is most frequently met with in children about the age of puberty, or in adults, and manifests its presence by the following symptoms: It is, as a rule, unilateral in the beginning; but after a shorter or longer period, varying from a few weeks to some months, the other ear becomes affected, deafness appears suddenly, and advances rapidly; it is not accompanied by pain, or any discharge, although occasionally an otitis media purulenta may be present. The patient complains of noises, dizziness, and sometimes even attacks of vertigo occur. The deafness is usually progressive, and after some weeks may become absolute. It is not improved by anti-syphilitic treatment.

While the above-mentioned points are of great diagnostic value in hereditary syphilis, there are others which, although perhaps not so common, are nevertheless of much significance when present.

Among these may be mentioned acute ulcerative destruction of the palate in young persons. This in itself is almost conclusive proof of an inherited taint.

Edmond Fournier² and some other French writers lay great stress on the findings in the fundus of the eye as an aid in the diagnosis of hereditary syphilis. In one case he describes atrophic chorio-retinal plaques in both eyes.

In another case the remains of an old papillitis was seen. Vascular changes, and alterations of pigment, which the oculist, Antonelli, stated could only be the stigmata of hereditary syphilis, were observed in one eye, and in the other there was a rudimentary optic neuritis, a diffuse retinitis of several months' standing, manifesting itself by several foci of exudations in the central region, by a suffusion which was quite extensive, and by multiple separations of the retina in the temporal and upper sections of the eye fundus.

Late hereditary syphilis may affect the skin, appearing as gummata, singly or in groups, of solid nodules, which are dark red in color, and are most frequently seen on the face or forelegs. These nodules may later break down and ulcerate. On the face they most frequently attack the nose, and when on the legs the anterior surface. The ulcers are sharply defined and clearly

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1. Archives of Dermatology. April, 1878.

2. Annales de Derm. et Syph., 1904, p. 152.

cut, with abrupt, uneven edges, and present the usual characteristic appearances of the ulcerating gummata of acquired syphilis. Unlike early acquired syphilis, we never have any scaly or small papular eruptions.

Notwithstanding all of these points, it must be admitted that there are patients in whom, in spite of the modern development of diagnosis, the recognition of inherited taint is still a matter of great difficulty, if not an impossibility. We must, however, be prepared to encounter now and then manifestations of inherited syphilis in those who do not show a single corroborative feature. Hyde³ remarks that not every child with Hutchinsonian teeth, with cranial bosses, with natiform skulls, or suffering from a rebellious affection, is the victim of inherited syphilis, and that even the painstaking labors of A. Parrot have not sufficed to obliterate the distinction between syphilis and rickets.

Cases of latent hereditary syphilis are not very numerous in the literature:

Jordan⁴ reports the following two cases:

CASE 1.—Patient, army officer, 22 years old. Applied April 23, 1902, for treatment for disease of the knee joint. He denied all knowledge of venereal disease. About the end of April, 1901, patient first complained of pain in both knee joints on climbing stairs. This without apparent cause. In June pain disappeared from the right knee joint, while the pain in the left became more intense. Early in July the army surgeon noticed a swelling of the knee joint and induced the officer to ask for a furlough.

Treatment.—No improvement was noted after treatment with baths and compressed applications, consequently the patient entered a surgical clinic in September, 1901. Effusion in the left knee joint was treated with iodine, compression and hot air. The swelling decreased in amount, but did not entirely disappear. Palpation of the joint was painful and an incision was made above the patella, under the supposition that the case was one of tuberculosis. Drainage of the joint with iodoform gauze. Examination of the urine was negative as to gonococci. The wound healed and the patient was discharged in November, wearing a plaster-of-paris dressing or cast. The end of March following the swelling in the joint, which had never entirely ceased, became increased.

Examination.—April 1, 1902, when first seen by Jordan, the left knee joint was markedly swollen and tender, and there was slight swelling in the right knee. Both joints were freely movable. A thorough examination of the young man did not reveal any signs of a past tuberculosis or lues.

Treatment instituted consisted of complete rest in bed, baths and compression bandages.

Diagnosis.—A week later, notwithstanding this treatment, the swelling increased in the right knee joint, and closer observation gave the impression that the cause of this swelling was syphilis. Jordan made his diagnosis by exclusion. Hydrops could not be accounted for by its usual etiologic factor. Trauma was excluded. Acute articular rheumatism was absent. No signs of gonorrhea were present and also no tuberculosis. The negative results of the incision, combined with all the preceding features, brought him to the conclusion that this was a case of lues. The slow bilateral effusion in the knees, the slight pain, the insignificant functional disturbance, the changing of the symptoms and the failure of all treatment were all facts in favor of syphilis. As acquired syphilis was excluded with certainty, it could only be a case of late hereditary syphilis. The favorable result following specific treatment justified this diagnosis.

Family History.—The family history of the patient disclosed the following facts: The patient's father was a physician and became infected with syphilis on the hand while attending an accouchement in 1872. He married in 1877. His wife, who was still alive, stated that on several occasions he had had eruptions on the face, and took iodid of potassium.

Maternal history: First pregnancy in 1878. Premature birth. Child died a few hours after birth. Second pregnancy. 1879. Miscarried at five months. Child dead. Third pregnancy, 1880. A normal, healthy boy. (Jordan's patient.) No affections. Fourth pregnancy, 1883. Aborted at two months. Patient's mother, in 1886, had a stroke of apoplexy, but completely recovered. In 1887 she had an ulcer of the soft palate, which rapidly healed under antisypilitic treatment. The patient's father spent nine months in an asylum in 1882 for some brain trouble. Marked improvement. In 1883 committed suicide.

The diagnosis in the patient's case was latent hereditary syphilis. The treatment was sodium and potassium iodid, with the result of complete recovery. In November the patient resumed his duties as an army officer.

This case is considered a typical one of latent hereditary syphilis, with a single localization.

The second case was one of bilateral exudative gonitis, combined with keratitis parenchymatosa, in which complete recovery followed antisypilitic treatment. The history of this case is as follows:

CASE 2.—Patient, a boy, 5 years of age, came to the clinic in July, 1895, suffering from a bilateral inflammation of the knee joints; the knees were swollen, and the ends of the bones considerably thickened. There was also a keratitis parenchymatosa. Dec. 15, 1895, after a course of treatment, the patient was discharged. In January, 1901, trouble appeared in the eyes. In the spring of 1903 the patient, who was now 12 years old, was again examined and found healthy. On the left cornea some cloudiness, due to scar, was found. This lessened the field of vision considerably. The joints were found to be normal. With the exception of the scar on the cornea, no evidence of syphilis could be detected.

Family History.—Father had an ulcer on the penis in 1881. Married in 1886, or five years later, and infected his wife in about a month. Symptoms in mother were roseola, condyloma of labia, and mucous patches in throat. By Oct. 28, 1886, all symptoms disappeared under treatment. In 1887 gave birth to child, which died two days after birth. In 1888 another miscarriage at six months; fetus dead. In 1889 again miscarried at six months; fetus dead. In 1890, the fifth labor was normal, and a boy, the herein-mentioned patient, was born. The next, or sixth, labor was normal, and the child, which at this time was 9 years old, was anemic and suffered from headaches. The seventh pregnancy: Premature birth, stillborn child. In 1895 eighth pregnancy, normal delivery at term; child at this time 7 years old and healthy. The ninth pregnancy was again premature; fetus dead. The last pregnancy occurred in 1898; labor normal and child healthy.

This case substantiates Fournier's observation that in a syphilitic marriage the birth of a healthy child does not warrant that the children which may follow will be healthy; but, rather, that a syphilitic child follows a healthy one. In this case the period of latency was five years.

Hünicken⁵ (Brunie) reports a case of syphilis hereditaria tarda:

History.—The mother of the patient, who had always been healthy, was infected by her husband in the second month of her pregnancy. The corroborative symptoms of the mother's syphilitic infection were condyloma of the great labia and anus; roseola; angina; and periostitic headache.

Treatment.—The symptoms all disappeared after six months of antisypilitic treatment (inunctions). It was expected the mother would miscarry. On the contrary, however, labor occurred at term, and a healthy boy was born. He remained healthy, with no evidence of syphilis; learned to walk when 2 years old; was vaccinated at age of 3 years. At 9 years old he complained of pain in the knee on walking. This was followed by swelling of both knee joints. Diagnosed simple synovitis. Was treated with ice, compression and rest for

3. Med. News, Dec. 14, 1897, p. 727.

4. Münch. med. Woch., 1903, 50, p. 1324.

5. Deutsche med. Woch., 1896, vol. xxii, p. 46.

three weeks, with no improvement. At this time both tibiae were discovered to be highly sensitive to the touch. The diagnosis was changed to latent hereditary syphilis, and the trouble, after four weeks' treatment by inunctions and potassium iodid, entirely disappeared.

Barthelemy⁶ reports the following case:

History.—A man contracted syphilis and was treated by Ricord for eighteen months, at the end of which time he married. For twenty-five years following he had no manifestations of syphilis. His wife bore him five children, all at term, except the last, when labor occurred at eight months. The first child was treated by Millard for submaxillary ulcerative lesions, which were diagnosed scrofulo-tubercular lesions. When Barthelemy saw this patient he took these lesions to be local bacillary lesions. She had become a woman, 25 years of age, and had given birth to a healthy child one year previously. The second child, a son, when 23 years old, was treated for two years for acquired syphilis.

Her third child, at this time a girl of 20 years, is the subject of this case. She has never had any stigma of syphilis, either on her body, teeth, eyes or ears. A month previously a bulla, the size of a fifty-cent piece, was noticed. This was thought to have been caused by a burn or stinging of an insect. Burning and itching were severe, and became more intense and deeper from day to day, until a large granulous wound was present, which showed all the characteristics of a tertiary ulcero-circinated syphilid, and a nummular gumma of the skin, which diagnosis Fournier confirmed, without reserve. The gumma was located on the knee, and appeared twenty years after birth.

E. Gaucher, Lacapierre and H. Bernard⁷ report a case of latent hereditary syphilis with dental dystrophia:

History.—A female, 19 years old, was brought to the Hospital Saint Antoine, March 14, 1900, in a state of semi-coma. Examination revealed a right hemiplegia, with aphasia. Patient had given birth to a child a month previously.

The diagnosis made at the time was puerperal infection and metritis; bilateral phlebitis of the thighs; pulmonary embolism, which accounted for the pain in the thorax. To explain the hemiplegia and aphasia, it was supposed to have been caused by a fibrinous coagulation in the heart, which is slightly dilated. Patient positively denies any venereal infection, and of her father's history nothing could be learned. The patient's child died a few days after birth, showing no trace whatsoever of syphilis.

Treatment.—The appearance of the teeth attracted attention and suggested the possibility of syphilis, which suggestion was followed out, and the patient placed on daily inunctions, and four grams of kali iodid internally. Marked improvement followed immediately, and the patient was discharged from the hospital May 24, 1900.

One year later (April 21, 1901), patient returned to the hospital for consultation. There were present tertiary cutaneous gummata on the legs. The diagnosis was latent hereditary syphilis. Dental dystrophia revealed the presence of hereditary syphilis at 20 years of age. No previous accident would suggest the existence of syphilis, but a few months later the appearance of gummata on the legs and the effects of treatment confirmed the diagnosis.

Lannelongue⁸ mentions a case of a young man, 34 years old, who had a typical gummatous ulcer on one of his legs, the nature of which had not been suspected until the patient consulted Lannelongue, who diagnosed latent syphilis of hereditary origin. He mentions also three more cases of latent hereditary syphilis, in young girls, who were about to be married, and who never knew that they were thus afflicted.

CASE 1.—Young girl, from a syphilitic father. Suffered with a gumma of the leg.

CASE 2.—Young girl, 23 years old, for past four years affected with a phagedenic serpiginous ulcer of the leg.

CASE 3.—Young girl, 20 years old, affected with gumma of the soft palate.

H. G. Anthony⁹ reports a case:

History.—Twenty years ago a man acquired syphilis. He married while the roseola was present, and immediately infected his wife. A child was born three years after the marriage. Eleven years ago, when the child was 6 years old, he examined the family. The father and mother showed unmistakable evidence of the disease, but the child was free from symptoms of hereditary syphilis. Since this examination the mother, knowing that she herself had had syphilis, has always been very solicitous regarding the welfare of her daughter, and watched for skin eruptions or other possible symptoms of the disease, and up to this time she had never observed anything of a suspicious nature.

In October, 1903, she brought her daughter to Anthony again. She was 17 years old, and was found to have a circinate, ulcerating, tubercular syphilid, situated on the anterior surface of the chest. There was nothing in the history of the case which would in any way suggest a possible extragenital infection, and genital infection could be excluded as thoroughly as it ever can be.

Born of a syphilitic mother, who was known to be syphilitic at the time of conception, there is every reason to suppose that this is a case of hereditary syphilis, in which no appreciable evidence of the disease was present up to the seventeenth year of life.

L. Duncan Bulkley¹⁰ reports the following interesting case:

Examination.—Mrs. H., aged 24; fairly well developed. When first seen there were the active elements of a tubercular eruption on the forehead, right ear, arms, knee and back. On the left arm there were two patches, of a dull-red color, about an inch and a half in diameter, composed of curved lines, or rows of tubercles, which have advanced, leaving scar tissue behind, which later surrounded the elbow. The right arm was similarly affected. On the shoulders was an eruption, dark red, or copper-colored, with some crusting in places, composed of irregular patches of tubercles, and cicatricial tissue by the side of the more recent disease. The eruption extended down the back six or eight inches. Near the left knee there was a patch of the same form of lesion, and a few scattered tubercles on the upper lip. All portions of the eruption presented the same features, composed of tubercles of a dark-red or coppery color, elevated from one to two lines above the surface, either touching each other or separated by an erythematous redness. The cicatrices are all alike; supple, mostly white. The more recent ones stained and slightly depressed. In the middle of the forehead there was a depression in the bone, pyramidal in shape, the apex resting at the bridge of the nose and being about two inches wide at the base.

History.—Of the origin of this she could give no exact account. It had taken place slowly, beginning, she thought, at about 16 years of age. There had never been any externally discharging ulceration there. When 5 years old she had a deep sore near the ankle, which lasted four or five months, and which left a scar. Two years afterward, when she was 7 years of age, the present eruption first made its appearance, and has continued since, a period of fourteen years. She had been under medical treatment off and on, but never with any great success.

Family History.—Her family history was not clear. She thought her father was healthy. A sister, 30 years of age, she said, had the same eruption; and her sister's children were also affected. She herself had been married seven years, and had had four children, two of which are dead.

This patient remained for a time under antisyphilitic treat-

6. *Annales de Derm. et Syph.*, 1899, 3d ser., vol. x, p. 262.

7. *Annales de Derm. et Syph.*, 1901, 4th ser., vol. ii, pp. 437-46.

8. *Bulletin de l'Acad. de Méd.*, Paris, 1903, 3d ser., vol. xlix, p. 532.

9. *Illinois Medical Journal*, November, 1903, p. 368.

10. *Archives of Dermatology*, January, 1878, p. 70.

ment, and improved nicely, but disappeared before sufficient time had elapsed to accomplish a cure, so the ultimate results of treatment can not be stated.

The two cases reported by Willis S. Anderson¹¹ contain several points of interest. The histories are as follows:

CASE 1.—M. B., a girl, aged 16.

Family History.—Mother, apparently healthy, with no history of syphilis. Father not seen. Mother has had nine pregnancies. The first and second children were boys, who are alive and healthy; the third and fourth were premature, at eight months; bodies decomposed. The fifth was the present patient. The sixth, seventh and eighth are alive and healthy. The ninth died of pneumonia when nine months old.

Personal History.—The patient's general health has been fair. Eighteen months previously she had pain in her legs for a number of weeks. Has had enlarged glands in the neck for years. About two months before coming to the clinic, she noticed a pea-like swelling at the mucocutaneous junction on the left side of the septal cartilage of the nose which she thought was a cold sore. This increased in size, spreading to the upper lip and into the nose, especially attacking the septum. There were no pain or constitutional symptoms.

Examination.—The examination of the nose showed that there was an extensive ulceration of the whole cartilaginous septum, including the columna, and of the upper lip. The ulcerated area was covered with thick crusts, and there was a foul, irritating discharge from the nose. The whole of the septal cartilage was nearly ready to slough out.

Treatment.—The next time the patient was seen, the entire cartilaginous septum, including the columna, was removed. The parts were kept clean, and potassium iodid given internally. The condition improved and the ulceration ceased.

CASE 2.—M. O., a girl, aged 14.

Family History.—No history of parental syphilis could be obtained. Mother always healthy; had had four children. Three alive and well. One died, aged seven months, of pneumonia. No miscarriages. Father is in excellent health, and denies ever having had syphilis.

Personal History.—Patient, when one year old, fell and struck on her nose, but no permanent injury resulted. Her general health has always been good and nasal breathing free. Six months before coming under observation she commenced to have obstruction to breathing through the right side of her nose. No cause could be discovered, unless possibly it was the result of boxing with her brother. The obstruction gradually increased, but was unaccompanied by pain or constitutional symptoms. She was brought for treatment, because of the obstruction, commencing deformity of the nose and enlargement of the lymphatic glands just below the angle of the jaw on the right side.

Examination.—Examination revealed a red, globular tumor, of about the size of a pea, attached to the right side of the septal cartilage, well forward. Just behind the anterior growth could be seen another globular tumor filling the nasal passage. There was bulging of the nose exteriorly, corresponding to the right ethmoid cells. As the nasopharynx was filled with the growth, it was evident that the tumor filled the whole nasal passage. There was marked swelling of the glands of the right side of the neck. The tumor in the nose was fairly firm in consistency; not painful, and did not bleed readily when touched. The glandular mass in the neck was not accompanied by any pain or tenderness. No ulceration was observed in the nose, and there was only a moderate acrid discharge. The growth in the nasopharynx had an angry appearance, and was covered with thick, tenacious mucus. The general health of the patient was little impaired. Her symptoms could all be accounted for by the nasal obstruction and the pressure of the growth.

Treatment.—The diagnosis of late hereditary syphilis was made by exclusion, and the patient placed on kali iodid inter-

nally and mercurial inunctions, with the result that the growth gradually melted away and the enlarged glands disappeared.

At the present time I have under my care the following case:

History.—A girl, 16 years old, is one of seven children, all healthy and robust. Patient's menstruation first appeared when she was a little over 15 years of age. About this time patient suffered intensely from pains in the legs and nocturnal headaches. On the right foreleg were noticed elevated red spots, as the patient describes them, varying in size from that of a split pea to almost, if not quite, the size of a twenty-five-cent piece. Within a month the left foreleg presented a similar condition to that on the right leg. When the patient first came under my observation, she presented typical ulcerating gummata on both legs, without any other evidence of hereditary taint, and an absolutely negative history as to any skin eruption or sickness of any character in the earlier years of her life.

Family History.—The mother of the patient is a subject of ichthyosis, and states that she had had two miscarriages, occurring without apparent cause; the first at between five and six months, and the second at between six and seven months. On the right hip of the mother examination reveals a scar which resembles that following a syphilitic ulceration, although she denies all syphilitic history. The patient's father refused to be examined or interviewed.

Treatment.—Under antisyphilitic treatment our patient made a prompt recovery.

Fournier¹² says that latent hereditary syphilis may manifest itself at any age, from young adult up to old age (less frequently in old age), at 51, even at 60 years, and older.

We have grown away from the teachings of Kaposi, Barends, Lang, and others, who state that cases of latent hereditary syphilis are not authentic. They say that if this disease be congenital or hereditary, there must have been infantile manifestations. We accept as facts the teachings of Fournier, Neuman, Sigmund, Hebra, and others, that these cases are authentic, and do occur.

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DISCUSSION.

DR. A. W. BRAYTON, Indianapolis—Those of us who are getting along into the second half century and have been practicing and teaching general medicine for twenty-five years can authenticate the statements made by Dr. Campbell in regard to the late manifestations of hereditary syphilis. I have never found a case of locomotor ataxia, and but few of general paresis, that I did not find a history of syphilis, and just as a parasyphilis may develop under varied conditions of acquired syphilis so we may look for late lesions in hereditary syphilis.

DR. L. DUNCAN BULKLEY, New York City—I have seen hereditary syphilis up to 20 or 30 years of age, and many cases even where there has been practically no clear antecedent syphilitic history. I do not, however, believe that a case of late hereditary syphilis never shows anything before. I have never convinced myself that there can be an infection and nothing take place until thirty years afterward, but I think that in many cases the earlier manifestations have simply been overlooked. I do not believe that anyone can look at a case of hereditary syphilis superficially and make a correct diagnosis. It is only by study, and by a careful consideration of a case, and exclusion of other conditions, that we can arrive at a diagnosis. Many of these cases that are often regarded as subjects of hereditary syphilis, I believe to be cases of constitutional syphilis, acquired during or after birth, which occurs much oftener than we imagine. Only a short time ago a child of two years was brought to my office with a large hard chancre on the prepuce. The father and mother were

11. New York Med. Jour., July 26, 1902.

12. Bulletin de l'Acad. de Méd., Paris, 1903, 3d ser., vol. xlix, p. 532.

certainly pure and free from any taint of syphilis, yet at two years of age the child had a chancre of the penis, not from circumcision. It was finally traced to the nurse, who had turned out to be a very loose character, and had just been discharged because she was found to be pregnant. She had given it to the child through lesions of the mouth. In the case of that child, if it had not been seen and diagnosed by some one who knew, but had recovered and had late lesions of syphilis, it could be readily supposed to be a case of hereditary syphilis, while it was really a case of early infection. Do not forget that those cases where you can not get a history may have had an infection early in life.

DR. C. W. ALLEN, New York City—Ranging myself with the older practitioners I would say that I have been teaching syphilis for a number of years, and I have had it happen many, many times, that in analyzing a case I have said to the students: here is a case where we can make out nothing but late hereditary syphilis without any history of preceding infection. I realize with Dr. Bulkley, that acquired syphilis may often escape observation. I have seen acquired syphilis in the very young where the parents have been healthy. I am convinced that without a preceding history, without knowledge of any syphilitic lesions having manifested themselves, an individual may arrive at the age of twenty or more years, up to thirty, and possibly far beyond that, and then show unmistakable lesions of syphilis.

DR. MORTIMER A. MOSES, New York City—Concerning the sign of hereditary syphilis described first, I think, by Silex of Berlin—the furrows at the angle of the mouth—is this sign of absolute corroborative value or is it seen in any other condition than hereditary syphilis?

DR. H. C. BAUM, Syracuse, N. Y.—I concur absolutely in all the findings of the paper. I had one case, a young woman 23 years of age, who had never employed a physician, but was delivered by a midwife. She came to the late Dr. U. H. Brown of Syracuse on account of a destructive gumma of the nose. He made a diagnosis of gumma, and his plan of treatment was indignantly rejected by the patient and by her husband, who had always been well, and by her mother, who accompanied her, and who was very much offended at any such suggestion; she herself having always been well, and never having had any other pregnancy than that of the patient. I was brought in and confirmed the physician's diagnosis, and yet treatment was refused. A year later she reappeared, with tremendous destruction, and applied for treatment. She responded nicely to treatment, and looking up the case afterward it was found that the father had died in a soldiers' home at Bath. I wrote there and was told the cause of death was syphilis.

DR. R. R. CAMPBELL—With respect to acquired infantile syphilis, it is gratifying to note that this form of the disease is far less common than is usually believed. Fournier has a record of but 45 patients of this class coming under his observation, though he adds that he believes, as many more have been seen by him, regarding which no notes were taken. In so far as I have been able to learn, the highest number of this class of cases reported by authorities other than Fournier, has been twenty-five. Replying to Dr. Moses, in my opinion the red furrows at the angle of the mouth can not be accepted as a symptom of any particular value in hereditary syphilis, for the reason that I have found it too often in the acquired form of the disease to grant it particular importance as an indication of the hereditary origin of the disease.

Hematemesis Substituting Menstruation.—Rapallo y. Vela of Madrid reports a case of gastrorrhagia recurring two months in succession at the periods of suppressed menses. The subject was a nervous, anemic young woman and the menses had been suppressed for several months. The gastrorrhagia was combated by rest in bed and cold, fluid food, with hot applications to the lower abdomen and legs and appropriate tonic medication. Menstruation returned normal the following month and thereafter. The case is cited in the *Semana Medica*, No. 21, 1903.

HAS INFLUENZA BEEN A CAUSATIVE FACTOR IN THE INCREASE OF APPENDICITIS?*

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In introducing a subject, the discussion of which is largely a matter of inference and analogy, I realize that I am presuming too much on the indulgence of a scientific body, and my apology may be stated in the desire for a more comprehensive knowledge of the causative agents of the diseases in question, together with the hope that this feeble effort will serve to stimulate a closer clinical observation bearing on the possible relations concerned, and especially a more extended scientific investigation looking to the nature and environment of the organisms involved.

THE HISTORY OF INFLUENZA.

A brief review of the many-sided disease—influenza—will recall to us its ancient and modern history. According to the report made by Parson to the British Medical Association in the year 1891, influenza was first recognized as an epidemic disease by Livy and Hypocrates in the year 412 B. C., and more than 200 years passed following their announcement before other supposed epidemics were recorded. During the sixth and ninth centuries Italy was said to have been visited two or more times by the same disease; this was followed in the early part of the tenth century by its appearance in Germany and France, after which time the world seems to have experienced a period of immunity for more than 200 years. Admitting that there may properly arise some question as to the accuracy of these earlier observations, Wilson states that our positive knowledge of this disease dates from the year 1510, when the first great epidemic visited Europe, including the British Isles. This was shortly followed by another visitation in 1557, and was the first of record observed in America. The history of the past four hundred and odd years records more than seventy epidemics, one-half of which have been so extensive as to deserve the name of pandemics. In the past century just closed there have been about forty visitations in this and European countries, those of special and more direct importance to us being of the winters 1889 and 1890, 1891 and 1892, 1894 and 1895, and that of the past winter, 1903 and 1904. I may state incidentally, however, that during the past five years the eastern and middle portions of our country have been more or less subjected to outbreaks of this disease, though less severe in form, than were the special epidemics to which reference is above made. The last epidemic of importance previous to the winters of 1889 and 1890, was in the year 1847, since which time a number of scientific investigators have been keen and persistent in their researches for the causative agent of this disease, believing it to be of bacterial origin, but it was not until the year 1893 that their efforts were crowned with any degree of success, at which time Robert Pfeiffer announced the discovery of an organism which he regarded as the specific exciting cause. This discovery has since been confirmed by no less able investigators than himself. It is not for me to challenge the statement that the Pfeiffer bacillus is the exciting or causative agent of influenza, and I shall raise no question as to this fact, whenever a pure

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