

Looking Back.

FROM

THE LANCET, SATURDAY, APRIL 30, 1825.

REVIEW.¹

An Essay on Venereal Diseases, and the uses and abuses of Mercury in their treatment; illustrated by Drawings of the different forms of Venereal Eruptions. By RICHARD CARMICHAEL, M.R.I.A., Vice President of the Royal College of Surgeons in Ireland, &c., &c. London, 1825. 8vo. pp. 376, 2d Edition. Longman and Co.

The venereal disease is said to have made its first appearance in Europe toward the end of the fifteenth century, viz. about the year 1494 or 5, and to have spread in the same manner and with the rapidity of the pestilence. It is pretty plain, however, that the various accounts which have reached us respecting its origin are but so many fables, and that what has been said respecting the siege of Naples, and the crews of Columbus is equally devoid of foundation. Ulcers on the genitals are mentioned by many ancient writers,—Greek, Roman, and Arabian; and in the annals of England there is the clearest proof of the existence of one form, at least, of the venereal disease. It was the subject of legal provisions as early as the year 1162, "which laws (says Webster) are still extant, and were then only a renewal of those which were still more ancient."

In the records of the Lordship of Winchester, there are many regulations respecting the stews which were authorized to be kept in Southwark, one of which expressly prohibits any "stew-holder to keep any woman that hath the *perilous infirmity* of (brenning) burning."^{*}

In a book written from a manuscript about 1430, in possession of the Bishop of Winchester, one article begins thus:

"De his qui custodiunt mulieres habentes nephandum infirmitatem," it goes on, "*Item*, That no stew-holder keep noo woman wythin his hous that hath any sickness of *brenning*, but that she be put out, upon the payne of make it a fyne into the Lord of a hundred shillings." ARDEN also, who was physician to Richard II. and Henry IV., between 1377 and 1413, speaks of a "certain inward heat and excoriation of the urethra." This disease was called a *burning*, and went by that name till the middle of the 16th century.

Here gonorrhœa is obviously described, and there can be no fallacy respecting it. We are satisfied that this disease is essentially different from syphilis; but we cannot dwell upon the topic now, as it is rather irrelevant to the subject under consideration.

The same author (Arden), says Beckett, "takes notice of those contumacious ulcers which we now call chancres; and the great trouble our ancient authors found in attempting their cure sufficiently discover them to have had their original from a venereal infection." Nodes on the shins were also known, and were termed by the old English writers the boon, or bone hawe, "a name (says Beckett) which gives a perfect idea, not only of the part affected, but after what manner it was diseased, for the old English word *have* signified a swelling of any part." But there is not the shadow of a doubt that a species of this disease existed in England as early as the Norman Conquest, and probably in other countries of Europe. Not a medical work of that period, however, if any was written, has survived the ravages of time.

It is said, by European authors, that this disease was prevalent among the natives of America when the Spaniards first visited the country. It is somewhat strange, however, that ULLOA, in his voyage to South America, Book 6th, declares, that "the venereal distemper is seldom known among the natives," although so common among the Spaniards as to have lost the infamy attached to it in other countries.^{**}

* *Burning* is a modern orthography, the ancient was *brent*, *brenning*—so Chaucer wrote it. *Canterbury Tales*, 2427, and in other passages,—

"The fires *brent* upon the auter bright
"That it gan all the temple for to light,"

** See *Philosophical Transactions*, No. 357—Badham's *Memoirs*, vol.

¹ Only a portion has been transcribed.

vi. 390—Webster, vol. ii. 440—Astruc de Morbis Venereis, vol. ii. 74to. par. 1740. This author is particularly elaborate. We are not sure that Moses does not allude to some form of the venereal disease, in Levit. cap. xv. See also Duncan's *Med. Commen.* xiv. 254, et alibi.

Correspondence.

"Audi alteram partem."

RITUAL CIRCUMCISION.

To the Editors of THE LANCET.

SIRS,—The remarks in the annotation in THE LANCET of April 25th, p. 1181, concerning ritual circumcision are very important. The subject has always had the most anxious consideration of the ecclesiastical authorities of the Jewish faith, amongst which people this religious observance is regarded with the greatest veneration and is universally observed. Unfortunately sad occurrences have recently taken place in connexion with it, to which a great deal of publicity has been given and in consequence the reports have in many instances been much exaggerated. As a matter of fact, it is surprising, considering the number of cases of circumcision which are constantly being performed, how few are the mishaps that occur. But however few, nevertheless, it is a very serious matter and is so regarded by everyone, and especially by those who have the control and supervision of this religious ceremony, which has been observed for thousands of years and is undoubtedly a simple operation, and when performed skilfully and with proper antiseptic precautions is quite free from danger.

There exists at the present time a medical board composed of qualified and registered medical practitioners whose duty it is to teach and to train all those who are destined to perform the religious rite and also who are deputed to be in attendance upon and supervise all cases performed by anyone who is not himself a qualified surgeon. This board is appointed to guarantee that all operations are skilfully performed and that proper antiseptic precautions are observed in accordance with the teachings of modern surgery. It is hoped and anticipated that with this supervision strictly enforced unfortunate occurrences will no longer be heard of in connexion with the performance of this most ancient and widely-spread religious observance.

I am, Sirs, yours faithfully,

M. CLIFFORD, L.R.C.P. Lond., M.R.C.S. Eng.

Clifton-gardens, W., April 28th, 1903.

To the Editors of THE LANCET.

SIRS,—I have read with interest your annotation upon the above in THE LANCET of April 25th, p. 1181. I also think I am at liberty to tender my experience after 21 years of professional work in the East-end of London. I have invariably made it my duty to be present at such ceremonies, especially in my maternity cases, and thus formulate my experience as follows: (1) the sucking of the glans penis as formerly practised is now all but given up; (2) the custom of ejecting a mouthful of wine over the penis is almost extinct; (3) the use of disinfectants or mild antiseptics is becoming general (a weak solution of carbolic acid is invariably used before and after the operation by means of a syringe called a "spritza"); and (4) the medical man is more often invited to be present on the occasion either by the "Mohelim" or parent.

I have taken upon myself to recommend certain Mohelim after watching the way they perform the operation. In many instances the medical man's opinion is sought, either by the Mohelim or by the parent, as to whether the infant is in a fit state of health to undergo the operation, it being a special religious feast to which not only friends and relations are invited, but likewise the medical attendant receives an invitation. It is more amongst the poorer class that these preventable accidents arise incidental to the circumcision. I would therefore advise that the presence of the medical man be insisted upon at all these religious ceremonies. I have frequently been called by the Mohelim to witness the operation. So far as my experience goes I have not had occasion to be called into many serious after-results demanding either medical or surgical aid. I am, Sirs, yours faithfully,

Mile End-road, E., April 27th, 1903. M. CURSHAM CORNER.

THE ABORTIVE TREATMENT OF SMALL-POX.

To the Editors of THE LANCET.

SIRS,—I shall esteem it a favour if you will allow me to make one or two observations on the interesting letter of Mr. L. W. Seymour, which appeared in *THE LANCET* of April 18th, p. 1127, on the above subject. Mr. Seymour suggests that the internal administration of carbolic acid is preferable to the outward application because it gets more directly at the cause, while the latter acts indirectly through the manifestation of the disease. I should like to point out that the rash of small-pox is not a manifestation of the disease in the same sense as the rash, say, of typhoid fever. I am of opinion that whatever may be the method by which the poison gains entrance to the body the microbe becomes deposited in the skin, as well as certain mucous membranes, and there produces colonies in a similar manner to the colonies which develop in a gelatin plate culture and that the development of these colonies gives rise to the characteristic rash. The severity of a case of small-pox is proportionate to the amount of the rash which develops in its course. Before the introduction of vaccination inoculation of the disease was practised. For that purpose the fluid from a vesicle was used and therefore that fluid contains the germs of the disease. Again, I think the most infectious period during the course of the disease is when the scabs are falling off, for it is then that minute particles of dried epithelium, &c., can be taken up in the air and carried even long distances.

If the above views be correct it seems to me that the outward application of a powerful germicide is more likely to destroy the poison and to render the patient less dangerous to those around him than the internal administration of a weak solution thereof. I am doubtful if the internal administration of carbolic acid with quinine, however beneficial the mixture may be in the treatment of the disease, can produce such an efficient disinfection of the resulting scabs, and the skin generally, as the local application of pure carbolic acid. Mr. Seymour says there must be a combination of the above drugs, and neither singly will give the result. But pure carbolic acid alone, applied externally, will give the result and, I contend, disinfect the skin more effectually. Since sending you the clinical note on this question in February last I have treated two other cases; one was severe but discrete and the other was an ordinary discrete case. Neither patient had been vaccinated since infancy and the result of the treatment in both cases was marked and satisfactory.

I am, Sirs, yours faithfully,

April 25th, 1903.

JAMES T. NEECH, M.D. Durh.

THE RELIEF OF PARALYTIC DISTENSION OF THE BOWEL IN OPERATING FOR INTESTINAL OBSTRUCTION.

To the Editors of THE LANCET.

SIRS,—In *THE LANCET* of April 11th, p. 1055, under the above heading Mr. C. A. Morton says that "if a portion of bowel has been very severely nipped it may be paralysed and unable to take on peristaltic action, even though the intestine above is not too distended to force the contents down to it, and it has been taught that this very limited paralysis may cause persistent obstruction after herniotomy. But, granting that the bowel so damaged may be paralysed, is it conceivable that the peristaltic wave in the proximal side cannot force the contents through a few inches of inert gut?"

This is a very important question and my experience leads me to agree with those who teach that "a few inches of inert gut" may cause a persistent obstruction. In fact, when the conditions described arise it seems to me that the chances are very strongly in favour of a complete valvular obstruction developing after a mechanical constricting obstruction has been relieved. The mode in which the small intestine is attached to the posterior abdominal wall is well calculated in normal conditions to prevent obstruction in that part of the bowel. In normal healthy conditions the bowels are not greatly distended, but if any part of the small intestine becomes unduly full the mesentery of that portion is stretched into an irregular wavy fan-shape and although the coil cannot be straightened it is

made to assume a gentle curve at the distal end of its mesentery. The flow of its contents round this curve is easy. A portion of the gut lower down then becomes distended, its mesentery is stretched, and the difficulty is gradually surmounted.

But the size of the abdominal cavity and the disproportion between the length of the mesentery at its attachment to the spinal column and that at its attachment to the bowel limit the length of any one coil of intestine, so that if there are several distended coils together the gut at the end of each coil must bend sharply, so as to recross the abdomen at the end of another fan-shaped portion of the mesentery. The angles thus formed may be very acute. They become more acute as the intestines become more distended and it is at these angles that kinking from over-distension occurs when the muscle of the intestinal wall begins to lose its tone. It is obvious that the drag on the mesentery would tend to make a curve even if the gut were inert. But when a piece of bowel which has not lost its peristaltic power distends it must push the ends of its coils against the boundaries of the peritoneal cavity formed by the abdominal walls and any piece of gut which is paralysed and inert must be bent at a sharp angle to an active piece of distended bowel with which it is continuous. Hence an inert piece of bowel must form a valvular obstruction and the more active the peristaltic efforts to overcome this obstruction are the more firmly will the inert piece of bowel be pressed upon and held at an acute angle to the end of the adjacent coil in which the power of making peristaltic efforts continues.

In these circumstances the fate of the patient depends on the ability of the surgeon to give the "few inches of inert gut" a sufficiently long rest to enable them to recover their tone by preventing for a time the efforts of the intestine above to propel its contents downwards. This may be done by emptying the gut and sewing up the opening or openings made in it or by making a fistula. These methods have dangers of their own but if the surgeon does not resort to one or other of them and does not resect the gut there seems to me to be no reason for expecting any but a fatal issue in the circumstances premised by Mr. Morton. Operations for obstructions of the intestine are probably the most fatal in surgery. When the nipping of a piece of bowel is not so severe as to paralyse the part there are good grounds for hoping that the relief of the obstruction will cure the patient. Hence it is important to operate early and the results of operations for hernia are exceedingly good if surgical aid is called for promptly. When the gut is paralysed at the seat of obstruction and the part above is also completely paralysed by distension the chances of recovery are very remote in any circumstances of treatment. Between these two conditions there may be a period in which the nipped bowel is paralysed but the bowel above retains its peristaltic function and in these circumstances I cannot agree with Mr. Morton that the formation of a fistula is an unreasonable method of treatment. A very great difficulty which Mr. Morton has not touched upon is the recognition of the state of the bowel which has been nipped as regards its power of peristaltic activity or its power of quickly recovering its tone.—I am, Sirs, yours faithfully,

Portman-street, April 21st, 1903.

JOHN D. MALCOLM.

CANCER "CURES."

To the Editors of THE LANCET.

SIRS,—With reference to your annotation on "Cancer Cures" in *THE LANCET* of March 14th, p. 745, I have recently learnt that when the writer of the article in the *Pall Mall Gazette*, entitled "A Triumph of Electricity," wishes to support her views she is in the habit of quoting in detail a case of mine affecting a gentleman whom I will call Mr. A. The lady in question does not hesitate to use both his name and mine freely in writing what she is pleased to call "private" documents intended to get into the hands of public characters. As the account thus given is full of errors will you permit me to tell the truth about the case, which really is of some interest?

Eight years ago I removed from Mr. A.'s left cheek a large and thick-based epitheliomatous ulcer. This growth has not recurred. But two or three years ago a small ulcer appeared on the lower lip and I excised it. Recurrence took place in the site of this. It is essential to remember that Mr. A. has suffered for years from a chronic inflammatory thickening of the mucous membrane of both cheeks and of the lower lip and that he has been a considerable smoker. There