Syphilitic Fever.

We extract the following account from a clinical lecture delivered by M. Potain at the *Hôpital Necker à propos* of a case of associated tuberculosis and syphilis, in which the problem was to determine whether the febrile symptoms were due to the tuberculosis or the syphilis. The lecture is published in the *Gazette des Hôpitaux*, 17th October, 1878.—

"Syphilis is, in fact, frequently accompanied by a febrile process; but it is generally only manifested by malaise, perceptible to the patient in a greater or less degree. If, moreover, the latter consult the physician for this indisposition, it often happens that he has not remarked the stains upon the skin, which sometimes are very inappreciable; the physician, for his part, does not think of a syphilitic affection, of which the patient presents or complains of no symptom, and he attributes the fever to some totally different cause. Oftentimes syphilitic fever is confounded with an eruptive fever, or with the beginning of a typhoid fever; the error is the more easy to make because frequently the prostration is extreme, and recalls completely that of synochal fever.

"From this fact a very useful practical lesson follows: whenever the physician finds himself in the presence of a patient affected with a remitting fever of indefinite character, for which he can find no very clear or satisfactory explanation, he ought to look for syphilis.

"In our patient the eruption of roseola immediately decided the diagnosis; but, if this eruption had not existed, we would nevertheless have found that the fever possessed a special character, and was not the fever which ordinarily accompanies the tubercular process. The attacks, in fact, are diurnal, and they commence with an intense chill, followed by heat and transpiration. This character alone should make us think of syphilis; it is altogether different from that of tubercular fever. In tubercular fever the febrile attacks recur at night; they commence, not by a chill, but with fever, sharp and severe, which is afterwards followed by sweating. Lastly, the chill only occurs when the body is covered with sweat, and from the fact of a loss of heat. The difference is therefore considerable between these two processes, as far as the fever is concerned. And if I insist upon this difference, it is not simply for the purpose of making a precise diagnosis; you will readily conceive the therapeutic indications will be different in the two cases.

Saturgine Anæmia, with Double Crural Souffle.

Patient, a man, twenty-nine years of age. Avocation, a decorative painter. He has never had colics, or arthralgias, and he presents no indication of paralysis. But he bears a slight saturnine border of the gums, which denotes, if not an intoxication, at least saturnine contact. He presents all the signs of profound anæmia: excessive feebleness of pulse, vertigo, jugular souffle, weak heart sounds, etc. Lastly, we find in him a special symptom, a double crural souffle.

It is known that when the stethoscope is applied over the crural artery in the normal state, the compression determines a dry diastolic *bruit*, of greater or less intensity, but always single. This *bruit de souffle* is normal. But in individuals affected with aortic insufficiency, Durozier has observed a double *bruit de souffle;* that is to say, that after the first normal diastolic *bruit*, there is heard another *bruit* somewhat less intense. This double crural *bruit* exists sufficiently constantly in patients with aortic insufficiency to be regarded almost as a pathognomonic sign of that affection, if there be at the same time observed a souffle with the second sound at the base of the heart. This peculiar *bruit* may also be heard in other arteries, in the brachial, carotid, etc. But it would be more difficult to determine its presence when it might be complicated with venous *bruits*, so that it is always looked for in the crural artery, where its discovery renders the question less complex. The double crural souffle has not been found in any other cardiac affection; but, by a still unexplained phenomenon, it has been found in patients suffering from saturnine intoxication; the cause of this singular peculiarity has not been determined. . . . . The treatment will therefore consist, apart from the prophylactic counsels which follow from these considerations, in combatting the saturnine intoxication, which is the cause of the anæmia, by the usual medication: purgative, and iodide of potassium. Lastly, we shall promote recuperation by tonics, iron, and sulphur baths.—*Gazette des Hôpitaux.*