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A CASE OF PROBABLE CHANCRE REDUX.

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The patient, a brewery worker, aged 38, reported at the Venereal Diseases Department of the Royal Infirmary, Edinburgh, complaining of "a lump on the penis" occurring at the site of a sore which he had had nine or ten years previously.

History.—In 1923 there was a typical indurated ulcer in the coronal sulcus which had been present for one week, having appeared ten weeks after exposure to infection. Spirochaeta pallida were found by dark-ground examination but the Wassermann was negative. The treatment was 9 grammes of arsenic, 6.75 grammes of bismuth and 31 grains of mercury given during two years. The Wassermann reaction was persistently negative, and at the end of treatment the Wassermann and colloidal gold reactions and globulin content of the cerebrospinal fluid were negative.

In July, 1934, the Wassermann was negative.

In 1936 he complained only of the small lump on the penis. The patient stated definitely that there had been no re-exposure to infection as he had had no coitus for three years.

Clinical Examination.—Nothing could be seen on examination, but a very firm elastic mass measuring three by one centimetres could be felt on the inner surface of the prepuce adjacent to the coronal sulcus. This nodule was circumscribed and not attached to the skin or underlying tissue. There was no erosion of the surface. Nothing else abnormal was found on clinical examination. The Wassermann reaction was negative.

When the reaction was repeated with the Kahn and Sachs-Georgi reactions, all were negative. The nodule was scarified but no Sp. pallida could be found and it was then excised for histological examination.

A week later the wound was healing normally but was surrounded by a ring of tissue, about one centimetre in depth, having the same consistence as the original lesion.

A provocative injection of 0.3 grammes of neo-kharsivan was given.

Ten days later the wound had healed completely and the raised margin had been replaced by fibrous tissue. The three serological tests were again negative.

Histological Examination.—The epithelium was normal. Immediately below the epithelium the corium was invaded by large numbers of small mononuclears and plasma cells and the capillaries of the superficial plexus were congested (fig. 1).

Beneath this zone the fibrous tissue was increased in amount. Scattered
throughout it were numerous areas of proliferating endothelial cells with giant cells and surrounded by mononuclears and plasma cells (fig. 2).

Several of these giant cells had finely granular homogeneous cytoplasm and numerous deeply staining nuclei arranged in horse-shoe fashion round the
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periphery of the cell. Others were smaller with only three or four nuclei and without the same ground-glass appearance of the cytoplasm.

Fig. 3.—Subcutaneous arteriole. Endarteritis and cupping. Stain H. and E. (× 200.)

Fig. 4.—Plasma cells and small mononuclears from the perivascular infiltration. Stain H. and E. (× 850.)

There were a few small areas of commencing necrosis, but this was not a marked feature in any part of the section. Young granulation tissue was associated with some of these areas.
All the arterioles showed endothelial proliferation (fig. 3). This was most noticeable in the subcutaneous arterioles where there was also a marked perivascular infiltration by mononuclears and plasma cells (fig. 4).

No spirochætes, tubercle bacilli, or other organisms could be demonstrated by appropriate methods of staining in any of the sections examined.

There was insufficient tissue for animal inoculation.

**DISCUSSION.**

The typical chancre redux or pseudo-chancre redux is regarded as being a circumscribed, gummatous, non-erosive nodule occurring at the site of the primary chancre. Dark-ground examination is negative but the Wassermann reaction is usually positive. There is no adenitis [1].

This case is fairly typical but the diagnosis presented several difficulties. The patient had had treatment which is even yet regarded by some as adequate, and the serological tests were persistently negative even after a provocative injection of arsenic.

Therefore the diagnosis had to be made from the histological examination. To make an absolute diagnosis by this means alone is generally considered impossible [2]. The difficulties are stressed by Capell [3], who describes, among others, a case similar to this.

There are several histological appearances in this case which are more suggestive of a gumma than of other granulomatous lesions. These are:

1. The endarteritis and perivascular infiltration of the subcutaneous arterioles at some distance from the actual lesion.
2. The infiltration by plasma cells as well as by mononuclears.
3. The small amount of necrosis with preservation of structural outline.
4. The presence of granulation tissue indicating a tendency to heal.

The sudden healing of the lesion, for which the provocative injection of arsenic might have been responsible, is also a characteristic of a gumma.

These factors combined with the history, gross appearances and absence of any other signs of tuberculosis or other possible cause for the lesion led to the diagnosis of a gumma.

The clinical term "Chancre Redux" has been used to include three conditions [4]. (1) The relapsing chancre or true chancre redux which occurs a few days after the primary chancre has healed and generally follows chancre in which there has been abundant induration. (2) The pseudo-chancre supposed to be due to a superinfection. (3) The chancriform gumma which is a tertiary lesion.

The first of these is excluded by the time at which the present condition occurred and the second by the definite statement of the patient that he had not been exposed to any reinfection.

The lesion belongs to the third group and is simply a gumma developing on or near the site of a previous chancre.

The treatment received appears to have been inadequate in spite of the persistently negative serological tests.
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Summary.

(1) A case clinically of "Chancre Redux."
(2) Being a gumma occurring at the probable site of the primary chancre ten years after supposed cure in a patient with negative serological reactions.

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References.


The Cause of Sore Feet amongst Troops and A Suggested Remedy.

By Captain E. J. Curran,
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What are the causes of sore feet amongst troops? This is a perplexing question of great moment and one which causes much anxiety to many a Commanding Officer. He naturally considers that there must be some chemical which either applied externally or taken internally would obviate the crop of blisters and abrasions which incapacitates his men and depletes his ranks. Surely the "doctor" must know. The Medical Officer is approached and finds it a very tricky question to answer. An old dictum reverberates in the back of his mind—remove the cause—but then it is too late, the cause has taken effect. Being "extraordinary tactful," he falls into line with the Commanding Officer and agrees, perhaps rather against his better judgment, that various applications have a protective effect. Alum, potassium permanganate, formalin, etc., and divers other solutions are suggested. The men conscientiously steep their feet, but on the line of march the inefficacy of the treatment becomes manifest. Too late to shut the stable door when the horse is gone. We humans are too ready to bid the devil good-morrow when we meet him. The fact is that the treatment should have been instigated the very day the soldier first donned an Army boot.

It is painfully obvious that before embarking on a march that a properly-fitting pair of boots is a sine qua non. This is not thoroughly realized. Frequently the fitting of boots is carried out in a perfunctory fashion. We are all cognizant of the changes that take place in the shape of the