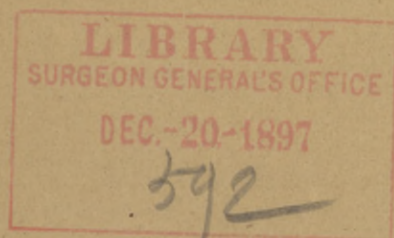


*Robbins (H.A.)*

**SYPHILIS.**

BY

HENRY ALFRED ROBBINS, M. D.





# SYPHILIS OF THE EYE, EAR AND THROAT.

By Henry Alfred Robbins, M. D.,

Washington, D. C.

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THIS colored man, aged 50 years, is a veritable museum of syphilitic manifestations. Dr. Arwine has presented him to us, so that we can observe every part of his body, and that is the proper way to study the polymorphous eruptions of syphilis. The room is warm and there is no danger of the patient's taking cold. You notice that there are patches here and there of a pale maculopapular syphiloderm. The patient first noticed the initial lesion—on the prepuce—a year ago. Now there is simply a cartilage-like induration. You will find enlargement and hardness of the glands in the inguinal regions, also the epitrochlear, and the post-cervical and the sub-maxillary. There are mucous patches in his mouth, and he complains of nocturnal headache and rheumatic pains. The patient is wearing dark glasses, and you will find that he has double iritis.

The initial lesion of syphilis has been reported in the literature of medicine as occurring on the eyelids, most frequently upon the free border of the underlid, and at both commissures. I mentioned quite a number in a lecture called "Unmerited Syphilis" which I delivered to a class of students on April 12, 1893. They were acquired in an innocent way—as in using the public towel in a railroad wash-room, and from contagion from a buccal mucous patch, communicated by a kiss, or by the filthy practice of removing foreign bodies from the eye by means of the tip of the tongue. The exquisite representation of chancre of the eyelid, to which I call your attention, I obtained in an old print shop in the Latin Quarter of Paris. Dr. Charles Stedman Bull reports a case of chancre that was confined to the conjunctiva.

Syphilis may attack any part of the

organs of sight, either directly or by impairing nutrition, resulting in opacity of the lens itself. Syphilitic iritis is not uncommon in the secondary stage of syphilis. You may hereafter be located where there is no ophthalmologist to consult, and it is important to know what to do. Give mercury by the inunction method until the constitutional effects are observed. Then follow the treatment of Dr. David Webster of New York City, given in a clinical lecture at the College of Physicians and Surgeons, 1881.

"Atropine, as I told you, is our sheet anchor in the treatment of iritis. Unless it is used, adhesions are very apt to occur between the pupillary border of the iris and the anterior capsule of the lens; such adhesions are called posterior synechiae. When formed, they interfere with the normal function of the pupil. If a healthy eye be exposed to a bright light, the pupil contracts; if darkness prevails, it dilates. When adhesions have taken place about the circumference of the pupil, no such contraction or dilatation can occur. If adhesions exist in the eye of a patient who has recovered from iritis, he will be much more liable to have recurring attacks of the disease than if there were no adhesions. The only way in which the recurrence of such attacks can be avoided is to perform an iridectomy—remove a part of the iris. By the vigorous use of a four grain solution of atropia we have prevented the formation of any permanent adhesions. Perhaps this would not have been accomplished had we used only atropine, or, in other words, except for the combined influence of atropia and mercury."

Allow at least a week to pass after giving mercurial inunctions for iritis before prescribing iodide of potassium,

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392

because the combination will produce coryza, conjunctivitis and salivation. Then begin with iodide of potassium, saturated solution, five drops in water, three times a day; increase drop by drop until the patient has had as much as he can tolerate. Apply leeches to the temples, where there is much pain, or where the progress is slow.

Many physicians pay little, if any, attention to the eyes in syphilitic cases they treat. Others, at most, look only for specific iritis. That there is a long list of such diseases liable to occur in connection with syphilis is often forgotten. Dr. Jonathan Hutchinson, in his little work on syphilis, gives the following list of these diseases: In acquired syphilis are the following:

1. Acute iritis; usually symmetrical; always in the secondary stage; of fairly common occurrence.

2. Inflammation of the vitreous body; often an accompaniment of iritis in its severe forms.

3. Diffuse keratitis. This is very rare in connection with acquired syphilis. It occurs in the secondary stage, chiefly, if not exclusively.

4. Neuro-retinitis. A primary inflammation of the ocular portion of the optic nerve and retina, attended by general haze, but without evidence of choked disk. It is usually seen in the secondary stage. It may affect only one or both eyes. Not common.

5. Scattered choroiditis; gummata of the choroid; choroiditis disseminata. This affection is rare and is seen only in connection with the late secondary stage. It may be attended by neuro-retinitis, or may occur alone. Usually it is almost wholly confined to one eye.

6. Optic neuritis, with swollen or choked disk; usually seen in the tertiary stage and in association with meningeal gumma. It is rare, affecting both eyes at once.

7. Serpiginous choroiditis. In this form large patches of absorption are seen, which slowly spread at their edges.

8. Aquo-capsulitis, a form of insidious and chronic iritis, of which the most conspicuous phenomenon is the

dotted condition of the posterior lamina of the cornea.

With inherited syphilis we have—

1. Acute iritis. It is rare; occurs at about the fourth month as one of the secondary class. It is very dangerous to sight.

2. Interstitial keratitis; tolerably common; usually affects both eyes; often attended with slight iritis and sometimes by choroiditis. Remarkable for its tendency to recover in most cases.

3. Choroido-retinitis; usually chronic and attended by atrophy; most frequent at periphery; may simulate the results of retinitis pigmentosa or approach choroiditis disseminata.

4. Optic neuritis, followed by white atrophy; very rare and almost never recognized, excepting in the atrophic stage. It will be observed that most of these forms of eye diseases are rare in syphilis, but their possible occurrence should always be kept in mind.

On October 20, 1881, Dr. C. S. Bull read a paper before the New York Academy of Medicine on "Lesions of the Orbital Walls and Contents due to Syphilis," in which he restricted his remarks to the study of the lesions of the bones and the adipose and connective tissues of the orbit. These lesions were not a common, though by no means a rare, manifestation of syphilis. The lesions considered were osteitis, periostitis, singly and combined, periostosis, hyperostosis, exostosis, of which two or more might coexist, caries and necrosis involving perhaps only a small portion and possibly the entire thickness of the bone invaded. According to most authorities these lesions belonged to the late manifestations of the disease, but Dr. Bull thought that they might occur earlier than had usually been supposed. They were more common in hereditary than in acquired syphilis and in warm than in cold latitudes. The earlier periostitis was much less indolent than that which appeared later and was never followed by exostosis or hyperostosis.

The symptomatology of these different lesions was illustrated by cases and the treatment of each variety was con-

sidered in detail. Mercury and iodide of potassium were the drugs chiefly used in the medicinal treatment and in some cases it had been found necessary to reach very large doses of iodide of potassium before the symptoms of the disease began to yield. Dr. Bull (Morrow, in *Dermatology and Syphilology*) gives beautifully colored plates and accurate descriptions of gummata of the conjunctiva and a well-marked example of gumma of the sclera or episcleral tissue on the temporal side of the eyeball, sometimes called scleritis gummosa. Also gumma of the iris pathognomonic of acquired syphilis.

Last evening at the Medical Society of the District of Columbia, Dr. Swan M. Burnett exhibited the pathological specimen of an eye in which there was a gummatus infiltration in the ciliary region. The patient, a young negro boy, had the history of an initial lesion dating back one year. Dr. Burnett reported several other similar cases, all occurring in young negroes, in whom the eye had to be enucleated. All began with iritis, which did not yield to treatment, such as inunctions of mercury and hypodermics of the bichloride of mercury.

Gumma is considered to be a tertiary manifestation, but syphilis is sometimes so rapid in its evolution that we are amazed to see the primary symptom and a tertiary product. Dr. Henri Roger, in 1863, presented to the Société Médicale des Hôpitaux a little girl two years old, on whom could be observed simultaneously all the symptoms of syphilis; the primary lesion, a chancre on the upper lip communicated by her mother who had at the time a chancre on the lower lip; secondary symptoms, specific roseola and mucous patches on the vulva and anus; tertiary symptoms, periostoses of the cranium, the humerus and both tibiae.

It is our object in these clinical lectures to turn syphilis inside out, as it were. We will drive the evil spirit out of his hiding places in the internal and vital organs. We have shown you how it attacks the eye. Now let us take up the ear, and you will perceive that it

sometimes finds an abiding place there. I have, in private practice, two patients who suffer from deafness caused by syphilis. Both have histories of having had the disease for eight or ten years. One of them is being treated by my friend Dr. John H. Metzertott, and his hearing has been remarkably improved. This is a case of disease of the middle ear. The other has impairment of the auditory nerve, and these cases are almost hopeless.

The external ear may be attacked with gummata, papules and condylomata. These sometime escape recognition by the general practitioner, who is not familiar with the masquerading proclivities of syphilis. In 1888, Dr. Lawrence Turnbull of Philadelphia wrote an article on syphilitic ear diseases, which is the best and briefest that I am familiar with. I take the liberty of quoting his conclusions:

1. That syphilitic diseases of the ear are less numerous in the United States than in great Britain or Europe, and that it is not so frequently a cause of deaf-mutism.

2. In almost all constitutional syphilitic diseases of the ear in children and young persons, it is associated with some affections of the eyes, throat and nose. The deafness which often follows the improvement in the eyes is sometimes profound.

3. Persons who have suffered from constitutional syphilis, especially young persons and children, have great impairment of conduction of sounds through the bones of the head. Even in adults with constitutional syphilis the tuning-fork in some instances cannot be heard on the bones of the head or face.

4. In a few cases the first indication of a syphilitic diseased ear is a primary ulcer in the throat, naso-pharyngeal space, or in the auditory canal, or near the membrana tympani.

5. Purulent otitis media, or otitis media serosa syphilitica, may occur in utero, or in very young infants, while in young persons and adults we may have congestion of the tympanic mucous membrane from the same cause, ankylosis

of the bones of the ear, with bands of adhesion in the middle ear, by extension from the throat to the Eustachian tubes.

6. Syphilitic disease may affect the most vital part of the internal ear, labyrinth, semi-circular canals and cochlea, with hyperemia, marked thickening and dryness of the membranes of the round and oval windows and vessels which supply the internal ear. There is also disease of syphilitic nature in the auditory nerve, also the brain itself, in the formation of disseminated small nodules within the nerve centers. This form of disease of the ear is most successfully treated by the combined use of pilocarpin and mercury. Another valuable preparation in obscure syphilitic cases is the following:

R.—Hydg. bichlor. . . . . gr. j  
 Acid. arseniosi . . . . . gr. j  
 Ferri pyrophosphat. . . . . gr. vj  
 M. Ft. Pil No. xxiv.  
 Sig.—One three times a day.

Care must be exercised in the use of powerful drugs, as there have been cases of jaborandi and pilocarpin poisoning. Two cases have been reported of poisoning; one from two drachms of the fluid extract of jaborandi (which required no antidote), and the other from swallowing a considerable dose of the fluid solution of pilocarpin used for stimulating the hair, instead of a solution of quinine. In both cases the symptoms were profuse perspiration and salivation, dimness of sight, prostration, a sensation of cold tremor and extreme general debility. The treatment of the pilocarpin case was with atropine, which is the antidote.

It is my intention to make you acquainted with all the forms of cures and treatment that have been tried or suggested. I found in a very old scrap book of mine an article on the "Influence of Febrile Diseases on Syphilis," in which it was stated that it is perfectly certain that several grave febrile diseases may modify the course of constitutional syphilis so as to change, or even cause the complete disappearance

of the external manifestations of the disease. Dr. Petrowski (*Vratsch*, No. 22) reports three cases of this description.

In the first, the patient had contracted the chancre six months previous to entering the hospital. He had an indurated chancre of the prepuce, balanitis, mucous patches on the glands and scrotum, ulcerations in the throat coincident with a scaly, syphilitic eruption on the face and scalp. A six weeks' mercurial course produced but slight amelioration. While at the hospital he fell sick with the smallpox; the attack was of exceptional gravity, but when the crusts of the smallpox eruption had fallen, no trace of the syphilitic eruption remained; the patient was under observation for several years, and none of the syphilitic manifestations reappeared. It has been suggested by a pupil of Dr. Hardy to inoculate the poison of smallpox in cases of syphilis which have resisted all other methods of treatment. (Garrigue, *De l'influence des maladies aiguës sur les diathèses*, Thèse de Paris, 1870.)

The second case is less striking; the patient had a syphilitic gumma at the angle of the jaw, and after an attack of typhoid fever, this gumma suppurated, leaving a cicatrix which bore no resemblance to ordinary syphilitic cicatrices.

The third case was that of a powerfully built soldier, twenty-three years old, who was found while suffering with facial erysipelas to have a superficial sore on the penis, swelling of the inguinal and cervical glands, erythematous redness of the pharynx, and broad condylomata on the soft palate, and on the pharyngeal wall. The erysipelas lasted fourteen days, and the fever was severe. With its subsidence, and without any mercurial treatment having been employed, all the manifestations disappeared, and none others ever made their appearance. This patient Dr. Petrowski also had under observation for several years.

Dr. Rudolph of Magdeburg reports two cases that illustrate the temporary subjugation of syphilis by an erysipelalous attack. In the first case, that of a

man fifty-two years old, the syphilis was of twenty-nine years' standing. The syphilitic manifestations observable at the time of his attack of erysipelas were two sores, one on the ala nasi and the other on the supra-orbital margin of the right side. On the ninth day of the erysipelas the sores had entirely healed. The patient was not seen after that, so it cannot be said that he continued free from syphilitic manifestations.

The other case was that of a young woman who had had syphilis for four years, had undergone three courses of mercury, one by inunction, and two by hypodermic injection, and had taken great quantities of potassium iodide. For all that, she was found to have several glands enlarged to the size of a pigeon's egg under the lower jaw on each side, and posterior cervical glands varying in size from that of a pea to that of a hazel-nut. She was very weak and emaciated, and, in consequence of rheumatic pains in the knees, accompanied by well marked inflammatory thickening, could walk but little. This rheumatic trouble, she said, had been present ever since she had syphilis, also exceedingly severe headache. There was paresis of the left half of the face, and occasionally there were spasms of that side of the face. In spite of her weakness, she was given another course of mercurial inunctions—a drachm of mercurial ointment being used daily for thirty days. The effect was nil and she declined to submit to further treatment.

In about a year Dr. Rudolph was called to attend her again. She was then extremely cachectic; she had been bed-ridden most of the time on account of great debility and pains in the knees, and her headaches had never left her. Moreover, her former manifestations of syphilis were still present. She was now in the early stage of what proved to be a severe attack of erysipelas, which spread from the face over the entire head. In ten days the fever and the exanthema had entirely disappeared; not only that, but she was apparently cured of her syphilis. The clusters of submaxillary glands, that had threatened to suppurate, melted away entirely

as the inflammation disappeared; there was no more headache or articular pain; the facial paresis and spasms gradually ceased, and her general health was so rapidly restored that in the course of a month she was able to return to work as a tailoress. A relapse occurred, however, at the end of a year.

Dr. John Noland Mackenzie (in Morrow's work on Dermatology and Syphilology) says: "This remarkable influence of the febrile state upon syphilitic inflammation and ulceration of the nasal passages and throat is also in a measure true of simple inflammatory conditions of these cavities. It were foreign to the purpose of the present article to elaborate this latter and cognate subject, and I shall therefore simply offer for consideration the fact that *simple* catarrhal inflammation of these regions occasionally disappear completely, and is permanently cured during the course of an acute febrile disease. Whether this occurs as a phenomenon of so-called substitution, or as the result of a profound impression made upon the nutrition of the parts by virtue of which abnormal secretion is arrested and the inflamed tract placed in a condition favorable to resolution, can only be determined by the accumulation of more exact scientific data concerning the reciprocal antagonism of pathological processes."

Not long ago, a new cure for cancer was announced. It was inducing erysipelas, by injecting its micro-organism into the substance of a malignant growth. This streptococcus of Fehleisen (named in honor of the bacteriologist who discovered it), it was supposed, made war upon and destroyed the cancer germs. I was investigating this subject, and had collected the above-mentioned cases, when day before yesterday I received a copy of the *New Albany Medical Herald* (December, 1896) in which there was a most able article from my friend Professor J. Abbott Cantrell of Philadelphia. The article was entitled, "Does the Streptococcus of Fehleisen exert a Curative Influence Upon Syphilitic Ulcerations?" He reported a case of apparent cure of syph-

ilis in a patient who was attacked with erysipelas. "The case, in fact, presented a picture which is rare to behold in this disease, which often shows such multiple disfigurements, and so varied were the appearances in this young man's case that it had been arranged to photograph it at my next visit, but, upon arriving at the hospital, I was informed that in some manner or other the young man had contracted erysipelas and consequently we were obliged to postpone our operations until a future visit.

During the course of the next few days the erysipelas was noted to have reached its height and what was more peculiar was that as the time progressed the ulcerating lesions were noticed to be becoming smaller each day until finally when the erysipelas was entirely relieved, these syphilitic points were found to be entirely healed and presenting the cicatricial condition only that is usually found after the removal of the effect of syphilis."

He says, "The impression of the writer is that the effect was not accidental. That the same effect may be produced in any case in which erysipelas is accidentally contracted. Another point to answer is: Is the effect entirely curative, *i. e.*, has the disease been forever cured, or is it likely to return? In answer to this I may say that it is probable that it will, and therefore the effect is probably not lasting."

Dr. Cantrell gave the report of the committee appointed by the New York Surgical Society to investigate the value of the streptococci of Fehleisen, that vegetable germ to which erysipelas is due, in cases of malignant diseases (*Annals of Surgery*, July, 1896).

"We believe that in the instances of apparent cure or marked improvement the correctness of the diagnosis is open to doubt."

"We therefore submit:

"1. That the danger to the patient from the treatment is great.

"2. Moreover, that the alleged successes are so few and doubtful in character that the most that can be fairly alleged for the treatment by toxines is that it

may offer a very slight chance of amelioration.

"3. That valuable time has often been lost in operable cases by postponing operation for the sake of giving the method of treatment a trial.

"4. Finally, and most important, that, if the method is to be resorted to at all, it should be confined to the absolutely inoperable cases."

After reporting the curative action of erysipelas upon syphilis, it is well to "give the devil his due," and report cases where syphilis has been reported in taking a hand in curing the most dreadful scourge of this country—pulmonary tuberculosis. Dr. R. Abrahams (*Medical Record*, December 28, 1895) reported the case of a man aged 35, who was far advanced in phthisis pulmonalis. He acquired syphilis. Under prompt and energetic anti-syphilitic treatment every symptom of syphilis and tuberculosis vanished. Five years later he was perfectly well. Dr. Ross (*Medical Record*, February 15, 1896) reported a similar case. Seven years later the patient was enjoying perfect health. Fournier reports the case of a man who was given up to die, who had every symptom of pulmonary tuberculosis. Syphilis was diagnosed. Iodide of potassium was given, resulting in a rapid and permanent cure. Brambilla reports the following: "In a hospital a phthisical patient occupied the adjoining bed to a syphilitic. The first was extremely ill and there was little hope of his recovery. Through a mistake of the apothecary, the mercury which was ordered for the syphilitic was given to the one with phthisis. He soon recovered his former health and vigor and left the hospital."

More than twenty years ago I reported the case of a man who was far advanced in pulmonary tuberculosis. He became interested in daguerreotyping and passed hours every day in the dark room, inhaling the fumes of the iodides. In a few months he had entirely regained his health.

In my next lecture I shall take up some of the syphiloderms and then show you cases as they come in.