MALIGNANT SYPHILIS.

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REFERRED to, but rarely discussed, is a type of syphilis seen by the Army surgeon of the present day, and known as "malignant or galloping syphilis," the "syphilis maligne" of French writers. A better name could not be devised for a disease whose effects are of the gravest, whose course is most rapid, where the prognosis is uncertain, and where death is not uncommon. The term "syphilis grave," according to Dr. George Ogilvie, is reserved for "that class of cases characterised by severe symptoms, or by serious visceral derangement." We could include in this category malarial complications, which are usually visceral.

Malignant syphilis is stated to have been frequently seen in Europe in epidemic form in the fifteenth century, at the time when syphilis was supposed to have been first introduced into Europe from abroad by Columbus and his followers. The above term, "syphilis grave," would probably have met most of the cases. It was also seen in the Peninsular War in 1806. Heroic doses of mercurial salts, however, accentuated the symptoms and retarded cure. Ferguson says that he had been "destroying instead of saving patients by murderous and unnecessary courses of mercury. The error lay in the abuse, not in the use, of the mineral." In the present day we notice that it is mainly from abroad, Burmah more especially, and chiefly at seaport towns with mixed populations which sailors frequent, that this class of disease is seen. It is rarely met with when prostitution is effectually supervised. Amongst women, primary syphilis increases in severity with the access of pyogenic organisms, with neglect and with the concomitants of famine, hunger and dirt.

We have ourselves noticed some twelve phagedenic secondary or tertiary cases in about 500 cases of syphilis amongst soldiers. Among 8,691 cases of syphilis treated in the Copenhagen Municipal Hospital during fourteen years, malignant syphilis was observed thirty-nine times, and with equal frequency in men and women. Professor Haslund says: "The name should never be applied to

cases of widespread tertiary ulceration. Extensive ulceration within one year of infection is usual in malignant syphilis. The disease, without treatment, even tends to a spontaneous cure.” The phagedenic character of the manifestations, more marked in secondary, but frequently seen in the primary stage; the rapid destruction of soft tissues; the tendency to spread and recur; the liability to early suppurating necrosis of bone with well marked hectic fever, and the occurrence of tertiary lesions in some instances before the induration of the primary state has disappeared, stamp it as quite a distinct type of disease, and make it stand forth from the ordinary mild course of syphilis in a manner so evident and so clear, that the impression made on the mind is of the most vivid and lasting character. Amongst soldiers it is known as “black-pox,” whether from the severity of the disease, or more probably from the supposed nature of its source from native races is uncertain. It appears to be due to an intense variety of infection, as it frequently occurs in robust and healthy men. We do not consider that the idiosyncrasy of the individual quite explains the severity. We consider, however, that the neglect of primary syphilis amongst native races would fully account for the increased virulence of the disease, when we consider how much neglect favours the advent of pyogenic organisms. The degree of infectivity is no doubt much increased in the case of the European by the implantation of the virus in a new soil from natives who thus habitually neglect their disease, so that the virus has not decreased in virulence. We find an analogue in the case of plague, in which disease virulence is decreased outside the body, but is markedly increased by passages through rats. No doubt the virulence of syphilis is similarly influenced by special conditions of blood in certain individuals. A marriage contracted outside our immediate sphere is commonly attended with benefit as regards the natural power of the offspring, who show commonly more stamina. So, too, syphilis transmitted from a vigorous to a less vigorous native, to a new or to a less resistant organism, is probably as potent in causing an exaggeration of severity in the person attacked. Haslund, of Copenhagen, thinks “that this type of syphilis is liable to occur in families where the ancestors have been but little affected with syphilis, so that there is little power of resistance against the disease.” We exclude cases of syphilis complicated by the malarial poison from our conception of malignant syphilis. Fournier of Paris thinks the contrary. In Spain during the Peninsular War, the Spaniards were not so severely affected by syphilis as were the English. They communicated a virulent
form of the disease, but did not themselves apparently, contract a severe infection. Malignancy is not the result of, though undoubtedly aggravated by, climate and famine. Although famine may be epidemic, cases of malignant syphilis are usually sporadic in origin. We are inclined to think that neglect and the superimposition of pyogenic organisms, are the two chief factors in causing and maintaining malignancy, and are consequently the principal means of aggravating a severe infection after disease has been contracted. It is admitted that neglect of treatment in the early stages of syphilis predisposes to tertiary lesions, but in cases of malignant syphilis the tertiary deep type of ulceration is an ordinary feature of the disease. There is commonly progressive debility and anaemia from the onset, with a tendency to lung complications, septic bronchitis and low forms of pneumonia. These conditions may, or may not, be additional, accidental, and not due to the actual syphilitic poison, but they are most certainly aggravated by the extremely fetid odour and by the acute suppuration from ulcers, or from necrosis in the buccal cavity. There is also liability in these cases to chill, from the concurrent condition of hectic fever, obstinate vomiting is frequent, as also are intense headache and absolute dejection of spirits. Malignant syphilis appears not to be directly influenced by alcohol, or by concurrent disease, such as tubercle. It is malignant from the first onset of secondary manifestations; and in many cases is quite independent of the misuse or of the abuse of mercury.

Whilst at Chatham in 1894, three men of the same corps had severe phagedenic primary disease, followed within two months by rupia, deep ulceration of fauces and palate, necrosis of bone, and later separation of a sequestrum in each case. As far as could be ascertained, the possible source of infection was the same. Other cases came under observation at Aden, where again several men, there is reason to suppose, contracted a severe form of infection from native sources. Although the characteristic of the disease is its early occurrence, yet it is undoubtedly true that malignant symptoms in rare instances may supervene later, the cause being wrapped in obscurity. Such cases have been seen; but should the term malignant syphilis be used to describe this class? For the sake of clearness in classification it is perhaps better to classify such “late” malignancy as merely severe tertiary. The “early” occurrence is the rule, to which this “late” variety forms the exception. As regards early or late malignancy, the practical result is the same for the surgeon. Early recognition of the actual condition is the real clue.
to success in treatment. In malignant syphilis, secondary and tertiary symptoms, commonly ecthyma, or rupia, and extending ulceration, usually appear well within four months from infection. Cases not infrequently occur, however, in which well marked tertiary disease has appeared within six to twelve months, but these cases may not have presented any malignant characters, such as "extensive" ulceration or "early" rupia, throughout their course. It is erroneous to class them as malignant. The limits of time within which, in ordinary cases, the tertiary period is stated to have arrived, is vaguely laid down in text-books as several years after primary infection. This is perhaps the rule, the exceptions, however, are very numerous. Well marked tertiary lesions may occur well within the year; the third to the tenth year is, however, the usual period.

The rapidity of the destructive process, and the acuteness of the suppuration, are perhaps the most startling features in malignant syphilis. One week, a man is seen to have a typical hard chancre of the penis nearly healed, and the following week he is covered with ecthymatous crusts and the throat found to be sloughing. Within a month necrosis of bone with acute suppuration may have commenced, commonly starting in the jaws, and often aggravated by mercury and originating in dirty or carious teeth. A few scattered papules may precede the pustular rash on the skin; the ecthymatous crusts, however, are usually superimposed on flattened papules. In some instances there are underlying ulcers. The rash is usually markedly pustular in the early stages of malignant syphilis, and, as often the case with any severe syphilitic papular or pustular rash, attacks the face and head; in ordinary non-infiltrated rashes, the face nearly always escapes. Syphilis commonly attacks the forehead, head and extremities in the malignant type; just as it does in neglected cases, other than malignant, where prolonged treatment has been omitted in the earlier stages. If syphilis were not so much neglected, ecthymatous rashes, rupia and iritis would be very rarely seen; not infrequently the neglect of gonorrhoea leads to serious complications. It is the purely symptomatic and the commonly inadequate treatment of syphilis that usually gives rise to severe intermediary and later tertiary manifestations. The acuteness of the supplicative process surrounding necrosed bone areas is very marked in malignant syphilis, the pus flow being fast and continuous. Iritis is rare in our experience, but treatment is usually commenced early in the Service, owing to the cases being
seen in the primary stage, and continuously treated by mercury and potassium iodide, with tonics intermittently. These drugs may be quite powerless for a time, but later on act well if the general systematic condition is first attended to. The patient must be enabled by judicious dietary and port wine to take mercury or potassium iodide. The throat and mouth are usually attacked severely. Large gummata are rare, but cutaneous papules rapidly ulcerating and resembling large tubercles are not uncommon; the severity of the rash and throat lesions are usually proportional, and often associated with early tertiary disease of the larynx. Ulceration, of a phagedænic nature, not infrequently attacks pre-existing large infiltrated nodules around the mouth and nasal organs, and rapidly extends; these nodules are an early manifestation of the late relapsing syphilitides. The factor that arises from the necrosing bone and from the breath is often so intense as to necessitate creosote inhalations, isolation and hourly dressings. Prognosis is favourable in most cases, but death may occur. The most favourable symptom when necrosis has occurred, is the sequestration of bone, when recovery rapidly ensues. Until this has occurred the disease will often progress in despite of all treatment. Death may occur from exhaustion caused by hectic fever, or from intercurrent disease; also from gummatous deposits in the lung, causing fatal hæmorrhage. Late chronic fibroid changes may occur. Fournier classifies all cases of syphilis complicated by ague as malignant syphilis. If so, malignant syphilis is very common in India. We remember to have seen on one occasion at Mhow, twenty cases invalided for secondary or tertiary syphilis; typical malarial cachexia was obviously present in five of them. These cases, although profoundly affected by ague, were not characterised by the extensive ulceration characteristic of malignant syphilis. Cases complicated by ague, although intractable, do not in our experience present the classical signs of malignancy, namely, severe or spreading ulceration. They are characterised rather by a progressive debility, by resistance to mercurial treatment, and by an anaemia presumably due to numerically deficient and physiologically defective red blood corpuscles. Tonic treatment is essential; mercury is commonly contra-indicated. We consider, with Dr. George Ogilvie, "that mercury may be greatly detrimental, and an additional source of severity." We have seen numerous cases of syphilis complicated and aggravated by the malarial poison; we do not, however, class them as malignant syphilis, nor do the symptoms occur early in the course of the disease, that is, within four to six
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months, but usually after the sixth month and generally in the second or later years. We concur in the view that these cases are severe and resistant to treatment. The Turkish bath, massage, general nutrition and change of climate, are the chief therapeutic measures to be relied upon. We would class this type as "syphilis grave," as visceral complications are not uncommonly present.

As regards the treatment of malignant syphilis the giving of general tonics is commonly more useful than the routine use of specific drugs. The local application of antiseptic solutions and the removal of the products of pus formation is satisfactory the more frequently the applications are made. Trained attendants are required and rest in bed desirable, as the temperature in some cases may be 100° to 102° for a couple of months or more. Mercury may be discontinued for a few days during a sudden excessive rise of temperature; personal hygiene should be studied minutely, and the changes rung when one form of local application is found unsatisfactory.

Dilute Condy’s fluid, in some cases of ulceration of the skin, appears to be more efficacious as an antiseptic lotion than solutions of mercury or of carbolic acid; iodoform preparations are especially valuable. The daily hot bath and prolonged soaking of diseased parts in warm water must be insisted upon, as the phagedenic nature of the ulceration is considerably aggravated by pyogenic organisms; this is more especially noticeable in the primary phagedenic ulcer. In the cases of severe ulceration of the throat, gargling is necessary for the same reason. Iodide of potassium can be tolerated in large doses in many cases, even up to one drachm three times daily. It often acts like a food, but it appears doubtful, however, with doses of over half a drachm, whether further benefit accrues. Opium is absolutely essential; it relieves the incessant pain, promoting sleep, and in cases of necrosed bone, assists nature in tiding over the long period before separation of the sequestrum can occur, when, as previously stated, recovery at once commences. Opium enables mercury to be given with less injurious effects, for the latter drug, though very useful, has to be used with great care when severe or phagedenic ulcers on the gums, or in the throat, exist. Mercury should be given in small tonic doses, half a drachm of the liquor hydrarg. perchlor. three times daily, combined with potassium iodide fifteen to thirty grains, and opium in liquid form. Inunction or mercurial vapour baths are especially valuable for pustular eruptions. Regarding the intramuscular injection of mercury in these cases, it appears to us to be contra-indicated.
lants and nutritious foods, eggs, milk, beef-tea and port wine are essential in every case where malignant symptoms occur early or late in syphilis. It is especially necessary to divert the patient’s thoughts from himself; this is often best secured by isolation, to avoid the too sympathetic expressions of friends. Sleep must be obtained; opium is the best soporific, and is also diaphoretic, being freely prescribed in doses of four to six grains daily in bad cases. When convalescence occurs, sea-side air is the best drug. Cod-liver oil and tonics, such as syr. ferri iodid. should be given, though these very often prove valuable throughout the case, if mercury and potassium iodide have failed. A useful line of treatment, if vomiting is present, is to rub ung. potass. iodid. into one groin and ol. morrh. into the other, every two hours. Relapses are very liable to occur within two or three months; if the relapse is promptly and satisfactorily dealt with, the future prognosis of the case is favourable, but every case must be decided on its own merits. Cure more frequently depends on the daily attention of the surgeon than mere dependence on drugs. The cases should be invariably treated as in-patients. Malignant syphilis is usually associated with prolonged fever; the place for such cases is in hospital. Should emergency require the cessation of all drugs, it is to be remembered that syphilis rarely kills, and that reliance may be placed on nature and in stimulating expectant treatment, dietetic or otherwise. Experience shows that these may frequently prove reliable when much vaunted specifics signal fail, and, too, when the case is apparently in extremis. As illustrating some of the points referred to, the following notes of actual cases, which have been under personal observation, may be of interest.

Case 1.—Private A., aged 22, admitted with primary syphilis. Hard chancre with phagedenic ulcer situated on corona glandis. Both groins equally and markedly indurated, the right groin later suppurated. Three weeks later a severe erythematous eruption appeared over the general surface of the body, mainly affecting the extremities and scalp. Simultaneously, severe sloughing phage-dea of the tonsils, uvula and soft palate occurred. Within another week gummata appeared in the left leg. Ulceration of the central portion of the gum, corresponding to the position of the pre-maxillary portion of the superior maxillary bone, shortly began. This portion suddenly necrosed and the sequestrum came away. The case was undoubtedly one of malignant syphilis. There was not any history of former venereal disease. The man belonged to a corps in which two other men were being affected in a similarly severe manner.
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Treatment.—A hot bath every two hours until the sloughing of the penis ceased. The free use of iodoform and black wash on lint locally. Calomel vapour baths combined with mercurial inunction. To the throat, swabbing with equal parts of glycerine and sulphurous acid, calomel inhalations, and black wash gargle. This had immediate effect. Internally, liq. hydrarg. perchlor., half to one drachm, iodide of potash fifteen to thirty grains, and tinct. opii three minims, were given three times daily, doses varied. Diet, convalescent, in form of soup, port wine, beef-tea, milk, eggs and porter. After one month from admission to hospital the primary sore healed with much loss of tissue, rupia disappearing, throat resolving, but the ulceration of the gums developed into necrosis of the alveolus. A month later no external manifestation was evident, and the man was sent on two months' sick furlough, and advised to report himself at a civil hospital if the symptoms reappeared. They did reappear, but he neglected the advice and returned at the expiration of two months. On his return he was at once admitted to hospital with extensive necrosis of the alveolus of the superior maxilla, necrosis of hard palate, with perforation into the nasal cavity, extensive ulceration of the pharynx, and probably larynx, as there was loss of voice, which was later permanent. Treatment as before, with great attention to diet and extras. Two months later, a sequestrum of bone came away corresponding to the pre-maxillary portion of the superior maxillary bone. Resolution at once began, and the other symptoms gradually cleared. Permanent loss of voice remained, and he was subsequently invalided out of the army.

Case 2.—Private B., admitted to hospital in 1894 for considerable hypertrophy of tonsils. The tonsils were removed. Two months later admitted with primary syphilis. The chancre situated on the glans penis of considerable size, erosive in nature, but without very evident induration, with a tendency to phagedæna. The inguinal glands were equally shotty on both sides, discrete, and the size of small marbles. A pustular rash with severe ulceration of both sides of the fauces appeared within the month. The ulceration of the throat spread to the soft palate, which sloughed, and on to the posterior wall of the pharynx, which necrosed, within three months of admission to hospital with the primary disease.

Diet and treatment as in the case of Private A. No improvement in the throat, which went from bad to worse. The rash disappeared, but intense debility and anaemia followed. The patient could not swallow solid food. Liquids were regurgitated through
the nostrils, necessitating feeding with nutrient enemata. Food was vomited from the stomach. The case lingered between life and death for several months, the man a mere skeleton, absolutely confined to his bed, unable to move from weakness. After eight months, during which time every form of treatment was tried, including large doses of mercury and iodide of potassium, separately and together, he was placed under the charge of four hospital orderlies, who were directed to rub iodide of potassium ointment into the right groin and ol. morrhææ into the left every two hours. After a month, a sequestrum of bone the size of a small walnut came away from the posterior wall of the pharynx. Hectic fever, which had previously been present for months, disappeared. The local lesion resolved. The man gradually became sufficiently convalescent to proceed to the sea-side. On his return no signs of active disease were present. After having been a year continuously under treatment, mainly in hospital, he was left with a permanently broken-down constitution, and was discharged from the Service.

Case 3.—Private C. Primary syphilis, June 23rd, 1893. Aged 20. In hospital sixty days. Secondary syphilis followed. Mercury and local treatment. Discharged clear of symptoms, August 20th, 1893. No return of symptoms until January 28th, 1895, when he was admitted to hospital with an indolent bubo of large size in the right groin and an ulcerated throat. Whilst in hospital suppuration of the glands in the groin occurred, and the glands were excised under chloroform. Mercury and potass. iodid. given throughout. Discharged from hospital June 28th; readmitted November 9th. "Secondary" syphilis twenty-four days; lesion unstated; mercury and potass. iodid. internally. Readmitted March 8th, 1896, with secondary syphilis twenty-seven days; bubo only, which was incised. Mercury and potass. iodid. No admission to hospital again until March 20th, 1897, when he was admitted under our care at Aden, with secondary syphilis. Sore throat only, no other lesion. There was a yellow-green indolent mucoid slough of chronic type on the posterior wall of the pharynx and on the tonsils. Ten days later a mucous patch developed on the upper gum at the base of a carious tooth. Mercury was given; the teeth were very dirty; stomatitis ensued, the gum ulcerating on the inner side and extending to the outer surface of the base of the upper central incisor teeth. The ulcer was touched with nitrate of silver and improved, but relapsed. Inhalations of calomel combined with tonics of phosphoric acid and nux vomica caused improvement.
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The gum again relapsed and fever ensued for a week; quinine and fever remedies prescribed. The temperature becoming normal, mercury and potass. ioid. combined with opium were given internally. Locally, a gargle of potass. permang. with iodoform as a tooth powder. The ulcer was then the size of a florin, and the two central upper incisor teeth dropped out, active necrosis commencing in the base of the cavities. Subsequently the upper jaw necrosed for one inch on either side of the median line and the teeth dropped out.

The cavities of the teeth were syringed hourly and packed with iodoform on lint steeped in black wash. The temperature rose to 101° and remained so for ten days. On April 27th, 1897, temperature normal; mercury, pot. ioid. and opium were again given in liquid form by the mouth. Mercury had been discontinued when the ulceration around the incisor teeth extended.

May 7th, 1897.—Marked improvement. The ulcers of the gum bleeding but looking more healthy. Great constitutional debility, with hectic fever from absorption of the products of decomposition. The hard palate ulcerated. Tonics, port wine, eggs, milk, and brandy given in addition to the diet. The temperature varied from 100° to 103° for the next three months, never becoming normal. June 28th.—Ung. pot. ioid. rubbed into the groins and glands of the neck four times daily. Cod-liver oil and specific drugs given internally. Hypodermic injections of morphia half a grain to relieve the intense pain. Ulcers in the mouth swabbed with sulphurous acid and glycerine. Inhalations of creosote and tincture of iodine. July 7th.—Necrosis of the alveolus more marked, but the previously profuse suppuration is less. Ulceration of the uvula and necrosis of the hard palate began. The upper lip attacked, the tissues having disappeared for an inch and a half on either side of the median line, leaving an infiltrated and thickened surface healing at the centre and spreading peripherally. Extensive phagedenic tertiary ulcers. 30th.—The lower lip and both angles of the mouth are involved in the ulcerating process, but healthy granulation tissue is appearing on the upper lip. Pot. iodid. increased to four drachms daily by the mouth, and fifteen grains in ointment. August 6th.—Perforation of hard palate. Uvula improved. Sleeps eight hours in twenty-four. Opium reduced from six to three grains daily. 15th.—Acute ulceration of upper lip, which now involves the alae nasi. Extension of ulceration of the lower lip. Ordered face bath of liq. hydrarg. perchlor. (1 in 2,000), the surface of the ulcer washed with 1 in 250 liq. hydrarg perchlor. and ung. iodef. and ung. hydrarg. with
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Vaseline applied. September 6th.—Both lips markedly better, cessation of ulceration. Alae nasi have disappeared to the extent of half an inch. Septum nasi attacked by necrosis. The tertiary ulcers on the tonsils, pharynx and soft palate resolved. Condy’s fluid face bath substituted for the mercurial one with marked benefit. Ung. hydrarg. nit. with ung. iodof. applied with benefit to the margin of the ulcer near nose. General health much improved. 25th.—Convalescent. No signs of active disease. All ulcers healed over. Considerable loss of tissue and great disfigurement. The man has a wolfish appearance of face. October.—Invalided to Netley, England. This case no doubt formed one of a class, if not one of the cases, so vividly described by the committee who reported on syphilis at Netley.
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