**Hard chancre of the tonsil / by Frank Donaldson, jr.**

(8)

# HARD CHANCRE OF THE TONSIL.

BY

FRANK DONALDSON, JR., B.A., M.D.,

CHIEF OF CLINIC FOR THROAT AND CHEST, UNIVERSITY OF MARYLAND,
AND SOMETIME SCHOLAR IN BIOLOGY, JOHNS HOPKINS UNIVERSITY.



FROM

THE MEDICAL NEWS,

August 15, 1885.

# HARD CHANCRE OF THE TONSIL.

BY

FRANK DONALDSON, JR., B.A., M.D.,

CHIEF OF CLINIC FOR THROAT AND CHEST, UNIVERSITY OF MARYLAND,
AND SOMETIME SCHOLAR IN BIOLOGY, JOHNS HOPKINS UNIVERSITY.

FROM

THE MEDICAL NEWS,

August 15, 1885.

# HARD CHANCRE OF THE TONSIL.

---

THOUGH hard chancre of the tonsil is by no means so infrequent as was formerly supposed, its etiology, symptoms, and appearance are so variable, and its positive diagnosis often so difficult, that the case given below may justify a résumé of the subject as it stands to-day; particularly, as I find in English nothing beyond mere records of cases.

The patient, a prostitute, æt. 29, presented herself at my clinic April, 21st, complaining of sore throat; and gave me the following history: At sixteen she had a sore on her genitals, and was treated, she said, by a physician now dead, for syphilis, who after a time pronounced her cured; at any rate, no constitutional symptoms had at any time developed. She remembered no particulars of her sickness, so many years having elapsed, and could give me no further information beyond the statement of her physician as above.

Having been ill with peritonitis in the University hospital during February, and having suffered constantly with great pain and tenderness over the abdomen since her dismissal in March, she had been unable to ply her vocation, and told me she had

had no sexual connection whatsoever since January 28th. In the house to which she returned after her acute illness, there was a man who was suffering from a severe attack of syphilis, with "sore throat and sores in his mouth." Both she herself and the only other woman in the house were fully aware of his condition, having been warned by him not to use his tumbler, knife, etc. Fearful of contracting the disease, my patient had taken pains to avoid using any thing that he might have touched, but had on several occasions, when "skylarking," kissed him in the mouth again and again, and though she would not confess it, resorted, I fear, to disgusting practices. Early in April her throat became sore and uncomfortable on swallowing, and a few days later she noticed a sore on her upper lip. Her throat had gradually become worse until she was led to seek relief.

On examination, the lesion on the upper lip was found to be a superficial erosion with a reddened, densely indurated base discharging a scanty serosanious fluid, and was beyond doubt a hard chancre. The lesion upon the left tonsil, in whose character we are more deeply interested, was a ragged pultaceous ulcer, grayish-white, and not deeply excavated. The tonsil itself was somewhat enlarged; owing to the situation of the ulcer and the natural resistance of the hypertrophied gland the exact degree of induration could not be determined; some glandular enlargement on the left side was present.

There was finally much doubt as to the exact nature of this tonsillar lesion. Was it a primary sore or a secondary manifestation following the sore on the lip? The case was referred to Prof. I. E. Atkinson, of the University, who declared both the sores to be hard chancres. Whether it was also a case of *reinfectio*

*syphilitica* it was impossible to say in the absence of more positive proof of a primary infection of syphilis thirteen years before.

The patient was put upon antisyphilitic treatment and the week following returned with a well-marked roseola and adenopathy, and complained of general malaise, feverishness, loss of appetite, and headache. It was, I think, exactly two weeks later, May 12th, when I saw her again, at which time her hair had begun to fall out and she was suffering considerably with syphilitic arthritis. The tonsil sore had in the mean time healed, leaving a distinct scar, with more or less hypertrophy and hardness of the gland; the labial sore was also much improved.

Under the same treatment the patient has continued to improve, though when last seen there was considerable syphilitic erythema of the palate and both lingual and buccal mucous patches had made their appearance.

Such being the complete history of the case: 1st. The great doubt that the woman had been affected with syphilis in her youth. 2d. The fact that she had been unable to have sexual connection for nearly four months owing to her illness. 3d. The unquestioned exposure and the character of the patient. 4th. The almost simultaneous appearance of the two sores and their physical characters, and finally, the full outbreak of secondary syphilis, would seem to confirm our diagnosis beyond a doubt.

Referring now to the points of interest in this case, the labial chancre needs no comment. The possible reinfectio syphilitica is interesting certainly, but the patient's statement alone as to her first attack is hardly sufficient, and it is unfortunately not now possible to corroborate her statement, the physician who treated her having since died. In view, however, of the in-

terest attached to such reinfection, the following references are given, for in them the subject is thoroughly discussed: Neumann,[1] ———,[2] Arning,[3] Boset,[4] Diday,[5] Rollet,[6] Mallet,[7] Sturgis,[8] Vidal.[9]

When we consider the number of cases reported since 1860, it seems strange that in all French literature there is no case of hard chancre of the tonsil on record previous to this date. As late as 1852 Velpeau declared that this particular lesion seemed impossible, and after him other writers, among them, Vidal de Cassis[10], Martelliere[11] (though the latter admitted the possibility of it), Buzenet,[12] Melchoir Robert,[13] Fournier[14] (in 1856), and Gibert,[15] though they give many hundreds of cases of buccal, make no reference to tonsil chancre.

Fournier (in 1860) was the first to observe and put on record a definite case of chancre of the tonsil, which was one of 77 cases of buccal chancre observed by him. In the following year, Diday[16] reported

---

1 Ueber Reinfectio Syph., Wien. Med. Presse, xxv. 1 to 6, 1884.

2 Reinfectio Syph. in due Conjugi, Lo Sperimentale, xlix., Firenze, 1882.

3 Ein Fale von Reinfectio Syph. Vrtlgsche. f. Dermat., x. 92, 1883.

4 Chancre induré devél. deux fois chez le méme individu, Arch. Med. Belges., xxxi., 1863.

5 Du chancre produit, etc., Gaz. Méd. de Lyon., xi., 1859.

6 Du chancre produit, etc., Ibid.

7 Deux cas de Syph. double. montpel. Med., xlvi., 1881.

8 A Second Infection of Syphilis. Am. Jour. Med. Sc., Phila., vol. 83, 1882.

9 Monit. des Hôp. de Paris, 1, 1213, 1853.

10 Traité des mal. Vénériennes, Paris, 1853.

11 De l'Angine Syphilitique. Thése, Paris, 1854.

12 Des chancres d. l. bouche et d. l. diag. différential. Thése. Paris, 1858.

13 Mal. Vénérienne, 1861,

14 In leçons sur le chanchre, par Ricord.

15 Traité prat. d. mal. d. l. peau et l. syph , 1860.

16 Comptes rendus Soc. Méd. de Lyon, pp. 45-70, 1861-62.

eight cases and in an elaborate treatise was really the first to give this lesion a definite place in the history of syphilis. Belhomme et Martin,[1] and Rollet[2] described tonsil chancre with cases, while in Desnos,[3] we find a long account of the same and of its complications. Gondouin[4] reports one case; Mauriac[5] and Julien[6] several; the latter describes with great care the initial lesion, its shape, the grayish-white discharge with which it is covered, its regular edges, its slow evolution. We find four cases reported by Hulot;[7] two by Schiragew;[8] four by Boeck;[9] one each by Spillman,[10] A. Hue,[11] Paul Hamonic,[12] Lavallée,[13] Brocq,[14] Merklen,[15] and Thomaschewsky;[16] Taylor[17] reports three from his own practice, one from that of Dr. G. H. Fox, and one from that of Dr. Wigglesworth, of Boston; Knight[18] gives two; Legendre[19] and Pivaudran[20] several of their own observation; and Morell Mackenzie[21] seven.

---

1 Traité de path. vénérienne, 1864.
2 Traité des mal. vénérienne, 1865.
3 Dict. de méd. et de chirurg. Prat. Vol. ii.
4 L' Union Médicale, 13 April, 1869.
5 Leçons sur maladie vén., p. 144.
6 Traité des mal. vénérienne, 1879.
7 Ann. de dermat. et syph., 1st. t. x. p. 29.
8 Petersb. med. Wochen., p. 39, 1880, and Vertljhrch. f. Derm. und Syph., 1881, p. 127.
9 Tidskrift f. prakt. Med., No. 13, 1883; and Monat. f. prakt. Dermat. 2, p. 317, 1883.
10 London Med. Record, p. 282, 1879.
11 La France Méd., vol. i. p. 752, 1883.
12 Ann. de derm. et syph., Aug. 1882.
13 Ibid, Jan. 1883. 14 Arch. gén. de Méd., Jan. 1884.
15 Ann. de derm. et syph., iv., 1880.
16 Wiener Med. Presse, No. 34, 1884.
17 N. Y. Med. Journ., May 24, 1884.
18 Ibid., June 24, 1884.
19 Arch. gén. de Méd., 1. 292, 1884.
20 Pivaudran, Thése de Paris, 1884, No. 338.
21 Dis. of the Throat and Nose, vol. i. p. 200.

Such being the history of hard chancres of the tonsil, I shall proceed to give the etiology and physical signs, the functional symptoms and the diagnosis of chancre in this situation. I have not been able to give the exact number of cases reported by each writer, several of the papers referred to being unavailable, and, after all, the exact number is not of particular importance, for it would not enable us to get at the comparative frequency of chancre of the tonsil.

Fournier, however, found one in 471 cases of chancre in different localities, and one in 77 of buccal chancre; while Diday in 671 chancres in various situations found not a single one back of the anterior pillar of the fauces. Morell Mackenzie has seen but seven in his great experience.

Theoretically, tonsil chancre should be more common among women than among men, and Morell Mackenzie's experience confirms this idea, for out of the seven cases seen by him, six were in women. Rollet[1] also found chancre of the mouth more common among women, and Ricord, in five years, saw one mouth chancre in 389 men, and two in 199 women. Diday and Desnos find no reason for thinking mouth and tonsil chancre less common in men, but after a careful examination of the separate cases given above, I think we are quite justified in concluding that chancre of the tonsil is more frequent in women than in men.

It is not necessary to describe the cause and mechanism of mediate or immediate contagion; those interested may consult the works of Diday and Desnos referred to above; suffice it to say that kissing is a fruitful source of contagion, when one or the other person is suffering from a manifestation of mouth

---

[1] Dict. Encyclop. 1st série, t. xv. p. 364.

syphilis, and disgusting practices also which need not be described.

In young children, chancres of the mouth often arise from taking the milk from the breast of a syphilitic woman, and Wigglesworth[1] tells of a medical student who put his mouth to that of an asphyxiated newly born child and inflated the lungs several times. One month later a hard chancre developed on his right tonsil. Knight,[2] too, tells of a lady who contracted a chancre of the tonsil by using the same tooth powder as her nephew, who was suffering from secondary syphilis. Again, the contagion is carried from one person to another by means of instruments, by knives, forks, glasses, and other household utensils used by more than one person; by nursing bottles (see case by Spillman[3]); by cigar stumps;[4] etc.

But of all the non-venereal causes of chancre of the tonsil, one of the most curious methods of infection is through the tube used by glass-blowers. Rollet, in 1858, was the first to call attention to this mode of contagion, having observed the epidemic at Rive-de-Giers. And later, Guinaud[5] published an elaborate paper describing epidemics at various places and giving the exact method of contagion, viz., the passage of the piece of glass as it was being blown into shape from mouth to mouth, of the glass-blowers. At present each workman has his own mouth-piece.

The objective and subjective symptoms of chancre of the tonsil vary so greatly, and its situation is so remote that it often passes unobserved, and when seen is not diagnosed. In this connection Taylor remarks "that there is little doubt that some cases of

---

[1] Quoted by Taylor, loc. cit. [2] Loc. cit.
[3] Ann. de derm. et syph., x., 1880.
[4] Bulkley, Arch. Derm., Phila. 1879, v.
[5] Syphilis des Verriers, Lyons Méd., 1880.

the *syphilis d'emblée* or *larvée* of the French were really instances of tonsillar infection." Primary chancre of the tonsil, when situated in the *pharynx*, is most always found upon one of the tonsils, owing, no doubt, to the structure of these glands, the lacunæ of which are prone to receive and retain the syphilitic virus. Tonsil chancre is usually unilateral, Rizat,[1] however, saw a young woman who had seven chancres in various places, with one on each tonsil, and Rollet also one with a hard chancre on each tonsil.

Tonsil chancre generally begins with slight redness and swelling, without perceptible induration of the gland. In a few days there is pain on deglutition, an increase in the redness and hypertrophy, soon followed by a superficial erosion with increased induration of its base, and more or less, though constant adenopathy on the affected side. A most important sign is the hypertrophy and general tumefaction of the tonsil gland itself, which would seem to be a constant accompaniment of tonsil chancre. This syphilitic hypertrophy of the tonsil will be found minutely described by Hamonic.

The second important sign is the superficial erosion, increasing to an active ulcerating surface, covered usually with a grayish-white coating, thicker or thinner as the case may be. Again the coating is granular, and somewhat irregularly distributed over the surface of the ulcer. Sometimes, however, the erosion at first is very slight and superficial, as in a case by Diday. On the other hand, the lesion may assume the phagedenic form of a deep, sloughing ulcer, with great tumefaction of the neighboring parts. This last form of ulceration would seem to be a rare complication of tonsil chancre, though cases of such ex-

---

[1] Quoted by Legendre, loc. cit.

tensive ulceration are reported by Brocq, Mauriac, and Rollet.

The third and most important sign of hard chancre here, as elsewhere, viz., induration of its base, is always present, though not always in the same degree, the amount of induration depending on the amount of hypertrophy of the gland before the development of the chancre. The less the chronic hypertrophy, the less the induration, and vice-versa. Induration of the base may, indeed, be the only sign on which to base a diagnosis of primary infection, as in the case reported by Hue.

The next important sign is the well-marked and early submaxillary adenopathy on the affected side. The engorgement is hard and indolent, and may become very great. Resolution would seem to take place in all cases without suppuration, and the submaxillary adenopathy is much more painful than the inguinal engorgement following genital chancres.

Diday thought the duration of tonsil chancre shorter than that of the primary sore in other places.

The functional symptoms of hard chancre of the tonsil are generally slight, and often an outbreak of roseola is the first intimation the patient has of his trouble. See a case reported by Mauriac.

There is generally, however, pain on deglutition. According to Rollet, among chancres of the mouth, those behind the anterior pillar are the most painful. It is in cases of phagedenic ulceration that the pain is greatest, and swallowing becomes impossible, the breath very fetid and the patient extremely prostrated.

Cohen[1] says, "Chancre of the tonsil is usually soft." I hesitate to disagree with so high an au-

---

[1] Diseases of Throat, Phila., 1870, p. 120.

thority, but after going over a mass of literature on the subject, I am unable to corroborate the statement.

The diversity in appearance and form of chancre upon the tonsil, the absence of functional symptoms, the very situation of the lesion, and oftentimes the denial of the patient, render the diagnosis of this trouble very uncertain. It is to be differentiated from epithelioma; from psoriasis of the mouth; according to Cohen, from the milky patches of smokers and from tuberculous ulcerations; from mucous patches and the perforating, cone-shaped ulcer of tertiary syphilis; from diphtheria (according to Pivaudran); from gangrenous angina of the throat; and from ulcerating gumma of the tonsil gland.

It would seem that a diagnosis between chancre and epithelioma in a case where there is considerable tonsillar hypertrophy, with an ulcer covered by a granular deposit, and where there is a negative history and the patient old, is by no means easy. An interesting case of this kind is given by Merklen.[1] The patient was a man, æt. 64, who had been suffering for two months with a tumor on the left side in the parotid region.

On examination the left tonsil was found to be greatly hypertrophied, hard, and more or less lobulated; there was an extensive granular ulcer, covering nearly the whole surface of the gland; the neighboring parts were infiltrated and hard; there was considerable pain on deglutition and inability to swallow solids; and finally, there was absolutely no history of past or recent syphilitic infection. A diagnosis of cancer was made. Prof. Verneuil, on further examination, pronounced it a case of primary chancre, and shortly after there followed an outbreak of

[1] Ann. de dermat. et syph., Paris, 1881, 2 s., ii. 673.

secondary symptoms, which, with the ulcer in the tonsil, rapidly improved under antisyphilitic treatment.

Cases may arise then, where the diagnosis is difficult, and as it is a point neglected by the author[1] in a paper on epithelioma of the tonsil, he is glad to take this opportunity to give the principal signs and symptoms of these two diseases:

| SYPHILIS. | CANCER. |
|---|---|
| *Functional Symptoms.* | *Functional Symptoms.* |
| Deglutition and swallowing painful, but rarely impossible, with freedom from pain when the parts are at rest. | Difficulty and pain in swallowing the first and constant symptom, increasing until it is impossible to take food. Lancinating pain referred to the ear. |
| *Physical Signs.*[2] | *Physical Signs.* |
| Some hypertrophy with early superficial ulceration in primary sore. The tertiary ulcer perforating and cone-shaped. Comparatively slight glandular enlargement, not painful, and subsides with the cause of the irritation. | Great hypertrophy, later widespread ulceration. Considerable glandular enlargement and induration, which become very painful, and do not disappear. |
| Hemorrhage rare. | Hemorrhage frequent. |
| Slight emaciation. | Great emaciation. |
| Amenable to treatment. | Not cured by any treatment. |

Tonsil chancre may, under some circumstances, be taken for a mucous patch, whose favorite seat would seem to be upon the surface of the tonsil; and this is more likely to happen when the patient is seen for the first time, and secondary symptoms have already manifested themselves, and an ulcer still remains upon the tonsil; or when there is hypertrophy of the tonsil, with an active, and by no means super-

---

[1] N. Y. Med. Record, March 8, 1885.

[2] Lennox Browne, Trans. Lond. Path. Soc., p. 407, 1879.

ficial, ulceration of the mucous patch. The mucous patch, however, always follows the roseola; and the patch is, as a rule, superficial and of characteristic appearance, etc. To determine finally between a chancre and a mucous patch upon the tonsil Diday says: "Cauterize the ulcer twice at an interval of five days, and, if it is a secondary ulcer, it will disappear; if a primary, hard chancre, it will not."

Pivaudran thinks that primary chancre may be confounded with diphtheria; but the course of the two diseases is so unlike that such a mistake is hardly likely to occur.

In exceptional cases chancre of the tonsil is complicated by an extensive slough. The presence of a grayish ulcer, surrounded by an œdematous circle, with inflammation of the surrounding parts, points strongly to a gangrenous throat affection, either of a syphilitic origin or a primary gangrenous angina, such as is described by Gubler and Trousseau.

The limitation of the ecchymotic spots, and the absence of its propagation to the pharynx, palate, and larynx, and the general course of the affection, with the appearance or non-appearance of secondary eruption, will settle the diagnosis.

Ulcerating, gummy tumor of the tonsil is distinguished from chancre by a deeper ulceration, and by its dug-out edges. According to Legendre, a good differential sign is the existence of an erythema and peripheral engorgement, which are never found in gummy tumors, but always present in throat chancre. Further, a knowledge of the patient's antecedents will be of great value.

Finally, if the lesion upon the tonsil has been of slow, unilateral development, is superficial, with grayish-white deposit; if there is a history, or even suspicion of syphilitic exposure; if there is glandular

enlargement; if the sore on the tonsil appeared from fifteen days to three weeks after exposure, and there is absence of chancre elsewhere; if the patient has not been subject to simple tonsillar angina; if the pain is on the affected side, has lasted for some days or weeks, and has not excited febrile reaction, and the whole is followed in due time by an outbreak of secondary symptoms, certainly we are justified in a diagnosis of chancre of the tonsil.