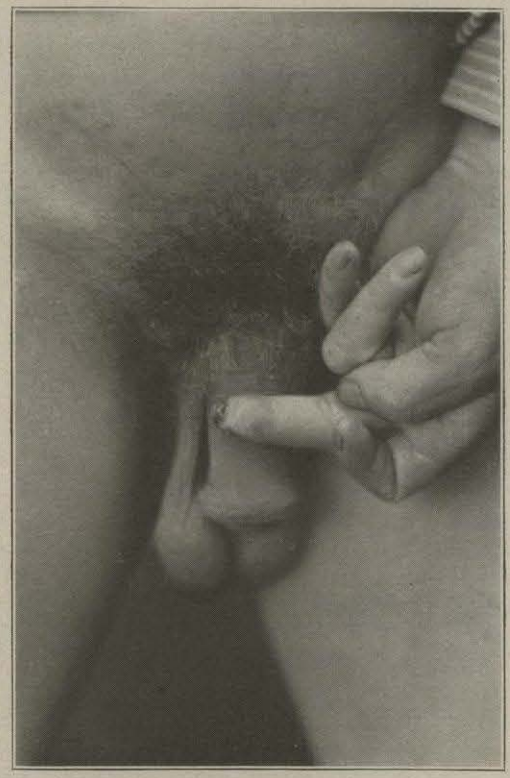

PLATE V.

MULTIPLE CHANCRE.

Double Hunterian chancre on penis; chancre of finger; occurring in a 27-year-old American tinsmith; spirochetes found in all three lesions. (*From the Dermatologic Clinic, Post-Graduate Medical School, Chicago.*)

served. The attending physician looked up the Moorish women and found that one of them presented undoubted secondary lesions. The syphilitic chancre of the conjunctiva is usually located at the larger angle of the eye, and at times at the external commisure. Those of the conjunctiva properly so called, the palpebral or bulbar, are quite rare. The method of contagion in the reported case by the practice of licking is not unknown by any means. Cases of this nature have been reported often but it is always well to mention such, that they may serve as reminders of the method of infection and lead to more exact and minute examinations of cases.

Face Syphilis. According to A. Ravogli,[2] the pallor and the sallow color of the skin at the beginning of the constitutional period of syphilis is well revealed on the face. The patient cannot conceal that color which shows the affection of the general system. The first eruption, the macular syphilide, usually known as roseola, not infrequently affects the face. Roseola is seen to cover the trunk and extremities, but only somewhat rarely affects the forehead in the form of reddish hyperemic spots, of the size of a finger nail, and of short duration. It is interesting to mention that at the beginning of the constitutional period a brownish seborrheic condition is often developed. Many sebaceous glands are on the nasolabial fold and on the chin. These take on a special activity and produce a dirty brownish-red color, from an increased secretion of the glands, which, together with a superficial scaliness of the epidermis, produces greasy rusts. Not rarely, the roseola recurring on the face, especially on the chin and the sides of the face, assumes a livid and infiltrated appearance. Involution takes place in the center of the patch, leaving circular lesions in the form of well-defined rings, which have been called *roseola annularis* or *figurata*. Papular syphilide is often seen on the face in all its forms and sizes. In the first the eruption has a bright hue, but soon takes on a mixed shade of dark blue or dark brown color. At times the efflorescence becomes so pale that it differs only slightly from the normal skin. Papules of the size of

(1) Lancet-Clinic, May 22, 1909.

split peas occur on the forehead, near the edge of the hairy scalp, of a brownish-reddish hue, which has given to the eruption the name of corona veneris. In some cases large papules the size of a bean, and the color of a biscuit or crust of bread, make their appearance in an irregular manner on the forehead and face, few in number and scattered. These giant papules, appearing as the first symptoms of the general affection, are usually considered as the omen of severe symptoms. Papules affecting the bearded face come so close together as to form thick patches, red, scaly and covered with greasy crusts. In some cases they resemble the vulgar sycosis and it is not easy to make the differential diagnosis unless helped by the other accompanying symptoms. In some cases exudation takes place at the apex of the papules, in the form of vesicles, which soon dry up and form scabs. This condition is often found in the hairy scalp and on the face, which has been called papulocrustous or papulopustular syphilide. In some cases the papules become hemorrhagic, and the eruption assumes a brown-bluish tinge, which lasts, and, although the papules have been involved, a dark-brown pigmentation remains for a long time. Papules, when on the mucous membranes, change their appearance, become flat, eroded and secrete fluid serum, and are better known as mucous patches. We may see these modified papules at the angle of the eyelids, of the nostrils, of the mouth and on the lips. Gradually, as syphilis becomes older, the lesions assume the characteristic tertiary forms. They have a tendency to appear isolated in the form of superficial dermal nodules on the nose or around the nostrils or the lips. The difference between a papule and a gumma is in the nature of the infiltration. The first will be reabsorbed without leaving a scar, while the second usually ulcerates and leaves a permanent scar. On the nose, ears and around the mouth, through conglomerating superficial gummata, ulcerated patches are produced, which sometimes may be mistaken for lupus, at other times for epithelioma, but the eye of the expert is able without much difficulty to recognize the luetic origin. Large subcutaneous gummata often appear on the forehead in the form of dark-bluish protuberances, often resembling abscesses. Likewise conditions have been observed in the orbit, as periosteal gummata, which suppurated, protruding above the upper eyelid, pressing the bulb of the eye downward.

Gummata frequently affect the nose in its integument, which, persisting, often lead to the destruction of the nasal cartilages, with resulting deformity. The cartilages and bones of the nose are more frequently destroyed in consequence of the ulcerative process starting from the skin or from the mucous membrane. According to the bones affected and destroyed, the nose assumes peculiar shapes. When the septum is destroyed it has a triangular shape, and that of a sunken nose when the perpendicular plate of the ethmoid bone has been lost. In cases of malignant syphilis the syphilitic infiltration may be destroyed by gangrene, causing enormous destruction in the form of gangrenous gummata. In one patient the lower lip fell into gangrene, due to necrosis of the diffused gummatous infiltration. In rare cases elephantiasis of the upper, and in one case of the lower lip, originates from chronic syphilitic infiltration. The pathologic changes which take place in the blood and lymph vessels, together with the effusion of infiltrating elements, cause a stasis of the lymph, with some organization of the connective tissue elements, causing an abnormal swelling of the lips, with hideous deformity of the patient.

Nose Syphilis particularly in the tertiary stage, is very misleading according to W. Thrasher,[1] who reports the case of a 48-year-old spinster who in July, 1906, consulted him for nasal stenosis of several years' duration. She was somewhat anemic. Both nares were blocked with grayish-red granulation tissue, which sprang from the septum and both middle and lower turbinals. It resembled, macroscopically, primary nasal tuberculosis, except that the granulation tissue was slightly firmer and had a little more color, and was comparatively dry, while in the tubercular cases the hyperplastic tissue is more friable and covered with a mucopurulent secretion. There were no other objective symptoms at this time, except a slight induration

(1) Lancet-Clinic, May 22, 1909.

of the anterior cervical glands, nor were any observed for 3 months. Microscopic examinations, made by two men a month apart, showed, they claimed, a small round-celled sarcoma. During the next 3 months the nose was operated upon three or four times, each time followed by rapid recurrence. Trypsin injections were used and tonics given. The septum became indurated and finally a perforation appeared in the posterior portion of the cartilaginous septum. She decreased in weight and the cachexia increased. One day she called attention to a dermal rash on her forearm. This was an erythematous syphilide of a purplish copper hue, which probably had been present for some time but overlooked. It seems somewhat anachronous to find an erythematous syphilide accompanying a lesion of the nose, which rarely appears before the latter half of the secondary or the first part of the tertiary stage. Under antisyphilitic treatment the hyperplastic tissue in the nose rapidly disappeared and the gummatous infiltration and induration of the septum receded. Within a short time the nose was normal except a small perforation of the cartilaginous septum. In the second case a 28-year-old man applied for relief from a "chronic cold in the head." The coryzal symptoms had persisted for about 4 weeks. Examination of the nose revealed a septal shelf on the left side just above the floor and hypertrophy of both lower turbinals. Thrasher attributed the catarrhal symptoms to this condition, and removed the shelf with the drill and reduced the turbinals with the electrocautery. At the end of 2 weeks, when the septal wound had practically healed, there was a slight tumefaction of the septum one-half inch above the septal wound and at the junctions of the cartilaginous and bony septum. The infiltration rapidly increased on both sides of the septum, and in a few days had some of the appearances of a septal abscess. Thrasher, considering the appearance of the septum, febrile disturbance and general malaise, thought that he had a streptococcus infection from the shelf operation. Not until a small focus of necrosis appeared on either side of the septum at the point of greatest bulging did he suspect that he was dealing with a gummatous infiltration, nodulation and ulceration of the septum. The patient admitted infection, 3

years previously, but having had systematic treatment did not associate the present trouble with the past. The pathologist who examined a specimen from the necrotic area said: "While it is not a typical epitheliomatous picture, I should advise close watching for any appearance of malignancy." Under vigorous antisyphilitic treatment the gumma rapidly subsided and the general health improved. When seen later he had no other symptoms except a diffuse scaling syphilide of the palmar surfaces.

As the gummatous nodule develops primarily under the perichondrium, the swelling of the septum will be bilateral, and in this way, until necrosis of the membrane takes place, resembles a septal abscess.

Differential diagnosis between a septal abscess and a gumma is usually not difficult. A septal abscess usually has a history of traumatism. Careful palpation will reveal a localized collection of pus in the septum, while a gummatous nodule imports a doughy, soggy feeling.

The initial lesion, when situated in the nose, is not as difficult to recognize as syphilitic hyperplastic fungoid growths or developing gummata, but quite frequently the macroscopic appearance and the pathologic report of a chancre are misleading and erroneous.

The third patient, a married woman, presented herself with a small growth springing from the lower portion of the septum of the left side. From microscopic examination, its extreme vascularity and rapid increase in size it was pronounced a sarcoma. Preparations were being made for its removal when the rapid enlargement of the cervical lymphatics and the appearance of a syphilitic dermal rash showed that there was an initial lesion on the septum of the nose which had taken this unusual form. The macroscopic appearance of this chancre was very misleading, for it resembled a cauliflower-like growth in some respects, and had none of the characteristics of a chancre. The woman's husband had syphilis.

A chancrous erosion is often mistaken for a herpes progenitalis, and it is not uncommon for an extragenital chancre, especially one on the skin, to be pronounced tubercular. An extragenital cutaneous chancre of the hand, in a boy of 13, was prononuced tuberculous in char-

acter, notwithstanding the presence of luetic ocular manifestations, a slight erythematous syphilide, syphilitic granulation tissue in the pharynx, intralaryngeal hyperplasia causing aphonia, and some induration of the epitrochlear, axillary and cervical glands. Potassium iodid and mercury hypodermically cleared up the manifold symptoms in a very short time, proving conclusively that this case was specific in character. The patient received a systematic course of treatment for several months and then discontinued treatment after the disappearance of symptoms. He returned later with a typical pustular syphilide covering the face and upper portion of the body, which rapidly cleared up under antisyphilitic treatment.

Acute coryzal symptoms are valuable diagnostic factors in approaching or developing gumma of the septum. The secretion is mucopurulent in character when the lesion is malignant or tubercular, while a gumma in the stage of induration and infiltration is accompanied by a thin serous discharge and other symptoms of an acute coryza.

The septum is the favorite location for gummatous formations, but occasionally the outer wall, including the turbinals and floor, will be attacked by gummatous ulceration. This condition, when not accompanied by other symptoms of syphilis, is very likely to be mistaken for an epitheliomatous growth.

In the fourth case, a middle-aged man presented himself with an extensive ulceration involving the lower and middle turbinals of the left side and a portion of the upper lip. The original ulceration began in the nose and had been curetted twice for the removal of cancer. At the time Thrasher saw him the appearance was that of a rapidly extending epithelioma. The area involved was so extensive as to contraindicate operation. To gain time to study the case, and with the possibility in mind that it might be specific in character, the patient was given small doses of bichlorid and 15 grains of iodid 4 times daily. Owing to a mistake in labeling the bottle at the dispensary, the man was given ¼ grain of bichlorid and 60 grains of iodid 4 times daily. He returned at the end of 10 days badly salivated, but the ulceration had begun to heal. Under proper treatment he made a complete recovery.

Thrasher has seen cases which undoubtedly would have resulted in an ulcerative condition similar to the one just described had antisyphilitic treatment not been instituted at the proper time.

This gummatous hyperplasia of the entire nasal mucosa, which frequently causes almost complete stenosis, might be mistaken for a simple hypertrophy were it not that the septum is thickened quite as much as the turbinals. The membrane is lighter, or paler in color, and the secretions more abundant and purulent in character than in those where the thickening is due to simple hypertrophic cell changes. In one case this condition of the nose was the only evidence of lues to be seen. The patient complained of hypersecretion and nasal stenosis. Both sides of the nose were closed on account of general hyperplasia and infiltration of the membrane covering turbinals and septum. The membrane had a doughy, soggy appearance and was pale, but not as light in color as cases of hyperesthetic rhinitis, and the secretion was abundant and mucopurulent. He had been treated 4 years previously for syphilis, but had not been very faithful. He was advised to use an alkaline spray, and referred back to the doctor for constitutional treatment. Vigorous mixed treatment cleared up the symptoms mentioned within a short time.

Thrasher reports a case of a prosperous 50-year-old German, the father of 9 healthy children, who became imbued with the idea about 6 years ago that he had contracted syphilis in some way and that the septum of the nose was undergoing necrosis which would eventually destroy the entire nose. He was strong and vigorous physically, but extremely neurotic. His nose was practically normal and entirely healthy, and he never had a sign or symptom of syphilis in his life. His mental and nervous symptoms increased to such an extent that Thrasher suggested a trip to Europe. Marked improvement followed a change of scenery and surroundings, but he occasionally needs assurance that his nose is free from the ravages of syphilis.

Treatment of Nervous Syphilis and Perasyphilis. According to D'Orsay Hecht,[1] semeiology of nervous syphilis includes syphilitic arteritis, meningitis and gummata. The nerve tissues themselves are not affected. It is the circulation and the supportive framework that are involved in degenerative changes occurring a considerable time after infection. Such are tabes and paretic dementia. Syphilis stands in direct and indirect causation of these diseases. The finding of the spirocheta pallida and the use of the Wassermann reaction aids us in diagnosis, and the therapeutic measures should also improve. Neither routine nor a haphazard administration of mercury or iodids is commendable. Mercury and iodids are of the utmost value, but must be combined with supportive measures and re-education of muscles in ataxia. Mercury by inunction is the best method of administration. The uselessness of mercury and iodids alone in parasyphilitic paretic dementia was long ago pointed out by Luys,[2] J. G. Kiernan,[3] E. C. Spitzka[4] and others, while upon the vasomotor factors as therapeutic indications, peculiar stress was laid.

Arylarsonates in Syphilis. F. J. Lambkin[5] reports 34 cases of syphilis treated by arylarsonates with good results and without untoward effects. After a course of arylarsonates, mercury, preferably in injections of metallic mercury, should be employed. Soamin was used in 26 cases. This is a para-aminoarsonate, having the formula $C_6H_4NH_2AsO(OH)(ONa)5H_2O$; in fact, it approximates very closely to the original preparation atoxyl. It has the advantage over the latter in that its purity can be assured. These 26 cases had their full course of soamin, which consists of a total of 100 grains, and in only two were there the slightest bad effects (cases 15 and 16); both as recorded showed slight toxic symptoms after they had had their eighth injection. The fact that the patients concerned were over 50 years of age might possibly account for the effects.

Eight were treated with the arylarsonate known as

(1) Medical Record, June 12, 1909.
(2) Maladies Mentales, 1881.
(3) Alienist and Neurologist, 1883.
(4) Insanity: Its Classification, Diagnosis and Treatment.
(5) Lancet, Dec. 5, 1908.

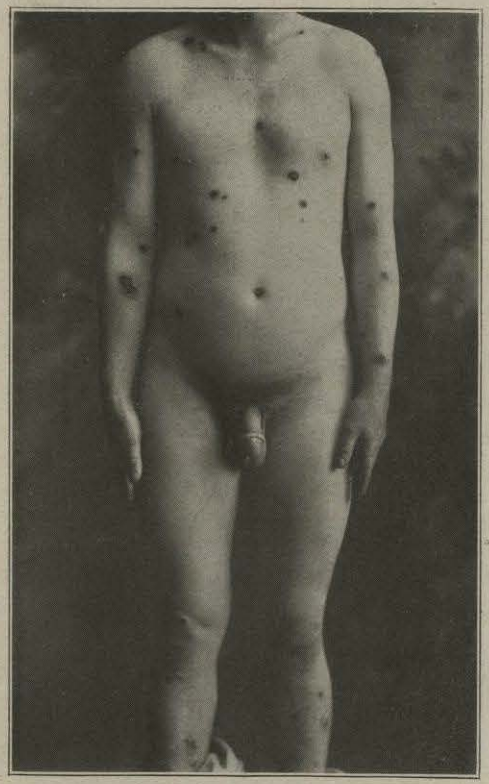

PLATE VI.

TUBERCULO-SQUAMOUS SYPHILIDE.

Occurring in a painter 30 years old; the interesting feature is the early appearance of this type of eruption three months after infection; the primary lesion is still present. (*From the Dermatologic Clinic, Post-Graduate Medical School, Chicago.*)

"arsacetin," which is a sodium acetyl-phenyl-arsonate. ($C_6H_4NHCH_3CO$). AsOOHONa=arsacetin. The preparation, according to Neisser, is certainly far less toxic than atoxyl, both healthy and diseased animals tolerating very much larger doses of arsacetin than of atoxyl. As far as it is possible to make any comparison as to the remedial action on syphilis, he thinks there is no doubt but that everything favors arsacetin. "No decomposition of any kind in the solution, even when stored for a long time, could be detected, nor does boiling daily alter the solutions in any respect." Lambkin gives 40 minims of a 15% solution every second day. This is equal to 7 grains of arsacetin. The preparation can be employed in either a 10% or a 15% solution. The latter has the advantage that it does not require the injection of so large a quantity of fluid and consequently the temporary painfulness in the locality of the injection is slighter. There is, however, this disadvantage, that the 15% solution deposits the salt when cold, so that before use it is necessary to heat it to bring it into solution. Arsacetin possesses advantages over soamin. Its solutions do not decompose; hence it is unnecessary to make them up fresh daily as is the case with soamin.

Atoxyl in Kala-Azar. Atoxyl has been found of decided value in one case of Kala-Azar fever by A. McKay.[1] The dose given was 9 grains daily. Kala-Azar fever is usually fatal. The patient made a good recovery.

Ammonia Uranate, according to A. Weil,[2] is of value in syphilis both as a mercurial adjuvant and singly. Ammonia uranate, which is known in commerce as uranium yellow and employed in the industries as a ceramic pigment, is but slightly toxic, contrary to the other salts of uranium which are so in a high degree. It possesses very clear radioactive properties, which seems to indicate that it acts upon the nervous system in which the syphilitic virus seems to quarter itself. It is employed in the same manner and doses as calomel; that is to say, the uranate of ammonia which is chemically pure is suspended

(1) Edinburgh Med. Jour., Dec. 5, 1908.
(2) Amer. Jour. of Derm., March, 1909.

in sterilized vaselin in the strength of 5%. A cubic centimeter of this solution corresponds to 5 centigrams of uranate of ammonia. The injections are made with this oil once weekly in the buttock; they are in no wise painful and have never brought about any untoward symptom. It has been possible to continue them for 2 months and very much longer (up to 30 injections consecutively) without inconvenience or dangers of intoxication. The trial of the remedy has been made on 50 patients, but the observation of the patients was not made for a sufficiently long time except in 39 cases. In all save one the action of the remedy was particularly fast. The average length of treatment was 2½ months, but the cure was beyond dispute. The slight toxicity of ammonia uranate gives it an unquestionable therapeutic superiority. In this respect it is much superior to mercury. From the point of view of curability of lesions, yellow oil possesses in certain cases an action as rapid as that of the most active mercurial salts.

Mercury Insufflation in Syphilis. Cronquist[1] has had good results from the following procedure: He uses hydrargyrum cum creta, or a finer powder containing 40% of metallic mercury. Of this powder 4 gm. are to be inhaled daily, in the form of a snuff, at four different intervals. A fifth may be given, but never more. This method of inhaling mercury is one that might become popular in snuff-taking countries, but hardly in others. In addition, the irritation to the nose is apt to be serious.

Gray Oil in Syphilis. Pernet[2] states that in intramuscular treatment of syphilis it is very important to use a properly made sterilized standard preparation. Gray oil is now official in the French Pharmacopeia. The formula is: Purified mercury, 40 gm.; anhydrous wool fat, pure and sterilized, 26 gm.; medicinal oil of petrolatum sterilized, 60 c.c. This is put up in small glass stoppered bottles of 1 c.c. of the preparation, containing practically 40 cg. of mercury.

(1) Amer. Jour. of Derm., May, 1909.
(2) Lancet, July 24, 1909.

Mercury: Internal Administration, Inunction or Injection in Syphilis. According to E. C. Hay,[1] all three methods should be combined at different periods during a full course of treatment. A course of treatment in the early inception of syphilis should start either with inunctions or injections and be followed by internal medication, instead of the pill or internal treatment being given first, and followed later by injections and rubs, as advised by most modern textbooks. The brilliant results to be obtained in the prevention of future accidents in any case are to be accomplished in the first year's treatment. Hay has formulated the following routine to be pursued in cases of syphilis as they ordinarily run: First Year.—Two courses of either inunctions or injections, covering a period of 2 months each; after each course of treatment a month's rest should be allowed and then internal medication 2 months during the interim up to within a month before resuming the second course, whether inunctions or injections, making 4 months rubs, 4 months internal treatment, 4 months rest. Second Year.—Two courses of rubs or injections 6 weeks each; two courses of internal treatment, 8 weeks each; two courses of rest, 6 weeks each, and two of 4 weeks each, making a total of 3 months heavy rubs or injections, 4 months pills, and 5 months rest. Third Year.—Treatment every other month, alternating between the internal and more intense methods. Fourth Year.—Six weeks of inunctions or injections. Fifth Year.—Four to 6 weeks of inunctions or injections. All three methods should be used in treating any case of lues. When first instituting treatment after infection, either inunctions or injections should be employed, followed by internal medication, instead of treatment with pills first, followed by more heroic methods, as advised by most of the leading writers. The inunctions, on an average, are superior to the soluble injections, and more lasting in their effects. The insoluble salts are too intense and profound to be employed in routine and should be held in reserve for rebellious cases and for cases in which rapid and pronounced mercurialization is desired. Finally, the long course of treatment should be pursued in all cases. The

(1) Jour. Am. Med. Assoc., Aug. 28, 1909.

six cardinal points in the therapeutics of syphilis are to keep a close observation of the weight, kidneys, bowels, stomach, gums and nervous system, especially the latter, as some patients will never manifest any evidence of mercury in the form of stomatitis and the first evidence one has is a profound and acute nervous prostration.

Syphiloid Diseases are just now looming up in nosology. One of the sixteenth century much discussed was the *morbus Brunno-Gallicus* in 1578, which, in 3 months, attacked 40 persons in Bruenn and almost a hundred in the suburbs; a considerable number of the country people were also affected. This disease presented symptoms similar to those of syphilis. The disease was generally supposed to have been promulgated by baths, and the practice of cupping in common use by the inhabitants. Thomas Jordan, the historian of this epidemic, draws a very gruesome picture of the appearance presented by those afflicted with it. The mind and the limbs lost all power of performing their functions. There was pallor of the face and putrid ulcers soon appeared. Pustules occurred upon the body, the face became hideous, mournful looking, the eyebrows dropped out, the face, back, chest, abdomen and the feet became the seat of a scabby formation, ulcers but slightly elevated above the skin being present. The pains which existed were excruciating and permitted no rest. The nights were sleepless until complete exhaustion permitted the wornout members to rest, in a more or less refreshing sleep of short duration. Various remedies were tried for this disease; but the following method seems to have been generally successful: After having bled the plethoric subjects, and given some purgative medicine, decoctions of guaiacum, turpeth mineral pills, and the expressed juices of wild endive and of fumitory were administered, while the ulcers were dressed with mercurial ointment. This syphiloid disease has also been known as the Moravian epidemic, and it appears to have been essentially syphilitic in nature from its symptoms and the fact that it was so amenable to mercurial treatment both internal and local.

Another disease which aroused a certain amount of interest among medical men, at the beginning of the last century, was *Sibbens*. It was observed in Scotland, particularly in Ayr, Galloway and Dumfries. According to Gilchrist, Sibbens showed itself under several forms. Sometimes inflammation of the velum palati and surrounding parts took place, accompanied with a white eschar or superficial bright red ulcer. At the same time aphthæ or small white spots or eschars often occurred on the velum palati or insides of the cheeks. Small elevations of a pearly or milky color also usually appeared on the commissures of the lips. Often, too, a very small excrescence or fleshy growth developed, resembling a raspberry, and which became covered with a crust. This growth was an almost certain indication of the disease, even when the sore throat did not exist. Trotter compared its appearance to that of toasted cheese. Another form of this disease was that of destructive ulceration, which often caused the entire loss of the velum palati, and the death from inanition of infants at the breast, deglutition becoming impossible. Sibbens occurred in other cases of the skin and under different aspects. Sometimes the whole surface of the body was spotted and clouded with a coppery, dusky red blush. At times a cluster of pustules appeared, over which several successive desquamations of the epidermis took place. Scabby eruptions of the hairy scalp, forehead, inner surfaces of the thighs, etc., appeared accompanied with little hard lumps in the thickness of the skin and an unpleasant itchiness. At other times tumors similar to furuncles were seen on the arms, shoulders, face, legs and feet, giving rise to ulcers that perforated the whole thickness of the skin and lay bare the muscles, which they sometimes also corroded. Adams believed that these ulcers were the result of the immediate contact of the virulent matter proper to the disease. Finally, the soft and spongy tumors, raspberry in form (whence the name of Sibbens or Sivvens, which is derived from Sibbens—raspberry), are the last symptoms of the disease; they do not seem to occur in all places alike, for several other forms of the disease were observed; several, indeed, which Gilchrist had never seen. According to Gilchrist, the bones were not affected in this disease. Bell, on the contrary, speaks of nodes and caries. Sibbens was rarely communicated by sexual intercourse; alterations sometimes seen in the genital organs took place consecutively. The

disease was frequently transmitted by nursing, and the common use of the same utensils, the use of the same pipe, for instance. The almost complete silence of writers after the first decade of the nineteenth century seems to show that the disease became extinct at about that period. The treatment bore a great resemblance to that employed in syphilis. The good effects of it led to the classification of Sibbens as a syphiloid disease by the older authors.[1]

Among other syphiloid diseases was that of Bay St. Paul, Canada, between the years 1776 and 1780. This disease, denominated *the disease of the Bay of St. Paul, le mal de Chicot, le mal des écoulements,* appeared in Canada, particularly in the Bay of St. Paul. According to Bowman, who was sent by Governor Hamilton to investigate, it was announced by a number of small pustules on the lips, tongue and the inside of the mouth. These pustules, which resembled small aphthæ, advanced rapidly. Children were seen whose tongues were almost entirely destroyed by them. The whitish and puriform matter they contained communicated the infection to those who touched it. There were nocturnal pains in the bones, which generally subsided when the ulcers appeared on the skin and in the interior of the mouth; cervical, axillary and inguinal buboes were often met with; at a more advanced stage the body was covered with pruriginous tetters which soon disappeared. The bones of the nose, palate, cranium, pelvis, thighs, arms and hands became affected with nodes and caries. The functions became greatly disordered and the senses disturbed. The patients died a prey to the most acute sufferings. Some, however, stood this complication of infirmities for many years, dragging on a most miserable life; entire limbs were sometimes known to sphacelate and fall off. The frightful disease spared no one, but it raged with peculiar virulence among children. Decoctions of the roots of patrientia, of arctium lappa and sarsaparilla were the usual remedies. A decoction of a species of fir, or beer composed of a decoction made with the branches and bark of the pine of Canada (Pinus Canadensis), was also used. The inhabi-

(1) Amer. Jour. of Derm., August, 1909.

tants of some parts of Canada, and, among others, those of the Bay of St. Paul, where the disease spread extensively, pretended that it was brought among them by the English. The disease rarely attacked the organs of generation and was contracted without any actual intercourse with individuals affected with it, even without touching them immediately. This did not imply that it could not be acquired by direct contact irrespective of the manner in which this contact occurred. Bowman's description recalls to Swediaur the account which the writers of the fifteenth century gave of syphilis.

The similarity to *scherlievo,* to be considered next, is striking. It was attributed to four sailors, who were supposed to have brought it from Turkey. It appeared in 1800 in the districts of Scherlievo, Gronemica, Fiume, etc. It was supposed by others, again, to have been imported in 1790 from Kukulianova by a peasant named Kumzut. A short time after his return his father and mother were affected by it, and afterward propagated it in Scherlievo, etc. The disease spread with so much rapidity in 1801 in the provinces of Buccari, Fiume, Viccodai and Fuccini that of a population of about 14,500 more than 4,500 were affected with it. A committee of physicians appointed in September, 1801, found more than 13,000 persons affected with it in a population of 38,000. It reappeared in 1808 and 1809, raging especially in Scherlievo, where it seemed to be kept up by the filth of the lower orders, whose damp cabins were shared by domestic animals. This disease usually commenced with lassitude and pains in the bones of the arms, thighs and spine, which increased during the night; the voice soon became hoarse and deglutition difficult; the face flushed; the velum palati, uvula, tonsils and sometimes the pharynx and larynx were red. Soon after an aphtha appeared, burst and discharged an ichor, which eroded the neighboring parts; small ulcers formed which united and created a sore of various dimensions, but always of a round shape and an ashy color, with hard, raised and dark edges. These ulcers in some cases evolved with great rapidity, covering the uvula, the tonsils, the velum palati and the surface of the cheeks and lips. Caries af-

fected the bones of the nose, when very fetid pus was discharged. The voice changed more and more until entirely lost. The exostoses, which had appeared from the beginning, occasionally but rarely shrunk and vanished along with the pains that accompanied them as soon as a pustular eruption evolved upon the skin. Lambini reported 4 cases in which pains in the bones became more violent, notwithstanding the treatment employed, and lasted throughout the disease. When scherlievo commenced with a pustular eruption, it was, according to Bouc, announced by violent itching, which lessened as the eruption came to an end. The pustules were of coppery color, round and of various extent. They most frequently appeared on the forehead and hairy scalp, but also on the inner surfaces of the thighs, legs and arms, and around the anus and genitals. An acrid ichor sometimes flowed from them, which inflamed the skin. This sometimes dried and formed scabs. The disease often remained stationary thus. After the scabs had fallen off, the skin retained marks of a coppery hue, difficult to remove. Scherlievo has begun with various sized coppery blotches, in the center of which ulcers were seen, from which matter poured out, that by drying formed scabs similar to those covering the pustules. These blotches were generally surrounded by an areola of a coppery hue. The female genitals were more frequently the seat of disease than those of men. Cambieri found one case of gonorrhea which came on after the desiccation of the pustules of the skin, and disappeared as soon as the eruption was restored. The ulcers which so frequently eroded the scrotum always appeared secondary to the general infection. Scherlievo was seldom the consequence of sexual intercourse but usually the effect of simple intermediate contact: the clothes, table utensils, such as glasses, forks, napkins, etc., and an atmosphere charged with the breath of those infected were all sufficient for infection. Some children brought the disease with them into the world or had it communicated by the nurses who suckled them. Buboes in the groins, or swelling of any of the other lymphatic glands, were rare. When it appeared as pustules, spots or ulcers in the mouth it readily yielded to anti-venereal remedies. The prognosis was unfavorable

when patients had been weakened by fruitless treatment or by previous complaints, when the ulcers had reached gangrene, when they occasioned caries of the bones, or when the patients were debauched, indulging in intemperance and neglect of personal cleanliness. Treatment of scherlievo did not, in any particular, differ from that of syphilis. One writer found that mercury bichlorid, given in the syrup of casinier (composed of senna and sarsaparilla), proved the most effectual means of subduing it. When caries attacked the bones the treatment might be concluded with advantage by 10 or 12 mercurial frictions. Opium combined with mercury was employed with complete success against the pains of the bones. Proto-chlorid mixed in the cerate with which the ulcerated pustules were dressed and a dilute corrosive sublimate solution, used as a gargle or wash to the ulcers of the mouth, always expedited the cure.

Uta is the Peruvian title of a disease attacking the face and nose and is distinct from lupus, syphilis, tuberculosis and leprosy, according to A. Ashmead.[1] The clinical and bacteriologic details given are insufficient to form an opinion as to its nature except as to its being phagadenic.

Bubois of Paraguay, according to Zanotti Cavazzoni,[2] is a disease of the skin characterized by chronicity and is very rebellious to treatment. There is extensive and deep ulcerations very destructive and corroding, at times eating through the muscles. It takes root most frequently in the extremities. Those afflicted with it have also the anchylostoma duodenalis. The germ is a tryponosome.

(1) Amer. Jour. of Derm., July, 1909.
(2) Rousski Vratch, January, 1909.