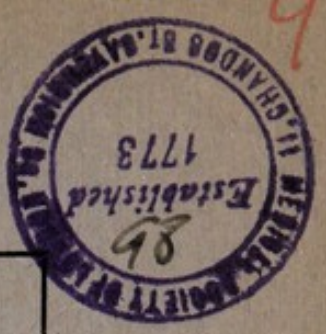
Visceral syphilis / by John M. Swan, M.D., M.D., Philadelphia.



VISCERAL SYPHILIS

BY

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PHILADELPHIA

REPRINTED FROM MEDICINE

E. G. SWIFT, PUBLISHER

JUNE, 1904

VISCERAL SYPHILIS.*

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In 1894 Musser[1] read a paper before the Association of American Physicians in which he considered the progressive diminution in the number of cases of syphilis and the mild character of the disease. He concluded that tertiary manifestations are not common and that visceral syphilis is rare. He based these conclusions on the statistics of the Philadelphia Hospital and the Presbyterian Hospital. In the latter institution, out of nine thousand cases there are records of two cases of hepatic syphilis and four of laryngopharyngeal syphilis only. I do not include the brain and cord lesions, which will be considered later by Dr. Burr. This rarity of visceral syphilis at the present time would seem to be confirmed by the evidence obtained by consulting the records of the Pathological Society of Philadelphia.[2] Since its foundation in 1857, specimens from only seven cases of visceral syphilis have been shown at its meetings: five cases of syphilis of the liver, one case of syphilis of the kidneys, and one case of syphilis of the pancreas. It is apparent, therefore, that one physician will see

* Part of a symposium on syphilis. Philadelphia County Medical Society, March 9, 1904.

very few cases of visceral syphilis, even when he has the complete clinical facilities at his command which are offered by our hospitals.

The Lungs.—Syphilis of the lung is probably not so rare a condition as might be supposed. According to Aufrecht,[3] pulmonary syphilis may be due to the formation of gummata or to true inflammatory conditions affecting the connective tissue or the parenchyma. The literature of the subject is thoroughly reviewed by the author just mentioned and by Stengel.[4] The studies of the many observers quoted by these writers seem to prove that diffuse pneumonic disease due to syphilis does exist. Whether or not there is a syphilitic disease of the lung that closely resembles tuberculosis in its clinical manifestations there is some difference of opinion. Osler[5] says that if this disease exist, he has no personal knowledge of it. Stengel's review of pulmonary syphilis, however, was prompted by the observation of a case in his wards at the Philadelphia Hospital in which the course of the disease very closely resembled that of pulmonary tuberculosis; and Berg[18] is of the opinion that a syphilitic lesion of the bronchi or the blood-vessels may be the exciting cause of pulmonary tuberculosis. He also believes that pulmonary syphilis complicated by tuberculosis is a more frequent condition than is generally believed. Furthermore, Winfield[21] reported a case of pulmonary syphilis in 1902 that had been diag-

nosed pulmonary tuberculosis and treated as such by a number of New York physicians. In considering the possibility of such a condition the diagnostician must always bear in mind that a tuberculous patient may become infected with syphilis and that a syphilitic subject may develop tuberculosis, whether or not one disease predisposes to the other. Carlier[6] unhesitatingly says, after a study of seventy-five cases of syphilis of the lung, that the gummatous form of pulmonary syphilis sometimes affects a dangerous resemblance to tuberculosis, so that the microscope cannot make a differential diagnosis. The latter portion of this statement may be challenged.

The clinical manifestations of syphilis of the lung are, according to all observers, as a rule, apparent in the right lung and in the middle lobe of that organ. The physical signs are those of a lobar pneumonia or a chronic fibrous hyperplastic consolidation. They consist of dulness, bronchial breathing, crepitant râles, and subcrepitant râles in the interscapular region as far as the base of the right scapula, and anteriorly in the second and third right interspaces near the sternum. When, however, the process is one of slow growth of connective tissue of the lung, these signs will not be present over the entire area until late in the course of the disease; so that dulness posteriorly may be accompanied by tympany anteriorly, and the

breath sounds may be weakened or absent over some part of the affected area.

The symptoms are those of chronic pulmonary disease in general. Cough is usually present, though of variable intensity. Dyspnea is frequently the most marked feature, as in a case of Aufrecht's. There is usually some expectoration, though it may be scanty, microscopic examination of which gives no positive evidence. Cases have been reported in which the sputum contained elastic fibers. Hemorrhage is rare and emaciation is not marked. The writers on this subject differ in their records of the temperature. Stengel published the chart of a patient in the Philadelphia Hospital which shows a marked febrile reaction with a maximum at noon or early in the afternoon. Probably there is always a more or less well marked rise of temperature at some stage of the disease.

While the middle lobe of the right lung is the one usually affected by syphilitic disease, areas of consolidation may be found elsewhere. How shall we make a diagnosis in the case of a syphilitic individual who presents the symptoms and signs of pulmonary disease at an apex? Probably the persistent absence of tubercle bacilli from the sputum is the most dependable feature. This fact, in addition to unmistakable evidences of syphilis in organs such as the liver, the bones, or the eye, for

which the syphilitic virus has a notable predilection, and an atypical symptomatology, will point strongly to syphilis as the cause of the lung disease. It will also indicate antisyphilitic treatment. If, in a suspected case of pulmonary syphilis, mercurial or mixed treatment aggravate the symptoms, the treatment should be immediately discontinued.

The Stomach.—Syphilis may produce hemorrhagic erosions, ulcers, and tumors in the stomach; it may result in stenosis of the pylorus; it may give rise to a symptom-complex exactly similar to gastralgia (Stockton[12]) and, according to Fenwick,[9] it may set up chronic inflammation of the mucous membrane of the stomach.

Clinically, we may assume that syphilitic disease of the stomach commonly results in a train of symptoms that may be mistaken for gastric carcinoma, gastric ulcer, or chronic gastritis.

Syphilitic tumor of the stomach is the result of the development of a gumma in the organ. Einhorn[7] reported two such cases in 1900, and a third in 1902. The last patient presented signs very suggestive of gastric carcinoma, but the symptoms were relieved and the tumor entirely disappeared on antisyphilitic treatment. In two of Einhorn's cases symptoms of stenosis of the pylorus were encountered, which were relieved by the institution of mercurial treatment.

Syphilitic ulcer of the stomach is probably usually the result of the breaking down of a small gumma. The symptoms are those of simple peptic ulcer. Indeed, a patient whose case was reported by Dieulafoy[11] in 1898 had resisted the routine treatment for simple peptic ulcer so long that he was about to be operated on, when the discovery of some old syphilitic cicatrices on his legs determined a trial of mercurial therapy. The institution of subcutaneous injections of mercury biniodide accompanied by potassium iodide was followed by cure. According to Fenwick, who has studied these cases clinically, pain is invariably present, usually in the epigastrium, and appears about one-half hour after taking food. When the disease is advanced the pain is often most intense during the night, and has been mistaken for the pain of a gastric crisis of locomotor ataxia. Vomiting is a conspicuous feature; at first the patient vomits only after his painful attacks, but later, as the accompanying gastritis extends, he may vomit after every meal. Hemorrhage is rare, although in the case reported by Dieulafoy, already referred to, hematemesis was a conspicuous symptom, and in another case of syphilitic gastritis reported by him in 1902 profuse hemorrhages from the stomach were noted. In the early stages of the disease free hydrochloric acid may usually be found after a test meal, and in those cases in

which nocturnal attacks of pain are present the vomitus contains an excess of hydrochloric acid. When the disease is advanced there is usually evidence of lactic fermentation. Perforation may occur, as in a case reported by Flexner[10] and one by Caesaris-Demel.[8] Other cases of syphilis of the stomach simulating gastric ulcer have been reported by Einhorn. Flexner, in addition to his own case, collected thirteen cases of gastric syphilis from the literature confirmed by necropsy and histologic studies, and one case of probable gastric syphilis not absolutely proved.

Syphilitic gastritis has been studied by Fenwick, who reaches the conclusion that there can be no doubt that there is such a disorder. The disease presents the ordinary phenomena of chronic gastritis from other causes, but presents the distinguishing feature of intractability to ordinary treatment.

A negro male, aged 39 years, presented himself at the Polyclinic Hospital, October 19, 1903, in the service of Dr. Daland. He complained of pain in the pit of his stomach. He was suffering from an iritis, for which he was being treated in Dr. Hansell's clinic. He gave a history of a venereal sore when he was 20 years of age; he was married at the age of 24, and his wife, who had never been delivered of a living child, had had eight or ten miscarriages, usually at about the third month. The

pain in the stomach of which this patient complained began about a week before he was first seen. It was of the nature of a dull, almost constant ache. He was nauseated, but did not vomit. He presented bilateral, painless enlargement of the superficial lymph nodes and signs of consolidation at the right apex. A physical examination of his epigastrium was without result.

At that time I believed that the gastric symptoms and the physical signs in the right lung were due to syphilitic disease of those organs. As the patient had no expectoration it was impossible to exclude tuberculosis of the lungs. The gastric symptoms, however, rapidly lessened and finally disappeared under mercurial treatment. It seems to me that if this were a case of gastritis in a syphilitic, the mercury would have aggravated the gastric symptoms rather than have relieved them.

In 1901 I saw a child, aged 11 months, the offspring of a syphilitic father. The child was born at term, but had always been sickly. At the age of three months he had an attack which was diagnosed congestion of the lungs, and during his fifth and sixth months he suffered from an attack of infantile scurvy. For a week before I first saw him he had been vomiting, had abdominal pain, and was constipated, but this last symptom was soon replaced by diarrhea; there was some fever. The attack re-

sisted the usual measures adopted in treating similar gastrointestinal conditions in improperly fed children until he was put on mercurial treatment, when he improved rapidly. The child had a second attack, similar to the first, about one year later, when mercurials were again followed by relief of the symptoms.

Since my experience with this child I have seen two cases in the dispensary of the Presbyterian Hospital in which mercurial treatment was followed by marked improvement in the marasmic children of syphilitic parents.

In the diagnosis of syphilitic disease of the stomach we must remember that there is no reason why a syphilitic subject should not have a carcinoma of his stomach, should not have a simple peptic ulcer, or that he should not contract a gastritis from some cause independent of his syphilitic disease. In fact, there are in many cases good reasons why a syphilitic should contract gastric inflammatory conditions. After due consideration has been given to the etiologic factors other than the specific disease, gastric syphilis may be diagnosed (1) after demonstrating the existence of a previous syphilitic infection; (2) when there is evidence of tertiary lesions in other organs; (3) by the resistance of the symptoms to ordinary treatment; and (4) by improvement and cure following antisyphilitic treatment.

Dieulafoy says that no one symptom points

conclusively to gastric syphilis, but that the symptoms of gastric ulcer in a syphilitic should lead to the supposition that the gastric disease is due to the constitutional disturbance. He also says that one should never forget to search for syphilis in the previous history of a patient presenting the symptoms of simple peptic ulcer.

The Kidney.—Syphilis sometimes results in the development of gummata in the kidneys during the tertiary stage of the disease. During the secondary stage of the disease cases are occasionally noted in which a true inflammation develops. This inflammation, according to Karvonen,[19] may be (1) an acute syphilitic nephritis; (2) a chronic diffuse nephritis; or (3) a chronic indurative and cicatricial nephritis. These nephritides are marked by the usual signs of renal inflammation, the appearance of albuminuria with hyaline, epithelial, and blood casts, fever, edema, anemia, etc.

In a given case of nephritis supposed to be due to syphilis, before a positive diagnosis can be made, the physician should know that the patient was not a subject of renal disease before he acquired his syphilitic infection. The diagnostician ought to be able to show that none of the ordinary etiologic factors of nephritis, such as alcohol, is active in the case under consideration—a requirement that presents great difficulty. The symptoms of renal disease should disappear promptly upon the insti-

tution of antisyphilitic treatment. Chauffard and Guoraud[13] hold the view that cases of syphilitic nephritis are characterized by an exceptionally high degree of albuminuria, in their patient fifty-five grammes to the liter. Other cases of syphilitic nephritis have also a high percentage of albumin: a case reported by Hoffman and Salkowski[14] showed 7 per cent of albumin; one reported by Ferras[15] gave 2.66 per cent (40 grammes in 1500 Cc. urine); one reported by Waldvogel[20] gave 9 grammes to the liter, 13.5 grammes to 1500 Cc. and 7.5 grammes to 2500 Cc. on three different occasions; one reported by Stepler[17] gave 1.2 per cent of albumin.

In the diagnosis of nephritis due to syphilis, account must be taken of cases in which skin eruptions have been erroneously diagnosed and the energetic administration of mercurials has set up a renal inflammation, as in a case recently studied by the writer.[16] In such cases mercury can be demonstrated in the urine.

The Liver.—The liver is probably more frequently the seat of syphilitic lesions than any of the other organs; at least, syphilis of the liver is more frequently diagnosed than syphilis of the other viscera.

From the pathologic view-point the disease may be diffuse (syphilitic cirrhosis) or circumscribed (gumma of the liver).

Clinically, syphilis manifests itself by the

production of icterus in the early secondary stage, and by the production of cirrhosis and of gummata in the tertiary stage.

The symptoms of syphilitic icterus differ from those of simple catarrhal jaundice by the absence of the accompanying gastrointestinal symptoms, although the stools are, as a rule, clay-colored. The usual etiologic factors, such as dietetic errors and exposure to cold, are also absent. The icterus is said by Lancereaux to be due to the pressure of the enlarged lymph nodes at the transverse fissure of the liver on the bile-ducts. This view is accepted by Quincke and Hoppe-Seyler.[23] The diagnosis is made by the simultaneous occurrence of the secondary lesions of syphilis, the absence of gastrointestinal symptoms, and the influence of antisyphilitic treatment.

The symptoms of syphilitic cirrhosis of the liver differ somewhat from those of alcoholic cirrhosis. According to Marcuse,[22] pain in the hepatic region is the most constant symptom, the liver is usually enlarged, ascites and general anasarca appear, but icterus from compression of the bile ducts is rare. The beginning of the disease is attended by gastrointestinal disturbances in two-thirds of the cases.

The enlargement of the liver in syphilitic cirrhosis seems to be one of the principal diagnostic points, and Osler lays great stress on the extreme irregularity of the organ, as revealed

by palpation. A history of syphilitic infection and the existence of syphilitic lesions in other organs will aid the diagnosis.

Gumma of the liver may exist without producing symptoms, but occasionally a superficial gumma may be mistaken for carcinoma of the liver, or a deep gumma may, by its growth, so isolate a portion of the liver substance that a resemblance to malignant disease is produced. Marcuse and Quincke and Hoppe-Seyler claim that the coexistence of splenic enlargement and albuminuria point to gumma; the first writer maintaining that these signs are never found in cases of carcinoma. The patient with syphilitic disease of the liver often has periods of retrogression of symptoms during which he feels comparatively well; but soon the symptoms reappear in force. Such a history is very suggestive of syphilis of the liver. In this, as in the other conditions already referred to, the history of infection with syphilis and the existence of syphilitic lesions in other organs aid in the diagnosis.

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3713 Walnut St., Philadelphia, Pa.

MEDICINE

A Monthly Record of the World's Progress in Medicine and Surgery

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VOL. 10. NO. 4. APRIL, 1904. $2.00 PER YEAR

CONTENTS.

E. G. SWIFT, Publisher
DETROIT, MICH.

Entered at the Post-office at Detroit, Mich., as second-class matter.