# DERMOCHROMES - II

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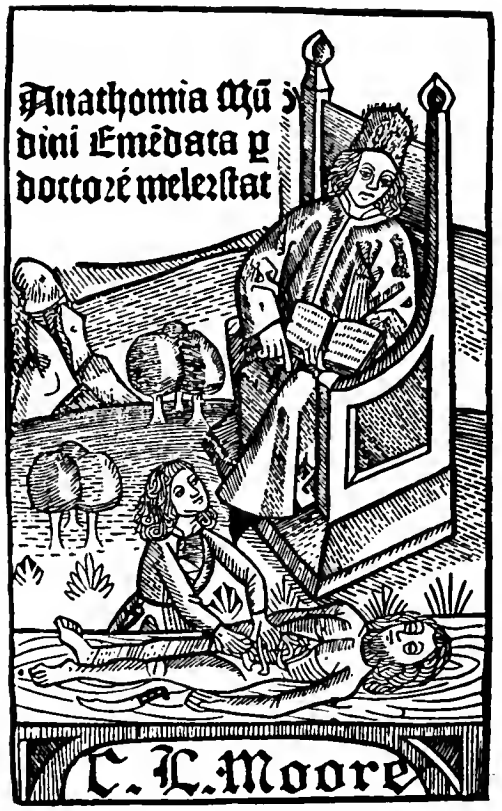

# DERMOCHROMES

**SIXTH REVISED EDITION**

# PORTFOLIO

OF

# DERMOCHROMES

BY

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*CHAPTERS ON SYPHILIS*

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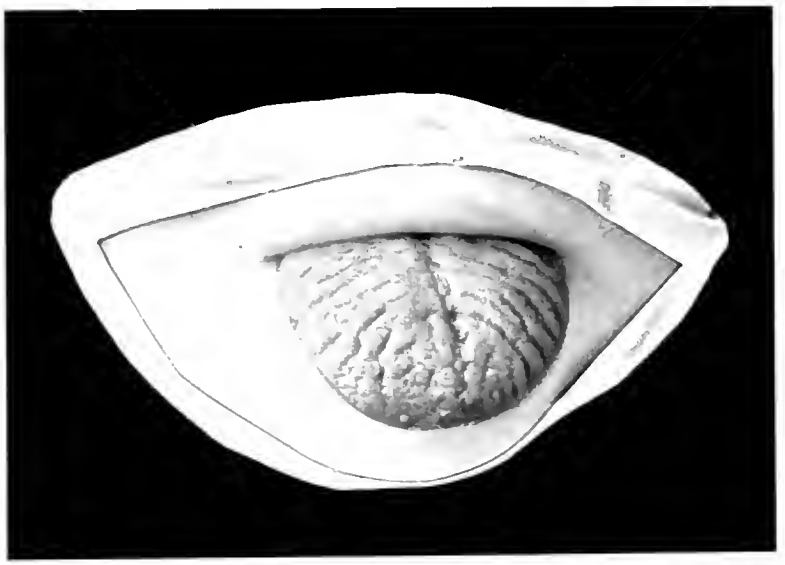


Fig. 89. Lingua scrotalis.

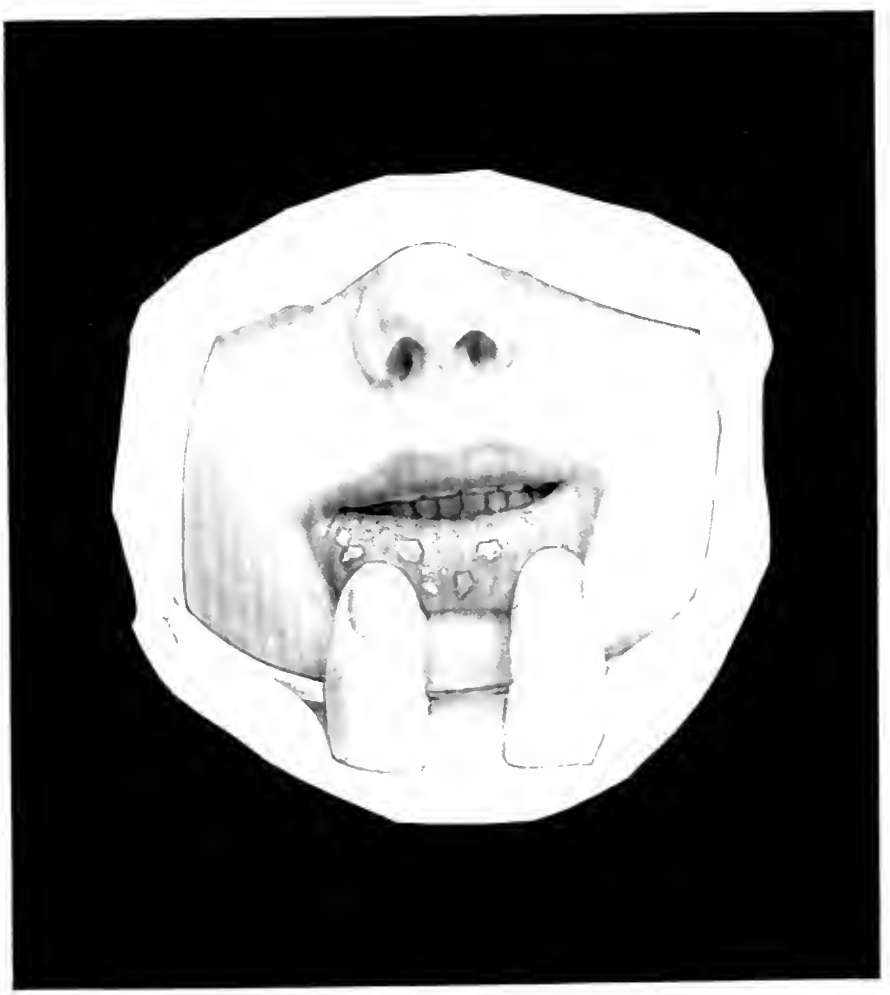


Fig. 90. Aphthae.

# Lingua Scrotalis

*Plate* **57,** Fig. 89

This affection, scrotal tongue, so-called from its resemblance to a contracted scrotum, is also known as lingua plicata, and by *Mikulicz* is called macroglossia with furrow formation. This affection is purely congenital and has also a familial incidence. The entire tongue is symmetrically enlarged, but is of normal contour. Its surface, however, instead of being smooth, is thrown into folds, numerous, and showing considerable bilateral symmetry. The median fold, corresponding to the middle line, is the deepest, as a rule. The entire tongue seems to be marked off into lobules. The papillæ are not enlarged and may be missing.

There are no especial symptoms beyond what has already been stated. The condition roughly resembles the lobulation which follows sclerotic glossitis. The geographic tongue sometimes shows lobulation.

*Treatment*

There are no indications whatever for treatment, at least none which could be carried out.

**Fig. 89.** Model in Freiburg Clinic (*Johnsen*).

# Aphthae

*Plate* **57,** Fig. 90

Aphthæ or aphthous stomatitis is an affection described in 1823 by *Billard,* characterized by multiple white circumscribed, superficial fibrinous patches. Fibrin is deposited in the midst of the epithelial cells with resulting death of the same.

The clinical picture is highly characteristic. In any locality in the mouth, notably on the tongue and lips, there appears an eruption of white or yellowish spots, these vary in size and are round or oval, and sharp contoured. They run a brief course and the epithelium is then exfoliated or shed, revealing a newly regenerated layer. The disease is kept up by the continuous formation of new aphthæ. The lesions are extremely sensitive, so that eating and speech are difficult. As the affection is largely peculiar to young infants—one to three years of age—it is prone to be attended by fever. Salivation is naturally present. Women also suffer from it in connection with all of the reproductive phenomena, and a stomatitis aphthosa not distinguishable in any way often complicates the acute infectious diseases of childhood. Certain individuals seem to be predisposed to attacks of aphthæ.

*Etiology*

Aphthæ of the mucosa appear to resemble closely vesicles on the skin, save that the exudate in the former is fibrinous. Impetigo has been produced artificially from inoculation with aphthous material. The staphylococcus aureus is often met with in the secretion of aphthæ. Children who are subject to aphthæ either have diminished general resistance, as in scrofula and rickets, or the mouth is in a vulnerable condition from some pre-existing local disease.

*Diagnosis*

The possibility of foot-and-mouth disease must be kept in mind.

*Prognosis and Treatment*

Aphthæ are so sure of spontaneous cure after a varying interval that their clinical importance is inferior. The tendency to recurrence of the lesions furnishes the real indication of treatment, but nothing is required beyond the use of antiseptic mouth washes. Caustics do not do good. General roborant measures are naturally indicated.

Fig. 90. Model in Polyclinic of Prof. M. Joseph in Berlin (*Kolbow*).

# Stomatitis Mercurialis

*Plate* **58,** Fig. 91

This affection, due to general mercurial intoxication, bears so close a resemblance to ordinary ulcerous stomatitis as at first sight to suggest that there is no specificity involved. It begins about the teeth, especially carious teeth and stumps and the wisdom teeth. The involved gums swell, and salivation is present. Next the portions of the cheeks and tongue which come in contact with the affected teeth participate. At the same time the process extends along the gums. At the junction of the latter with the teeth a yellow, pultaceous mass forms, consisting of cast-off epithelia, tartar and bacteria. The breath has now become extremely foul and exceedingly characteristic of its mercurial origin. Ulceration now begins under the pultaceous deposit. The ulcers have a yellowish or greenish flow of lardaceous quality and are surrounded by a broad, bright-red areola. Ulcers also appear here and there upon the mucosa of the mouth and tongue. The entire mucosa swells, the cheeks receive the impression of the teeth, the tongue may attain such size that the mouth cannot be closed. Even in the worst cases there may be portions of gum left intact. In the severe cases the patient naturally presents symptoms of general hydrargyrism. In individuals with good teeth and mouth care the only lesions may be a few scattered ulcers on the cheeks and tongue.

*Etiology*

The mercury may be received into the system in any of the possible ways. Cases from the therapeutic use seldom occur to-day, for a variety of reasons, and all measures are taken to prevent this accident. In the industrial arts there is also prophylaxis, but cases are occasionally reported in looking-glass makers, bronze workers, etc.

*Diagnosis*

The tenderness of the gums on striking the teeth together and the peculiar breath odor should suffice for a correct diagnosis.

Fig. 91. Stomatitis mercurialis.

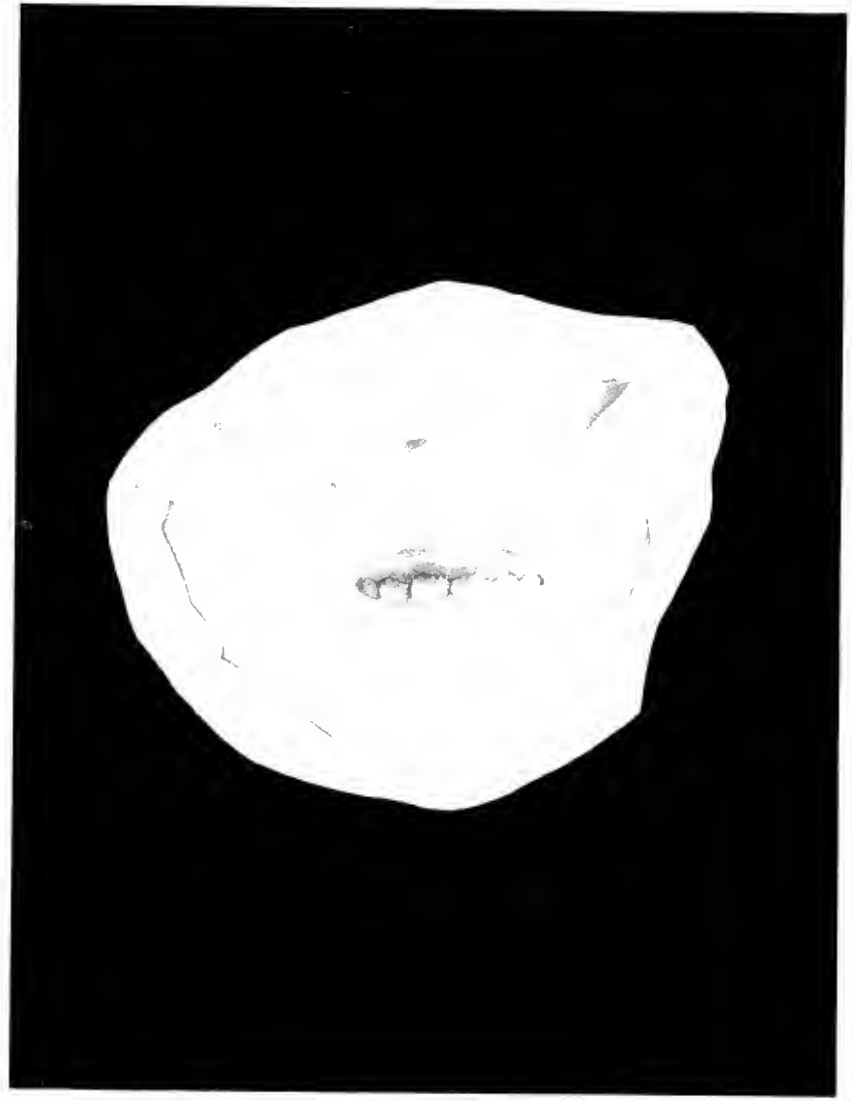


Fig. 92. Dyschromia gingivae saturnina.

*Treatment*

The most scrupulous asepsis of the mouth must be observed, with, of course, cessation of exposure to mercury. The mouth should be irrigated with solutions of boric acid, hydrogen peroxide, or chlorate of potassium. In very severe cases, iodoform should be applied in any efficacious manner between the gums and cheeks.

**Fig. 91.** Model in Finger's Clinic in Vienna (*Henning*).

# Dyschromia Gingivae Saturnina

*Plate* **58,** Fig. 92

This condition is the "lead line" which forms on the gums in subjects affected with saturnism. Plumbers and other workers in lead develop as one phase of poisoning with the same, stomatitis with gingivitis and swelling of the mucosa almost wholly confined to the margin of the gum. In this locality fine particles of metallic lead or lead sulphide are deposited, the clinical result being the line in question. This is bluish-gray or bluish-black in color. The patients are often unaware of its existence. The breath has a peculiar characteristic odor. The lead reaches the mouth through the salivary glands, which may inflame. The lead line has great diagnostic significance.

*Treatment*

The management of lead poisoning in general is indicated, together with antiseptic mouth washes.

Fig. 92. Model in v. Bergmann's Clinic in Berlin (*Kolbow*).

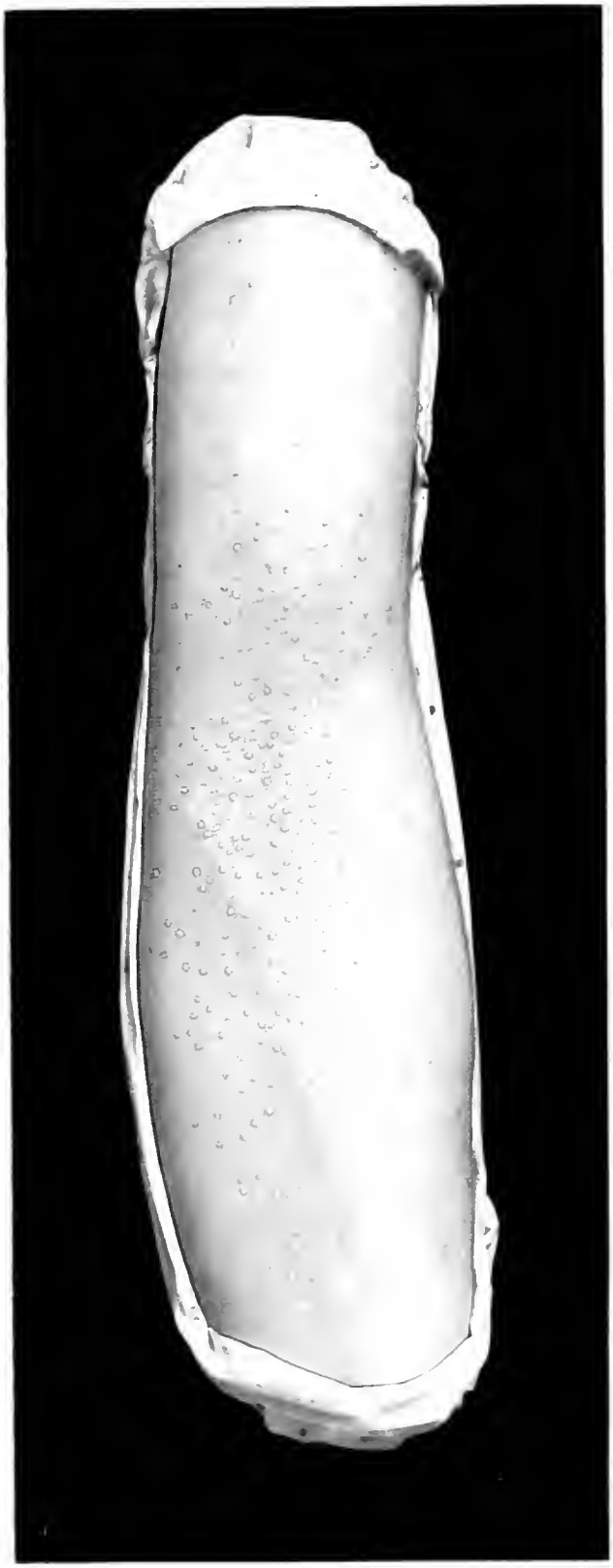


Fig. 93. Miliaria rubra.

# Miliaria Rubra

Synonyms: Lichen tropicus, Prickly heat

*Plate* **59,** Fig. 93

This eruption consists of inflammatory miliary vesicles and papules at the mouth of the sweat-follicles. The small clear vesicles representing occluded sweat-pores may become inflamed so that sometimes a complex state results. The affection occurs during intense paroxysms of sweating, producing a characteristic prickly sensation added to ordinary itching. The covered parts in which radiation is most difficult, suffer chiefly. In some individuals prickly heat is most apparent after cooler weather succeeds great heat. Professionally it is seen in workers at high temperatures who drink beer or even water to excess. Strophulus is a local miliaria occurring only in infants on the surfaces which are naturally warmest.

*Etiology*

The trouble is caused by excessive heat and the wearing of heavy underwear. It is most common in obese subjects, especially in those overheated by injudicious eating or drinking.

*Diagnosis*

The recognition of this affection is seldom difficult, although at times it may suggest acute vesicular eczema.

*Treatment*

Cooling diuretics and laxatives with a light diet afford the quickest relief. Sedative lotions and dusting powders relieve the pruritus and with the removal of the causal factors the eruption soon disappears.

Fig. 93. Model in Neisser's Clinic in Breslau (*Kroener*).

# Folliculitis Barbae

Synonym: Sycosis non-parasitica

*Plate* **60,** Fig. 94

This affection is not to be confounded with ringworm of the beard, which is sometimes termed parasitic sycosis. Since eczema, when it attacks hairy localities, shows a tendency to suppurate from accidental infection with pyogenic microorganisms, it might at first sight be assumed that folliculitus barbæ is only an eczema of the bearded area. This, however, is by no means the case, for a similar purulent folliculitis may occur in any area covered with hair. The scalp is rarely attacked, save at its borders. The eyebrows may be involved and sometimes the pubes and axillæ. It is not recorded that a generalized folliculitis of all the hairy integument can occur in a single subject. The opposite tendency is more in evidence and even in a preferred locality, like the beard and mustache; the disease is often limited to definite areas. In some instances, as in sycosis of the middle of the upper lip, the predisposing or exciting cause is connected with a discharge from the nostrils. In other cases the affection seems to take root in a particular locality and travel from follicle to follicle by local infection. The degree of suppuration, the amount of scarring and obliteration of follicles, and the presence or absence of keloidal scarring all combine to characterize individual cases.

*Etiology*

Folliculitis barbæ is regarded at present as due to the entrance of ordinary pyogenic staphylococci into the follicles of the beard and elsewhere. In certain cases pus does not form, so that only a papular folliculitis occurs. The reaction to the disease varies greatly with the individual. Infiltration about the follicle may be slight or extensive. It was formerly taught that the hairs of the beard were not loosened by the disease, but this sometimes occurs. Some patients seem naturally disposed to loss of substance and scarring; so much so that a group disease of necrotic folliculitides may in time be established.

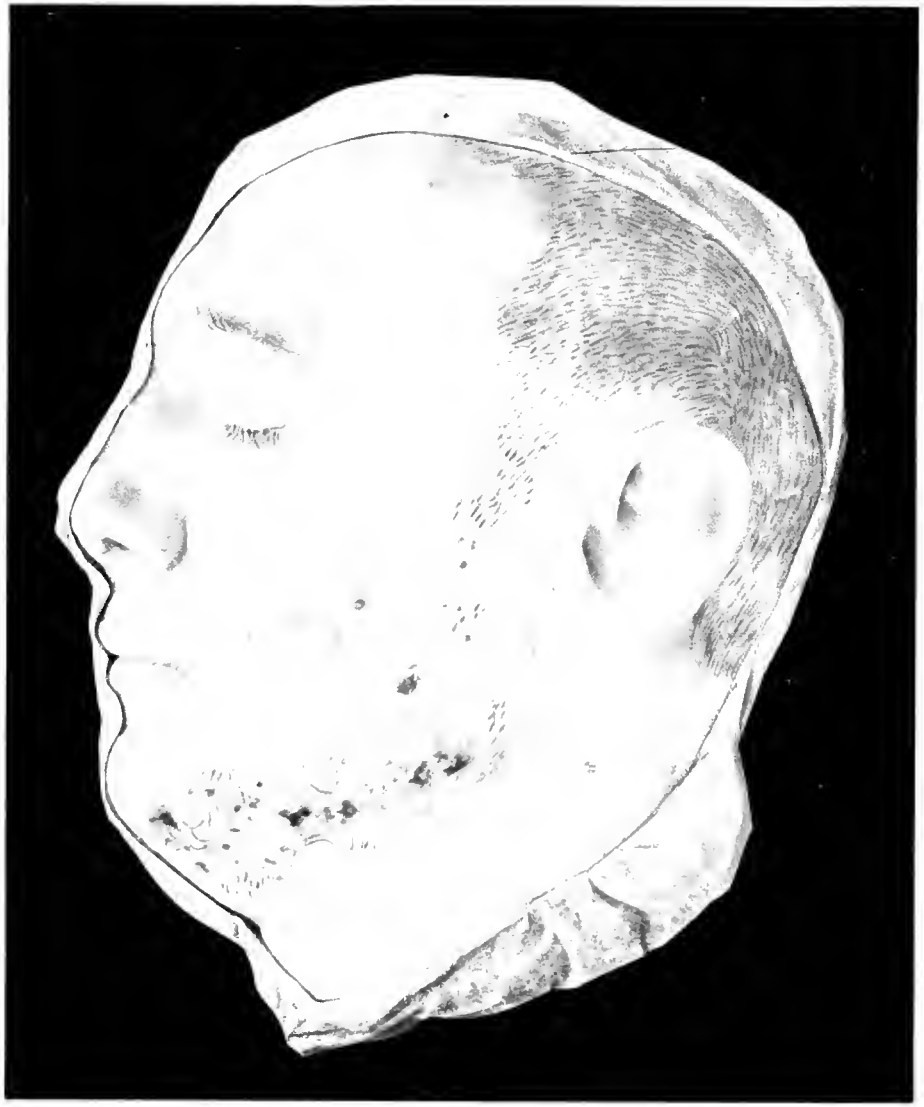


Fig. 94. Folliculitis barbae.

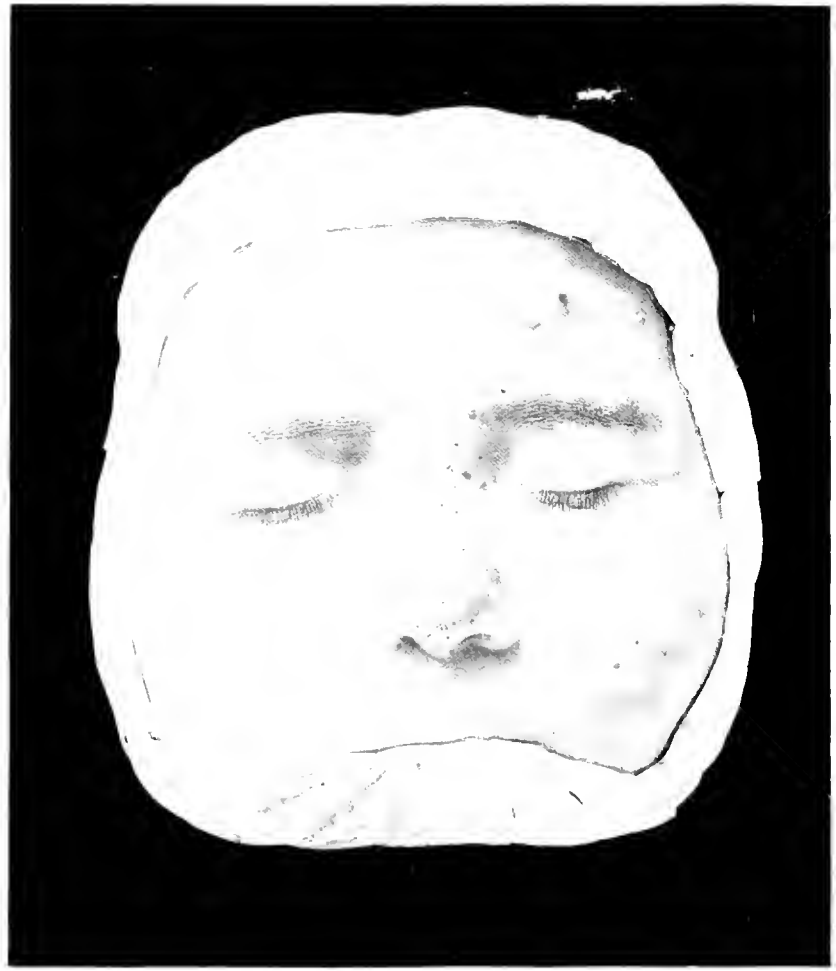


Fig 95. Acne varioliformis.

*Diagnosis*

To distinguish between ringworm of the beard and sycosis is of first importance and this is readily done by epilation and examining the hairs for fungi.

It is very difficult to differentiate radically between eczema limited to the beard, etc., and sycosis, the chief marks of distinction being largely academic. Sycosis does not itch much, and a drop of pus may be squeezed from a follicle.

Pustular acne may also be mistaken for sycosis, but in acne the pustules are larger and there is generally other evidence of sebaceous disease.

Some of the lesions of syphilis may at times resemble sycosis. The pustular syphiloderm which might be mistaken for sycosis is never confined to the face alone and the late papular tubercular syphilide, which might be limited to one region, would seldom be symmetrical, as in sycosis. The lesions would be larger, less acutely inflammatory, and would not exhibit the pustular points surrounding the hair-follicle.

*Prognosis*

As in folliculitis from other causes the disease is naturally very chronic and refractory to treatment. It is very difficult to destroy the organisms in the follicles.

*Treatment*

The beard must be clipped short, for the irritation caused by the growing hair is great. Soothing applications are then indicated until the patient is able to shave. This is practically as beneficial as epilation, an old resource. The patient is now placed upon mild antiseptic ointments, white precipitate or sulphur usually having the preference. If the face is considerably irritated an ichthyol or diachylon ointment may be substituted. In chronic cases good results are often obtained by the use of X-rays. Autogenous vaccines are probably of more value in folliculitis barbæ than in any other cutaneous affection.

Fig. 94. Model in Freiburg Clinic (*Johnsen*).

# Acne Varioliformis

*Plate* **60,** Fig. 95

The resemblance of this affection to variola lies only in the scars, for the lesions are of very slow evolution. The expression acne varioliformis has also been applied for years to molluscum contagiosum; so that in some quarters the term folliculitis varioliformis is used. The lesions, discrete papulo-pustules, occurring on the face, naturally resemble an acne, but show a special tendency to occur on the forehead, especially along its hairy border. They also extend well into the hairy scalp and this fact alone serves to differentiate the affection from ordinary acne. Another important point is the absence of comedones and of anything like free suppuration. The pus in the centre of the pustules cannot be squeezed out, and this is not due to any perifollicular location, but only to the fact that the central core is not really pus but a yellow slough. This forms and separates very slowly and the loss of tissue is replaced by a depressed scar or pit. Although the lesions are chiefly discrete they sometimes occur in small groups. Some individual lesions may be as large as a bean, and if a number of large lesions are closely aggregated there is at times a marked resemblance to syphilis.

*Etiology*

The affection is rather rare and little is known as to its intimate nature. Those who do not believe in the individuality of so many new diseases incline to regard this affection as a tuberculide.

*Diagnosis*

The differential points of common acne have already been outlined —location, character of pustule, etc. The *Wassermann* reaction should help distinguish it from syphilis.

*Prognosis*

The disease is an obstinate one, and also tends to recur, but is curable.

*Treatment*

Applications must be made to penetrate into the follicles with a view of preventing new lesions. The integument should first be prepared with a salicylic acid ointment, after which sulphur, ammoniated mercury, naphthol, resorcin or other bactericide appears to be sufficient, with patience, in removing the affection.

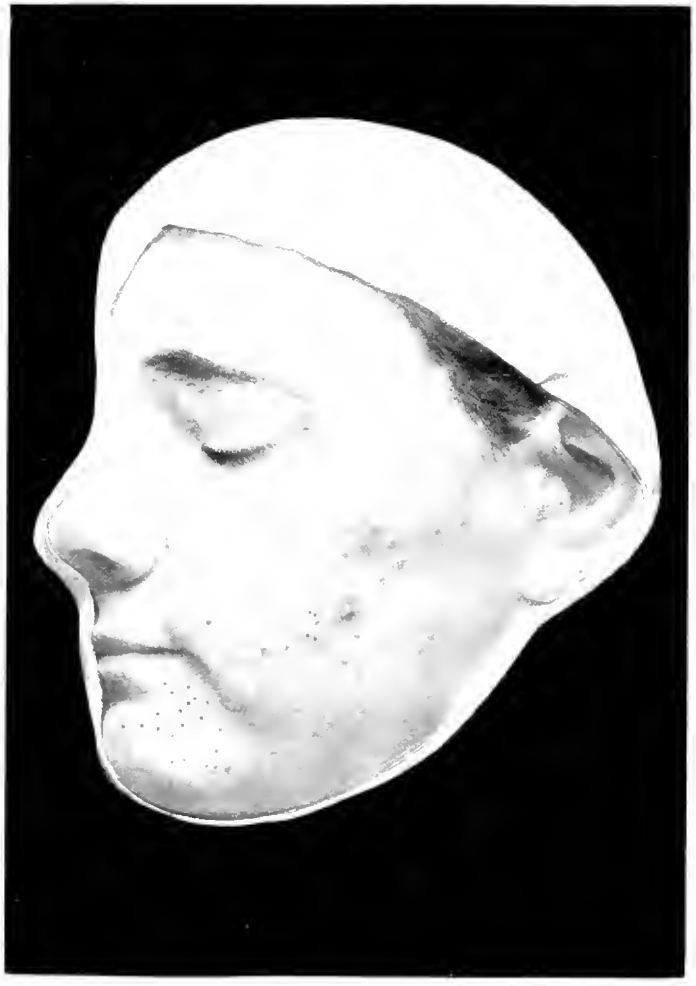
Fig. 95. Model in Neisser's Clinic in Breslau (*Kroener*).

# Acne Vulgaris

*Plate* **61,** Figs. 96 and 97

This affection, nominally almost peculiar to the sebaceous glands of the face with a slight tendency to extend over the shoulders may exceptionally occur thickly over the upper two-thirds of the back, in which situation its relationship to these glands is much less apparent. In certain individuals acne may also occur on the limbs, nor is there any evidence that these subjects are notably in poor general condition or uncleanly. The incidence of the disease upon the face is readily explained by the prominence of the sebaceous glands in this locality, the patent state of the outlets and the tendency for these to become obstructed from within or without. Acne, however, is much more than a mere obstructive affection, for in the worst lesions the chief mischief occurs and may begin outside of the follicles. Dermic abscesses often form on the face and back, some of these being quite extensive, and deep pits result which sometimes resemble those of smallpox. Nor in cases where these lesions occur is there any evidence that the process necessarily began with obstruction of the sebaceous outlets. Treatment directed to cleansing the skin and opening the pores may not be able to avert the formation of these perifollicular lesions. For these and other reasons an attempt was long made to distinguish radically between acne vulgaris, the obstructive type of acne of the face and acne indurata, occurring on the face, shoulders and back alike, and consisting essentially of perifollicular suppuration. At the present time this distinction is only made from the clinical standpoint, as it is impossible to state where one begins and the other ceases.

Acne vulgaris in the narrow, clinical sense can often be traced step by step. Beginning with a plugging of a sebaceous duct, the lesion is then known as a comedo or black head. The first evidence of follicular reaction, as shown by the formation of a reddened papule, is termed acne papulosa, or pimples. As a matter of fact, however, the papules of acne very often represent pustules which have been evacuated. When pus forms in the centre of a papule, as a result of



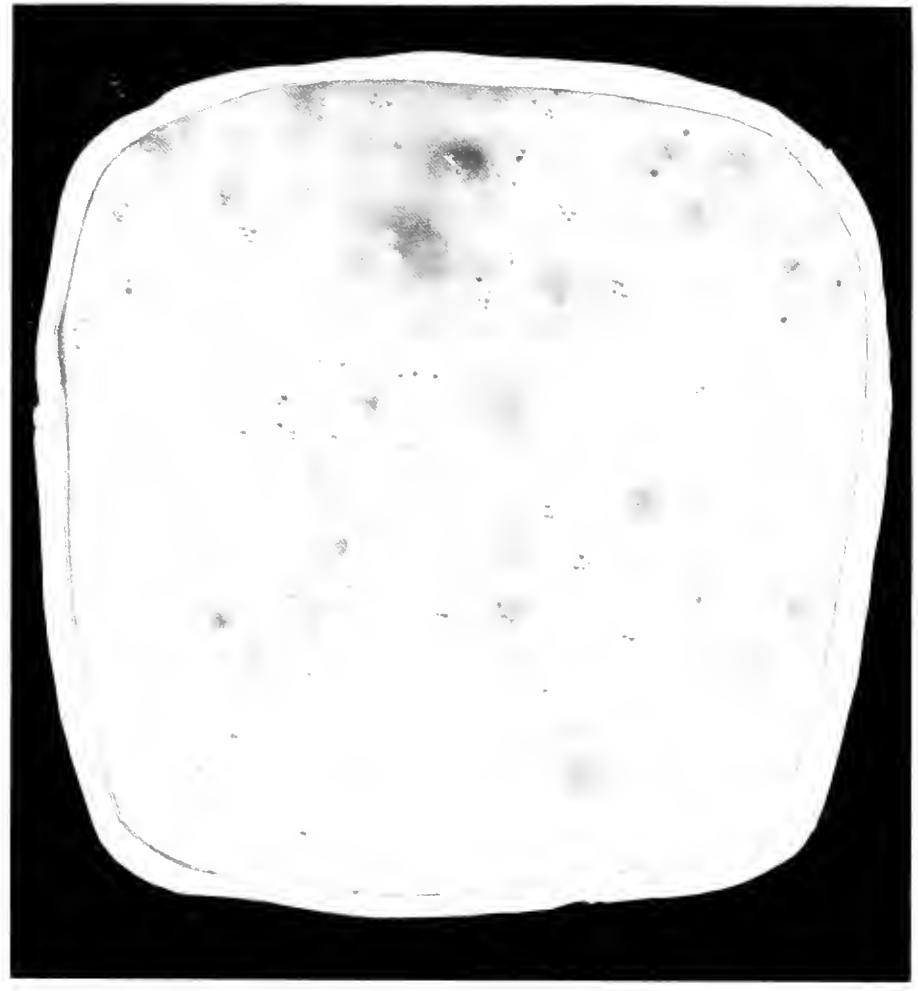


Fig. 96. 97. Acne vulgaris.

infection within the latter, the condition constitutes an ordinary acne pustule or pimple which has come to a head. Large papulo-pustules, slow of evolution, which do not come to a head, and which often do not discharge any pus, represent a deep-seated inflammatory process which involves a group of sebaceous follicles. In certain cases pus either does not form at all, or becomes encysted; so that nodules may persist in the skin for weeks, or until fresh suppuration occurs. In some of the larger lesions several foci or pus may form, and these may coalesce to produce a large cavity. In many cases the dermic abscesses behave like the cold abscesses of scrofulous subjects and occur in patients of a marked scrofulous habitus.

Acne is essentially a multiform affection in which comedones, papules, small pustules and perifollicular abscesses may occur side by side. Certain cases never pass much beyond the comedo stage, and many have no other lesions than comedones and small papulo-pustules. It by no means follows that the latter do not scar, for they often produce fine pits; but these tend in time to become hardly perceptible. A characteristic feature of acne lesions is that they are disseminated quite uniformly. Although there appears to be no good reason why many contiguous follicles do not become involved together, it is a fact that acne lesions do not coalesce to form large patches. We have already seen that some coalescence of perifolliculitis is necessary to produce the large indurations and abscesses. Acne tends to come out in successive crops or continuously, and there is a considerable relation between the character and duration of the lesions. Small papulo-pustules may go and come quickly, larger ones have a much longer cycle. The indurated lesions which cannot be evacuated may persist for weeks. Acne on the back seldom bears any relationship to acne of the face. The latter may show but few lesions in a patient whose back is densely covered.

*Etiology*

The tendency of an acne to begin about puberty and to disappear spontaneously within a number of years, shows the presence of a marked developmental element. Acne depends so closely on so many different factors that these must be regarded as elements, which, however dissimilar, all tend to make the follicles a culture medium for various pathogenic germs. The number of dietetic articles which may determine acne in different individuals is very large. For each patient there are a few classes of food or single articles which cause the breaking out, and it is not impossible that anaphylaxis is responsible.

Otherwise it is hard to understand how in some subjects, nuts, cheese, etc., always appear to determine new lesions. The claim was once made that a dilated stomach is largely responsible for acne lesions, and that if this underlying condition is treated properly much benefit results. Constipation is often clearly associated with the formation of comedones and intestinal autointoxication due to constipation is also a factor. Menstruation is often sufficient to produce a number of papulo-pustules which run their course rapidly. The part played by microorganisms is very evident, but the disease is not contagious and it is doubtful if it is even autoinoculable.

*Diagnosis*

Acne vulgaris may be confused with iodic and bromic pustules. The only actual disease which may simulate it is the papulopustular syphilide, and this shows certain groupings and does not spare any area, while acne does not occur in the eyebrows or on the eyelids.

*Prognosis*

Acne vulgaris is often very hard to control during the first years of its existence, but after puberty is well over it responds better to treatment.

*Treatment*

The treatment of acne is both general and local, and to be of permanent value should be continued faithfully for a long time.

General treatment consists of hygienic, dietetic and medicinal measures calculated to improve the physical condition of the patient.

Cold bathing or sponging, as much out-door exercise as the patient's strength permits of, with regular hours for eating and sleeping, should be insisted upon. Late hours, especially with late suppers, are injurious, and all foods liable to cause gastrointestinal fermentation should be avoided. It is always advisable to impress the necessity of this firmly upon the patient. Fried greasy food, rich soups and gravies, and pickles and cheese should be eliminated from the dietary.

For the gastric fermentation the following rhubarb and soda mixture will be found serviceable:

℞ Pulv. rhei ..... ʒi
Sodii bicarbonat ..... ..... ʒiii
Aquæ menth. pip ..... ℥iii

M. et ft. Sig.—Teaspoonful after meals.

If there is atony of the stomach-walls, 3ii of tincture of nux vomica can be added to the above; and if constipation is also present, 3ii to 3iv of the aromatic fluid extract of cascara sagrada can be added also, or the cascara can be given in the form of tablets at bedtime.

In plethoric patients *Bulkley* recommends:

℞ Potassii acetatis ..... 3vi
Tinct. nuc. vomica ..... 3ii
Ext. cascara sagrada fl. ..... 3ii
Ext. rumex fl .....ad ℥iii
M. et ft. Sig.—Teaspoonful in water one-half hour before meals.

Anemia must be treated with iron and arsenic tonics. The elixir of iron, quinia and strychnia is a valuable preparation, and the following will be found exceptionally good:

℞ Ferri et ammoni. citratis ..... 3i
Liq. potassi. arsenitis ..... ..... 3i to 3ii
Liq. potassiæ ..... 3i to 3ii
Tinct. nuc. vomica ..... 3ii
Tinct. gentian comp ..... ℥i
Aquæ .....ad ℥iv
M. et ft. Sig.—Teaspoonful in water after meals.

Where constipation with anemia exists, the following modification of *Startin's* mixture is excellent:

℞ Ferri sulphatis ..... ..... 3i
Magnesii sulphatis ..... 3iv to ℥i
Acidi sulphurici diluti,
Syrupi zinziberis .....āā 3iv
Aquæ ..... . ad ℥iii
M. et ft. Sig.—Teaspoonful in glass of water after meals. Take through a tube.

This is especially good in the indurated type with large pustules.

The local treatment of acne is very important.

All comedones should be removed mechanically and the pustules opened; this hastens the cure and lessens the scarring. This should always be done by the physician and never left to the patient.

The face should be washed in cold water only and no soap should be used. Steaming the face and using hot water leaves the pores dilated and increases the tendency to comedone formation.

The plan used so much abroad of using peeling ointments is seldom

advisable. It can be used occasionally on the forehead when large numbers of blackheads are present; but its use must always be followed by the regular routine treatment described below.

The following ointment causes desquamation. It should be spread thickly over the part to be peeled and allowed to remain in place for about an hour, then removed with dry cotton. This is repeated daily for three or four days.

℞ Betanaphthol ..... ℈ii
Pulv. sulphur precip ..... ʒiv
Saponis mollis,
Paraffini mollis .....āā ℈v
M. et ft. Sig.—Scaling paste (Lassar).

When dermatitis develops water must not be used, but a bland dusting powder or a soothing lotion can be applied to relieve the feeling of tension and burning. After desquamation has begun a mild ointment such as cold cream or boric acid ointment can be used.

The best results are obtained by the use of lotio alba, to which three per cent. of precipitated sulphur is added.

℞ Pulv. sulphur precip.,
Zinci sulphate,
Potassii sulphuret .....āā ʒi
Aquæ rosæ .....ad ℥iv
M. et ft. lotio.

The potassium sulphuret should be fresh, as it changes on exposure, and the lotion made from an old article is practically useless.

As the skin becomes tolerant, the strength of the lotion can be increased three or four times. This is to be applied thickly night and morning.

When the skin is very oily and the pores become clogged easily, it is advisable to apply the above at night and use the following in the morning, rubbing in well:

℞ Pulv. sulphur precip. ..... ʒi
Etheris sulphurici ..... ʒiv
Spr. vini rect .....ad ℥iv
M. et ft. lotio

Occasionally the patient's skin will not tolerate the above, especially in the beginning of the treatment. In these cases the following modification of the *Kummerfeldt* lotion is useful:

℞ Pulv. sulph. prep ..... ʒii
Camphori ..... gr. vi
Pulv. acaciæ ..... ʒi
Aquæ calcis ..... ʒiv
Aquæ rosæ .....ad ℥iv
M. et ft. lotio

Seborrhoic dermatitis of the scalp frequently accompanies the acne, and this must be treated. For this condition the following lotion is very good:

℞ Hydrarg. bichlor. ..... gr. i
Resorcin ..... ʒii
Spr. vini rect. ..... ʒiv
Aquæ rosæ .....ad ℥iv
M. et ft. lotio

If this makes the hair too dry, a small amount of glycerine, ʒi to ʒii, may be added to the lotion.

Vaccine treatment in acne has proven very disappointing. *Trimble,* in a large series of cases at the New York Skin and Cancer Hospital, had generally unsatisfactory results.

**Figs. 96 and 97.** Models in Neisser's Clinic in Breslau (*Kroener*).

# Acne Rosacea

*Plate* **62,** Fig. 98

In this affection there are acne lesions of a peculiar type plus a condition of dilated blood-vessels. Both classes of lesion are due to persistent flushing or congestion of the face and seldom appear until after the period in which developmental acne has run its course. The vascular or hyperemic element gives the lesions a peculiar, angry look. In young subjects pustules on or beside the nose may present this angry appearance, but there is never any general outbreak. These rosaceous papules and pustules come and go very rapidly and suppuration plays a much smaller part than in other common forms of acne, the typical lesions being macules, papules and tubercles. Pus formation is usually limited.

The manifestations of this affection differ greatly, for the two elements may be combined in many ways. The mildest type is confined to the nose, perhaps only to the tip, and is present as a mere intense redness, paling on pressure. The lesion may be due to a pustule from an occluded gland in which case it usually quickly subsides when the pus escapes. Much more commonly is the red area on the nose a simple congestion without any glandular implication, and which tends to persist for an indefinite period. The lack of an acne element in these cases induces some authors to make a distinction between mere rosacea and acne rosacea, but the dependence of both lesions on a common cause is indisputable. Thus the pure rosaceous type is very commonly associated with oily seborrhea. The entire nose may be bright red in color without any acne element associated. The redness comes and goes and in the course of time permanent telangiectases appear. Redness and oiliness may involve the entire face and is a matter of physical habit or complexion rather than an actual disease. In these skins the sebaceous glands are prominent and are often seen to be the seat of comedones. Small, scattered telangiectases are seen here and there. In another type of skin which is finely grained and free from any predisposition to disorder of the sebaceous glands a naturally florid skin becomes with advancing years a network of telan-

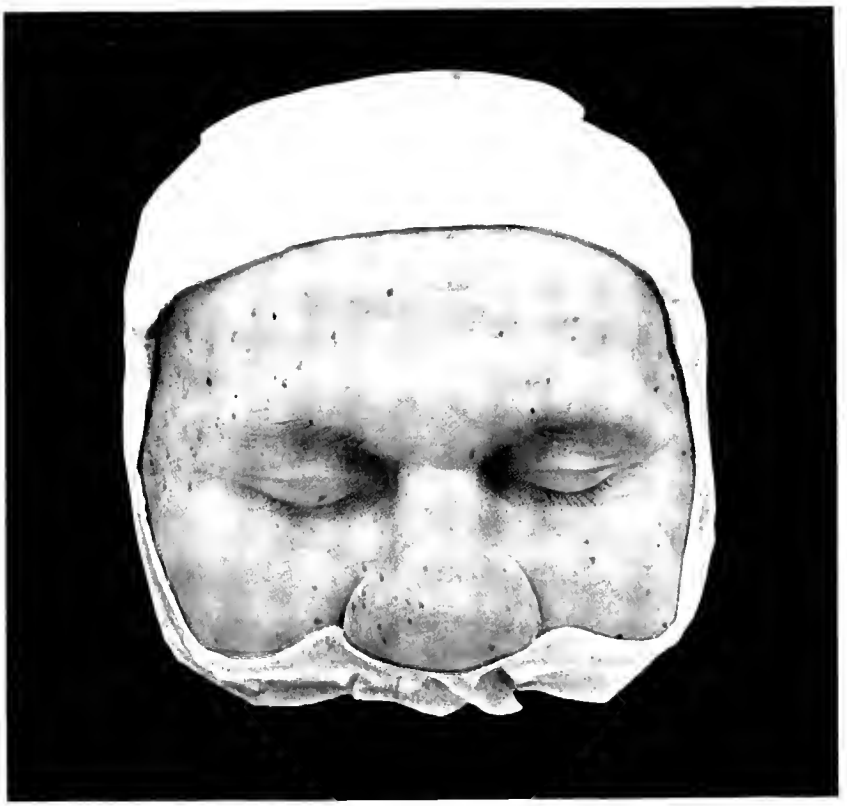


Fig. 98. Acne rosacea.

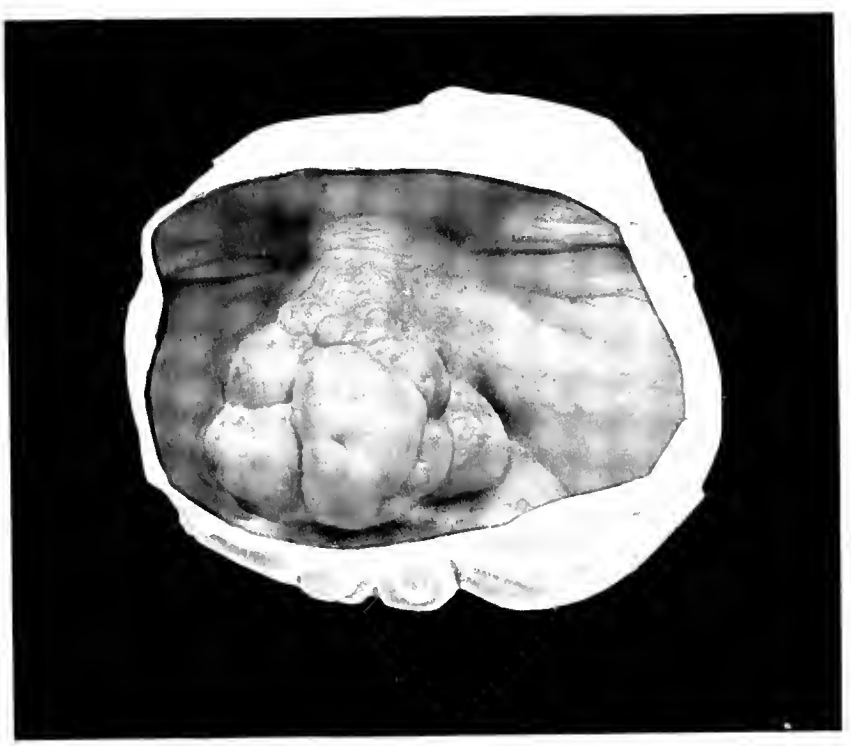


Fig. 99. Rhinophyma.

giectases which may reach down upon the neck and involve the ears. This type shows clearly that rosacea may be entirely distinct from acne or seborrhea and result from constant congestion.

The diffuse type of acne rosacea is well marked. Certain individuals after a few days' excessive use of liquor and tobacco, which ordinarily produce a simple flushing of the face, may break out suddenly over the entire congested area with acne rosacea. It may appear with almost the suddenness of a rash, the entire face and forehead being covered with macules and papulopustules. There are no selective areas. These cases soon subside with removal of the cause, but if the latter continues in action the condition becomes steadily aggravated. The varying element of predisposition is seen in the fact that not all men who use alcohol have congestion of the face and of those who do, only a small minority develop acne rosacea.

The most typical form of acne rosacea is diffuse with a tendency to develop in a special area, to wit, the forehead, middle of the face and chin. In bald people it may be noted that the lesions on the forehead may extend upon the scalp. Acne rosacea seldom appears before the age of thirty, and it will very often be found that these subjects have suffered from juvenile acne and sometimes the latter passes directly into the other form. These patients show combinations of acne and rosacea. The nose may be the seat of the latter alone, while the papules show a certain tendency to be aggregated into circumscribed patches on the lower portion of the forehead, centre of the cheeks and chin. This form is essentially chronic or recurrent, due to deep-seated causes.

In chronic acne rosacea a type of lesion appears which is not seen in acne vulgaris and which is doubtless a consequence of the protracted congestion. This is a superficial tubercle or nodule, which evidently represents a hypertrophy from excess of nutriment. While it may occur wherever there is a focus of disease, its higher degrees are almost peculiar to the nose.

*Etiology*

Aside from the palpable effects of alcohol the causal elements are obscure. Occupation is seen in the rosacea of cabmen, resulting from prolonged exposure to cold with sudden transition to hot rooms, and the free use of alcohol. The rosaceous element greatly preponderates over the acne in these. Most of the factors which determine and aggravate acne vulgaris may be seen in acne rosacea. Chief of these are digestive disorders and menstrual irregularities. In a number

of my cases it has occurred to me that the acne was more or less related in its etiology to pyorrhea alveolaris. The rosacea seen in hale old men often indicates defective metabolism incidental to advanced age and inability or disinclination to change their mode of life.

*Diagnosis*

In rare cases in which eczema attacks the acne area a distinction may be impossible at first. Acne rosacea, however, does not itch and the skin may be cooler than normal. A hyperplastic circumscribed patch of acne may closely simulate lupus of either form or a syphilide but no real confusion should arise here.

*Prognosis*

The prognosis with full and proper management is good for recovery and the chance of spontaneous recovery or recovery under half measures is correspondingly poor.

*Treatment*

The regulation of the diet and habits is the same as that required in acne vulgaris. In addition the digestive organs may benefit by direct treatment of the indigestion which often seems far more in evidence than in acne vulgaris. The services of a dental surgeon are often indicated and in refractory cases a gastro-enterologist may render much service by making an exact diagnosis of the state of the digestive organs.

Saline purgatives and other derivative and depletive measures, provided they do not flush the face, often accelerate the reduction of the congestion of the face. In some cases no impression is made on the disease until all causes of flushing are eliminated. Thus hot drinks and hot soup at meals have to be forbidden. The frequent occurrence of rosacea in dressmakers seems due to a combination of causes which have this tendency, as drinking much hot tea, improper posture, sewing for hours in front of a hot lamp, etc.

In some cases considerable benefit follows the internal use of ichthyol. This should be given after meals in doses of from ten to twenty grains, either in capsules or well diluted in water.

Not much can be accomplished by local treatment, aside from surgical measures, beyond the constant use of a protective sediment-lotion. The most serviceable application is strong lotio alba. Whenever the seborrhoic element is very marked, resorcin is specially indicated.

In well-developed forms, much may be done by various instrumental resources—scarification of densely congested areas, electrolysis of telangiectases, etc., with hot applications to encourage bleeding and promote the slow circulation. Hydrotherapy appears to exert a favorable influence in restoring the tone of the vessels.

Fig. 98. Model in Neisser's Clinic in Breslau (*Kroener*).

# Rhinophyma

*Plate* **62,** Fig. 99

This condition has been termed the third stage of acne rosacea, but it is best regarded as an independent affection. It is nearly always confined to males and as the name implies is limited to the nose. Were it actually the extreme stage of acne rosacea we should expect it to develop more frequently. As a matter of fact, however, the affection is a very rare one and may occur in men who have previously had but little acne. So far from being a mere hypertrophy or hyperplasia, there is said to be a new formation of fatty tissue. The affection behaves in every way as a neoplasm, growing to an almost indefinite extent with a tendency to lobulation and the production of pendulous, more or less pedunculated lobes at the dependent portion. The histologic picture is a variable one. There may be found all stages of inflammation, capillary dilatation, hypertrophy of the sebaceous glands, as well as granulation and cicatricial tissue.

*Treatment*

The only treatment is surgical. The lobulated and thickened portions should be removed and the underlying tissue pared down to the cartilage. Healing is prompt and the results are generally satisfactory.

Fig. 99. Model in Neisser's Clinic in Breslau (*Kroener*).

Fig. 100. Dermatitis papillaris capillitii.

Fig. 101. Granulosis rubra nasi.

# Dermatitis Papillaris Capillitii

Synonym: Acne-Keloid

*Plate* **63,** Fig. 100

Not much is known of this peculiar affection beyond the fact that it is limited to the nuchal region at the scalp border, a locality prone to folliculitis and furunculosis, and that it often depends on persistent irritation of the neckband. The earliest lesions bear a considerable resemblance to those of sycosis barbæ when the latter forms nodes and tubercles; but there is no evidence that the present affection is a folliculitis. As in sycosis, raw papillary outgrowths appear and form crusts. The infiltration which causes the nodules and the proliferation at the surface are attended with a sclerotic and cicatricial tendency, the latter having a disposition to form a scar keloid. The lesions are densely aggregated at the nucha, and the various changes which take place tend to cause atrophy and destruction of the follicles. This is offset by a tendency of the process to extend upward along the occiput. The keloidal element is regarded as characteristic of this affection, and sufficient to distinguish it from any form of folliculitis, acne or furunculosis.

*Diagnosis*

The diagnostic points have already been outlined. Confusion with any other affection is hardly possible.

*Prognosis*

For a benign affection its course is singular, persistent and refractory to treatment.

*Treatment*

Improvement in nutrition and withholding of irritation do not exert a beneficial influence. Cleanliness, epilation and mild antisepsis produce surface improvement only. Destruction by cautery and even excision of the diseased area have been followed by recurrence. Improvement often follows the protracted use of the X-rays.

**Fig. 100.** Model in Freiburg Clinic (*Johnsen*).

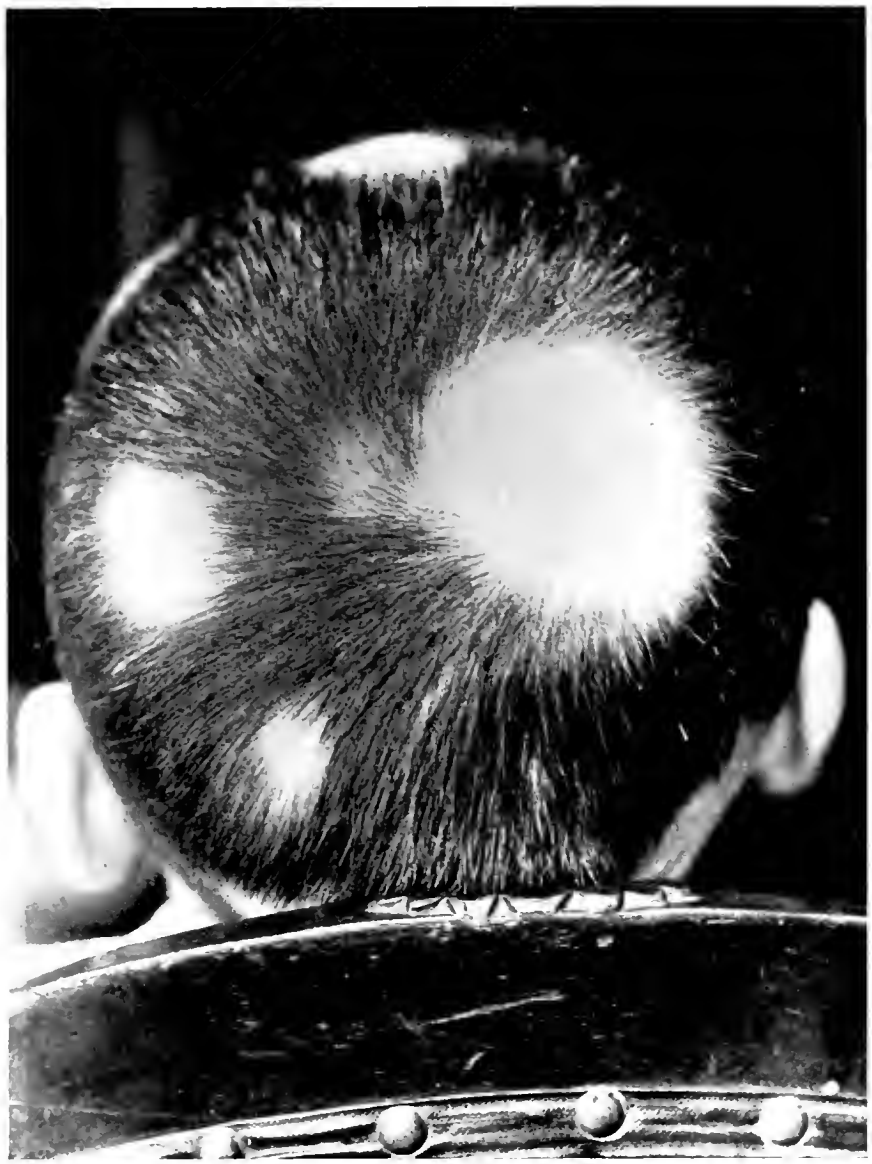
# Granulosis Rubra Nasi

*Plate* **63,** Fig. 101

This affection was not described until 1900 by *Luithlen. Jadassohn* named it, and made the first important contribution to the literature, reporting a considerable number of cases. It is believed to stand in necessary relationship with sweat-glands, so that it ranks in this respect with hyperidrosis and other functional anomalies of these organs, miliaria and sudamina and hydrocystoma; also with various diseases in which the sweat-glands appear to be involved secondarily. The affection appears to be peculiar to the face and largely restricted to the nose. Exceptionally it may extend from the latter and involve the upper lip or cheeks.

Clinically, it is a form of red nose, which, however, has nothing in common with acne rosacea, and which, moreover, is almost or quite peculiar to young children, who seldom or never suffer from the other malady. Hence a red nose in a child or a young adolescent should suggest this possibility. Despite the diffuse redness, the affected skin is seen to be the seat of papules, which remain discrete, although placed close together. The individual lesions do not exceed the size of a pinhead, and are bright red or brownish red in color, paling readily on pressure. It could hardly be confounded with seborrhea, but resembles to some extent both forms of lupus. There is no reason for regarding it as a tuberculide. The affection is one eminently chronic, but destined to be outgrown during late adolescence. It therefore has a developmental element. Thus far the subjects have been delicate children in the second period of childhood —from seven to fifteen years. Hyperidrosis often coexists both in the affected skin and elsewhere, and is regarded as part of the predisposition. The occasional presence of hydrocystoma also adds strength to this view. The individual papules appear to undergo some central suppuration and desiccation. Neither scars nor stains are left. Little or nothing is known of the intimate nature of the affection, and no successful remedies have yet been recognized.

Fig. 101. Model in Neisser's Clinic in Breslau (*Kroener*).



# Alopecia Areata

*Plate* **64,** Fig. 102

This affection is that form of baldness in spots which is not due to any known form of parasite nor secondary to any other known affection. Our conception of it is negative rather than positive. The fact that it may develop with relatively acute symptoms and involve all or several of the hairy regions of the body is sufficient to distinguish it from all ordinary local forms of baldness. There is no essential difference between alopecia areata and the universal shedding of all the hair which may occur in general diseases and after profound nervous impressions. This fact, combined with much other evidence, seems to point to other than merely local causes of alopecia areata. On the other hand, well-known fungi can produce baldness in spots, and this, with other evidence, points to a parasitic origin of at least certain cases. Many authorities therefore speak of two separate forms of the disease. Aside from the unicistic and dualistic viewpoints, a compromise view is possible. We may suppose the coöperation of constitutional or nervous influence weakening the soil, and a germ of low pathogenicity able to act upon such a soil.

Alopecia areata was evidently well known to antiquity and under such names as area Celsi and ophiasis receives rather more description than other more important affections. Ophiasis is commonly spoken of as referring to a serpiginous or creeping form which denudes the scalp in bands or sinuous tracts. It is, of course, barely possible that the name comes from the shedding of its skin by the serpent.

As already implied, the skin itself undergoes no change, and in the frequent absence of any efficient causes the spontaneous character of the process suggests something foreordained to occur. The identity of the circumscribed and diffuse types is paralleled by the alopecia due to syphilis. As a rule, the loss of hair is confined to circumscribed areas, comparable in size and shape to prints of the finger-tips. Exceptionally there is relatively rapid loss of hair in bulk.

In a very few instances an epidemic incidence of this affection has been noted. While at first sight this seems conclusive evidence of contagion, the wholesale occurrence of disease may be due to other factors, especially those able to act upon the ductless glands.

In the majority of cases patients present themselves with bare spots on the scalp, and a history of sudden or more insidious shedding of the hair. After a lock of hair has been shed, the hairs at the margin continue to come away until as a rule self-limitation occurs. Hence the greater the number of the primitive spots, the greater the likelihood of extensive baldness. In certain cases, however, the process may extend in a straight or sinuous band, and the balance of the scalp may or may not be involved. In a third type the baldness cannot be said to occur in spots, for the hair of one-half of the scalp may be shed almost en masse. In still another type the marginal shedding of the hair about the early bald spots may not be arrested, but may persist until all the scalp hair is sacrificed. It is thus seen that there are several ways in which the scalp may be largely or fully denuded.

In some of the more acute, diffuse cases of alopecia of the scalp, shedding of the eyebrows and eyelashes may also occur. This complication need not indicate a general disposition to shedding of the hair, because the innervation of the eyebrows is the same as that of part of the scalp. This is also true of cases in which the beard is involved. But there are cases of total loss of scalp hair in which the face is unaffected. In true alopecia universalis the axillary, pubic, and all the scattered hairs over the surface may be shed. One of the most characteristic features of alopecia areata in general is the well-marked tendency of the hair to grow in again at some more or less remote period.

The eyebrows and beard are sometimes involved without the scalp, and in the former, by reason of their limited area, the different varieties of shedding may all be studied. In some cases the hair is simply thinned out, without formation of spots. In others a spot forms and the rest of the eyebrow remains intact; or the spot may spread until the brows are denuded. There may be an irregular combination of small irregular spots and thinning which causes an eroded or moth-eaten look. Finally, the hairs may be shed suddenly en masse. There is no doubt that all these modes of shedding occur in the scalp and elsewhere. Therefore the initial bald spots are not necessary steps in the development of the disease but only the commonest step.

When patients with alopecia areata present themselves late in the evolution of the disease decided attempts at regeneration of the hair may be noticeable. An old, self-limited patch may be the seat of a downy growth, or pigmented bristle-like hairs may be sparsely pres-

ent. In certain cases opportunity is afforded to see the shedding of this second growth.

A pertinent question refers to whether or not cases of apparent parasitic or internal origin exhibit any differences in symptomatology. This question does not seem to be answered fully by authors and but little data are available for this purpose.

*Etiology*

The association of certain cases of alopecia areata with psychic and nervous factors is unquestionable and a long series of examples is given by all systematic writers. It is to be feared, however, that if all such cases could be added together they would make only a small fraction of the total material. There is also much variation among these psychoneurotic factors. Some are examples of psychic shock, and it is not a simple matter to connect this factor with the innervation of special areas of the scalp. In physical injury the psychic element is doubtless paramount, but there are not a few cases which have followed various injuries of the scalp itself. In a few instances alopecia areata has been seen as a familial disease, which almost amounts to a demonstration of some sort of transmissible inferiority or biological anomaly. The best-marked examples of a neurotic factor are those in which a direct or reflex disturbance of innervation may be inferred. Eye strain and dental lesions, particularly the former, may be mentioned here as possible causes. On the other hand, anomalies of the hair, eyes and teeth may be associated together on developmental grounds. In certain cases, however, the crucial test of treatment seems to point to the presence of a neurotic factor.

At the other end of the etiologic scale may be mentioned the parasitic element. In a relatively small percentage of cases this seems to be undoubted or probable. The few accounts on record of epidermic incidence point in the same direction. The dilemma which confronts us is whether to assume that all cases are parasitic, on the one hand, or to attempt to isolate a special contagious form of disease. Of the two the latter seems to be the safer course. For the past seventy years, or almost as far back as clinical microscopy extends, authorities have claimed the discovery of the parasite of alopecia areata. At present it is evident that no one microorganism can be accused. There is much evidence in favor of any one of three or four kinds, including bacilli, cocci and fungi, the latter indistinguishable from the ringworm fungi. Several observers assert that a slight inflammation of the corium is always at the bottom of alopecia areata; in common with other obscure affections, the latter has been

attributed to a periarteritis or thrombosis of the nutrient blood-vessels.

*Diagnosis*

Alopecia areata has to be distinguished from all other forms of baldness in spots and in fact baldness of any sort. Ordinary baldness begins as a bare spot on the crown and a localized loss of hair on the temples high up. Some of the symptoms are much the same, for example, shedding of hair on the pillow, etc. The only lesion of an alopecia areata may chance to be on the crown. Both forms are under general and nervous influence to some extent, and in both there may be attempts at regeneration, although in ordinary premature baldness these are practically never successful. In ordinary premature baldness we may isolate certain types which have nothing in common with alopecia areata, but there is a residue of cases in which this separation is not so easily effected. Much that would be termed alopecia areata represents a gradual thinning or a copious irregular shedding, and some cases show no tendency to regeneration; so that we are forced to ask if premature baldness may not begin at times as alopecia areata. In syphilitic alopecia the bald spots are smaller than those of alopecia areata, and other symptoms of syphilis are generally present.

There remain for consideration only the bald spots due to known parasites—the tricophyton. This may sometimes denude the scalp cleanly of hair. In such cases hairs at the margin of the bald spots should come away readily and show the presence of parasites. Secondary baldness from destructive lesions and wounds should be readily recognized, for the follicles have been obliterated.

*Prognosis*

There is quite a pronounced tendency to spontaneous regeneration, especially below a certain age limit, which is placed at about forty years. This is offset, however, at times, by the inferior character of the second growth, which may also fall out anew. In cases of prompt, complete regeneration, we are once more reminded of a physiologic shedding of the hair, or rather of an occurrence in brief time of a process which goes on normally more or less imperceptibly. On the other hand, ordinary premature baldness may perhaps appear as alopecia areata, and in such cases no regeneration is to be expected. Prognosis should be guarded, but encouraging the patient will lead him to take pains with the treatment, and the prognosis with good treatment is naturally much improved. Extensive, rapid, generalized alopecia, especially after the age of forty, gives a bad

prognosis. Patency of follicles and presence of downy hairs are of good prognostic significance. Blistering a small area in a bare spot will sometimes cause the sprouting of a tuft of good hair. This test is usually a good prognostic, although it cannot be relied on implicitly.

*Treatment*

As in any affection with an inherent tendency to self-limitation and regeneration, numerous plans of management and individual remedies have gained an ill-merited reputation for curative properties. If the hair is still being shed it is well to use constitutional measures, tonics and nerve stimuli. Arsenic, phosphorus, nux vomica, iron, pilocarpin, etc., one or several, may be pushed and the various electric currents may be employed. On the same general principle errors of refraction should be corrected with proper glasses, carious teeth be filled, etc. On the supposition that a parasite is involved, the patient must be protected from auto- and heteroinfection. The scalp should be washed frequently with parasiticides, and the patient should use only his own set of combs and brushes, which should be kept clean.

The actual direct treatment consists of stimulating the scalp to secure a new growth of hair. The stimulating remedies may also figure as parasiticides, so that the double indication may be filled with a single prescription, one, for example, containing sulphur and Betanaphthol. This plan is for the entire scalp, but for the individual bald spots, especially when the latter are of some age, intensive local treatment is indicated. This also applies when a large area of denuded scalp or the entire scalp is involved.

While applications of every grade of severity, short, of course, of destroying the follicles, have been employed for this purpose, it is doubtless best to apply at the outset one of the stronger remedies—chrysarobin in full strength, pure carbolic acid, tinct. cantharides, tinct. capsicum, corrosive sublimate, oil of turpentine, etc. The desired effect is vesication. Cantharidal collodion, equal parts tinct. cantharides and glycerine, pure carbolic acid, pure lactic acid are efficacious. One good application should be sufficient. A period of about two weeks is required for the sprouting of new hairs. Excellent opportunities are offered for control studies, as several vesicants may be tested simultaneously. The local treatment of alopecia areata is resolved practically to using a succession of the most efficacious vesicants, going from one region of the scalp to another.

Fig. 102. Half-tone, Dr. Kingsbury, of New York.

# Alopecia Congenita

Synonyms: Alopecia adnata, Hypotrichosis, Universal congenital atrichia

*Plate* **65,** Fig. 103

Congenital alopecia, a very rare condition, is characterized by a partial or total absence of hair at birth, or a short time thereafter. It is occasionally accompanied by defective development of the teeth and nails. The hair loss may be patchy in character, or the hair growth scanty and marked by the appearance of lanugo hairs or down. The eyebrows, and later in life the axillæ or pubes, may, or may not, be affected. Many individual cases of so-called hypotrichosis are seen at a very late period, and it is then not always possible to exclude an early infection of the scalp, with secondary hair loss. Occasionally nail dystrophy is the most important feature, the hair being involved to a less extent. Defective development of the teeth may exist in all gradations, from a few misshapen and irregular teeth, to total edentation. Other abnormal conditions, sometimes associated with hypotrichosis, are diminished or abolished secretion of tears and sweat.

*Etiology*

The condition is due to a congenital anomaly in the development of the hair pouch from the epiblast, and heredity is the most important factor in its causation. The disease has frequently been traced through several generations in the same family. *Nicolle* and *Halipre* knew of no less than thirty-six cases of hair and nail dystrophy in six generations. In the three cases illustrated (Fig. 103), the maternal grandfather had the same disease. The father of the maternal grandfather was said to have been bald all of his life and two of his brothers were also absolutely devoid of hair.

*Diagnosis*

Alopecia areata, which at times may resemble it, begins later in life, occurs in round or oval, well defined areas, which soon show

evidence of the return of hair. Even when complete, there is a history of its beginning in areas.

*Prognosis*

This is unfavorable in the great majority of instances.

*Treatment*

Any underlying constitutional disturbance should be corrected. The local treatment should be of a stimulating character.

Fig. 103. Half-tone, Dr. Kingsbury, of New York

# Vitiligo

Synonym: Leucoderma

*Plate* **66,** Fig. 104

This affection represents a disappearance of pigment in patches with a tendency to increase peripherally. Just external to the patch there is usually an increased deposit of pigment, so that the affection is rather a dyschromatosis than a mere atrophy. Vitiligo is neither to be confounded with congenital absence of pigment, nor with secondary loss of the same.

The disease tends to appear not only on exposed regions but also on the trunk. In the black race, the peripheral hyperpigmentation is seldom noticeable. The spots, rounded in contour, enlarge and coalesce. The skin is otherwise absolutely unchanged. The hairs—eyebrows, for example—usually turn white when involved in a patch, but in some cases remain unchanged. In certain cases a peculiar illusion is produced, as when the affection has extended over an entire area, save a few islets of normal skin. Here the white color may seem the normal shade, while the normal skin imposes itself as chloasma or some similar pigment anomaly. This illusion is not uncommon in a very chronic case of vitiligo on the backs of the hands, which is a favorite seat for the affection.

*Etiology*

The affection is evidently very deepseated. It is common in dark races, and may be inherited. Mixture of race may conduce to it, although some of its extreme manifestations occur in pure-blooded negroes. Psychic shock, nerve injuries and local irritation appear to have initiated the process in a few cases. It is claimed that the pigment is originally increased before it disappears. This would account for the outlying pigmented zone.

*Diagnosis*

The affections which might cause confusion have in part been mentioned. If there is any confusion with chloasma, or other dis-

Fig. 104. Vitiligo.

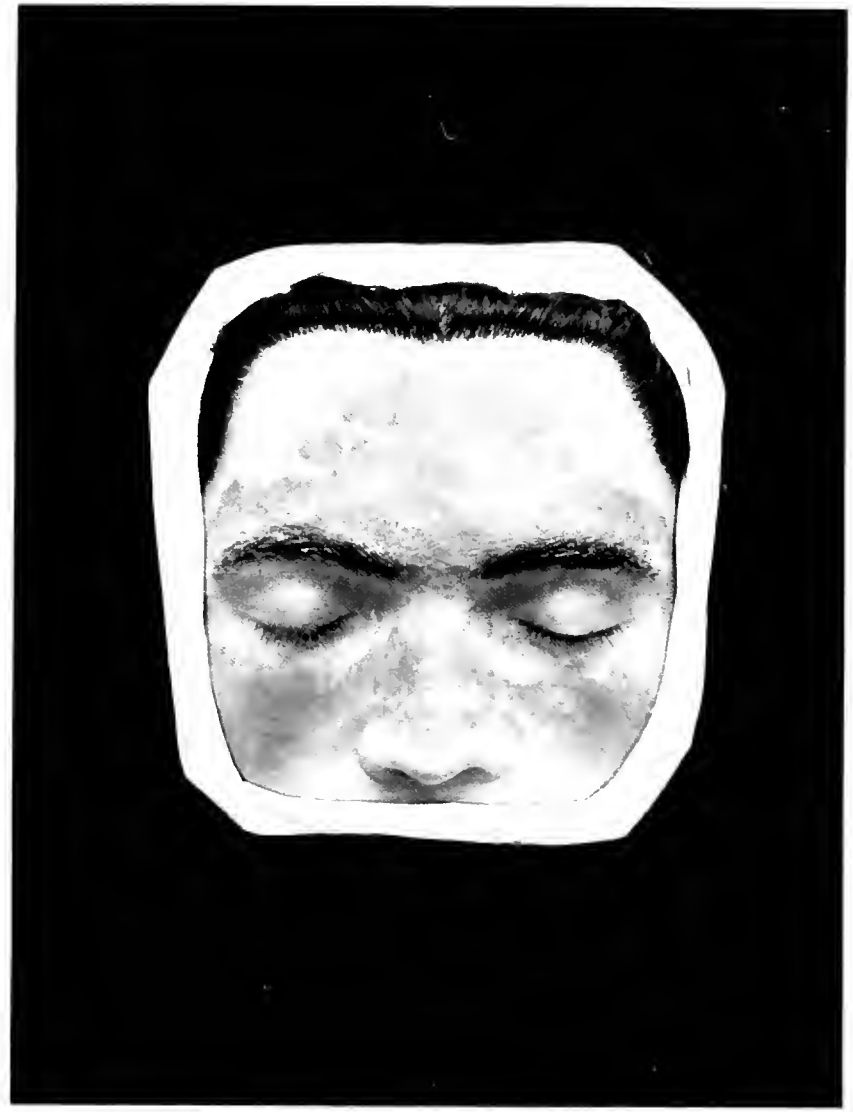


Fig. 105. Chloasma.

coloration, the presence of the scalloped convex border of vitiligo will usually dispel it. In leper countries, and especially among dark races, vitiligo is often confused with leprosy, especially so as non-pigmented patches often occur in anesthetic leprosy. Syphilitic leucoderma, so-called, occurs on the neck, and nearly always in women.

*Prognosis*

The affection, while progressive, seldom or never becomes universal. Not only is its march very slow, but it eventually ceases.

*Treatment*

Arsenic, nux vomica, phosphate of zinc and other nerve tonics are recommended on theoretical grounds. The only satisfactory local treatment consists of cosmetic measures designed to diminish the contrast between the patches and the normal skin.

Fig. 104. Model in Neisser's Clinic in Breslau (*Kroener*). On the abdomen there are two urticarial wheals.

# Chloasma

*Plate* **66,** Fig. 105

While this term is used somewhat as a synonym for hyperpigmentation in general, it is best restricted here, as it is in the clinic, to a single condition known as chloasma uterinum, this being a definite, common and well-characterized affection. In passing, it may be stated that hyperpigmentation is due both to external and internal causes. The former class include all darkening of the skin from exposure to the weather, and from chemical, thermal, and mechanical irritation. The latter, also termed symptomatic, include, besides chloasma uterinum, many forms of pigmentation from general diseases, especially *Addison's* disease, malaria, and cachexiæ in general, and from certain drugs, as arsenic.

Chloasma uterinum, so-called, is, as the name implies, peculiar to women, and especially to pregnant women. It is usually limited to the face, and much more pronounced in brunettes. Exceptionally it is seen on the trunk and limbs. On the face, the site of choice is the forehead, and in non-gravid women it is often limited to that region. It sometimes covers the entire face, as with a mask, and this is perhaps oftener seen in pregnancy, or at least the "mask of pregnancy" is a common expression. The lesions occur naturally in small irregular blotches, with a strong tendency to become confluent. The color varies from yellowish to deep brown, and in the less marked degrees is hardly distinguishable from freckles. The affection does not involve the epidermis, the skin being of normal texture.

*Etiology*

The appearance of chloasma in the gravid woman is usually connected with the deepening in color of the areolæ of the nipples and linea alba. From this viewpoint it should be almost physiologic. Others regard it as a mild manifestation of the toxemia of pregnancy. But since it often accompanies uterine and ovarian diseases in the non-gravid, it may also be called a reflex, although the rationale is

unknown. Finally, it occurs in women not known to have utero-ovarian disturbance, and is then attributed by the laity to biliousness. From the fact that it is peculiar to women, and women during the menstrual cycle, and that it appears in pregnancy to vanish after delivery, and also stands in a similar causal relation to utero-ovarian diseases, it evidently stands in intimate association with the reproductive cycle. In women the affection may exceptionally be almost universal.

*Diagnosis*

On its usual site, the face, chloasma could hardly be confounded with any other discoloration except chromidrosis. In other localities, unless also present on the face, diagnosis might prove very difficult. It might be necessary to exclude various other pigment anomalies and stains. For confusion with vitiligo, see account of the latter.

*Prognosis*

Although chloasma in the gravida disappears with the cause, this is not necessarily the case with chloasma in the non-gravid, although it is common enough, especially when the discoloration appears to stand in close relationship with some pelvic lesion. When no such relationship is in evidence there may be no tendency to disappear.

*Treatment*

The management comprises, first, attempts to remove the cause—for example, ovarian dysmenorrhea. The other resource, which is purely cosmetic, is removal of the discolored cuticle by vesicants. Not all the pigment may come away, but the balance will probably be absorbed. However, the trouble may readily recur. Of various preparations used as vesicants may be mentioned corrosive sublimate in 5% aqueous solutions, saturated solution of salicylic acid in alcohol, and salicylic acid collodion.

Fig. 105. Model in the Freiburg Clinic (*Johnsen*). Ninth month of pregnancy.

# Naevus Vascularis

Synonyms: Nævus sanguineus, Port-wine mark—Mother's mark

*Plate* **67,** Fig. 106

These differ radically from nævi verrucosi in being neoplastic, the latter ranking only as hypertrophies. Technically they are angiomata of various types with the exception of the telangiectases, which are usually held to be acquired as the result of long-continued congestion, active or passive. The number of clinical forms is very considerable. In some cases large nævi are present at birth upon the head or face, and on account of the disfigurement are often removed at a very tender age. They may grow rapidly and become pulsatile. In certain instances they disappear of themselves. There is some danger of injury, hemorrhage, infection and sloughing, also of certain regressive changes. The second familiar type is the port-wine mark, a flat formation having a red or livid hue. These birth marks differ greatly in size and shape and coloration, hence their supposed resemblance to strawberries and other objects and their supposed dependence on maternal impressions.

*Etiology*

Beyond the possibility that these formations have an embryonic origin, but little is known of their intimate nature. An alternate view is the dependence on amniotic adhesions.

*Diagnosis*

These neoplasms should be readily recognized.

*Prognosis*

If the tumor is growing rapidly or is pulsating, the possible outcome has already been alluded to. The mother's mark form does not undergo any changes.

*Treatment*

Small angiomata may be destroyed by carbonic acid snow, radium electrolysis or chemical caustics. Large growths are usually treated

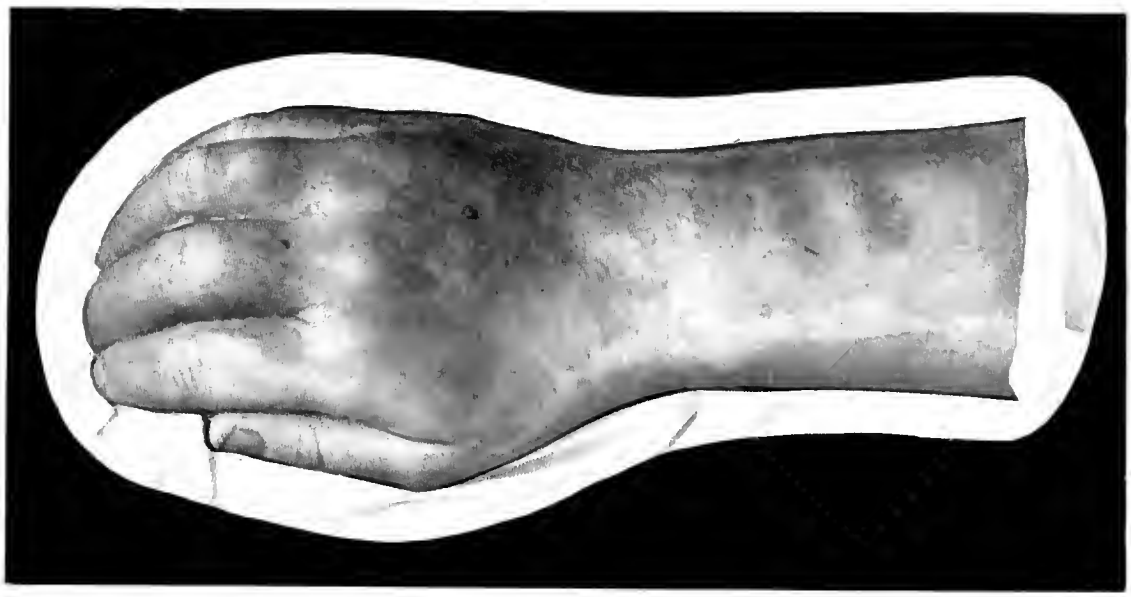


Fig. 106. Naevus vascularis.

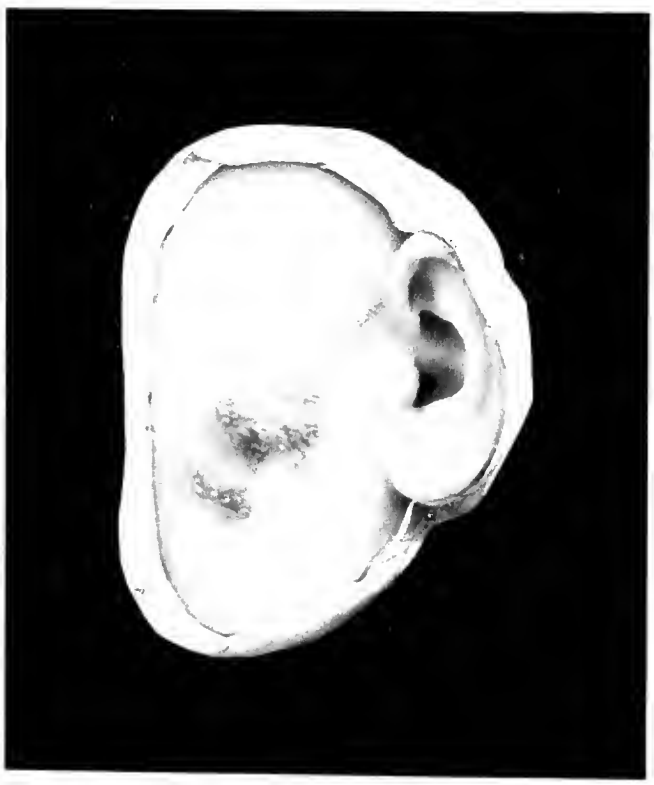


Fig. 107. Naevus linearis.

by operating surgeons. Port-wine marks are usually treated with electrolysis, but this does not cause the total obliteration of the mark, the latter only paling somewhat. Good results are sometimes obtained by the use of carbonic acid snow.

Fig. 106. Model in Freiburg Clinic (*Johnsen*). A girl, seventeen years of age, with an enormous *nævus flammeus* covering nearly the entire half of the body, and leaving but little healthy skin.

# Naevus Linearis

*Plate* **67,** Fig. 107

While this type does not differ much in structure from nævus verrucosus, there is often a special development of the horny layer. In other cases the warts of which it consists have a discrete papillary formation which closely simulates an eruptive affection. The chief characteristic of the linear nævus is the close agreement of its area of distribution with that of the cranial or spinal nerve for the area. This causes them to assume a linear or rather band-like outline upon one half of the body. The nature of this localization is by no means apparent. A neurogenous theory is not necessary, for it may be shown equally that the nævi follow the metameric segments, embryonic sutures, lines of skin cleavage, etc. In other words, the mischief has evidently been done before the nerves have been differentiated. As a rule these formations are extensive, occupying half the face, or neck, etc.

*Treatment*

Chemical caustics are often employed for the removal of the growths, but better results may be obtained by the use of the sharp curette.

Fig. 107. Model in Neisser's Clinic in Breslau (*Kroener*).

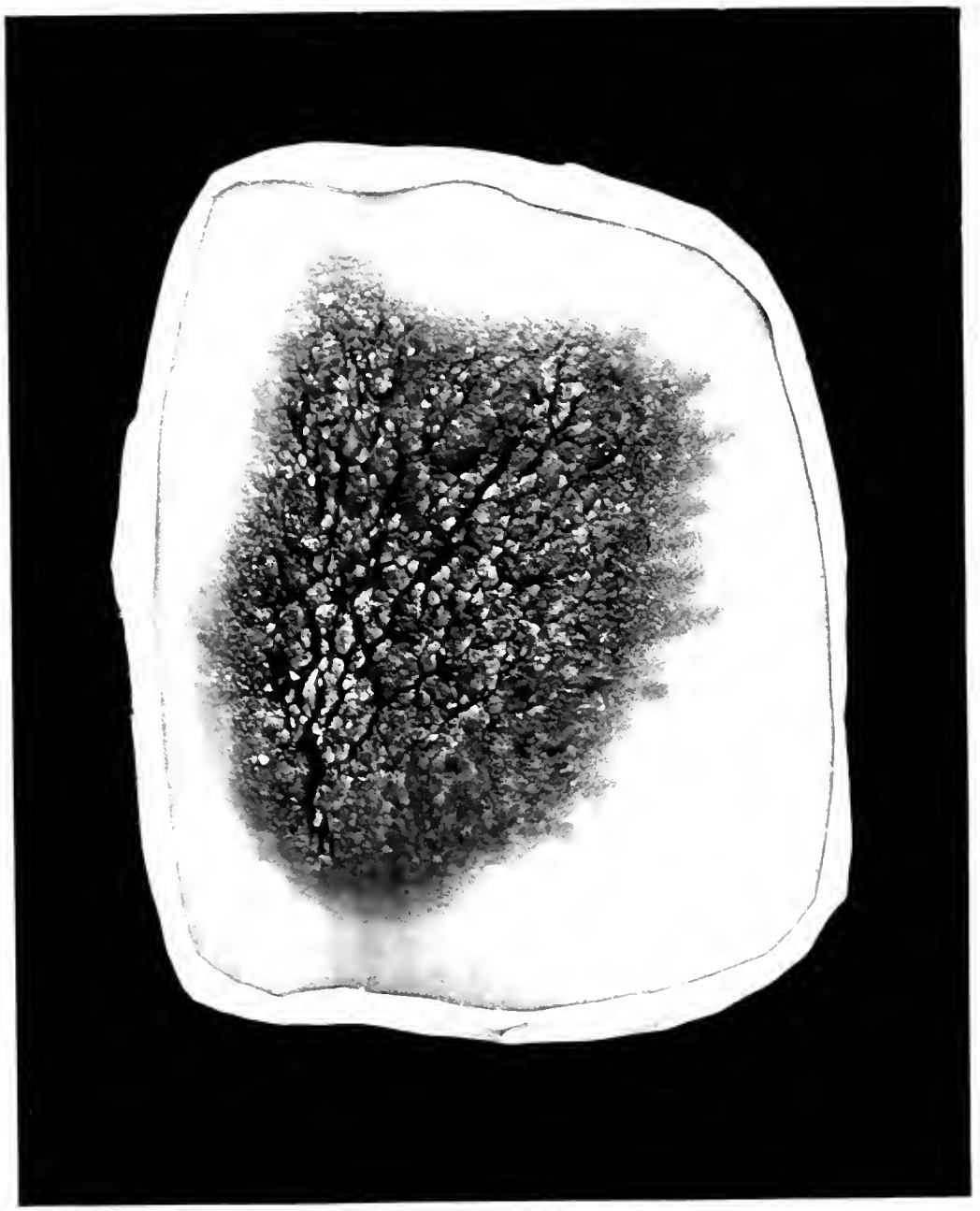


Fig. 108. Naevus papillaris pigmentosus.

# Naevus Papillaris Pigmentosus

*Plate* **68,** Fig. 108; *Plate* **69,** Fig. 109

Most writers make a special group-affection known as nævus pigmentosus, which they subdivide into flat, hairy and warty types. The two first-mentioned appear to represent abortive forms in which the new formation is limited chiefly to the pigment cells and hairs. The resulting hypertrophy is simply a flat, smooth pigmented disk of variable size, with or without the presence of a certain number of bristle-like hairs. In the verrucous form, on the other hand, the entire thickness of the skin may be involved in the hypertrophy, especially the papillary layer of the corium. The pigment cells and hair usually participate, so that a large or small, warty, uneven patch is formed, almost always pigmented and piliferous. If the connective tissue participates the growth usually contains much fatty tissue, and may hang loose upon the skin. The favorite localities for all these overgrowths are the head and face, neck and upper part of the trunk. As a rule the particular area involved appears to possess no special significance, although an exception must be made of the linear, unilateral type. Aside from this type the formations may vary greatly in size, shape and number, and no laws can be laid down for their distribution. They may be of the finest size or may occupy the entire shoulder area.

*Etiology*

As a rule they are spoken of as congenital, although not necessarily actually present at birth. There can be but little doubt as to their embryonic origin.

*Diagnosis*

These overgrowths are absolutely typical and can never be confused with any other condition.

*Prognosis*

They attain a certain growth and have no tendency whatever to disappear. In rare cases they form the starting point for malignant melanotic tumors (Fig. 109).

*Treatment*

Wide excision is the most satisfactory treatment, as the possibility of malignant degeneration is thereby discounted. This, however, is often impracticable, for several reasons. Small moles may be removed by caustics or electrolysis, the latter also being indicated to destroy the growth of hair. For extensive formations, it may be necessary to proceed piecemeal, levelling the surface with curved scissors, and cauterizing the exposed surface.

Fig. 108. Model in Neisser's Clinic in Breslau (*Kroener*).

Fig. 109. Model in v. Bergmann's Clinic in Berlin (*Kolbow*).

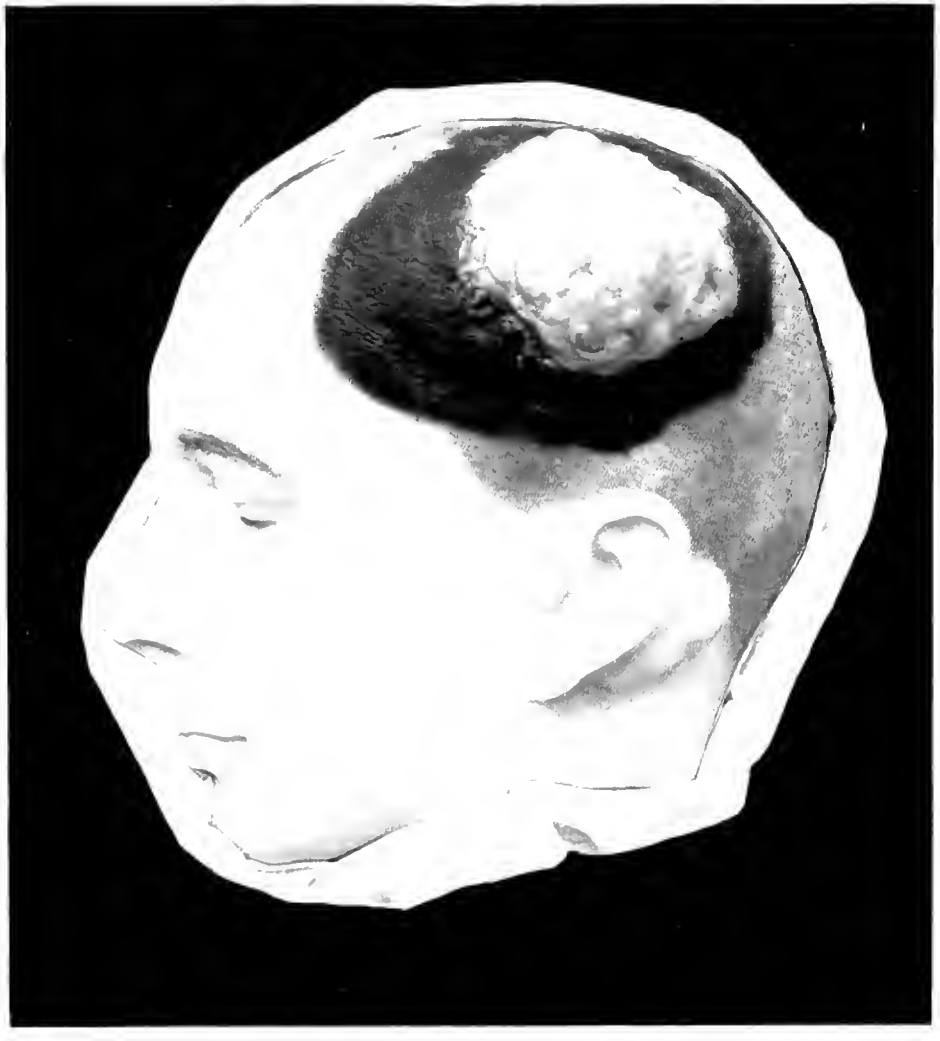


Fig. 109. Naevus pigmentosus (sarcoma).

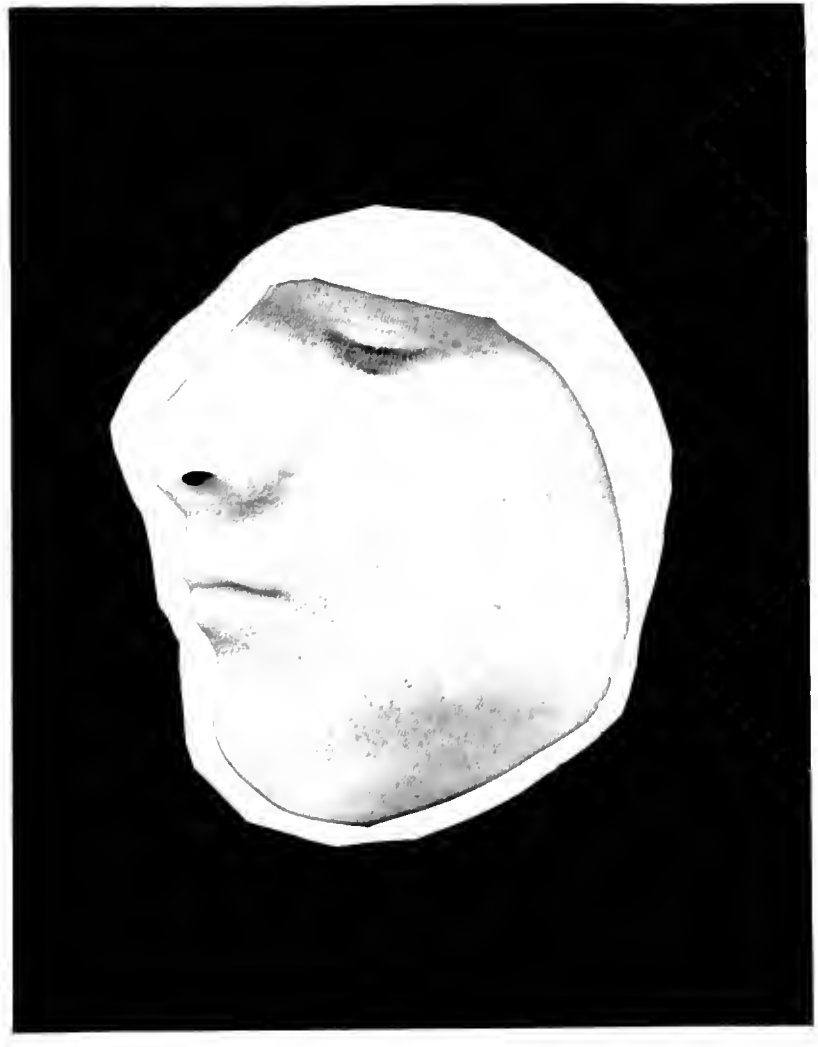


Fig. 110. Adenoma sebaceum.

# Adenoma Sebaceum

*Plate* **69,** Fig. 110

This rare affection is classed with new growths to-day, although at one time it was placed among the nævi, of which it was supposed to represent a papulovascular type. It develops from the sebaceous glands of the face, its highest development occurring at the sides of the nose. The new growths, varying in size from a pinhead to a small pea, are very numerous and closely aggregated. They are either devoid of special color or are red or brown in hue, these shades depending on a vascular or pigment component. They are congenital, although not necessarily visible at birth. Like all congenital hypertrophies or neoplasms, their appearance may be delayed for years. They may be associated with other malformations and the patients are generally of a low grade of mental development.

*Diagnosis*

These lesions may simulate a number of affections, especially of the sebaceous glands—acne rosacea, multiple benign cystic, epithelioma, molloscum contagiosum, and colloid milium. It should, however, be possible to exclude all of these without much difficulty.

*Treatment*

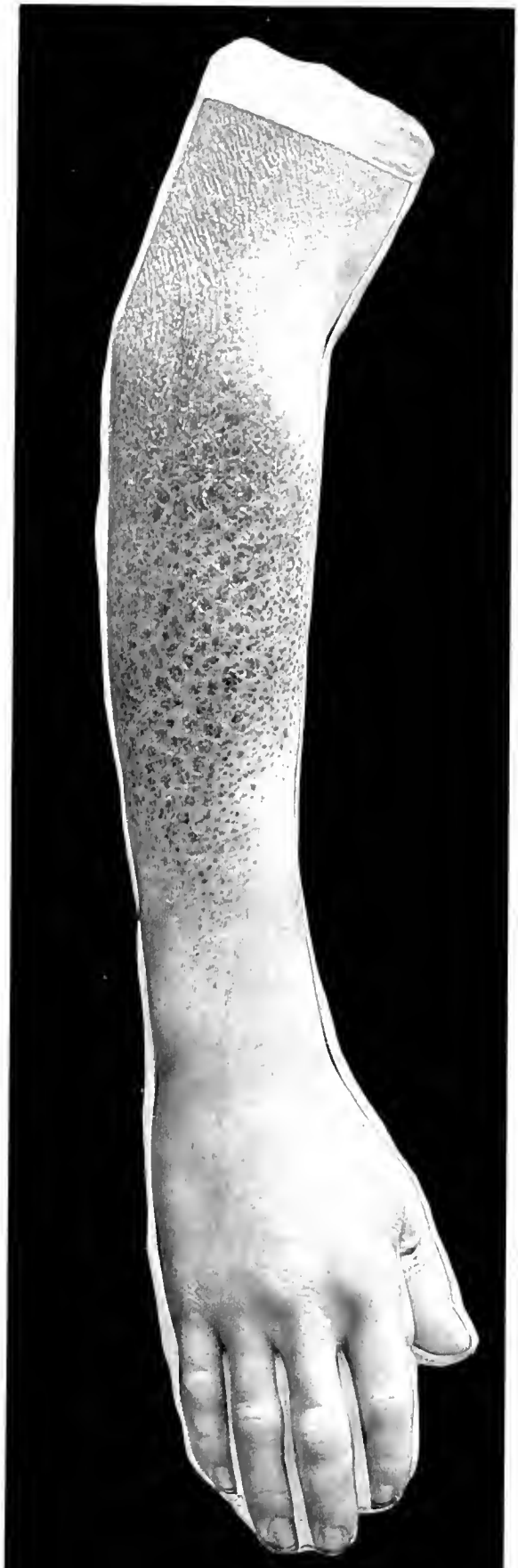
This affection is well adapted to electrolysis. Another resource is the production of exfoliation by any vesicating application.

Fig. 110. Model in Neisser's Clinic in Breslau (*Kroener*).

# Ichthyosis Simplex

*Plate* **70,** Fig. 111

Essentially a hypertrophy of the horny layer of the epidermis, this condition also represents a defect because of the abolition of the cutaneous secretions. It is not certain whether the latter is due to pressure atrophy or whether both atrophic and hypertrophic features belong to a single dystrophic condition. Ichthyosis simplex may be present in varying degrees, and the overproduction and character of the scales often suggest the skin of a fish or reptile. The symptomatology, therefore, varies with the case, to such a degree that different cases may resemble one another but slightly or not at all. In the very mildest form the skin feels and appears dry and does not perspire. The hair-follicles may form small firm papules on the upper arms, thighs, etc., giving the appearance of permanent goose-skin. Such integument has been likened to a nutmeg grater. The condition is similar to that seen in lichen pilaris, an affection which can exist without ichthyosis. This degree of the disease is characterized by slight desquamation. A prominent feature is that it is not much in evidence in warm weather, but returns again with the approach of winter. Hence remedies may be believed to have cured cases which improved spontaneously. When skins of this sort are treated with inunctions of oily matter, they may appear natural for the time. In these mild cases the regions of preference are the extensor surfaces of the extremities, but unnatural dryness may be made out on the back and elsewhere. In cases of higher degree a tilelike arrangement may be noted, corresponding in part to the natural folds of the thickened skin. However, there is also a cleavage in the opposite direction, so that the skin is mapped out into polyhedral areas, suggesting strongly a retrogression to the fishes and reptiles. In the highest degrees of hypertrophy of the scales, there is some tendency to the formation of fissures, while the low vitality appears to predispose to other affections.



*Etiology*

Ichthyosis is eminently a congenital affection, as shown by occasional familial incidence, and doubtless originates at an early period of intrauterine life.

*Diagnosis*

Well-developed ichthyosis simplex is unmistakable. But mild degrees are readily confounded with other kinds of dry skin, inherited or acquired. The history of ichthyosis, when one is obtainable, will be sufficient—appearance in early childhood, improvement in warm weather, etc.

*Prognosis*

As a deformity, ichthyosis may exceptionally in mild forms be outgrown. It may be kept down by treatment. Otherwise it is incurable.

*Treatment*

The skin must be kept soft, all accumulated scales to be first removed. Alkaline baths, soap and salicylic acid all conduce to the latter end. The best emollient is probably glycerole of starch, although lanolin should be valuable. Of specific remedies, sulphur and resorcin have been praised.

Fig. 111. Model in Freiburg Clinic (*Johnsen*). The transitions from the slightest grade of *Ichthyosis simplex* to the fully developed *Ichthyosis serpentina* are beautifully rendered in this picture.

# Ichthyosis Hystrix

*Plate* **71**, Fig. 112

This affection is regarded by some authorities as an advanced degree of ichthyosis simplex, but such a view seems hardly tenable, because of the localized character of the alterations, which often have a purely lineal grouping. However, the two forms are often seen side by side, and in some severe types of ichthyosis simplex a few of the lesions of hystrix appear here and there; while on the other hand this apparent unity of nature is shattered by cases in which the severest forms of hystrix appear on smooth, supple skin. In this type of cases we are reminded irresistibly of linear nævi of an unusually horny quality, and the histological examination shows practically no indifference between hystrix warts and ordinary acquired verrucæ vulgares.

Like ichthyosis simplex, hystrix occurs in various degrees, types, shades of color, etc. When the lesions are very acuminate, they suggest the spines of a porcupine; when flattened, they are likened to the bark of a tree, etc. Hystrix does not properly occur in large diffuse sheets, and if this alteration is present, as when an entire foot and ankle are involved, the condition is usually classed under the severest type of ichthyosis simplex. Linear hystrix shades imperceptibly into a group of affections in which hypertrophy of some of the cutaneous structures is often associated with the distribution of one or more spinal nerves.

*Etiology*

While clinically by no means the same condition, whatever has been said concerning the congenital nature and histology of ichthyosis simplex will apply in a measure to hystrix, although in the latter the structure of common warts is parallel, i.e., the rete is involved in proliferation as well as the horny layer, and tends to dip into the interpapillary spaces, while the papillæ show more or less hypertrophy.

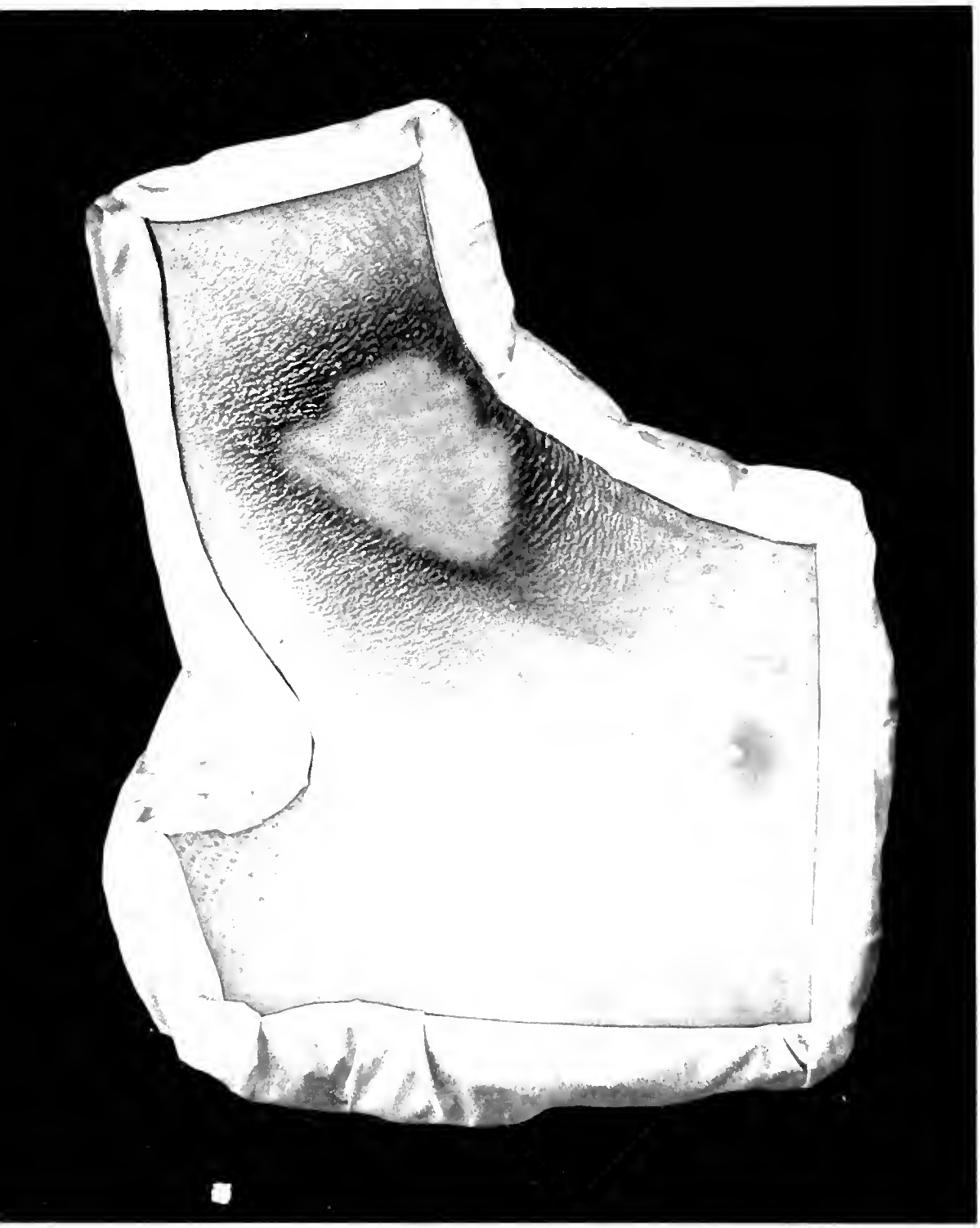


Fig. 112. Ichthyosis hystrix.

*Treatment*

This is summed up in a few words. The horny masses must be dissolved by strong alkaline solutions (liquor potassæ) or strong salicylic acid ointments. The hypertrophied papillæ must now be destroyed by curettage or caustics, and if the patient does not object to the scarring which in time follows this practice, the prognosis is notably better than in ichthyosis simplex.

Fig. 112. Model in Freiburg Clinic (*Vogelbacher*). Very pronounced case of *Ichthyosis hystrix*. Palms and soles are strongly involved.

# Ichthyosis Congenita

*Plate* **72,** Fig. 113

This affection is very rare, and not all cases so termed deserve this title, for they simply represent exfoliation of the skin of the newly born from other causes. That ichthyosis congenita is of little practical significance well appears from the fact that such children, often prematures, usually perish within a short time. The affection is one of fetal life, and at birth the integument is hopelessly involved and has even undergone marked retraction, so that ectropion occurs and the condition of the mouth makes nursing impossible. The thickened epidermis fissures in various directions and the peculiar appearance has caused the patient to be termed "harlequin fetus." The condition is not to be confused with one characterized by an unusual quantity of hardened vernix caseosa which cracks in a similar manner. The subjacent skin in this condition is normal, save that the fissures may sometimes involve it to some extent. However, unless promptly removed by inunctions, the deposit may lead to the death of the newly born by interference with nutrition and thermogenesis.

Fig. 113. Model in Neisser's Clinic in Breslau (*Kroener*).

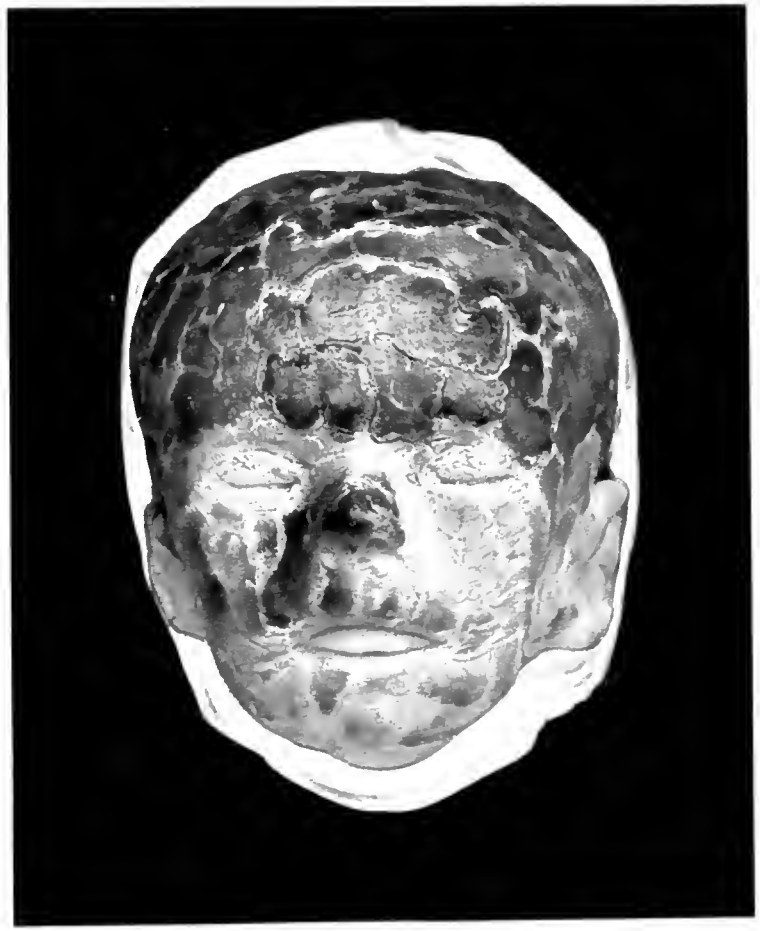


Fig. 113. Ichthyosis congenita.

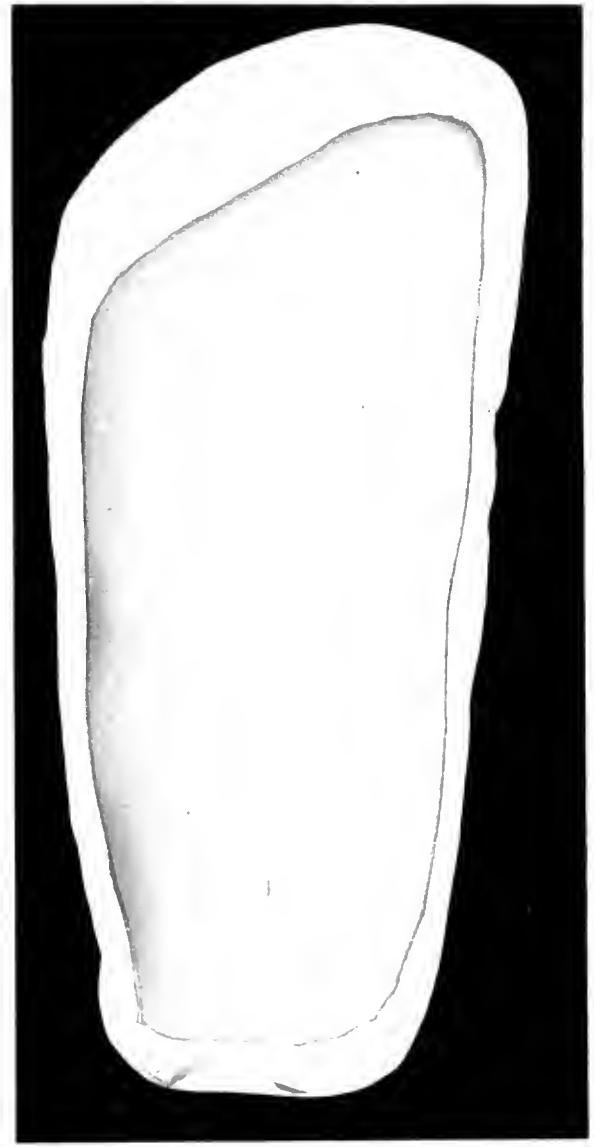


Fig. 114. Keratosis pilaris (Lichen pilaris).

# Keratosis Pilaris

Synonym: Lichen pilaris

*Plate* **72,** Fig. 114

This affection represents an hypertrophy of the corneous layer of the epidermis about the hair-follicles. The regions involved are confined largely to the backs of the arms and outer, posterior aspect of the thighs. The papules are skin-colored, reddish or darkish, and are often transfixed by a broken hair. They are closely studded together, but not grouped, suggesting the prominences on a nutmeg-grater.

Lichen pilaris is hardly a disease in the ordinary sense of the word, but a deformity. It may be confused with goose-skin, a transitory affection produced by muscular spasm, and patients may consult physicians for cosmetic reasons. In its mild forms it is by no means uncommon. Like ichthyosis, it begins to be conspicuous in cool weather, and is at its best in summer.

*Etiology*

It seems to be a feature of a preternaturally dry skin, such as is usually congenital, but may come about from actual disease or from too much use of soap and water.

*Diagnosis*

This is seldom difficult, although the affection has doubtless been confused with lichen scrofulosorum and pityriasis rubra pilaris.

*Prognosis*

This depends largely upon the attention given to treatment.

*Treatment*

Frequent bathing in warm water is indicated, and the use of green soap and a rough wash cloth generally removes the horny plugs. Anointing the skin with a bland oil or fat at the time of

bathing is useful. The following is an agreeable and effective ointment for this purpose:

℞ Acidi carbolici ..... ℈i
Boroglycerini ..... ʒii
Lanolini ..... ʒi
Ungt. aquæ rosæ ..... ʒiii
M. et ft. ungt.

Fig. 114. Model in Neisser's Clinic in Breslau (*Kroener*).

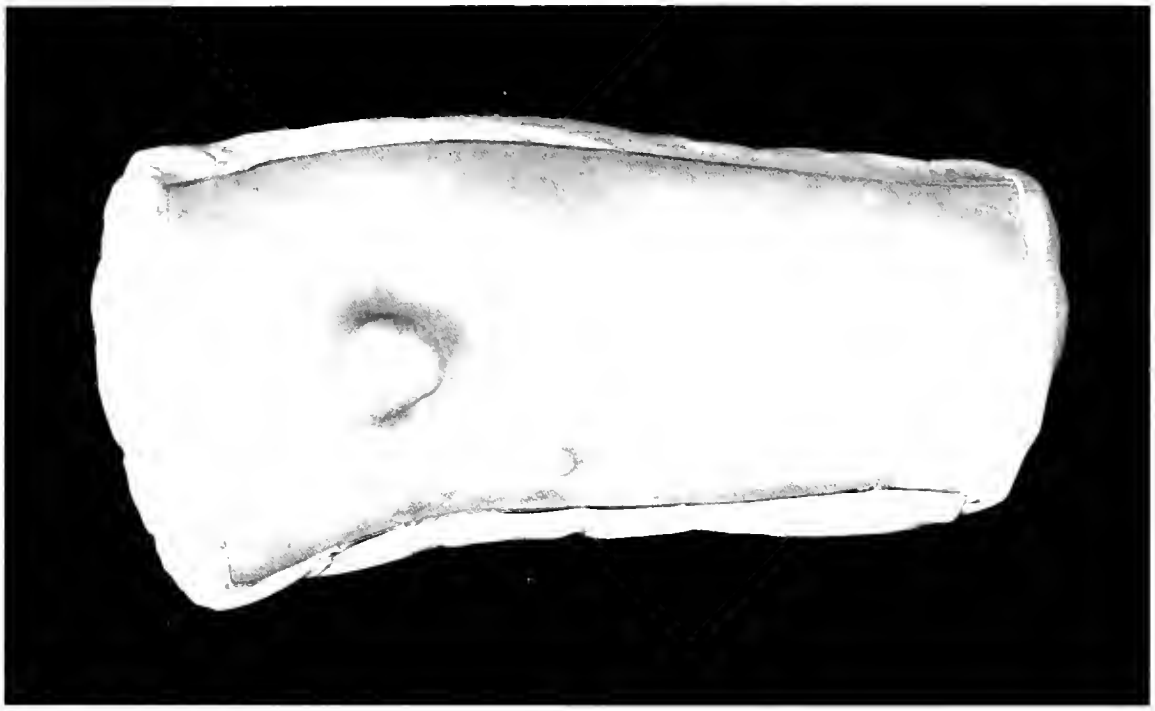


Fig. 116. Dermatomyoma multiplex.

Fig. 115. Fibroma molluscum.

# Fibroma Molluscum

Synonyms: Molluscum fibrosum, Molluscum pendulum

*Plate* **73,** Fig. 115

This term is applied alike to one or a few of the soft pedunculated tumors of the skin, to the massive lesions which form a clinical type of elephantiasis, and to a generalized fibromatosis in which the entire surface may be more or less thickly covered with tumors of various sizes. The growths have to attain a certain size before they can hang down, so that all below a certain size are sessile, and project but little beyond the surface. The pendulous property, however, is dependent on something besides the weight of the mass, for the size of the attachment is all important. The broader the latter the less the tendency to hang down. Conversely, a very minute tumor with a narrow insertion will hang down. In generalized fibromatosis nearly all of the tumors are sessile. There is both a tendency to grow and to be arrested, as shown by the great variation in size. The large elephantiastic tumors usually appear on the head or neck, otherwise the trunk is the favorite locality both when lesions are few and when they are numerous.

*Etiology*

This affection is to be regarded as a deformity rather than a disease. It may run in families, and its nearest congeners are other benign tumors, such as lipomata and neuromata. They do not destroy life, but may cause great discomfort and incapacity when very large or numerous.

*Treatment*

In certain cases arsenic appears to have some influence in decreasing the size of the tumors. The larger tumors should be removed by excision or ligature.

**Fig. 115.** Model in Lassar's Clinic in Berlin (*Kasten*).

# Dermatomyoma Multiplex

*Plate* **73,** Fig. 116

This is a rare affection, the diagnosis of which can only be established fully with the microscope. It is a multiple benign neoplasm, composed in part of smooth muscle fibres. A variable amount of fibrous tissue is associated, so that in certain cases fibromyoma is the proper designation. The tumors are seated for the most part on the limbs and may be discrete, but are usually grouped. Their color varies from that of the skin to pink, red and reddish-brown. They do not exceed the size of a pea, are firm, somewhat flattened, round or oval, and in some cases quite painful. Most subjects who present these lesions are adult females. The causes are entirely unknown, and the début is insidious. A probable diagnosis can be made from the color and the subjective sensations. These growths never become malignant, and never ulcerate or undergo any notable degree of degeneration. They sometimes disappear spontaneously.

In addition to the multiple form, solitary myomata also occur in the scrotum, vulva and nipples. These may attain a considerable size. The only treatment for dermatomyomata is excision.

**Fig. 116.** Model in collection of Prof. Touton in Wiesbaden.

Fig. 117. Verrucae vulgares.

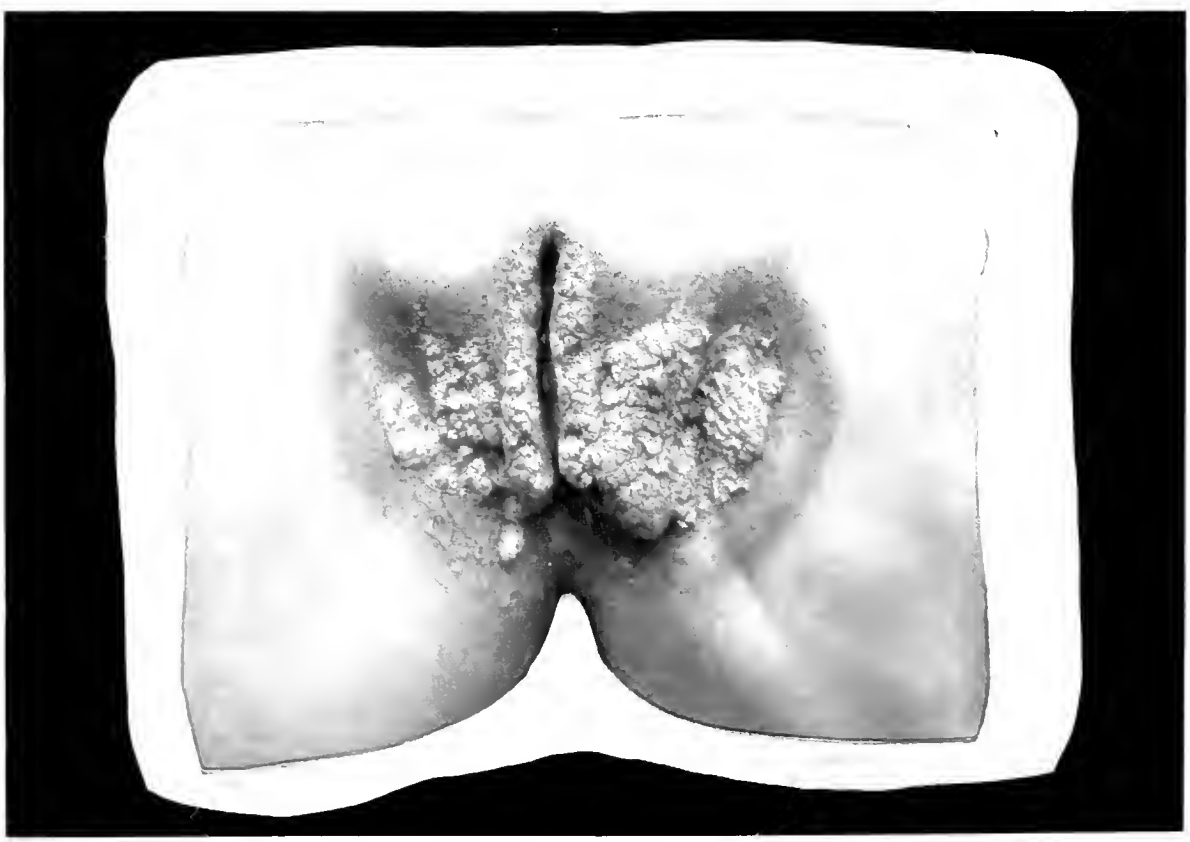


Fig. 118. Papillomata (condylomata acuminata).

# Verruca Vulgaris

Synonym: Common warts

*Plate* **74**, Fig. 117

These represent a circumscribed hypertrophy of the papillary and epidermic layers of the skin, and are invariably acquired, although similar to congenital warts in structure and appearance. They may be flat or pointed, have a wide sessile base or be filiform with narrow attachment. They occur by preference on the hands, but also are common on the soles of the feet, between the toes, etc. In these localities they are related to ordinary corns and callouses and have the same causation. These callous warts occur much more infrequently than corns and callouses. A third locality for warts to develop is the scalp, where they may be very numerous. Common warts of the hands sometimes appear to have a primary lesion or mother wart, from which others develop. They may be very numerous, and sometimes become aggregated to form a large mass.

*Etiology*

Warts on the hands, which constitute a well-marked clinical variety, are almost peculiar to the young, when they appear in crops. Isolated warts are seemingly of a different nature and may result from mechanical irritation at any period. Warts apparently arise from inoculation and autoinoculation. They may come and go rapidly, despite the fact that there is a much greater disposition to appear slowly and remain stationary. When warts are removed from one hand they sometimes disappear from the other. We know nothing as to the contagious element, but it should resemble that of molluscum contagiosum. A long incubation period is required, measured sometimes by weeks and even months. The microbic cause should operate by an ordinary irritation.

*Diagnosis*

Common warts can hardly be confounded with anything else; but since certain forms of irritation of the skin may cause a wartlike

growth, it may be well to bear this fact in mind, for different processes, even epithelioma, begin as ordinary warts, although late in life.

*Treatment*

A tendency to warts is believed by some to yield to a course of arsenic, others advise the administration of repeated doses of sulphate of magnesia.

Various forms of local treatment are recommended: surgery, electrolysis, caustics, and keratolytic applications. The high frequency spark is often effective but it is always exceedingly painful and on the whole the more primitive therapeutic measures are to be preferred. The application of a twenty per cent. salicylic acid plaster or of salicylic acid in collodion (3ss to 3ii) softens the horny part of the wart and greatly facilitates its removal with the sharp curette. Touching the base with the nitrate of silver stick will generally prevent recurrence. Nitric acid should not be used as it sometimes produces keloidal scars that are quite as disfiguring as the original lesions.

Fig. 117. Model in Neisser's Clinic in Breslau (*Kroener*).

# Papillomata

Synonym: Condylomata acuminata

*Plate* **74,** Fig. 118

These are the so-called venereal or gonorrheal warts which have no relationship with any other form. They are virtually peculiar to the mucous and cutaneous surfaces of the genitals of both sexes, but could doubtless occur in any locality under precisely the same conditions. Thus they have been seen on the thighs at considerable distance from the genitals, and even in the axillæ and navel. No precise causal agent has ever been isolated, least of all the gonococcus. Were the latter the cause it would not be easy to account for the high degree of immunity often seen. The contagious, autoinoculable nature of these warts may be seen in the evolution of the latter; as when, for example, they develop in the anus after the latter is exposed to the secretions of warts in the vulva. The warts may be dry or bathed in a contagious gonorrheal secretion.

They usually appear on the inner side of the prepuce and glans, as the characteristic thin, pointed coxcomb-like vegetations, and on the corresponding regions in the female. There may be only a few warts or they may be so numerous and confluent as to produce striking deformity. In the male we may see paraphimosis develop, while in women the entire vulva may be so covered with them as to occlude the vaginal entrance. One of my first obstetrical cases as a medical student occurred in a woman suffering from this condition to a marked degree and I still retain a vivid recollection of the very protracted second stage of that particular labor.

*Etiology*

It is unknown how far this affection has a special contagious principle and whether it passes directly from one sex to the other, or only through the medium of gonorrhea.

*Diagnosis*

The only affection with which these warts could be confounded is hypertrophic mucous patches. The term cauliflower excrescence has been applied to high degrees of each kind, but practically belongs to the former. The association of the two processes is perhaps responsible for this confusion.

*Treatment*

Mild cases usually subside rapidly under cleanliness and a strong astringent like glycerotannin. In higher degrees the warts are much firmer and more highly organized, so that surgical measures are usually required. One of the most common plans is excision with scissors followed by the application of the galvano-cautery to the base. Some authorities seem to regard this as unnecessary and prefer to use strong caustics like nitric acid, applied in serial sessions.

Fig. 118. Model in Freiburg Clinic (*Johnsen*). A servant girl, nineteen years of age. Gonorrhea not established.

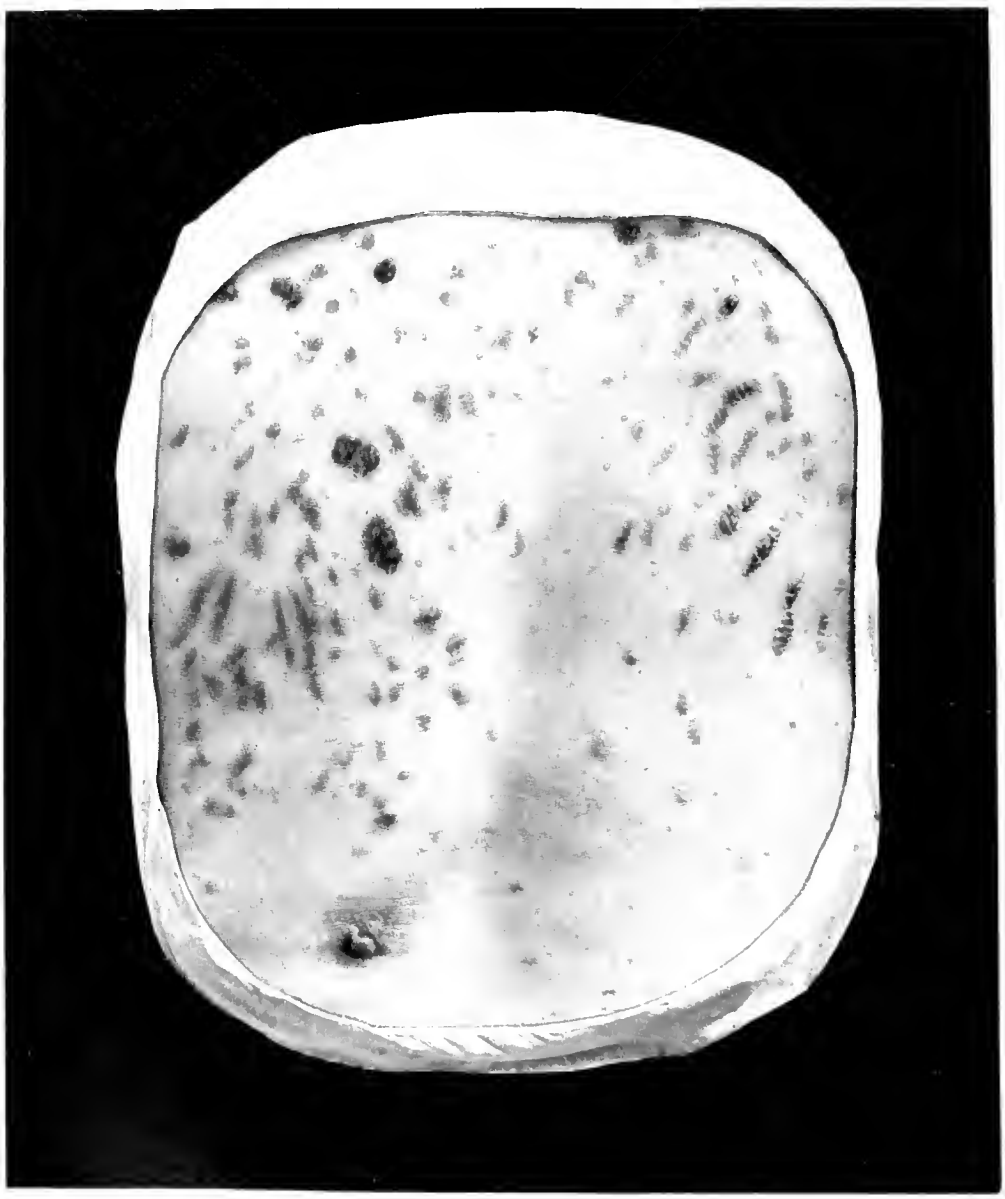


Fig. 119. Verrucae seniles (cavernomata senilia).

# Verruca Senilis

Synonym: Senile warts

*Plate* **75,** Fig. 119

The seborrheic warts which appear in the elderly are sometimes accompanied by another type of senile new-growth, the cavernomata. These are really small angiomata, the papular capillary varices of old people. Aside from their occurrence in late life, wherein they resemble telangiectases, they may be considered in the same class of growths as ordinary angiomata. These lesions, like the seborrheic warts, are most frequently situated on the chest, abdomen and back, often very abundantly about the shoulders. The latter lesions sometimes show a bandlike management (Fig. 119). They vary in size from a quarter of an inch to one inch in their long diameter. At first they are light brown in color, but later they become gray or brownish black. The surface is scaly and slightly granular.

*Diagnosis*

There should be no difficulty in recognizing either the verruca or the cavernomata.

*Prognosis*

The possibility of malignant degeneration should be borne in mind.

*Treatment*

As the verruca are quite superficial, the best results are obtained by the use of the sharp curette. The cavernomata should be excised or left entirely alone.

Fig. 119. Model in Neisser's Clinic in Breslau (*Kroener*). On the lower part of the back is a carcinomatous tumor in course of development.

# Keratosis Senilis

*Plate* **76,** Fig. 120

This condition is most commonly seen on the back and face in middle-aged and elderly subjects. In these they present different features from the flat warts in children, owing to their peculiar covering. The verrucous part is flat or slightly papillomatous, and covered by a dark sebaceous or horny crust. The lesions seem intermediate between warts and moles. In size they range from a split pea to that of a finger-nail, and may be single or multiple. In many cases they appear to represent the earliest stage of an epithelioma. If the crusts are detached they at once reform. The diagnosis should be easy, save for the question of a possible beginning epithelioma.

*Treatment*

These formations yield readily to the X-rays. It is better treatment, however, to curette or excise the growth.

Fig. 120. Model in Freiburg Clinic (*Vogelbacher*). On the upper lip and on the cheeks several incipient small epitheliomata, which yielded promptly to X-ray treatment.

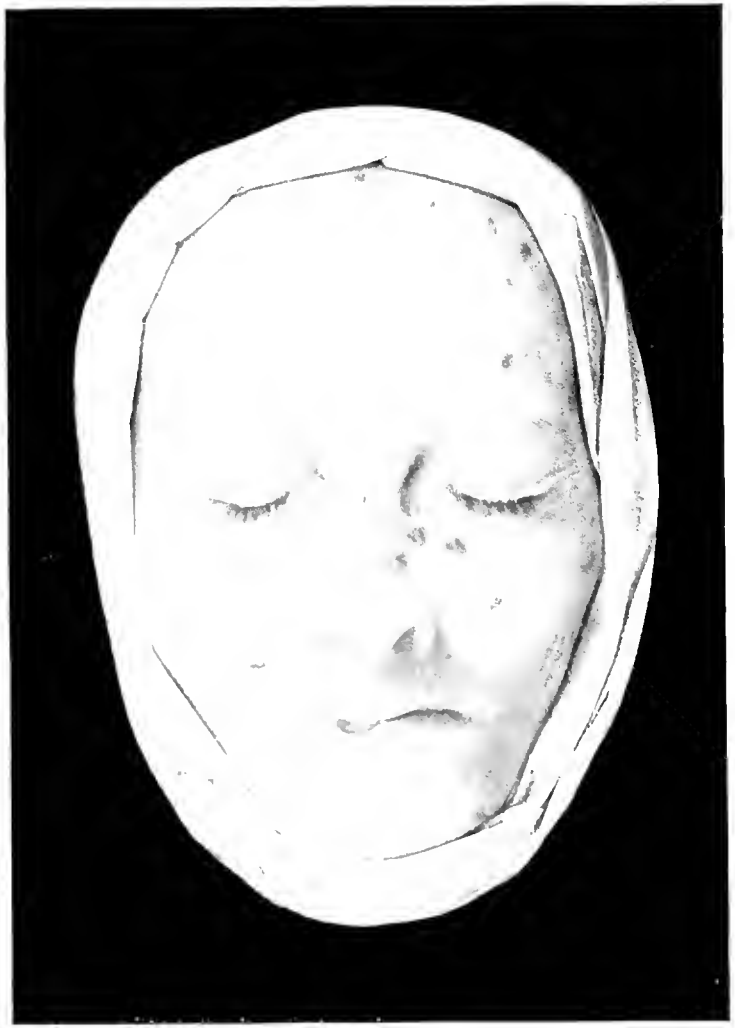


Fig. 120. Keratosis senilis.

Fig. 121. Xeroderma pigmentosum.

# Xeroderma Pigmentosum

*Plate* **76,** Fig. 121

This affection, first recognized and named by *Kaposi* (1870), is a very rare and eminently familial malady, which may be roughly characterized as a congenital defect of the skin that simulates the ordinary senile integument, and undergoes changes seen in the latter with a special tendency to malignant degeneration. An important question relates to the identity of the atrophic, hypertrophic and degenerative changes of this affection with the same lesions occurring under more familiar circumstances, and the consensus of opinion answers in the affirmative. In infancy and early childhood it is only noted that the patients have a thin, dry skin which freckles easily and is easily irritated. Macular atrophy and telangiectases develop later. In the course of years, perhaps much earlier, the freckles are seen to be undergoing changes into flat pigmented nævi and verrucæ. Retraction of the skin has been slowly taking place until ectropion develops with perhaps contraction about the nostrils and mouth. Eventually the nævi and warts become the seat of malignant degeneration. The ordinary freckle area is the one involved in this disease.

***Diagnosis***

This affection could not be mistaken for another save perhaps in its earliest stages.

***Prognosis***

The outlook is highly unfavorable. Exceptionally the period of malignant degeneration may be so deferred that the patient dies from some other disease but practically he is doomed to a lingering death by marasmus. The individual lesions do not menace life as is usually the case with epithelioma.

***Treatment***

This is entirely expectant and symptomatic.

**Fig. 121.** Model in St. Louis Hospital in Paris, No. 1464 (*Baretta*). Quinquaud's case.

# Keratosis Follicularis

Synonyms: Darier's disease, Psorospermosis

*Plate* **78**, Fig. 122

This rare affection, first recognized by *Darier* in 1889, belongs among the hypertrophies of the corneous layer and in its inception bears some resemblance to the lesions of lichen pilaris. As the papules increase in size they are seen to contain a sort of sebaceous core. At the outset they are discrete, but later they tend to form patches composed of individual lesions which never exceed a large pinhead in size. Beginning as a rule on the face and head or less commonly on the hands, they develop very slowly, the lesions becoming thicker and more confluent, while new localities are successively attacked. Preferential regions are the sternum, loins and genitocrural folds. Lesions may also occur on the extremities. With age the sebaceous plugs may become horny. In some cases the accumulations distend the follicles; and the resulting cavities may become transformed to secreting ulcers.

*Etiology*

*Darier* believed it to be of parasitic origin, but this view has been rendered untenable. The affection is decidedly familial, although not to the extent that some are, for the majority of cases are of solitary incidence. It is not manifest at the early age of most of these presumably congenital affections, for in most cases it developed in adolescence. Still a few began in infancy. Histologic studies appear to show that we have to deal with errors in keratinization—a parakeratosis. This error is probably a deep-seated one, dating back to the developmental period, but perhaps not manifested ordinarily until the later development of the pilosebaceous system. The affection remains throughout a very superficial one, the corium suffering no notable changes.

*Diagnosis*

So few cases are known that not much can be said in regard to possibilities of diagnostic confusion. In theory the latter might

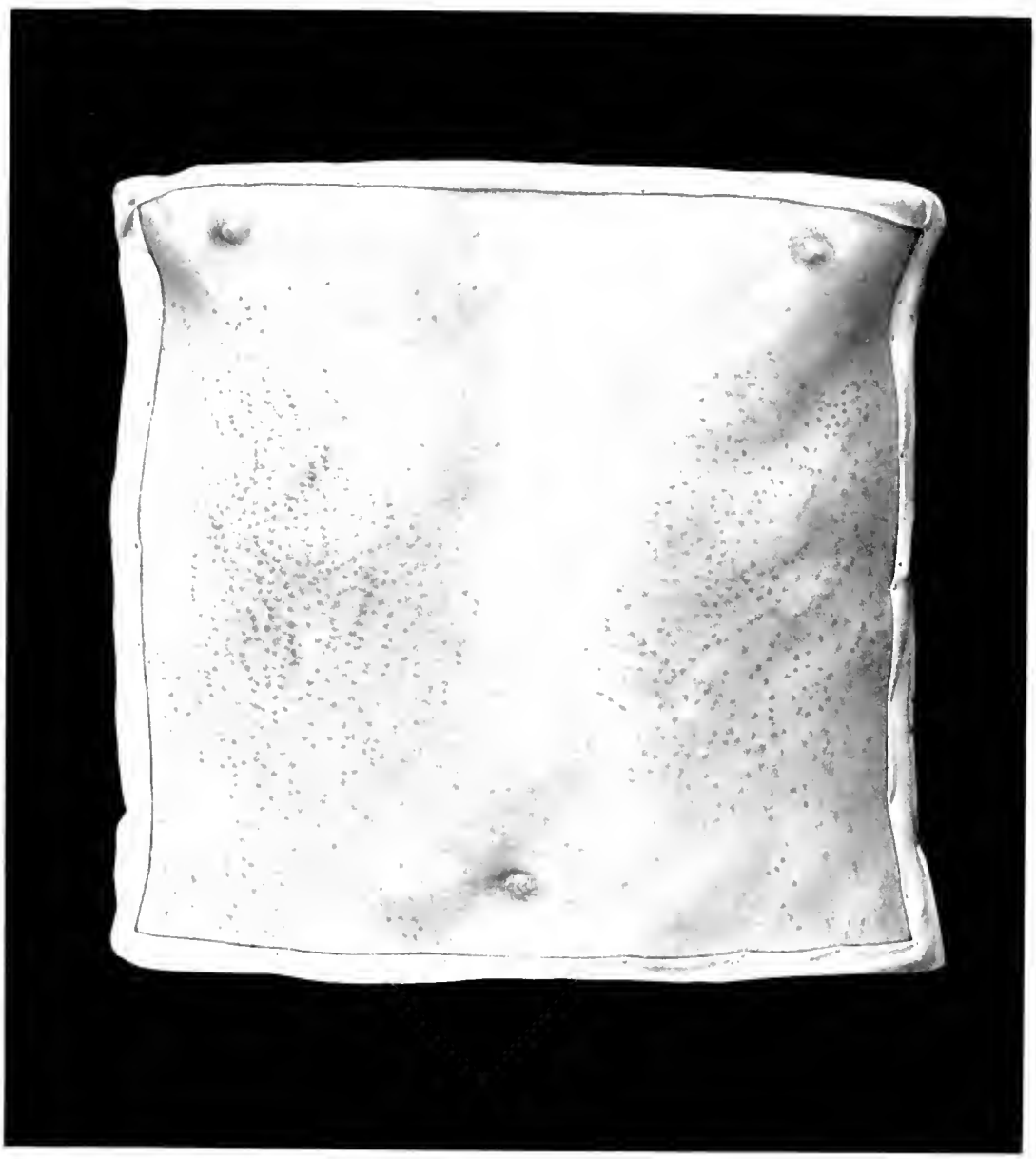


Fig. 122. Keratosis follicularis.

arise in reference to other forms of lichen before the disease had fully developed, especially lichen pilaris. Again it possesses some resemblance to molluscum contagiosum in that both affections have a central, removable core. In fact, *Darier* believed the two to be related.

*Prognosis*

There appears to be no tendencies to self-limitation or to spontaneous recovery. Tendency to degenerative change may exist, as shown by the development of epithelioma in one case, but this was perhaps a mere coincidence. The general health does not become impaired.

*Treatment*

The disease cannot be cured, for it is too deep-seated; but it can be benefited notably and by reason of its disagreeable character and the disfigurement it requires vigorous management merely from the cosmetic viewpoint. The management is similar to that of ichthyosis, the concrements being cleared off with weak caustic alkalies and salicylic acid applications. The X-rays may produce benefit and there is some room for minor surgery in destroying the follicles.

Fig. 122. Model in Freiburg Clinic (*Johnsen*).

# Elephantiasis Penis et Scroti

*Plate* **78,** Fig. 123

The prepuce is highly disposed to edema, so that frequently recurring inflammation appears to close up the lymphatics and cause a stationary edema, which in the course of time results in a thickening of the skin and subcutaneous tissues. The constructive nature of this process is apparent from the fact that in extreme cases all subjacent tissues participate. In such cases the integument may appear smooth and intact or be the seat of ulcers and papillary outgrowth.

It is common to consider this condition along with elephantiasis of the face, limbs, etc. In other words, there is often a single process underlying all these forms. While in temperate zones we cannot lay bare any single factor, in elephantiasis in the tropics we find a special cause in the filaria sanguinis which is able unaided to cause elephantiasis of the penis and scrotum.

*Diagnosis*

The diagnosis of the condition presents no difficulties.

*Prognosis*

This varies according to the cause.

*Treatment*

When produced by the filaria sanguinis the treatment is naturally for that condition. In chronic cases satisfactory results sometimes follow ablation of the hypertrophied tissue.

Fig. 123. Model in Cochin Hospital in Paris (*Jumelin*). Mauriac's case.

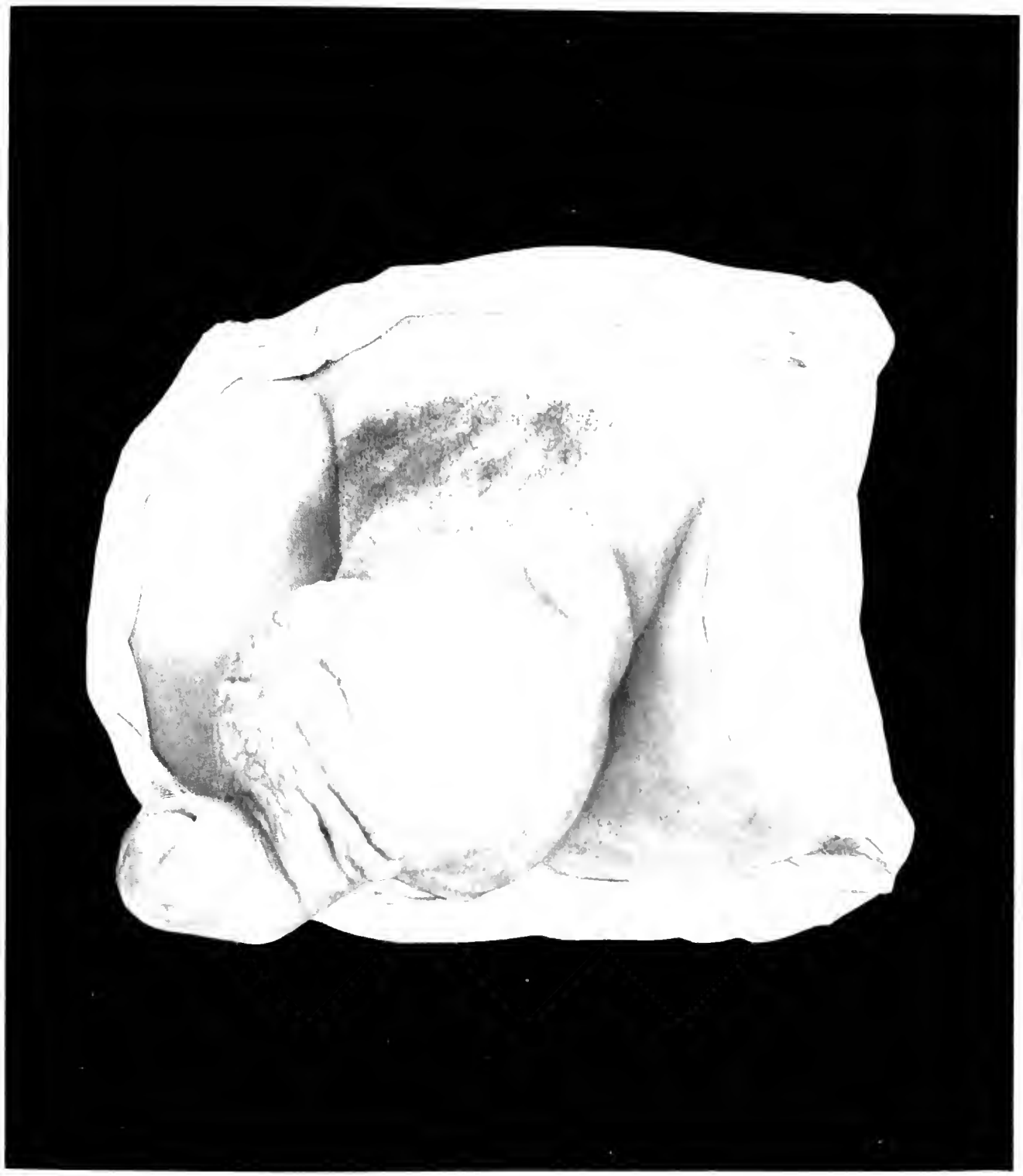


Fig. 123. Elephantiasis penis et scroti

Fig. 124. 125. Scleroderma.

# Scleroderma

*Plates* **79** and **80,** Figs. 124, 125, 126

This is probably a general affection, which is manifested chiefly in the skin. The weight of evidence upholds the view that the earliest manifestations are in the blood-vessels, and that an angioneurotic element is also present. An initial stage of edematous infiltration is soon followed by atrophy and shrinking of the skin, which as a result becomes hidebound.

The affection manifests itself under three very different clinical forms, which, while closely related and often occurring side by side, are known by different names, and have been and still are, held by some to be different affections. Occurring in small circumscribed patches, the disease has always been known as morphea, and the peculiar discolored appearance—yellowish, bluish, pinkish, etc.—with its border of dilated blood-vessels, and its ultimate atrophy, causes it to resemble greatly a patch of skin in lepra anesthetica, and it has even been regarded as an anomalous form of that affection. However, there is no anesthesia, nor does morphea as a rule occur with any definite relation to a sensory nerve. The lesions of morphea may occur on the face, trunk or limbs. Diffuse scleroderma, or scleroderma in the narrower sense, may occur in a number of scattered localities, or occupy a large portion of a limb, or may cover the greater part of the surface, even to becoming universal, in which case the patient becomes, as it were, mummified. When the entire face and neck are involved, the result is called the sclerodermatous mask. The mucous membranes may be attacked. The third form of the disease—sclerodactylia—attacks the digits, extending for some distance centrally. This expression of the disease, especially in its typical isolated form, is ranked with the acroneuroses, because the trophic element is very pronounced. Not only do the fingers become hidebound, but the bones and joints may undergo involutional changes and ulcers may result.

The general form of the disease may run an acute course with

general symptoms resembling those of acute rheumatism. The edematous stage is well marked in such cases, and often results promptly in atrophy. As a rule, however, the disease begins insidiously, is chronic when first noticed, and while edema is absent there is considerable infiltration, which may not show atrophic changes for a long period. The acute type of lesion not infrequently undergoes spontaneous involution. The tendency of the disease is to incapacitate the subjacent organs. In the limbs the muscles atrophy from pressure and disuse, and in some cases are directly attacked by the disease. The joints are immobilized, the thorax impeded in its movements, the emotions are no longer expressed, chewing and swallowing are interfered with.

*Etiology*

Only in a few cases is there any conclusive relationship between effects and causes, and such cases do not agree among themselves. The apparent rheumatic nature of certain cases is of no help in explaining the affection, and although a positive *Wassermann* reaction is sometimes obtained, it is generally believed that the disease is in no way related to syphilis. Further speculation on the nature of the affection is unprofitable.

*Diagnosis*

The resemblance of morphea and sclerodactylia to other affections, already cited, is evident; but diffuse scleroderma can hardly be confused with any other condition save perhaps in its stage of edema and infiltration, when it has been taken for myxedema.

*Treatment*

Owing to the fact that some cases improve and even recover relatively without aid the benefits of treatment are naturally open to doubt. Time is an important factor. The patient should be guarded against cold, and residence in a warm climate is desirable. Internal treatment is of little avail except when directed to improvement of the general health. For this purpose ferruginous tonics, codliver oil, strychnia, quinia, and occasionally arsenic are useful. Pilocarpin properly supported by a stimulant has been recommended. Thyroid extract has strong advocates as well as disappointed experimenters. In extensive cases it is at least worthy of trial. A few of my cases were apparently slightly benefited by the use of potassium iodid. *Hebra* has reported good results from the intramuscular injection

every second day of ten minims of a fifteen per cent. solution of thiosinamin. The local treatment consists of massage and friction with bland oils or ointments. Galvanism sometimes improves the circulation and occasionally the X-rays may be of value.

Fig. 124. Model in Neisser's Clinic in Breslau (*Kroener*).

Fig. 125. Model in Lassar's Clinic in Berlin (*Kasten*).

Fig. 126. Model in Freiburg Clinic (*Johnsen*). The universal form of scleroderma in a woman, aged forty-two years, who was suddenly attacked with swellings about the ankles 7 months previously. For 6 months the skin of the whole body had been of boardlike hardness, shiny and deeply pigmented, with scattered lighter spots and excoriations here and there, especially about the anchylosed joints. The patient became intensely emaciated, and died of an acute pleurisy with effusion.

# Atrophia Cutis Idiopathica

*Plate* **80**, Fig. 127

Under this designation are at present comprised several clinical conditions of which the most important are diffuse idiopathic cutaneous atrophy, dermatitis atrophicans, and acrodermatitis chronica atrophicans (*Herxheimer*). In the two last named there is clear evidence of an antecedent inflammatory stage; but in regard to the so-called diffuse "idiopathic" condition the evidence as to a preliminary inflammatory stage is conflicting. This point is of vital significance, for as a matter of fact the so-called "idiopathic" atrophy is often secondary; while conversely, if the lesion is really primary, it cannot be of the same nature as the secondary conditions, but should be classed with congenital and hereditary hypoplasia of the integument.

In even the most modern literature there appears to be a hopeless confusion between primary and secondary atrophy, and the impression appears to prevail that the same picture may be produced whether the affection is dystrophic or secondary to an inflammatory stage. The more one looks into the subject the more the designation "idiopathic" seems to be unwarrantable. It can only imply that in a person born with sound integument, and in the absence of any exciting factors, atrophic conditions can develop.

In order to comprehend such a condition we may invoke, for comparison, the disease scleroderma. Here we see many points of resemblance with our affection. There is usually a primary stage, which, however, may be latent. The localization is either diffuse or circumscribed; in the latter case especially involving the extremities —in scleroderma the very fingers, but in the other form the hands and forearms or legs. Scleroderma, itself a most mysterious affection as far as its initial phases are concerned, causes, under typical conditions, a most thorough atrophy of the skin.

Nevertheless, there is no close resemblance between the two conditions. In so-called idiopathic atrophy there is no retraction present, as in scleroderma. Instead of being hidebound, there is a laxness of

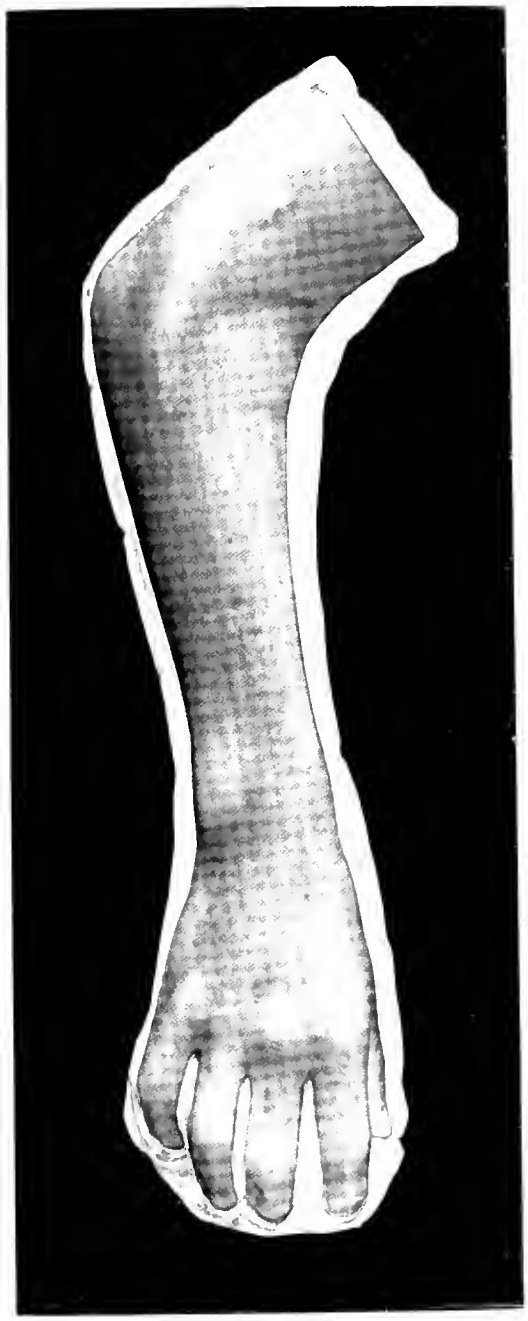


Fig. 126. Scleroderma.

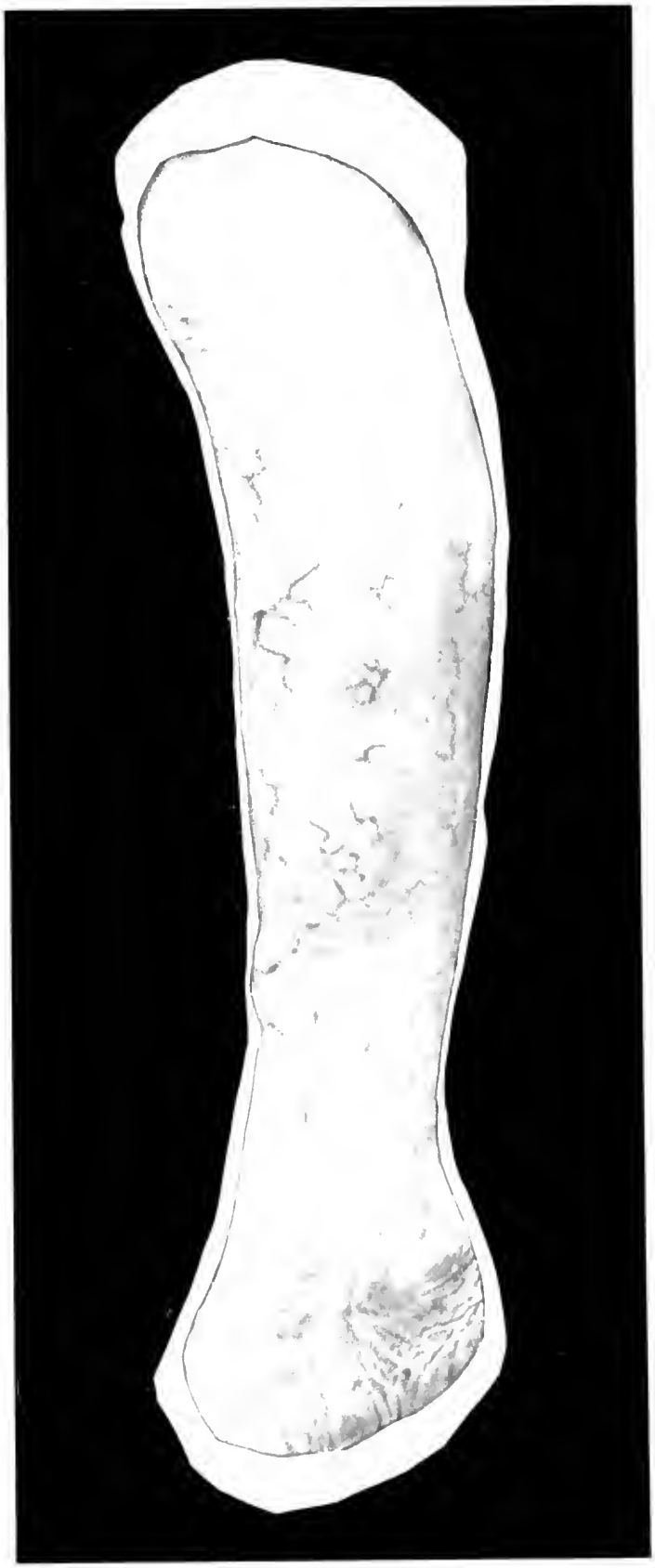


Fig. 127. Atrophia cutis idiopathica.

the skin, which is further suggestive of crumpled cigarette paper. But cases of scleroderma have been reported which fulfil all these conditions. Several authorities have recently expressed the opinion that all cases of dermatitis atrophicans represent abortive scleroderma.

A survey of the sections on symptomatology, etiology and pathology of this affection in the more recent text-books throws but little light on our subject. The description applies equally to primary and secondary affections.

In view of the anarchy which prevails in this field we can only sum up our existing knowledge by stating that we cannot be clear as to the primary or secondary nature of this disturbance; that it affects the middle-aged and especially the old by preference; that irrespective of its origin it may progress and even involve the entire integument; and that there is no known plan of treatment capable of modifying its course.

Fig. 127. Model in Neisser's Clinic in Breslau (*Kroener*).

# Striae Distensae

*Plate* **81**, Fig. 128

This is the condition originally described as "striæ et maculæ atrophicæ." Maculæ occur so frequently, however, that in some localities the term is no longer employed. The lines have often been termed lineæ albicantes from their shining quality.

The phenomenon is normal in the gravida but is not of universal occurrence. The same is true of rapidly acquired adiposity of the abdomen and thighs. It is commonly held that the lesions appear after delivery or rapid loss of flesh, but since a rupture of the corium is believed to give rise to the striæ, the latter might be in evidence before the loss of flesh.

Observation shows that the lines are for the most part parallel, their length is several inches and width about a quarter of an inch. The color has been given as pure blue, livid or white, but these shades are largely fortuitous and of no diagnostic significance. It is safe to say that the lines are of a paler shade than the surrounding intact skin.

Fig. 128. Model in Freiburg Clinic (*Vogelbacher*).

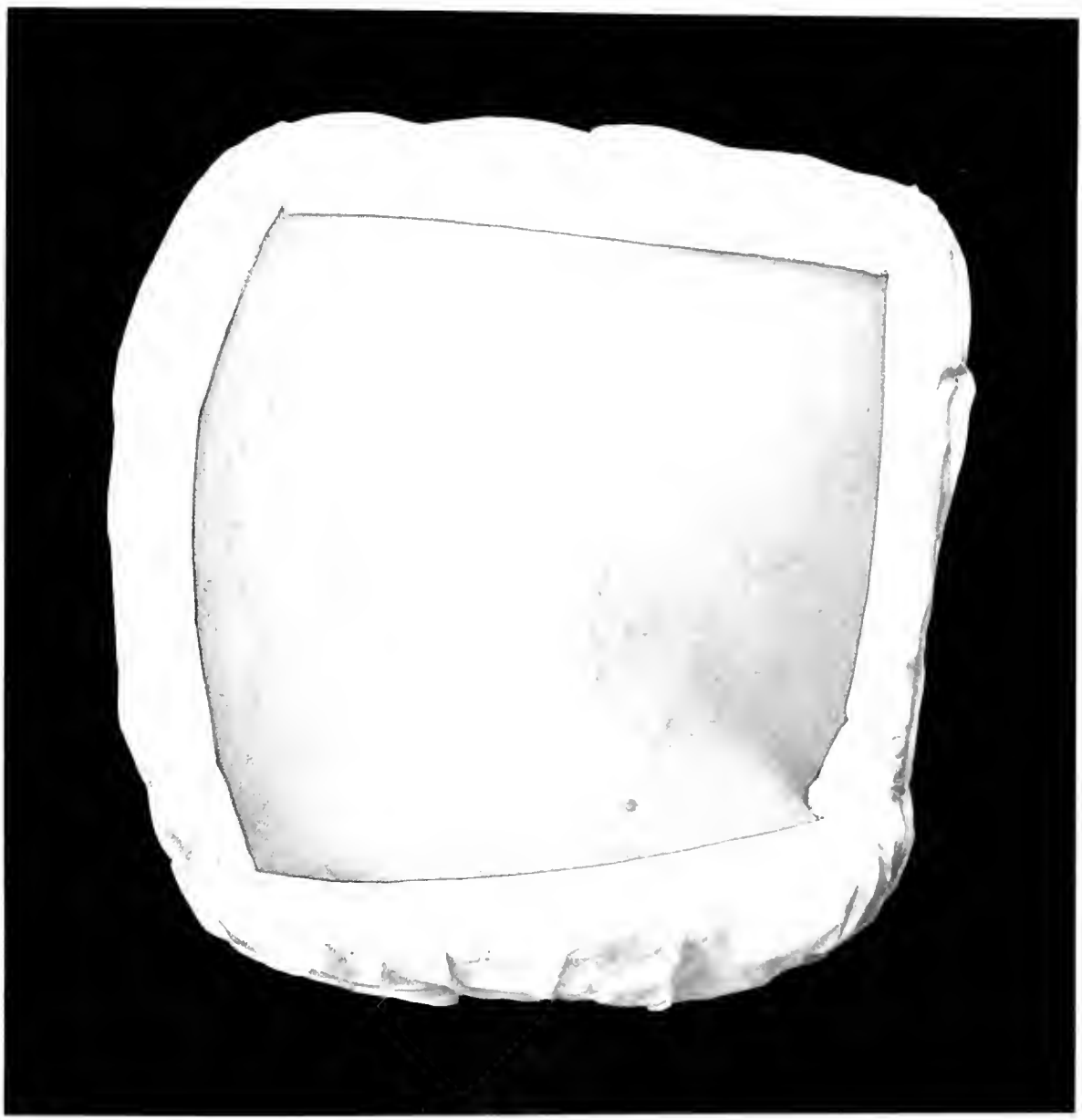


Fig. 128. Striae distensae.

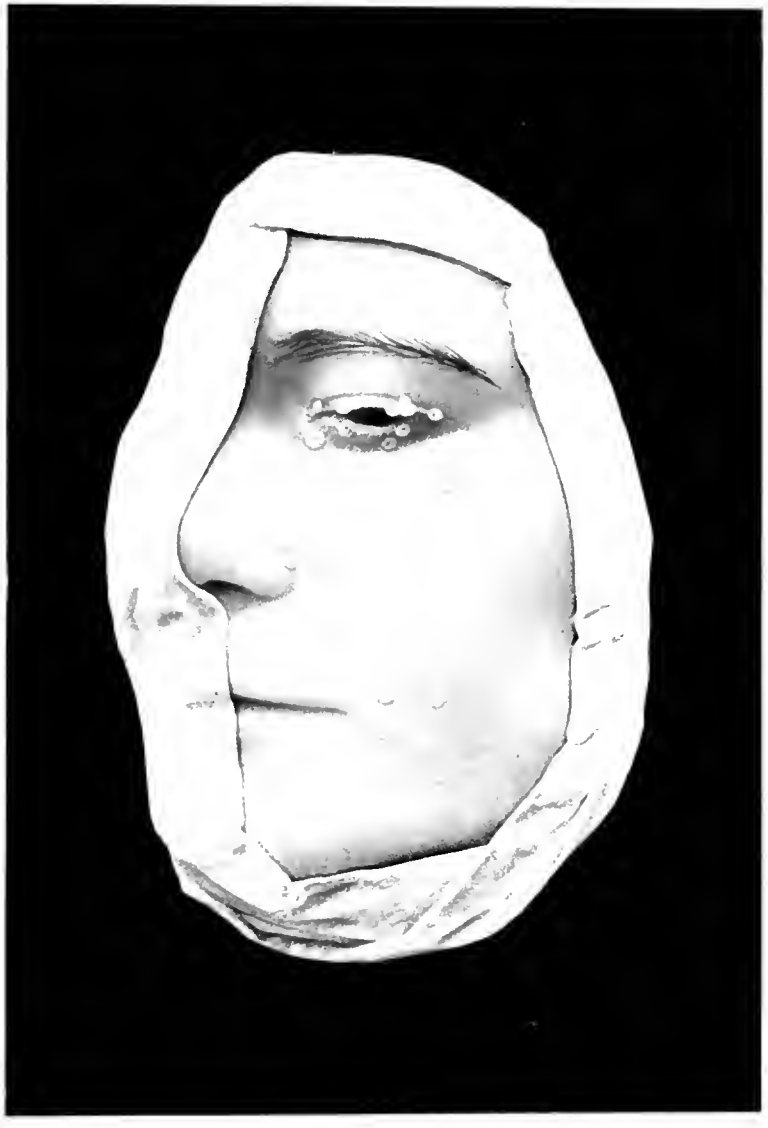


Fig. 129. Molluscum contagiosum.

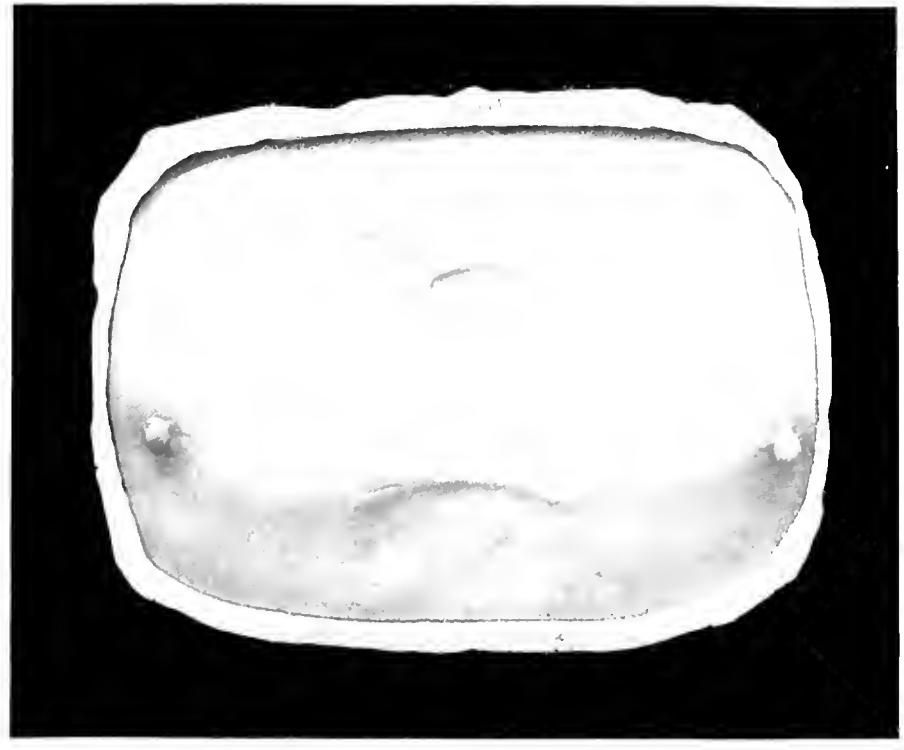


Fig. 130. Keloid.

# Molluscum Contagiosum

*Plate* **82**, Fig. 129

This mysterious contagious affection shows resemblances to numerous widely different dermatoses. It has been classed as a form of acne, sebaceous tumor and neoplasm; and one of its oldest names (acne varioliformis) is based on its resemblance to the umbilicated vesicles of smallpox. For some years it was believed to be due to certain parasites—coccidiæ—but this view has almost been abandoned. Under the microscope it represents a benign form of epithelioma, and presents some superficial clinical resemblance to multiple, benign cystic epithelioma. The lesions resemble cysts, in having fluid or solid contents, which may be squeezed out of a central opening. They leave no traces, not even in case of suppuration, which sometimes results.

The lesions vary from pinhead to pea size, are multiple, and are either pearly white or pink. They are discrete, but may form small groups, and while they may occur exceptionally in any area of integument, are usually found on the face or genitals. They are firm to the touch, of globular outline, with slightly flattened summit, and naturally sessile, becoming pedunculated in some cases at a later period. Atypical varieties have been described.

*Etiology*

Not only can no parasitic cause be found for this affection, but even the conditions under which it can be propagated are barely known. Like impetigo contagiosa, it tends to prevail among the children of the poor and in institutions. There is a small per cent. of cases in which direct inoculation is evident, and it may also be inoculated experimentally. Despite its occurrence on the genitals, there is no evidence of venereal transmission. There is quite a consensus of opinion that it follows visits to bathing establishments. The affection was long believed to involve primarily the sebaceous glands, which if true would make the matter of contagion more

intelligible. As a matter of fact, however, the disease begins in the rete and has no connection with glands or follicles. The central opening, which originally suggested the sebaceous gland theory, is part of the evolution of the tumor.

*Diagnosis*

The peculiar formations with their central depressions and duct-like orifices, when typical, can hardly be mistaken for the lesions of any other affection. Atypical lesions about the eyes might be confused with milia or warts. Beginning lesions present some analogy to acne papules.

*Treatment*

Many cases terminate in spontaneous recovery in a few weeks or few months, but the contagious nature makes vigorous treatment necessary. Parasiticides, such as sulphur or mercurials in ointment form, rubbed in forcibly, are curative, and are usually prescribed if many lesions are present. The treatment for individual lesions is incision or expression, followed by cauterizing with pure carbolic acid.

Fig. 129. Model in Lesser's Clinic in Berlin (*Kolbow*).

# Keloid

*Plate* **82,** Fig. 130

This term is applied to a scar-like new-growth of the skin. Its resemblance to a scar is by no means accidental, for in the majority of cases it develops in a recent cicatrix, and in its mildest form is nothing but a redundant scar. In a degree one remove higher it appears at first as a redundant scar, but grows beyond the original scar limits; and in the highest degrees it appears to develop spontaneously in sound skin. This, however, is very questionable, for in these so-called spontaneous or idiopathic cases the skin has almost always been subjected to friction and intermittent pressure; and when we bear in mind that about half of these idiopathic cases occur over the sternum and have a history of mechanical irritation, the inference is that an initial abrasion or some other slight traumatism may have furnished the impulse for the new-growth. And we know, besides, that scar keloid so-called can follow a very small lesion of the skin. There is no doubt that a marked predisposition to these growths exists, but beyond the fact that negroes show a distinct tendency in this direction, we cannot formulate it.

A keloid tumor, however produced, shows a marked tendency on the part of the fibroplastic tissue of which it is constituted to retract, like the ordinary scars of burns. As a result the growth has numerous processes resembling claws, whence the name. The superficial processes or roots of a keloid are roughly analogous to the so-called roots of a cancer of the breast which are also produced by the retraction of the fibroplastic tissue; and keloids, like cancers, have a notable tendency to recurrence after removal, although they are not malignant.

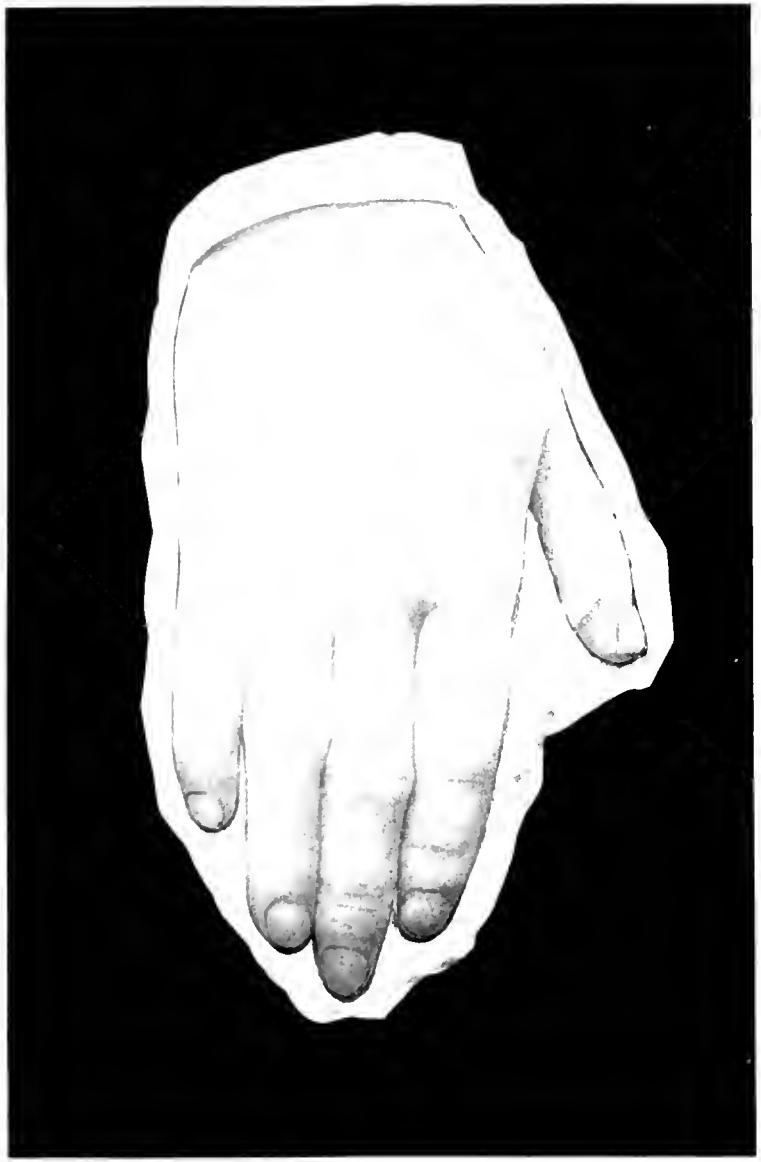
*Diagnosis*

A keloid can hardly be mistaken for any other affection because its appearance must suggest a scar.

*Treatment*

This has always been far from satisfactory. Excision is always contraindicated. Palliative treatment (anodynes) is necessary at times when the growths are painful. A combination of fibrolysin injections, linear scarification and electrolysis may prove successful in some cases. Improvement often follows the use of the X-rays. Naturally the treatment is in part comprised under that of disfiguring, incapacitating and painful scars such as follow extensive injuries.

Fig. 130. Model in Kaposi's Clinic in Vienna (*Henning*).



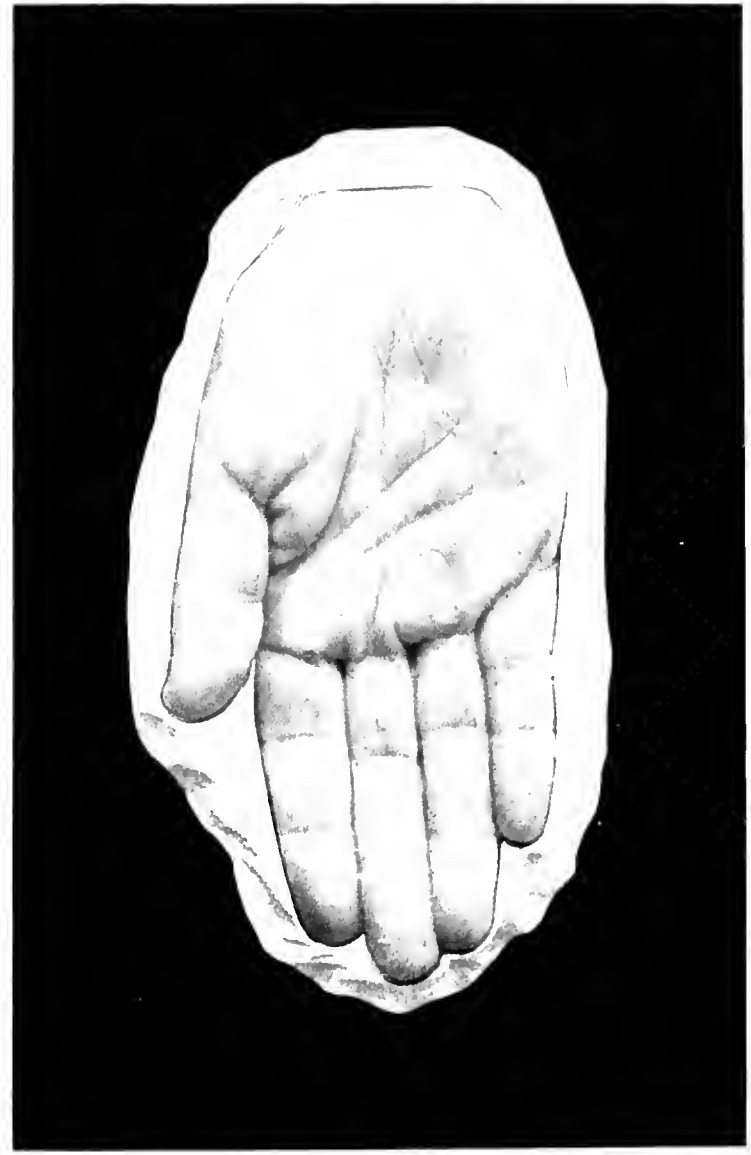


Fig. 131. 132. Xanthoma tuberosum multiplex.

# Xanthoma Tuberosum Multiplex

*Plate* **83.** Figs. 131 and 132

In this type of disease nodules occur, as the name implies; but flat patches sometimes coexist. This form is only exceptionally seen about the eyelids, but occurs disseminated in various localities, so that it is termed xanthoma tuberosum multiplex. Favorite localities are the hands, knees, elbows, buttocks and feet. The individual nodes are about the size of a pea and as a rule they are closely aggregated. A puzzling feature is the frequent association of jaundice, although the xanthomatous nodes and plaques in no wise owe their yellow color to bile.

The coalescence of nodules may be so extreme that true tumors result. Otherwise the condition is simply very slowly progressive, with little or no tendency to disappear by involution nor to degenerate.

*Etiology*

Zanthoma has been recognized as a familial affection, cases having occurred in at least four generations. The lesions are known to develop in some of the internal organs. Little or nothing is known of the determining causes. The neoplastic tissues appear to contain a special kind of fat to which they owe their yellow color.

*Diagnosis*

Xanthoma tuberosum multiplex, when it occurs away from the eyelids and vicinity, is hardly to be confused with any other malady. It is stated that urticaria pigmentosa has been known to simulate it. In theory it might be confounded with the so-called xanthoma of diabetics. This, however, represents a fatty degeneration of disseminated inflammatory lesions. Occurring on or about the eyelids, it might of course be confused with xanthoma planum; but xanthoma tuberosum, while it may occur on the lids in a flattened form, will always be accompanied by the tuberous lesions elsewhere on the body.

As in the case of neoplasms of any sort, extirpation is the only treatment. The affection is well adapted to curettage, and if the lesions are small or few in number, electrolysis or the use of moderately strong caustic solutions may be sufficient. If there is fear of disfiguring scars a strong salicylic acid plaster or collodium solution applied repeatedly may cause the disappearance of the lesions. For large plaques on the elbows and knees the X-rays may be used.

Fig. 131. Model in St. Louis Hospital in Paris, No. 655 (*Baretta*). Besnier's case.

Fig. 132. Model in St. Louis Hospital in Paris (*Baretta*). Du Castel's case.

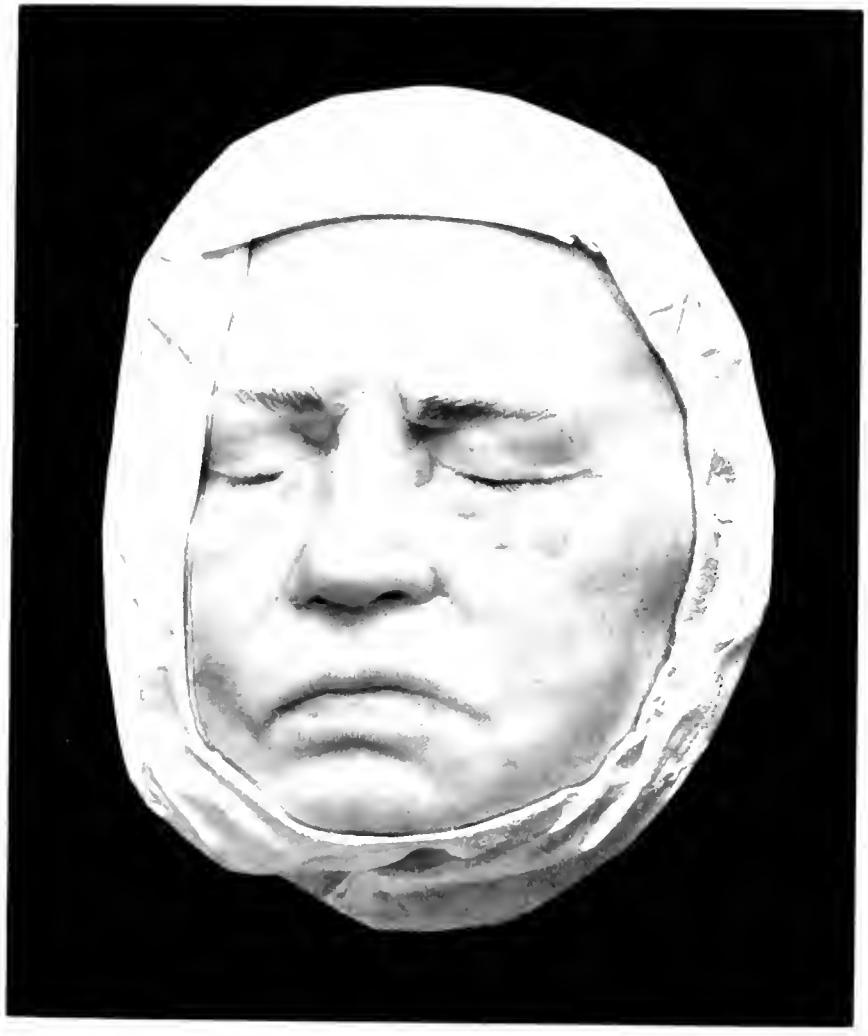


Fig. 133. Xanthoma palpebrarum.

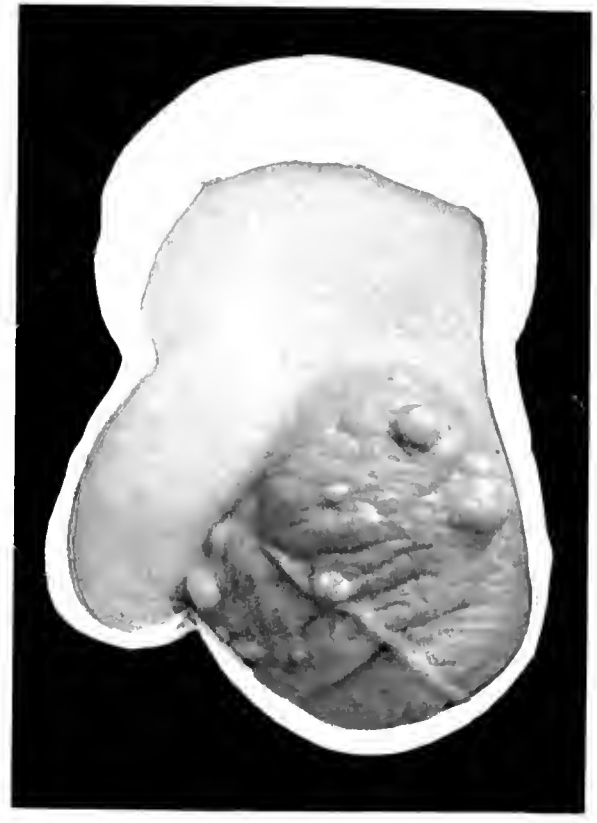


Fig. 134. Atheroma multiplex (cystes sebaceae).

# Xanthoma Palpebrarum

*Plate* **84,** Fig. 133

This affection seemingly has no connection with xanthoma tuberosum multiplex. As the name implies, it is peculiar to the eyelids. It is roughly symmetrical and both the upper and lower lids may be affected. The lesions are of a chamois color and of oval form, from one-eighth to one-half of an inch in their long diameter. Adjacent lesions may coalesce and form irregular bands and patches. The affection is seen most frequently in women, particularly those showing dark pigmented rings around the eyes. Although rare in men it is occasionally encountered.

*Etiology*

But little can be said regarding the cause of the affection aside from the fact that it is known to possess a fairly definite hereditary tendency.

*Diagnosis*

This affection is frequently confused with typical xanthoma, especially when the latter is seated in the lids, in which case it assumes a similar flattened type. The absence of lesions on the body, however, should prevent this diagnostic error.

*Treatment*

The growths may be destroyed by electrolysis, refrigeration, or by chemical caustics. Touching the lesions with pure nitric acid is a simple but effective treatment.

**Fig. 133.** Model in Lesser's Clinic in Berlin (*Kolbow*).

# Atheroma Multiplex

*Plate* **84,** Fig. 134

Wens, or sebaceous cysts, despite the above designation, are usually single and seldom numerous. Since the contents of these cysts is ordinary sebaceous matter, the first impression is naturally that we have to deal with ordinary retention cysts from occlusion of the ducts. But not only are the latter often patent, so that the contents are easily pressed out, but mere stoppage of a duct is evidently insufficient in itself to cause a wen.

Wens may be of any size up to that of an orange, and after reaching a certain size—for example, that of a bean or an almond—undergo no further change unless they inflame. Their favorite locality is the scalp and adjacent parts of the face and neck, and the back, but they may occur in any locality whatever. In certain localities they show peculiarities which cause them to pass for special affections, as the chalazion of the eyelids, which are connected with the Meibomian follicles. They often occur in the scrotum, and sometimes the labia majora are affected. In wens with patent duct, cutaneous horns are occasionally produced.

Wens naturally lie beneath the skin, which moves freely over them; and if they do not inflame the contents gradually harden. It is asserted that if there is no patent outlet the growths become more bulging. A low grade of inflammation causes the cyst-wall to adhere to the skin, which itself may inflame, become thin and ulcerate. An ulcerated wen may show papillomatous outgrowths, and may even become the seat of an epithelioma.

*Diagnosis*

Without a history of the case, a wen might readily suggest a subcutaneous granuloma, either syphilitic or tuberculous, especially if no opening is to be seen. The presence of the latter, and the escape of sebaceous matter therefrom under pressure, is characteristic of

wens. In dubious cases a needle puncture might be made, but the indications for extirpation are so marked that refinements of diagnosis are hardly called for.

*Treatment*

This consists in incising the skin and shelling out the cyst, save in small, beginning wens, which may be simply punctured, evacuated and cauterized. When adherent to the skin, careful dissection is required.

**Fig. 134.** Model in Neisser's Clinic in Breslau (*Kroener*).

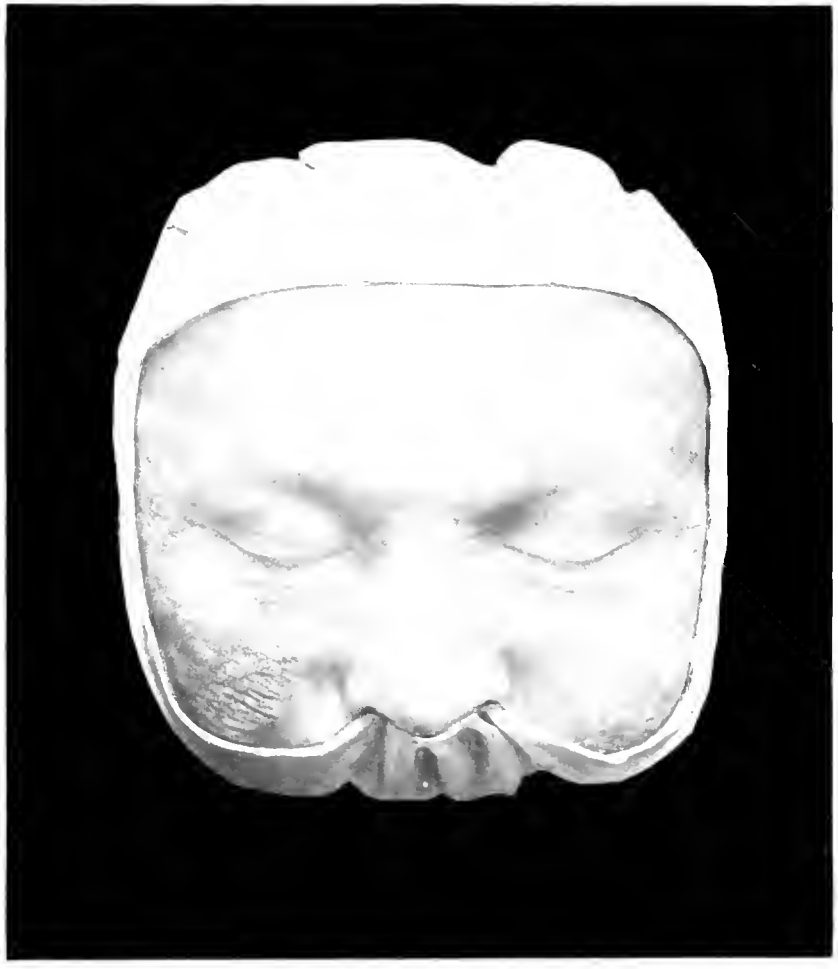
# Lupus Erythematosus

*Plate* **85,** Figs. 135 and 136; *Plate* **86,** Figs. 137 and 138; *Plate* **87,** Fig. 139

This affection comprises two types of disease, which differ so notably as almost to constitute clinically separate affections. Nevertheless, they show transitions and the ability to pass from one phase into the other.

The first type to be described has a decidedly rashlike character, and is known as the exanthematous or disseminated. It varies greatly in degree and severity, and in its mild forms seems to be regarded by most authors as belonging to the localized, circumscribed type. In this form a few scattered lesions may appear on the face, and perhaps also on the hands and arms. These lesions are mere erythematous spots, varying much in size, but seldom larger than a bean. They may be very few in number, with a tendency to appear on or about the nose, in which locality they may simulate seborrhoic dermatitis or acne rosacea. On the other hand, the face, hands and forearms may be quite thickly sprinkled with lesions, so that they bear considerable resemblance to erythema multiforme. It is difficult to associate such insignificant-looking lesions with the word lupus. Like any other exanthem, these spots may disappear spontaneously, and often yield readily to local treatment. As a rule, however, they tend to reappear. When they vanish they may leave behind superficial temporary white scars. Some spots appear to scar in the centre only. Subsequent lesions, when they appear, no longer show any tendency to recovery and become ordinary circumscribed chronic lesions which make up most of the cases of this affection.

There is also an infrequent, much more severe and generalized form of exanthematous lupus which may involve a much greater area. and be attended with constitutional symptoms. This type is often fatal. Most of the cases are associated with general tuberculosis, others with nephritis or syphilis. This type has been known to develop in subjects already affected with the ordinary chronic localized form. The eruption may itch notably, and show much poly-



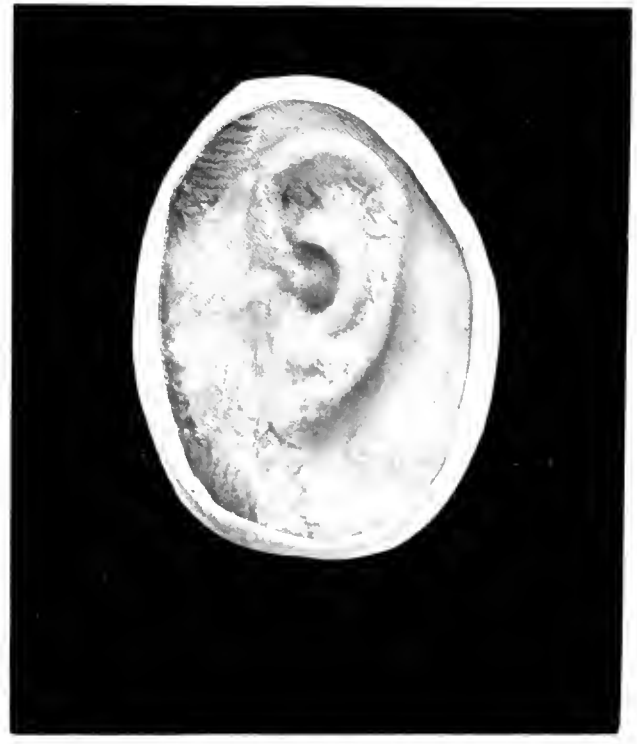
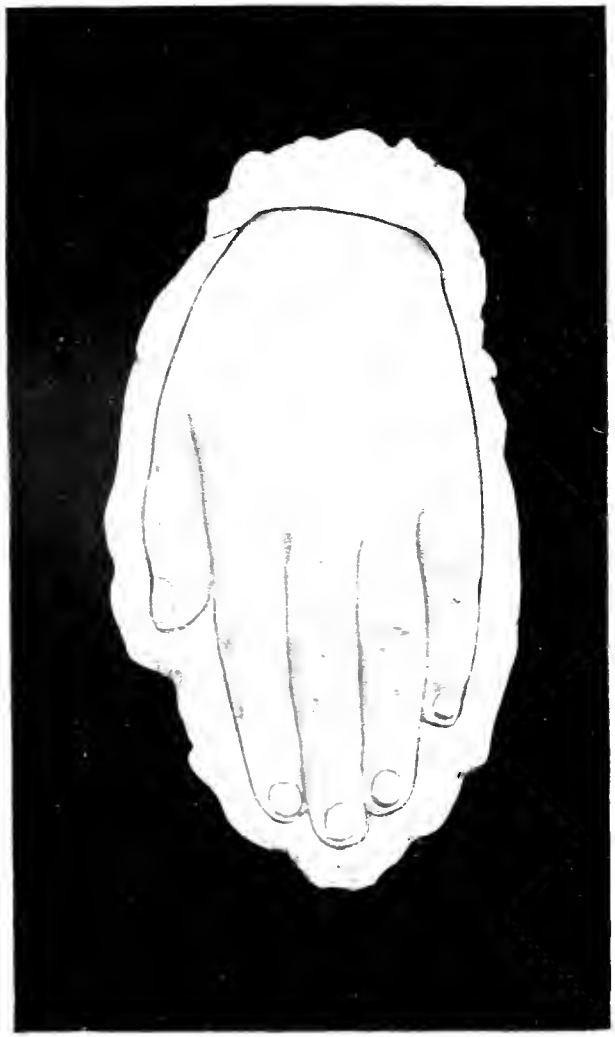


Fig 135. 136. Lupus erythematosus.



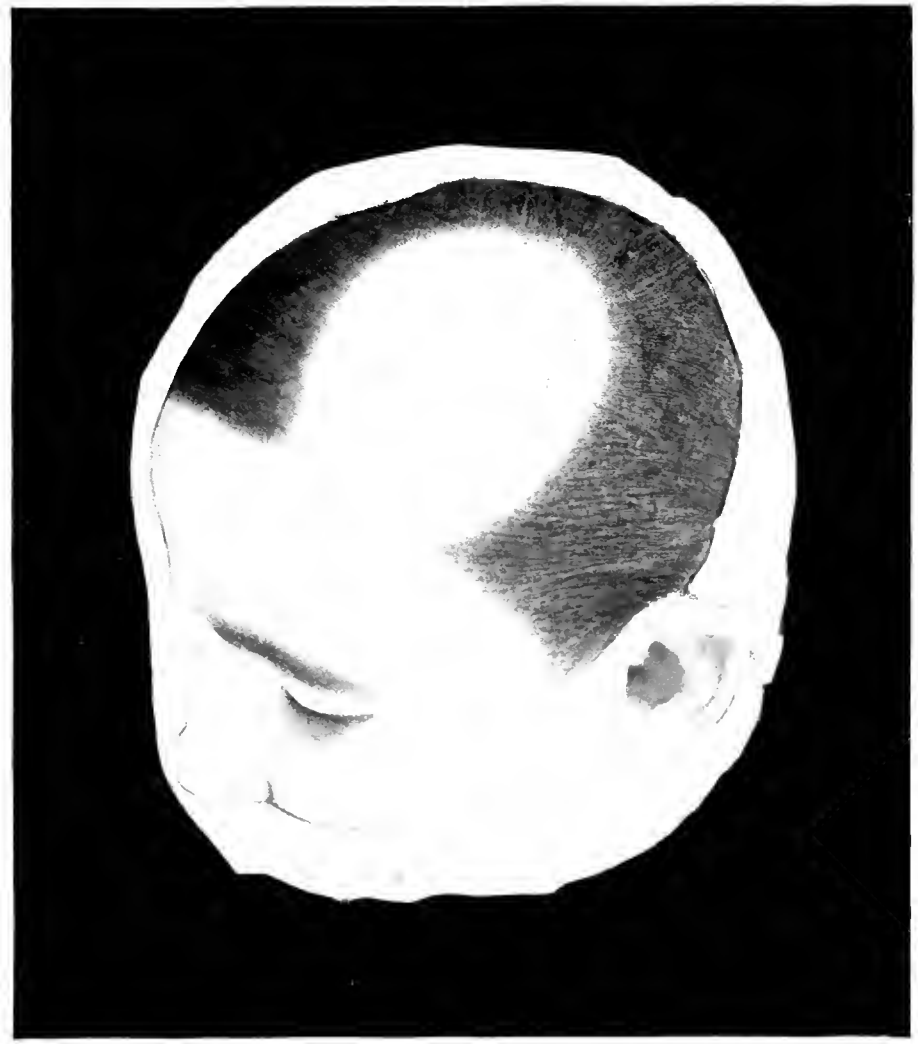


Fig. 137. 138. Lupus erythematosus.

morphism. It frequently resembles a generalized erythema multiforme, to such a degree, in fact, that no distinction can at first be made.

However interesting and striking these cases may be, lupus erythematosus is for all practical purposes a very different affection—an eminently chronic, localized process, confined to certain areas. These comprise the nose and adjacent parts of the cheeks, the ears and region behind them, the scalp, fingers and hands, and occasionally the toes. The same subject does not as a rule present lesions on both the head and extremities, so that clinically two different local types may be represented. Exceptionally other localities near the favorite ones may be involved, as the eyelids and the red border of the lips. The most striking and characteristic location is the so-called butterfly area, in which one large patch occupies the nose and entire infraorbital regions; and generally speaking, symmetry is highly typical of this form of disease. Thus, if one ear is affected the other will be. If there is a patch behind one ear, there will be a corresponding one on the opposite side. If a large number of cases are analyzed, it will be found that the majority follow a single local type, the lesions being confined entirely to the nose, cheeks and lobules of the ears.

These lesions may be perfectly flat or even slightly below the level of the skin, but as a rule more or less infiltration is present, so that they are elevated above the skin. These variations are due to the fact that in chronic erythematous lupus there is always a new formation of small cells which have some tendency to undergo atrophy. We may therefore see either hyperplastic or atrophic change and sometimes both side by side. This infiltration is able to destroy the integrity of the skin and produce scarlike tissue without previous ulceration. The resulting lesion is not a true scar and there is little or no retraction, but it imposes itself as scar tissue. The infiltrated skin has a bright red color, and does not pale on pressure; this is true also of exanthematous lupus. Thick, closely adherent scales may be present on the patches, and the borders are sharply outlined. Exceptionally, even after considerable infiltration, the skin may remain intact, so that after the retrograde changes it appears normal. On the fingers or elsewhere in the chilblain area the lesions may be livid instead of red. Exceptionally, a patch may appear edematous. Patches in the hairy scalp cause localized permanent alopecia.

*Etiology*

But little is known of the intimate nature of the malady. It has often been claimed that the disease is in some manner dependent upon

tuberculosis, but proof of this fails. Bacilli do not appear in the lesions, and to claim that circulating toxins are responsible leads to nothing. Its choice of locality may be determined by the fact that these areas are naturally hyperemic or congested, and it sometimes seems to develop in previous affections in these localities.

*Diagnosis*

Beginning lupus about the nose often suggests seborrhoic dermatitis or rosacea, and as the disease may begin in these forms, it may be impossible to give a positive opinion for a time. In lupus the sebaceous follicles are often very prominent. The patches of exanthematous lupus may simulate eczema, as they may itch and show small papules and vesicles. The one disease which offers the closest resemblance is lupus vulgaris, and in a small percentage of cases diagnosis becomes so difficult that a hybrid form has been spoken of. Otherwise, the resemblance is chiefly illusional, for in the great majority of cases the affections present little in common.

*Prognosis*

In a case with some tendency to spontaneous improvement, vigorous treatment may bring about complete recovery; but in the great majority of cases it is a question of improvement only.

*Treatment*

Internal treatment should be directed first of all to the correction of any defect which may be found in the patient's general health.

A great many remedies have been recommended on account of their supposedly specific action upon the disease itself or upon the toxemia causing it or for their power of contracting the dilated blood-vessels. The most important of these are arsenic, the salicylates, carbonate of ammonia, quinia, the iodides and ichthyol. The results from all, however, are usually disappointing.

In the hyperemic-spreading cases iodine in the form of iodoform is frequently of value. The spreading is checked, the acute inflammatory condition subsides and occasionally a cure is effected. *Whitehouse* recommends that it be given in one-grain pills, coated with keratin or salol to prevent solution in the stomach. The dose is one pill three times a day after meals, gradually increased to the limit of tolerance, which is usually eight or nine pills a day. Its effect upon the digestive tract and upon the kidneys must be carefully watched, and its use should be continued for several months. *Bulkley* recommends phosphorus in the form of *Thompson's* solution in increasing doses pushed to tolerance.

For external use the number of remedies is even larger than for internal, and in most cases their action is quite as disappointing. The choice of the remedies will depend upon the type of the disease and the character of the individual skin.

In the acute inflammatory or vascular type only soothing applications are indicated, such as a calamine and zinc or a zinc and magnesia lotion and boric acid or mild ichthyol ointments.

As the acute process subsides, more active remedies can be used, such as painting the surface with liquor potassæ, allowing it to dry, and then covering it with collodion. The collodion peels off after four or five days and the process is repeated.

Lotio alba gradually increased in strength from 3i each of zinc sulphate and potassium sulphuret in ℥iv of water to 3vi of each, is often valuable in this stage. It is to be applied from two to four times a day.

Resorcin, from five to fifty per cent. in alcohol, is also useful.

Green soap applied either as a plaster or in the form of the tincture removes the scales and may stimulate a healing process.

The best results from all of the above are seen in the semiacute cases which show only slight infiltration: in the fixed chronic cases they are of but little use, and more radical methods must be employed. The action of all active remedies must be watched closely, and whenever an inflammation is excited they must be discontinued and one of the soothing applications used until this subsides.

In the chronic fixed cases one of the best remedies is equal parts of tincture of iodine and glacial acetic acid applied two to four times a day. The amount of iodine can be increased as the skin becomes tolerant.

*Hollander* recommends that quinine in increasing doses be used in conjunction with iodine externally.

Curettage is beneficial, especially in those cases with excessive scaling and thickening.

The remedy, however, which offers the best results is carbon dioxide snow. Its use should be restricted to those cases where the process has become stationary; or to lesions which have persisted for several months and show no tendency to spread.

There are several ingenious mechanical devices for making the $CO_2$ crayon, and while they are convenient, a piece of blotting-paper will answer the purpose quite as well. The blotting-paper is rolled to form a cylinder about three or four inches long with a diameter to fit snugly over the outlet of the tank containing the liquid $CO_2$.

This is firmly bandaged on the outlet, the tank inverted and the valve opened gradually allowing the liquid $CO_2$ to run out. With a little practice a firm, hard crayon is obtained, which can be trimmed with a knife to the desired size.

The reaction following the use of the snow is often quite severe, and it is not advisable to use it over a surface larger than one or one and a half square inches at one treatment. Over the bony prominences, and where there is little subcutaneous tissue, as the nose, it must be used very carefully to avoid too much destruction of tissue and sloughing. It should not be used at all on the ears. It should be applied first at the edges of the patch to be treated, and at least one-eighth of an inch of normal skin should be included in the process. The amount of pressure and the duration of its application vary in individual cases, and in the beginning it is advisable to limit both. Twenty seconds, with moderately firm pressure, is safe, and from this one can estimate what will be necessary later. The crust which forms usually separates in from ten to fifteen days.

Figs. 135, 136 and 138. Models in Neisser's Clinic in Breslau (*Kroener*).

Fig. 137. Model in St. Louis Hospital in Paris, No. 1437 (*Baretta*). Vidal's case.—Symmetrical *lupus erythematosus* of the hands of 2 years' standing. The face was likewise affected.

Fig. 139. Model in Freiburg Clinic (*Johnsen*). The superficial invasion of the skin of the cheeks permits the recognition of the existence of numerous small circular lesions, especially in the marginal portions of the disease. Under internal treatment with quinine and painting with iodine the affection was soon reduced to minimal proportions.

Fig. 139. Lupus erythematosus.

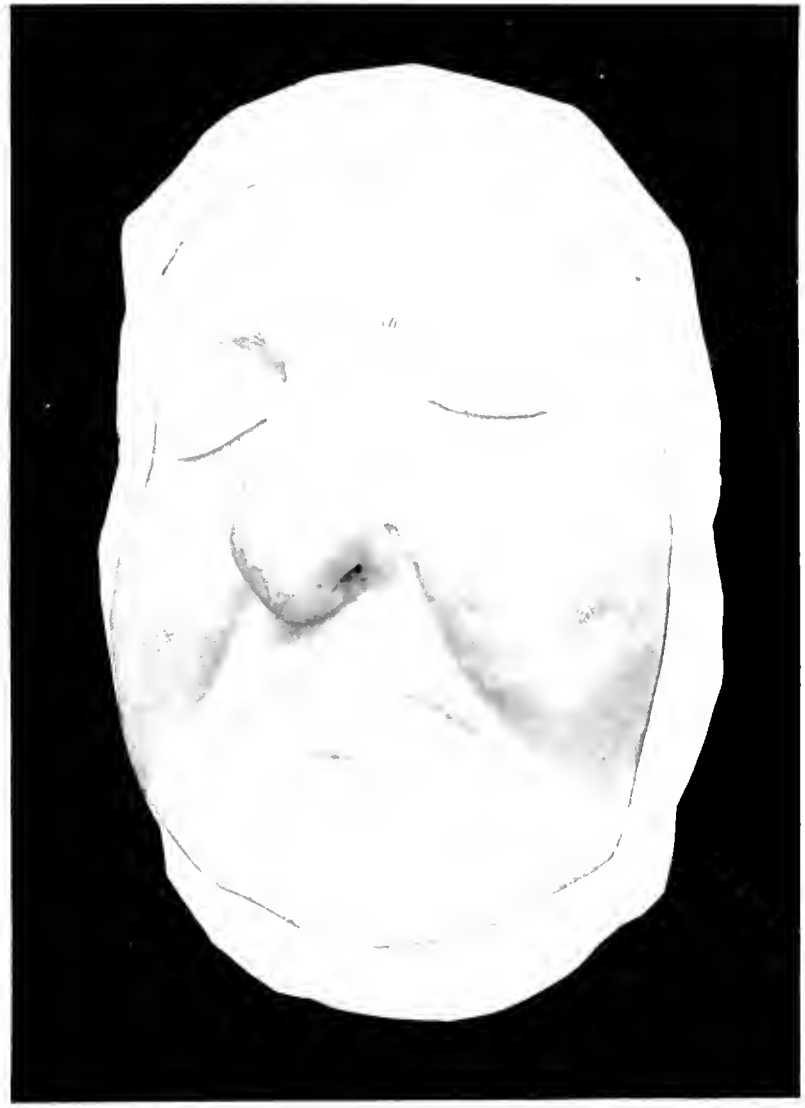


Fig. 140. Lupus pernio.

# Lupus Pernio

Synonym: Chilblain lupus

*Plate* **87,** Fig. 140

It has already been stated that lupus erythematosus may appear only upon the hands, and that when confined to the fingers and toes it may occupy the chilblain area and possess a resemblance to chilblains otherwise. Most authors make a special type of disease of chilblain lupus, asserting it to be a different affection from lupus erythematosus. They point to the fact that similar congested, livid areas appear in other chilblain localities, as the nose and ears; that the subjects are anemic with poor circulations, and are subject to chilblains, and that the affection itself may begin upon this foundation. In this form of lupus the thick adherent scales, the dilated and obstructed sebaceous ducts, and the sharply outlined, elevated border are absent. The affection may recover without scar-formation, even after years of persistence. The same secondary lesions develop as in severe cases of common chilblains. The only distinction between the two is the principal fact that chilblain lupus is present the year around, once it has begun. But if the face and ears are involved together, as is often the case, the condition could not, of course, be mistaken for the effects of the weather, even in winter.

*Treatment*

The management is essentially that of severe chilblains, viz., attempts to improve the circulation by internal and local treatment. Severe local measures are contraindicated.

**Fig. 140.** Model in St. Louis Hospital in Paris, No. 1694 (*Baretta*). Tenneson's case.

# Lupus Vulgaris

*Plates* **88** to **94**, Figs. 141 to 152

This form of tuberculosis of the skin is believed to differ from other species in being caused by the action of a limited number of germs of low virulence upon tissues which may have a certain predisposition or immunity. They resemble the so-called tertiary lesions of tuberculous infection, and also bear a close resemblance to the tertiary syphilitic lesions of the corium. On the other hand, it is believed that they originate from inoculation in or near the seat of the lesions, and that the low degree of virulence may come about from the fact that the subject has become partly immunized by the disease. Transitions occur between lupus vulgaris and ordinary inoculation tuberculosis (where a predisposition is not in question), and typical lupus itself plainly results from inoculation in certain cases. A special disposition to the disease is furnished by certain localities, as portions of the face and hands; these agree roughly with the areas of choice in circumscribed erythematous lupus, and to this parallel is due the fact that the latter affection, although not technically destructive enough to merit a designation like lupus, has come down to us as a process cognate with true lupus.

The affection begins as a characteristic nodule occupying the thickness of the true skin. These are minute and readily coalesce to form disease foci. When one of the latter has become conspicuous it is seen to have a peculiar hue, often likened to those of apple-sauce or apple-jelly. It becomes less marked on pressure, but still has a yellowish-brown color. This corresponds to an infiltration of granulomatous tissue, which soon softens, so that a fine probe readily enters it. This new tissue has already destroyed the thickness of the skin, yet the lesions may long remain at an apparent standstill before any further changes occur. New lesions tend to appear close by, however, so that in time a patch of considerable size has been formed.

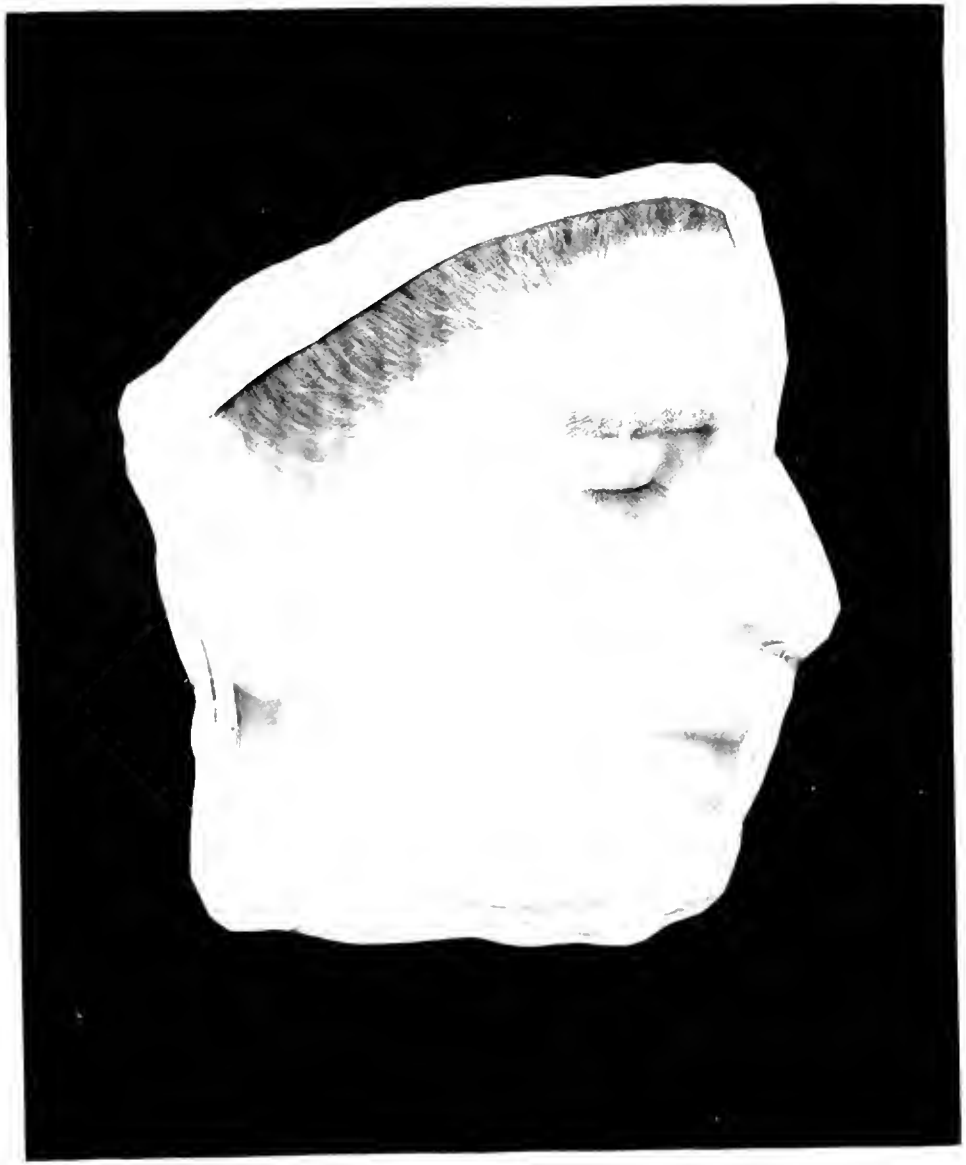


Fig. 141. Lupus vulgaris incipiens.

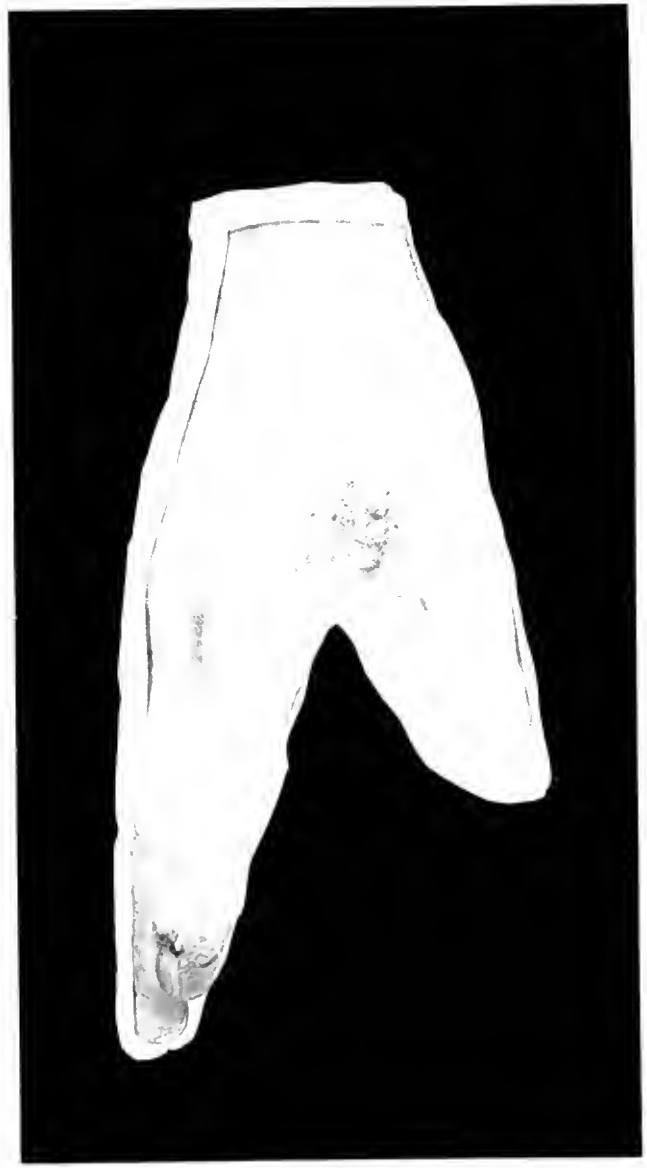


Fig. 142. Lupus vulgaris verrucosus

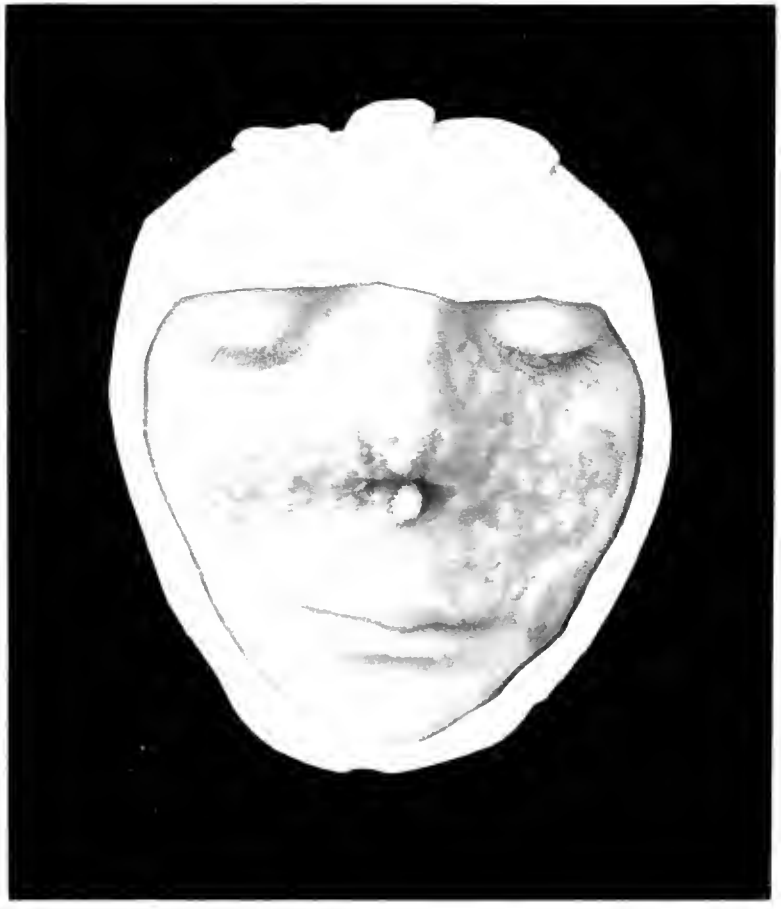


Fig. 143. Lupus vulgaris.

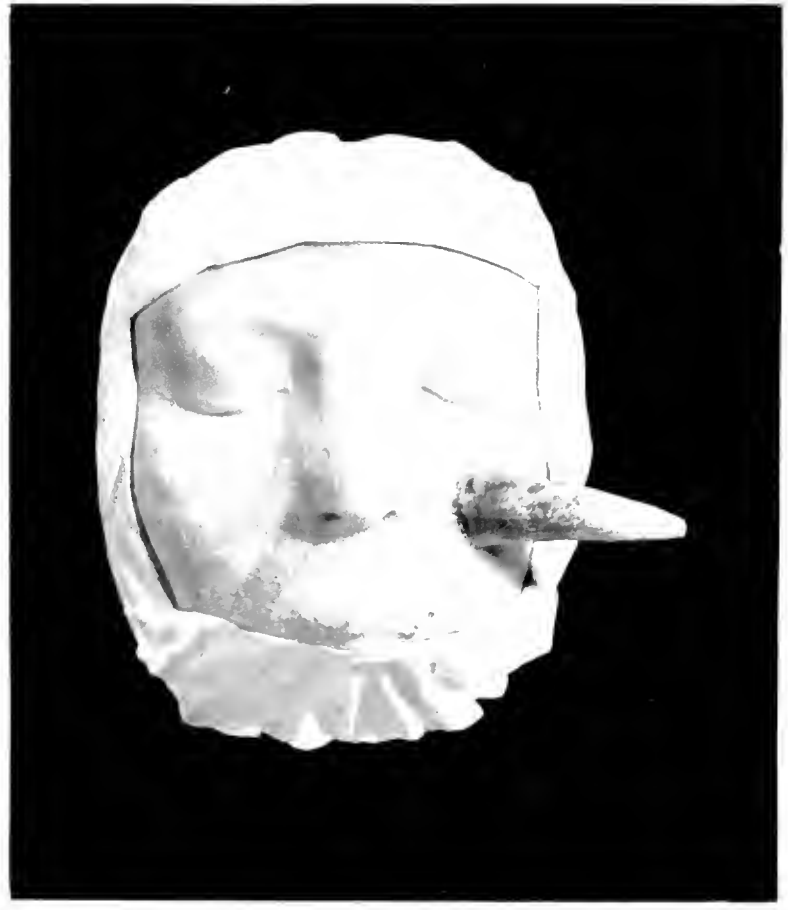


Fig. 144. Lupus vulgaris (cornu cutaneum).

These patches are usually a dull or bright red. In time the older lesions begin to show regressive changes. The natural tendency is to very slow absorption, leading to atrophy of the derma. During this process a peculiar anomaly of desquamation is usually present. Large masses of scales become partly loosened, but remain adherent, so that when forcibly detached hemorrhage results. At the completion of the atrophy this scaling ceases. The other termination is by ulceration, and this may be due largely to mixed infection from without. The ulcers discharge pus, which quickly dries into dark-colored crusts. In certain cases exuberant granulations form. An old patch of lupus which has slowly formed during years presents a characteristic appearance; several or all of the changes just described may be present at the same time. The new lesions naturally appear on the margin of the patch, sometimes forming a serpiginous border so characteristic of parasitic disease in general.

Despite the areas of preference, the disease readily occurs on the limbs, buttocks, and in fact in almost any locality, and it is not uncommon to see it develop simultaneously in widely separated localities. It attacks any of the superficial mucosæ, and may be primary here as well as secondary. The great disfigurement which it is capable of causing is not due to any penetrating power or ability, like cancer, to attack all structures, but to cicatricial or atrophic retraction about delicate orifices, and to interference with the nutrition of the more fragile bones and cartilages. Hence the sinking in of the nose. On the other hand, ordinary acute tuberculosis caused by large numbers of virulent bacilli is able to attack any of the tissues and produce destruction in a short interval. The area involved, however, is fortunately small, so that clinically there is no resemblance to lupus. There is, however, a process described by some authors as acute lupus, in which there are evidences of active inflammation and a tendency to rapid disintegration.

The affection, in the majority of cases, begins in childhood, and since it is quite compatible with a fair state of nutrition and does not kill either directly or indirectly, and, moreover, since it tends to progress or at least to remain stationary and is not especially amenable to treatment, the patient is almost sure to suffer with it during the entire life, be this long or short. Since practically its progress is very slow, the phenomena vary essentially with the duration. The older the case the greater the amount of atrophic and cicatricial tissue. The intensity of the disease at a given period is shown by the extent of new patches of disease. A time may come

when there are no longer any fresh nodules, the lesions then being wholly made up of the secondary changes. Although the disease may be extinct, or at least latent, the slow retraction may still be in evidence. Thus the entire face may be transformed to atrophic and cicatrized skin, and the apertures of the nostrils, eyelids, and even the mouth may be narrowed to an extreme degree, the nasal prominence being at the same time affected. Yet with all this local mischief the general health may remain excellent. The fingers and toes may also undergo analogous changes.

Typical lupus is but slightly raised above the skin level during the period of infiltration, and the exuberant granulations which may form on ulcerated surfaces have been mentioned. But aside from this there is a distinct tendency in certain individuals to proliferation of the various tissues which make up the corium. There results, then, clinically, such varieties as lupus hypertrophicus, lupus papillomatosus, and lupus verrucosus. The same occasional tendencies are seen in other destructive diseases of the skin, and are doubtless due to individual peculiarities, although lupus verrucosus occurring on the fingers or hands is seen in butchers and dissectors without special predisposition, and seems to stand midway between true lupus and actual inoculation tuberculosis. The typical lupus nodule does not occur here, which has led to the rejection by many of this affection as a form of true lupus.

Lupus is also atypical in the lesions known as scrofuloderma, which often stand in actual relationship to scrofulous glands and acute scrofula in various organs. Some of these lesions represent small cold abscesses of the corium, and in general there is here a transition between true lupus and the more acute forms of tuberculosis.

*Etiology*

Much has been said under this head, and it only remains to discuss the probable relationship between true lupus and general or pulmonary tuberculosis. The evidence points to the fact that in lupus, as in certain so-called scrofulous affections, the patient seems to have become partly immunized to fatal tuberculosis. Nevertheless, in a certain per cent. of cases there is no immunity, and the patients perish of pulmonary tuberculosis. There is no doubt whatever that lupus patients come of tuberculous stock in a preponderating proportion.

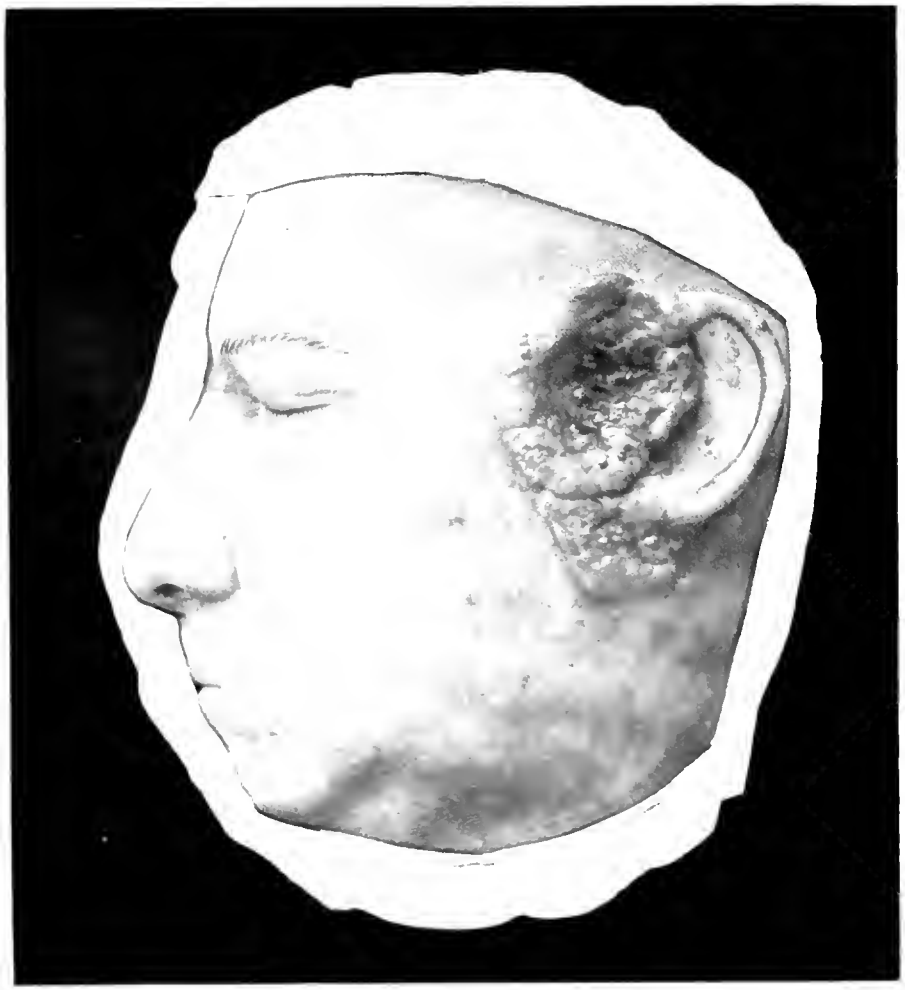


Fig. 145. Lupus vulgaris (epithelioma).

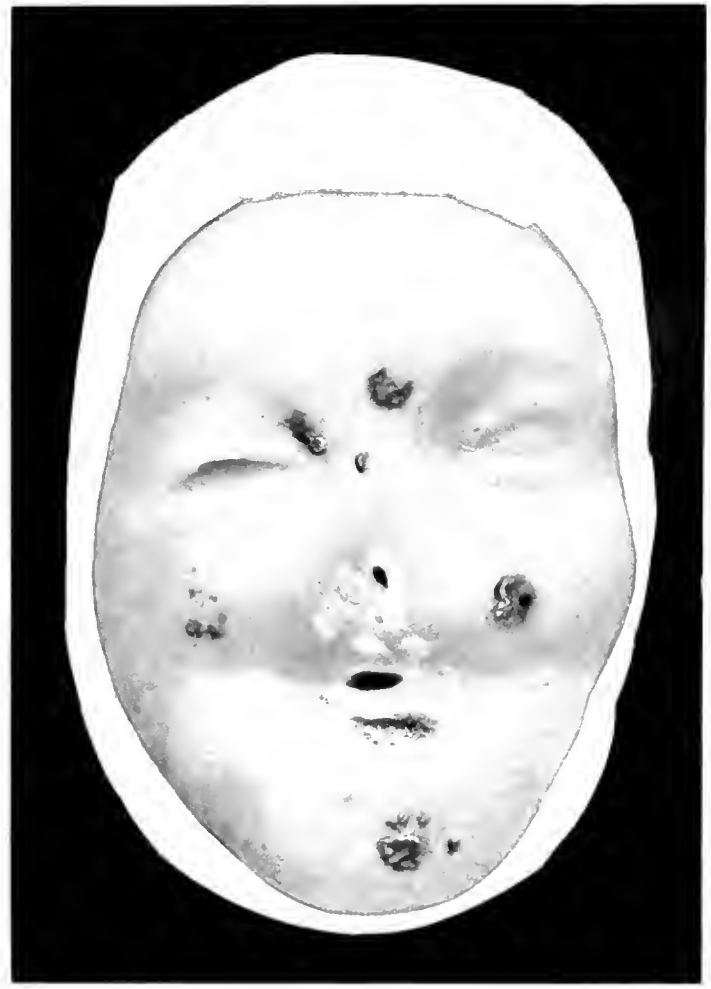


Fig. 146. Lupus vulgaris.

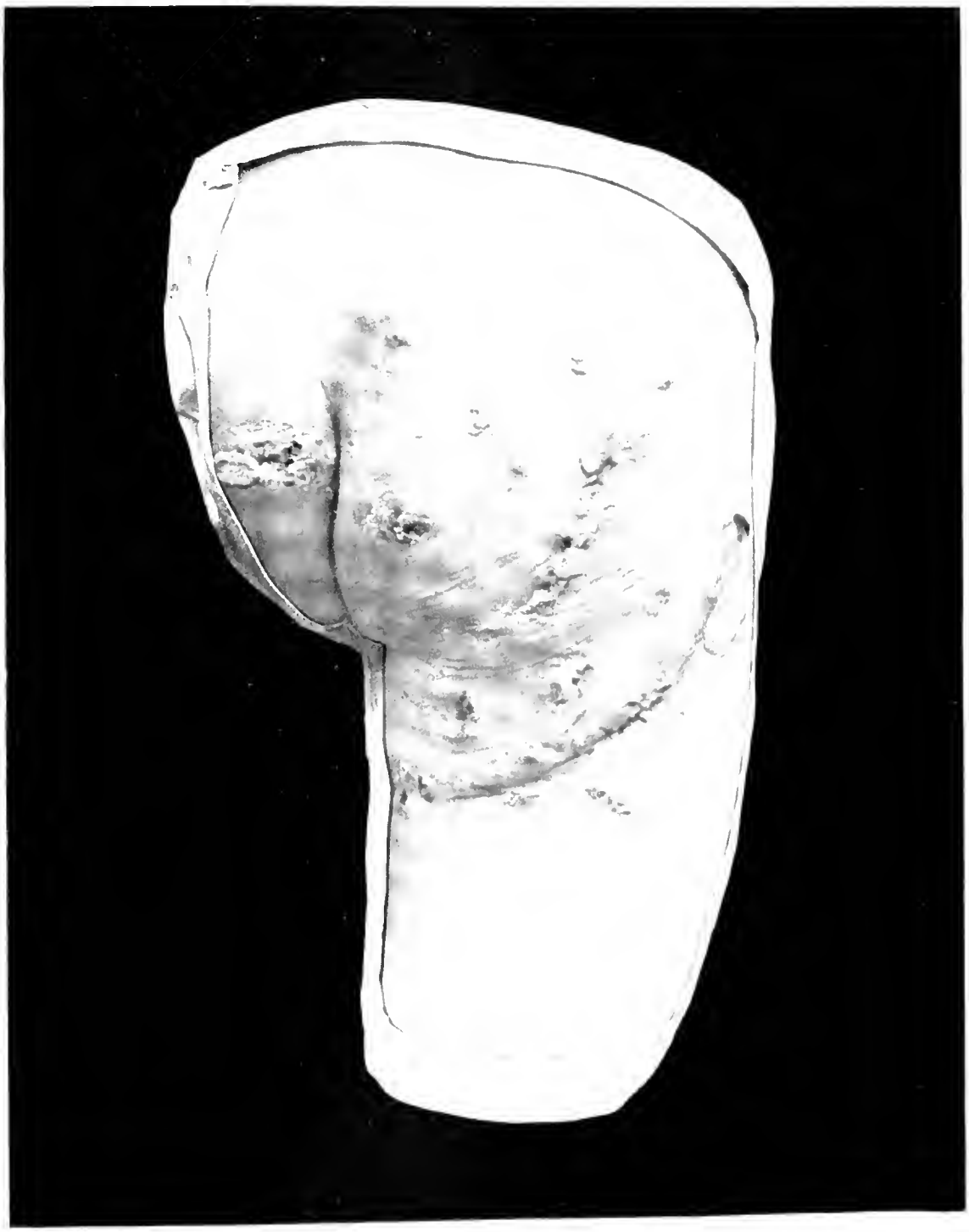


Fig. 147 Lupus vulgaris serpiginosus.

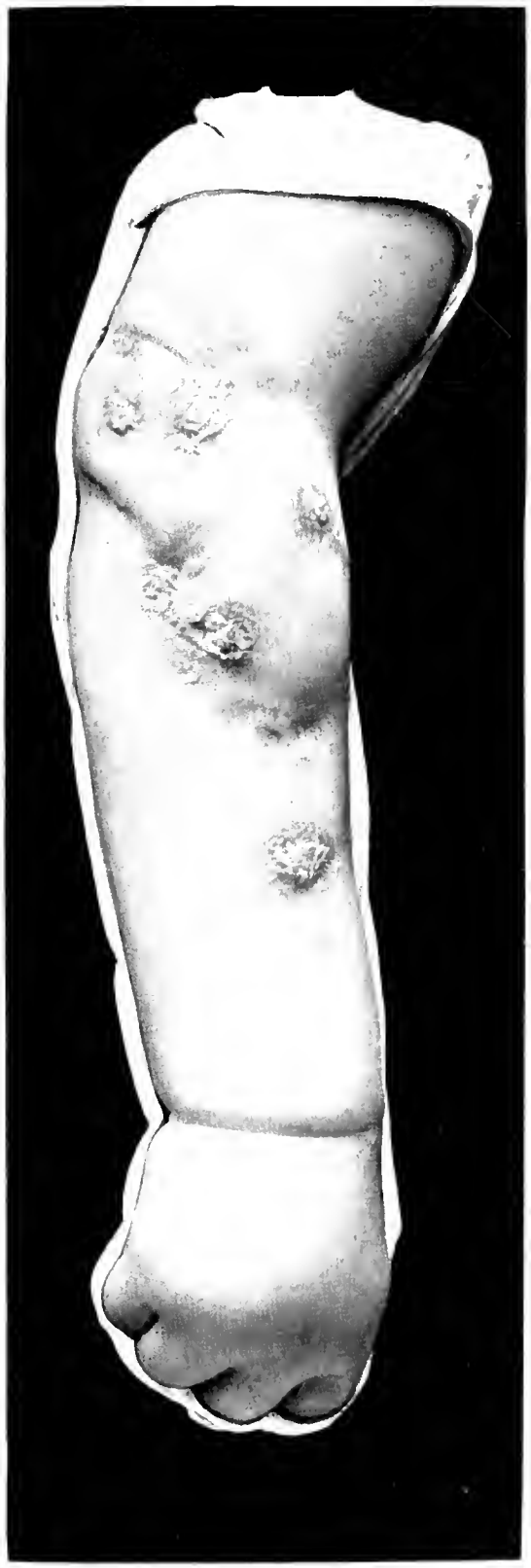


Fig. 148. Lupus vulgaris (elephantiasis consecutiva).

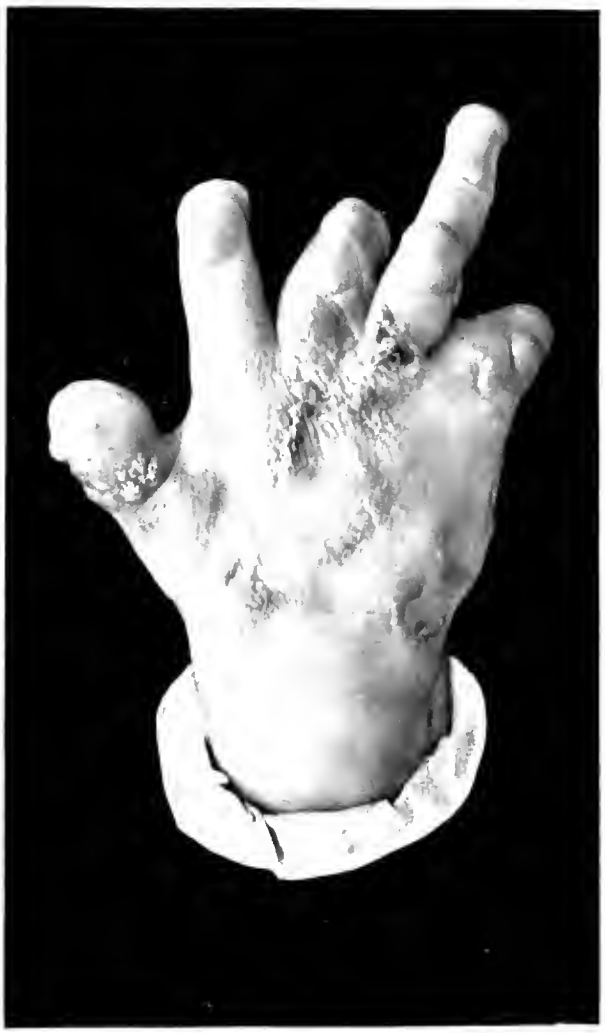


Fig. 149. Lupus vulgaris (mutilatio).

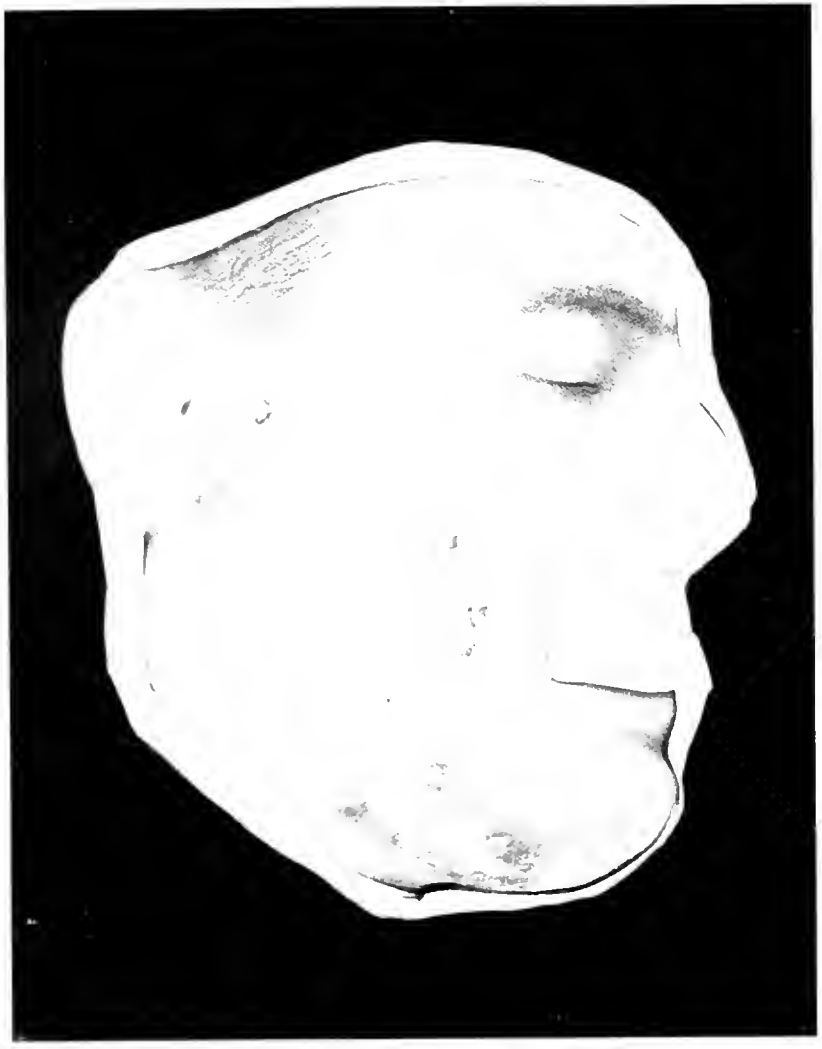


Fig. 150. Lupus vulgaris hypertrophicus.

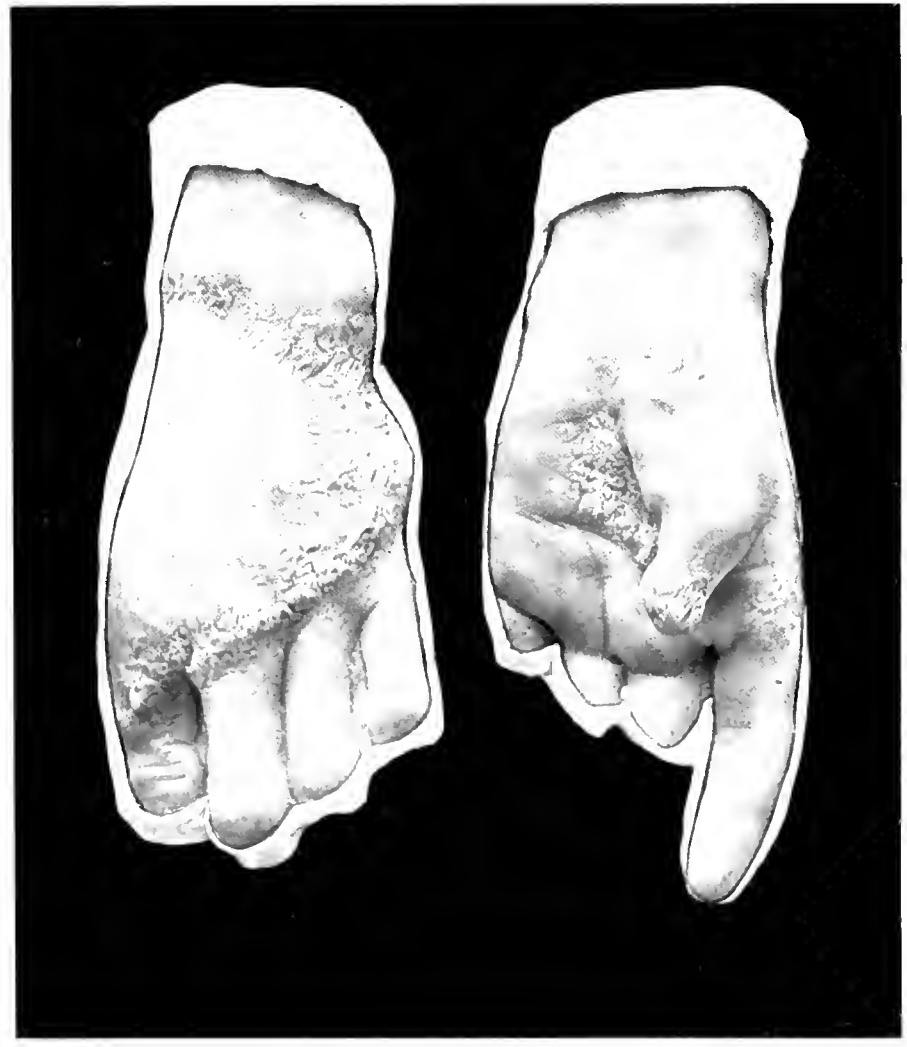


Fig. 151. Lupus vulgaris.

*Diagnosis*

Typical lupus may easily be recognized from the characters already given. Atypical forms may so mimic other destructive affections, such as lupus erythematosus, tertiary syphilis, rodent ulcer, epithelioma, tubercular leprosy, blastomycosis, etc., that diagnosis for the time may be quite impossible, or at least extremely difficult. The *von Pirquet* test and the *Wassermann* reaction are often of great help in differentiating lupus from syphilis. Certain fungi (blastomyces, etc.) may produce lesions accurately simulating lupus of the face and extremities. This confusion is more likely to occur in tropical countries. The only way to solve these puzzles is by microscopic studies, which may reveal the presence of blastomyces. Leprosy, when it first invades the nasal chambers and septum, readily simulates lupus, or, perhaps better, tuberculosis. The reason for the reciprocal simulation of granulomatous affections is due to the fact that these represent a group disease, and behave more or less alike. A rodent ulcer which heals partly while still progressing resembles a small isolated patch of lupus at times, and it is now known that lupus can begin in the elderly. Again, epithelioma readily develops in an ulcerated lupus, and in such a case has to be differentiated from lupus with overgrowth of tissue. An ulcerated lupus may also pass directly into cancerous ulcer without any additional infiltration.

*Treatment*

The *Finsen* light treatment is in some respects a specific for lupus, the X-rays, however, constitute a more available resource, having nearly as great efficacy. The large number of exposures necessary and the resulting tediousness, however, make some more rapid method in demand for all save those who wish above all for cosmetic results. One plan of treatment which may be summed up as asepsis and antisepsis seeks to minimize the disease by excluding septic infection. This may be carried out in a variety of ways. The lupus nodules will then pursue an uncomplicated course. The antiseptics most in use are pyrogallic and salicylic acids. This treatment can, of course, be pursued with lupus of any stage or variety; and it seems to be preferred by many over active destructive measures. Destructive cautery, curettage, and excision seem to be indicated less and less since a combination of X-rays with antiseptics have come into vogue. The latter does far more, perhaps, than merely prevent secondary infection. Pyrogallic acid has considerable power as a mild destructive caustic. If the superficial tissues are first softened

by salicylic acid, pyrogallic acid is able to penetrate into the tissues and perhaps to destroy the tubercle bacillus and arrest the small cell infiltration. It thus works hand in hand with the bactericidal action of the rays.

Figs. 141, 142 and 150. Models in Freiburg Clinic (*Johnsen*).

Figs. 143 and 147. Models in Neisser's Clinic in Breslau (*Kroener*).

Fig. 144. Model in St. Louis Hospital in Paris, No. 1059 (*Baretta*). Guibout's case.

Fig. 145. Model in St. Louis Hospital in Paris (*Baretta*). Besnier's case. Male, aged fifty-one; disease of 22 years' standing, only slightly treated, especially never with thermo-cautery.

Fig. 146. Model in Neisser's Clinic in Breslau (*Kroener*). Patient is still living.

Figs. 148, 149 and 151. Models in Neisser's Clinic in Breslau (*Kroener*).
Fig. 152. Model in Freiburg Clinic (*Johnsen*).

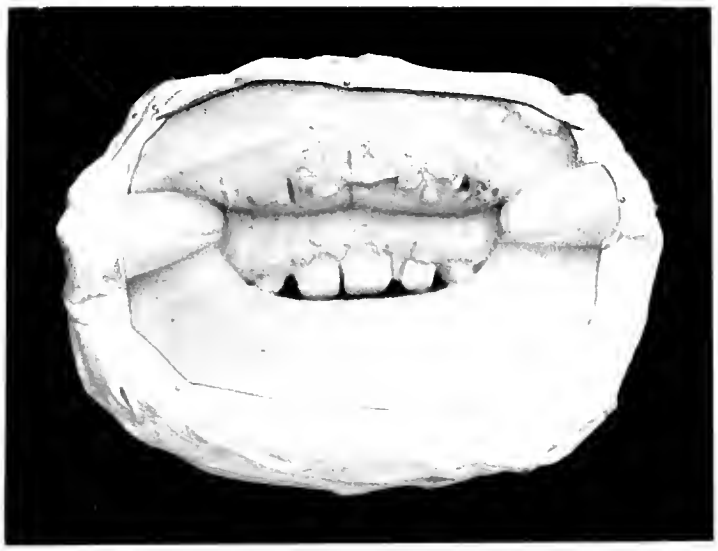


Fig. 152. Lupus vulgaris mucosae oris.

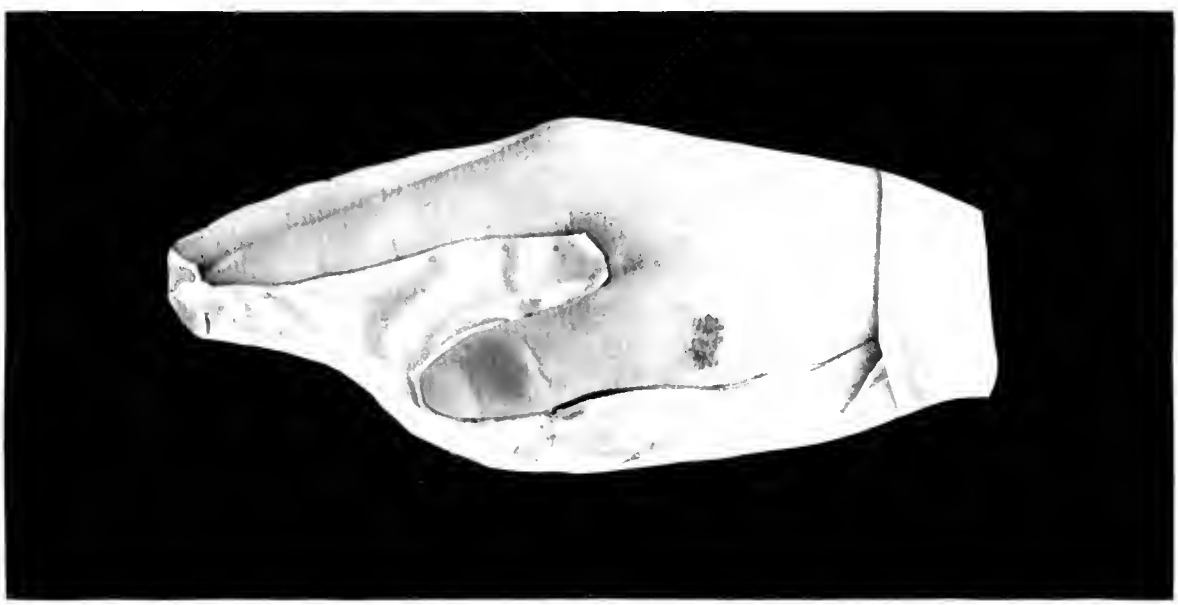


Fig. 153. Verruca necrogenica.

# Verruca Necrogenica

Synonym: Post-mortem wart

*Plate* **94**, Fig. 153

Under lupus vulgaris mention was made of a form, lupus verrucosus, described by authors, which in some instances appeared to result from direct inoculation with tuberculous matter. Such lesions, while sharing some of the features of common lupus, are usually held to be more allied to ordinary inoculation tuberculosis, about to be described. In these cases there is no predisposition required. Butchers and dissectors alike may be professionally inoculated, the accident occurring as a rule over a knuckle. The lesions must not be confounded with dissection pustules which are due to ordinary pyogenic cocci. The lesion develops slowly, resembling a wart in its evolution. There is an overgrowth of papillæ, a slight secretion of pus and the formation of a crust, which forms again whenever detached. A considerable size may be attained—an inch in diameter; and as the lesion increases there is some disposition to heal in the centre. That such a condition may pass by transitions into lupus verrucosus is manifest. Since no predisposition or special immunity exists, the natural defensive forces are operative and the lesion either heals of itself in time or in rare cases infects the organism with acute general tuberculosis. Fatal cases are very rare, however, and the more severe cases are probably due to mixed infection, with lymphangitis and general toxemia.

A condition known as tuberculosis verrucosa cutis, which occurs on the hands and feet and may be very extensive, occupying an entire foot, stands in some common relationship with lupus verrucosus and verruca necrogenica.

*Diagnosis*

Post-mortem wart must be differentiated from ordinary warts,

which often grow rapidly after local irritation, and post-mortem pustules. A microscopic examination should decide the matter.

*Treatment*

It should be easy to destroy these growths with the thermocautery. Cases may arise in which it would be more expedient to use the X-rays.

Fig. 153. Model in Freiburg Clinic (*Jacobi*).

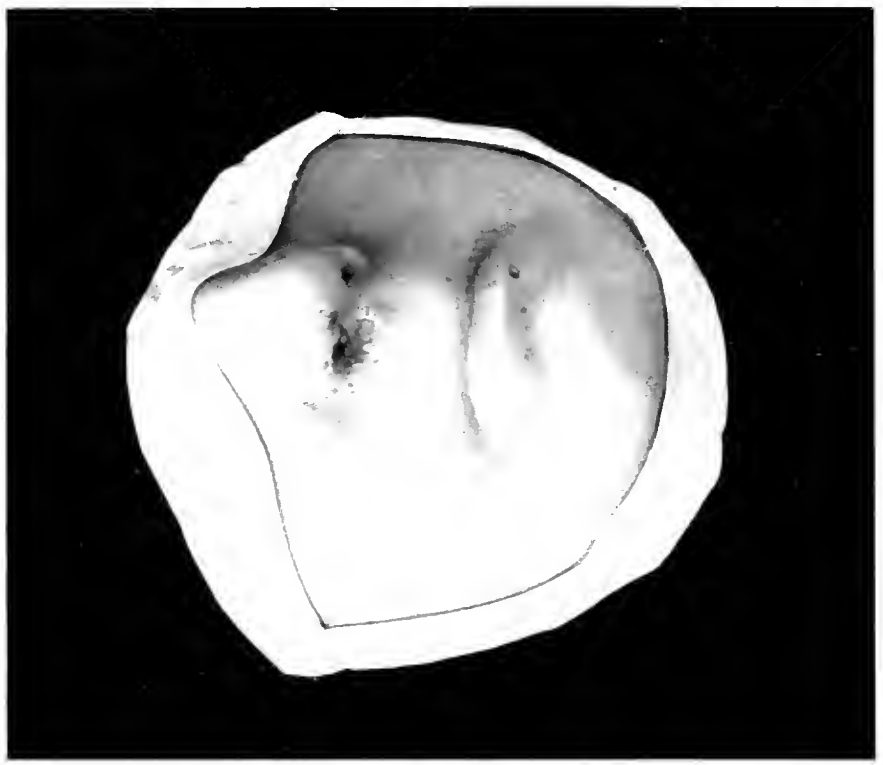


Fig. 155. Tuberculosis nasi.

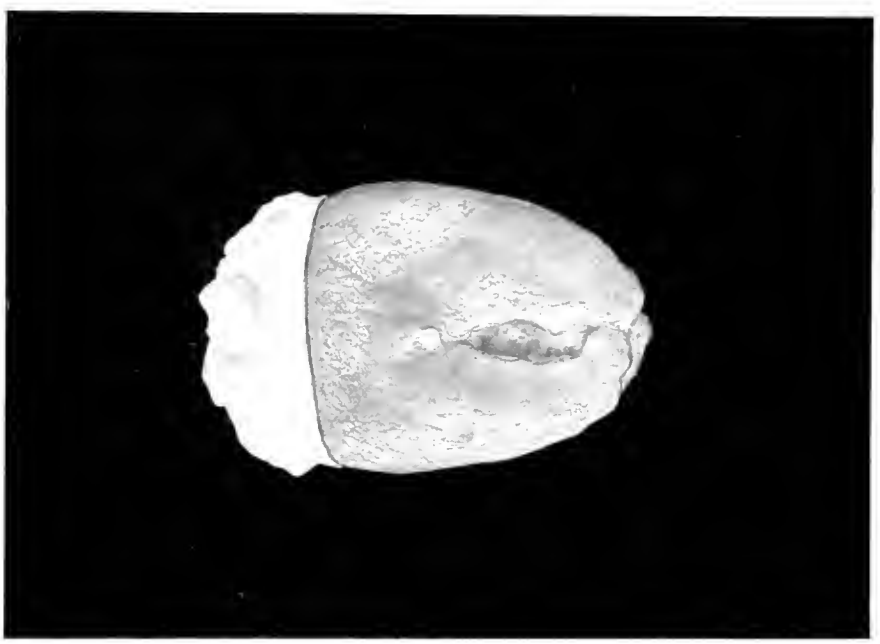


Fig. 154. Tuberculosis linguae.

# Tuberculosis Linguae

*Plate* **95,** Fig. 154

The tuberculous ulcer, or as it is more commonly called rhagade of the tongue because of the greater frequency and importance of the fissured form, is in the great majority of cases situated on the sides or dorsum of the organ. The first stage is the deposition of tubercles which sooner or later break down. The ulcer, when one forms, seldom exceeds the size of a bean. It is of variable depth and presents a grayish-green floor. Sometimes there is an attempt to granulate, notably after treatment. The edge is usually undermined and somewhat indurated. The rhagade is more common and is narrow and deep in comparison with the ulcer. It may appear shallow until the edges are separated, may even appear as a mere furrow. It may persist for a long time and eventually take on more of an ulcer form. Meanwhile new tubercles may form and ulcerate. The slow course sometimes pursued suggests an analogy with lupus. Tuberculous lesions of the tongue are usually secondary, but exceptionally they seem to be primary and as such have a relatively good prognosis.

*Diagnosis*

This is often made with great difficulty. Syphilis and cancer are the principal diseases to be excluded.

*Treatment*

This in primary tuberculous ulcer should be radical. In the milder cases, if the diagnosis is assured, a wedge-shaped section should be removed. If the area involved is considerable the paquelin or galvano-cautery, the curette, lactic acid, iodoform, and creosote should be our chief resources.

**Fig. 154.** Model in St. Louis Hospital in Paris, No. 1768 (*Baretta*). Tenneson's case

# Tuberculosis Nasi

*Plate* **95**, Fig. 155

Two lesions aside from lupus may occur about the nostrils from tuberculosis. One is the tuberculous tumor, or gumma, which may be primary, and forms just within the nostrils, usually in the septum. This may soften and ulcerate. The other lesion formed by the coalescence of miliary tubercles to form a typical tuberculous ulcer is seen as a rule only in people with advanced phthisis and is extremely rare. There is reason to believe, however, that it may occur in latent pulmonary tuberculosis. The lesion resembles in every way the types seen in other localities.

Fig. 155. Model in St. Louis Hospital in Paris, No. 2236 (*Baretta*). Hallopeau's case.

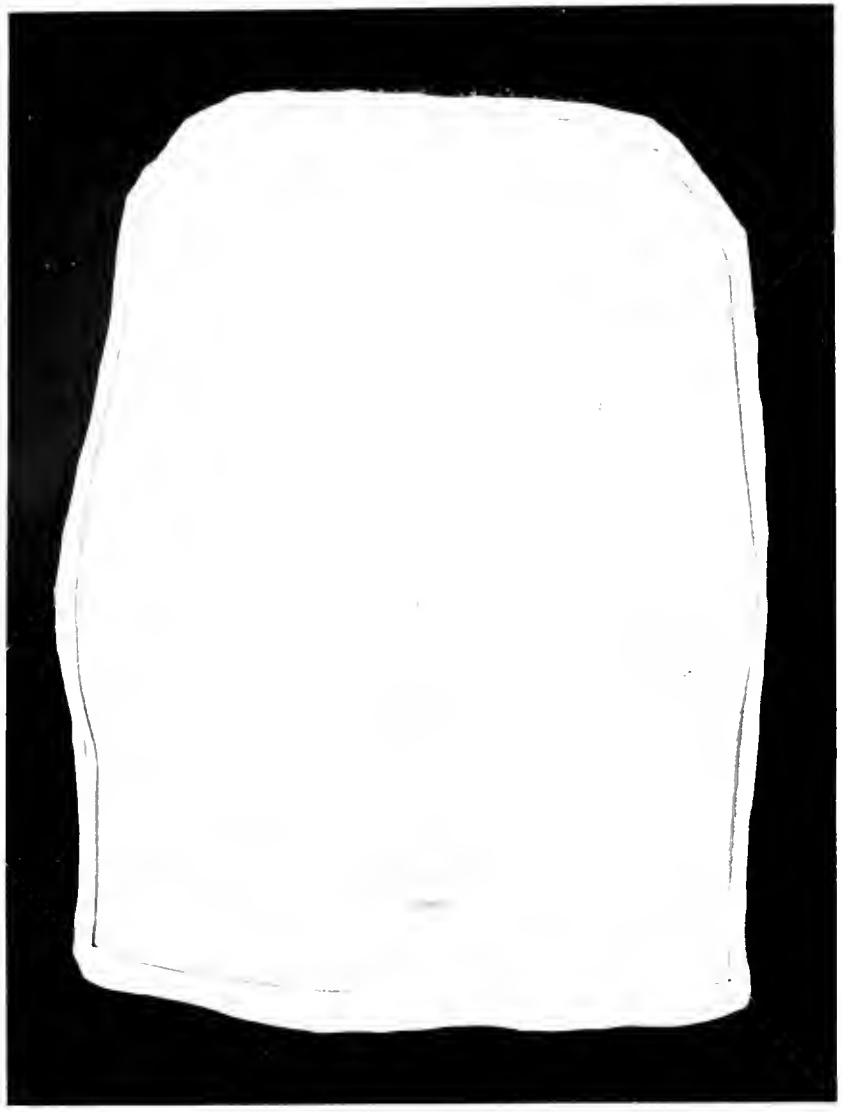


Fig. 156. Lichen scrophulosorum.

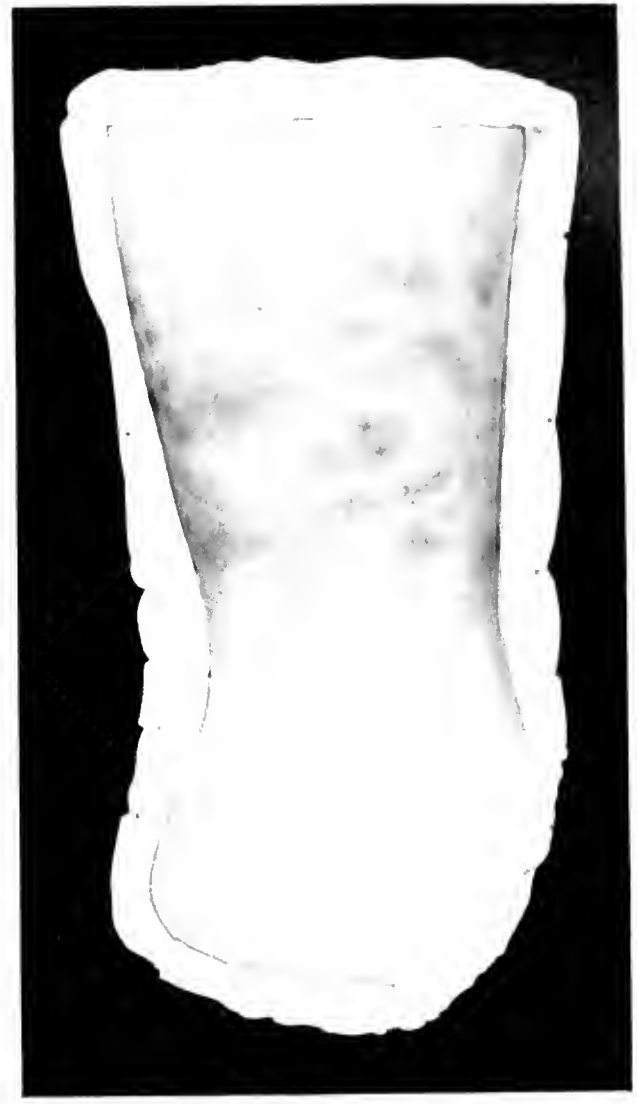


Fig. 157. Erythema induratum scrophulosorum (Bazin).

# Lichen Scrofulosorum

*Plate* **96,** Fig. 156

This affection is not conspicuous and gives rise to but little discomfort. The primary lesion is a miliary papule, these being closely grouped. They are red only at the outset. Sooner or later they become decolorized and may be either yellowish or skin-colored, in the latter case resembling goose-flesh. Sometimes they are tawny or brownish, as if from pigmentation. The closely set papules are each surmounted by a little scaliness and when involution begins the more centrally seated papules go first, and circinate lesions are often formed. Sometimes minute hemorrhages occur giving the lesions a livid hue. In certain cases the follicles seem to be implicated more directly and the papules then contain a sebaceous plug.

The patients are usually accidentally found to have this peculiar eruption on the trunk, usually about midway. The subjects are children or young adults of scrofulous habit. Of this affection it may be said that aside from the lesions themselves there are no symptoms. In rare cases similar lesions are seen on the limbs.

*Etiology*

The affection is believed to be a tuberculide, and in a few cases bacilli have actually been found. It stops short of being an active tuberculosis, although histologically it seems to consist of a tuberculous process about the hair-follicles. From the results of experiments it is possible that the process is due to the action of the toxins alone, although the rationale is obscure. It is known that scrofulous lesions of whatever kind are much less virulent than tuberculous ones, and that the subjects appear to have become immunized in a measure.

*Diagnosis*

There are a number of affections which produce miliary papules, but the seat, grouping, color and collateral evidences of scrofula should make the diagnosis. Other affections are keratosis pilaris,

papular eczema, lichen urticatus and syphilis, and in none of these, save perhaps when the limbs are involved, should there be any possibility of confusion.

*Prognosis and Treatment*

With no tendency to absolute recovery, since new lesions may replace old ones, the affection is nevertheless readily controlled by antiscrofulous measures—chiefly cod-liver oil internally and externally.

Fig. 156. Model in Freiburg Clinic (*Johnsen*).

# Erythema Induratum Scrofulosorum

Synonym: Bazin's disease

*Plate* **96,** Fig. 157

This affection bears considerable resemblance to erythema nodosum, being seated like the latter chiefly in the legs; it is, however, always a chronic condition, as a result of the continual appearance of new lesions. The lesions may be palpated beneath the skin before they become visible. They are then no larger than peas, and increase very slowly in size, nearly that of an English walnut. The skin over them becomes livid. They may in time undergo spontaneous involution or soften and ulcerate. Under the latter condition they naturally resemble syphilitic gummata. There is no suppuration, and the process is really a central necrosis, the resulting loss of substance being small at first. Eventually the entire nodule sloughs and this may even occur at the outset. There are several other clinical forms, as for example when a large node undergoes necrosis at two points, or two closely placed nodules each ulcerate.

The patients are almost always girls and women in poor health and circumstances and the lesions are largely peculiar to the legs, especially the lower portion. In a case of some duration various sized nodules and ulcers are seated side by side and between the lesions the skin appears purplish. Scars may be present and small nodules may be felt under the skin.

*Etiology*

This affection is believed to be related to tuberculosis, but the connection is hard to trace as the bacilli have never been found. The presumption is based on histologic and inoculation tests; also on the scrofulous habit of the patients.

*Diagnosis*

The resemblance to multiple syphilitic gummata is at times startling, but the course is more indolent, and late syphilis is not a

symmetrical disease. Erythema nodosum is at the beginning an acute disease while the other is sluggish; the former, while it may become chronic, never ulcerates, while the latter as a rule does. The bright yellow discharge from the lesions is said to be characteristic.

*Prognosis*

The scrofulous habit must be antagonized and if this can be done the prognosis is good.

*Treatment*

The usual regimen is prescribed. The best remedy is rest. The ulcers heal up under mild antiseptics and ointments which encourage granulation.

Fig. 157. Model in Freiburg Clinic (*Vogelbacher*).

Fig. 158. Scrophuloderma.

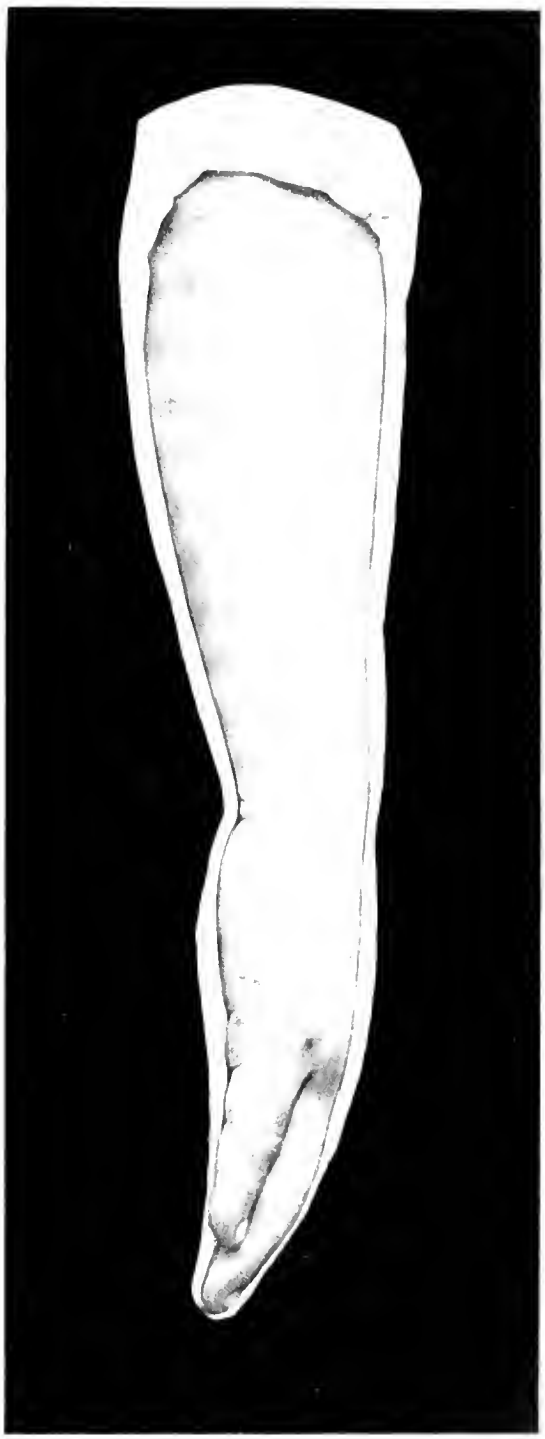


Fig. 159. Papulo-necrotic tuberculide

# Scrofuloderma

*Plate* **97,** Fig. 158

This term has been and is still rather loosely applied. It should be a generic term for all the cutaneous lesions which are clinically allied to scrofula in general. From this viewpoint affections like erythema induratum, and lichen scrofulosorum should be the leading representatives. From a narrow viewpoint the term is only applied to the cutaneous lesions which follow the rupture of a scrofulous abscess due to suppurating lymph nodes. Scrofuloderma is supposed to be different both from true tuberculosis of the skin and from the tuberculides so-called. The term is here applied to lymphoid swellings whether of original subcutaneous lymph nodes or independent formations in or under the skin. When these formations undergo caseation and indolent suppuration results, the overlying skin becomes thinned and livid and eventually gives way. There remain certain ulcers or shallow sinuses, the latter often multiple. The skin about them has a peculiar purplish color, the ulcers are undermined, granulate imperfectly, and have but a scanty secretion. Sometimes a fragile cicatrix forms. In these cases we may see supervene the so-called inoculation lupus or even an active tuberculosis, showing the close relationship of all these processes.

In certain patients who seem, while fairly healthy, to have been ravaged by the most polymorphous type of scrofula, so that hardly any tissue seems to have escaped, a peculiar eruption of papulopustules occurs, resembling most closely a syphilide of the same character. Before the introduction of the term tuberculide, this affection was termed by *Duhring* and *Bulkley* scrofuloderma. By exclusion it could be shown to be none of the known affections and the eminently scrofulous character of the subjects, who seem never to have had any other illness than some form of scrofula, causes the diagnosis of scrofuloderma. The affection consists of small papulopustules, of a torpid character, livid or brownish, scattered sparsely over the face, trunk and limbs. The lesions leave scars.

*Diagnosis*

The ulcerative lesions often resemble syphilis, but this disease should be readily excluded by the absence of other symptoms.

*Treatment*

The general health of the patient should be improved. Cod-liver oil, iron, arsenic, hypophosphates, etc., are indicated. Locally the lesions should be treated on general surgical lines.

Fig. 158. Model in Neisser's Clinic in Breslau (*Kroener*).

# Papulo-Necrotic Tuberculide

Synonyms: Folliclis, Necrotic granuloma

*Plate* **97,** Fig. 159

The papulo-necrotic tuberculides belong to a large group of skin manifestations, showing a great variety in appearance, but possessing many similar characteristics. They are frequently associated with tubercular manifestations elsewhere, such as tuberculous disease of the lymph-glands or lungs. The essential, and most frequently seen lesions are small, indurated, extremely indolent granulomas, showing a tendency to undergo central softening and necrosis. The site of each resolved lesion is marked by a prominent depressed, punched-out scar, much like that of variola. The lesions are bilateral and rather symmetrical. They appear most frequently on the upper extremities, particularly the forearms and hands. They occur mostly in individuals of scrofulous habit or history, and are frequently met with in chlorotic factory girls, with a depressed peripheral circulation.

The relationship between the tuberculides and tuberculosis is a very close one, but the exact nature of this relationship is unknown. Histologically, giant cells and a tuberculous architecture have frequently been demonstrated, but the tubercle bacillus has not been found. Many cases show only changes incident to simple inflammation.

*Diagnosis*

The symmetrically distributed indolent papules, with necrotic centres, and variola-like scars, together with the history and course of the disease, will serve to differentiate it from syphilis.

*Prognosis*

The disease is extremely chronic, and may continue for years.

*Treatment*

As the disease occurs mostly in those in poor general health, fresh air, sunshine, and good food are of prime importance. The

internal remedies vary with the indications of each individual case. Cod-liver oil and iron are frequently used, and are often of decided value. Tuberculin therapy has apparently cured, or greatly improved, a number of cases. Ammoniated mercury ointment, in from five to ten per cent. strength, has proved the most valuable local application. Antiseptic washes of mercuric chlorid (1:5000) or boric acid have been used. Curetting, with the subsequent application of pyrogallol salve has been recommended. Where the lesions are few excision may be practised. Good results in some cases have followed the application of the *Finsen*-light treatment. The X-rays are of less value.

Fig. 159. Model in Neisser's Clinic in Breslau (*Kroener*).

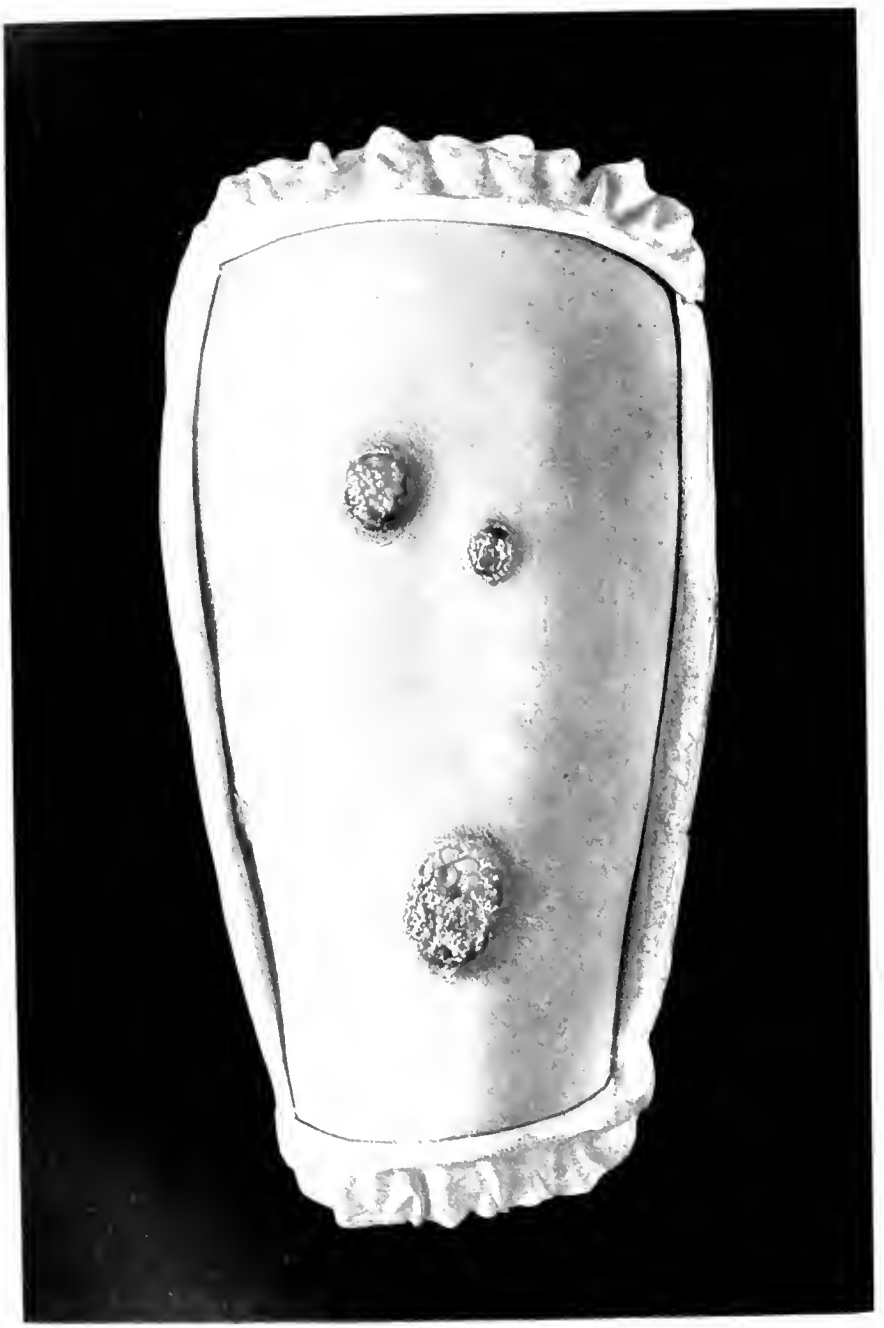


Fig. 160. Ulcus endemicum tropicum.

# Ulcus Endemicum Tropicum

*Plate* **98,** Fig. 160

Under this designation we find comprised a number of conditions old and new: the *Biskra* button, *Aleppo* evil, oriental boil, etc., and in recent years "Leishmaniosis ulcerosa cutic," due to the fact of its trypanosome origin.

From the earliest records, we have known that various local conditions, which closely resemble one another, impose themselves upon us as separate affections, having separate local designations. These affections may be traced from Morocco to the Ganges. Briefly summed up we have to do with chronic ulcers, sometimes multiple, on exposed localities. Some sort of insect undoubtedly acts in propagating this affection, not only from one subject to another, but in the same individual. The lesion, at first an itching papule, becomes in time a broad, itching pustule, covered with a crust. Removal of the latter shows a deep ulcer of uneven surface and various shades of color. Smaller pustules appear at the periphery, break down and become continuous with the mother pustule, increasing its area so that it may attain a diameter of several inches. The latter may slowly heal, perhaps only after years.

*Diagnosis*

This lies in recognizing the extreme chronic occurrence of a sore on an exposed surface.

*Prognosis*

Although extremely chronic the ulcers sometimes heal spontaneously.

*Treatment*

Destruction of an entire structure.

Fig. 160. Model in St. Louis Hospital in Paris (*Baretta*). By permission of Dr. Beurmann, from Iconographia dermatologica, No. IV.

# Lepra

Synonyms: Leprosy, Elephantiasis Græcorum, Leontiasis, Satyriasis, Spedalskhed

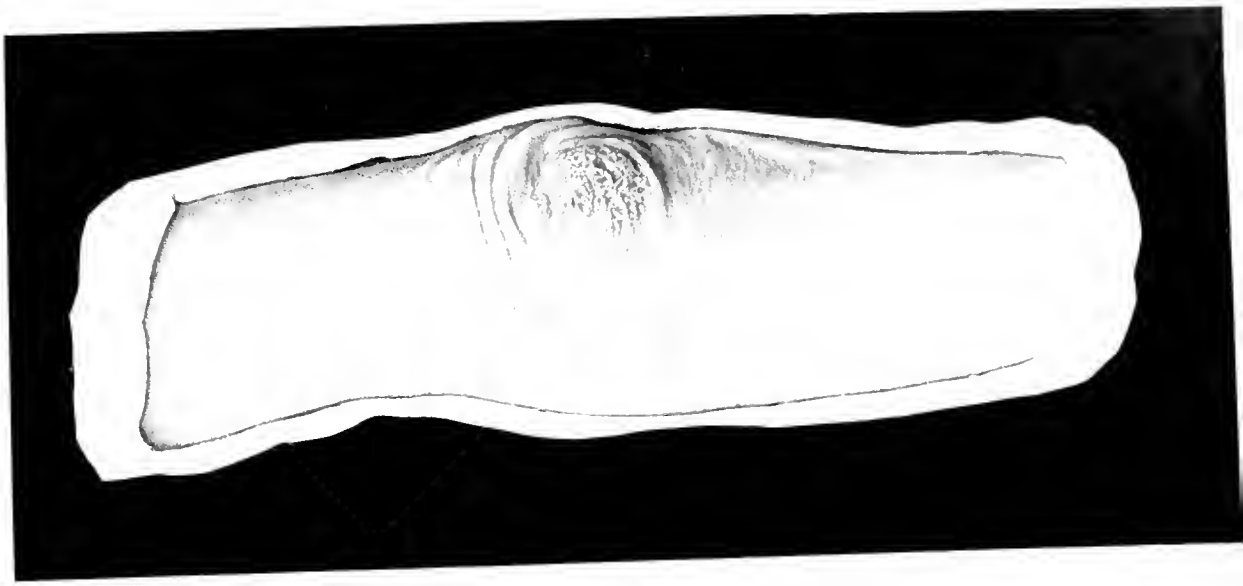
*Plate* **99,** Figs. 161, 162; *Plate* **100,** Figs. 163, 164; *Plate* **101,** Fig. 165; *Plate* **102,** Fig. 166

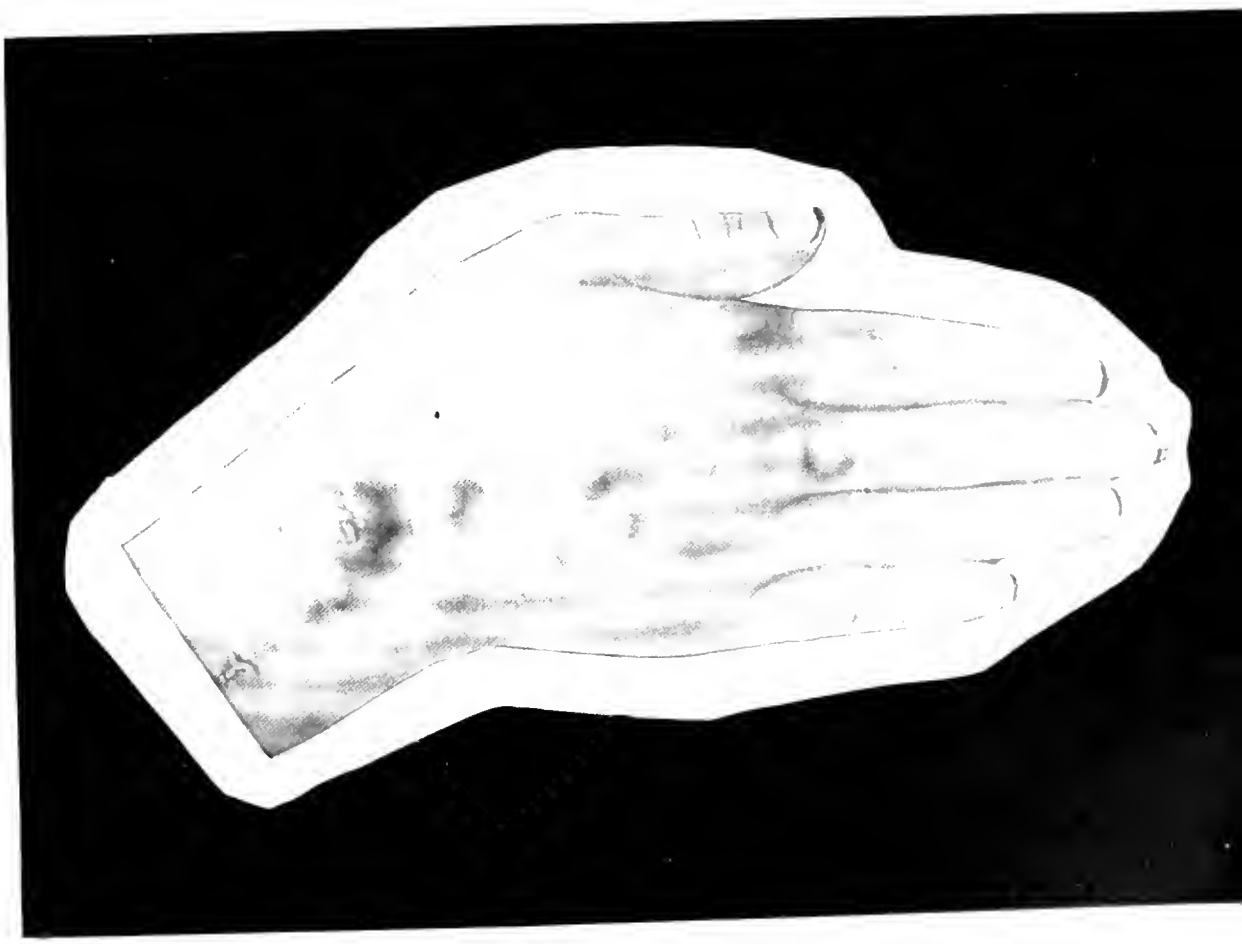
This is one of the oldest endemic affections, and from its disfiguring effects is readily recognized as the elephantiasis leontiasis and satyriasis of the Greeks. The connection between this disease and the satyrs of mythology is obscure; it may have referred to the fact that lepers were forced to shelter themselves in the depths of the woods, and this with their deformed appearance possibly suggested the opprobrious appellation. The usual explanation that lepers suffered with inordinate venereal desires, therein resembling satyrs, is not in accordance with facts, the contrary being the case. This, however, may have been the popular belief. The word lepra meant to the Greeks only a scaly affection, probably psoriasis. The word lepra was first applied to leprosy by the Arabians, who confined the term elephantiasis to a different disease (filariasis). Much ingenuity has been displayed in trying to identify biblical leprosy, which probably comprehended a number of chronic skin diseases characterized by scaling or mere whiteness without scaling. Hence both psoriasis and vitiligo might belong here. The confusion with true leprosy doubtless arose from the fact that in the prodromal and early stages of leprosy, peculiar eruptions which simulated benign dermatoses are very common. Not less vague was the significance of medieval leprosy, and it is hardly worth while to attempt to trace the exact source of our present conception of the disease.

While there are two quite distinct varieties of true leprosy, the tubercular and the anesthetic, the latter was probably known in earlier times only in mixed cases. The purely anesthetic type is so unlike tubercular leprosy that it should be separately considered.

*Lepra Tuberosa*

This type of leprosy belongs to the infectious granulomata and resembles other members of the group, notably syphilis and tuberculosis in various ways, and especially in its ability to attack almost the entire integument with the upper air and food passages, involving destruction of the facial bones. If we bear in mind what tertiary





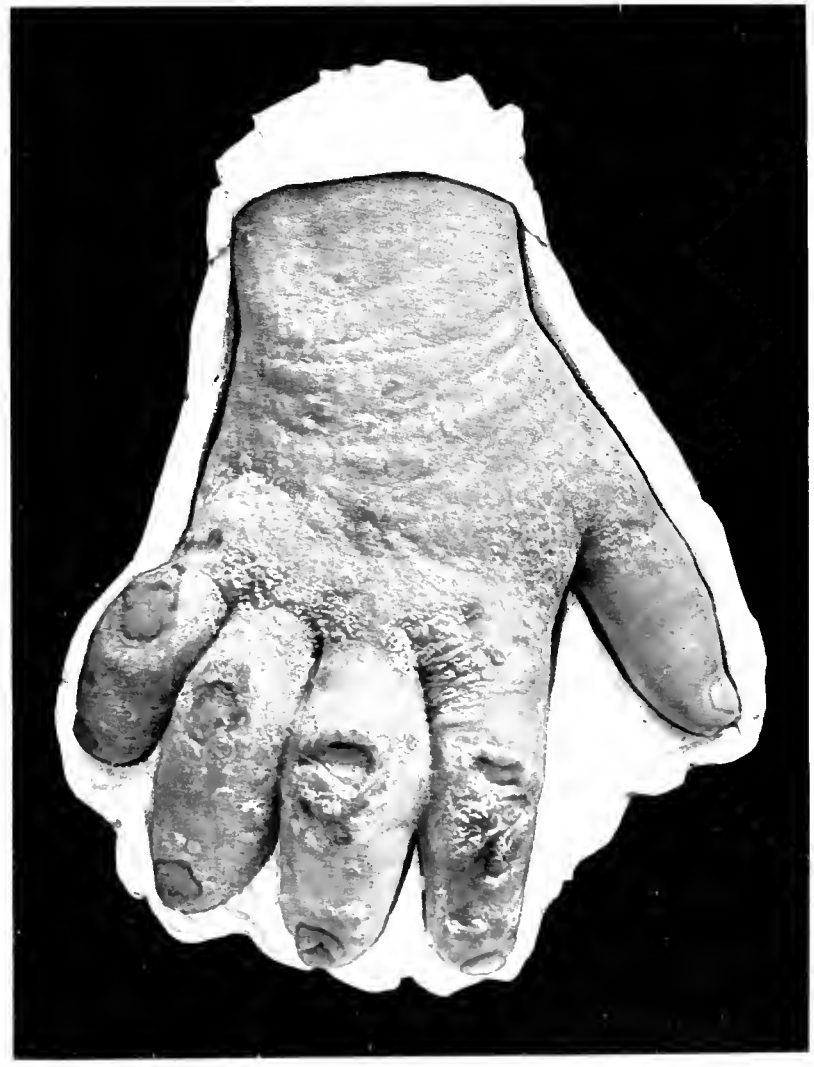


Fig. 163. 164. Lepra tuberosa

syphilis is, it will at once become apparent that when the tubercles and nodules of leprosy appear in the skin, the disease should already be old, and in a late stage of development.

The word tertiary is justifiable if we accept the theory of prominent authorities as to the primary lesion of leprosy; the secondary stage would imply the date of the infection of the blood. Before the tubercular lesions appear there are vague symptoms which point to the presence of a toxemia; no doubt coinciding with the blood infection; while paresthetic sensations of all kinds show an early implication of the nerves at some point in their course and distribution. In some cases there is a transitory eruption of an erythematous type which is seldom recognized. At a later period macules appear, which are permanent and eventually become the seat of tubercles. These vary greatly in color, contour, etc., and often simulate ordinary eruptions. There is usually an increase of pigmentation, which associated with hyperemia gives rise to red and livid blotches on the one hand, or brown, black or slate-colored areas on the other. The individual lesions show the greatest variation in size and details in general. The amount and character of the pigmentation may suggest a number of affections, but the leprous nature is usually recognized at once by the anesthesia.

The macules are by no means a constant phenomenon, and when the individual with developed leprosy appears he usually presents quite a different picture. The face is the part to manifest the tuberous process, as a rule, and the tubercles may appear in one of several localities, sooner or later symmetrically. In one patient there may be, for example, a few flesh-colored tubercles, closely grouped, over the cheek bones. The lobe of the ear is also a favorite early site, and merely feeling of the lobes is one of the routine ways of arriving at a diagnosis. Instead of these circumscribed groups, we may see a general infiltration of the skin of the forehead, especially of the eyebrows, or of the nose, lips or chin. There appears to be no law governing the choice of location or order of evolution. When the process is sufficiently diffuse and deep-seated the appearance is typical of the disease, and is described by the term leontiasis. In some cases, however, the features which give to the face its expression are but little affected, although there may be very many tubercles on the forehead, cheeks and chin. The greatest disfigurement results from the corrugation of the forehead, the loss of the eyebrows, which is practically constant, the infiltration of the upper eyelids, the spreading of the nose and thickening of the lips. All of these may occur in the same subject, and in the most extreme development the

entire face is uniformly thickened and lobulated by folds like that of a pachyderm—hence the designation elephantiasis.

During the appearance of the tubercles on the face there is commonly a similar evolution in the nasal chambers, mouth and throat, and the early perforation of the septum is sometimes regarded as the primary lesion of the disease, but this is unlikely. Loss of the nasal bones occurs, as in lupus and syphilis, in a certain proportion of cases. There is also a marked tendency to lepra of the larynx, producing aphonia, and frequently there is also destruction of the sight.

Despite the severity of leprosy in the face and its accessory cavities, the scalp enjoys almost an immunity. The deposition of the tubercles is usually preceded and accompanied by pigment anomalies, but these are of minor significance. Tubercle and nodules occur in all localities outside of the face, and the nodules may reach the size of tumors. The diseased surface is prone to form intractable ulcers. The skin at large may also be uniformly thickened. Thus, in one leper the hands and fingers may retain their normal contour and yet be the seat of many tubercles and nodules, or the entire hands may be swollen out of shape, the fingers resembling bananas. The participation of the lymphatics plays a considerable rôle in leprosy as it does in leukemic tumors and mycosis fongoides. When these are involved the amount of swelling and thickening is greatly increased.

*Lepra Anesthetica*

It is of course understood that the so-called anesthetic or nerve leprosy may complicate ordinary tubercular leprosy, in which case its manifestations are overshadowed by the severity of the latter affection. It is also understood that in exclusively tubercular leprosy there is always implication of the terminal nerve filaments, so that anesthesia is a constant symptom. What is meant by lepra anesthetica or nervora, in the strictest sense of the term, is a limitation of the disease to one or more nerve trunks, or in other words isolated leprous neuritis. This is a not uncommon type of the disease which presents no further deformity than results from this one class of lesions. The subjects, often superior in their station, may be found in schools or offices or in society, with no one, not even themselves and their families, aware of the nature of the malady. The patient seems to develop the disease in the usual manner, i.e., with obscure evidences of toxemia. They may also have the prodromes and early maculo-anesthetic lesions, but tubercles never develop. The bacillary or toxic cause of the disease is neurotrophic only. A neuritis develops,

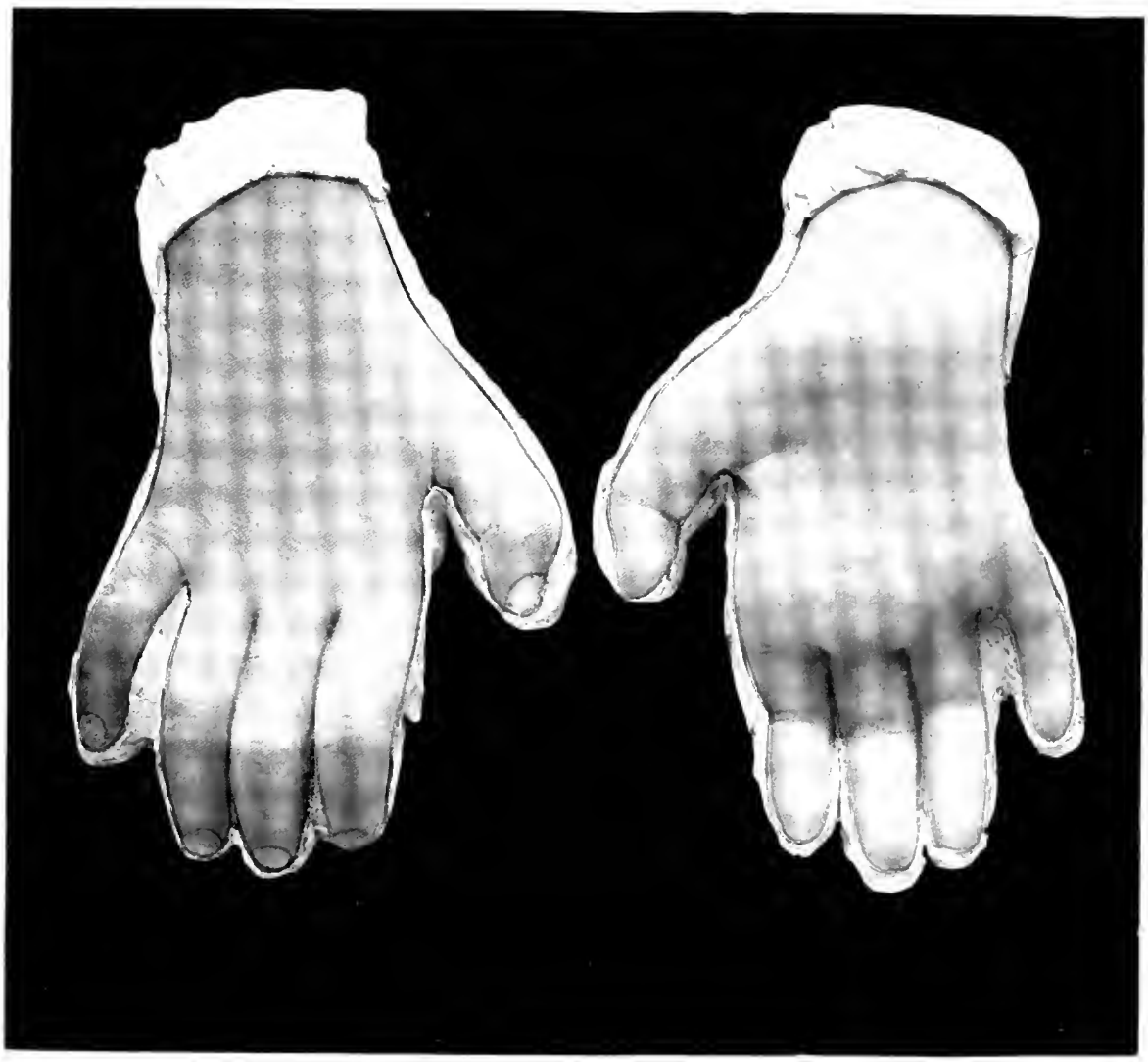


Fig. 165. Lepra anaesthetica.

just as it may in a number of diseases. A pemphigoid eruption often attends the supervention of the neuritis.

The patients usually present themselves after the neuritis is fully developed. If seen early enough there may be present the indefinable toxic symptoms, the paresthesiæ and the preliminary maculo-anesthetic eruption on the trunk. The latter is not so marked and deep-seated as in lepra tuberosa, and does not present such wide diffusion or deep stains. Great variety is shown, however, in color and extent and presence of an atrophic element which causes lesions suggesting vitiligo and morphea. There is also considerable variety in the sensory disturbances, which may be hyperesthetic or paresthetic at first, but end in anesthesia. One nerve only, usually the ulnar, is involved, and there may be found some macular lesions on the face, or perhaps not even that—only subjective anesthesia in limited areas. When a particular nerve trunk like the ulnar is involved, the picture is simply that of a severe, persistent neuritis with eventual trophic alterations, perhaps of the highest type. It is doubtful, however, if a single detail is characteristic of leprosy. The claw hand, the sloughing of the phalanges, the perforating ulcers of the sole of the foot, when the peroneal nerve is involved, are shown to be of leprous origin only by collateral evidence and exclusion. The neuritis of the ulnar and peroneal nerves is fully developed, but analogous lesions on the face and trunk are much less typical, suggesting morphea or hemiatrophia facialis. On account of our ignorance of many localized trophic affections, a few authors look upon them as survivals of nerve leprosy. Syringomyelia, with its anesthesia and trophic lesions on the hands, resembles nerve leprosy, but is symmetrical while the latter may be unilateral. There appears to be no reason for pure nerve leprosy being fatal. Subjects admittedly have lived twenty or more years.

*Etiology*

Leprosy is due entirely to the parasitism of *Hansen's* bacillus, which can now be cultivated and inoculated. The bacillus greatly resembles that of tuberculosis, and in animal experiments the two may be made to produce much the same lesions. All attempts to trace the passage of the germs into the human body have been unavailing. Although leprosy is prevalent in hot countries, this fact is a mere coincidence, for the disease also flourishes in the coldest countries. The abundance of insect life in hot countries and the huddling together of people in vermin-infested huts in cold climates strongly suggests the intermediation of insects. There is no initial or parent lesion known in leprosy, as in some of its congeners.

Whatever the mode of transmission, there is a notable immunity to the disease on the part of relatives and neighbors, and this may be an acquired immunity, for we know nothing of any minimal forms of the disease. The familial character suggests also an inherited disposition to the malady.

*Diagnosis*

Only in the earliest stages is there any difficulty, and this usually in non-leprous countries. In the long prodromal period there are many vague symptoms suggesting a chronic or recurrent toxemia, which most naturally remind one of malaria, while the paresthesias may suggest various affections of the nervous system. If there is a pronounced macular stage antedating the tubercles, the presence of anesthesia is significant. There should be a special examination of the septum for a lesion, also of the skin of the face for the first tubercles. The ulnar nerve is sometimes felt to be thickened at the internal condyle. During the first evolution of the tubercles on the face, both syphilis and lupus may be simulated, but not to such an extent as to lead to confusion. The tuberculin test is negative in lepers, except in those who are also suffering from tuberculosis, but the *Wassermann* reaction is generally positive, especially in the nodular type of the disease.

*Prognosis*

Leprosy tends to appear in successive exacerbations. One of these may not amount to a confirmed disease, for in very rare cases there is no succession. These self-limited cases may be responsible for erroneous ideas of treatment. The affection once developed is practically incurable. Despite the malignity of the disease, vital organs are not attacked, and although the patient is literally dying by inches and menaced by a score of other diseases by reason of his low vitality, he may live many years, the average being eight or nine or even more. The anesthesia robs the disease of much suffering, but the patient, largely disabled by his infirmities and ostracized by society, is reduced to continued martyrdom. In about half the cases death occurs from tuberculosis. The leper somehow develops immunity to septic infection to which he is constantly exposed, and cancer is almost unknown among them.

*Treatment*

While segregation protects the community at large, emigration benefits the individual leper. Change of residence to a non-leprous country or otherwise healthy climate invariably lengthens the life

of the patient and lessens the severity of the disease. The reverse is true when the patient remains in a locality where leprosy is endemic or when a victim of the disease is forced to associate with other lepers.

In addition to the best dietetic and hygienic management, and the treatment of symptoms as they arise, the various drugs generally recommended as antileprous remedies should be employed. The best accredited of these is chaulmoogra oil. Symptomatic betterment nearly always follows the use of this oil, and some believe that by perseverance a technique may be devised by which it may become a veritable specific, attacking the bacillus in all the tissues. At present the great drawback to the use of oil is the frequency with which it causes gastric disturbance. As it should be given in large doses, its administration subcutaneously or by inunction is not very satisfactory. Gurjun oil and hoang-nan are drugs that have been extensively used in leprosy. *Crocker* strongly recommends the intramuscular injection of bichloride of mercury.

In the anesthetic type of the disease improvement has sometimes followed the administration of large doses of nuc. vomicæ. Arsenic has often been used for its general tonic effect, and in some cases of tubercular leprosy apparent improvement has followed intravenous injections of salvarsan. The X-rays have been largely used and are now known to be of considerably less value than was formerly supposed. Nastin, prepared from a streptothrix found in leprous nodules, has recently attained considerable attention as an antileprous remedy. Its therapeutic value, however, has not as yet been definitely determined. Serums and vaccines are still in the experimental stage.

Fig. 161. Model in Lassar's Clinic in Berlin (*Kasten*).

Fig. 162. Model in Neisser's Clinic in Breslau (*Kroener*).

Fig. 163. Model in St. Louis Hospital in Paris, No. 1000 (*Baretta*). Lailler's case. A leper from the Isle of Bourbon.

Fig. 164. Model in St. Louis Hospital in Paris, No. 1217 (*Baretta*). Vidal's case. A leper from Calcutta.

Figs. 165 and 166. Models from Neisser's Clinic in Breslau (*Kroener*). The daughter of a fisherman from the neighborhood of Memel, aged seventeen, with disturbances of sensibility; wasting, especially of the arms and legs, noticed for a year and a half; pigmentary and blanched areas on the trunk; atrophy of the hands, especially of the thenar, hypothenar, and interosseous muscles.

# Rhinoscleroma

*Plate* **102,** Fig. 167

This affection, which is often at the present day termed simply scleroma, because it is not peculiar to the nose nor does it necessarily begin in that organ, was originally seen only in certain localities in Eastern Europe, where at first it seemed to affect only Orthodox Jews. At a later period it was found farther west, and also among other races, and it is now known to occur in Central and South America. From its original locality in Europe it has also been carried into various countries, the United States included, by immigrants.

Rhinoscleroma is limited to the nose, pharynx, larynx and trachea, the same area in fact to be attacked by ozenous affections with which it is thought to be in some way related. It may be primary in any of these localities, but in about ninety per cent. appears first in the nose. Its location here is the only one of dermatologic significance. It begins in the mucous membrane, from which locality it involves the cartilages and soft parts of the nose. These structures are infiltrated with extremely hard neoplastic tissue, and the process may extend to the lips, the nose becoming broad and the nostrils narrowed. The actual lesion is a flattened nodule and these may remain isolated or be crowded together.

The description thus far given follows that found in dermatological works. It is, however, a serious error to regard this affection as one which primarily concerns the dermatologist, who sees as a rule only such advanced forms as have involved the face. The rhinolaryngologist is bound to see a greater number of cases than does the dermatologist, for he sees the types which have not attacked the skin. The affection, in fact, is one of the nasal cavities which may extend either forward or backward. It seldom climbs upward, so that the olfactory portion of the nose is non-participating.

The primary focus is most commonly found on the anterior region of the floor of the nose, or from the continuous portion of the septum and the contiguous area of the inferior turbinal. Even when its

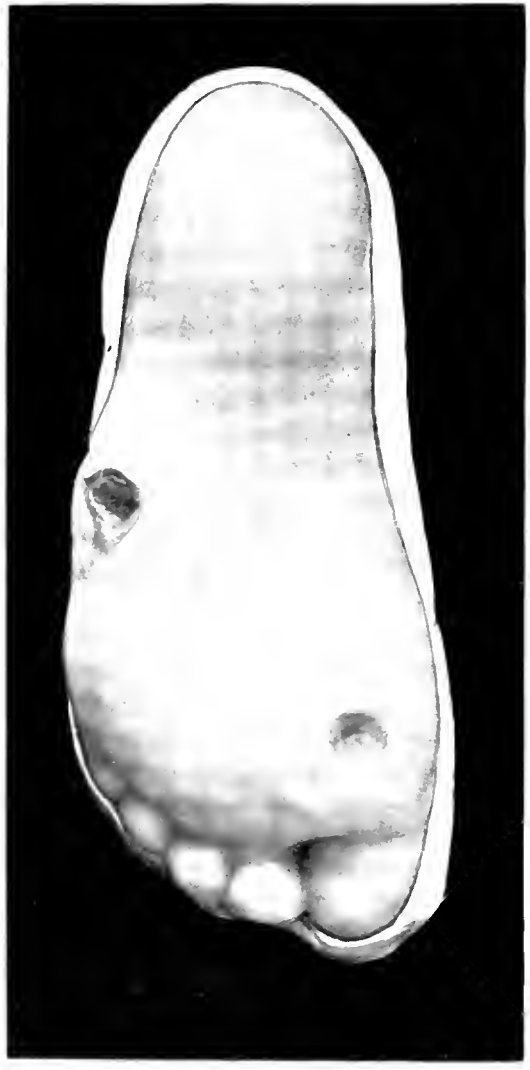


Fig. 166. Lepra (ulcus perforans).

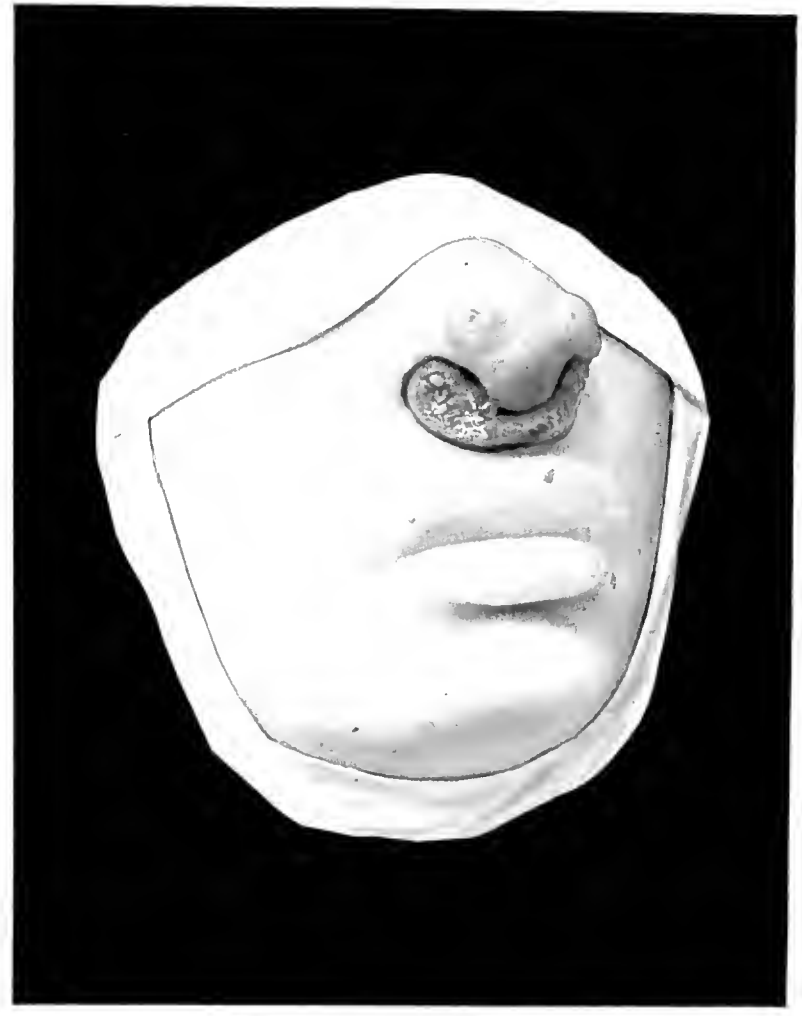


Fig. 167. Rhinoscleroma.

development has not transcended this locality, it is recognized by the rhinologist. In the meantime it advances in growth within the nasal chambers, and in many cases extends backward to involve the pharynx and larynx.

The affection tends to appear in nodules, discrete or confluent, which cause much deformity through the resulting thickening of the various tissues attacked, but seldom leads to secondary changes of any sort. Ulceration does not often appear.

*Etiology*

The primary prerequisite seems to be squalor. Race is no longer believed to be a prominent factor. A characteristic bacillus appears to be the efficient cause, one which differs in no wise from the bacillus ozenæ and bacillus of *Friedlander* pneumonia. Once thought to be a disease of adult life, it is now known to attack children.

*Diagnosis*

This could undoubtedly be made by exclusion in cases of doubt, but when well developed the nature of the condition should be evident.

*Treatment*

The disease cannot be extirpated surgically, for new nodules are bound to reappear. The troubles caused are entirely mechanical, and hence nasal and laryngeal obstruction have to be prevented, if possible. The treatment may be summed up in radiography and auto-vaccino-therapy, which sometimes serve at least to clear up the obstructions to breathing.

Fig. 167. Model in St. Louis Hospital in Paris, No. 1615 (*Baretta*). Besnier's case.

# Leukemia Cutis

*Plate* **103,** Fig. 168

The general condition known as leukemia, from the initial blood state, is characterized by lymphoid tumors of certain structures along with a general lymphoid infiltration of the viscera. Exceptionally both these features are seen in the skin, and the resulting condition of the latter bears a not inconsiderate resemblance to certain cases of multiple sarcoma and granuloma fungoides. The earliest manifestations in the skin, whether or not due to interference with the lymph circulation, sometimes consist of a dermatitis or eczema, which itches intensely, and becomes infiltrated with time. These eruptions, however, do not pass directly into lymphomatous lesions, as might be expected from the analogy with granuloma fungoides. An irregular thickening of the skin from participation of the lymphatics also occurs without previous dermatitis. Both the dermatitis and the elephantiasis lesions occur in more or less circumscribed areas. Tumors occur in two principal forms. In one, the lesions are small, in size up to a cherry and very numerous, sometimes arranged in series. The other consists of individual masses which may attain large dimensions. All these lesions, which depend evidently on more or less common factors, may occur singly or in combination. The head and face, arms and genitoanal region are the localities of choice. Occurring in the face a condition of leontiasis results. The affection does not necessarily have a leukemic basis, for the same lesions occur in pseudo-leukemia or *Hodgkin's* disease. Despite the severity of the condition the lesions do not appear to undergo much retrograde change nor do they seem to be able to increase indefinitely. In any case death from the underlying disease would take place before such results could transpire. The prognosis for recovery is hopeless.

*Diagnosis*

In any of the affections of this type a blood count must be made to exclude granuloma fungoides and pseudo-leukemia. There is little doubt, however, that all these affections form a group disease.

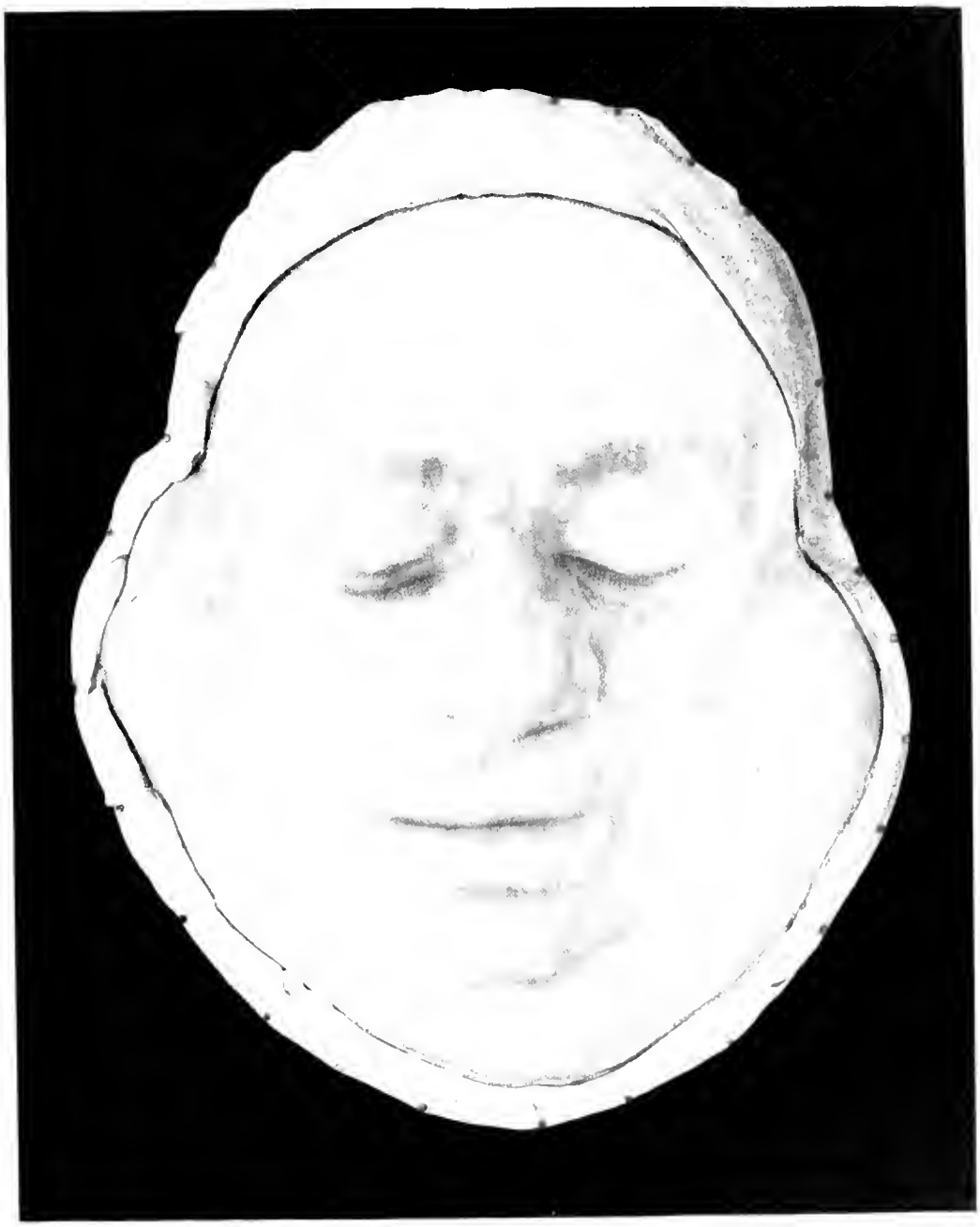


Fig. 168. Leukaemia cutis.

*Treatment*

The X-rays are much used at present for the general condition of leukemia, and from their power over neoplasms they furnish almost our sole resource. Arsenic injections have a certain influence in some cases.

Fig. 168. Model in Neisser's Clinic in Breslau (*Kroener*).

# Granulomo Fungoides

Synonym: Mycosis fungoides

*Plate* **104,** Fig. 169; *Plate* **105,** Fig. 170

This very rare affection, first described by *Alibert* in 1814, presents some notable analogies with leukemia of the skin and pseudoleukemia, resembling these more than multiple sarcoma with which it has sometimes been confused. In a few cases a leukemia blood picture has been found in typical granuloma fungoides. The most remarkable parallelism with leukemia lies in the initial pruriginous eruptions. These manifestations in the case of leukemia are said to point to an underlying systemic infection. In the polymorphous character of these exanthems, their occurrence in successive crops, the intense itching, and the chronic intractable character, we are reminded of some features of dermatitis herpetiformis. Eczema has also been exactly simulated, and even psoriasis. These eruptions may be more or less generalized or narrowly circumscribed. This preliminary phase lasts for months or years, crops of eruption succeeding one another, until at last the presence of infiltration is noted, at first in small areas, causing flat nodes from pea size to that of a cherry. We see something of this sequence in other granulomata of the skin—superficial eruptions followed by nodulation. The nodules, however, in this case become distinct tumors, the tendency of the former being toward aggregation into patches. Tumors, however, may also arise from apparently healthy integument. Here, too, it may be emphasized that the so-called premycotic stage is sometimes lacking, the disease beginning entirely as multiple tumors. Notwithstanding their formidable characters, they sometimes undergo involution. With the appearance of tumors there is no extinction of the premycotic manifestations which continue to appear. The first tumors are small and not numerous, but others soon appear and the entire surface may in time be studded with them. They tend to be larger in successive crops and more disposed to retrograde changes. They vary much in appearance and have been likened to various

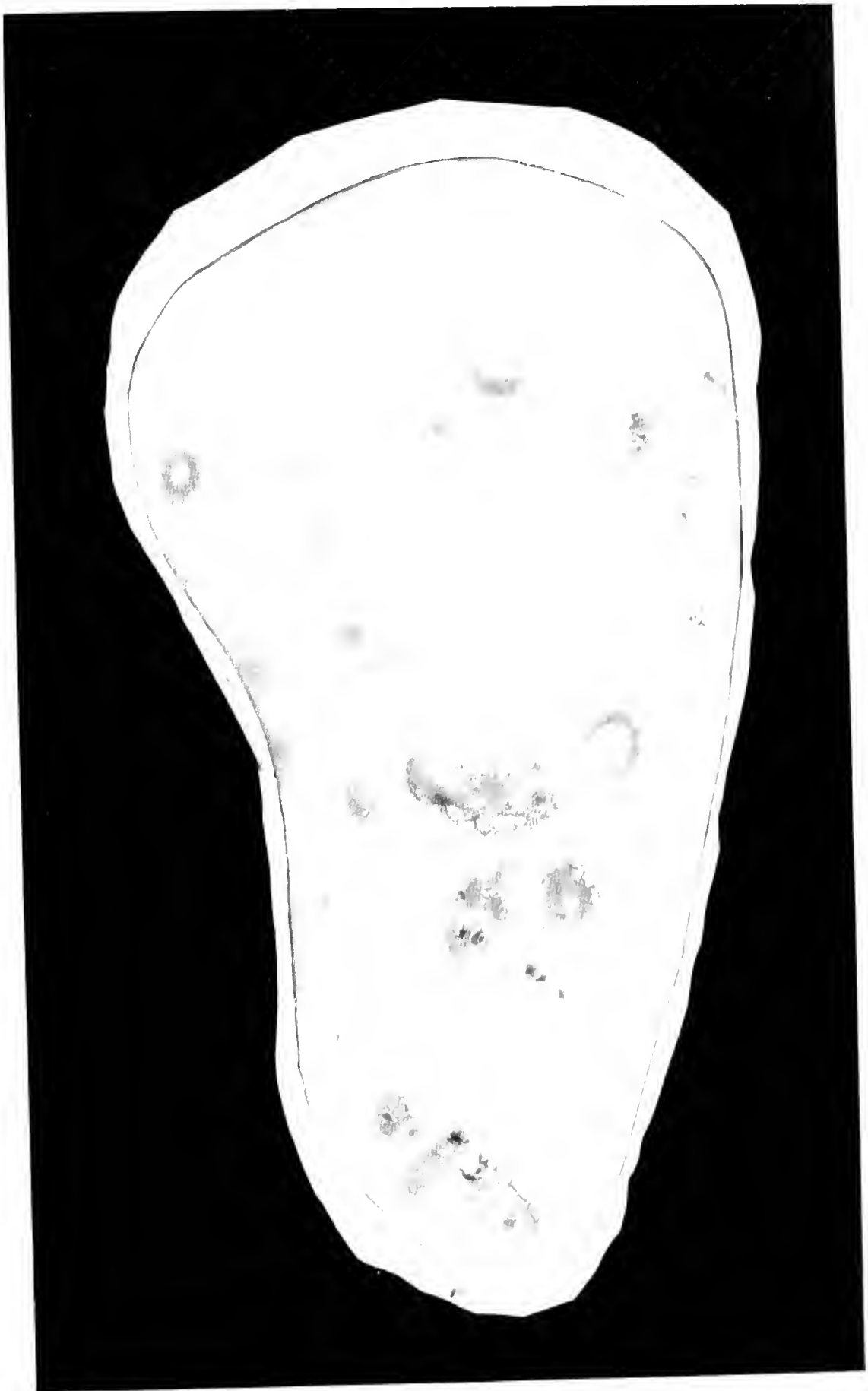


Fig. 169. Granuloma fungoides.

objects, as tomatoes, there being a tendency to lobulation. The appearance presented by tumors is not to be confused with the changes which supervene after ulceration. The latter is not a universal process, else the patient would hardly be able to maintain his general health. It is perhaps exceptional that a tumor softens and ulcerates at the summit, after which the proliferation from the exposed surface is of a fungoid character. In certain cases, however, the mushroom-like lesions may predominate, so that as in *Alibert's* first case there was a condition like yaws. The patient's general health, often maintained throughout, now begins to succumb to marasmus, and death ensues.

*Etiology*

The disease is regarded by many as being of parasitic origin, although this as yet has not been proved. The general aspect of the affection is much like that of sarcoma. Blood changes are sometimes seen in granuloma fungoides but they show variable pictures. The blood changes sometimes seen—eosinophilia, polynucleosis, etc., are only such as may accompany toxic, infectious, and other obscure chronic diseases. As a matter of fact they differ in nowise from blood pictures seen in syphilis and tuberculosis.

Next in interest to the blood pictures are the visceral lesions. The aggregate amount of study which has been bestowed on these is not extensive. Many of the changes are only such as would naturally be found in any chronic constitutional disease. The question as to whether do actual metastatic growths occur which are identical with those of the skin is naturally of the greatest importance. Lymphoid hyperplasia has been found at times which, however, presents nothing specific. It cannot be said that any of the questionable finds duplicate throughout in structure the tumors of the skin. There are, however, a few cases on record in which careful histological study of the viscera has revealed lesions which conform in every way to the cutaneous growths. *Bosellini* found such changes in the cortex of the brain which he regards as possessing analogy with luetic and tuberculous gummata in the same locality.

*Diagnosis*

In the early stage the affection may bear a very decided resemblance to eczema, psoriasis or urticaria. In the stages of infiltration and tumor formation, however, the condition is unique and a diagnosis may be made by exclusion. The microscopical picture is characteristic even in the early stage and a biopsy should always be made in suspected cases.

*Prognosis*

The duration is very uncertain, depending largely upon the period at which the fungoid stage develops. After this has appeared death is a question of months, the utmost survival being perhaps two years.

*Treatment*

Constitutional treatment consists essentially in the use of tonics combined with a generous diet.

The X-rays have a very decided influence upon the symptoms and lesions of the disease. In the early stage the pruritus is greatly relieved and in the late stage the tumors may be made to practically disappear. A few years ago it was thought that with the X-rays a symptomatic cure could be obtained, and many of the highest authorities still look upon their employment with favor. In cases that have been under my own observation, however, I am convinced that death followed the apparent improvement obtained by the use of the rays more rapidly than would otherwise have been the case.

Arsenic is generally recommended, and has been used extensively, sometimes with benefit. It should be given in large doses, internally, and by subcutaneous injection. In one of my cases very decided improvement followed intravenous injections of salvarsan. Potassium iodid is occasionally of value in the fungoid stage.

Local treatment is merely palliative. In the prefungoid stage, the various antipruritic remedies used in eczema may be employed. In the late stage ablation of the tumors may be performed or the growths destroyed by the thermo- or electro-cautery. When the tumors break down antiseptic applications and dressings are indicated. Dry dusting-powders are often useful.

Fig. 169. Model in Neisser's Clinic in Breslau (*Kroener*).

Fig. 170. Model in St. Louis Hospital in Paris, No. 1706 (*Baretta*). Hallopeau's case.

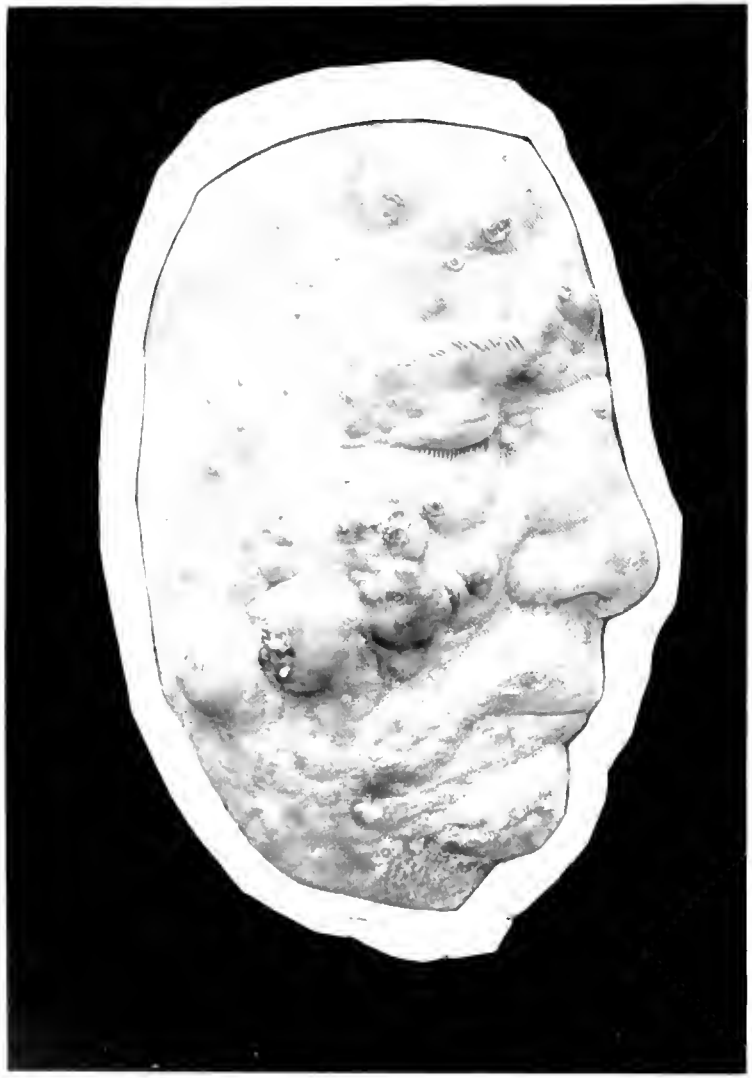


Fig. 170. Granuloma fungoides.

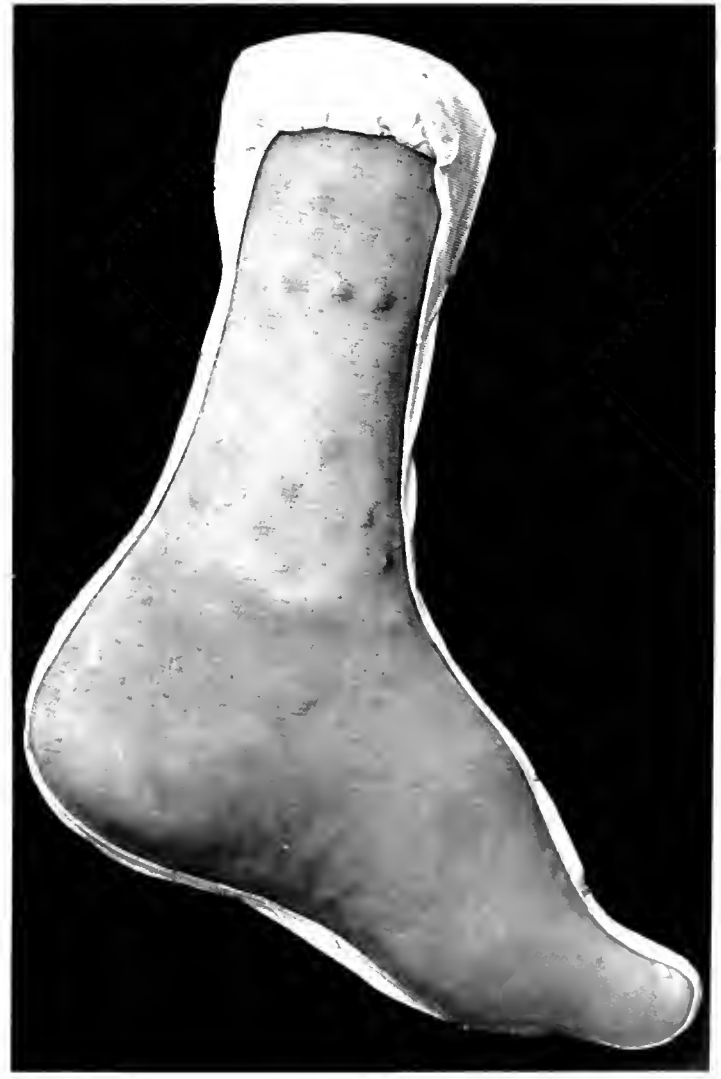


Fig. 171. Sarcoma idiopathicum multiplex haemorrhagicum.

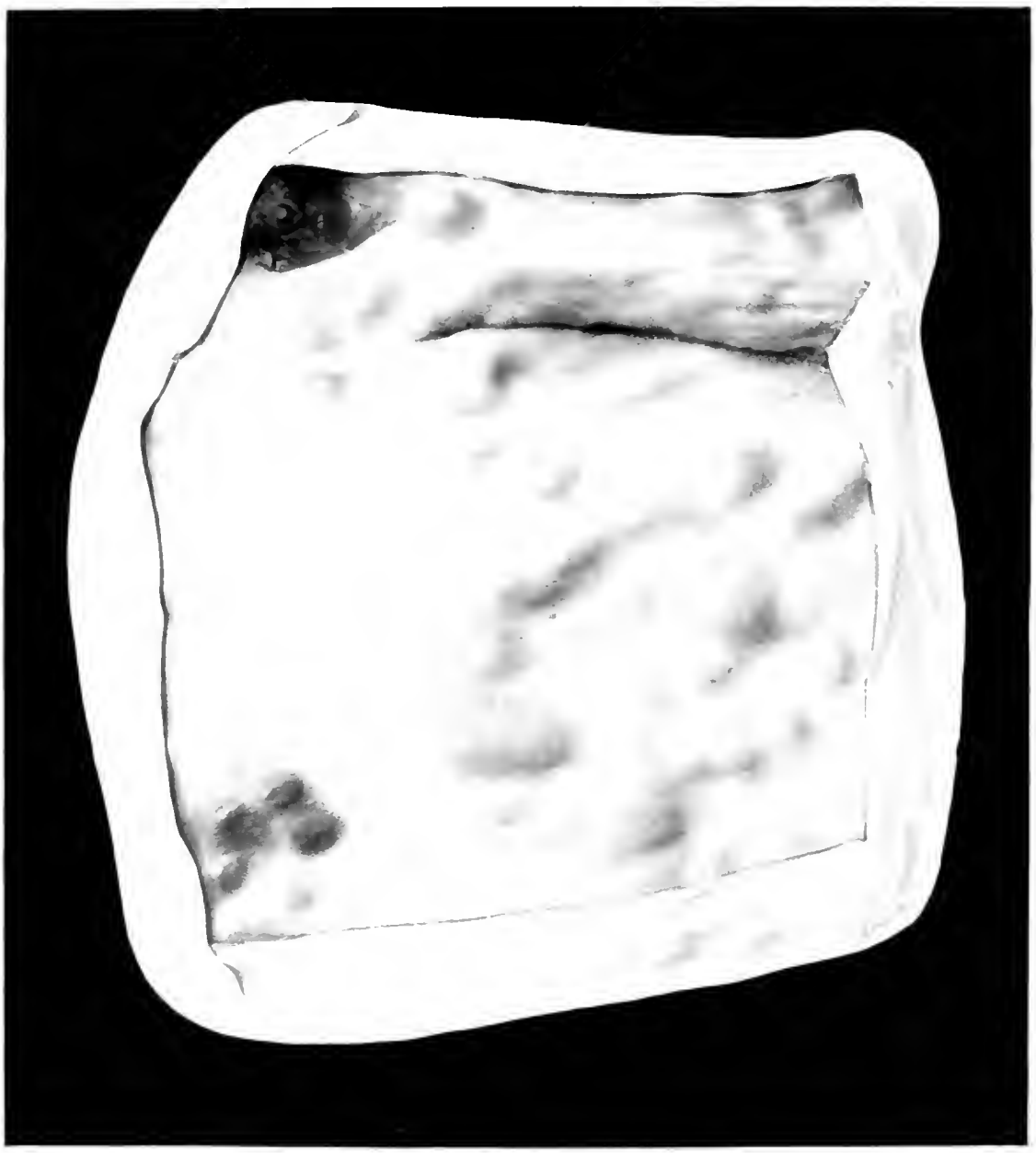


Fig. 172. Sarcomatosis cutis.

# Sarcoma Cutis

*Plate* **105,** Fig. 171; and *Plate* **106,** Fig. 172

Four varieties are described of sarcoma cutis based upon the presence or absence of pigment and whether or not multiple.

Single, non-pigmented sarcoma is a very rare affection and not highly malignant. It usually develops in a previous lesion—mole or wen, does not run to any particular type or types, varies extremely in size, shape and location, seldom attains a size larger than a fist and tends to be fatal through internal metastases.

Single pigmented or melanotic sarcoma is a much more typical affection which may begin in a pigmented mole, but often first appears on the hands or feet as a bleb or felon-like lesion. Pigment is so essential that it may be noted before there is any tumor. The primary lesion not only grows with great rapidity, but metastases quickly appear, even in the skin and mucosæ. Aside from secondary tumors there are simple deposits of pigment.

Generalized or multiple non-pigmented sarcoma has no connection with any other form of sarcoma cutis and begins with a number of separate growths near together. Some of these cases appear to be leukemic in origin, others resemble more or less closely granuloma fungoides. Others again may be multiple cutaneous metastases of internal sarcoma. All in all, the nosologic position of this affection is not clear. Affections described under this name are relatively malignant. The lesions, unlike typical sarcoma, have considerable tendency to ulcerate before they attain much size. The inflammation which sometimes develops about these growths and the intense itching often present has caused them to be termed pseudogranuloma fungoides. The fourth form, idiopathic multiple hemorrhagic sarcoma is much more readily characterized than are the preceding. It begins on the extremities in multiple foci, showing various shades of blackish or bluish. The earlier lesions may in part undergo involution, but are soon followed by others. The limbs may be so studded as to constitute a form of elephantiasis. An angiomatous or telangiectatic new

formation commonly coexists, so that the tumors bleed easily. The course is less malignant than in the other forms, for the patients often survive for many years.

*Etiology*

Absolutely nothing is known of the intimate nature of these affections, beyond what is known of malignant disease in general. They occur at any age, and are much more common in males, large, vigorous men being often noted among the subjects.

*Diagnosis*

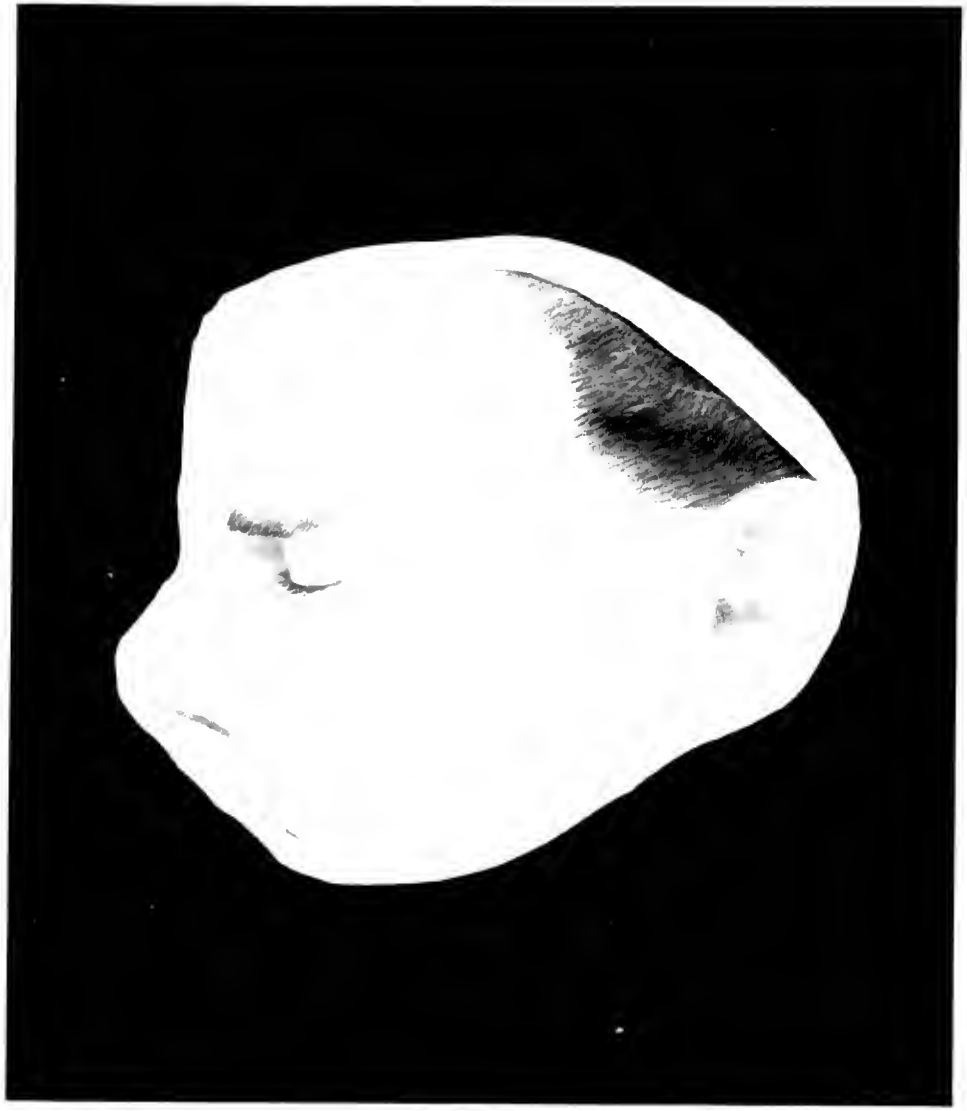
Aside from a few allied forms of malignancy—leukemic tumors and granuloma fungoides—there is no affection which should give rise to confusion, save, of course, in the very earliest stages.

*Prognosis and Treatment*

Save in the case of isolated non-pigmented sarcoma, there is no real remedy, not even early excision, which seems to precipitate the extension of a pigmented sarcoma. A few cases of cure have been attributed to arsenic injections. Some of the earlier nodules disappear spontaneously, so that it is credible that very exceptionally there may be no recurrence, and the affection is self-limited. This fact does not furnish any indications for successful treatment. In idiopathic multiple hemorrhagic sarcoma improvement sometimes follows the use of the X-rays.

Fig. 171. Model in Neisser's Clinic in Breslau (*Kroener*).

Fig. 172. Model in Lesser's Clinic in Berlin (*Kolbow*).



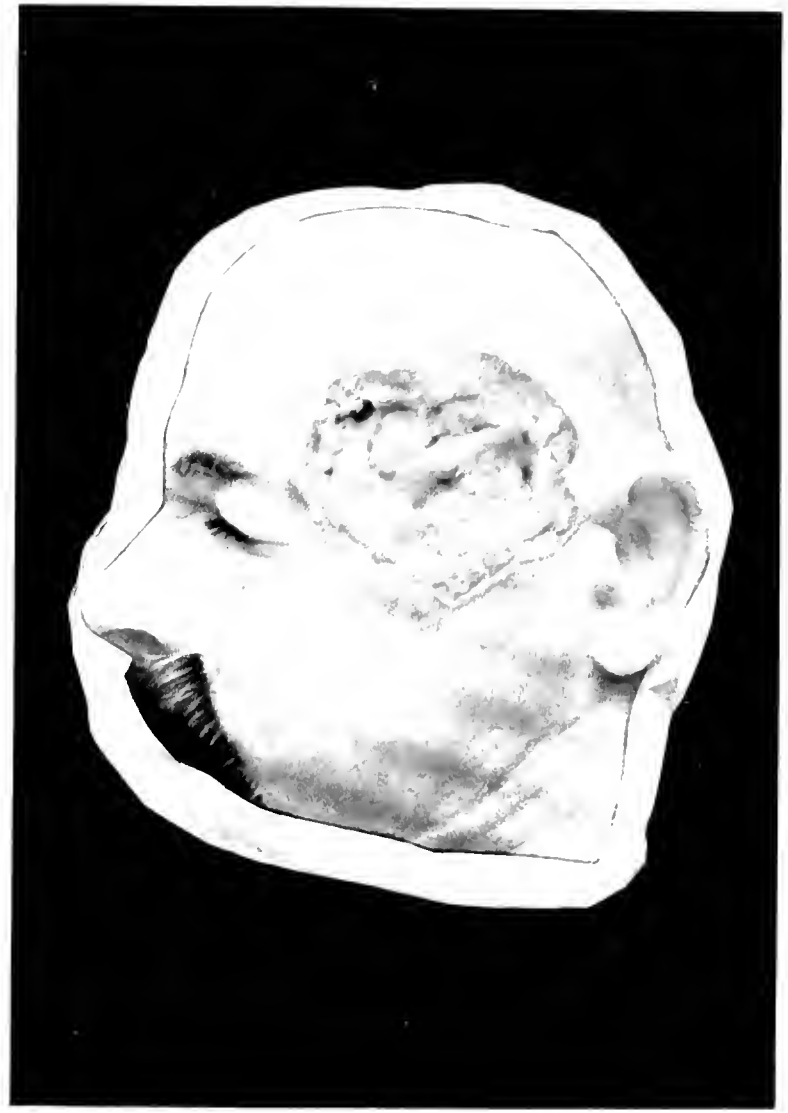


Fig. 173. 174. Ulcus rodens.

# Ulcus Rodens

*Plate* **107,** Figs. 173 and 174

This affection is a special clinical type of epithelioma of the skin, which was originally confounded with lupus and termed lupus exedens. Its ultimate recognition was due chiefly to the microscope, for clinically it has considerable analogy with lupus, and the confusion is heightened by the fact that an ulcerated lupus lesion not infrequently becomes an epithelioma. Some authors make a distinction between rodent ulcer and superficial epithelioma, but for clinical convenience it is best to regard the former as a mere variety of the latter, in which ulceration of a progressive character is the essential part of the disease, which may therefore cease to be superficial, although never becoming cancerous in the strict sense. While superficial epithelioma may develop elsewhere in rare cases, it is practically limited to the face and chiefly to its upper half.

The disease, like any form of epithelioma, may begin in a preexisting lesion—as a seborrhoic wart, but as a rule first appears as a characteristic lesion—a nodule of a peculiar pearl-like lustre, but sometimes of a reddish, yellowish or brownish hue. These nodules are elevated and sharply defined, and not mere circumscribed infiltrations. They are softer than the surrounding tissues, from which they are readily scraped away with the curette. In this, as in other respects, a comparison with lupus vulgaris is inevitable; but this is hardly worth while, because the latter almost always begins in childhood, while epithelioma is a disease of advanced life. In rodent ulcer, loss of substance is evident from the first, and the destructive process may be quite rapid, so that a flat, raw surface quickly appears. A characteristic of rodent ulcer as compared with the ordinary form is the lack of any attempts at repair. There may be nothing at first sight about these ulcers to throw any light on their nature, although the fact of their occurrence about the eyelids or sides of the nose or temples in an elderly subject would at once suggest the disease. In

some cases, however, a thin, pearly border is in evidence; and it becomes apparent that the tendency of the disease is for the degenerated tissue to ulcerate before it can become visible to the naked eye. This feature, coupled with the frequent inability of the centre of the lesion to cicatrize and the occasional tendency to attack the deeper tissues, suffices to differentiate rodent ulcer from the alternate form of the disease. Rodent ulcer has but little discharge, and this dries into a thin, adherent crust.

The typical form of superficial epithelioma is a much more chronic affection. The pearl-like nodules may persist for months without any tendency to break down, and are replaced very slowly by small losses of substance. A thin adhesive crust usually covers the latter, and reforms promptly when detached. The ulcer extends very slowly and new nodules at the periphery may often be seen to precede this extension. As the ulcer becomes larger, its entire border may be seen to be constituted of this new tissue. Another more or less characteristic feature is the marked tendency of the ulcer to undergo cicatrization and retraction. It is not uncommon to see a case even untreated in which a large area of scar tissue makes up nearly the whole of the lesion, while only here and there does a small incrustation, raw surface or group of new nodules proclaim the active state of the process.

Naturally, all attempts to separate wholly the two forms of superficial epithelioma from each other or from the deep forms are more or less unsatisfactory because transitions sometimes occur. Rodent ulcers practically never cause metastases of the lymph nodes, and on account of their chronic course in people already advanced in years seldom destroy life.

*Diagnosis*

One set of difficulties is connected with the initial manifestations, and chiefly when these occur secondarily to some preexisting lesion—a wart or mole. However, all signs of activity in old lesions are uniformly regarded as suspicions of a precancerous state. In senile warts which do not manifest themselves until advanced age it is more difficult to recognize precancer—in fact, impossible. The most significant sign is the appearance of a small crust, which announces the presence of an underlying abrasion or fissure, and which quickly reforms when detached. Other difficulties are connected with excluding syphilitic and tuberculous ulcers, which may themselves develop into epithelioma. Serological tests should be of help in certain obscure cases.

*Prognosis*

This depends much more on the opportunities for proper treatment than is the case with many affections because of the great chronicity and relative benignity of the process. Seated in localities which forbid excision as a rule, these lesions are nevertheless curable in the great majority of cases, even when quite far advanced. Left to themselves or improperly treated, there is barely any tendency to improve.

*Treatment*

While these affections are not believed to originate from local irritation to any marked extent, it is none the less true that they sometimes improve notably under soothing applications. These cases are naturally those which have been aggravated by improper treatment, and are much more common among deepseated cancers. The old name of "touch me not" applied to rodent ulcer shows that these were readily aggravated by improper treatment.

For beginning lesions and those which have not surpassed a certain size the principal resource is the curette, followed by chemical cauterization. This in the majority of cases is enough to cure the condition as it stands, although new nodules may appear later.

A large rodent ulcer may be excised outright in suitable localities. In others the raw surfaces may be destroyed by the use of the curette and caustics as before, but in recent years X-rays have been extensively used, alone and in combination with mild caustics, and are adapted especially to cases where severe measures would produce deformity and functional incapacity.

Figs. 173 and 174. Model in Freiburg Clinic (*Johnsen*). Patient came from Jadassohn's Clinic in Berne.

# Paget's Disease of the Nipple

Synonym: Malignant papillary dermatitis

*Plate* **108,** Fig. 175

This affection should be given its full title, as *Paget's* name is also associated with another, though quite dissimilar disease, osteitis deformans.

The affection of the nipple was first described by *Sir James Paget* in 1874 in a paper based on the study of fifteen cases, and it was originally regarded as an eczema of the nipple and areola, to which carcinoma of the mammary gland is frequently consecutive. It is now known to be a malignant process practically from the beginning; a superficial new-growth with a peculiar precancerous inflammatory phase.

The disease is not necessarily limited to the female nipple nor to the reproductive organs as a class, but is one that may occur in almost any locality. Cases have been recorded of its attacking the scrotum, penis, anus, axillæ, umbilicus, as well as other parts. Its immediate interest, however, lies largely in the original disease as it affects the nipple.

In seventy-five per cent. of cases the right nipple is attacked, a disproportion at present inexplicable. The eczema-like patch which first forms about the nipple is very insidious in its development and for a long time may present only a scaly erythema which itches more or less. Its circumscribed area is due in part to the fact that it is at first confined to the areola. It passes beyond the latter in some cases, but not far in its eczematous phase. The second stage presents a surface like eczema rubrum, raw and moist. The true nature of the process may generally be recognized at this stage by the sharp contour and slight sense of induration. The nipple also undergoes changes which could never result from mere eczema, being eroded and retracted. The disease now ulcerates and extends over the surface of the breast while at the same time it passes along the ducts

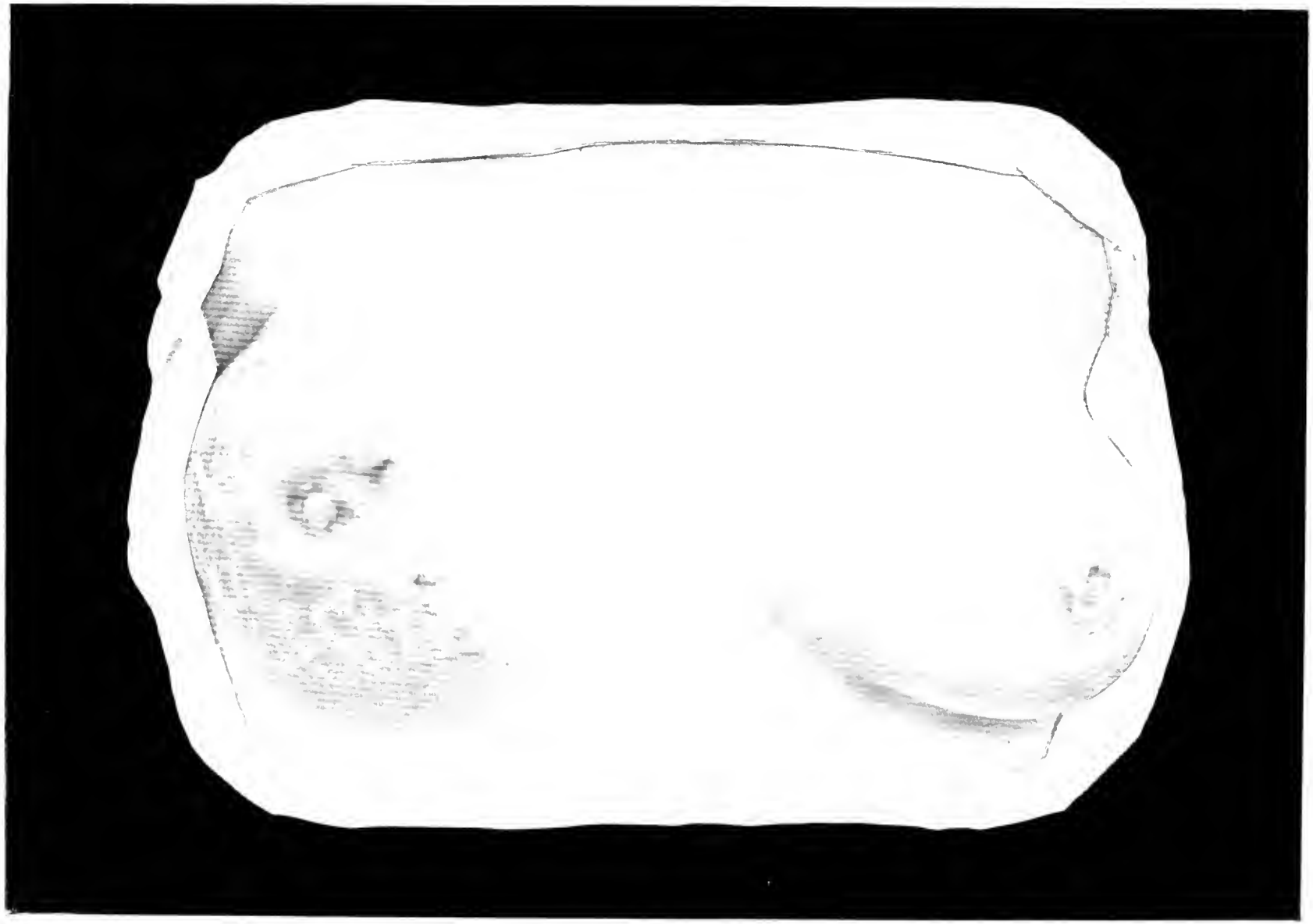


Fig. 175. Paget's disease of the nipple.

and involves the gland proper. As ulceration is taking place about the nipple the eczematous area may be extending at the periphery. It is probable that at the present day most of these cases come to treatment long before extreme stages are reached.

*Etiology*

The disease attacks the same victims as does ordinary cancer of the breast. Beyond this nothing is known as to causation, although it may be taken for granted that any kind of irritation of the nipple is a causal factor.

*Diagnosis*

No confusion should arise save in the earliest phase of the disease. At this time, when there is only a slight scaly patch with a little viscid secretion, the condition might easily be confounded with eczema or dermatitis. The test of treatment should be of value here, as an eczema or dermatitis should readily yield to appropriate treatment.

*Prognosis*

If seen early and treated radically the growth may generally be removed. The prognosis, however, in old, extensive, and neglected or badly treated cases is always unfavorable.

*Treatment*

No permanent good can result from the application of soothing ointments or from the employment of cauterizing agents. The growth is always more extensive than the cutaneous involvement would indicate and the only rational treatment is the amputation of the breast. The X-rays should not be employed in this affection, except possibly as a post-operative procedure.

Fig. 175. Model from Pospelow's Clinic in Moscow (*Fiwcisky*).

# Carcinoma Linguae

*Plate* **109,** Fig. 176

This lesion is, in over ninety per cent. of all cases, an epithelioma similar entirely to epitheliomata of the lips, floor of the mouth, etc. The high degree of malignancy which attends it is very seldom due to internal metastases and ordinary cancerous cachexia but to the power of rapid local extension and the high degree of glandular implication. The location may vary in respect to any form of irritation which distinctly serves as a nidus for the neoplasm, but irrespective of this fact it usually begins at the sides or tip of the organ.

*Etiology*

The disease occurs in the middle-aged, and its frequency is by no means rare. The part played by so-called precancerous states, of which there are a great number, is great, but cancer in this locality may develop in a perfectly intact mucous membrane, and statistics show that at least some of these preexisting lesions are notably absent. To enumerate the latter, there is the irritation from sharp teeth, leukoplakia, syphilitic lesions and scars, glossitis and *Rigg's* disease. Smoking is often accused as a source of constant irritation, and is undoubtedly an important etiological factor.

*Diagnosis*

Since cancerous, tuberculous and syphilitic ulcers may occur on the tongue, the main point is to exclude cancer. A negative *Wassermann* generally excludes syphilis. Tuberculous ulcers are very rare, the primary type especially; the secondary form could readily be excluded. A suspicious induration or abrasion of the tongue may often be recognized as cancer by excising a small fragment for microscopical examination.

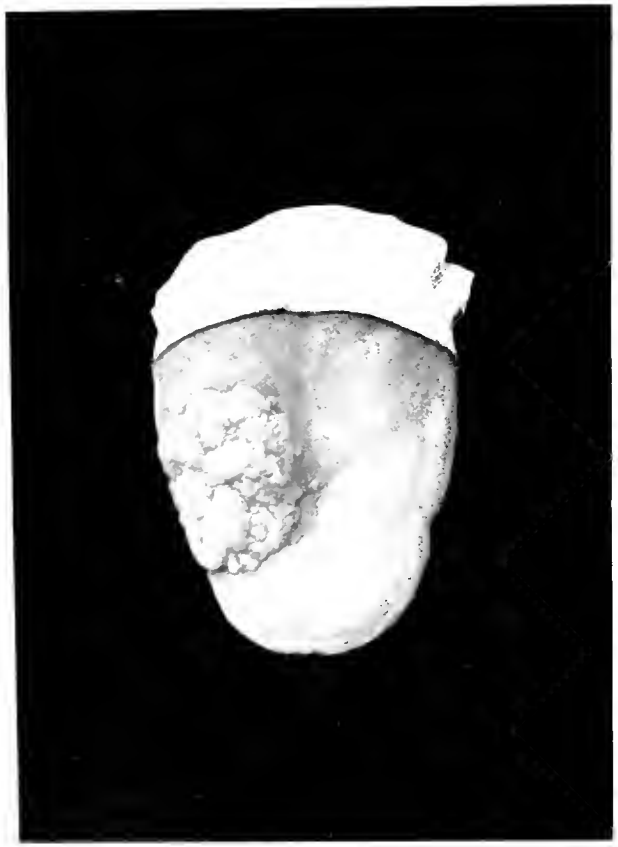


Fig. 176. Carcinoma linguae.

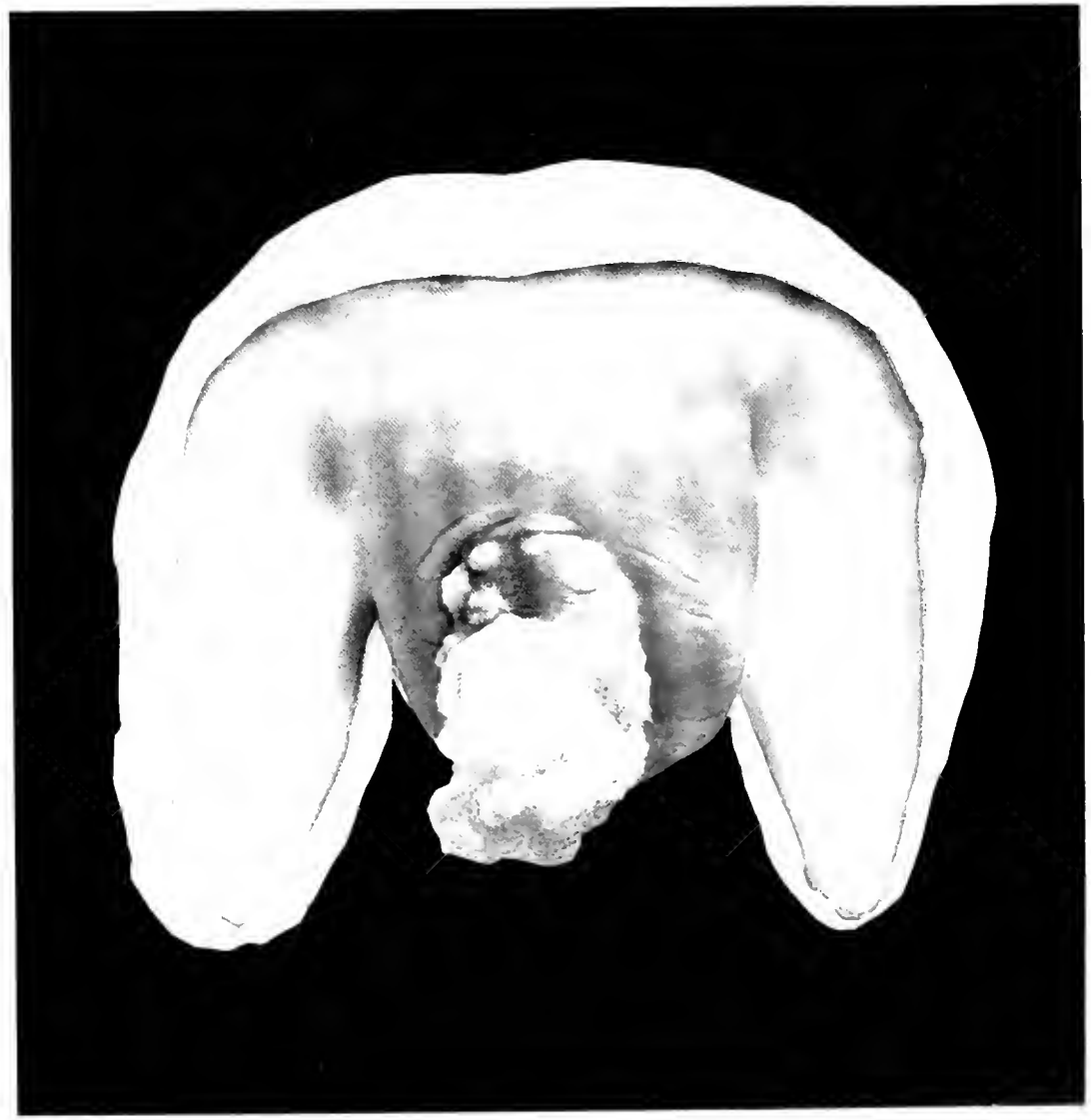


Fig. 177. Carcinoma penis.

*Prognosis*

This varies according to the duration and extent of the growth at the time of operation.

*Treatment*

The only real benefit wrought is by early and radical operation.

**Fig. 176.** Model in St. Louis Hospital in Paris, No. 1557 (*Baretta*). Hallopeau's case.

# Carcinoma Penis

*Plate* **109**, Fig. 177

The first manifestation is most commonly on the glans, the prepuce being less frequently attacked. The initial and precancerous stages show considerable variation, for this is described by patients as a wart, pimple, raw surface, ulcer, scab, or smooth induration. The lesion is almost invariably an epithelioma, and however it begins, tends to invade the deeper tissues and proper lymph nodes. After it has fairly begun the progress of the disease, which may be rapid, follows one of two types: first a sort of rodent ulcer in which the lesion consists of a rapidly extending ulcer with a hard border, and second, a productive or papillomatous type which results in a so-called cauliflower cancer. The two types shade into each other. Although these growths may show much malignancy they are sometimes of very slow growth lasting for a number of years; nor do the glands always become involved. The proportion of cases which would be comparable to superficial epithelioma and rodent ulcer of the face is probably much larger than is commonly believed.

*Diagnosis*

Cancer of the penis has to be differentiated carefully from chancre, syphilitic gumma and tuberculous ulcer, but the classic tests should be sufficient for this purpose.

*Prognosis*

This is always grave.

*Treatment*

A few cases may be benefited by cauterization, curettage, or excision, but in the great majority it is not only necessary to amputate the penis but to remove all of the inguinal glands as well. Recurrence is common, as elsewhere. Radium and the X-rays have their advocates.

Fig. 177. Model in Neisser's Clinic in Breslau (*Kroener*).