THE ROUTINE TREATMENT OF VENEREAL DISEASES.

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F. B. GREENOUGH, M. D.

[*Reprinted from the Boston Medical and Surgical Journal of August 17 and 24, 1882.*]

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THE subject of venereal disease is not a savory one in this community. We have in this respect, as in some others, inherited from our Puritan ancestors the tendency to get over an unpleasant fact or problem by simply ignoring it. But venereal disease is one of those facts in modern civilized life that cannot be ignored, and sooner or later must be admitted as an existing evil, and combated with the weapons which medical and social science have placed in our hands. There can be no doubt that this evil is an increasing one; what with the greater laxity of morals of the present day, the large influx of a foreign element and consequently of foreign habits, the increased cost of the necessities of life and the considering as necessities what used to be luxuries, — thus preventing a large number of ambitious young men, whose parents have been able to give them the advantages of an education which opens to them the field of a professional, literary, or artistic life, from marrying, — there can be no doubt, I say, that at the present time illicit sexual intercourse is much more common than it was forty or fifty years ago, and as a matter of course its concomitant evil, venereal disease, also. But however important the subject of venereal disease may be to the welfare of the community, it has the additional claim to the attention of the medical profession of being one of the most wonderful and interesting chapters in the whole book of pathological science. What

[1] Read before the Surgical Section of the Suffolk District Medical Society, May 20, 1882.

can be more extraordinary than the history of syphilis? Here is a disease which appeared spontaneously four or five centuries ago, which is acquired by the absorption of an infinitesimal amount of an unknown entity which we call virus. This results in a series of pathological manifestations which follow each other with as much regularity and certainty as is the case when a seed is sown and we have a plant develop which goes through the processes of growth, flower, fruit, and seed. Within a certain quite definitely marked limit of time after the absorption of the virus, we find the cutis or mucous membrane at the point of entrance breaking down, and around this point an increase of connective tissue takes place, producing the well-known induration. After another equally defined period, constitutional symptoms of a febrile nature appear; and these are accompanied by inflammatory processes of the skin and mucous membranes, — the former appearing as an eruption which may run through the whole sequence from simple erythema through the papular and pustular to the ulceration stage, and the latter as lesions from the simple abrasion on the inner lips to that form of papillary hypertrophy on the tongue, tonsils, or about the anus, which we call a mucous patch. This same inflammatory process may affect the periosteum or the iris. During this period we find the lymphatic glands enlarged, at first those especially in the vicinity of the point of entrance of the contagion; later, others are affected; still later, if the disease is not checked, we find a new and more serious set of symptoms. Neoplasms, gummy tumors, are found in the skin, bones, brain, or internal organs, which break down, forming large abscesses, and destroying large portions of the tissues in which they happen to exist. Not only is the individual affected by this series of symptoms, but the disease is transmitted to his posterity. That a disease such as is thus most hurriedly and incompletely sketched should attract the attention of the followers of medicine is not to be wondered at, and, in fact, some of the best

minds of the students and investigators who have preceded us have devoted much time and attention to the subject. Until a comparatively recent time, however, the matter was involved in much confusion and uncertainty; the other two affections which, with syphilis, are classed as venereal diseases, that is, gonorrhœa and the local venereal ulcer or chancroid, — the latter more especially, — being for some time mixed up and confounded with the new disease. From our present point of view it seems hardly credible that such should have been the case; but it was only after years of careful and patient investigation and experiment that the French syphilographers, headed by Ricord, could force the truth of the existence of dualism to be accepted generally. To give even an abstract of the most important points in this controversy would carry this paper far beyond its proper limits; therefore I will merely say that at the present time it is all but universally admitted, — most certainly so by all accepted as authority, — that syphilis is entirely a separate and distinct disease from the local ulcerations which we call chancroids. Probably most practitioners would admit this theoretically, but practically, as far as treatment goes, it is almost the rule to confound them together, and as this is one of the forms of routine treatment that I want most earnestly to protest against, I must beg your indulgence for a few words on the subject of differential diagnosis.

The only points in common between syphilis and the chancroid are, first, that they both are acquired by the absorption of the contagion-bearing element, that is, the virus, — generally, but by no means necessarily so, during the act of coitus; and, second, that in certain cases, for a certain space of time, it is difficult, in fact sometimes impossible, to say whether the lesion we see is a primary syphilitic one or a chancroid. Outside of these two points, and the first one is certainly of no importance, the two affections are as different and distinct as variola and acne. In this connec-

tion, then, we have only to do with the primary lesion of syphilis as being possibly mistaken for a chancroid, or *vice versa*, and it is only during a certain period of the life of the former that any doubt can be possible. Time will therefore settle the question, even in the most puzzling cases. The period of incubation of the primary lesion is comparatively a long one, from ten days up to twenty or even thirty. It appears at first as a papule; is usually single; the surface becomes abraded, exuding a serous rather than a purulent secretion; the inguinal glands on both sides become enlarged; if the lesion is a large one, one of the chain may be larger than the rest, but even this is not inflamed or very tender. On the other hand, the chancroid shows itself soon after contagion, from two or three days to a week. Its first stage is that of a pustule, the roof of which, breaking down, leaves a round or oval ulcer. This ulceration is deeper, its borders looking punched out; the base is of a dirty-yellowish pultaceous character; and the secretion is abundant, and consists of creamy pus. The lesions, also, are very apt to be multiple. There is no surrounding induration, the inguinal reaction is confined to one side, and one gland only on that side is affected. The enlargement of this gland is greater, more acute, and is due to one of two processes. It is either sympathetic, that is, due to the inflamed condition of the tissues at the seat of the chancroid, exactly as we find a gland in the axilla enlarged and tender after a bruise or irritated sore on the hand, and in this case it may or may not go on to suppuration, or it is due to the actual transmission of the chancroidal virus along the lymphatic vessels until it is arrested at the first gland; and in this case it must of necessity result in the formation of a focus of pus in the gland, which pus has all the properties of that secreted from the base of the chancroid, and on inoculation reproduces a chancroid.

These certainly are two very different pictures, and one would suppose that there could not be much diffi-

culty in distinguishing one from the other, but practically this is not always the case. In the first place it is often next to impossible to get any reliable information as to the period of incubation; it is extremely rare that the lesion is seen at an early stage of its existence, that is, early enough to be able to determine whether it began as a papule or as a pustule. On the other hand, it is very likely to be seen before the characteristic induration of the lesion itself and the subacute enlargement of the inguinal glands could have developed, supposing it to be syphilitic. Or very possibly it may have been touched up with nitrate of silver, or blue-stone, or some more active caustic, causing an amount of inflammatory induration which, when seen for the first time, cannot be told from the specific induration of syphilis. Again, during the first two or three days of the appearance of multiple chancroids, the lesions themselves cannot be distinguished from a crop of vesicles due to simple herpes progenitalis. In short, the fact is that however distinct and different these diseases are, not unfrequently it is absolutely impossible at the time of the first examination to give a positive diagnosis. It is a matter of vital importance to the patient's welfare and peace of mind to be able to make this diagnosis. The difference between having a local sore which at worst may result in a suppurating bubo, and being in for an attack of syphilis is very great, and we should most certainly avail ourselves of all means in our power to get at the desired knowledge, and *a fortiori* avoid doing anything which would impede or obstruct as early a decision as possible. And yet this is exactly what is done in a very large proportion of cases of venereal sores.

As a rule, the ulcerations are either irritated with nitrate of silver, or cauterized with some more powerful caustic, and the patient is immediately put upon a course of mercury or iodide of potash, or a combination of the two, according to the fact of his adviser's having definite ideas as to the greater value of the two

drugs, or his being doubtful and wanting to make sure by combining them. Now this is not only irrational, as it is undertaking a course of treatment without having diagnosticated the disease, but what is of much more importance, it is positively injurious and unfair to the patient. It is done, of course, under the supposition that the lesion will, or may be, followed by constitutional symptoms, and that by using specific treatment at once those symptoms may be modified or prevented. If there is one thing that is settled by observation and experience it is that syphilis cannot be aborted by treatment: that is to say, if we have a primary syphilitic lesion which is simply the notice put out to show that the syphilitic virus has been absorbed at that point, no amount of specific treatment will prevent the constitutional or secondary symptoms from showing themselves; but it may retard their appearance, and interfere with the regular sequence of symptoms which we observe in a typical case. It is an established fact that a primary syphilitic lesion will be followed by secondary symptoms, probably within three months, and certainly within six; and the reverse holds true, that if a sore is not followed by constitutional symptoms within these limits of time, it could not have been a syphilitic one; but if the patient has been under specific treatment the case is altered, as the symptoms may have been delayed, and it may be years before he can feel sure as to whether he ever had syphilis or not. I have seen cases whose whole life has been ruined, who have abstained from marriage, and have been running from one physician to another, thinking that every slight ailment they felt was due to a supposed case of syphilis, who, I am as sure as one can be of anything, never had syphilis at all. Such cases, if they had been properly treated, at the expiration of six months could have been absolutely guaranteed that they never would have any trouble of a syphilitic nature.

It must therefore be admitted that in doubtful cases

those that are not syphilitic are seriously wronged by being put on specific treatment. The natural query follows, Are those that will prove to be syphilitic sufficiently benefited by being put at once on constitutional treatment to balance the wrong that is done to their more fortunate fellow-sufferers? I have already said that if the syphilitic virus has once been taken into the system, no treatment can prevent the development of constitutional symptoms, and clinical experience of the best observers has shown that not only is this the case, but that those cases in which the specific treatment is begun before the manifestation of secondary symptoms do not do any better than those in which it is delayed until evidence of constitutional infection shows itself. One of our teachers, to whose opinion we must all bow down, especially in matters pertaining to surgery, has said, I am told, that in deferring treatment we are practically allowing a fire to get well under way before we begin to put water on it. But that is hardly a fair comparison. We know that a certain course of treatment has a most marked effect on certain constitutional symptoms of syphilis, but we do not know that the same treatment will act as a preventive to the development of those same symptoms; on the contrary, we do know that it will not, and a fair statement would be that we are at least wasting time and water in pouring water into a building in which as yet no fire exists. I would say, then, that in any case of venereal sores in which any doubt exists as to their nature, we are doing the patient a serious wrong when we put him on specific treatment. Practically, unless there exist special reasons for immediate treatment, such as a very obstinate primary lesion, or one that takes on a destructive action, or where the healing quickly of said lesion is a matter of great importance to the patient, I much prefer to delay constitutional treatment until the appearance of constitutional symptoms. What is, then, the proper treatment of a venereal sore which we are called upon to treat?

This will depend, of course, upon the character of the lesion, but in no case can any benefit be obtained by touching it with nitrate of silver. If a caustic is needed, which is rarely the case, the nitrate does not act as such. The only use that can be properly made of this agent is in cases of ulcers, either chancroidal or true syphilitic ones, that have arrived at the reparative stage, and show indolent vascular cellular granulations which need stimulating applications. Up to five years ago every text-book on the subject laid down destructive cauterization as the proper treatment for the chancroid, and in many to the present day the same stands. At that time I published a short paper protesting against such treatment, and advocating the use of iodoform as a local application. My experience since has been such as to confirm me in the opinions then expressed, and I hope to be able to take up the subject again, but in the present connection I will simply say that cauterization is rarely necessary. The objections to cauterization are, the great and needless suffering to the patient, the chance of producing an inflammatory phymosis if the lesions are on the prepuce, and consequently preventing proper cleansing and topical applications, the undoubted tendency to start up a sympathetic adenitis, the obscuring and masking the diagnosis by creating an inflammatory induration, and last, but by no means least, the fact that this treatment does not shorten the course of the disease.

The marked influence of iodoform as a topical application in diminishing suppuration and hastening the process of cicatrization has been admitted, and attracted much attention among surgeons lately, especially in Germany, and in no cases is this action more decided than in those of venereal sores, whether chancroids or true chancres. Its use has the serious disadvantage of being most offensive to the olfactories of the patient and his friends, but by care in applying it, and avoiding spilling it about, this can be somewhat controlled.

The advantages of the treatment are so marked,

however, that some slight inconvenience ought to be cheerfully put up with; but even in the exceptional cases where iodoform cannot be used, we can do very well with other local applications without falling back on cauterization. The rapidity with which chancroids will clean up and heal under iodoform is at times little short of marvelous, and even the true chancre will in a short time skim over, the specific induration, however, still existing. There is one form of the chancroid that is apt to prove more obstinate to treatment, and that is a type that has been described by Clair as the exulcerous or elevated chancroid. It is usually multiple and situated on the free border of the reflected prepuce, in individuals where the glans penis is completely covered. Instead of looking punched out, the sore is actually raised above the level of the surrounding tissue, although its base and edges are the same as those of the usual sore. It is very apt to be the result of autoinoculation from subpreputial lesions, and its peculiar form and obstinacy may be due to the fact that it is either washed over by the urine or irritated by the act of retraction at each act of micturition. At any rate it heals much less quickly, but in time it will do so, and, if we attempt to use destructive cauterization, from the situation of the lesions we are sure to get an inflammatory phymosis.

Up to this point I have endeavored to show that it is not rational treatment to cauterize a venereal sore, or to put a patient on specific treatment until constitutional infection is made evident. Let us see now what the rational treatment should be in those cases where we do have an outbreak of secondary symptoms. In syphilis we have one of the rare instances of a pathological process, to combat which we have undoubted empirical specifics, that is to say, drugs that for some unknown reason and in some unknown way do actually act as antidotes to the disease and exert a decided curative influence. All authorities on the subject admit the marked power of mercury and iodide of potash on

syphilitic disease, but when we come to the method of administration, and more especially the length of time that treatment should be persisted in, we find a great diversity of opinion. Those who advocate a certain definite and well-marked-out course of treatment may be divided into two classes: the French school, headed by Fornier, who believe in an interrupted course (*coup sur coup*), that is to say, using the mercurial until the secondary symptoms have all disappeared, and then giving the patient a rest for a few weeks; then resuming treatment for a certain time, and then omitting it, and so on. The other, of which Dr. Keyes is the exponent, believe in an uninterrupted course of mercury in small, or tonic, doses for as long a space as two years or more. Both use the iodide to combat certain symptoms. Dr. Keyes has very decided ideas on the subject of treatment, which he has given to the profession. He prefers the protiodide of mercury as the form of the drug to be used in treatment by internal administration, and beginning with as small a dose as one centigram or one sixth grain, three times a day, he gradually increases the dose until he gets evidence of intestinal disturbance. He then takes half the amount that was required to produce the irritation of the bowels, and calls that the patient's tonic dose. This he administers for the space of two years, using the iodide of potash if symptoms occur which call for its exhibition. He did claim that patients who had undergone this course of treatment could be assured that they would not have relapses. Since his publishing this course of treatment, however, he has somewhat modified his views, chiefly in the way of prolonging the treatment even beyond the period of two years. The truth of the matter undoubtedly is, that by no method or length of treatment can we be sure of absolutely curing every case. But I think that we stand the best chance of so doing by giving a protracted course of a mercurial, in small or so-called tonic doses. The term tonic, as applied to a mercurial course, has been objected to, but it

is a perfectly fair use of the term, — long and most carefully conducted experiments in counting the red blood corpuscles, under the microscope, having shown that during such a course these corpuscles are decidedly increased in number. It does seem as though the virulence of syphilis must have been modified during the last century. Undoubtedly the avoidance of pushing mercury to the point of calling forth its toxicological action, which was formerly always done, has had much to do with this, but there must be something more to account for the comparative mildness of many cases. That some cases are capable of a spontaneous cure is proved to every observer who sees much of the disease. Some are so susceptible to mercury that the use of it even in very small doses cannot be persisted in ; others from recklessness or ignorance, or belief in real homœopathy, practically have no treatment at all ; and yet some of them recover, and never hear from the disease again. So true is this that some of the first syphilographers, notably Didary in Lyons, and Sigmund in Vienna, do not consider it necessary to use mercury in a mild typical case. Inasmuch, however, as in cases where we do use it we are struck by its marked beneficial action, it does not seem as though we are justified in not taking advantage of the power which we have in this drug, unless there is some harm done by its use. And that is not and cannot be the case where it is given in proper doses, and the patient is carefully watched to see how he bears the treatment. I myself do not think it is necessary to test each patient as to the amount he can bear, and then halve that as the regular dose. Most patients will do very well on one third grain of the protiodide, three times a day, given on a full stomach. Cases occur where even this moderate dose will disturb the bowels, and in such it is better to try some other form, rather than to combine opium with the prescription. The bichloride is often well borne where the protiodide is not, and the average dose would be one fifth grain, three times a day.

There are cases, however, where any form administered internally cannot be taken with impunity for any length of time, and in such we can have recourse to the method by inunction. This method has not only the advantage of not disturbing the digestive tract, but by its means we can bring the system under the desired influence of the drug much more rapidly and surely than by that of internal administration, and for these reasons it is the sole form of treatment used by some practitioners. My reasons for not doing so are that it is dirty and disagreeable, and many patients will not use it for any length of time, or at least only very carelessly and inefficiently; and as a large proportion of cases do perfectly well under the more easily, and more-surely-to-be-thoroughly-carried-out method of internal treatment, I prefer to reserve inunctions for obstinate cases, or for those that have advanced into the later stages of the disease. In these latter, combined with iodide of potash internally, inunction is a most valuable and reliable help. Whatever form or method of mercurial treatment is used, the possibility of salivation should be borne in mind. With proper doses, especially at first, and proper precautions, there is not much danger of its occurring, however. Some patients have such a susceptibility to mercury that an incredibly minute amount will salivate them. Hebra used to tell, with great glee, of a Russian princess whom he salivated by the topical application of the acid nitrate of mercury to a plaque muqueuse, but such cases are extremely rare. Of the large number of cases treated at the dispensary, many of whom are stupid, and take no care of the state of their teeth or gums (a most important thing by the way), I have had an average of less than one case a year, and in private practice I never saw one. In iodide of potash we have as valuable a drug as in mercury. The generally received axiom, however, "secondary, mercury; tertiary, iodide," is not true, the fact of the matter being that as a *cure* for syphilis, mercury is our mainstay in the primary (if it is treated at all), sec-

ondary, and tertiary stages; the *rôle* which the iodide fills so successfully being to combat certain symptoms, and of these some occur in the very earliest part of the disease. Thus in the violent syphilitic headaches which sometimes just precede, and often accompany, the first secondary manifestations, the action of the iodide is most wonderful. Patients who have been suffering atrocious torture, especially at night, for days, will after twenty-four hours' use of the iodide be entirely freed from all pain. Any of the periostites that are so painful subside like magic; and as for the new formations, the gummy tumors, which may have reached the size of a pullet's egg, and look and feel as though suppuration had already commenced, in a week's time they will have melted away like snow. The deep ulcerations, also, whether of the cutis or mucous membranes, heal rapidly under iodide, but in all these cases I believe that a mercurial should be given in combination with it. Theoretically, the protoiodide of mercury should not be prescribed with the iodide of potash; the bichloride or biniodide being the forms generally used, or, as I said before, inunctions. When I say that mercury should be always combined, I mean, of course, unless there should be something to contra-indicate its use. For obtaining a decided effect from the iodide, not less than ten grains, three times a day, should be given, and in some cases this may and should be much increased. There is another class of comparatively early symptoms besides those I have mentioned, that is, the specific headaches and periosteal inflammations, on which the iodide has a marked influence. I refer to the secondary lesions of the mucous membrane of the mouth and throat. It was only after careful investigation of a large number of cases that I was convinced of this, but I do not think there can be any doubt as to its truth. One word as to local applications for these lesions. I feel very strongly that cauterization can be abused here as well as in the case of the primary lesions. As the true mucous patch is an

indolent papillary formation, the occasional use of lunar caustic has a very good effect, and the same holds true in the case of the superficial secondary abrasions on the inner lips; but no lesion of the mucous membrane can heal, if it is being cauterized constantly. In the deeper ulcerations in the later stages cauterization is rarely useful. Of course the important factor is the constitutional treatment, but besides that, cleanliness, gargles, spray, especially of iodine, and insufflation of iodoform or calomel will act as useful adjuvants.

Dr. Wigglesworth read a paper on this subject at the last meeting of the Dermatological Association, based on cases of his own and Dr. Cushing's, which was published in the *Archives of Dermatology*, which contains a great deal of truth on this subject. As an application for the ulcerative forms of cutaneous symptoms I know of nothing better than the mercurial ointment, more especially now that by using a petroleum product for a vehicle in the place of lard we avoid the irritating action of the latter when rancid. The oleate of the oxide of mercury is a more elegant and expensive preparation, but neither as a dressing nor as a means of inunction have I found it as reliable as the plain unguentum.

Having thus hurriedly run over some few of the most important points in the rational treatment of syphilis, we come to the very important question as to how long this should be kept up, and the almost vital one to the patient, as to what answer we can give him when he asks, Am I cured? I do not see how, under any circumstances, an absolutely and unconditionally affirmative answer can be conscientiously given. I do believe, however, that quite a large proportion of cases are practically cured; or perhaps I should say, recover; that is to say, that neither they nor their posterity will ever be in any way influenced by the disease. To say that the disease is not eliminated, but only made latent, is, if it always remains latent, a mere quibble. As Hebra used to say, What

would not we give to be able to render phthisis, or carcinoma, or Bright's disease latent to the same degree? However, those cases, rare it is true, but undoubted, where a patient acquires a second case of syphilis and goes through the whole sequence of symptoms from the primary sore in regular order, do prove that all remnants of the first attack must have been thrown off. Unfortunately, that means of proof would not be a very satisfactory one to that individual patient. If we cannot tell the patient that he can feel absolutely sure that his troubles are over forever, we can at least give him the benefit of the chances, and tell him that many others who have in the past been through what he has are now perfectly well and fathers of healthy families. I believe myself that if a patient has a fair constitution, takes proper care of himself, undergoes a protracted course of treatment in doses of such moderation that his general health does not suffer, and a couple of years have elapsed since treatment was stopped without the appearance of any sign of a relapse, — I do believe, I say, that the chances of there ever being a relapse in the future are very small. That I believe, and have never had occasion to call my belief in question.

One other disease of those classed as venereal remains to be spoken of, and it is the one which in point of frequency of occurrence stands at the head of the list. I refer to gonorrhœa. Undoubtedly many physicians look upon a mere case of clap as being of very little importance to the patient, and certainly of not much interest to the doctor. My experience has led me to believe that a smart case of clap is very likely to be a pretty serious matter for the possessor, and the fact that a disease differs decidedly from others of the same inflammatory type, and is extremely obstinate to treatment, ought to make it interesting to the student. We have in gonorrhœa an inflammation of the mucous membrane lining the urethra, which membrane, from its anatomical situation, occupies an exceptional position, in respect to being of necessity subjected to

sources of irritation. Several times during the course of each twenty-four hours it is washed over by a fluid, — the urine, — which is acid in its reaction and holds various salts in solution, the irritating action of which is most conclusively proved by the excruciating pain caused by the act of micturition when the inflammation is at its height. In the conjunctiva we have a mucous membrane which, under exceptional circumstances, that is, during the act of weeping, is bathed by a fluid of somewhat the same nature, but less heavily charged with irritating salts; and yet the inflammatory result of a fit of crying on that membrane is well known to everybody. Besides being subjected to this special source of irritation, the mucous membrane lining the urethra has the peculiarity of being in direct continuity with that of the prostate gland, the bladder, and the convolutions of the epididymis of the testicles, so that the inflammatory process may, and in point of fact not unfrequently does, by simple extension, affect more important organs, producing troublesome and painful complications. As additional points of interest in the disease, I will merely refer to the fact that in some cases it seems to be brought forth by secretions which do not contain any specific virus, and to the mysterious sympathy which in some individuals exists between the urethra and the synovial membrane of certain joints, especially the knee, as a result of which an inflammation of the former will call forth an affection of the latter, subacute it is true, but very obstinate and annoying. Last, but not least, as a claim to the interest of the student and observer, is the fact that while the indications for treatment are very evident the results thereof are far from satisfactory. I am convinced that, unlike most inflammatory affections, that of gonorrhœa does not in the majority of cases tend to resolution and a return to a healthy and normal condition. Some time ago, at the Dispensary, for quite a time I treated all cases of gonorrhœa that had no complications calling for special relief in as near an

expectant manner as was consistent with having them continue under observation; that is to say, with quite small doses of a simple diuretic, and quite a large proportion of them resulted in chronic affections. The endoscope has been the means of demonstrating to us how this takes place. As a result of long-continued suppurative inflammation the mucous membrane at a certain point loses its normal epithelial layer, and in its place we find a red, rough, pus-secreting surface, which consists of cellulo-vascular granulations of exactly the same nature as those which we see in any lesion of continuity of the cutis or mucous membranes resulting from a wound, burn, or any other cause. The moment we get an irregularity in the lining of the urethra we have the retention of a small amount of the urine behind it, which keeps up the irritation. The result of this granular condition in the urethra is, as elsewhere, the production of fibrous or cicatricial tissues, the tendency of which to contract is one of the best-known facts in pathological anatomy. Hence the marked influence of chronic urethral trouble in causing stricture. Exactly the same process goes on in plain sight of the oculist in those cases of chronic inflammation of the palpebral conjunctiva which result in "granular lids." We see there, in the first place, the conjunctiva become granular, then the granulations change into fibrous tissue, which, by contracting, pulls the lid inwards, so that the eyelashes actually press and rub against the eyeball. We have, then, in gonorrhœa, a disease which not only may by simple extension of the inflammatory process affect such important organs as the testicles and bladder, but has a tendency to result in certain structural changes of the urethra, the gravity of which is appreciated by every surgeon. One would think that, such being the case, the least that could be expected of the practitioner would be to carefully avoid doing anything that could aggravate matters, and yet a large proportion of cases of gonorrhœa are put on a course of urethral injections with-

out any regard to the amount of inflammation which exists. Fully aware as I am of the benefit to be got from injections used properly, and they are invaluable, I thoroughly believe that had a urethral syringe, even so perfect an instrument as the Royal Excelsior P, never been manufactured, the mass of urethral patients would be better off than they are. The bad effect of injections is most especially to be noticed in the class of ignorant and stupid patients that we have to treat in the various out-patient services, and so frequently have I had reason to think that treatment by injections was absolutely doing harm in my service at the Dispensary that for some time I have all but dispensed with them except in chronic cases. Even theoretically I have never been able to understand how an astringent solution applied to an inflamed and highly congested membrane is supposed to reduce the inflammation. It is true that temporarily it causes a contraction of the capillaries, but if I remember my physiology correctly this is followed by a reaction, in which they are distended even more than previously. Of course, where for some length of time the astringent action of cold can be obtained by means of constant bathing or cold compresses, we can conceive of keeping this action up long enough to prove beneficial. In the conjunctiva we have a mucous membrane, the action on which of local applications can be watched, and our colleagues the oculists, or at least a great many of them, have come to the conclusion that the result of the use of strong astringent collyria during the acute stage of inflammation of that membrane is not satisfactory. In an acute case of clap we do have certain perfectly evident indications for treatment. Quiet and rest, in a recumbent position if possible, are important, and the diet should be such as will avoid increasing the irritating character of the urine. As this irritating action of the urine on the inflamed membrane is one of the chief sources of keeping up this inflammation, we should of course modify it if possible. This

end may be accomplished in two ways : either by the exhibition of an alkali, and thus chemically neutralizing the acidity, or by increasing the watery constituents of the fluid, rendering it more dilute and consequently less irritating. In the alkaline diuretics we have the means of obtaining both of these desired results. They are best given in flax-seed tea, barley-water, or any other demulcent drink. The anti-blenorrhagics, copaiva and cubebs, have a very varying effect in different cases. In some they seem to have a marked action in cutting down the discharge, in others the action is not appreciable. The oil of sandal wood is even more uncertain, but in my experience it rarely does much good during the earlier stages of the disease ; later, at times its action is little short of marvelous. As the inflammatory symptoms disappear we can begin cautiously with a mild injection, the sensations of the patient being a very reliable guide as to the propriety of going on with them or not. I believe that if the injection causes anything like real pain or scalding it will be worse than useless. One other point with regard to urethral injections should not be lost sight of, and that is, that in the same way that a lesion of the skin or mucous membrane cannot heal if constantly cauterized, so no urethra can return to its normal state of dryness while astringent solutions are being squirted into it three or four times a day.

I should be very sorry to be understood to claim that even by using the greatest possible caution and care in treatment we can be sure of escaping the complications by extension of inflammation which I have spoken of. On the contrary, some of the cases that have followed all directions in the most conscientious manner will have as serious a time as those that have kept up drinking and every sort of imprudence, or who have been treated by too strong injections. But it certainly must be a comfort to the conscientious practitioner to feel, when he sees his patient suffering the tortures which a smart combination of cystitis and

prostatitis is accompanied by, that his treatment cannot have been the means of producing this condition. Under the most careful treatment cases of gonorrhœa often are very obstinate and troublesome. We hear of a certain method of treatment curing all cases in a few days, and perfectly honest gentlemen will tell you of cases that they have had no trouble in discharging well in a week or two. It is impossible for me to reconcile such statements with my personal experience without some means of explaining the apparent direct contradiction of facts. This explanation, I think, may be made in two ways. In the first place, many patients are undoubtedly discharged as well when they have by no means arrived at that condition. They are told that the slight discharge that they find, especially in the morning, does not amount to anything, and that it will in time wear away, which it sometimes does, and then again not unfrequently it does not. Again, there exists in the community quite a large class of men who will tell you that they never "can see a woman even" without getting caught. Such cases are generally cured very quickly, and the chances are that some friend of theirs to whom they have given the prescription which worked so well with them is much disgusted to find that it has no effect, or certainly not a beneficial one, in his first case of gonorrhœa. The fact is that these patients do not get infected each time, but that they have a chronic urethral trouble from which they never are free. This may during quiet life be in such a quiescent state as not to cause any appreciable amount of discharge, but the excitement of the sexual act will start it up, and it merely requires abstinence from alcohol and an astringent injection to put it back into its latent condition. If you examine the urine of such cases you will find several long shreddy filaments floating in it. The importance of these filaments, by the bye, as a means of diagnosis, is not sufficiently referred to in the books. On introducing an olivary instrument you may or may not get a little hitch on

passing by a certain point; but you will be pretty sure, unless there is a decided hitch, showing that fibrous tissue has already formed, to find that a drop or two of blood will follow the instrument. In short, they have chronic trouble of the urethra, which is aggravated by coitus, and this aggravation is a very different affair from a smart fresh case of gonorrhœa. I will not enter into the misery which attends the treatment of many of these chronic cases, and merely refer to the importance and interest which they possess for the surgeon when they have gone on to the point where contraction begins; in other words, have become cases of stricture. It is too soon yet to speak with any confidence, but I hope that in the soluble gelatine bougies we may have an important agent in treating chronic cases. The irrigator described by Dr. Harrison, of Liverpool, is of great value in some cases, but like every other method of instrumental interference with the urethra it sometimes starts up an acute exacerbation. It consists in simply a velvet-eyed soft catheter of three or four sizes smaller calibre than the meatus, which is introduced beyond the seat of urethral trouble, and by means of a bulb syringe a stream of medicated fluid is gently washed from behind forwards.

The nature and magnitude of the subject I have attempted to treat of is such that, even after having abused your patience to the extent which I have, I have merely been able to skim from the surface the froth, as it were, of the main points of interest in the indications for treatment of venereal disease. What I have more especially endeavored to do, however, is to call attention to some of what seem to me to be decided and not uncommon mistakes in treatment, which I have taken the liberty of calling routine, and these are the use of caustics on chancroids or chancres, herpetic abrasions, or other local lesions of the penis, the prescribing specific treatment in cases where a doubt exists as to the diagnosis, and the abuse of astringent injections during the inflammatory stage of gonorrhœa.

I should be very sorry to be thought to have been pleading for the need of special treatment in venereal diseases generally. On the contrary, there is nothing in the great majority of cases which the general practitioner should not be perfectly able to see to, but I do think that the patient has the right to expect the same amount of interest in his case, as well as of knowledge, experience, and common sense, that he would if he were being seen through a case of typhoid fever or treated for a fractured thigh.