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# ORGANIC SYPHILIS.

BY HENRY A. ROBBINS, M. D.

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Medical Department, University of Georgetown.*

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A lecture delivered at the Central Dispensary and Emergency  
Hospital of Washington, D. C., on April 12, 1893.

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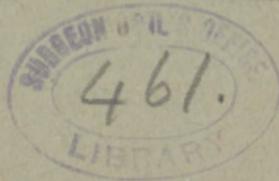
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ART. VII.

ORGANIC SYPHILIS.\*

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Sir Astley Cooper, in his lecture on Surgery, taught that "some parts of the body are incapable of being acted upon by the venereal poison, such as the brain, the heart, and the abdominal viscera. Indeed," he writes, "this poison does not appear to be capable of exercising its destructive influence on the vital organs, or on those parts most essential to the welfare and continuance of life."

This statement of Sir Astley, who is probably oftener quoted than any surgeon of ancient or modern times, is liable to be productive of infinite harm, for the very opposite of it is now proved to be the truth.

In direct opposition to the views above expressed are the statements of my old teacher, Dr. Samuel Wilks, of Guy's Hospital, who says; "Syphilis in its ultimate form is capable of affecting every organ of the body; the internal may become equally as obnoxious to the effects of the virus as the external. Many obscure and intractable organic disorders are cases of visceral syphilis, and it cannot be too forcibly impressed upon the young practitioner that syphilis may affect not only the cranium, but the brain within it, or the nerves; not only the muscles of the limbs and tongue, but the heart; not only the pharynx, but the œsophagus; not only the larynx, but the trachea, bronchi, and lungs; also the

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liver, spleen, and other viscera." (*Guy's Hospital Report*, Vol. IX, 1863.)

Van Swieten taught that "no organ escaped the influence of venereal poison, and recognized it as the cause of gummy tumors, exostoses, deep-seated pains, apoplexy, epilepsy, blindness, deafness, paralysis."

Benjamin Bell, however, was the first writer who put forth clinical facts in support of his belief that "venereal disease induces blindness, deafness, amaurosis, phthisis, rheumatism, epilepsy, and mania."

Aitkin says: "A history of syphilis in soldiers is too often the starting point of a fatal disease. The impairment of the health takes its origin from the date of the *infecting* syphilitic sore. Early implication of the lymphatic glands leads to impoverishment of the blood as an immediate result, and then to the degeneration or wasting of tissues, which attends the general cachexia, and which eventually terminates in death, with complicated and varied lesions, especially implicating the internal viscera."

I will first call your attention to syphilitic lesions of the brain. Medical literature is exceedingly rich in material on this subject, and your acquaintance with it may be your starting point to a successful professional career. A correct diagnosis, and your knowledge of the treatment, will make you famous as the direct result of an apparently miraculous cure of a patient who may have baffled the skill of leading physicians.

Bonnet, Ricord, Callerier, and Lallemand have described gummatous tumors of the brain. Ricord described them as syphilitic tubercle of the brain.

Virchow described lesions of the great vessels in those who died from syphilis with lesions in the brain.

Dr. Steenberg (physician for the insane at Schleswig) believed that a great proportion of the syphilitic affections of the brain are subsequent to lesions of the arteries; he also observed syphilitic localizations in the organs of circulation generally.

Dr. Wilks says : " In the cases where cerebral symptoms have long co-existed with syphilis, a quantity of tough yellow, fibrous tissue united together the surface of the brain with the adjacent membrane, and this again is adherent to the bone. The cortical substance of the brain at the affected spot is often partly destroyed, and the adventitious material occupies its place. The question has still to be solved as to what structure is primarily affected. Many have given the authority of their name to the opinion that the disease commences first in the bone, but simply for the reason that the osseous is that which had so long been recognized as liable to be affected. But, since we know now that other structures may be similarly attacked, we are prepared to look for its commencement in other parts, and even in the brain structure itself. The cases which are so frequently met with are those where the deposit involves both sides of the *dura mater*, and includes in it the bone on one side and the brain on the other. The probabilities are in favor of its occurring in the *dura mater* first, as it arises in the periosteum on the exterior of the cranium."

The nervous symptoms are alteration of intelligence, of sensibility, and of motion. These in connection with local lesions, as caries, or necrosis of the facial bones, or of the cranium ; or tumors on the external surface of the cranium, such as gummata, periostitis, or exostosis, at once point to cerebral syphilitic lesions, which are sometimes expressed by persistent epilepsy.

According to Zambaco, besides neuralgia, long recognized as one of the results of syphilitic poisoning, chorea appears as being occasionally developed under its influence.

Paralysis is the most frequent result of the syphilitic poison upon the nervous tissues. Jonathan Hutchinson remarks " That so frequently is syphilis a cause of paralysis, that in all cases where it happens without evident cause, and in which syphilitic antecedents are even possible, it is advisable to try the effects of specific treatment. Undoubtedly

we often by such means get a clue to the real nature of many an obscure affection of the nervous system."

Professor Jakstch says hemiplegia is the most frequent form of syphilitic paralysis, and may appear from five or ten months to eighteen years after the primary lesion, but in most instances from three to ten years, and often very insidiously. These conclusions were derived on an analysis of fifty-two cases—twelve occurred in his own practice. Paralysis of the muscles of the trunk was not made out in a single case.

Enough has been said on syphilis of the brain to lead you to further research, and the time you give the subject will amply repay you. You will have to go over your anatomy, and you will have to look up all mental diseases, which you will find to be interesting, improving, and useful, both to yourselves and your future patients.

Virchow describes syphilitic growths in the substance of the heart, and refers to those recorded by Ricord and Lebert. Ricord, in his Atlas, calls them "syphilitic muscular nodes in the substance of the heart." They were found in the substance of the ventricles, and consisted of firm cheese-like masses. There was a history of chancres and ulcerated tubercles of the skin. Lebert reports that gummata were seen at a comparatively early stage of development in his case, and were found in the wall of the right ventricle. There were tubercles of the skin, of the subcutaneous tissue, genital organs, and bones of the skull. In Virchow's case there were syphilitic gummata in the testicles.

In the Museum of the British Army Medical Department at Netley there are two preparations which show such gummata in the substance of the heart. "One occurred in the case of a soldier, twenty-four years of age, under treatment for venereal ulcers, of nine months' duration, in various parts of the body. He had lost his palate, and eventually sunk from exhaustion, with symptoms of phthisis. Sections of the muscular substance of the heart showed several iso-

lated deposits in its substance and beneath its serous covering, and isolated portions of the lungs were converted into a substance of the consistence of cheese."

On January 9th of the present year (1893) John S. Bristowe, M. D., LL. D., F. R. S., of London, read an article on Syphilitic Affections of the Nervous System before the Medical Society of London. I take the liberty of quoting two of his cases, illustrative of syphilitic arterial disease.

"The first of these was brought before the Pathological Society by Dr. Walter Edmunds on May 3, 1892. The patient was a man aged thirty-six, who came under Sir Wm. MacConnar's care on account of an aneurism on the right side of the neck, which had been rapidly increasing in size. He had, a few days before admission, been seized with a sudden attack of faintness, and after admission the mere handling of the tumor frequently brought on similar attacks. Owing to this circumstance, the belief that his arteries were extensively diseased (for no trace of pulsation could be felt in any of the arteries of either upper extremity, and there was a loud basic systolic murmur), and to the fact also that the patient was exceedingly ill, it was decided not to attempt any operative procedure. The patient had well-marked syphilis twelve years previously. He died comatose twelve days after admission. The heart was large, and the pericardium adherent by easily broken down adhesions. The valves were healthy. A gumma about two inches in diameter projected from the groove between the right auricular appendage and the pulmonary artery. The whole of the thoracic aorta, including the arch, was enormously thickened, all the coats being involved, but the outer coat much more so than either of the others. In places they were collectively more than eight times as thick as natural. The thickening extended along the innominate and right subclavian, the latter of which would admit of the passage of a bullet probe. The right common carotid was healthy, but the right internal had springing from it near its origin a globular aneurism about two inches and a half in diameter. The left common carotid was diseased, and only admitted a bullet probe; and the left subclavian, about an inch from the aorta, ended in an impervious fibrous cord. The cerebral and abdominal

arteries were all healthy, and no other visceral syphilitic lesion was discovered.

“The second case was exhibited before the same Society and on the same evening by Dr. Herbert Hawkins. It was that of a girl aged eleven, who was admitted into St. Thomas' Hospital suffering, it was supposed, from acute nephritis. After experiencing one or two short attacks of illness, probably due to infarction of the lungs, she was observed on February 7th to have swollen and cold legs, and, a few days after, swelling of the face. She was admitted on the 20th, being at this time extremely ill. She had general dropsy, was passing very little urine, which contained a small quantity of albumen, but no casts, and there was evidence of pulmonary congestion. Subsequently she passed a little blood on one occasion with her urine, which continued to be for a time very scanty, but, during the last four days of her life, it became fairly abundant and ceased to be albuminous; the lower part of her lungs became solid; her pulse of high tension, she presented the Cheyne-Stokes breathing, and died (apparently from uræmic poisoning) on March 22d. At the post mortem examination gross disease was found in nearly all the arteries of the body. The first part of the aorta was studded with gray translucent spots and patches, from the size of a split pea to that of half a crown; and for a length of three inches, immediately above the bifurcation, the thickening was so great that the channel barely admitted a bullet probe. Similar patches were observed in the common carotids and subclavians, in the left internal carotid as it entered the cranial cavity, and in the right internal carotid involving the origin of the middle cerebral. There was similar disease throughout the pulmonary arterial system. The renal arteries towards their entrance into the kidneys were completely obstructed by clots, which were old and white at the periphery, but red and comparatively recent centrally. There was an old infarct in the kidney, but neither organ showed any evidence of nephritis. The liver presented a patch of peritonitic thickening, and was rather large. The spleen was large and firm, and its capsule thick and covered by old adhesions. The lower and back parts of both lungs were consolidated and contained large infarcts. There was hæmorrhage into each lateral lobe of the cerebellum, the clot in each case being the size of a hazel nut.”

“There can be no doubt, however, that the lesions in this case were the result of congenital syphilis.”

I find in *London Lancet* (Jan. 1, 1887) the following:

“*Syphiloma of the Heart*.—At a late meeting of the London Pathological Society, Dr. W. Pasteur showed a specimen of syphiloma of heart from a woman, aged thirty, who was taken to Middlesex Hospital *in articulo mortis*. She was probably a prostitute. None of the ordinary signs of syphilis were visible except in the heart. The liver had a peculiar marbled appearance. There was some recent lymph on the surface of the left ventricle, which was hypertrophied and dilated. Grayish opaque patches of varying size and distribution were seen in the wall of the ventricle and septum. At least one-half of the ventricle was diseased. The right ventricle was less diseased. The patches were ill-defined and translucent at the edges. There were milky looking patches on the endocardium. Microscopical sections showed infiltration of corpuscular growth, which was very vascular at the margin; the nuclei were spirical and distended. In some of the vessels of the heart doubtful evidences of periarteritis were to be seen, and possibly also of endocarditis. The liver showed numerous accumulations of small round cells, like that met with in some forms of interstitial hepatitis of congenital syphilis.”

Syphilitic lesions in the lungs have been fully described by many authors. The patient may have all the symptoms of tuberculosis, and yet there may be no tubercle existing in the lung. There is great dyspnoea and periosteal tenderness, and the bodily temperature is not generally increased. I will relate the following typical case, who was a patient of Alfred Fournier at Hôpital St. Louis, Paris:

The patient was admitted on March 1, 1884. He had been wasting for two months, as he said, and lately he had become so easily fatigued that he was unable to work. He was 39 years old. He had only had a cough for a few days, and had not suffered from night-sweats or hæmoptysis. After admission, however, he spat a blood-stained, muco-purulent fluid. At the left apex there were all the signs of a large

and advanced cavity—cavernous breathing, gurgling and cracked-pot sound on percussion. Over the right lung, the breathing was somewhat blowing in character, with subcrepitant râles. Fournier diagnosed tuberculosis of both lungs, but most advanced in the left. The left tibia was enlarged and irregular, and on the same were two gummy ulcers. The discovery of these signs led to the administration of iodide of potassium in a daily dose of 60 grains. After two months' treatment, the signs of lung mischief had almost disappeared, and the nodes had considerably diminished in size. Eleven months later, the patient was again seen. His general health was then excellent, and the chest lesions appeared to be completely cured. The patient, however, had only continued the iodide for a month after his discharge, and ulceration had reappeared in the left leg.

Attention is directed to the fact that there were no physical chest signs in this case, by which the diagnosis between tubercle and syphilis could be made. It was only by effects of treatment that the true nature of the affection became evident.

Dittrich and Gubler were the first to give an accurate description of syphilitic deposits in the liver. Virchow described peri-hepatic lesions, and simple gummy interstitial hepatitis. The former never occurs alone, but is generally associated with the latter. The hepatic substance atrophied, and the deposit contracting, is eventually absorbed, causing a cicatrix-like mark. The liver lesions are usually among the later symptoms of syphilis, and are well described by Virchow and Wilks.

In former years, I passed several months in walking the wards of Guy's Hospital, and was present daily in the pathological room, which was under the supervision of the late Dr. Moxon, whose sad death occurred a few years ago. Dr. Moxon found syphilis deposits in the spleen, consisting of sulphur yellow nodules, of the size of peas, plentifully scattered, deep seated, and fatty in their centre. Gummata have been found in the pancreas.

*Specific Nephritis.*—I take the following from the *Annales de Dermatologie et de Syphilographie*, April, 1881 :

“ M. Barthélemy at first quotes from the London Clinical Society. At a meeting of this body, held in January, several cases of hereditary syphilis were reported, in which, among other affected organs, the kidneys had been involved, being the seat of parenchymatous nephritis. Referring to such patients, Mr. Hutchinson stated that when death occurred as a consequence of syphilis, the fatal result was directly due to the nephritis. Dr. Coupland was convinced that patients who had been suffering for a long time from syphilis acquired a true predisposition for parenchymatous nephritis, and were liable to death from this condition. As a result of his personal researches, M. Barthélemy offers the following: Nephritic lesions are among the complications of all the stages of syphilis, even of acquired disease. Such nephritic complications are always grave. Nevertheless, they are sometimes curable, not only when they occur in adults as a result of acquired syphilis, but also in children affected with the hereditary disease. Together with other specific lesions, they have this characteristic in common: their gravity is in proportion to the age of the patient's syphilis, and the period of time which has elapsed before specific treatment was begun. In children affected with hereditary syphilis, specific nephritis should always be taken into consideration, when the patients are subjected to accidents for which nephritis may be held accountable. When a physician meets nephritis in an adult, he would do well to think of the possible specific origin of the renal difficulty in view of the great number of cases of unsuspected syphilis.”

In 1878, Dr. L. P. Yandall, of Louisville, Kentucky, reported (*Maryland Medical Journal*, May, 1878) a case of syphilitic albuminuria which is of great interest.

The patient was an intelligent German, sixty years of age, and was an inmate of the Louisville City Hospital, Dec. 1, 1876. “ He was a subject of general dropsy, and on the card over his bed was written, ‘albuminuria.’ His pale, waxy-looking skin, puffy eye-lids, constant indigestion, slight bronchitis, disturbed vision, hemicrania, pain in the

back, muscular debility, and frequent nocturnal micturition, all confirmed the diagnosis, and examination of the urine showed it to be excessively albuminous, and abundant in tube casts and renal *debris*."

"Deriving no comfort from treatment, and indeed growing gradually worse all the time, and having no hope of recovery, he begged to be allowed to desist from treatment, and the request was granted at the end of two weeks."

The patient's nose had the "saddle-shaped" appearance, so often associated with tertiary syphilis, where the nasal bones have come away. This, with other indications of syphilis, decided the doctor to give the patient the *therapeutic test*. The doctor prescribed a scruple of the iodide of potassium, to be taken in skimmed milk or water, every three hours when awake—the doses to be increased ten grains each every day till iodism, gastric disturbance, or relief of symptoms should occur. He took on several occasions an ounce of the medicine daily, and never had any discomfort from it. "He got iron and bitter tonics at the same time. His improvement was marked at the end of a few days. The throat rapidly healed; his strength, appetite and color returned, and the urine ceased to evince any sign of renal disease. In two months he was well."

The cases reported above show that organic syphilis is not detected in many cases by the physician, and it will never be known how many have died, or may die, where the cause of death is certified as coming from *morbus Brightii*, *disease of heart*, *apoplexy*, *phthisis pulmonalis*, *marasmus*, etc., but where in the dim background stands the grim monster, Syphilis.

They also show that when a proper diagnosis is made, what brilliant results follow the proper treatment.

1750 M STREET N.W.







