AN ATLAS OF THE COMMONER SKIN DISEASES

WITH 120 PLATES REPRODUCED BY DIRECT COLOUR PHOTOGRAPHY FROM THE LIVING SUBJECT

BY

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The text has been enlarged and brought up to date, and for much it may have gained I am beholden to W. N. Goldsmith's *Recent Advances in Dermatology*, which proved quite invaluable for the purpose.

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HENRY C. SEMON.

LONDON, W.1.
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THE purpose of this Atlas is to portray from the living subject, and in natural colour, a collection of the dermatoses most frequently seen in the routine of out-patient practice.

Abbreviated clinical descriptions, the differential diagnoses where considered essential, and the outlines of treatment are presented in an easily accessible position with regard to each plate. These should be considered as accessory to, and not substitutes for, the detailed study of actual cases, and it is believed that if they are employed with this reservation, they will afford valuable help in diagnosis. The

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more experienced may utilize them as *aides mémoires*, and will be able at the same time to refresh their recollections of differential diagnosis and the established lines of treatment.

It is confidently claimed that the colour values are superior to any as yet produced by other processes, and for this achievement we have to thank Finlay Colour Ltd., who in the persons of Major E. A. Belcher, C.B.E., M.A. Oxon., the Managing Director, and Mr. John A. Cooper, their photographic expert, have most loyally co-operated towards the result. We have further to acknowledge the painstaking and highly skilled collaboration of the Grout Engraving Co. Ltd., of Bromley. The technical difficulties of their work must be seen to be appreciated. The selection of cases and the preparation of the text have fallen to my share ; the elaboration of a new technique, including the standardization of the source of light, the posing of subjects, and the general supervision of the photography, were undertaken by Dr. Arnold Moritz, who in this work has surpassed his former achievements in Sequeira's *Text-book of Dermatology* and D'Arcy Power's *System of Syphilis*.

The omission of a few subjects has been unavoidable for lack of opportunity, and will be remedied if, as we hope, the work earns sufficient commendation for a subsequent edition.

To facilitate rapid reference, the various diseases have been grouped in alphabetical order, with the exception of some of the less common, which are arranged at the end.

For reading proof sheets and some valuable suggestions, we are much indebted to Dr. H. W. Barber.

In conclusion we desire to thank Mr. John Wright, of Messrs. John Wright & Sons Ltd., Bristol, for his invariable courtesy and consideration. By supplying the means he has enabled us to realize a long-cherished ambition.

HENRY C. SEMON.

LONDON, W.1.
1934.

ACNE
(Acne Vulgaris)

(PLATE I)

YOUNG persons of both sexes are frequently the victims of acne. Appearing about the time of pubescence it may continue if untreated with varying intensity to the age of 25 or even 30. The commonest localization is the face, and then the presternal and interscapular regions—all of which are rich in sebum-producing glands and their ducts. Acne cannot occur in areas devoid of these, such as the palmar and plantar surfaces. A predisposing cause appears to be the condition called seborrhœa oleosa, though dry skins are not immune, and greasiness can occur without acne.

The essential lesion is the comedo—a small, raised, usually black point caused by accumulation of keratinized cells in the mouth of the sebaceous duct. Infection of the comedo with staphylococci and the acne bacillus soon produces the reddish papule, and from that it is but a step to the pustule and various cystic and nodular modifications of it. Scars and keloidal transformations may further disfigure or permanently mark the skin in varying degree.

The plate illustrates the prevailing form of acne vulgaris in its papulo-pustular stage in a young man of 22. Inflamed papules and pustules abound on the forehead, temporal and malar areas, and to a considerable degree on the chin. Comedones were not very evident in this case owing to previous treatment, but the minute pitted scars of old healed lesions are easily picked out.

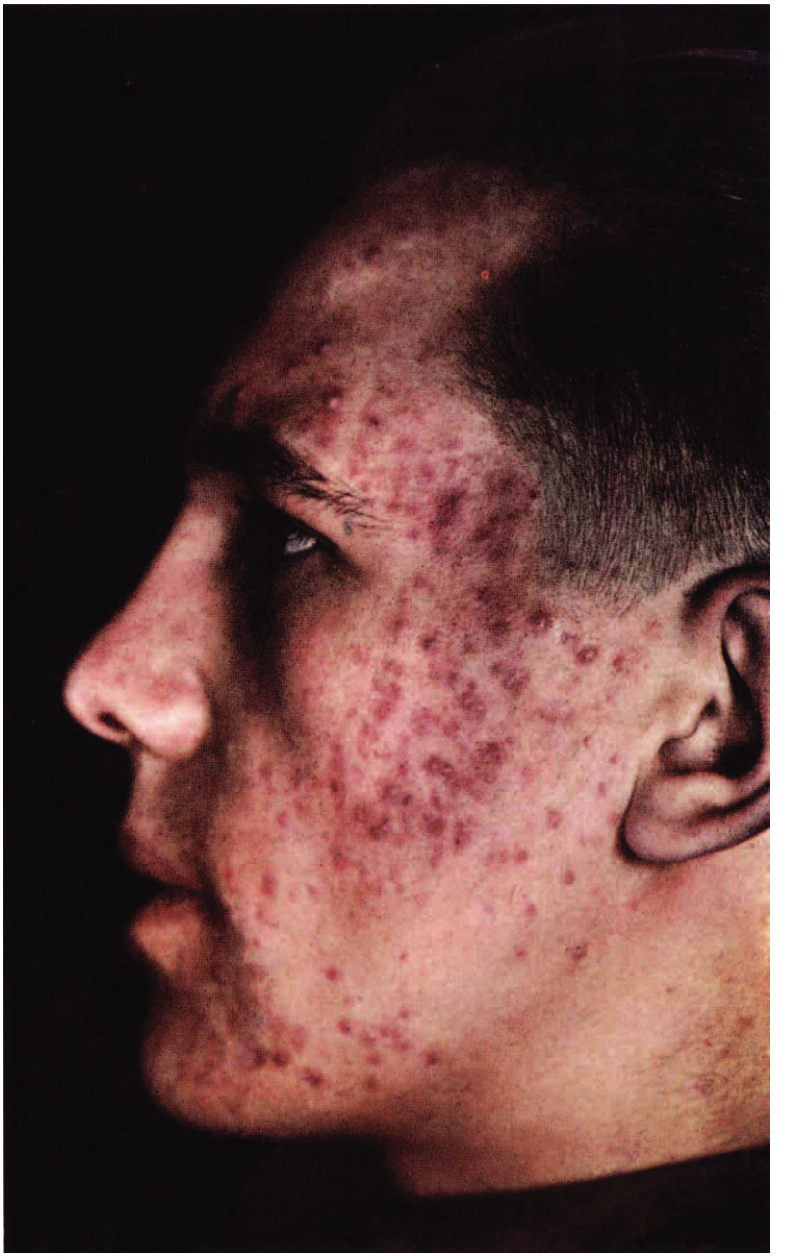
Differential Diagnosis.—In cases diverging from this, the commonest type of the disease, and in others unduly resisting treatment, we should bear in mind the possibility of causation by drugs, especially the *bromides* (*Plate XII*) and iodides. They can be conveyed to nurselings in their mothers' milk, and a bromide appears to be used occasionally in baking powders in the form of potassium bromate, as an 'improver'. The cutaneous lesions so caused closely resemble acne vulgaris, occur in similar situations, but are devoid of comedones—a valuable point in differentiation. It follows that treatment by bromides in cases of acne is best avoided.

Lubricating oils and camphor (in liniments) may give rise to atypical forms of the eruption, but the localization—usually the anterior surfaces of the thighs in the former, and the chest in the latter—will arouse suspicion of the cause and lead to inquiry in the history.

Tar is another cause of acne, and is seen in road workers and others handling pitch in sprays, etc. Comedones are usually plentiful, and the associated dermatitis on exposed parts is aggravated by sunlight and may be later associated with the development of epitheliomata. (*See Plate XXIV.*)

Both syphilis and tuberculosis may initiate cutaneous lesions closely resembling acne. Comedones are absent, the lesions may occur anywhere on the body surface, and are not therefore necessarily connected with the presence of sebaceous glands,

PLATE 1



ACNE
(Acne Vulgaris)
3

a most important point in the differential diagnosis, which is further assisted by a pronounced cicatricial and occasional pigmentary tendency especially in the syphilitic cases.

Treatment.—Dietary and medicinal treatment are not so important as the local applications, which must be conscientiously continued until all comedones are eliminated by exfoliation. This is best achieved by lotions containing sulphur in a finely divided, nascent, or colloidal form. From 10 to 20 gr. each of potassium sulphurata and zinc sulphate in an ounce of lotio calaminæ should be applied nightly after lathering with an ichthyol or sulphur soap and plenty of hot water. The desired branny desquamation is usually attained with some discomfort to the patient in about ten days. Disinfection of papulo-pustules and elimination of the comedones proceed *pari passu*. Much soreness can be counteracted with 1 per cent salicylic acid in cold cream. The same result can be obtained by carefully graded doses of ultra-violet light, while the X rays should be reserved for cases in which the above methods have failed and in which persistent scarring threatens to ruin a complexion permanently. In experienced hands it is almost always effective. Rich food should not be allowed, and it is usual to forbid sweets, chocolate, cheese, white bread, and cooked fats. Drugs, other than laxatives, do not appear to be of much service.

Antuitrin S, rising from 1 to 2 c.c. twice or thrice weekly by intramuscular injection, has been recommended recently on a theory of sex-gland dyscrasia, by Lawrence and Feigenbaum, while other writers claim good results by administration of vitamin D, in the form of viosterol, 20 drops daily.

The well-known fact that acne in girls and young women is frequently worse at the menses has initiated some research work recently at the Royal Northern Hospital by Dr. Franz Herrmann (late of the Dermatological Clinic at Frankfurt). His results, so far as they go, tend to show that the blood-sugar curve is atypical in such cases, and by giving small doses of insulin (5 units) for five days prior to the onset, we have succeeded in preventing the usual aggravation, and in 3 cases caused marked involution of chronic persistent nodular lesions, without X rays or any other local treatment.

ACNE

(Furuncular Type of Young Women)

(PLATE II)

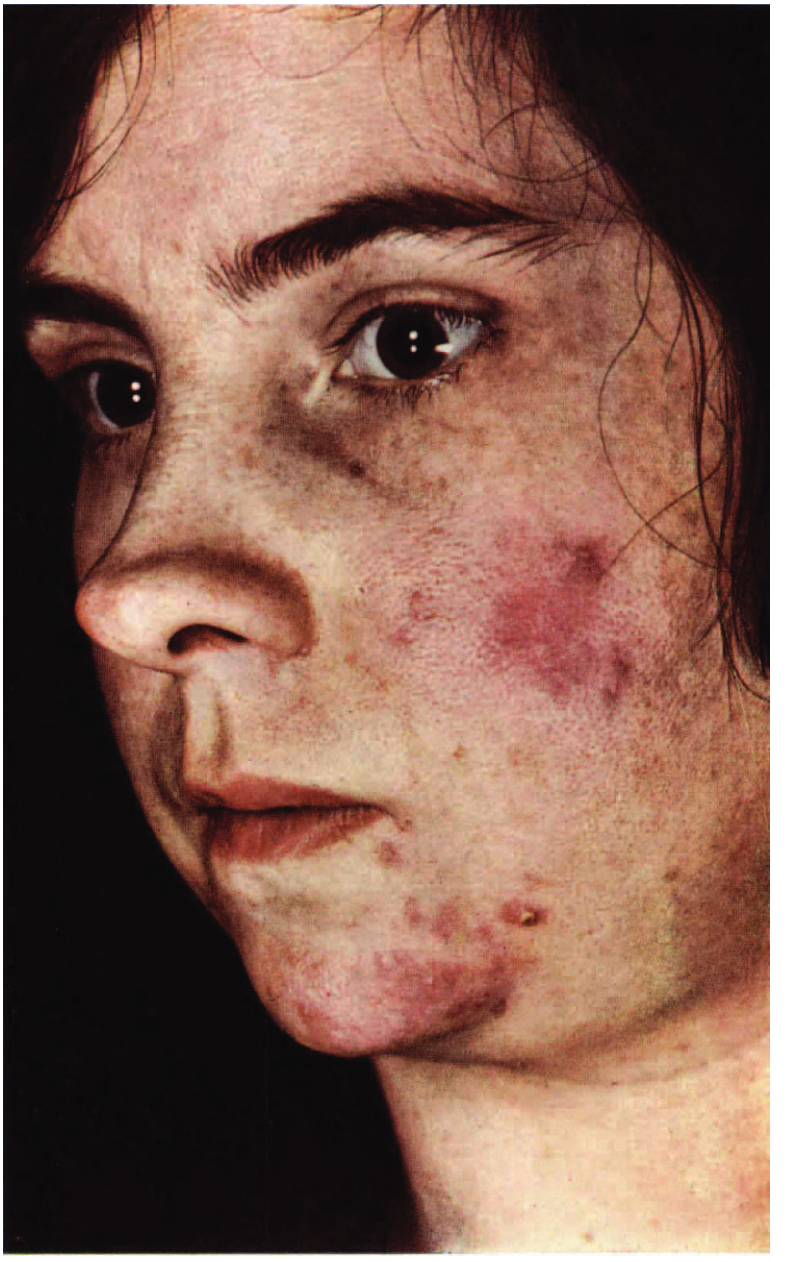
THE illustration represents a type of case that seems to escape special comment and recognition in text-book descriptions. The lesions are almost always present on the chin, and occur more rarely on the cheeks and forehead of young women in the early twenties. Neither the comedones of acne vulgaris nor the post-prandial flushing of rosacea are at all common in such patients, nor have I been able to convince myself that the lesions are associated, as emphasized mainly by French writers, with menstrual disorders (*see* note on p. 4, however). Dietary measures, vaccines, and local applications seem to be of little help in preventing recurrences, and only X rays have achieved any demonstrable success in my hands. Latterly, however, I have been struck with the frequency of coincident pyorrhœa, apical dental infections, and/or unerupted, and sometimes septic, wisdom teeth. In quite a number of cases (chiefly in private practice) in which radiographs have revealed the dental infection, and the requisite treatment has been carried out, the results have been most gratifying, and for the last two years I have rarely found it necessary to resort to radiotherapy.

The marked *necrotic* and *scar-forming* tendency suggests a deep rather than a superficial cause such as seborrhœa in the ætiology, and it is possible that the origin of these lesions is metastatic—lymphatic or circulatory. Whatever be the explanation, there is no doubt that that the elimination of bucco-pharyngeal sepsis—in teeth, tonsils, or accessory sinuses—is frequently successful in treatment.

Local applications of colloidal sulphur in calamine lotion, and the use of a mild superfatted sulphur or ichthyol soap, are useful in the alleviation of established pustular lesions, but of little value in preventing relapses.

N.B.—These cases seem to me on a par with the frequently relapsing furuncular lesions on the necks and scalps and the auditory and nasal meatuses of men, mostly of middle age. In not a few of these the elimination of dental sepsis has brought about a cure when all other measures had proved futile.

PLATE II



ACNE
(Furuncular Type of Young Women)

ALOPECIA AREATA

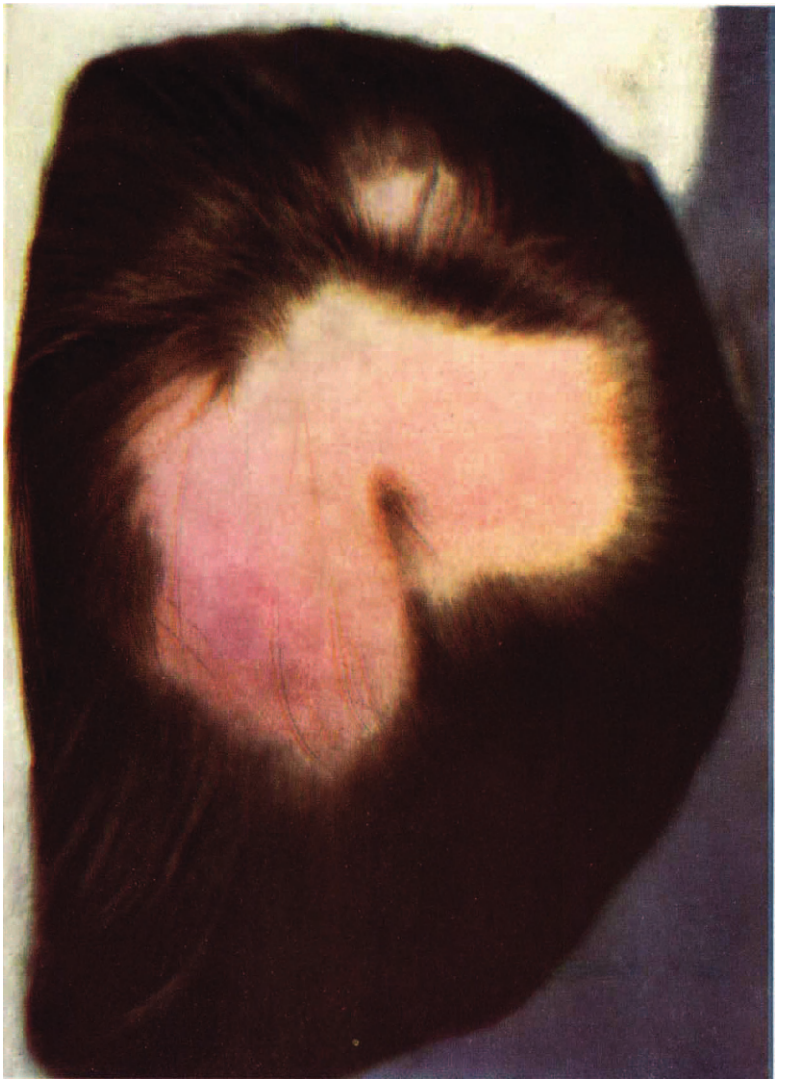
(PLATE III)

THE picture illustrates the main characters of a developed and still progressive patch of this interesting condition. The absence of scaling—invariably present in bald patches due to ringworm—should be particularly noted. The disease spreads by confluence of outlying areas, one of which can be seen as a small detached area anterior to the main patch of denudation. The circinate character of the depilation is indicated on the right half of this patch, and in the margin of this were to be seen with a + 1 lens a line of typical 'exclamation' stumps (!), with their thin tapering shafts and thicker free extremities—on which features the diagnosis is made.

The cause of alopecia areata is not established, but accumulating evidence points to an associated involvement of the sympathetic nervous system, and its implication is accepted by most authorities as the most likely cause of the disease. H. W. Barber, in his Lettsomian Lectures, has evolved a useful classification of the external factors or stimuli which may initiate the symptom. These are: (1) the psychic—such as worry, emotion, and shock; (2) the septic or infective—in teeth or tonsils; (3) the reflex, as from astigmatism or unerupted wisdom teeth; and (4) the traumatic, following wounds or surgical operations on the scalp. A consideration of the possible influence of one or more of such factors will sometimes afford help in the treatment of the individual case. Recovery of a patch does not occur under three to four months, and may take longer. The tendency to recovery is in inverse ratio to the number of stumps seen with a lens at the periphery of the individual patches at succeeding examinations. The prognosis also varies to some extent with the age of the patient, children seeming to recover more rapidly. Patches occurring circumferentially in the occipital and temporal regions—the band type—are less favourable, and sometimes end in complete and permanent alopecia totalis, with loss of the eyebrows, lashes, and the hair in other parts of the body as well.

Differential Diagnosis.—There are three other conditions in which patchy hair loss might lead to error, viz., tinea tonsurans or ringworm, lupus erythematosus, and so-called cicatricial alopecia—the 'pseudopelade' of Brocq. In the first-named the scalp is nearly always scaly, and the stumps broken, twisted, or deformed, and opaque because of the endo- or peritrichial growth of the fungus, which is easily demonstrable under a 1/6 objective in potash. In lupus erythematosus some degree of atrophy in the patch and hyperkeratosis round the follicles can usually be demonstrated with a hand lens, while in Brocq's disease the onset is exceedingly insidious, the affected areas are very small at first and tend to enlarge by running together into irregular atrophic

PLATE III



ALOPECIA AREATA

patches in which brush-like remnants of unaffected hairs give the developed condition a highly characteristic appearance. Equally rare but worthy of mention is the alopecia left by favus. The patients are nearly always foreigners (Poles).

Treatment includes elimination of all accessible septic foci such as those in teeth and tonsils, correction of errors of refraction, and the application of counter-irritants such as iodine, lysol solution (1–4) daily, or weekly irradiation with the Kromayer mercury vapour lamp.

Recent claims for the efficiency of the grenz or ' borderline ' rays of Bucky are put forward by Spiethoff, who uses them to produce sustained erythema in doses of 2000 to 4000 r to the bald patches once a month. As grenz rays are superficial in action there is no risk of damage to the hair follicles—unavoidable if ordinary X rays are employed.

Similar effects might be obtained as a result of the erythema produced by thorium X—a pure alpha-ray producer—in the form of ointment (1000 electrostatic units in 1 c.c.), or alcohol, or varnish.

CHILBLAINS

(PLATE IV)

CHILBLAINS (perniones) are exceedingly common on the hands and feet of young women and children during the English winter. The case illustrated is remarkable for the proneness to ulceration of the bluish congested areas, one of which is indicated along the ulnar border of the right hand. The patient, a single young woman of 24, was otherwise healthy and well nourished, but, as the cicatrices demonstrate, had had this chilblain tendency for many years.

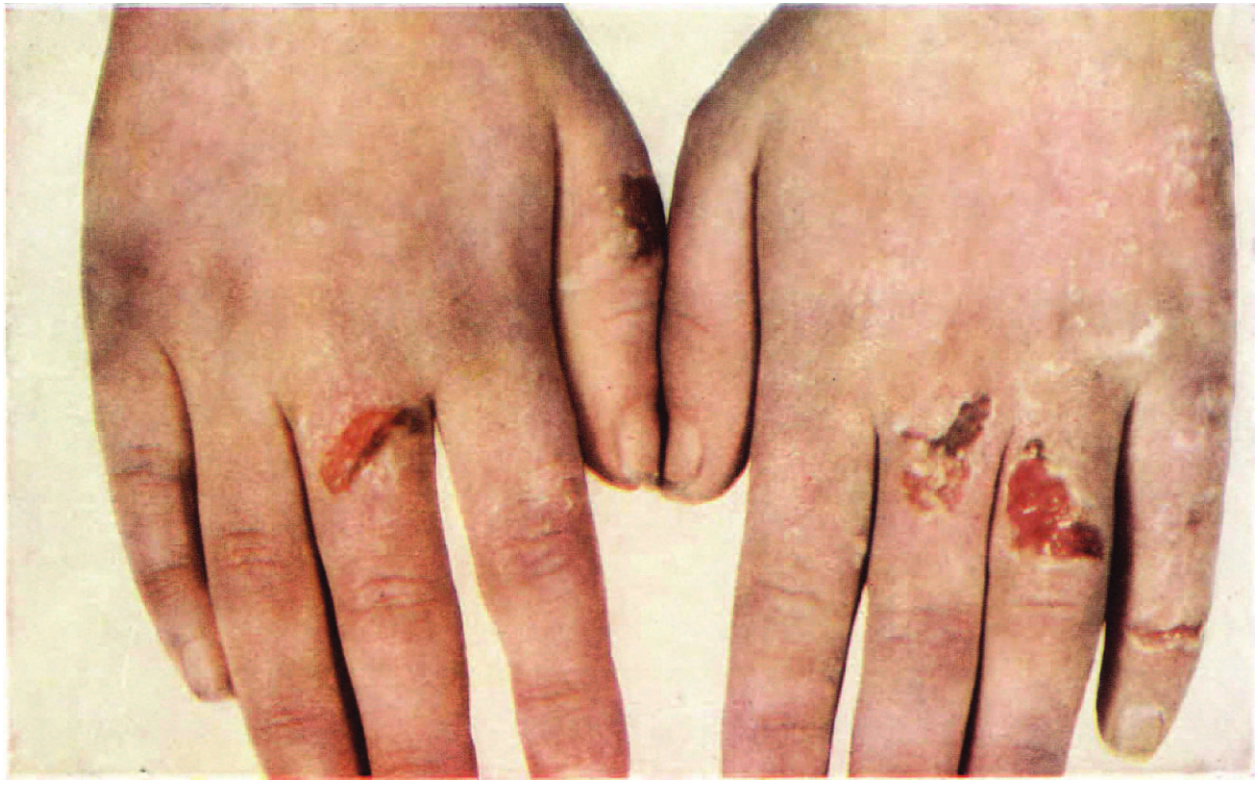
A deficient or sluggish peripheral circulation is an invariable concomitant of the condition, and a disordered calcium metabolism is suggested by a prolongation of the clotting time of the blood, and by chemical analysis.

Treatment.—General tonic treatment by a diet rich in vitamins, cod-liver oil, and regular exercise, especially skipping, are valuable prophylactics. The hands and the feet must not be allowed to get damp in their respective coverings, while massage and active purposive movements should be encouraged.

The unbroken chilblain should be painted with rubefacients such as tincture of capsicum (fortior) with equal parts of flexile collodion, or exposed to fractional doses of X rays, or still better, borderline (grenz) rays. General carbon-arc baths and the hot melted paraffin-wax bath are of some value. The broken, ulcerated lesion should be dressed with a stimulating ointment or paste containing balsam of Peru (1 to 2 per cent) or ichthyol. There is some evidence that calcium, in colloidal suspension, and given intramuscularly once or twice weekly, is of value as a prophylactic.

In very severe and intractable cases it would appear justifiable to consider the modern operation of preganglionic sympathectomy. In one of my cases, an unmarried woman of 26, who had suffered for many years from chilblains on the fingers, associated with Raynaud's syndrome, and an ulcerative condition of the legs indistinguishable from Bazin's disease, Mr. A. L. Able operated on all four extremities consecutively. An apparently normal circulation was established in each within forty-eight hours, and all the local symptoms cleared up, including the Raynaud's syndrome and the inveterate ulceration on the legs, by the time she left hospital—a week later. While the permanence of these results cannot be guaranteed, similar cases have remained free of all recurrences for a period of three years and longer.

PLATE IV



CHILBLAINS
(Ulcerated)

DERMATITIS ARTEFACTA

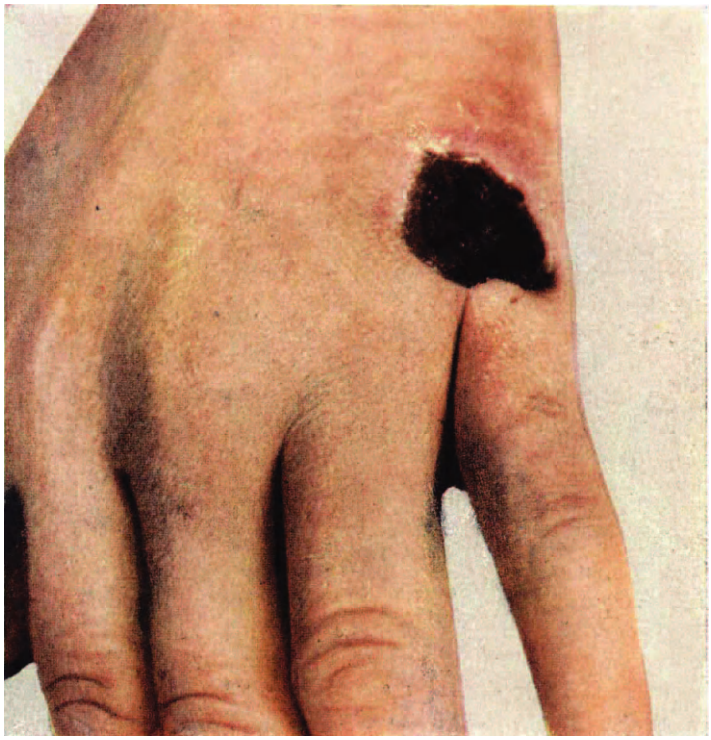
(PLATE V)

SELF-INFLICTED damage to the skin may be deliberate by the malingerer or merely the symptom of an otherwise latent hysteria. The former is seen more commonly in wartime, but is occasionally met with after injury or accident involving compensation. The diagnosis is seldom difficult once the possibility is suggested in the history. The deliberately produced lesion has an artificial appearance. It is often of quadrilateral or angular outline and always within reach of the operator's hand. Litmus paper sometimes indicates the application of caustic alkali or a strong acid.

The plate illustrates a case of the second category, in a single woman of 29, living alone with her mother, who was also of markedly unstable temperament. The case had puzzled the surgical department for fifteen months. There was a history of damage to the hand in a lift accident and compensation had been continuously paid throughout. Around the deep slough-covered ulcer there was *complete analgesia to superficial and deep pin-prick*, and both corneal and palatal reflexes were absent. Cautious questioning by a psychologist elicited a confession of peculiar dreamy states during which, it was admitted, interference might have taken place. The patient expressed a strong desire to be cured and to return to work, and under an occlusive dressing, and the oral administration of valerian and bromides, the ulcer rapidly took on a healthy appearance and healed completely in five weeks.

When last seen she had resumed her occupation and appeared to be happy and contented. The analgesia (glove and stocking type), however, was still present, and the corneal and palatal reflexes unresponsive.

PLATE V



DERMATITIS ARTEFACTA

DERMATITIS ARTEFACTA

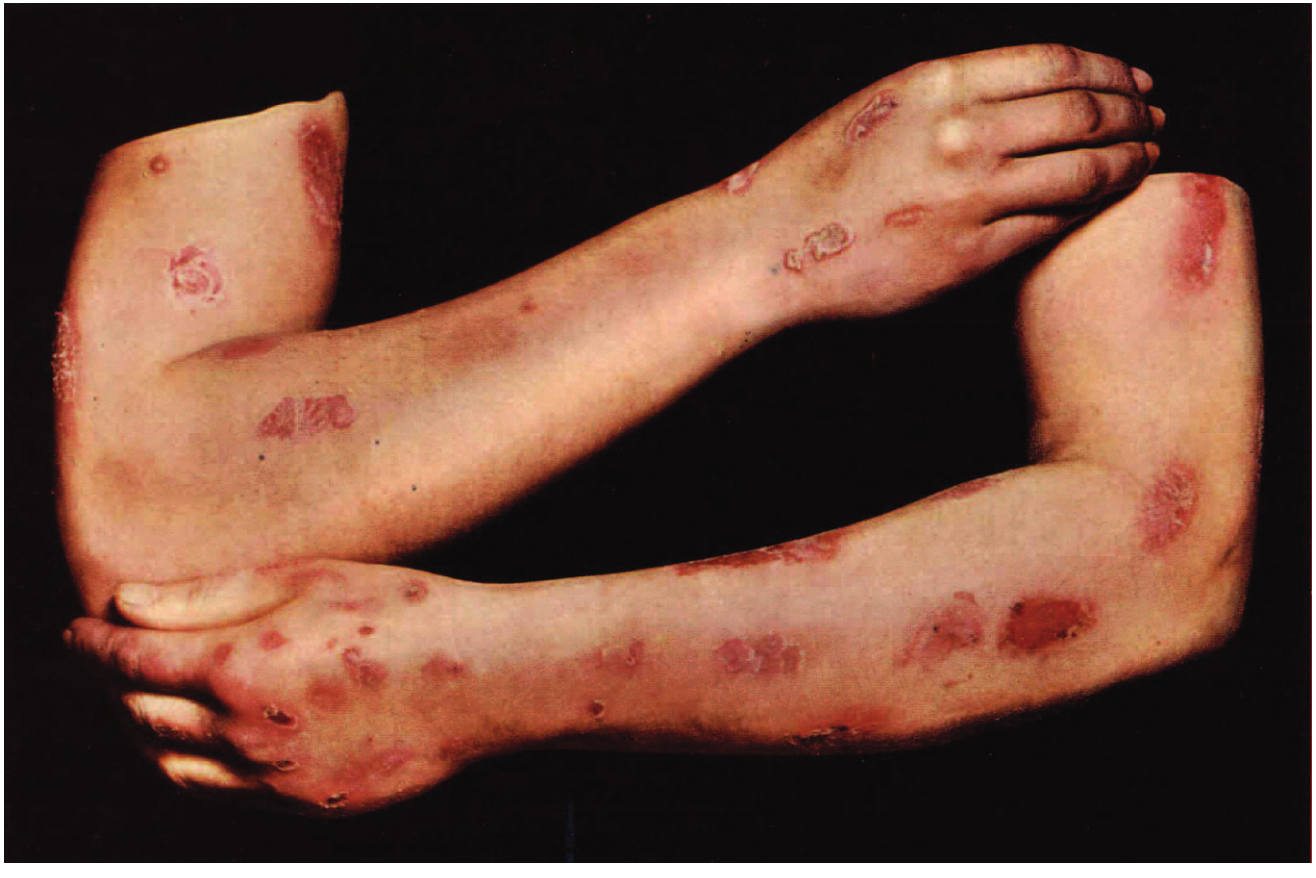
(PLATE VI)

THE case here depicted in a young woman of 18 had been correctly diagnosed by her practitioner, but neither he nor my department, nor the psychologist consulted, was able to elicit either from her or her family the slightest hint as to why, or by what means the damage had been caused. The patient was not informed of our views as to the nature of her eruption, but she refused admission to the wards for its treatment and proved non-cooperative in every way. Her palatal and corneal reflexes were strikingly deficient—an almost invariable association of this type of dermatitis artefacta —but there was no demonstrable anæsthesia, and the pin-prick test was also negative.

The lesions, which were stated to have been present and spreading for two months, consist of various-sized epithelial defects, some of them oozing serum, others dry or superficially crusted. Their localization is on both surfaces of the forearms, backs of the hands and wrists, and is less marked on the upper arms. The outlines of the patches should be carefully studied, for they give the clue to the diagnosis. In all cases they are sharply defined, and in some cases present the highly characteristic *straight line or angular* demarcation which is never seen in any other skin condition. The absence of sepsis and inflammatory reaction suggests that some antiseptic, possibly carbolic acid or lysol, may have been used to provoke them. (The litmus paper applied gave the ordinary mild alkaline reaction of serum.)

Treatment by occlusive "Variban" bandages was eventually successful in promoting a cure, and the patient's subsequent demeanour encouraged the belief that 'relapses' were unlikely to occur.

PLATE VI



DERMATITIS ARTEFACTA

DERMATITIS, GENERALIZED EXFOLIATIVE

(PLATE VII)

UNIVERSAL exfoliation or peeling of the skin may occur in the course of a number of cutaneous diseases, of which it must therefore be regarded as a stage, or specialized reaction. The occurrence of a primary exfoliation *sui generis* is exceedingly rare, and, more often than not, wrongly diagnosed. It need not concern us here.

The case illustrated is that of a married woman of 34, who stated that she had been attending the skin department of another hospital for four and a half years for the treatment of psoriasis. The truth of this statement was afterwards confirmed, and we were likewise informed that she had been given some twenty-four intramuscular injections of a mercury and arsenic preparation, subsequent to which the tendency to exfoliation had developed. It must not be assumed, however, that these injections were the cause. In her case it was not so, as was later proved. Psoriasis may become universally exfoliative without any treatment, especially in the acute cases, and the symptom has not infrequently developed in the course of pemphigus, seborrhœic dermatitis, pityriasis rubra pilaris, and after various drugs such as mercury, novarsenobillon, and the other salvarsan compounds. Small doses of gold salts, given for lupus erythematosus, may provoke the complication.

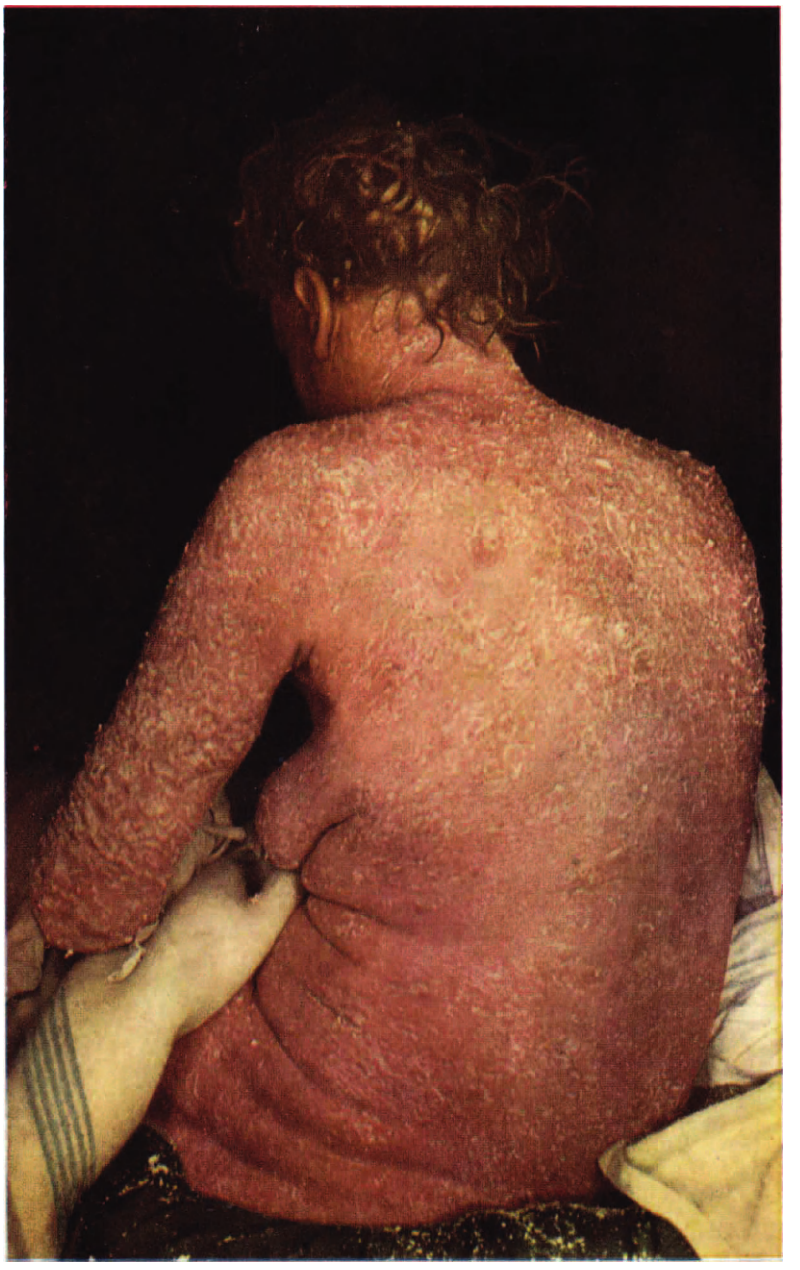
There can be no confusion with any other dermatological condition, when once the physician has seen a case. The skin of the whole body is reddened and continues to peel, and it is this *continuation* or recurrence over weeks and months that is the important feature in the diagnosis.

Besides the diseases already mentioned, exfoliative dermatitis may occur in the course of certain blood disorders, and in the premycotic stages of mycosis fungoides. Such was the ultimate development in this case, for the exfoliation gradually diminished and the skin became universally infiltrated with cells resembling lymphocytes, which increased at such a speed that they became aggregated into lymphocytic tumours. The colour and consistency and the tendency to ulceration conformed in every respect with the so-called tomato tumours of the fully developed and inevitably fatal disease, mycosis fungoides (*see Plate CXII*).

Prognosis should always be guarded in cases of exfoliative dermatitis, and every effort should be made to ascertain the cause of the symptom, by blood-counts, histological sections, etc.

Treatment is purely palliative. Weak soda or oatmeal baths usually afford some relief to the sometimes intolerable itching, and soothing creams will be required for the tendency to excoriation and fissuring which so frequently occurs. If gold salts or other metallic injections were associated as a causal factor, intravenous injections of thiosulphate of soda, 0·6 to 0·75 g. thrice weekly, may be of some help.

PLATE VII



GENERALIZED EXFOLIATIVE DERMATITIS

DERMATITIS HERPETIFORMIS

(PLATE VIII)

THE very serious and widespread eruption depicted in the plate is fortunately a rare variety of the disease, which differs in its clinical appearances not only in different individuals but in the same individual in succeeding attacks. It has to be distinguished from pemphigus (*Plate CXV*), in which the outlook in widespread and prolonged cases is usually hopeless. Dermatitis herpetiformis, although never fatal on its own account, can seriously undermine the patient's general health, when constantly recurrent and prolonged in its attacks, so that he may succumb to pneumonia or some other intercurrent infection. The intense irritation, often relieved by the rupture of the vesicles (spontaneous or mechanical, as by scratching), is an almost constant feature ; pemphigus does not cause irritation as a rule.

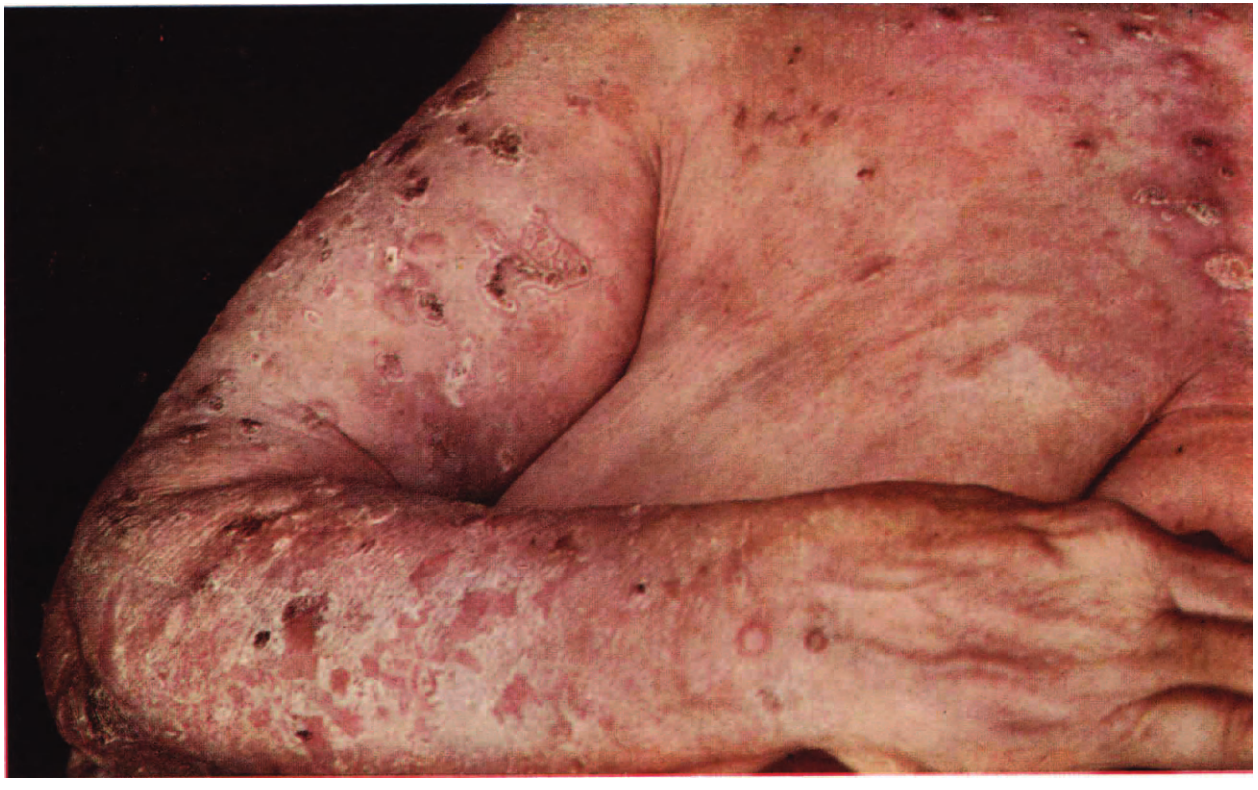
Dermatitis herpetiformis is a multiform eruption—usually vesicles and erythematous patches intermingled. These two elements are clearly visible in the patient shown in the plate—an elderly woman, who had been continuously affected for five months with this almost universal eruption. The disease should not be diagnosed when only one type of eruption is present. The characteristic distribution is on the shoulders and buttocks. The lesions tend to appear in successive crops, and consist of small or of larger vesicles in groups (herpetiform) on an erythematous base. Circinate or gyrate patches of slightly infiltrated type are associated. When healed the affected areas are frequently pigmented, and slightly atrophic or scarred. Lesions may occur in the mouth and other mucous membranes, but not so severely as in pemphigus, in which denudation of the lining membrane may give rise to great distress.

Treatment is mainly empirical, as we know nothing of the aetiology, though there is evidence of intestinal toxæmia in some of the cases. In many such, intestinal lavage has proved beneficial. Arsenic, administered by the mouth or subcutaneously, has a decidedly useful effect in others. I remember a pensioner who obtained great relief in this way, but eventually achieved so great a degree of tolerance to the drug that during the attack he took as much as a drachm of Fowler's solution thrice daily ! When last seen he had developed arsenical changes on the hands and feet. In other cases of a mild type, autohæmotherapy should be tried, for some respond surprisingly well, and are saved sometimes on the brink of a relapse. Iodine and iodides (either per os or locally applied) are badly tolerated, and may aggravate existing lesions or provoke relapses. Bromine acts similarly. This intolerance, as Goldsmith suggests, may account for the beneficial effects of intravenous sodium thiosulphate injections (0·6 g. thrice weekly for three weeks) as it possesses the faculty of reducing free iodine.

In one of my own cases—the patient being a spare woman of 45—the eruption which had troubled her for many months rapidly involuted on this treatment alone, and she remains free of it three and a half months later.

Any local application that soothes may be used. Patients vary very much in this respect. In the drier forms a weak sulphur ointment ($\frac{1}{2}$ to 2 per cent) gives relief; in the moist types with ruptured vesicles or bullæ, dusting powder and baths (weak boric and alkaline) will have to be relied on.

PLATE VIII



DERMATITIS HERPETIFORMIS

DERMATITIS, LICHENIFIED

(PLATE IX)

LICHENIFIED DERMATITIS, lichen simplex chronicus, lichen Vidal, and neurodermatitis are synonyms for a group of eruptions the aetiology of which is sometimes associated with a functional disorder of the nervous system. A large number of patients are women approaching the climacteric—a fact which would suggest an endocrine dyscrasia and a possible implication of the sympathetic nervous system.

According to Urbach, neurodermatitis is related to eczema and of allergic aetiology. In some cases he found hypersensitiveness of the skin to egg-white, in others to horsehair and feathers. On this assumption patch and scratch tests are worthy of trial, and it should be remembered that the responsible allergen may reach the skin either by direct contact or indirectly through the blood-stream.

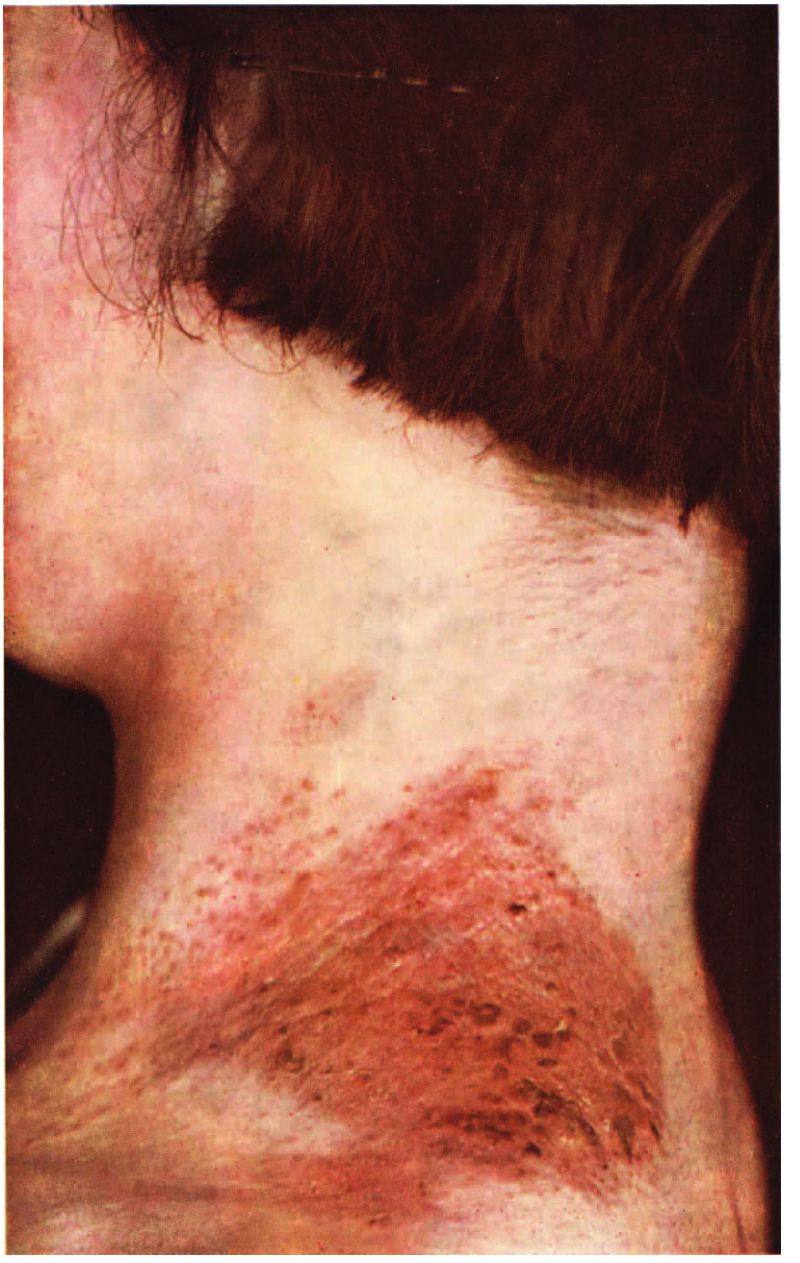
Clinically the effects are manifest as an area of circumscribed pruritus of varying intensity, by the uncontrolled rubbing and scratching of which an appearance of lichenification is more or less rapidly produced. If the part is protected by an occlusive dressing so that the patient cannot handle it, both the irritation and the objective appearances tend to subside.

The most frequent localization is the nape of the neck, at the junction of the scalp margin, and in this situation a secondary infection with seborrhœic organisms, or breaking of hair shafts by intermittent friction, may lead to erroneous impressions of the underlying aetiology. A circumscribed, raised, reddish or reddish-brown patch, with linear or criss-cross morocco-leather grained surface, and marked erection of the somewhat hyperæmic follicles—such are the characteristic features of the average case, a good example of which is manifest in *Plate IX*.

Treatment should include the elimination if possible of disturbing emotional factors, the administration of valerian and bromide, the local application of soothing salves or plasters containing tar, and X rays, grenz rays, or thorium X, which usually have a striking effect in allaying irritation and promoting involution.

The administration of ovarian substance in suspected deficiencies and at the menopause is always worthy of trial. In some of my cases of pruritus vulvæ recently, the results have been little short of miraculous.

PLATE IX



LICHENIFIED DERMATITIS

DERMATITIS, LICHENIFIED

(PLATE X)

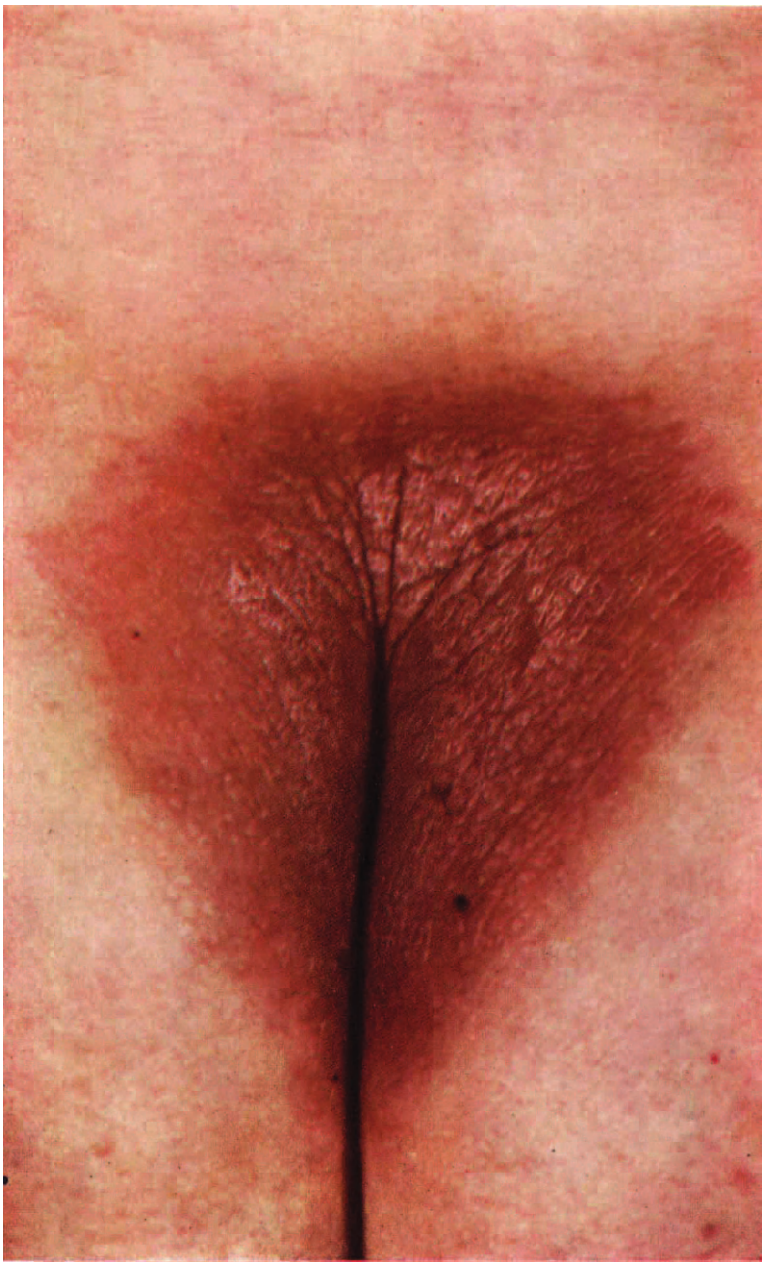
THIS plate should be studied together with *Plate IX*, for they are both good examples of the same underlying cutaneous and neural reactions. A patch of localized pruritus may occur from a variety of causes in any individual, but it is not every case that subsequently develops the chronic thickening (lichenification) with its peculiar leather-grain striations and *spasmodic* crises of irritability. This factor is invariably present, and is responsible for the uncontrolled rubbing and scratching of the affected patch. The condition affords a simple example of the *circulus viciosus*.

The commonest situation is undoubtedly the occipital and posterior cervical region in women about the climacteric. Next in frequency are the perianal (as in this case) and genital regions, where the disease may give rise to one form of pruritus vulvæ. These are by no means the only situations, and there is in fact no area of the skin surface *within reach of the hand* which is entirely exempt.

Treatment should concern itself with measures directed against hysterical and emotional tendencies, and the protection from friction—deliberate or accidental—of the affected areas by occlusive tar or ichthyol plasters. X rays, grenz rays, or thorium X in ointment or varnish, are usually effective in relatively small doses. The last, whose content is 90 per cent alpha radiation, is particularly valuable on uneven surfaces, and entirely devoid of dangerous sequelæ—a great advantage in resistant cases. Any primary cause of irritation, such as fissures or anal sepsis, as in this case, must of course receive appropriate attention.

In pruritus vulvæ, if the patient is a woman at the climacteric, natural or induced, the administration of an ovarian hormone, preferably by injections, is well worth a trial.

PLATE X



LICHENIFIED DERMATITIS

DERMATITIS MEDICAMENTOSA
(Lichenoid Type)

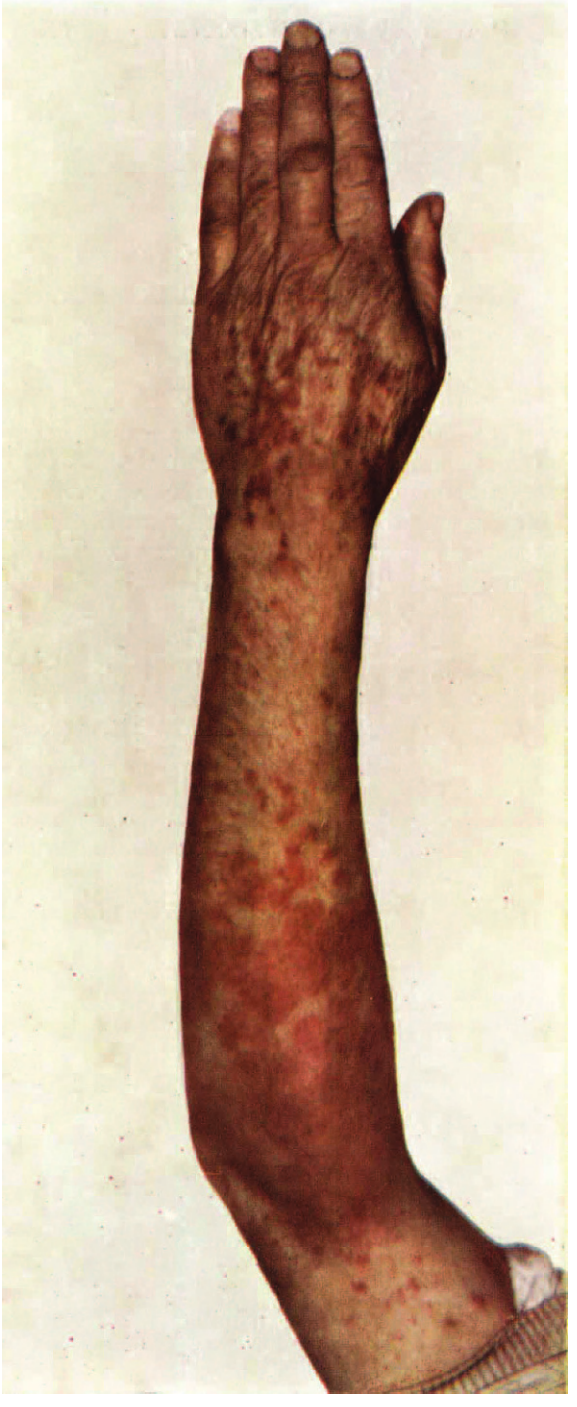
(PLATE XI)

THE eruption depicted was very profuse on the extremities and less so on the trunk. It occurred in an elderly man with an inveterate Wassermann reaction during the third course of N.A.B. and bismuth. Appearing suddenly in the region of the elbows it was first thought to be acute lichen planus, but lacked the characteristic features of this disease. There was little or no pruritus, the colour was brownish and lacked the typical violaceous tint, and there were no polygonal burnished papules, such as are illustrated in the characteristic eruption in *Plate LII.*

This type of medicinal rash is rare, but has been recorded during the administration both of arsenical and bismuth preparations, so that it is uncertain which of the two drugs was responsible on this occasion. Intravenous injections of thiosulphate of soda (0.6 g.) were given twice weekly for five weeks, but the manifestation persisted for about three months.

Eruptions during the course of arsenical treatment for syphilis, and even in the intervals of rest, are by no means uncommon, and should be regarded as symptomatic of threatening intolerance. A slight pruritus in the antecubital fossa associated with erythema, or a faint papular rash on the arms and legs, calls for a halt and the antidotal intravenous injection of thiosulphate. Neglect of the warning and persistence in the antiluetic therapy has resulted on more than one occasion in the generalization of the skin symptoms and the production of the dreaded complication of exfoliative dermatitis, which usually persists for months (*see Plate VII*), and may end fatally.

PLATE XI



DERMATITIS MEDICAMENTOSA (Lichenoid Type)

DERMATITIS MEDICAMENTOSA
(Bromide Eruption)

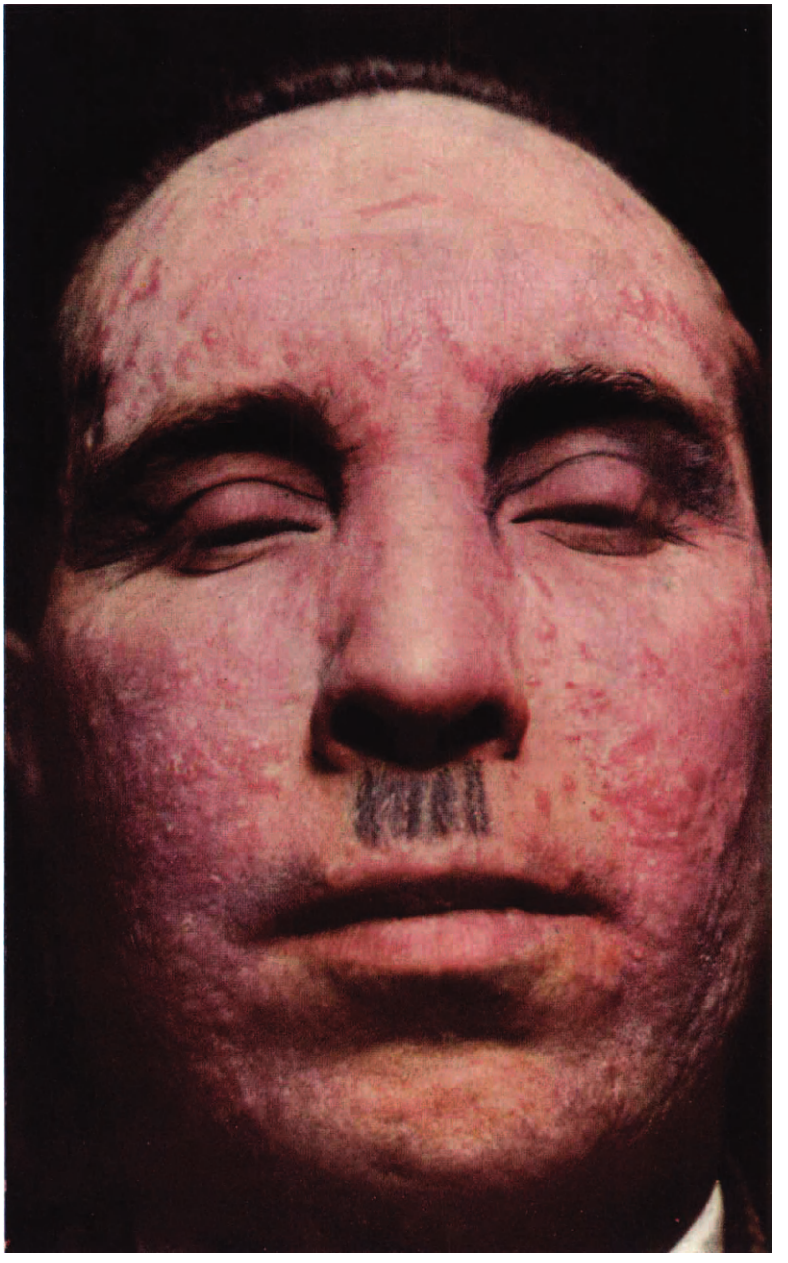
(PLATE XII)

WHENEVER an eruption or a skin lesion does not resemble a classified dermatosis, the possibility of a medicinal cause should be thought of. The bromides are perhaps the commonest in this connection, and two main types, the acneform and the granulomatous, are recognized. The plate illustrates the former, and might well have been mistaken for a papular syphilide or a profuse acne vulgaris. The absence of bucco-pharyngeal involvement, the acute onset, and the colour seemed to exclude a luetic aetiology; there were no comedones, and the patient was considerably over the age at which acne first makes its appearance. The absence of irritation, crusting, or scurf, although the eyelids were obviously œdematous, further militated against a seborrhœic causation, and by a process of exclusion the probable diagnosis of dermatitis medicamentosa was reached. The history afforded ample confirmation and on omitting the bromide, which had been administered over some weeks, the eruption subsided.

The granulomatous type is sometimes met with in cases of renal or cardiac failure, mostly on the face, and the large crusted rupioid lesions might give rise to confusion with syphilis of the late secondary or tertiary stages. I have twice seen such lesions on the legs of patients undergoing treatment by bromides for chronic alcoholism.

Treatment.—The treatment of the acneform variety is simple. The lesions gradually disappear after withdrawal of the drug and on applying a desiccating treatment with calamine and spirit lotion. In obstinate granulomatous cases the administration of large amounts of common salt (mass action) appears to accelerate recovery, and in one case with an unusual proliferative tendency I found mild doses of X rays of distinct value.

PLATE XII



DERMATITIS MEDICAMENTOSA (Bromide Eruption)

DERMATITIS MEDICAMENTOSA
(Acute Mercurial Reaction)

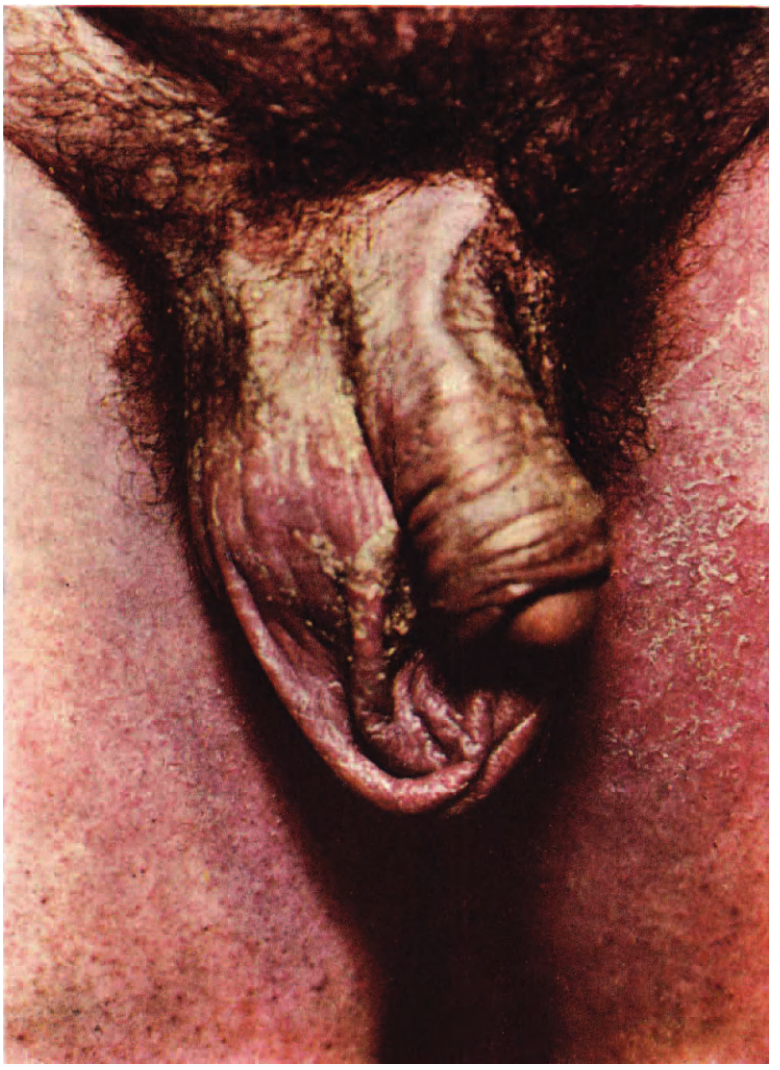
(PLATE XIII)

THIS patient who had pediculosis of the pubic and axillary regions had been advised by a chemist's assistant to rub the affected parts vigorously with mercurial ointment (ung. cinereum).

The result after three days of such treatment is illustrated in the plate, and occurred in a lesser degree in both axillæ. The pubis and scrotum and the inguinal folds and even the corpus cavernosum and the inner aspects of both thighs became violently inflamed, the itching was intense and continuous, and in a word, the cure was far worse than the disease. Blue ointment used always to be prescribed for pediculosis, and pictures such as this were relatively common before the war. It is of course far too powerful a remedy, and those who prescribe it are apt to forget that some persons have an idiosyncrasy to mercury while others in their disgust of the infestation are much too drastic in its application. It ought therefore to be given up as the remedy of choice. The prescriber has a choice of various remedies, and if he is wise he will discard any such as may provoke dermatitis. Three or four rubs with mitigal (Bayer) will do much the same as it does to the acarus of scabies, without any risk of either causing or aggravating dermatitis. Another useful remedy is 2 per cent beta-naphthol in soft paraffin. In this particular case the existing reaction indicated soothing applications, e.g., lead lotion sponged on t.d.s., and lin. calaminæ on strips of unmedicated gauze at night.

In the differential diagnosis we should have to consider tinea cruris and seborrhœic dermatitis, but in the great majority of cases the history will prevent error.

PLATE XIII



DERMATITIS MEDICAMENTOSA
(Acute Mercurial Reaction)

DERMATITIS MEDICAMENTOSA
(Acute Vesicular Iodine Dermatitis)

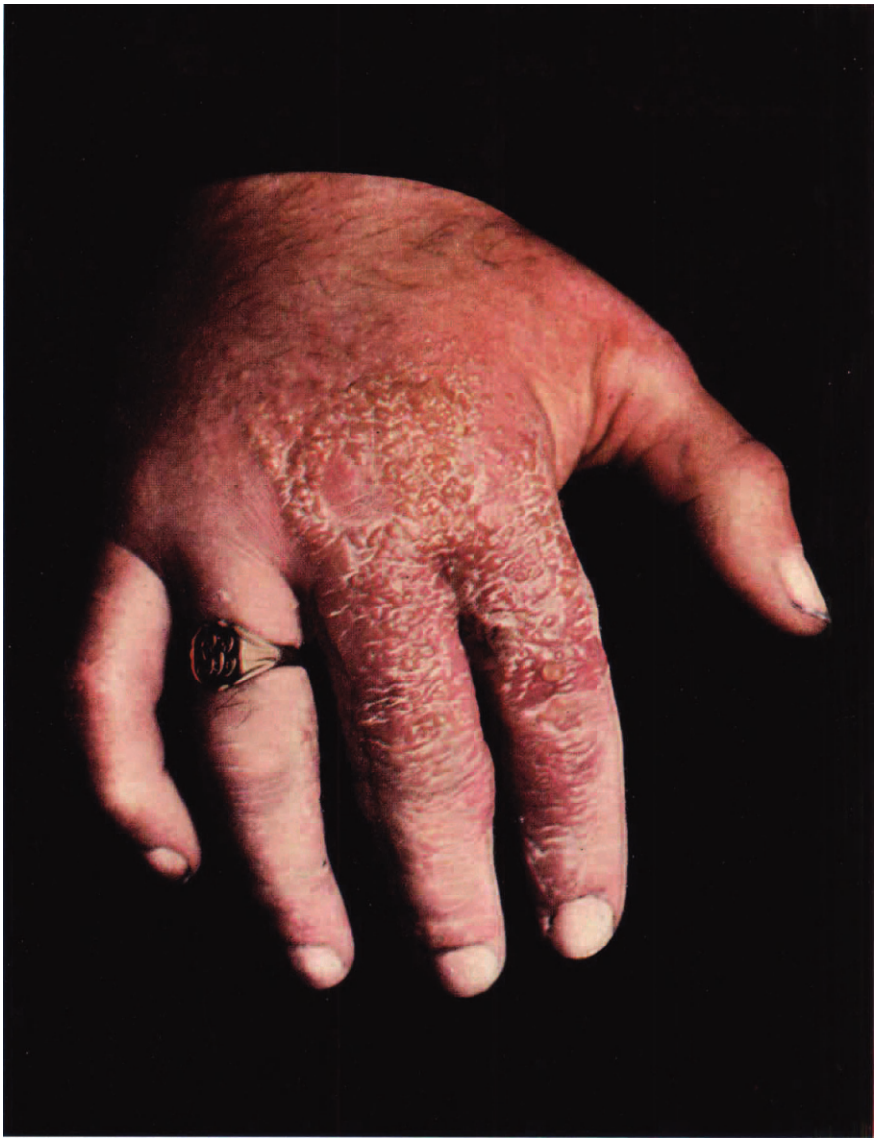
(PLATE XIV)

THE patient, a plethoric middle-aged man, had been advised to apply the B.P. tincture of iodine for an irritable eruption of small vesicles in the interdigital spaces of the first and second fingers of the right hand. After three or four applications the original eruption was greatly aggravated, there was marked extension of vesiculation over the back of the hand, between the fingers, and to some degree on the palm, with coincident increase of erythema and swelling. The result is well illustrated in the plate which may be regarded as an example either of iodine idiosyncrasy or the effect of an irritant erroneously applied in an acute and unsuitable condition. There was commencing secondary dermatitis of mild type on the neck, and slight œdema of both eyelids—a common allergic effect in cases as acute as this, and one which may be the prelude to recurrent eczematous eruptions of uncertain duration.

It cannot be too strongly emphasized that in acute manifestations strong applications of any kind are contra-indicated, and that where doubt exists it is better to temporize with lead or calamine lotion until a definite amelioration has set in.

There was no difficulty in the diagnosis, and treatment with calamine and lead lotion compresses was followed by rapid involution and subsidence of all the symptoms. It is probable that the condition originally present was due to infection with one of the mycelial fungi.

PLATE XIV



DERMATITIS MEDICAMENTOSA
(Acute Vesicular Iodine Dermatitis)

DERMATITIS, MYCOTIC

(PLATE XV)

THE condition illustrated here is exceedingly common in both sexes and at all ages between 20 and 40 Supposed at one time to be due to a disorder of the sweat glands, it has long been labelled ' dysidrosis ', and, for want of a better, the name still persists.

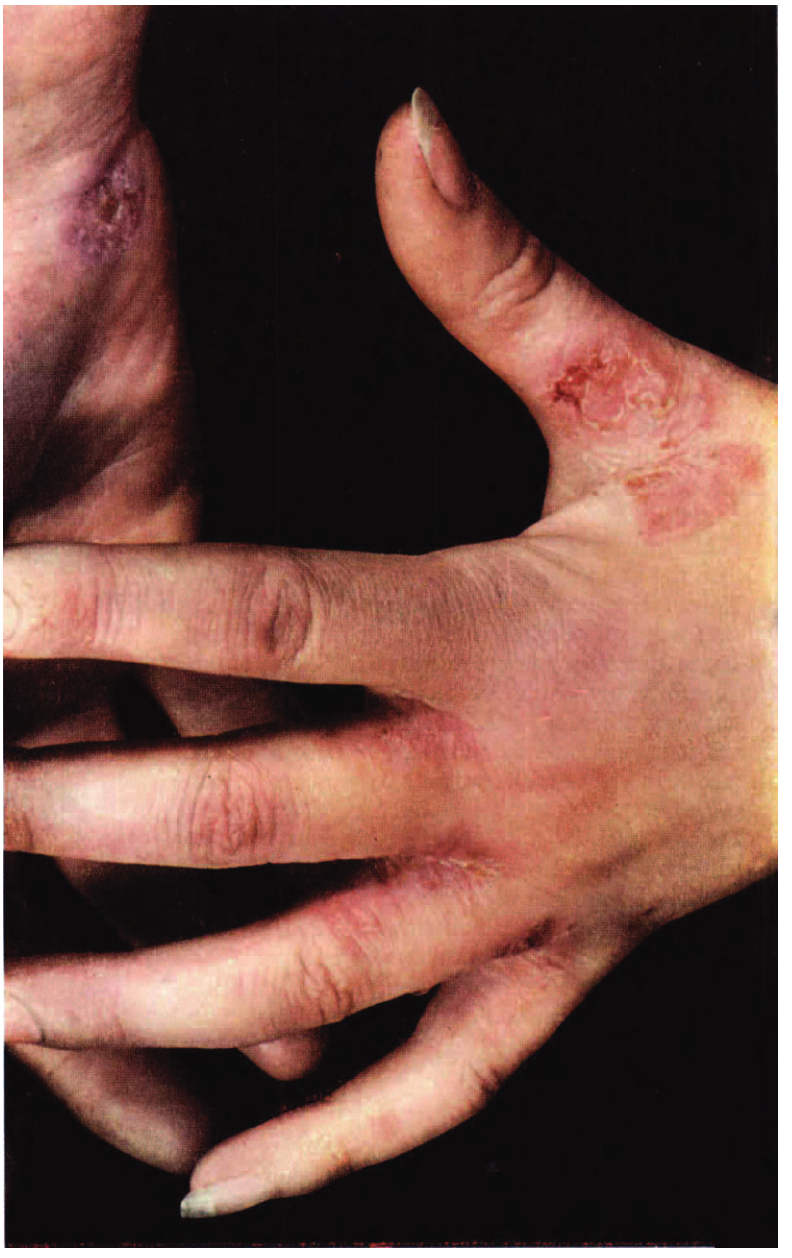
The current view adopted at the present time favours a mycotic origin in the great majority of cases, and although a fungus can but rarely be demonstrated or cultured in eczematized cases, it affords a rational explanation of the symptoms, and a satisfactory basis for treatment.

Clinically the condition is generally ushered in by itching or burning and the appearance of a few minute ('sago-grain') vesicles either on the webs or on the juxtaposed borders of one or more fingers, first of one and then of the other hand. With the rupture of the vesicles the itching usually subsides, and the next stage is well illustrated in the plate, in which we note a superficial patch of scaly dermatitis on the ulnar border of the root of the left thumb, a similar patch on the ulnar border of the right wrist, and interdigital erythema with some scaling on the webs between the fingers of the left hand. The process may spread, with the appearance of irritable rashes on the forearms, upper arms, and neck, and in severe cases even on the face, so that the clinical signs may differ in no particular way from those of allergic dermatitis. Many of these cases are seen in laundry workers and in those whose domestic tasks involve the use of more than the usual quantities of hot water, proprietary cleansers, and soda. These, being alkaline in reaction, and relatively caustic and solvent in their action on the corneous layer, permit the penetration and further the spread of the mycelial fungi causing the clinical manifestations and frequent relapses to which such patients are prone.

Every patient with presumed mycotic infection of this type should be questioned as to previous attacks, and particularly as to the condition of the feet, which should be microscopically investigated for the presence of epidermophytosis which may be acting as the primary focus of the hand infection, and from which it may have been derived by contact or even through the blood-stream. Monilia infections are also found in some cases of the interdigital type, especially in those exhibiting the bolster-like thickening of the free edge of the nail-fold termed paronychia (*see Plate LXVIII*).

Treatment.—If these premises are correct we have at least one definite indication to observe in treatment. The patient must be forbidden to use soap or soda, or even to immerse his hands in water. If the vesicles are unruptured a 1 per cent salicylic lotion in spirit should be used as a frequent local application. As scaling ensues, Lassar's paste, with salicylic acid from 1 to 5 per cent, should be applied under gloves at night, and the spirit lotion continued by day. Later when the more active stages are over, tar (liquor picis carbonis) in small percentage may be added to the Lassar's paste, and in very obstinate and relapsing cases small doses of X rays may be given. The treatment of the primary focus on the feet (*see* p. 76), if present, either as an interdigital peeling or as fissures, should not be neglected, for actual experiment has shown that hand lesions (epidermophytides as they have been called) respond much better when this has first been done.

PLATE XV



DERMATITIS, MYCOTIC

35

DERMATITIS, SEBORRHŒIC
(Acute)

(PLATES XVI, XVII)

PERHAPS the commonest of all skin diseases, this disease may occur in either sex and at any age. It is met with as frequently in private as in hospital practice, and there are reasons for supposing that deprivation of light, air, certain vitamins in the diet, and exercise, the wearing of hats, constipation, and other ' constitutional ' factors, play a part in the causation. The most important cause is undoubtedly the neglect of a scurfy scalp, and this predisposing and all too common factor can usually be ascertained in the history, and is sometimes a family feature.

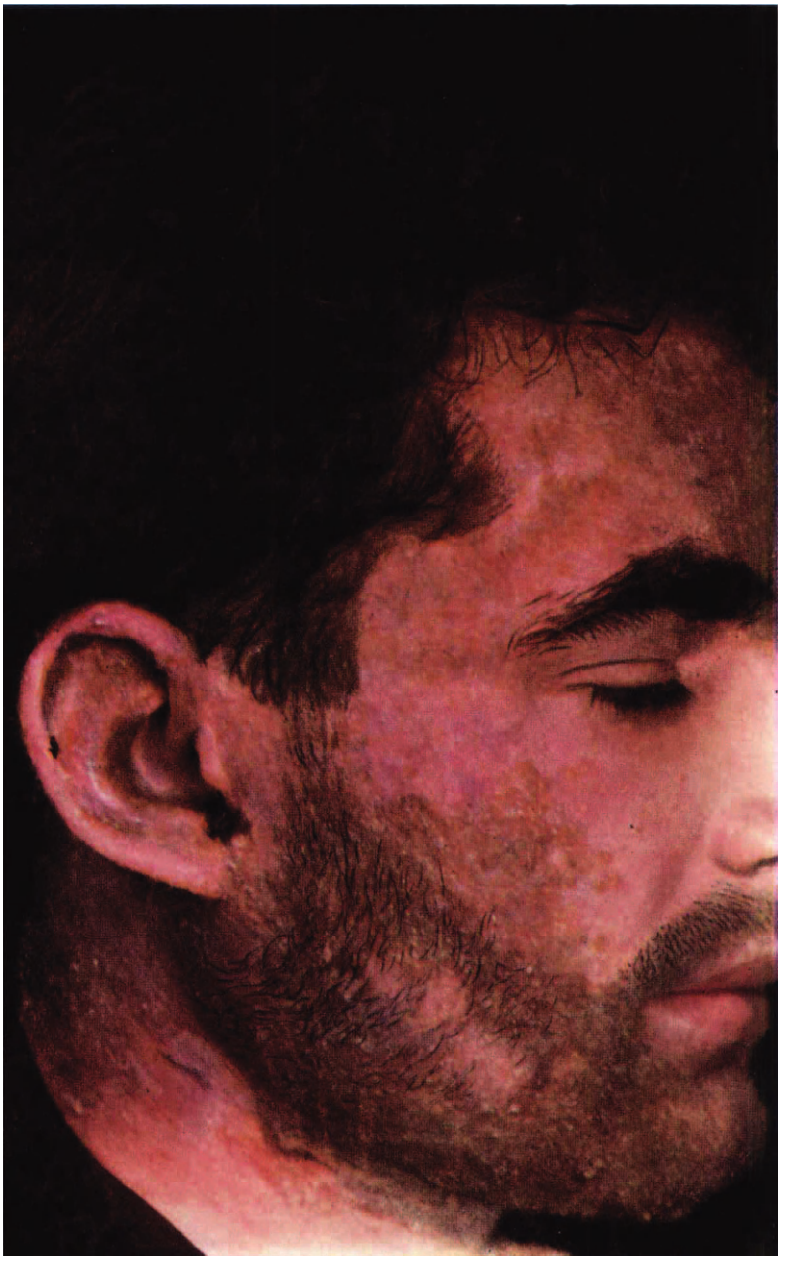
The disease occurs in two forms—acute or subacute illustrated in *Plates XVI* and *XVII*, and chronic, when it may initiate and is practically identical with sycosis. The features of the former type once seen are easily memorized. They include weeping and crusting on the scalp and ears in varying degree, and an erythematous and sometimes weeping eruption on the face and neck, which tends to involve the eyebrows and lashes, and may spread thence to the axillæ and groins. There is often œdema of the eyelids, as can be seen in *Plate XVII*. The post-aural crack or fissure is an exceedingly common association or sequel, and can occur in any seborrhœic subject even without a very obviously scurfy head. It seems to occur in this form especially in women, and it is suggested that the modern small ' cloche ' hat fashion may be an aetiological factor, in view of its tendency to promote apposition of two skin surfaces, often for the greater part of the day. Such cracks are sometimes seen at the mouth angles or paranasal sulci.

Once well established, an acute seborrhœic dermatitis of the scalp may give rise to endless trouble. I have had under treatment for over twenty years a young woman whom I first saw in infancy. Rigorous and persistent treatment has succeeded in preserving the eyebrows and lashes, but she has been an in-patient on several occasions, and is still subject to acute relapses in the summer months.

The only condition which is likely to be mistaken for acute seborrhœic dermatitis of the scalp and face is that following the use of a hair-dye (*see Plate XXVI*). If he remembers that possibility, the physician is not likely to make the mistake, and in most cases of the latter condition the patient herself will make the diagnosis.

Treatment.—It is rarely necessary or desirable to cut or shave the hair. In the weeping stages, 2 per cent lead, or a 1 per cent aluminium acetate lotion should be applied constantly, with or without the use of a gauze face-mask, throughout the day. At night an oily liniment should be substituted, which may contain $\frac{1}{2}$ per cent resorcin in solution. As improvement occurs the lotion may be replaced altogether by creams containing increasing additions of sulphur and salicylic acid (from $\frac{1}{2}$ to 2 or 3 per

PLATE XVI

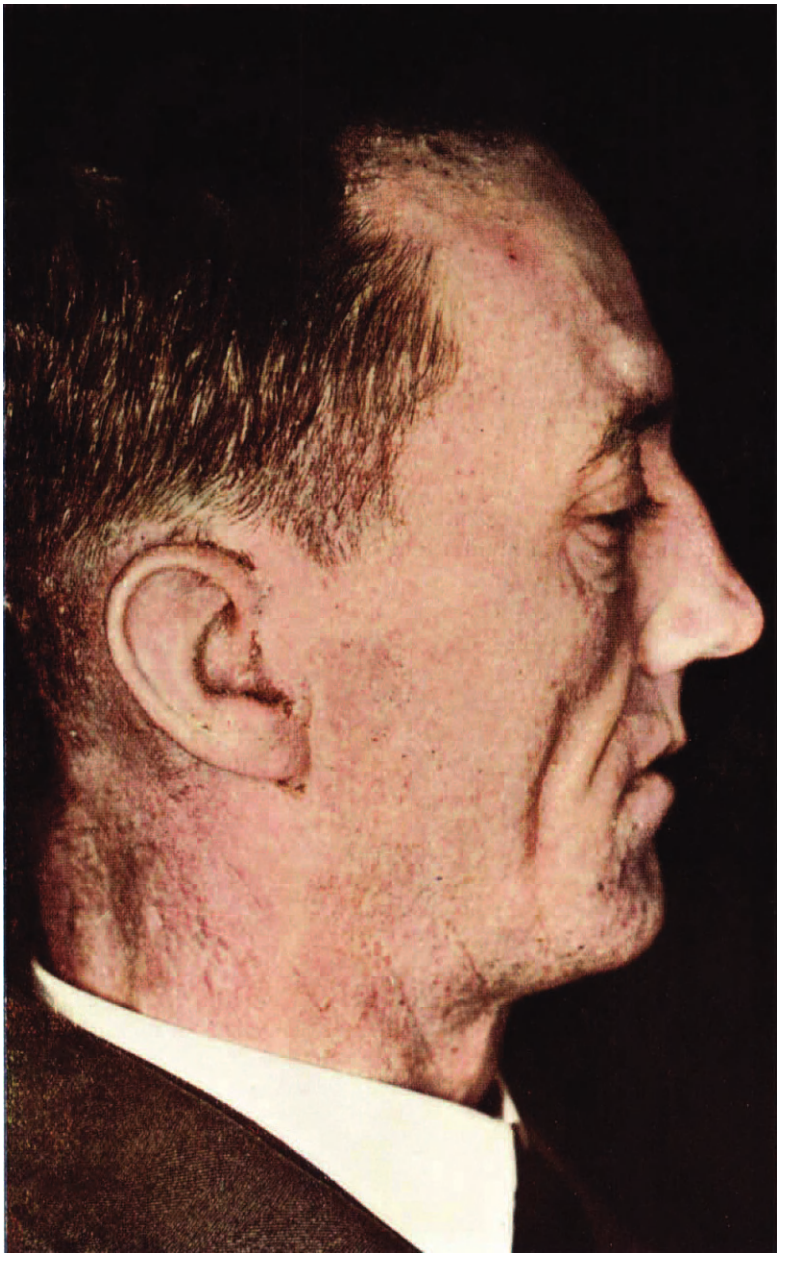


SEBORRHŒIC DERMATITIS (Acute)

cent). If there is much pus or a tendency to furunculosis, the addition of ichthyol, both in the lotions and liniments, is indicated. The later stages favour the application of tar in some form—the liquor picis carbonis in lotions, the oil of cade in oily or greasy preparations. In combination with salicylic acid, it is most valuable as a daily hair dressing for the prevention of relapses.

In a recent case which closely imitated the clinical appearances of a seborrhœic infection of the scalp, with post-aural fissuring, œdema of the eyelids, and secondary furuncular lesions on the forearms in a young married woman of 24, the offending organism was found to be a *Streptococcus hæmolyticus*, and it was not until a 1–4000 perchloride lotion had been substituted for the routine treatment above described that improvement and a slow recovery eventually supervened. Superinfection with a streptococcus is by no means rare in seborrhœic infections, and its possibility should always be envisaged in resistant cases.

PLATE XVII



SEBORRHŒIC DERMATITIS (Subacute)

DERMATITIS, SEBORRHŒIC
(Chronic)

(PLATE XVIII)

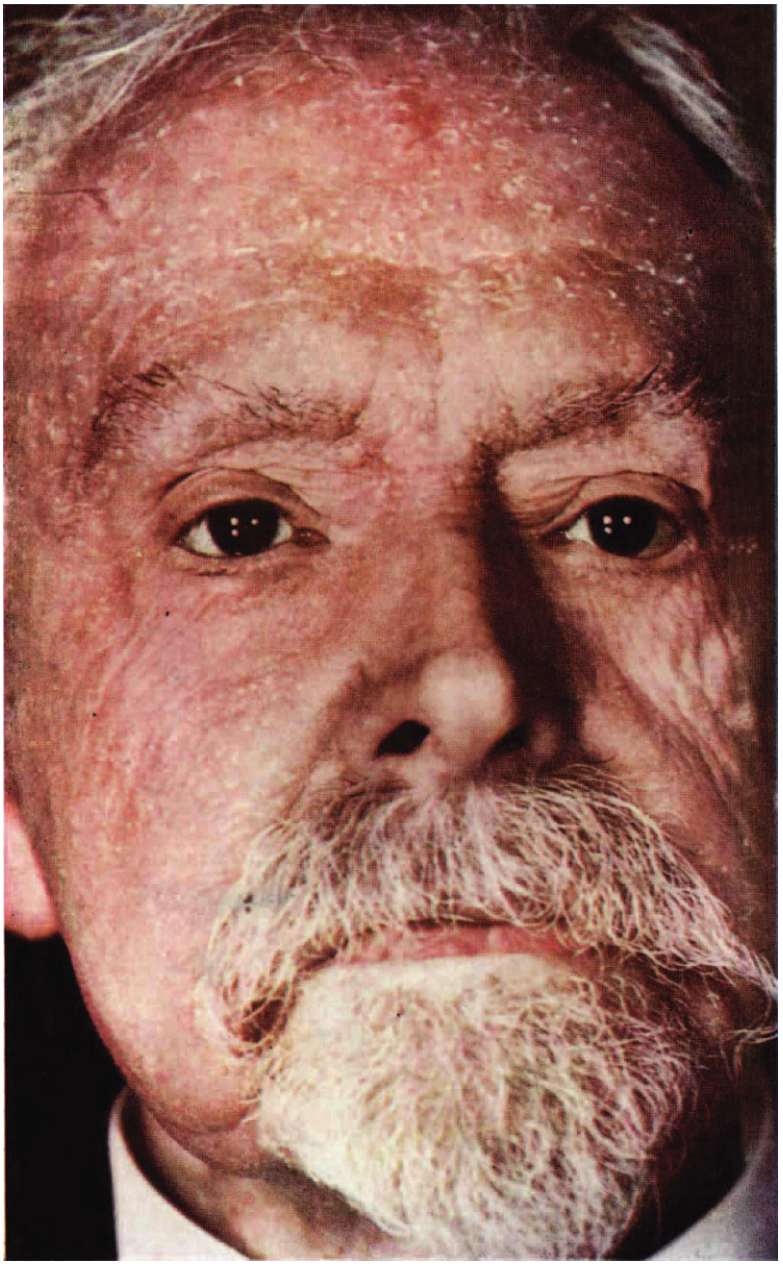
THE chronic facial dermatitis here shown is part of a general seborrhœic dermatitis from which the patient, aged 65, has suffered on and off for over twenty years. As will be observed, the condition has spread from the hairy scalp to the face, the skin of which is thickened, erythematous, and scaly. The eyelids are hyperæmic and have lost most of their lashes. This general seborrhoic tendency has affected the whole integument, and predominates on the legs, where erythema, thickening, and scaling approach very near to the more serious complication which may occur in this disease (and psoriasis)—chronic exfoliative dermatitis.

The patient was admitted to the wards and improved considerably with continued applications of weak sulphur, salicylic, and tar ointments, under which the chronic thickening was considerably reduced and the irritation relieved.

The prognosis at his age and under the circumstances of his home life is not good, and a complete recovery is most unlikely.

Treatment.—The best results are obtained by a combination of methods, for there is no specific therapeutic agent, and every case needs individual investigation and study. It has recently been stated by Ingram of Leeds that nasopharyngeal sepsis, and particularly chronic sinusitis, are common associations. Elimination of septic stumps, dead or devitalized teeth, and infected tonsils, should whenever possible precede other measures for relief, and are frequently rewarded by rapid improvement in the chronic types of the disease. Rectal lavage, or the so-called 'Guelpa cure' in which the patient is given 1 oz. of Epsom salts in a pint of water, and then kept on a strictly fluid diet (orange or lemon drinks with glucose, weak tea, soup from vegetable stock, barley water, etc.) for two to four days, has often proved a useful preliminary in my experience. The improvement that follows suggests an associated intestinal infection, and cultural examination of the fæces usually lends colour to that assumption, and justifies the older practice of cutting down excessive starch, carbohydrate and protein consumption in subsequent regulation of the diet. Many of these patients do not drink enough, and it is a good plan to recommend a glass of cold water immediately before each of the principal meals, thrice daily. There is much to be said, too, for graduated solar or ultra-violet ray therapy, especially in young subjects, and the rapid improvement that invariably follows a holiday in Switzerland or by the sea supports the recent contention that one of the most important factors in the causation of seborrhœic dermatitis is vitamin deprivation.

PLATE XVIII



SEBORRHŒIC DERMATITIS (Chronic)

DERMATITIS, STREPTOCOCCAL, BULLOUS

(PLATE XIX)

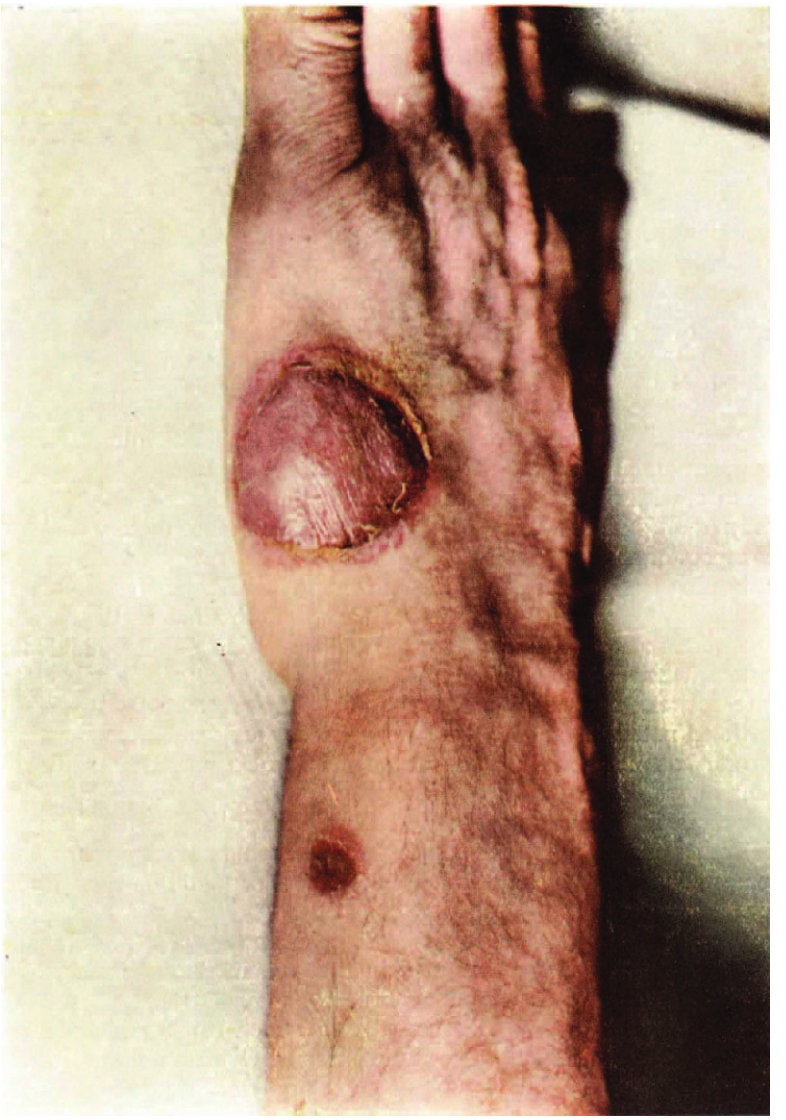
IT is not easy to affix a dermatological label to the by no means uncommon streptococcal lesions here depicted on the ulnar border of the left hand and wrist, and the reader may search the text-book indexes for a similar title, in vain. At first sight the diagnosis of tinea circinata, due either to a trichophyton or some other mycotic infection, seemed probable, but neither in this case, in which the lesion had persisted unchecked by the usual antiseptic applications for three weeks, nor in another which I had under strict supervision, was mycelium ever demonstrated. This latter was an exactly similar clinical lesion on the dorsal surface of the left thumb and adjoining interdigital space. The patient, a lady casualty officer at one of my own hospitals, had noticed a vesicle two or three days after attending to a septic case (without gloves), and she had tried to effect a cure with ung. hyd. ammon. dil., etc., for some four weeks before she showed it to me. Examinations for mycelium, treponemata, and tubercle bacilli were all negative, but on culture there was a profuse and almost pure growth of hæmolytic streptococci, with here and there a staphylococcus colony.

The initial lesion is a small flaccid bulla or vesicle which spreads centrifugally and without much irritation, rather like impetigo. Adenitis was not present in either of the two cases, nor does it seem to be a common association. Satellite lesions of similar aetiology may appear in the neighbourhood, especially if boracic fomentations are applied, and in children the dermis may become involved, leading to many isolated small circular ulcers, very indolent in type, to which the name 'ecthyma' is usually applied, and which end as a rule in the production of circular cicatrices.

Differential Diagnosis.—The most common error in such cases is a diagnosis of ringworm, which may be very closely simulated. It should, however, be possible to avoid it if one remembers that tinea is usually very irritable, and that small vesicles (not bullæ) appear consecutively in the peripheral spreading margin, while the centre tends to clear up. A reference to the illustration demonstrates an oozing reddish base with a slightly raised overhanging margin and without the particulate peripheral vesiculation so characteristic of the mycotic invasion. Another and much rarer disease which might give rise to confusion is pemphigus. In this the bullæ arise *de novo* in normal skin and with little or no inflammatory reaction. They may be very tense before the clear serous contents become turbid and the walls rupture with the production of a superficial ulcer. Lastly, we have to consider erythema multiforme (*Plate XXXVIII*), in which the lesions, although they tend to appear in a similar situation on the backs of the hands, and may become bullous, are multiple and symmetrical, and are always preceded by a very characteristic circular, sometimes target-shaped or iris-like, infiltration.

Treatment.—The case of the casualty officer is instructive. Her lesion involuted completely in forty-eight hours under a continuous dressing of ung. streptocide, which contains a member of the sulphanilamide group.

PLATE XIX



BULLOUS STREPTOCOCCAL DERMATITIS

DERMATITIS, RECURRENT STREPTOCOCCAL

(PLATE XX)

THIS disease is fortunately not common even in dermatological clinics, for the problem of its causation in the individual is often insoluble. It resembles the acute disease (erysipelas) in its colour and causation (streptococci in an attenuated form), but differs from it in the absence of a defined margin and the acute and dangerous febrile reactions, without which the diagnosis of the graver malady is manifestly in doubt. The face is by far the commonest localization.

All authorities agree that the tendency to recurrences must be ascribed to the persistence of a septic focus, usually in the immediate neighbourhood of the rash. This should be sought for in the teeth, tonsils, antra, eyelids, or even in a small fissure or crack behind the ears, or at the angles of the mouth or alæ nasi. In a case of the author's—a hospital nurse—the dental surgeon traced the source of infection to a small sinus *behind* the right upper canine tooth, extraction of which immediately cured a series of attacks extending over eighteen months.

Another case, with rigors and pyrexia associated, is worth recording. The patient, a married lady of 55, had had fourteen attacks in all, and all of them were localized to the internal aspect of the lower third of the right leg. The first attack and the most severe, necessitating ten days in bed, occurred without warning in January, and the last a week before I saw her on November 22. Beyond residual erythema and slight scaling there were no local manifestations, but on examining the foot for a possible focus I found extensive epidermophytosis involving all the interdigital spaces, with a deep fissure between the second and third toes. A similar but less marked fungus infection was also noted in the left foot. The patient admitted having noticed it for over two years, but neither she nor her doctor had connected it with the acute manifestations above described.

There could be little doubt that the fissure had opened the door to a streptococcus, for, if the infecting organism had been an epidermophyton, immunity would long since have become established, and one attack would almost certainly have sufficed to cure the tendency.

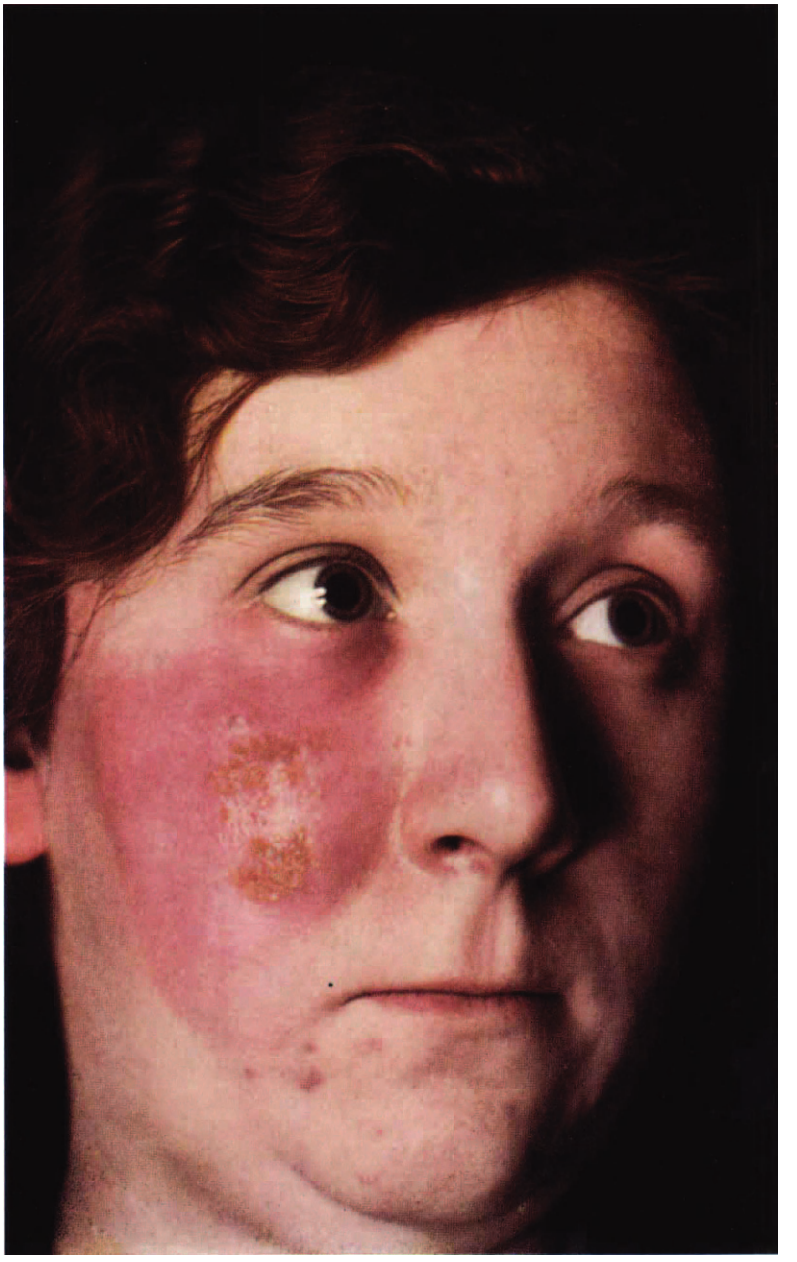
The treatment advised was that for chronic epidermophytosis (p. 76), and a small dose of X rays was given to the area of skin involved in the recurrences, with the purpose of desensitizing it to the streptococcus.*

Persistent recurrences may lead eventually to lymph-block, which may involve a lip or an eyelid in the repellent complication termed elephantiasis nostras.

Treatment of the attack itself with weak ichthyol and calamine lotions must never be allowed to take the place of repeated and patient search for the causative factor. X-ray treatment in the intervals is of some prophylactic value.

*There had been no recurrence six months later.

PLATE XX



RECURRENT STREPTOCOCCAL DERMATITIS

DERMATITIS, VARICOSE

(PLATE XXI)

THE cutaneous complications of varicose veins are extremely common among the cases attending dermatological out-patient departments all over the world. Elderly and middle-aged women with large families and heavy domestic duties preponderate in the series, and there is no doubt that both they and the physicians who treat them owe a debt of gratitude to the methods devised and advanced by Dickson Wright and others for the relief and cure of the underlying cause—the varicose vein.

The elastoplast bandage has come into general use as a result, but its contra-indications are not sufficiently recognized. To seal off and occlude with a more or less impermeable fabric the discharges from a chronically inflamed or infected skin—on the assumption that it is good for the tissues to be bathed in the products of their own infection—may be correct in theory, but is not always borne out by the results, however urgent may be the necessity to relieve or counteract the back-pressure in the dilated veins.

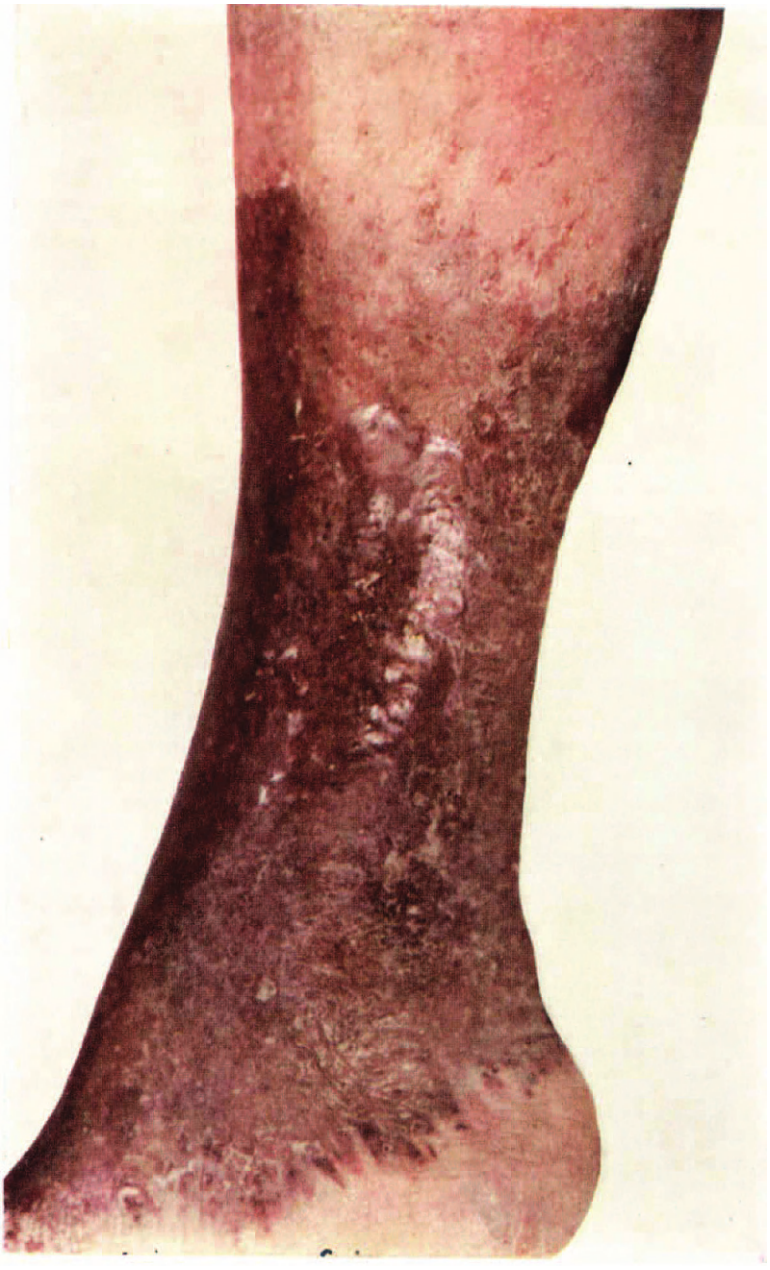
It may be taken as an axiom that caution should be exercised in all cases in which, in addition to an ulcer, there is any marked degree of dermatitis around it. The old treatment of elevation of the limb in the supine position, with the local and constantly renewed application of simple soothing remedies—such as lead lotion, calamine or half-strength red lotion, calamine liniment, with or without $\frac{1}{2}$ to 1 per cent ichthyol added—is still the safest procedure, and should precede the occlusion by any form of elastic support, *especially those that make direct and adhesive contact with the skin*, for at least a week. A neglect of this precaution is not infrequently followed by the local spread of the dermatitis and an allergic reaction of the whole integument. Dermatitis may develop on the other leg, on the forearms, the neck, and even the face, so that the patient either returns to implore the removal of her bandage, or cuts it off herself and seeks fresh counsel at another institution.

Treatment.—If the area of dermatitis is small and not acute, a good plan is to cover it with the varicosan or modified Unna's bandage before affixing the elastoplast This to some extent will allay the inflammatory tendency of the skin adjoining an ulcer, and may serve to prevent the appearance of the complications above described.

Plate XXI presents a typical chronic example, in which, without an excavated ulcer appearing (cf. *Plate XCVIII*), diffuse and intractable dermatitis with considerable excoriation and serious discharge was aggravated by the direct contact of an elastoplast bandage. Such a case could only be treated satisfactorily by putting the patient to bed, elevating the limb, and constantly re-applying on gauze or butter muslin (*not lint, and never oiled silk*) one or other of the preparations specified above.

Subsequent injection treatment of the (at present obscured) varicosities would be required to prevent the tendency to a relapse on assuming the upright position, and measures should be taken to counteract any general or constitutional disabilities such as obesity, hyperglycæmia, or gout, to which such patients seem especially disposed.

PLATE XXI



VARICOSE DERMATITIS

DERMATITIS VENENATA
(Occupational or Trade Eczema)

(PLATE XXII)

THE diagnosis largely depends upon the localization and the history, for there is no essential clinical difference between a patch of dermatitis produced as the result of a local irritant and the patches which arise *de novo*, widely and diffusely, from a known or obscure endogenous cause. The lesions consist, according to the stage of the disease, of acute papulo-vesicular, vesicular, or crusted and sometimes pustular (impetiginized) patches, or chronic infiltrated (lichenified) plaques, in which scaling or papular conformation may predominate.

The figure shown demonstrates a common type of trade dermatitis met with in hospital out-patient departments. The patient was a labourer whose forearms were constantly exposed to dust and semifluid mixtures of cement, which owing to its lime content has a definitely alkaline reaction. It may be noted in passing that alkalis like soap, soda, and proprietary cleansing preparations are by far the most frequent direct cause of trade or occupational dermatitis, for they have a softening and macerating action on the horny layer of the skin, and by thus damaging the first line of defence render the epidermis as a whole less able to counteract the entry of micro-organisms and fungi.

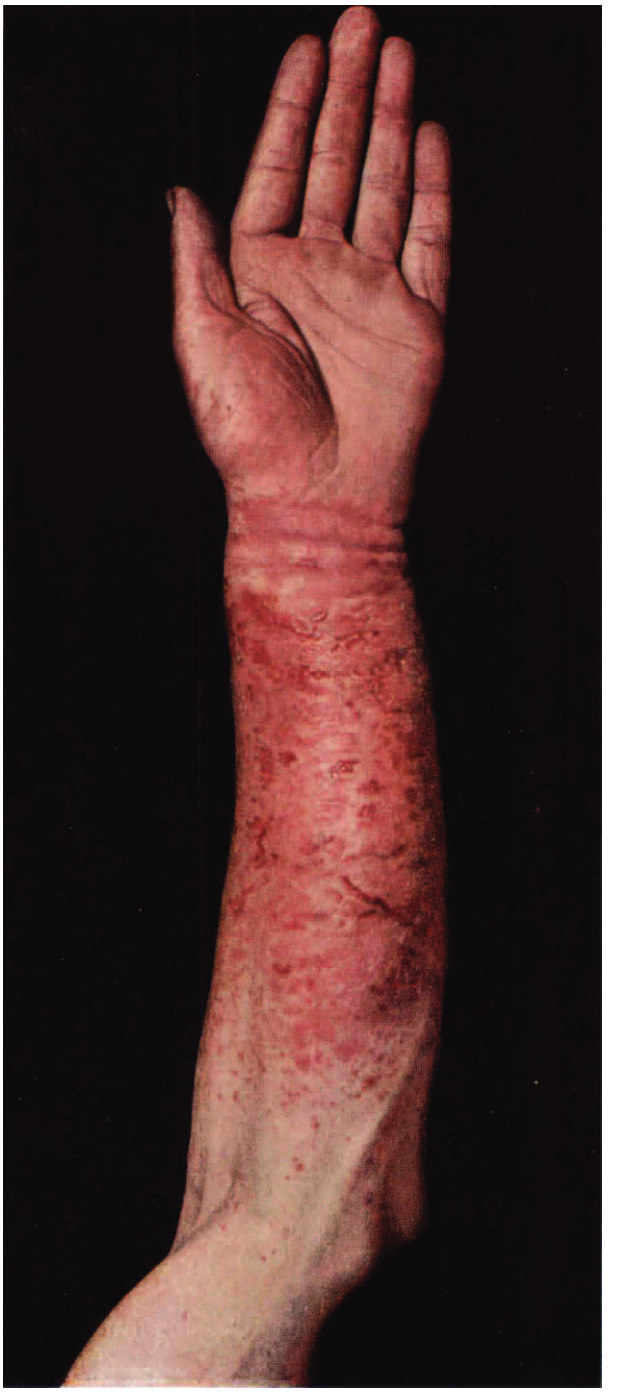
The weeping red excoriated surface is typical of the acute stage. The affection was bilateral and symmetrical, and a certain amount of œdema was associated. The outline is diffuse, not sharply demarcated, and the spreading edge in the antecubital fossa fades off imperceptibly into healthy skin in which a few outlying papules can be seen. Left to itself or wrongly treated such a condition may spread with great rapidity and involve distant parts of the body, especially the neck and face, in which the eyelids soon become œdematous.

Itching is a constant feature of all cases both of occupational dermatitis and allergic eczema of internal causation, and relapses are frequent in both, unless the causal factor is recognized and eliminated.

Treatment.—In the acute stages rest and protection are essential. Strips of butter-muslin are soaked in lead or calamine lotion every hour or two and bandaged on the affected parts in a loose manner to allow of proper aeration. As the weeping diminishes, an oily liniment is indicated, e.g., equal parts of lime water and olive oil, to which may be added the liquor plumbi subacetatis (1 to 2 per cent) or ichthyol or resorcin (1 to 2 per cent). It should be applied in a similar manner but at less frequent intervals. Later still, in the scaly desquamating stages, Lassar's paste is efficacious, and even more so with the addition of a little crude coal tar or liquor picis carbonis (1 to 5 per cent). X rays in small doses are often of great value in obstinate and relapsing cases.

Prognosis.—The burning question in almost all cases of trade dermatitis is whether the patient will ever be able to resume the occupation which caused the

PLATE XXII



DERMATITIS VENENATA (An Example of Trade Dermatitis)

trouble. Extreme caution in assessing his chances cannot be too strongly urged. Speaking generally the danger of relapse is in direct proportion to the degree of exposure necessary, and inversely to the rate of onset after exposure. That is to say, that the apprentice who develops french polisher's dermatitis after working for only a few weeks is exceedingly likely to relapse soon after a return to work. He has, presumably, an inherited susceptibility to one or more of the ingredients employed. The man who exhibits the symptoms after thirty years of work must have acquired the idiosyncrasy, and a long abstention from his work, with measures adapted towards hardening the epidermis, will usually permit of his ultimate return.

It cannot be too strongly emphasized that *careful note-taking from the first moment* such a patient attends for treatment, will always repay itself. At a medical society meeting last year, a well-known judge in compensation cases made this statement his central thesis, and urged it on the members present: " Each observation should be *dated*, and although such notes may not be read in court, they may be referred to in the witness box, and will, if the doctor himself attends to testify to their accuracy, be regarded as most valuable evidence in the legal sense." The same speaker further observed that the doctor's first duty was to ' assist the court.' He must not regard himself as a witness for or against the claimant—an all too common practice in such cases. If he confines himself to the evidence, and gives no opinion until asked, avoids the use of long names, and the enunciation of disputable theories, he will usually escape the rigours of unfriendly cross-examination. If, nevertheless, an aggressive line of policy is pursued by counsel, he, the witness, will never fail to obtain the judge's protection and a fair hearing.

DERMATITIS VENENATA
(Occupational or Trade Eczema)

(PLATE XXIII)

THE eruption here shown is limited to the backs of the hands and forearms, and has been recurrent in this situation for over a year. It consists of reddish vesicular patches which are moderately irritable, and tend to weep on very slight provocation.

The patient, a journeyman-baker, had been unable to resume his work—the handling and kneading of dough (which was presumed to have caused the symptoms)—for many months. The dermatitis set up in baking seems to be a particularly intractable variety of those due to a trade, for I can remember at least two other cases, very similar in type and localization, in which the usual treatment by occlusion under weak tar paste, lotions, X rays, etc., proved ineffective for a long time. This patient has done well with whole-blood injections and a 3 per cent crude coal-tar paste, but he is still under treatment (15 months), and receiving compensation under the Act.

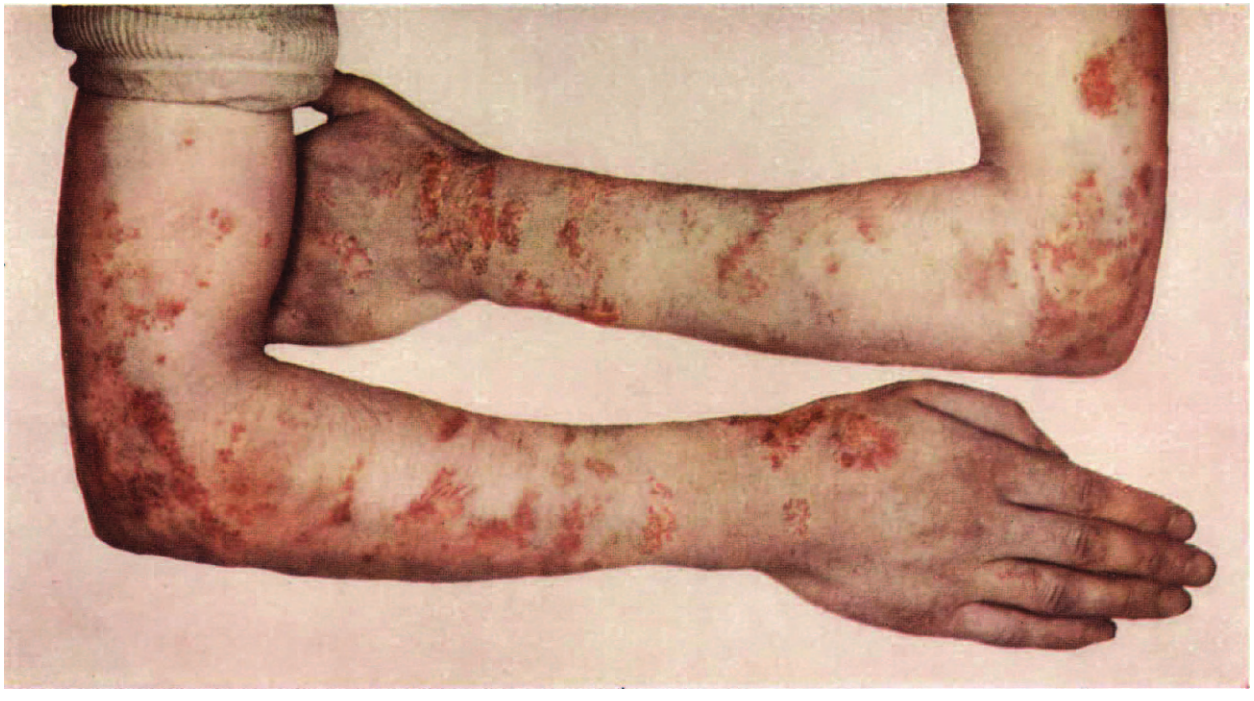
Prognosis.—Under this heading there is from the practitioner's point of view nothing more important in dermatology. No one with a panel practice, especially in an industrial centre, can hope to escape either the tedium of treating these cases or the responsibilities so frequently associated with the claims for compensation. He should familiarize himself with his legal status and duties under the Workmen's Compensation Acts (1906, 1907, and 1918), and is strongly advised to take brief notes, *with corresponding dates*, from the very first day of seeing any case in which the possibility of a process at law may subsequently develop. With such notes in his possession—and he is legally entitled to refer to them—his attitude in the witness-box will be confident, and his evidence of the greatest value to the court.

The difficulty of assessing the period of disability in a trade eczema, or any form of dermatitis for that matter, can hardly be exaggerated, and the more the doctor knows of such cases, the less he will be inclined to commit himself. Any case of more than six weeks' duration in a first attack is liable to recurrences even without direct contact with the offending agent, and many are rendered susceptible for months to such ordinarily innocuous stimulants as soap, the heat of an open fire, or even their own perspiration in rubber gloves. It is safe to say that every subsequent attack renders the skin more liable to react with inflammation to the specific cause of the original dermatitis. It is therefore reasonable to assert that after two or more separate attacks the patient ought not to be allowed to resume his original employment, or indeed any in which he would be exposed to irritants that might conceivably cause dermatitis.

There is no doubt that the incidence of industrial dermatitis could be considerably diminished by the regular and conscientious application of effective skin protectives. Among many such for which efficiency is claimed, that recently recommended by Dr. P. B. Mumford* and provisionally labelled H.E.B. is deserving of notice. It is easily spread, very stable, both as regards durability and in the presence of most chemical agents, and is not easily transferred to delicate fabrics in the manufacture of which the workman may be engaged. Moreover, it is not unduly expensive.

* *Brit. Med. Jour.*, 1939, Feb. 11, 266; *Brit. Jour. Dermatol. and Syph.*, 1938, 1, 540.

PLATE XXIII



DERMATITIS VENENATA (Occupational or Trade Eczema)

DERMATITIS VENENATA

(Occupational or Trade)

Tar Melanosis, 'Mollusca', and Epithelioma

(PLATE XXIV)

THIS illustration affords a classical example of the ultimate effects on the skin of the face of the fumes from boiling pitch, acting over a number of years. I had seen the patient—an otherwise healthy man of 41—some eight years previously, for facial dermatitis, conjunctivitis, melanosis, and recurrent 'tar warts', together with others employed in the task of stirring a fuming mixture of pitch and asbestos in open vats. I inspected the factory and made strong representations to its owners on the need for more efficient ventilation, the substitution if practicable of closed retorts for the primitive open cauldrons, and the provision of proper cleansing facilities. In another part of the factory the finished product, which resembled vulcanite, was being turned and polished on lathes into various articles such as electric insulators, fountain pens, etc., and here, too, I noted the preventable effects of the tar dust with which the atmosphere was continuously polluted. Most of the girls employed in this section were affected by recurrent dermatitis of the face and hands, especially in the summer months, and were very emphatic regarding the aggravation of their symptoms by sunlight—a well recognized effect in other tar industries, e.g., road sprayers. From this angle, tar and hydrocarbons derived from it might be regarded as photosensitizers.

A great deal of research has been published on the subject, and those interested should consult Prosser White's admirable summary (*The Dermatergoses*, 4th ed., 1934, 228–36. London: H. K. Lewis), in which all that is relative is fully discussed.

In studying the photograph of this very typical case we should note: —

1. The peculiar swarthy tint—a bronze discoloration of the epidermis—which at first sight might be mistaken for the normal effects of sunlight.

2. An overaction of the sebaceous glands as evidenced by the prominence of their ducts, and the presence of excessive grease (sebum).

3. The characteristic warts which bear a strong clinical resemblance to the small lesions of molluscum contagiosum (cf. *Plate LXIV*).

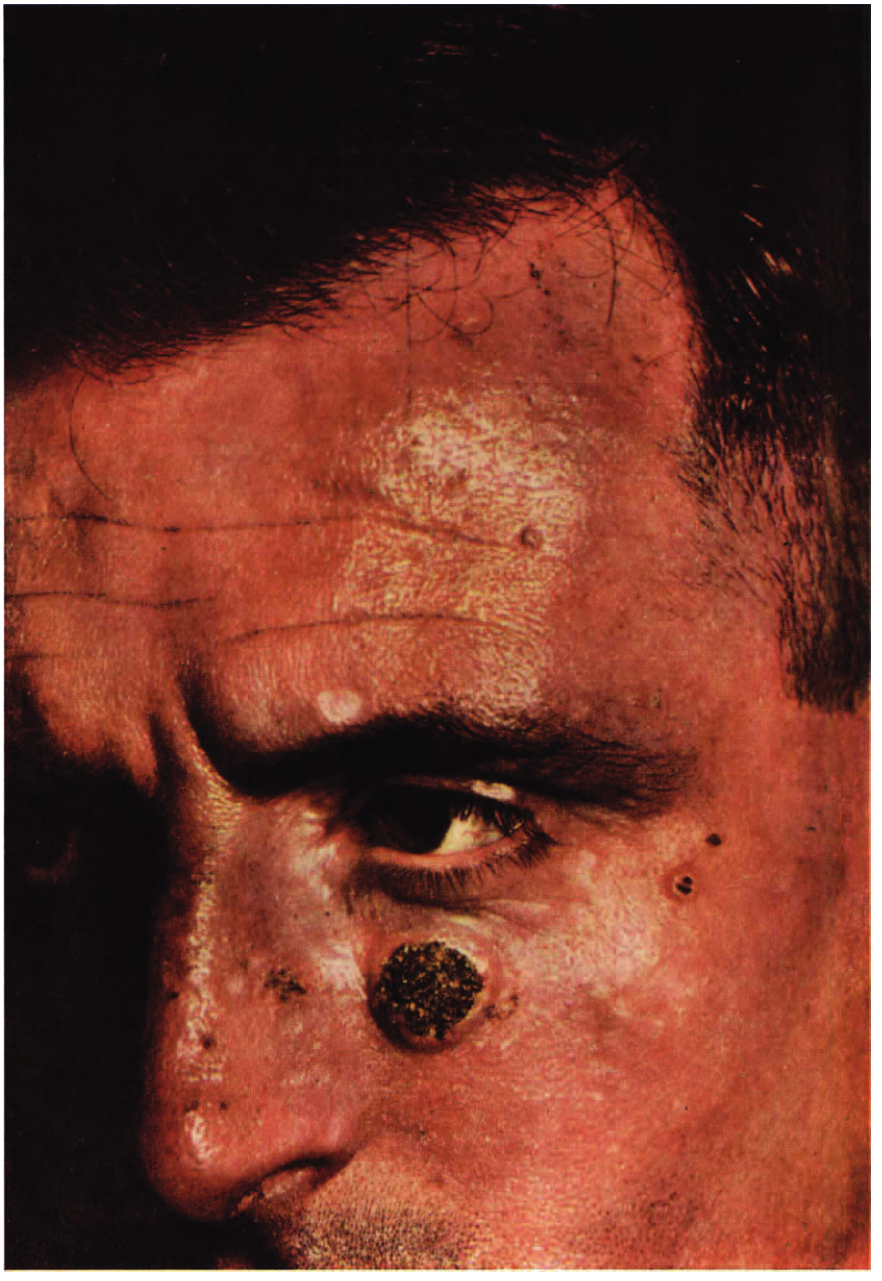
4. The large circular neoplasm, of proliferative rather than ulcerative type, with its prominent raised circumvallate and well defined ridge. Histologically these epitheliomata are usually of prickle-cell type (Goldsmith, *Recent Advances in Dermatology*, p. 411).

Similar tumours can be produced artificially by repeatedly painting the shaven skin of white mice and other rodents with tar or its water-soluble carcinogenic extracts (auxetics) (Bierich, Dielman, Ross, and others).

These cancers are relatively benign, and do not tend to recur after local destruction—at least in early stages. Mortality from secondary general invasion is very small.

Diagnosis.—Once seen the condition could hardly be confused with any other dermatosis. The localization on the exposed parts—face, neck, backs of hands and

PLATE XXIV



DERMATITIS VENENATA (Occupational)
With Tar Melanosis, 'Mollusca', and Epithelioma

wrists, the history of exposure to tar (or its products by distillation) over long periods, and the characteristic triad of melanosis, ' mollusca ', and epitheliomata make the diagnosis easy.

Prophylaxis.—There is no disease in medicine to which the old adage—prevention is better than cure—is more applicable. It is purely a question of preventing the continuous contact with the skin of tar in liquid form or dust, or of tar fumes, and it is well within the scope and authority of the Home Office and the Ministry of Health to issue strict regulations to all the trades concerned, which now has to a large extent been done.

Treatment.—Once established the dermatitis is apt to be associated with the formation of hyperkeratoses, very much like those resulting from solar or X-ray over-exposure, or the effects of arsenic medication for prolonged periods. These and their sequelæ—the epitheliomata—may appear later, *at any time*, even though the subject is permanently removed from all possibility of contact with the original cause. The likelihood of such developments can nevertheless be reduced by adopting local measures of protection against such auxiliary irritants as excessive sunlight, and the application of soothing creams, lotions, and liniments which, of course, must not contain tar derivatives. The ' mollusca ' or tar warts can be destroyed by the CO_2 pencil, as was done effectively, eight years previously, in the case illustrated, while radium or intensive X-ray treatment is reserved for such frankly epitheliomatous proliferations as have developed in this patient.

DERMATITIS VENENATA
(Fur)

(PLATE XXV)

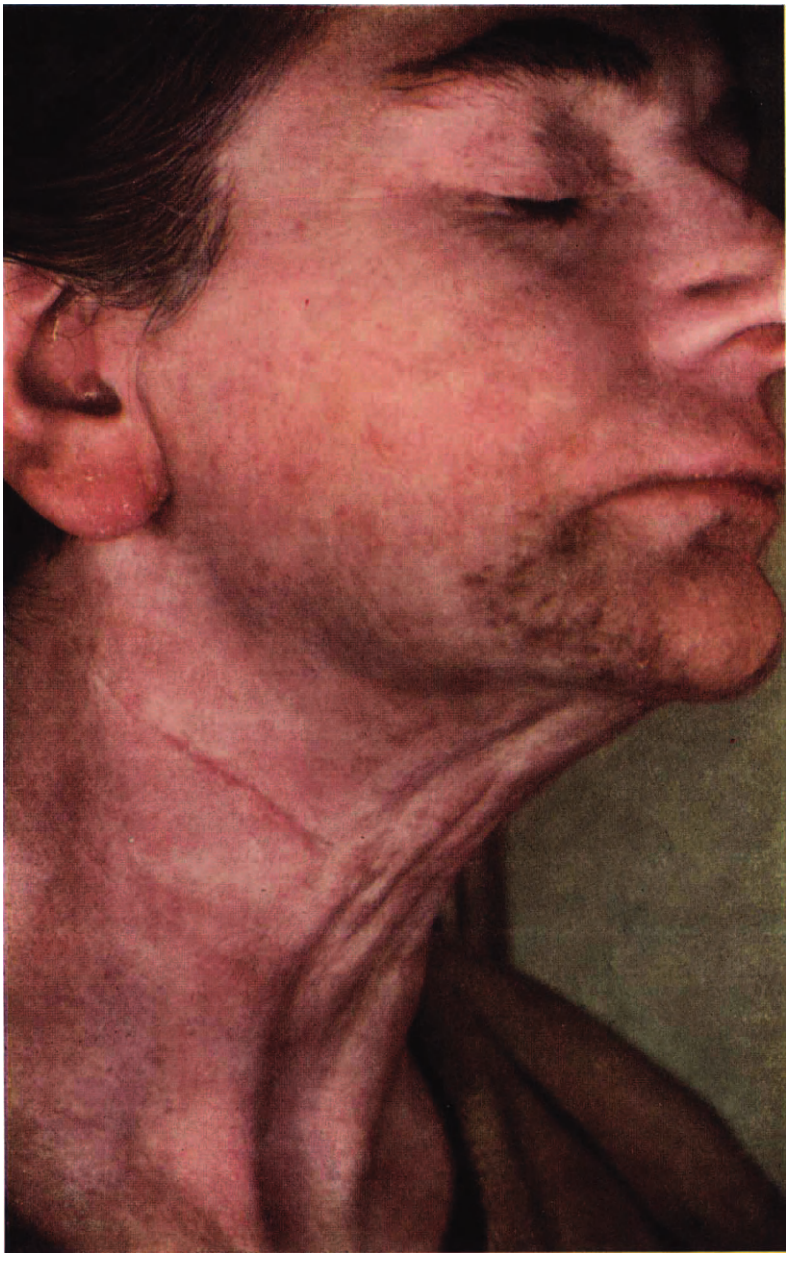
THE diagnosis of a dermatitis from contact with dyed fur cannot be made from the characters of the eruption alone, for these do not differ from the usual epidermal response to any irritant. They may be erythematous, papular, or vesicular according to the degree of concentration of the stimulus (antigen), the duration or repetition of its application, and most of all in direct proportion to the acquired or inherited susceptibility of the patient.

The point which should arouse a suspicion of the cause is the localization, which in the plate is more than ordinarily typical. It includes the lobe of the ear, the line and ramus of the jaw, the chin, and the sides of the neck—all areas, be it noted, at which contact with the fur of a turned-up collar is practically continuous. The eruption is at its greatest intensity at the sides of the mouth, and an unusual feature is the linear superficial fissure running horizontally in the fold of the neck.

A case such as this could hardly escape early diagnosis, for the patient herself would probably recognize the cause. Nevertheless it would be advisable to perform a *patch test*, in case of subsequent legal developments. An unaffected area such as the front of the forearm is selected, and a few hairs from the suspected fur are placed on a small piece of strapping, which is then affixed and left untouched for forty-eight hours or more, unless irritation should previously develop at the site. A similar piece of ' undoctored ' strapping is fixed on the front of the other arm as a control. If redness and irritation develop under the hairs, the test is regarded as positive and proved for the fur under suspicion. A similar test can be used for dermatitis due to hair dyes, or any other irritant suspected as a causal factor. As a biological demonstration of cause and effect it must be regarded as superior to any other method of proof as yet available for either clinical or legal purposes.

Treatment.—The treatment of fur dermatitis, or that due to a hair-dye, is simple and differs in no respect from that applicable to any other acute dermatitis due to the application of an external irritant. Lead and calamine lotions, an indifferent dusting powder, and later, as a dry or exfoliating stage may develop, oily liniments or cold cream, with or without a little lanoline, soon counteract the irritation and burning, and restore the skin to a more or less normal condition. In some cases the sensitivity developed may continue for some weeks, and render the affected areas unduly responsive to the mildest stimulants, such as water, soap, cold winds, and the heat of the fire. Ultimately, however, and *always provided that the patient avoids the risk of contact with the causal dye*, a complete recovery ensues, and a permanent disability is never contracted.

PLATE XXV



DERMATITIS VENENATA (Fur)

DERMATITIS VENENATA
(From a Hair-dye)

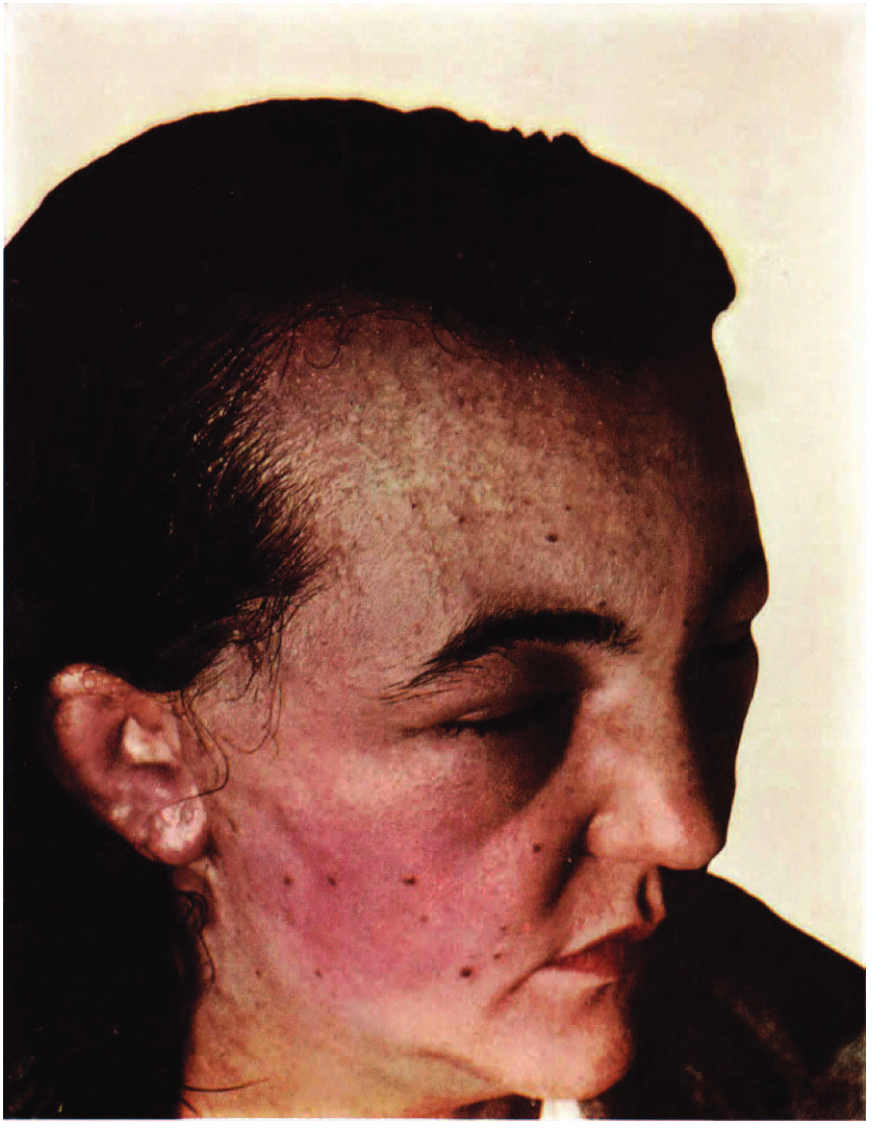
(PLATE XXVI)

THE characteristic effects of allergic reaction to a hair-dye are unusually prominent in this illustration. There is firstly an unnatural black, metallic lustre of the hair itself, which if one could examine it with a lens does not extend evenly throughout, or for the full length of the hair shaft. There is, secondly, a well developed and acute dermatitis of the exposed area of the forehead and the right ear (unavoidably out of focus); and lastly, a pronounced œdema of both eyelids, which at the time of the examination had reduced the palpebral fissure to a narrow slit. The patient had applied the dye herself, without previously testing for possible idiosyncrasy, as is nowadays advised by all manufacturers and operators in this field, and noticed irritation of the scalp twenty-four hours later. All the above-described symptoms had developed by the fourth day, and it was nearly a week before she could properly open her eyes.

The dye used was one of the paraphenylene-diamine series, usually responsible for such reactions. They are the same as those used in the dyeing of fur necklets and collars (*see* p. 58), and have given rise to much disability and many claims for compensation and damage in the courts. Legal decisions recently appear to have been influenced to some extent by whether or not the claimant had previously been tested for idiosyncrasy, and where tinting or dyeing of the hair by one of these dyes is contemplated a patch test of the solution to be used should never be omitted—*no matter how many times previously* the application has been made. The usual place for the test is just behind the ear, and at least twenty-four hours should be allowed to elapse before the result is declared negative.

For treatment *see* p. 58.

PLATE XXVI



ACUTE DERMATITIS (From a Hair-dye)

ECZEMA
(Chronic, with Lichenification)

(PLATE XXVII)

THE patient, aged 48, has suffered from recurrent bouts of eczema since early childhood. He is an ichthyotic subject, and the constant tendency to rub and scratch has resulted in the loss or diminution of the eyebrows, and the lichenification of the skin of the forearms and to a lesser extent of the neck and lower limbs. This peculiar reaction (lichenification) is a feature frequently present in the constitutional type of allergic dermatitis. This, too, is the group in which the eczematous may alternate with asthmatic attacks, and in which two or more members of the family may be involved.

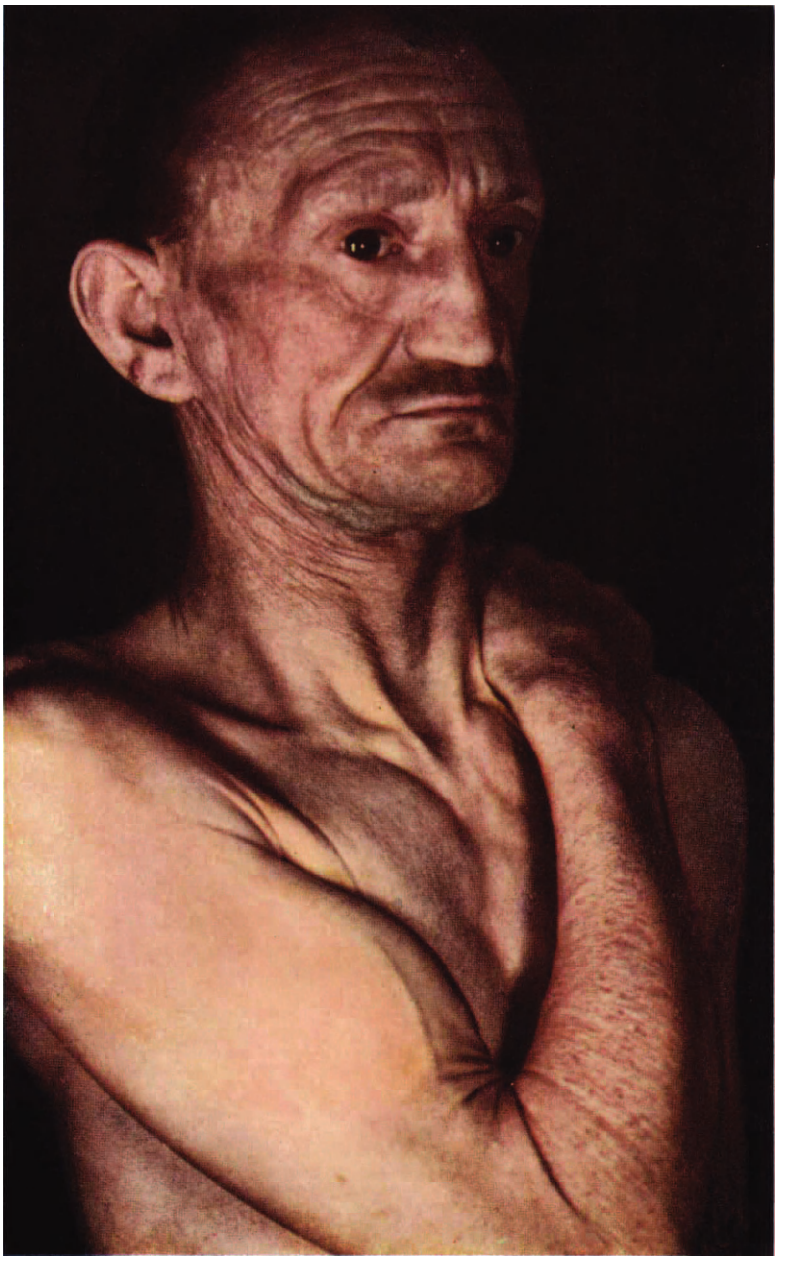
Much recent work has revealed the important fact, which has long since been recognized in the case of asthma, that many of these cases are sensitive to a particular (usually) protein substance or group of substances, and that when they are subjected to the action of these, the eczematous reaction is elicited *de novo*, or aggravated. The elucidation of these substances (antigens) is a matter of extreme difficulty, and their discovery is rare by the methods at present available. Once the sensitivity (allergy) is established, the skin will react to extremely small doses, so small in fact as to render continual protection almost impossible. Desensitization, by injecting even smaller doses of the antigen when discovered, is only temporary.

Treatment has therefore to be empirical in almost every case. Locally the affected parts are covered with an ointment or Lassar's paste containing coal tar in percentages varying from 1 to 5, while non-specific desensitization as by an increasing series of whole-blood injections (autohæmotherapy) will be found as valuable as any other method. From 2 to 12 c.c. of the patient's own blood are given weekly for five or six weeks into the musculature of the buttocks.

The administration of arsenic by the mouth or by injection is sometimes helpful.

Graded injections of Oriel's urinary proteoses (by their inventor) have proved most beneficial in two severe cases of the author's.

PLATE XXVII



CHRONIC ECZEMA WITH LICHENIFICATION
(In an Ichthyotic Subject)
63

ECZEMA

(Alimentary)

(PLATE XXVIII)

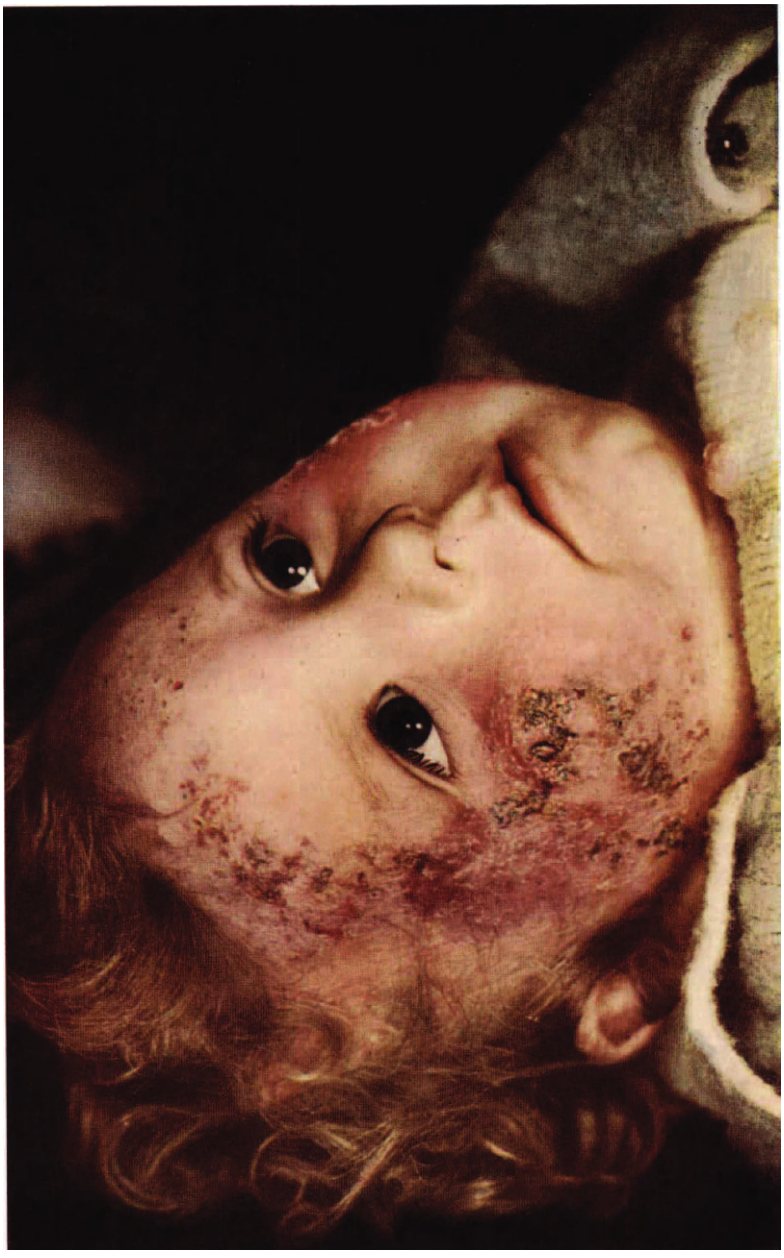
THE child here shown might well have been the direct descendant of the case depicted in *Plate XXVII*, for both the history and the clinical manifestations and probably the underlying dyscrasia—though not the actual causal antigens—are similar. A pronounced tendency to asthmatic symptoms is common to both patients and to their immediate relations, and the man shows in a chronic form what the child is displaying during a subacute exacerbation of his reactions.

As far as could be determined, and as is commonly the case, the antigens were multiple, and included meat, milk, and bread, all or any of which seemed to aggravate the existing eczema when given in the food. The difficulties of arranging a diet sufficient to sustain or increase the body weight under such circumstances can be imagined, for in a child so young (2 years) some protein and starch is an absolute necessity. All attempts to desensitize, already tried at another hospital, where he was an in-patient for five months, failed, and our own efforts with milk and spleen injections were equally futile. The only treatment which gave alleviation was radiotherapy, which, applied in very small doses to the chest and back, afforded a measure of temporary relief. Chronic catarrhal symptoms drew our attention to the tonsils, which were enlarged. Subsequent enucleation with removal of adenoids was of some benefit.

At the time of the photograph the eczematous condition was obviously most concentrated below the nose and around the mouth. For six months the case has been warded and a 2 per cent coal-tar cream has been regularly applied and bandaged on the extremities. The elbows have had to be splinted to prevent the constant tendency to rub and scratch. A liberal supply of glucose, recommended in the allergic state in children, has had no appreciable effect.

Prognosis.—While some improvement is to be hoped for with advancing years, permanent relief and cure is unlikely in the present state of our knowledge.

PLATE XXVIII



ECZEMA (Alimentary)

65

ECZEMA, INFANTILE

(PLATE XXIX)

THE plate admirably demonstrates the main clinical features of the allergic response of an otherwise healthy infant to a circulating antigen probably derived from the alimentary tract. The cheeks are usually affected primarily and most violently, and from there the pronounced irritation spreads to the forehead and sometimes to the chin. As observed by Cranston Low, the central area of the face is spared, and is a point which helps to prevent confusion with seborrhœic dermatitis. The vesicles, which precede or accompany the erythema, oozing, and secondary crusting, are so rapidly broken by reflex scratching and rubbing that they are rarely seen. From the face the eruption may spread to the scalp, the flexor surfaces of the limbs, and the trunk, and in that case may cause some difficulty in the differential diagnosis from seborrhœic dermatitis. The latter is regarded as due to an external infection with the pityrosporon and *Staphylococcus albus*, and begins usually on the scalp in the form of a pronounced excess of scaliness or scurf, probably contracted from the mother or nurse. Generalization is more pronounced, as also is the tendency to impetiginous secondary infection and yellow greasy crusting. A special feature frequently seen in the seborrhœic type is the streptococcal fissure behind the ears, and furunculosis is a by no means uncommon complication or sequel.

Treatment of allergic eczema involves a careful (and usually unsuccessful) search for the responsible antigen. Egg albumen has a bad reputation in this respect, and may be ingested in the mother's milk. Cow's milk may need to be replaced by one of the proprietary foods,* and some diets err on the side of too much fat or carbohydrate. Each case demands a special study, but practically all are improved or cured by the local application in various forms and dilutions of crude coal tar. Cardboard splints are affixed to the flexor aspects of the forearms, especially at night, and a 2 to 5 per cent coal tar cream is applied on a mask of butter-muslin or white gauze every few hours. The same application can be used for the body, and for a time olive oil should be used instead of soap and water for cleansing purposes. If these measures fail, recourse must be had to carefully graduated doses of X rays, which were most successfully employed in this case. Ultra-violet light is contra-indicated, and the affected areas always need protection from direct sunlight and cold winds.

* I have found " Allergillac " a valuable substitute in more than one case.

PLATE XXIX

INFANTILE ECZEMA

ECZEMA OF THE SCROTUM

(PLATE XXX)

WHATEVER the cause, external or internal, and wherever the localization, eczema is a dermatitis or inflammatory reaction of the skin to an irritant to which the patient has inherited or acquired a specific susceptibility. The irritant or antigen is usually a protein—e.g., primula extract, egg albumen, wheat, etc.—but may be a comparatively simple substance like soap, soda, turpentine, applied continuously for years to a skin, the tolerance of which ultimately breaks down, with the production of a characteristic reaction. This may continue indefinitely in one or other of its phases, although the patient gives up the work, or occupation, or food which was originally responsible.

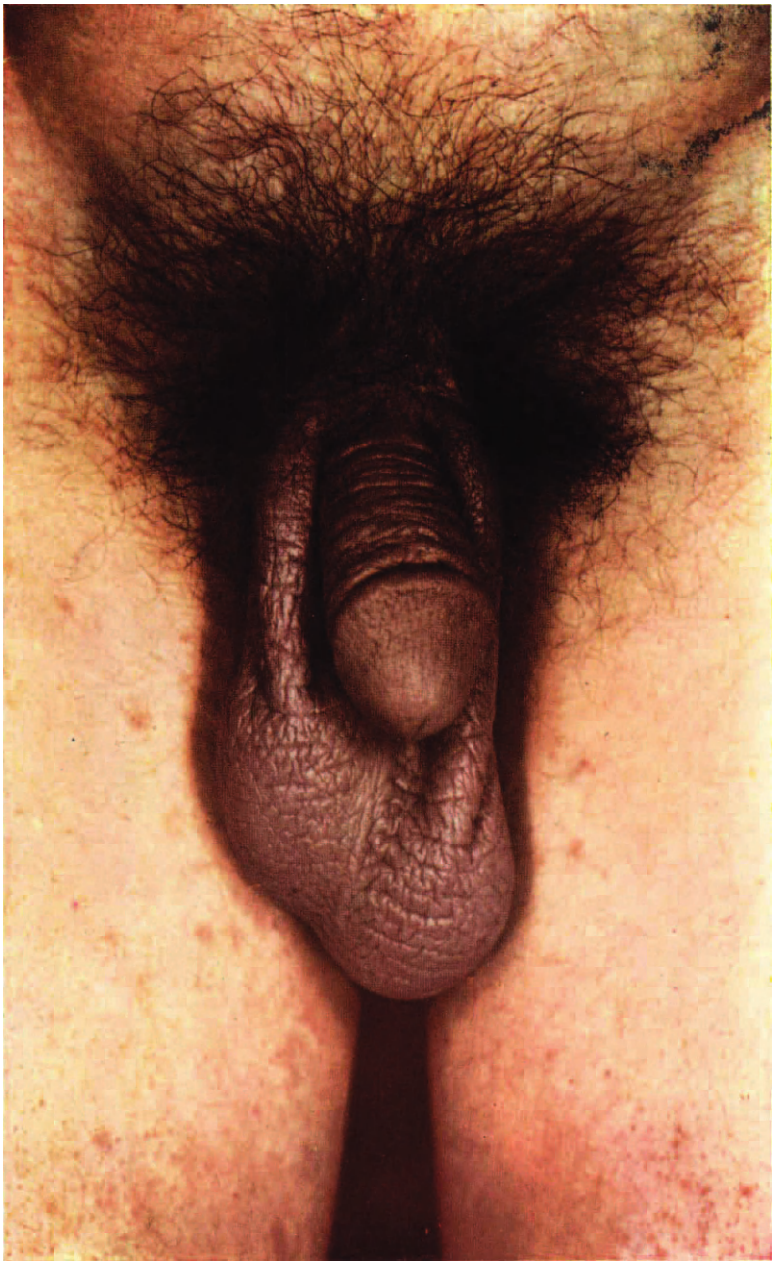
The plate illustrates the œdematous stage of a dermatitis or eczema of the scrotum, where it persisted after clearance by treatment of a general eruption which had involved the face, arms, and legs on and off for years. It further illustrates the extreme chronicity of the reaction in this part of the body, for, as stated, the eruption had involuted elsewhere when the photograph was taken. The cause of the eczema in this case could not be ascertained, having persisted with short intermissions since childhood.

The diagnosis offered no difficulties, as the eruption was a regional relic of a generalized outbreak. But for this it would have been necessary to consider the possibilities of a local cause, among which a fungus infection (dhobie itch), glycosuria, seborrhœa, or a localized psoriasis would have required differentiation.

Treatment.—Treatment by various tar preparations having proved ineffective, the symptoms were ultimately relieved by small doses of X rays, given with due regard to the risks of sterilization.

Grenz rays (soft X rays) or thorium X ointment (or lotion) would have very much the same therapeutic effect without that associated risk.

PLATE XXX



ECZEMA OF THE SCROTUM

ECZEMA, VESICULAR

(Acute)

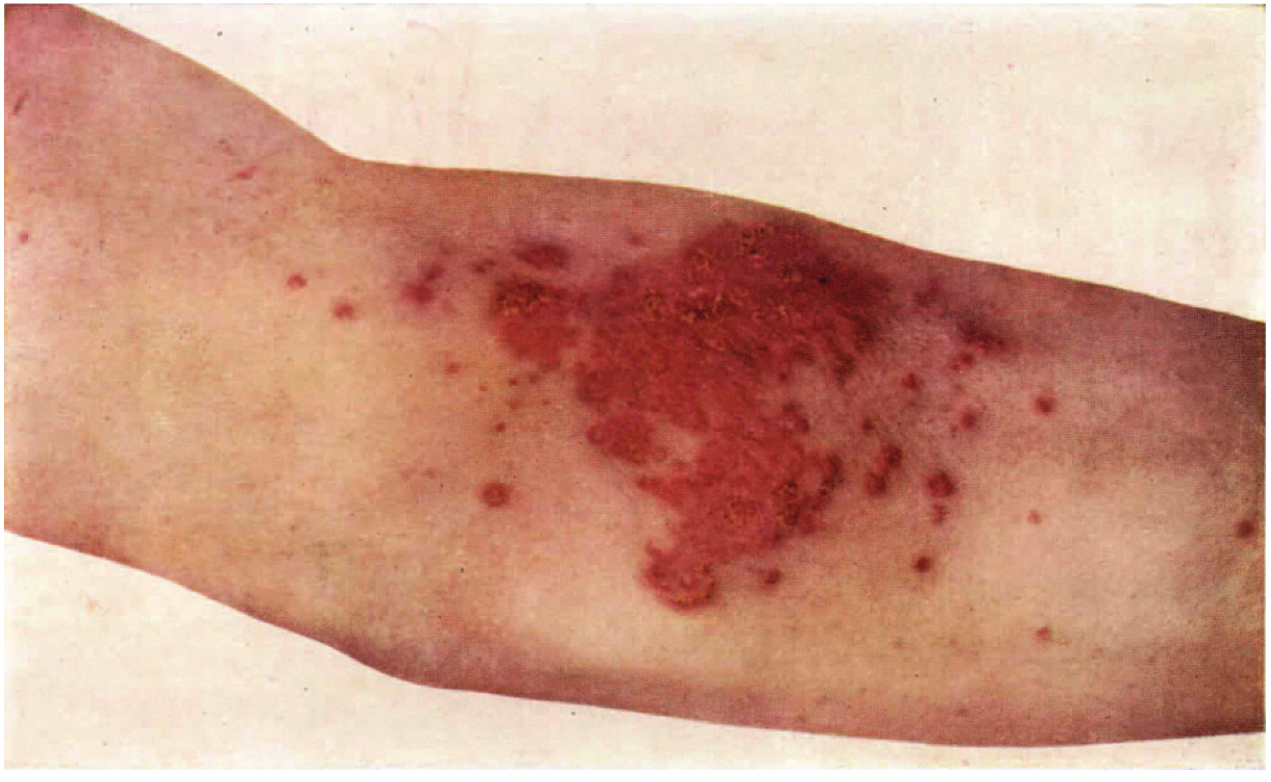
(PLATE XXXI)

A PATCH such as this is a frequent source of vexation both to the patient and his doctor. The plate is in fact a very representative example of what is implied by the modern substitute for the term eczema—namely, 'allergic dermatitis'. This implies the local or general sensitization of the epidermis to some antigen—usually unknown and only rarely determined by exhaustive tests. As examples of known and universally established antigens we may mention: certain synthetic dyes used in fur, leather, and hair tinting; extracts of Chinese primula and 'poison ivy' (plant dermatitis); and the dermatitis contracted by french-polishers, bakers, chemists, doctors, photographers, and a host of other trades and professions inalienable from contact with some specific irritant, the antigen. The characteristic of the antigen is that it is specific only in varying degree, for some persons can work with it or have it applied to their skins for years without any harmful 'eczematous' effect, while others succumb on first contact.

In the case illustrated the antigen was unknown, and the patient had continued to suffer from outbreaks of the succulent weeping patches on all parts of the body for many years. The patch is situated on the flexor aspect of the left forearm and is in an acute stage.

Occasional applications of a $\frac{1}{2}$ per cent silver nitrate solution in spirits of nitrous ether, immediately followed by calamine lotion, soon had the effect of calming the local outbreak, and in two or three days we were able to substitute Lassar's paste containing increasing proportions of tar (pix carbonis prep.).

PLATE XXXI



VESICULAR ECZEMA
(Acute)

EPIDERMOPHYTOSIS
(Acute)

(PLATE XXXII)

THE acute form of epidermophytosis is admirably depicted in this plate. The plantar aspects of all the toes and the anterior part of the soles adjoining have been acutely infected by the fungus and are red and moist. Weeping fissures are present between the toes. The case was the result of exacerbation of the chronic latent type during the hot summer of 1933, in a middle-aged woman. Many such cases, in various stages and with secondary eruptions on the fingers and other cutaneous areas, were seen, and there are grounds for the belief that the infection is increasing.

Prognosis.—In acute cases occurring for the first time, this is good; but in the chronic relapsing types in which the toe-nails share the infection, a permanent cure should never be guaranteed, for the recurrences are very frequent, even if the patient submits to removal of the demonstrably infected nails (*see* p. 212).

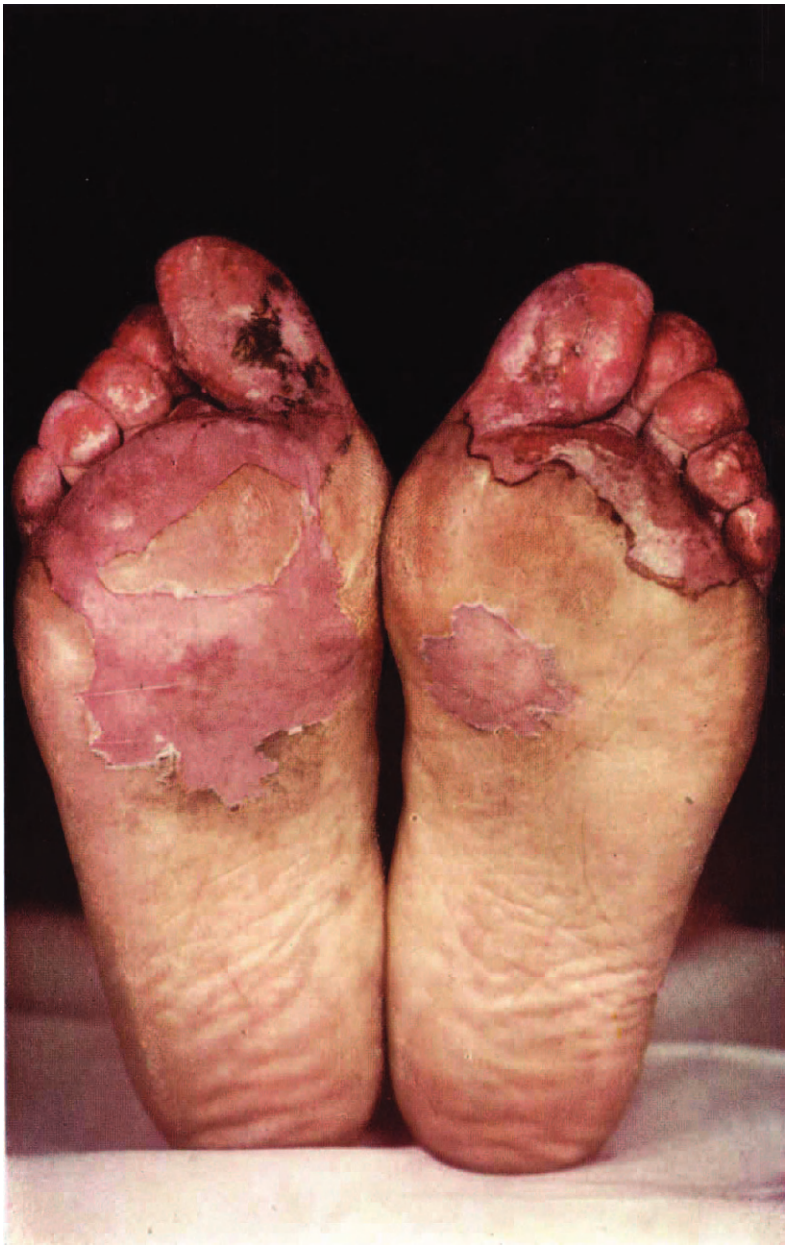
Treatment.—Some years of experience in the treatment of this common infection have convinced me that heat (as by fomentations), moisture, especially when associated with heat, and antiseptics generally, always aggravate all the symptoms, and induce allergic, possibly blood-borne, eruptions on distant parts of the body.

That heat and moisture should be harmful is not surprising when it is remembered that it is just under such circumstances, i.e., in a hot shoe or boot, in the summer months, that clinical signs of the disease are most in evidence. That antiseptics should be more or less useless seems equally obvious to me, for none of them can penetrate the keratin in which the mycelial elements of the fungus is growing—even if it—the fungus—were specially vulnerable to their effects. It is demonstrable that most of them tend to act merely as additional irritants. Practice has proved the soundness of such theoretical considerations, and for the last two years I have discarded iodine, mercury, carbolic, or even the weak solutions of dyes, such as methyl violet, carbolfuchsine, brilliant green, etc., and the numerous 'non-irritating' proprietary specifics so widely advertised at one time.

For the great majority of my cases I use only one remedy—salicylic acid—dissolved in spirit, and for the reason that, applied even to normal skin, it is a mild exfoliant. The spirit is a desiccant, and dies the epidermis as it is peeled off. The principle underlying the treatment is to exfoliate the skin even more rapidly than the fungus can do it, and so remove the spreading mycelium in the scales as fast as or faster than it can grow. The procedure is aided by the application of an indifferent dusting powder, and by *keeping the feet cool*, exposed to the air, and if the patient has to get about, in sandals. Socks and dressings of any kind are contra-indicated, especially in the acute stages.

When there is a tendency to pustulation or purulent discharge, *tepid* footbaths of weak permanganate (1–5000) for five to ten minutes twice daily are useful. Residual pus is gently wiped off with cotton swabs, and the feet then powdered with

PLATE XXXII



EPIDERMOPHYTOSIS
(Acute)
73

an indifferent talc or zinc oxide powder, and if possible only lightly covered with gauze strips till the next footbath. In a day or two the purulent element will have been controlled and the salicylic acid and spirit treatment can take its course. Beginning with a $\frac{1}{2}$–1 per cent concentration of the salicylic acid, it will be found that as the inflammation subsides stronger concentrations, up to 4 or 5 per cent, are soon tolerated, and should be applied by swabbing three or more times daily, until profuse *non-inflammatory* exfoliation is in full swing, between all the toes and on the soles as well. The treatment is usually complete in about ten days, but the patient should be kept under observation for at least six weeks and instructed to repeat a course of the salicylic 4–5 per cent swabbing if there is the slightest sign of a recurrence, even if it is only peeling between the fourth and fifth toes.

Dusting powder night and morning, cashmere or cotton or silk hose, light and not tight shoes, avoidance of rubber soles, and occasional application of the salicylic spirit lotion, should be enjoined and adhered to rigorously, especially during the summer months.

EPIDERMOPHYTOSIS
(Chronic)

(PLATE XXXIII)

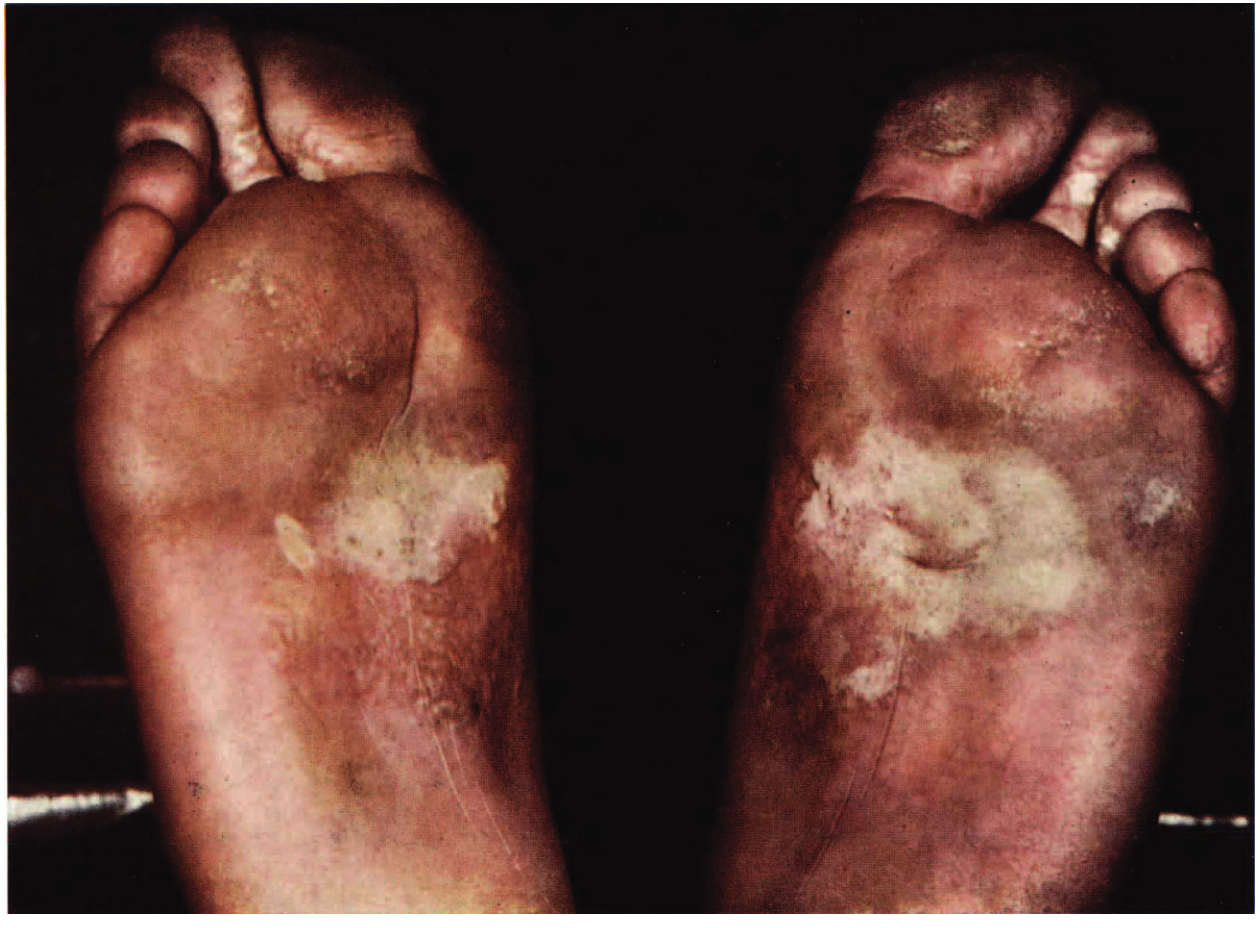
THE form depicted is exceedingly common and intractable. It began according to the patient's observation in the interdigital clefts with peeling and fissuring some years before it spread, as here shown, to the plantar surfaces. Such is the usual history. The infection lies dormant in the winter months, and there are periodical exacerbations, especially in the summer, until some complication or acute spread, with intense local irritation, brings the sufferer for medical advice.

There is no end to the diversity of the complicated clinical picture, and the striking representation in *Plate XXXIII* is only one of many possibilities. The disease may, and usually does, infect the nails, not only of the toes but sometimes of the hands as well, and one type of dysidrosis (cheiropompholyx) of the fingers is undoubtedly caused by the epidermophyton, which can also infect the groins and cause tinea cruris (dhobie itch—*see Plate XCV*).

The main source of spread is the domestic towel, with which both auto- and hetero-infection can be conveyed. Bath mats, lavatory seats, and football 'shorts' in school epidemics fall naturally under suspicion. Once contracted in the chronic form the infection is rarely eradicated, and there is little doubt that the boot or shoe—which is an excellent incubator—is not only a potent factor in promoting relapses, but that, by creating a highly favourable environment, it facilitates infection, and aggravates it when present. It follows that the wearing of sandals, or walking barefoot in the sea, and wherever possible on land, should facilitate recovery. Experience confirms the theory, in the chronic forms at least.

Treatment.—Much help is afforded by the local application of salicylic acid. This acts by causing exfoliation, presumably at a more rapid rate than the fungus can grow. In acute cases (*see* p. 72) it must be used with great care and very dilute as a $\frac{1}{2}$ per cent spirit lotion, but in a chronic case like the one depicted it may be used as a 5 to 10 per cent ointment or paste, or even as a 5 per cent plaster, which by virtue of its relative impermeability macerates and penetrates the overgrowth of horny skin not infrequently seen in the more chronic cases. When ointments are used on the feet they should be well rubbed in at night and cleaned off every morning, preferably with a 2 or 3 per cent solution of salicylic acid in spirit. The affected parts are then dusted, and socks and stockings changed daily, while neither boots nor shoes should be worn so tight as to promote cramping of the toes together. All treatment should be based on an attempt to keep the feet cool, and the toes apart, so that if possible a current of air can always circulate freely between them.

The writer does not believe that it is possible to disinfect boots or shoes as is so frequently advocated, nor is this necessary, if the socks are boiled or frequently renewed.



EPIDERMOPHYTOSIS (Chronic)

EPITHELIOMA: RODENT ULCER

(PLATE XXXIV)

THE rodent ulcer is not necessarily 'rodent' or burrowing, although it is always erosive in character. Such is the case in the example here depicted, which admirably demonstrates all the essential features of the condition. Men are affected more commonly then women, and the disease is very rare under 50 years of age. Chronicity, often extreme, is the rule, and a duration of ten years is by no means uncommon, for unless bone is involved there is no pain, and nothing but the disfigurement or threatening encroachment on some important structure, such as the eye, to bring the patient to the doctor.

In contradistinction to the squamous-celled type, the rodent or basal-celled carcinoma never gives rise to secondary deposits in the glands or other structures, and is therefore not directly dangerous to life. In common with other forms of cancer the aetiology is still unknown. The rodent ulcer is extremely rare in more than one situation in the same patient, but it is known in multiple form, and the case shown in *Plate CVIII* is an example of this rare abnormality—which it is evident could easily be mistaken for patches of psoriasis. Squamous-celled carcinoma occurs about equally in the sexes, and not necessarily in the later years of life. It may occur in any situation, and unless speedily recognized rapidly disseminates itself in the glands, and, in the case of melanotic carcinoma (*see Plate CXVI*), in the lungs and bones.

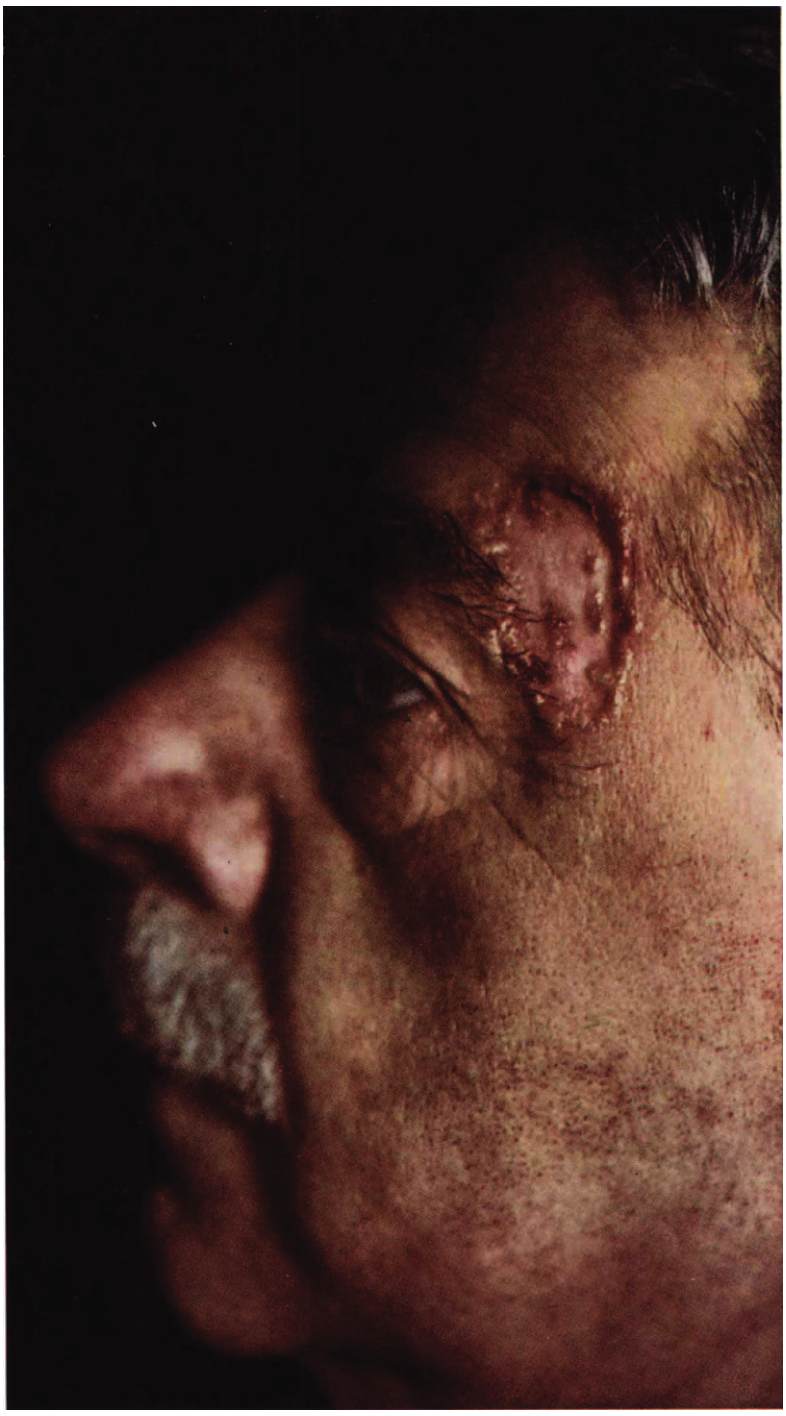
Localization.—The rodent ulcer is almost always met with between two lines drawn horizontally from the angle of the mouth to the lobe of the ear, and from the root of the nose to the summit of the pinna. The eye and the ear are therefore in the danger zone, and the disease not infrequently invades the cornea and ultimately necessitates enucleation of the eyeball. It is therefore of the utmost importance to establish the diagnosis at the earliest possible moment and before serious damage has been done, or even before it is threatened.

Clinical Manifestations.—In its earliest stage the epithelioma, whether squamous or basal-celled, is a papule, of firm consistence, and, unlike a sebaceous cyst, apparently a part of the surrounding healthy skin and not freely movable in it. A papule appearing thus *de novo* should be regarded with suspicion, and is best excised and submitted to microscopic investigation, as is the rule with tumours elsewhere when there is a possibility of malignancy.

Ulceration is the rule eventually in both types, but is not an essential feature. In the case shown in *Plate XXXIV*, healing has kept pace exactly with the ulcerative tendency, so that scabbing was never observed during the four years of duration. Nevertheless, destruction has obviously taken place, and the normal skin has been replaced by a thin flat scar, in which some persistent papular elements are growing—doubtless small pearly epitheliomata.

The character of the edge of the enlarging ring should be carefully noted. It is raised, slightly reddish in colour, and 'rolled' like the smooth ripples on a calm

PLATE XXXIV



EPITHELIOMA: RODENT ULCER (Of Four Years' Duration)

sheet of water, not cut sharply or overhanging like the edge of a gummatous ulcer, or frayed and irregular like that seen in tuberculosis of the skin.

Small vessels, easily identified with a pocket lens, are usually to be found coursing irregularly over the smooth surface of the rolled edge and the early papule ; these are significant and valuable diagnostic features in doubtful cases, in which furthermore a histological examination is indispensable from the point of view of both diagnosis and treatment.

Treatment.—The early papule is best excised under local anæsthesia with a wide margin of healthy tissue. This procedure establishes the diagnosis and is usually sufficient to ensure a cure, but prophylaxis by X rays or radium is usually advised. In cases occurring in situations where excision is difficult, as on an eyelid, radium is the ideal treatment. If bone is already involved, the case should be referred to a surgeon. When the histological examination reveals a squamous type of carcinoma, his help will also be required in dealing with the regional glands. In advanced and inoperable cases the X rays are helpful in controlling spread and assuaging pain. The older methods by cauterization with arsenic or zinc chloride pastes are also worthy of consideration in such cases, while the cold cautery (fulguration) is valuable in skilled hands.

The so-called ' contact therapy ', a recent development of X-ray technique, marks a notable advance in the treatment of all malignant neoplasms of the skin. It demands a shock-proof apparatus and the meticulous calculation of dosage by modern dosimeters. The results so obtained by Mr. Anthony Green, the radiotherapist at the Royal Northern Hospital, in all the cases I have referred to him in the last year have been uniformly successful.

EPITHELIOMA: RODENT ULCER

(PLATE XXXV)

A NEW growth or tumour which appears in a middle-aged or elderly person between two parallel lines drawn horizontally forward from the summit of the ear and the lower margin of the lobe should always be regarded with suspicion. The dermatologist is constantly seeing such early 'rodents' and is more apt to diagnose malignancy erroneously than to miss it. When complete surgical excision is possible, it is probably the best treatment, and permits of an accurate diagnosis by the histologist. The small linear scar should be treated prophylactically with radium.

The eyelids, both upper and lower, are not uncommon sites, and here sometimes surgical procedures are not always possible, and radium alone has to be relied upon. The naso-maxillary angle, the temporal region, the frontal area, the free margin of the ear, and any part of the cheek between the above mentioned lines may be involved, and it is curious how rarely the typical 'rodent' affects other parts of the body. When it does so (*see Plate CVIII*) the histology is usually atypical, and squamous or mixed types of cell structure are met with.

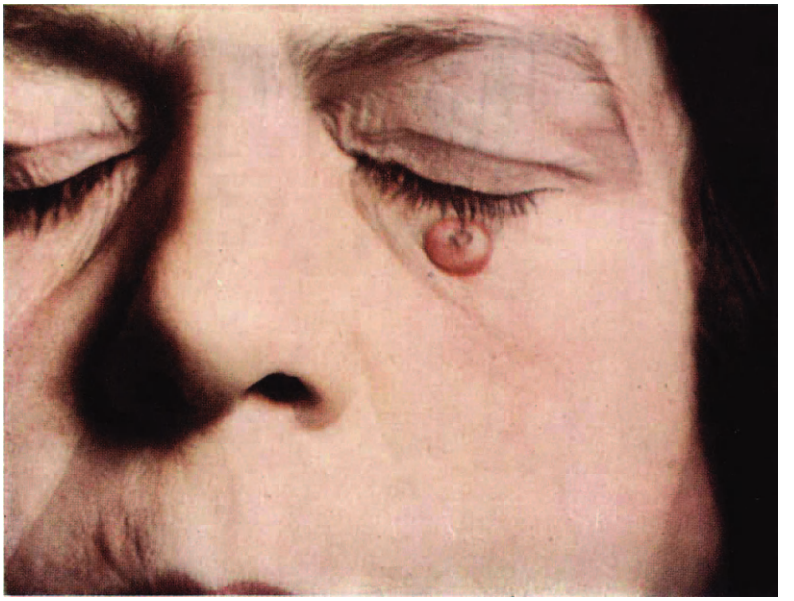
The clinical signs of an early rodent are as follows: A very slowly growing raised oval or circular tumour, varying in size from a large pin's head to a split pea or hazelnut (larger than that it is apt to ulcerate). In consistence it is firm or even hard owing to the formation of fibrous tissue, and can easily be felt as such between finger and thumb as it *lies in the epidermis itself*. It cannot be moved apart from it like a cyst. Sometimes it is adherent to underlying parts such as the tarsus, the frontal bone, the aural or nasal cartilage, and in that case the outlook is less favourable and the treatment more difficult. The colour is described as pearly-white, but varies somewhat according to the number of overlying venules, which in the case illustrated were numerous. They can be seen in nearly every case with a pocket lens, and are of value in arriving at the diagnosis.

Left untreated or unrecognized, a cancer of this type slowly increases in size; it may involve with deplorable results neighbouring structures such as the eye or the cheek, and suddenly take on its well-known boring or 'rodent' tendency, with perforation into the underlying soft and hard tissues, opening an antrum, or completely destroying the nasal cartilages and exposing the turbinate bones and ethmoid cells. Such cases, the despair of surgeons and dermatologists alike, were seen not uncommonly in the out-patient departments of the larger hospitals before the war. Nowadays, owing to the better instruction of both lay and medical circles, they are fortunately extremely rare.

The typical 'rolled' edge of the rodent ulcer is another characteristic feature illustrated in *Plate XXXIV*, in the text to which other features are emphasized.

The early diagnosis of a rodent is of as great importance to the patient as that of a primary luetic chancre, and the practitioner will do well to avail himself of all opportunities for study and memorization of the salient features of the initial stage, in which a cure can be achieved in 100 per cent of cases.

PLATE XXXV



EPITHELIOMA: RODENT ULCER

ERYSIPELOID

(PLATE XXXVI)

THIS characteristic dermatosis, first described as ' erythema serpens ' by Morant Baker, and later classified by Rosenbach as an infection due to a bacillus resembling that of swine fever, has certain clinical resemblances to erysipelas. It should not be mistaken for the graver malady, for febrile reactions and complications such as cellulitis and glandular abscesses are practically unknown. In this case, however, in a fishmonger of 26, the eruption, which had been present a week, was ushered in by some pain and mild lymphangitis with coincident enlargement of the axillary glands. The house surgeon had diagnosed erysipelas, although the temperature had not been raised, and prescribed prontosil tablets, before referring him for an opinion.

These cases should certainly be regarded as of occupational origin and classified with trade dermatitis for compensation claims. In every case I have seen (eight or nine), the patient was either a butcher, a cook, or a fishmonger, i.e., a person who has to handle *uncooked* and possibly decomposing *animal matter*, and it is doubtful if the infection has ever been contracted outside this source of infection.* Preceding trauma with bone splinters is a common history, and would afford a port of entry.

Clinical features common to most cases are localization to the hand, finger, or wrist, a purplish diffuse raised erythema with a well defined spreading convex edge, the older portions flattening down and leaving a yellowish stain. The surface of the lesion is smooth, and scaling or crusting is not observed. Subjective symptoms are confined to a feeling of tension, slight burning, or tingling.

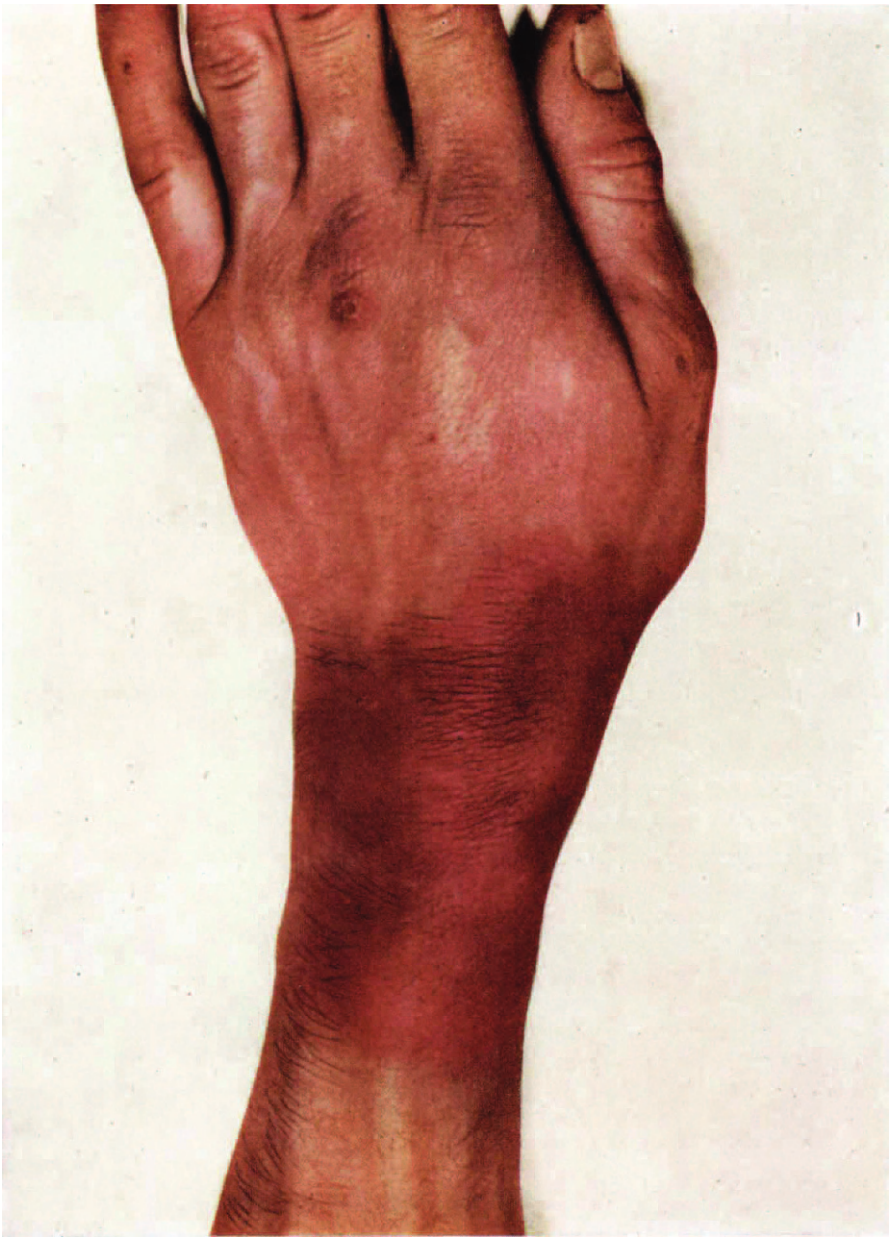
Differential Diagnosis.—Once seen this interesting lesion is not likely to be confused with any other dermatosis. Besides erysipelas, which is of a higher colour, spreads more rapidly and is associated with constitutional symptoms, erythema multiforme might need consideration, but in this disease the lesions are always multiple, and the patient has usually had previous attacks which may have involved the buccal or genital mucosa.

Prognosis.—In all the cases I have seen the infection was mild and involution occurred within three weeks, but an occasional exaltation of virulence may prolong recovery, and in one or two instances has been associated with septicæmia and a fatal issue.

Treatment.—Local applications of 10 per cent ichthyol in calamine lotion, with elevation of the arm in a sling, relieve subjective symptoms, and, as in the case illustrated, intramuscular injections of 5–10 c.c. aolan (milk protein), which can be repeated every other day, are a valuable adjunct in resistant cases. I would use them in preference to the specifically immunized horse serum which carries with it the risk of anaphylactic reactions.

* Crab bites are on record as a cause, and it is notorious that these animals feed on decomposing refuse of all kinds.

PLATE XXXVI



ERYSIPELOID

ERYTHEMA INDURATUM

(Bazin's Disease)

(PLATE XXXVII)

THIS very typical example of the hypodermic nodules and ulceration on the legs, usually below the knee and in the looser tissues of the calf in otherwise apparently healthy young women, is a presumed tuberculous affection and belongs to the so-called 'tuberculide' group. The surrounding skin is usually, as will be noted here, quite normal, but occasionally there is some erection of neighbouring follicles (goose-skin) with a suggestion of chilblain circulation. The course of the malady is towards necrosis, and accounts for the ulcer depicted in the lower third of the left leg.

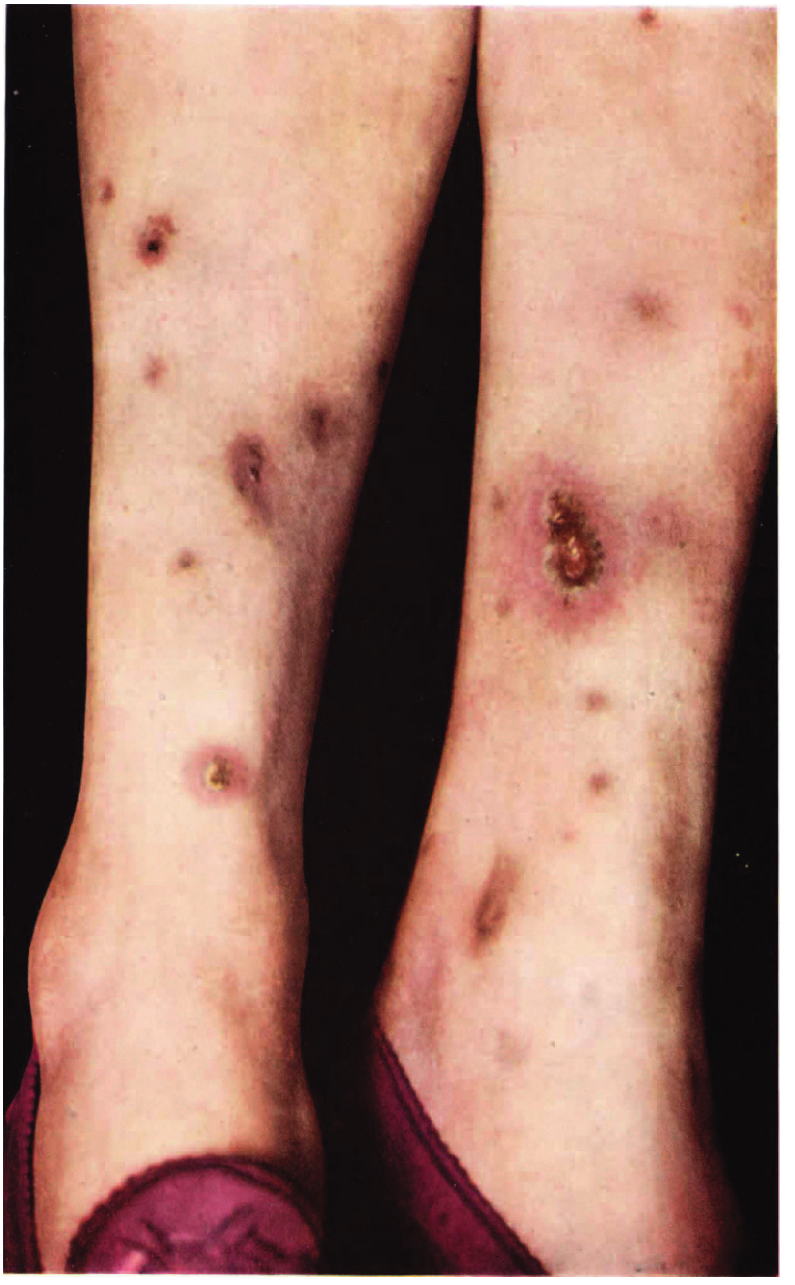
A history of cervical adenitis (or the presence of scars in this region), an old pleurisy, or tuberculous disease in other members of the family, is a suggestive feature in many of the cases, and the tuberculin tests have always proved positive in my cases.

The differential diagnosis from syphilitic gumma and ulceration offers little difficulty. The multiplicity of the lesions, their symmetry, the pain on ulceration, the dark-red or livid colour of the nodules, and their common localization in the lower third of the legs in Bazin's disease, afford sufficient criteria for a correct diagnosis to be made.

Treatment should include rest in bed and general light baths, together with cod-liver oil and the other measures recommended for chronic tuberculous conditions. Tuberculin proved of value in the case here depicted, and is thought to have prevented the early relapse from which the majority are apt to suffer when they return to work.

A simple and often effective remedy, as in erythrocyanosis crurum (p. 94), is the application of adhesive elastic bandages, which can be renewed, provided the skin tolerates them, as often as may be required, while in a recent paper (July, 1938) to the British Association of Dermatology, Professor Telford, of Manchester, recorded an almost uniformly successful result after lumbar ganglionectomy, thereby throwing doubt on the hitherto accepted tuberculous aetiology of the disease and bringing it into the category of conditions due to vascular spasm, like chilblains and Raynaud's syndrome.

PLATE XXXVII



ERYTHEMA INDURATUM (Bazin's Disease)

ERYTHEMA IRIS

(PLATES XXXVIII, XXXIX)

THIS variety of erythema multiforme is perhaps the most common met with in this country. Women are more frequently affected than men. The usual situation is the dorsum of the hands and wrist (*Plate XXXVIII*), rarely the palms (*Plate XXXIX*), and the eruption is always symmetrical. Sometimes the feet are affected, and coincident involvement of the lips, buccal mucosa, and genitals is sometimes observed. The primary lesion is well demonstrated in *Plate XXXVIII*, and consists of an erythematous vesico-papule, raised slightly above the surface, and resulting in local symptoms of burning and irritation. The subjacent exudation spreads concentrically outwards from this point and results in the formation of rings of variable size, and sometimes of varying colour, so that the end lesion has been likened to a target or the round figure of a bird's iris.

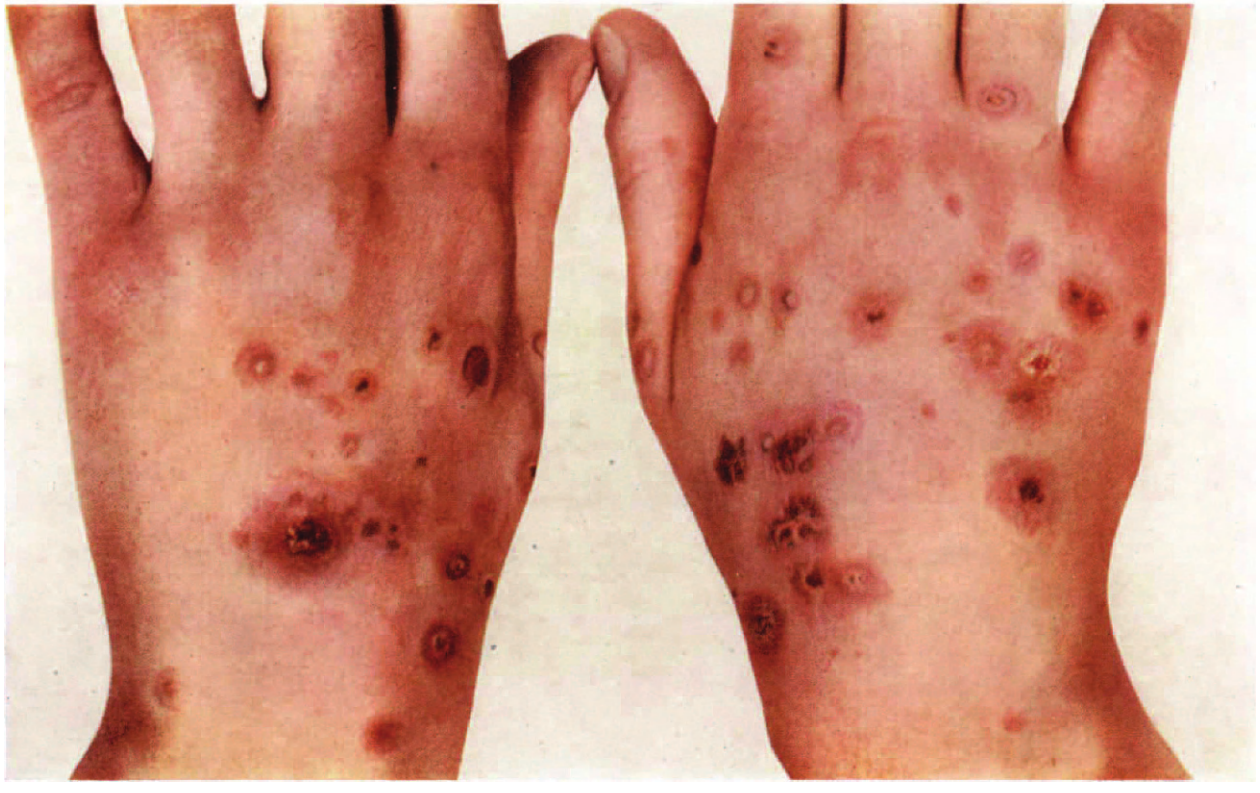
Recurrences are frequent from year to year, and quite severe ulceration (slight in the case shown in *Plate XXXVIII*), and even necrosis, which can give rise to much trouble in the mouth, are sometimes seen.

The attack usually lasts about four weeks, and frequently disables the patient for that time.

Treatment.—While not actually proved, focal sepsis is generally believed to be at least a factor in production, and every endeavour should be made to eradicate this wherever it may be present and accessible, as in the teeth or tonsils.

The actual onset is best treated by purgatives such as calomel and the oral administration of salol or salicin 5 to 10 gr. thrice daily. Locally only soothing lotions of calamine and lead with 1 per cent ichthyol, followed by liberal applications of a bland dusting powder, are indicated.

PLATE XXXVIII



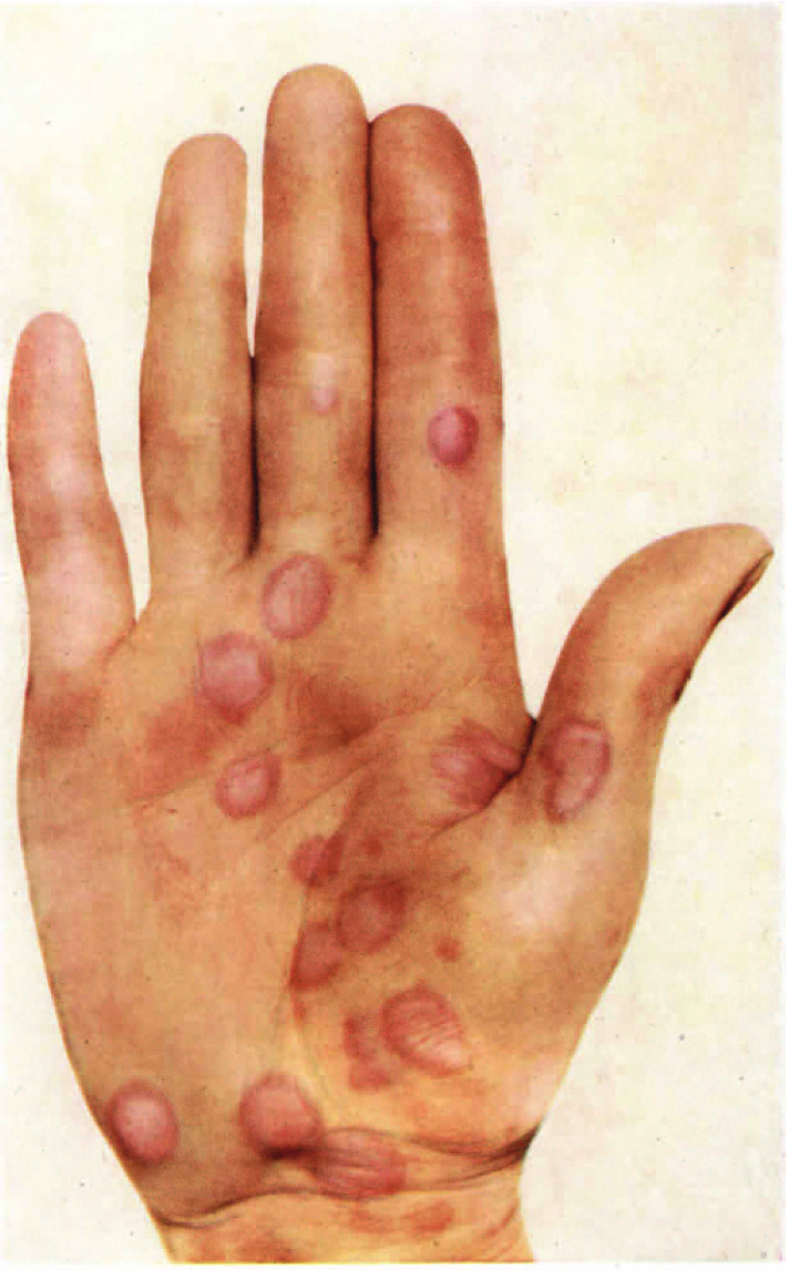
ERYTHEMA IRIS

ERYTHEMA IRIS

(PLATES XXXVIII, XXXIX)

For text, *see* p. 88.

PLATE XXXIX



ERYTHEMA IRIS

91

ERYTHEMA NODOSUM

(PLATE XL)

THE disease most commonly affects young women and girls of the hospital class. The exact aetiology has not been established as yet, but the prevailing opinion is that there is an underlying tuberculous infection which is activated by streptococcal or rheumatic superinfections. It is certainly striking how closely the lesions of erythema nodosum, both in appearance and evolution, resemble those of the positive intradermal tuberculin test, while the fact that it is so frequently associated with swelling or pains in the joints is no proof that erythema nodosum is of rheumatic origin.

The appearances of the average case are well demonstrated in the plate, in which besides the dusky cyanotic, tender, hypodermic nodules in the typical situation, there were also joint pains and fever. With rest in bed and salicin per os these lesions subsided in a few days. The patient, an emaciated girl of 15, came from a very poor Irish family, and the father was said to have died of tuberculosis.

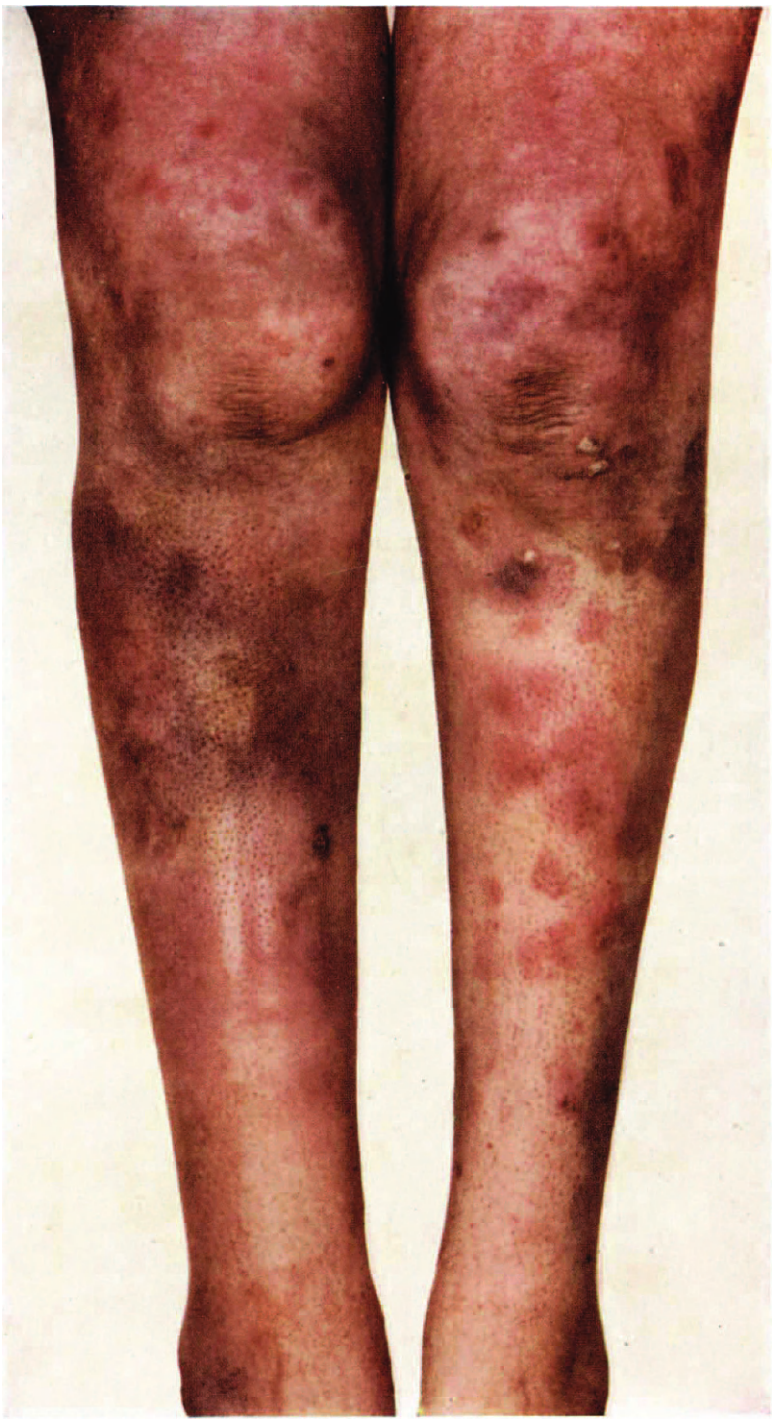
The occasional association of endo- or pericarditis should be noted, but a careful search for tuberculous stigmata should be carried out in every case.

In contradistinction to Bazin's disease, in which the calves are more often affected than the shins, the nodules never ulcerate, and are soon absorbed without scarring.

Treatment must include rest in bed during the acute stage, and the administration of salicin. A search for septic foci, such as tonsils, should be supplementary to that for the tuberculous. Their elimination after convalescence may prevent relapses or more serious subsequent developments.

NOTE.—Those interested in the aetiology should consult Goldsmith's admirable discussion in *Recent Advances in Dermatology*, 1936, pp. 298–301. (London : J. & A. Churchill.)

PLATE XL



ERYTHEMA NODOSUM

ERYTHROCYANOSIS CRURUM PUELLARUM

(PLATE XLI)

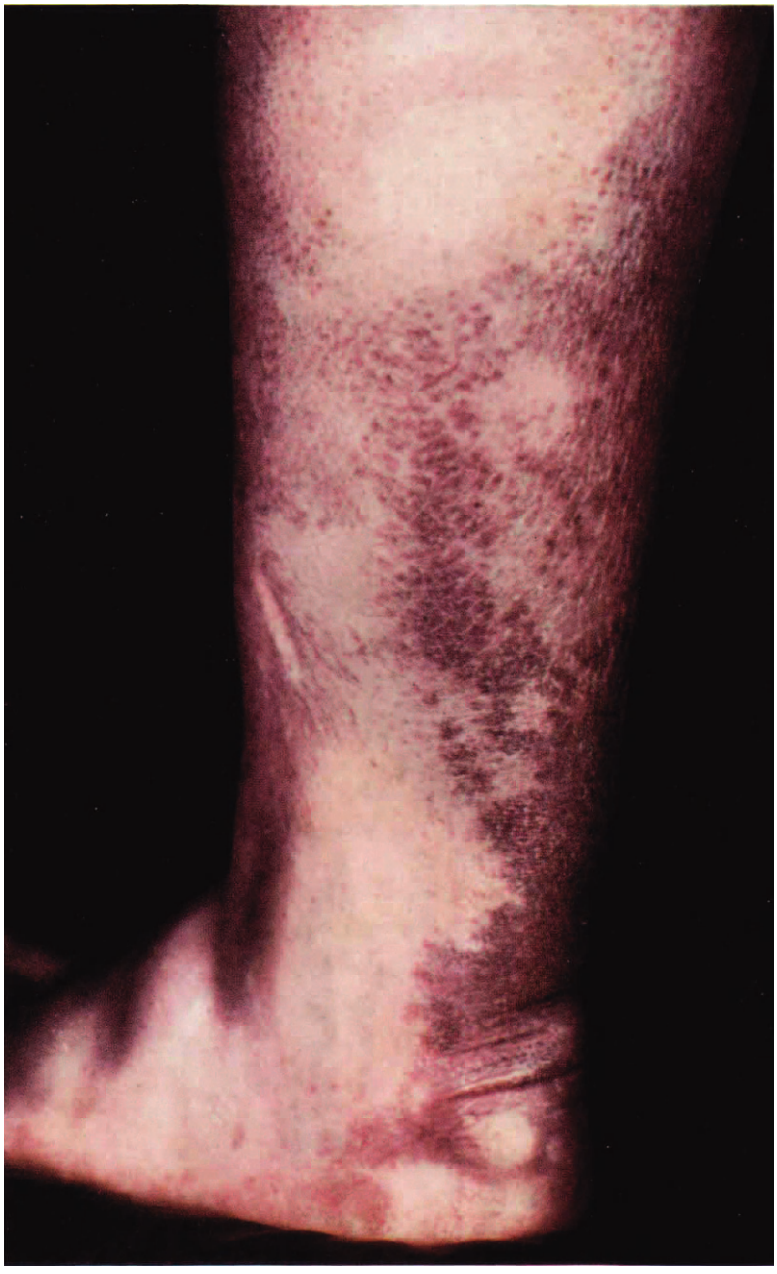
THIS condition is not so much a disease as a symptom of poor circulation in the chilled lower extremities of young women. Many of them give a history of chilblains on the hands, and these are sometimes coincident. The wearing of thin silk stockings, tight garters, the tendency to constipation, and the occupations that necessitate continuous standing and resulting venous congestion, are all factors which may contribute to an apparent increase of this condition in most out-patient clinics. There is no evidence to support a tuberculous aetiology, and the cases must be sharply distinguished from erythema induratum (Bazin), which starts as a hypodermic nodule, and is prone to ulcerate (*see Plate XXXVII*).

The chief features are well illustrated in the plate. A bluish or purple mottling of patchy distribution in the lower third of the leg is always present. It is due to vascular paresis and ensuing passive engorgement of the cutaneous capillaries, in which it differs in no respect from the pathology of the chilblain. In contradistinction, however, ulceration never occurs spontaneously. Secondary œdema and fibrosis, the result of long-continued congestion, may give rise to subcutaneous lumps and nodules simulating tuberculous infiltrations.

Treatment, as in the case of chilblains, is not altogether satisfactory. The above-mentioned factors in causation should be eliminated as far as that is possible, and every effort made to improve debility and raise the metabolic rate by thyroid extract, regular exercise (especially skipping), ultra-violet ray light baths, cod-liver oil, strychnine, etc. Local massage with methyl salicylate or iodine ointment and galvanism are sometimes helpful, as is also the wearing of elastoplast, or some other variety of adhesive compression-bandage.

In very severe and unresponsive cases the question of lumbar ganglionectomy, as recently practised by Telford (*see* p. 86) for Bazin's disease, might receive consideration.

PLATE XLI



ERYTHROCYANOSIS CRURUM PUELLARUM

GLOSSITIS, CHRONIC SUPERFICIAL

(PLATE XLII)

THIS disease is practically always the result of otherwise latent syphilis, and much more common in men than women. Usually the Wassermann reaction is a strong indicator of the aetiology, but sometimes the reaction is weak or negative, and reliance has to be placed on the clinical features alone. Apart from soreness when eating hot or spiced foods, or the irritation of a tooth-plate, there is little to arouse the patient's attention or bring him to a doctor. The onset is always gradual, and sometimes medical advice is not sought until ulceration has occurred. In the majority of cases the ulcer is epitheliomatous, and it is a recognized fact that chronic superficial glossitis is a precancerous condition. For this reason its early diagnosis and treatment is of the utmost importance.

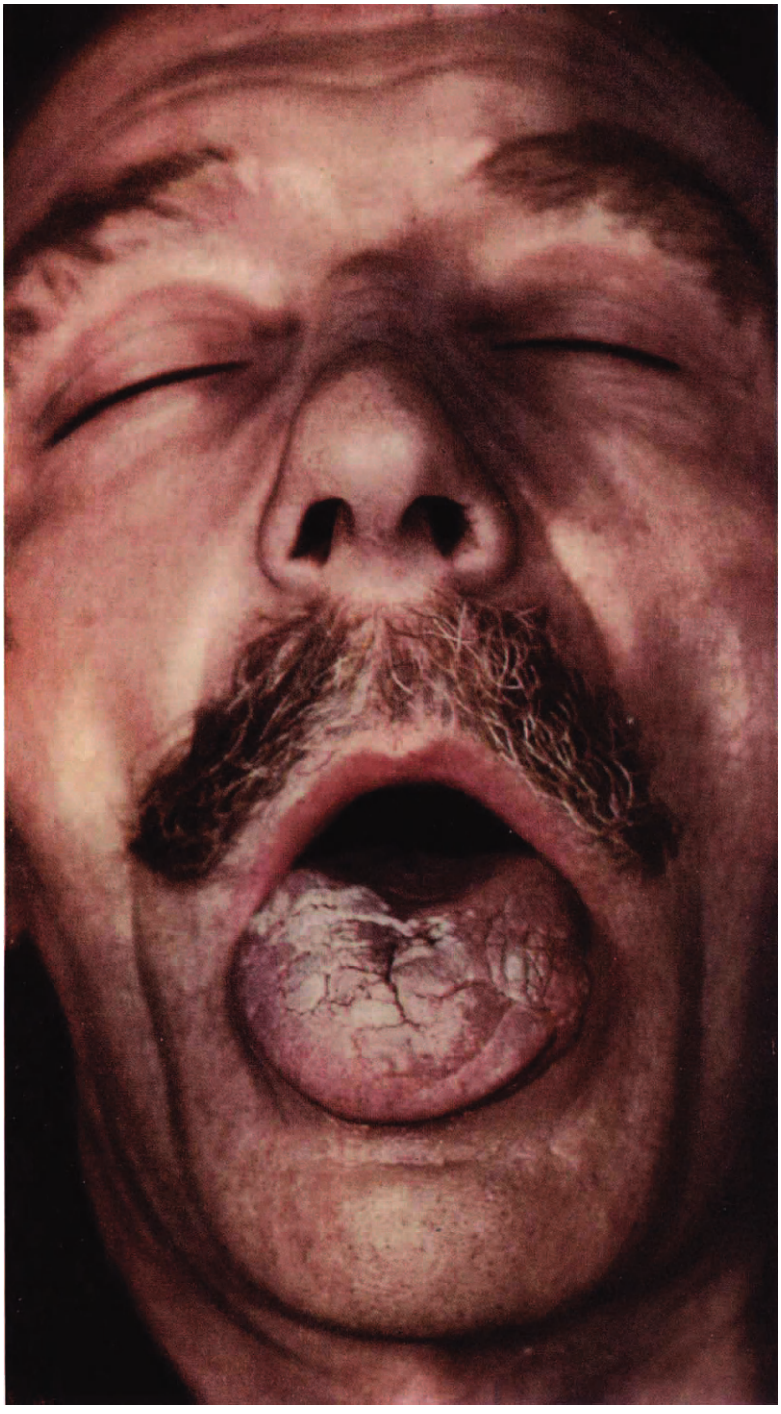
The characteristic appearances are manifest in the plate. The normal papillæ have entirely disappeared. The left side of the tongue is glazed and atrophic, and has a ragged, irregular, and, in its upper half, almost protuberant outline, owing to subjacent fibrosis and consequent shrinking. The surface is intersected by arborescent fissures, which may later become deep cracks and give rise to irritation and pain when in contact with food. A deep fissure roughly separates the two halves, of which the right presents hypertrophy with maceration of the epithelium. The picture is one which should be memorized, for such a case is almost certain to become epitheliomatous.

Treatment.—A complete cure of the case here shown can scarcely be hoped for, and is rare enough even in slight and much earlier cases. No local applications except the most soothing should be attempted, and all efforts should be directed towards intravenous and intramuscular therapy on general antisyphilitic principles. I have an impression that the silver-salvarsan group is more useful than the others. Full doses of iodides should be given at the same time, and the patient ought to give up smoking entirely, get rid of carious teeth, and avoid all hot and spiced foods. On the slightest suspicion of a malignant tendency a surgeon should be consulted.

It would seem reasonable to excise small inveterate leukoplakic patches—whether on the tongue or buccal mucosa—if they fail to respond to antiluetic treatment, and this has been successfully accomplished in one of my cases—an inveterate leukoplakia of the lower lip.

More recently Mr. Hamilton Bailey has undertaken the relief of some of my inveterate cases by surgical ablation in various degrees. The procedure is neither very painful nor disabling, and the patients are able to return to their normal life and occupations after 10 to 14 days. In none of the cases so far (three years) has a carcinoma developed, and if thereby the dreaded complication can be altogether prevented, such lines of prophylaxis are well worth considering. In any case they are much superior, in my experience, to radiotherapy, freezing by CO_2, and the more destructive, because less controllable effects of electro-coagulation.

PLATE XLII



CHRONIC SUPERFICIAL GLOSSITIS (Leukoplakia)

GRANULOMA ANNULARE

(PLATE XLIII)

THE characteristic features of this otherwise asymptomatic disease are well illustrated in the plate. The patients are usually children, from 5 to 10 years of age, and the sites of election are the backs of the hands, the knuckles, the knees or elbows, and rarely the ears or other areas in which bone or cartilage is closely underlying.

The lesions consist of smooth, firm, raised, usually circular or crescentic plaques, the nodular elements of which are deeply situated in the cutis where histological examination reveals a chronic inflammatory reaction in which mast cells predominate. As the nodules evolve and coalesce in ringed patterns the tightly packed cellular constituents and the compressed blood-supply—never so deficient as to cause ulceration—induce a pallor in the lesions which is described as *ivory* or *waxy*, and which becomes more obvious when the epidermis is stretched over them. This is a helpful point in the diagnosis, the salient features of which are the lack of subjective symptoms, the often symmetrical localization over bony prominences, the age-incidence, and the chronicity with absence of vesiculation or blister formation. The latter point serves to differentiate the disease clinically from ringworm, with which I have seen it confused on more than one occasion. The error actually occurred in the case here depicted, which conforms in every particular to the above description. The history of five months' duration in an otherwise healthy boy of 5 is also characteristic, and the family history unusually suggestive. His mother told me that her mother and her father-in-law had both died of 'consumption', and that another son of hers, aged 6, was now in hospital with tuberculosis of the spine. Such a story appears to afford support for those authorities who believe in the tuberculous aetiology of the lesions.

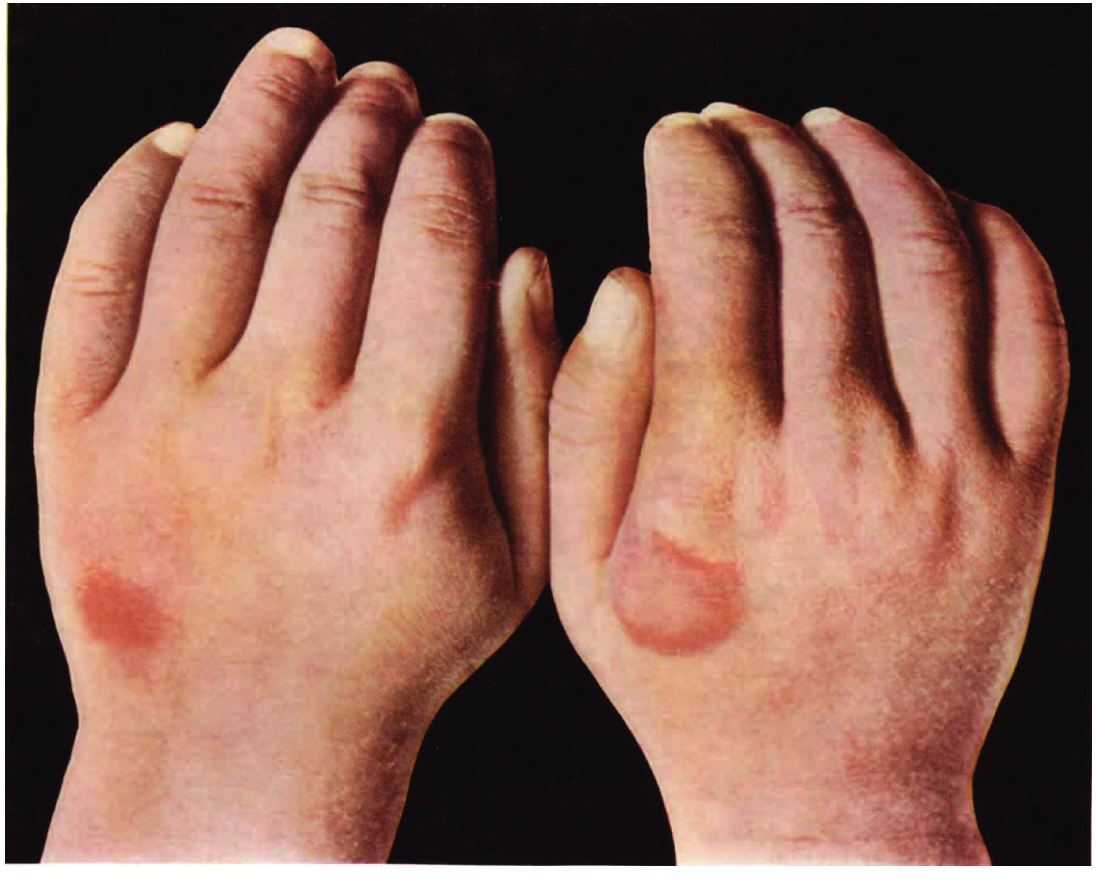
Within a week or two of seeing this case I saw another, also in a child, in whose antecedents I was unable to trace any tuberculous disease whatever. The question of the aetiology is still in dispute.

Prognosis.—The cases always get well eventually, and, so far as I am aware, do not tend to develop tuberculous manifestations in later life.

Treatment.—The best is undoubtedly X rays, and in my experience the lesions always yield to one or two sub-erythema doses. Recurrences some weeks or months later are the rule, however, and in view of the very benign character of the disease it is hardly worth the risk of protracted radiotherapy.* Pressure by strapping will sometimes cause involution, and many disappear spontaneously and always without a trace of scarring. It does not seem justifiable therefore to apply a caustic, or even CO_2 snow which has been advocated in some text-books, for fear of leaving a permanent mark, or keloid cicatrix.

* A recent case in a boy of 8 responded equally well to grenz ray therapy, which, owing to the absence of any of the risks associated with X rays, I shall in future prefer.

PLATE XLIII



GRANULOMA ANNULARE

GRANULOMA PYOGENICUM

(PLATE XLIV)

THIS somewhat rare form of papilloma is exceedingly vascular and gives trouble because it tends to bleed on the slightest contact. It may occur on any exposed area—usually the back of the hand or the knuckles—and is the result of slight injury and the penetration of the papillary layer of the epidermis by the *Staphylococcus aureus*. That such organisms were present in this case in abundance is proved by the yellowish greasy scales of seborrhœic infection which can be clearly seen among the hairs of the temporo-frontal region.

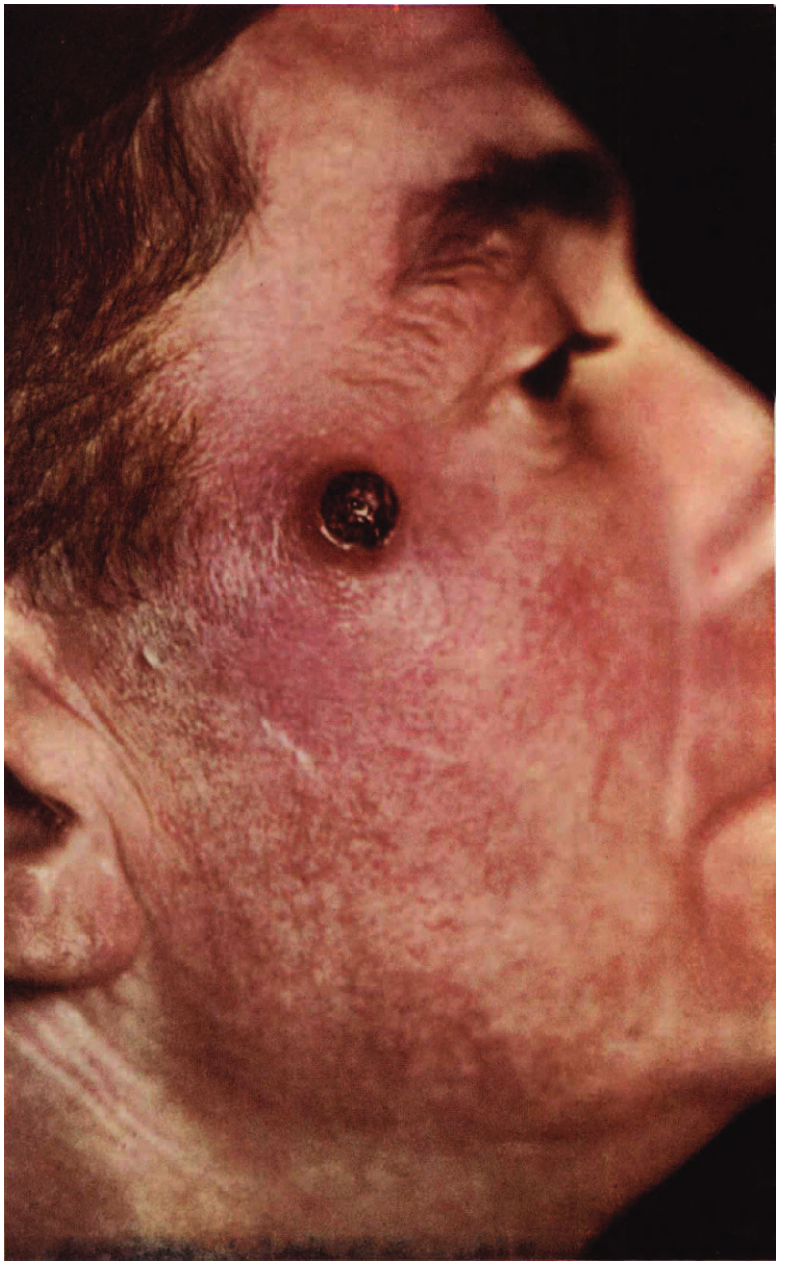
The little tumour here shown is covered with a brownish crust of dried blood, is circular in shape, and slightly raised above the surrounding niveau. It had been noticed for about three weeks—a fact which excludes the likelihood of epithelioma or anthrax (malignant pustule), with which it might well have been confused. In cases of doubt a microscopic investigation would decide.

In the differential diagnosis a primary chancre would have to be considered, but the chancre is never a vascular tumour, and the associated lymph-glands are invariably and typically affected.

Treatment.—In view of the pronounced hæmorrhagic tendency, treatment should aim at complete destruction of the papillæ involved, either by the cautery or fulguration.

(The slight reactionary erythema and œdema which surrounds this particular example of granuloma pyogenicum is unusual.)

PLATE XLIV



GRANULOMA PYOGENICUM

HERPES ZOSTER

(PLATE XLV)

THIS early example of herpes zoster (shingles) demonstrates both in its colour and grouping the characteristic small vesicles on an erythematous base, which are always apparent at some stage or other of this common and interesting complaint. Its zoniform distribution along the body segment supplied by a particular section of the spinal cord led to the discovery that it is always the result of irritation of spinal ganglia, in which inflammatory changes take place during the attack. The responsible virus has never been isolated, but there is some evidence to suggest that it may be identical or similar to that which causes varicella. It is always a unilateral affection, and although a few vesicles may sometimes be found across the middle line of the body for an inch or two, the occurrence of symmetrical groupings or lesions on other parts of the body practically negatives the diagnosis. A coincident swelling and tenderness of the segmental glands is the rule, and is present in this case, midway between the two groups of vesicles on the plate, in the left inguinal region. General symptoms of malaise and mild fever frequently precede the appearance of the vesicular eruptions.

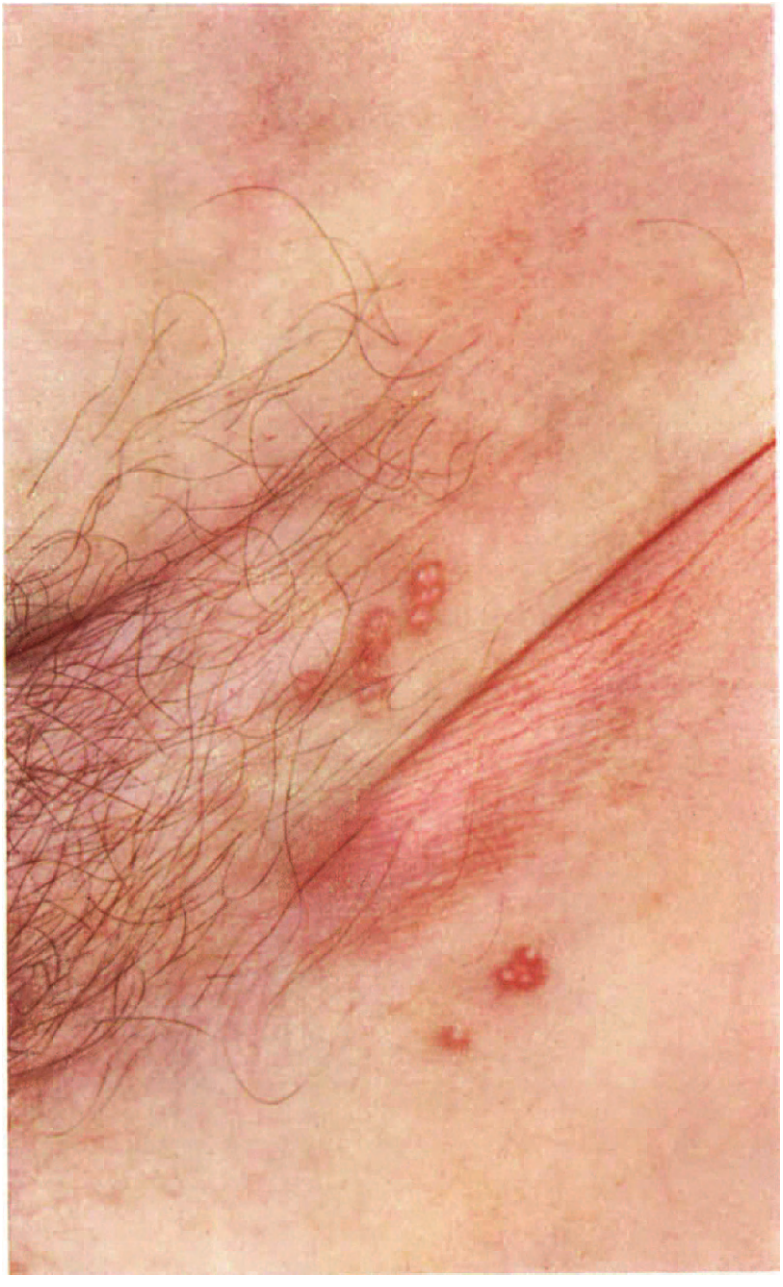
A mistaken diagnosis should hardly be possible in so typical an example as this, yet it is surprising how frequently errors are made. I have seen the abdomen opened twice for erroneously suspected appendicitis. The equally serious diagnosis of a basal pneumonia has sometimes to be corrected, and twice recently I have had to negative a diagnosis of dermatitis medicamentosa in cases in which it was thought that the application of an ointment for 'rheumatism' had produced the eruption. The associated or preceding pains doubtless resulted from irritation of the spinal ganglion, and these may be troublesome, and may tend to persist, with certain paræsthesia, for months after the cutaneous manifestations have cleared up, especially in elderly subjects.

Aetiology.—The histological identity of the zoster and chicken-pox vesicles, and the many reported cases of undoubted reciprocal contagiousness, both fortuitous and experimental (Lipschutz and Kundratitz), and the immunity phenomena resulting afford strong evidence of at least a close relationship of the cause of both. This is generally believed to be a virus. The occurrence of zoster after injury, during emotional stress, or in the course of arsenical or metallic injections for the treatment of syphilis, suggests further the probability of predisposing factors, and it is now presumed that such may lower nervous tissue resistance to the zoster virus and favour its local development in the ganglion.

Treatment is simple, and purely symptomatic. Local protection is important, and may be effected with pellanthum or some other skin varnish. If the vesicles are broken, calamine lotion and dusting powder may be generously applied, while pain may need to be treated with analgesics and soporifics, occasionally with morphia. Persistent areas of neuralgia sometimes yield to X rays, either applied directly to the site of the eruption, or, better, to the area of the spinal segment concerned.

Dr. Barber informs me that he has been able to abort the attack in its early stages by autohæmotherapy. The method has been successfully employed by other dermatologists for the alleviation of the post-herpetic neuralgia. (*See also under* TREATMENT, p. 104.)

PLATE XLV



HERPES ZOSTER

HERPES ZOSTER
(Frontalis)

(PLATE XLVI)

THE sudden unilateral eruption of grouped vesicles on an erythematous base, and always in the track of the segmental sensory nerve distribution of the affected area, allows of no other diagnosis. The plate illustrates a relatively common site of this acute and usually painful infection, and denotes the implication of the upper sensory root of the Gasserian ganglion. Although the eyelid is obviously œdematous and inflamed, the cornea has escaped, for the reason that its nerve-supply is derived from the ophthalmic or middle branch of the 5th nerve. Involvement of the cornea is always a serious complication and imperils the eye itself, as a result of the ulcerating vesicle. The vesicles are very obvious in the picture, and show, as they often do, a gangrenous tendency, in the outer of the two groups just above the left eyebrow. The effect of such a process on the cornea can be well imagined, not only immediately by involving the anterior chamber, but subsequently as a result of the inevitable cicatrization.

Associated and often prolonged neuralgic pains are sometimes a troublesome feature, and this patient was no exception to the usual experience, which accords it most frequently to subjects at or beyond middle age.

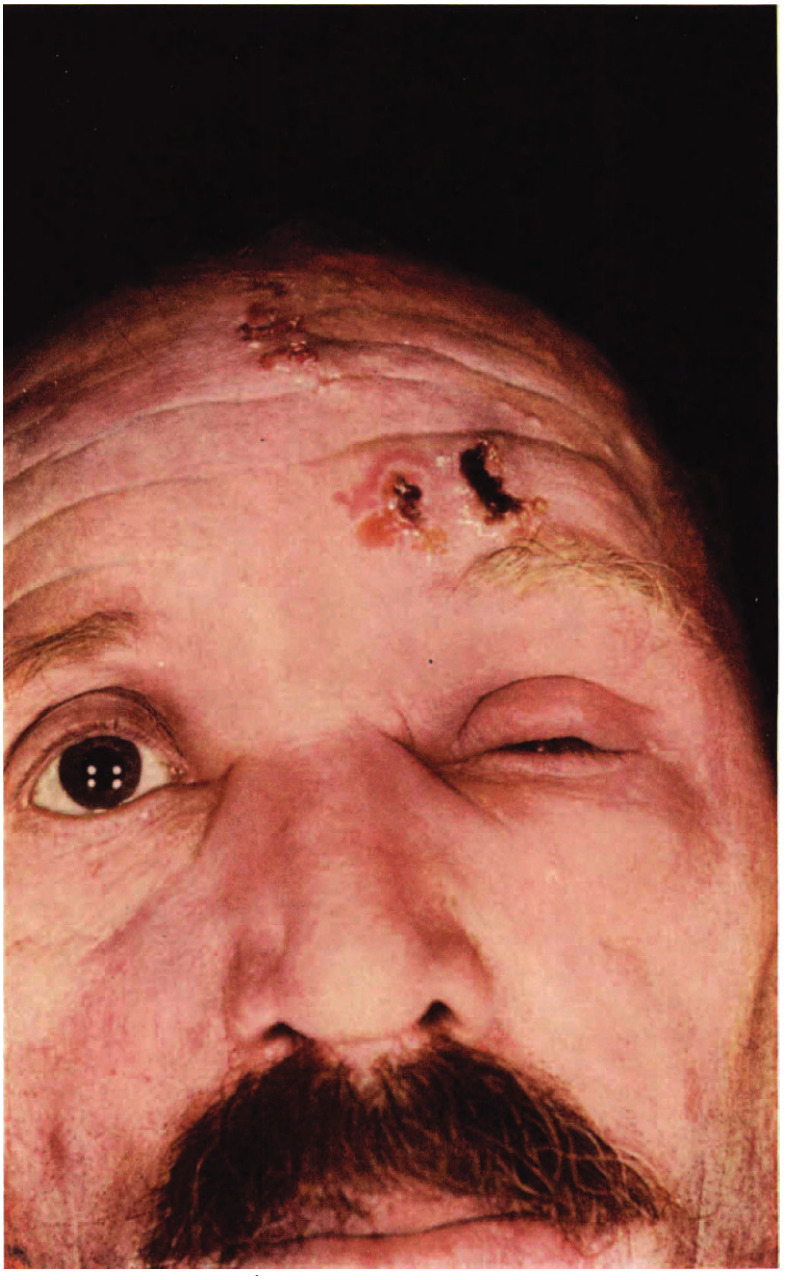
Treatment includes protective and soothing applications of calamine and lead lotion (the latter must not be used for the cornea), and plenty of a simple dusting powder. If the vesicles are not ruptured, a varnish such as pellanthum is useful.

Analgesics and soporifics have to be prescribed in the neuralgic types, and when the symptoms do not yield a month or two after the attack, recourse may be had to radiotherapy of the affected ganglion or to autohæmotherapy.

In any case involving the ophthalmic division of the 5th nerve, the case ought to be referred to an ophthalmologist who will consider the advisability of temporarily protecting the insensitive cornea by sewing the lids together.

Modern remedies for the treatment of herpetic (and post-herpetic) neuralgia include pituitrin (1 c.c. intramuscularly every other day—three doses in all), with or without thiosinamine ethyl iodide, 1 c.c. daily for six days, or atophanyl (atophan and sodium salicylate), 1 ampoule daily. The results rarely justify the claims that have been made for these remedies, and it should be remembered that pituitrin is contra-indicated by pregnancy, and atophan in cases in which liver damage has been demonstrated or suspected.

PLATE XLVI



HERPES ZOSTER
(Frontalis)
105

IMPETIGO
(Bockhart)

(PLATE XLVII)

THIS is a pustular folliculitis of the pilo-sebaceous orifices, and the name is distinctly misleading as the infecting agent is not the streptococcus but the staphylococcus (*Staph. albus* or *aureus*).

The infection occurs only where there are hairs and sebaceous glands, and the areas most liable are therefore the extensor surfaces of the limbs and the scalp. The reasons for separating it from sycosis barbæ which is also a staphylococcal folliculitis are not very obvious, for both diseases may originate from a preceding injury, or from some form of infection, such as a boil, or from irritation, e.g., the razor in one case (mechanical trauma), camphor liniment, tar, paraffin, or sulphur (chemical irritation), in the other.

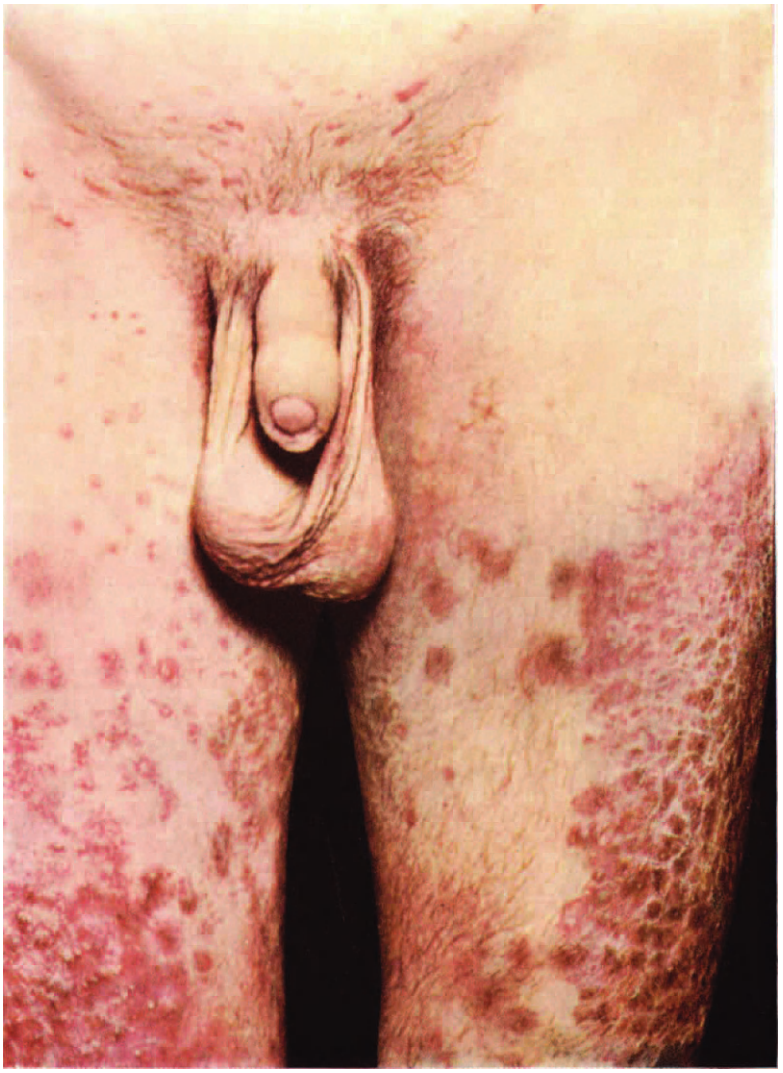
The case illustrated was a young mechanic whose overalls had been consistently soaked with petrol and paraffin for months and had eventually set up the condition of folliculitis for which he sought relief. (It is worth noting that so-called ' oil acne ' might also have resulted.)

Diagnosis.—There is no condition which could be confused with this localized follicular infection, but a concomitant dermatitis may sometimes mask its salient features. The history of the patient's employment should suffice to prevent errors, which are rarely made in these cases.

Treatment.—In my experience ointments are not well tolerated. When there is much crusting and impetiginization, preceding boric-starch poultices applied for not longer than half an hour at a time will allay the severe irritation sometimes present and prepare the area for the application of a weak tincture of iodine (1–4 in spirit), followed immediately by generous dusting with an indifferent powder. The procedure should be repeated twice daily, and care must be taken to ensure some clean covering, such as gauze or linen, next the skin. If iodine is not tolerated, as sometimes happens, a 1 per cent gentian in 25 per cent surgical spirit should be substituted and the area dusted and protected as above. If irritation persists with dryness, a little Lassar's paste may be applied at night.

It is unusual to have to use X rays for epilating the hairs (as in sycosis—*see* p. 184) but in recurrent or intractable cases they may have to be employed.

PLATE XLVII



IMPETIGO
(Bockhart)
107

IMPETIGO CONTAGIOSA

(' Scrum-pox ')

(PLATE XLVIII)

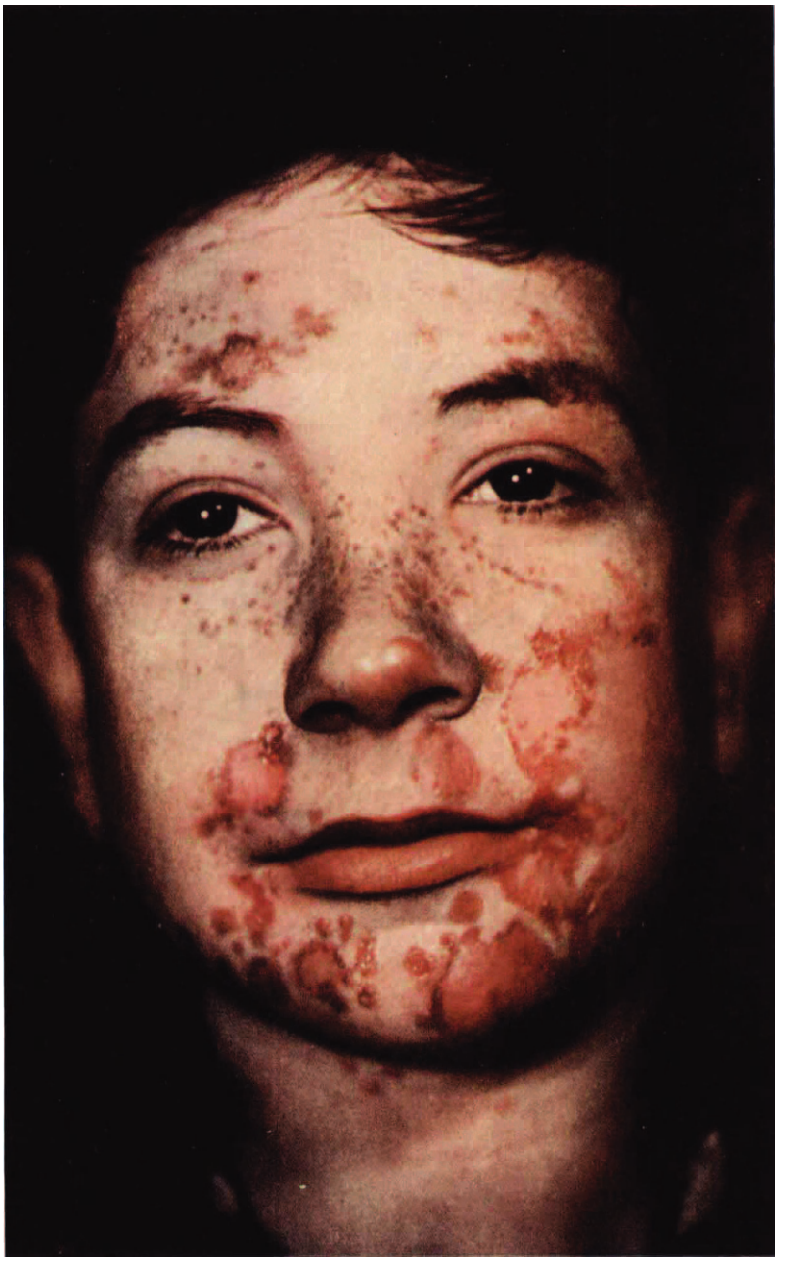
THE well-known honey-crusted variety of this extremely contagious *streptococcal* infection does not appear to be so common as formerly, and cases generally, especially in out-patient departments, have diminished *pari passu* with the effective limitation of head lice in school children. A careful search for them or their ova is still advisable.

The plate provides a very typical example of circinate and confluent impetigo in a freckled youth of 16. The eruption is limited to the face, as is so often the case, and began with a single lesion in the region of the left angulus oris, from which a rapid extension has involved the chin, left cheek and upper lip, nose, left eyebrow, and right frontal area. There were no pediculi, and the source of the infection was not determined.

A striking example of the way in which the infection can be conveyed is worthy of record. I was recently consulted by a practitioner for the treatment of his son, a schoolboy of 14, the whole of whose face and ears were covered by ruptured vesicles, scabs, and weeping eczematized patches—an obvious case of extensive impetigo contagiosa. In spite of assiduous applications of a 1 per cent zinc and copper lotion, with calamine liniment at night, the infection continued and spread spasmodically to the back of the neck. It persisted longest round the mouth, where it had begun, and on the ears, and eventually after six weeks' treatment took a turn for the better, and cleared up. Before a cure was achieved his father developed a small group of vesicles on the left ear. He was on his holiday at the time, in Scotland, but had no doubt that he had contracted the infection a day or two before he left London. When later we discussed the possibilities, it transpired that the boy had used the telephone just before his father was called to it, and as the lesions in the latter case had first made their appearance on the left ear there was little doubt that the actual carrier of the streptococci from the son to his father was the earpiece of that instrument. It is furthermore of some interest to note that the course of the disease in the second case was almost identical. The lesions spread from the face to the back of the neck—an uncommon situation—and also persisted for six weeks before they finally cleared up.

The close similarity in their courses and clinical appearances invites some speculation as to the underlying pathology in these two cases. We are certainly justified in assuming that the responsible streptococci were of the same strain, and it is interesting to note that the lesions caused and the sites affected were also very similar. Last but not least we are struck by the fact that the duration in both cases was six weeks—about twice the average time required for the development of resistance or immunity conditions sufficient to check the further spread of the lesions. The two patients being such close blood relations further justifies the assumption of a close similarity of terrain or culture medium. In view of these facts it is likely that the streptococci causing impetigo are not always of the same type, and just as in other

PLATE XLVIII



IMPETIGO CONTAGIOSA

(' Scrum-pox ')

infections may lose or gain virulence according to their environment, the source of their supply, or the line of treatment adopted to cope with the spread of the lesions. It is not too much to hope that with the introduction of prontosil* and other members of the sulphonamide group we shall soon be in a stronger position to abort or shorten the usual course of this occasionally resistant malady.

Differential Diagnosis.—The common mistake is to label impetigo 'ringworm' because of its circinate contour. There are several points of difference, but the most important is the appearance of the isolated lesion. In tinea the characteristic feature of the 'ring' is a clearing centre with minute vesicles in the periphery. If one of these is carefully lifted off and examined in potash under a 1/6 objective, with the light cut down by the diaphragm, the typical mycelium can nearly always be seen branching dichotomously across the slide. This finding is conclusive evidence of ringworm, which furthermore is slower in development than impetigo, prefers the covered parts of the body, and always causes more irritation than impetigo.

When impetigo persists beyond three weeks or relapses after apparent cure, a search should be instituted for evidence of seborrhœa, on a basis of which streptococci are particularly prone to flourish. A little sulphur added to a 1 per cent white precipitate paste or ointment will sometimes solve the difficulty and promote a cure.

The primary lesion is a superficial minute vesicle, raising the horny cells by peripheral extension into a bulla, exuding serous fluid containing both streptococci and staphylococci, and drying into crusts. Persons with an eczematous tendency often prove exceedingly refractory to treatment and may relapse again and again after apparent cure. A further complication may occur when the infection invades the hair follicles in the shaving area, giving rise to one form of sycosis barbæ.

Treatment should be governed by the fact that most cases tend to clear up spontaneously in about three weeks. Strong antiseptics invariably aggravate, and I am inclined to the view that mechanical removal of crusts does the same. It is not often necessary to order the boric-starch poultice, which may do more harm than good by reason of its macerating quality. When used it should be applied for short intervals only, not longer than half-an-hour at a time, while in the intervals the whole affected area is sponged *with a* $\frac{1}{2}$ *per cent solution of zinc and copper sulphate* ; this lotion, a modification of the famous eau d'Alibour, is in my experience the most effective simple remedy for impetigo. The same criticism is applicable to all greasy ointments, which—especially in hot weather, when the disease is most rife—tend to run, and actually spread the infection to other areas. A 1 per cent white precipitate ointment is useful sometimes in the later scaly stages. Unless eczematization is pronounced, the lesions seem to do better if left uncovered and exposed to the air. The ultra-violet rays should not be used except by experts, and X rays only as a last resort in very obstinate and relapsing types.

* A recent very resistant case was eventually cured by the continuous application of ung. streptocide, a proprietary preparation containing sulphanilamide.

INTERTRIGO
(Streptococcal Dermatitis Following)

(PLATE XLIX)

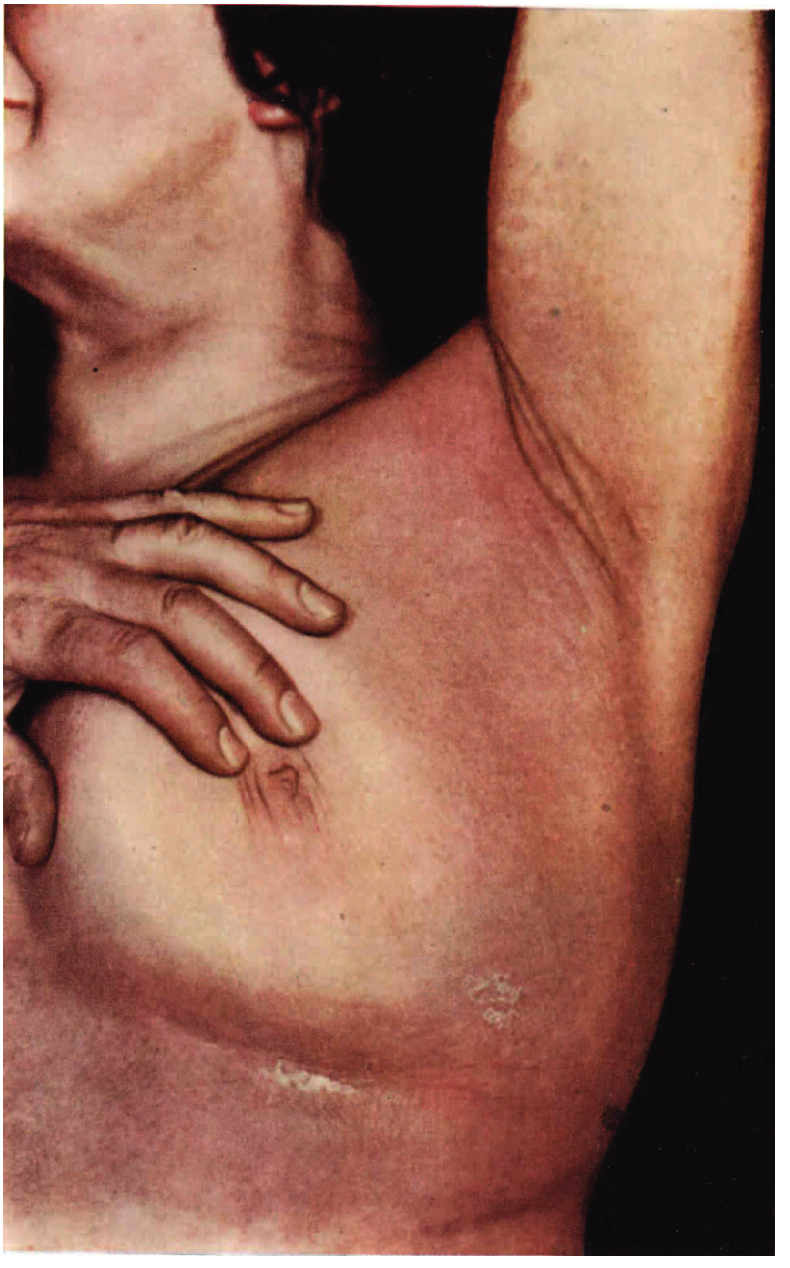
THE submammary, the post-aural, and the internatal regions, where skin surfaces are normally in contact, are especially prone to maceration due to moisture in hot weather. Infants and stout women who perspire freely are sometimes sufferers in this respect, and infections of streptococcal type are not infrequently superimposed (intertrigo). They may be contracted locally from persistent streptococcal fissures such as are common behind the ear in persons with scurfy scalps and other manifestations of the seborrhœic state. Sometimes, especially in infants, the infecting organism is *Monilia* (*see Plate LXVI*), which belongs to the group of pathogenic yeasts. Most submammary intertrigo could be avoided if due care were taken to prevent undue and continuous contact and compression of pendulous breasts by supporting apparatus made of thin washable webbing, and keeping the skin in a dry and clean condition with spirit and dusting powder.

The moist, slightly infiltrated flexural dermatitis here present began in the submammary fold and spread with great rapidity to the axilla and deltoid region. It subsided with almost equal speed on the application of a 1 per cent ichthyol and black wash lotion and liberal dusting with starch and zinc powder. A small submammary fissure which appeared subsequently near the area of white exfoliation soon yielded to a 2 per cent solution of silver nitrate in spirit of nitrous ether, applied with a camel-hair brush once daily.

A special form of inguino-scrotal (or vulval) intertrigo is occasionally met with in the adult. It is always symmetrical and consists of moist red oozing patches, at the spreading margins of which there are conspicuous vesicles, mostly ruptured and sodden or macerated. The sticky mucoid discharge from these swarms with the *Monilia* fungus, easily demonstrable in potash under a 1/6 objective.

In such cases we must never neglect to examine the urine for sugar, for on two occasions in my experience the patients were found to have diabetes, of which they had previously shown no other symptoms.

PLATE XLIX



INTERTRIGO
(Streptococcal Dermatitis Following)

KELOIDAL AND HYPERTROPHIC SCARRING

(PLATE L)

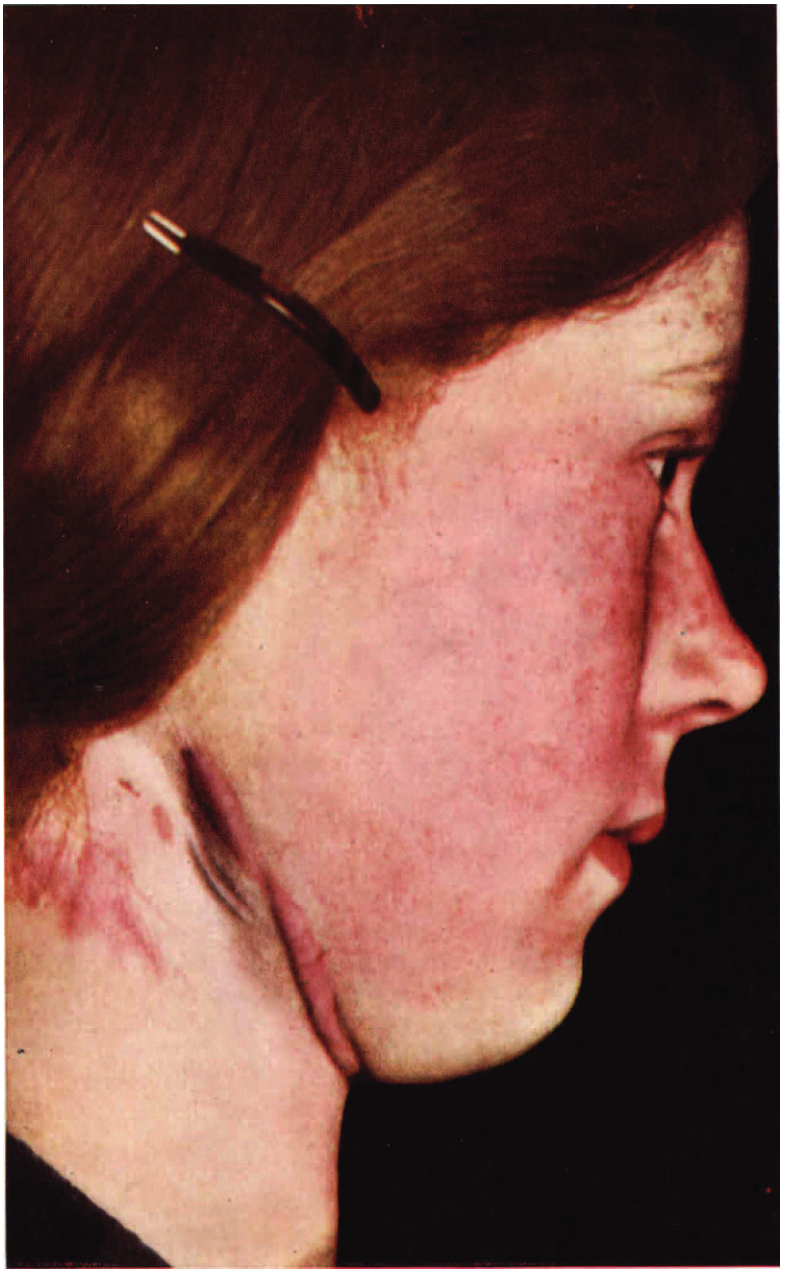
THE true keloid differs from a hypertrophic scar in its tendency to grow or extend beyond the site of the original trauma or cicatrix that preceded it. The clawlike extensions are responsible for the nomenclature ($\chi\eta\lambda\eta$ = a claw). While in both types there is some evidence for an inherited predisposition, the nature of the original injury is quite as important, for burns, scalds and damage by caustics are particularly prone to be followed by hypertrophic scarring. I well remember a case in which a bottle of trichloracetic acid belonging to my department had found its way on to a shelf used by the dental surgeon. It was handed to him by a nurse in mistake for sal volatile to stimulate a hysterical young woman coming round from an anæsthetic. In her struggles the bottle was upset and the fluid trickled over her mouth and down both sides of her neck. The subsequent disfigurement by hypertrophic scarring formed the basis of proceedings in the county court.

The nodular and suppurative forms of acne are an occasional cause of the condition, but the commonest probably is the long-standing tuberculous sinus. Its main features and a frequent localization are well illustrated in the plate. This girl of 17 had been surgically treated for tuberculous glands some three years previously, and the smooth, bluish-mauve or livid, firm, linear elevations had supervened in the line of the original incision. Subjective symptoms are never severe, and the burning or pricking complained of is doubtless magnified by the desire to be rid of the disfigurement, which in the case of large areas in the flexure of a joint may carry with it a considerable functional disability.

Treatment.—The earlier a keloidal scar is treated—i.e., the softer to palpation it is—the better the result by radiotherapy (X rays or radium), which is the generally recognized indication. Very long-standing stationary and fibrous growths should be excised. If there is a definite tendency to extension beyond the limits of the original trauma (true keloid), X rays should be prophylactically administered immediately after the operation.

Roxburgh has found the subcutaneous introduction of radon seeds more effective than external irradiation by either X rays or radium.

PLATE L



KELOID OF NECK

KERION

(PLATE LI)

THIS is the name given to a special type of reaction to the specific infection by the ringworm fungus, usually of animal origin (trichophyton), but sometimes of the human or microsporon group. The reaction is a stage in the process of immunization, and, when it occurs, should be regarded as a salutary rather than an adverse symptom. The kerion consists histologically of a group or aggregation of swollen, œdematous, and sometimes pustular hair follicles, which being individual structures do not permit of the confluence of the infected material and the consequent formation of a large abscess, which the appearances not infrequently suggest. Hence it is quite useless to puncture or incise a kerion in the hope of evacuating the pus.

The proper treatment is to apply boric compresses or fomentations to encourage the natural reactions. Most cases clear up in a week or two, and as they do so immunity is established, and other foci of ringworm infection, whether of the hair or body, vanish with them. The stumps in the kerion circumference are shed, and sometimes, but not always, contain mycelium, which can be demonstrated microscopically or grown on special media in the laboratory.

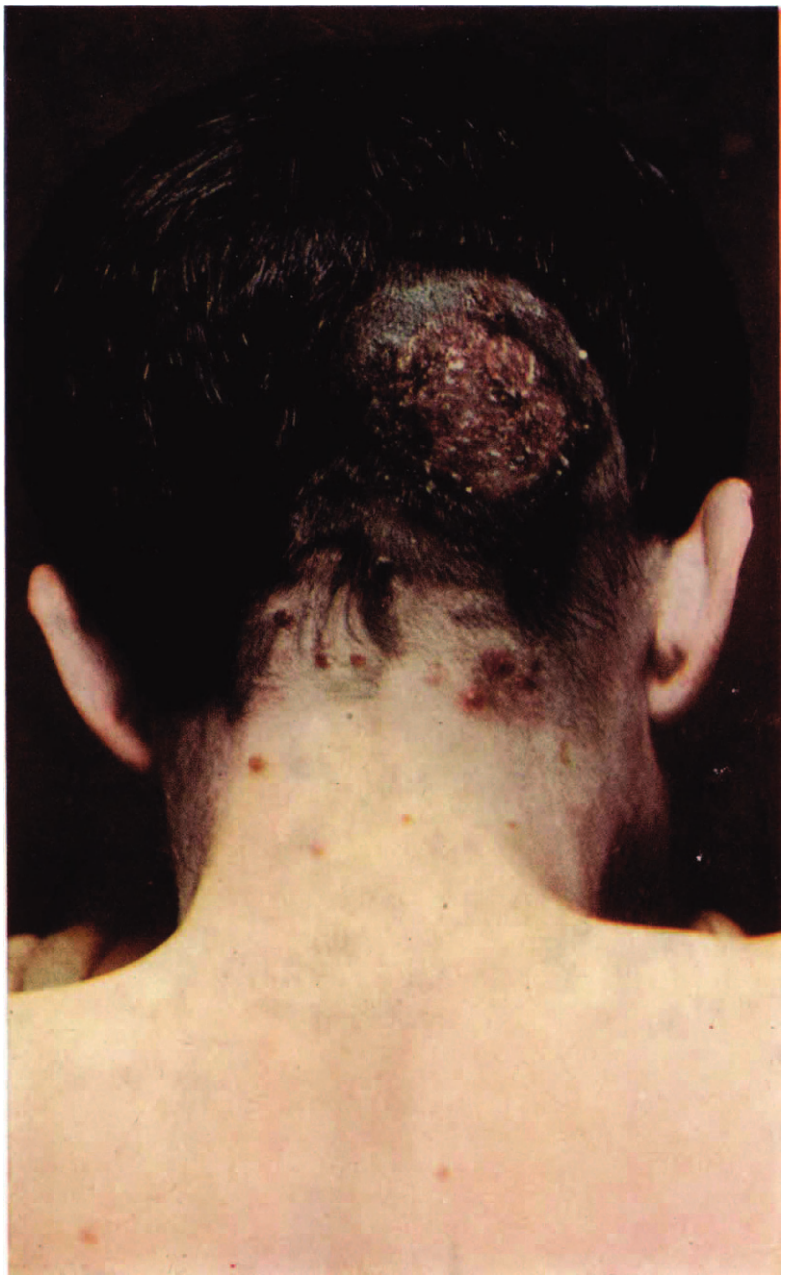
The hair in the denuded patch usually recovers, but if the suppuration has been very severe, the follicle is permanently damaged and a bald patch may result. It is for this reason that local applications other than fomentations are not advised in cases of kerion, for they may subsequently be suspected as the cause of the bald patch.

Secondary rashes—trichophytides—sometimes occur in association with a kerion, in the shape of follicular raised lichenoid patches which may be aggregated into sheets, mainly on the back between the shoulder-blades.

The clinical appearances of the kerion are well illustrated in the photograph. The occipital localization is common, and, as already indicated, the kerion itself is a swollen, raised, œdematous, sometimes pustular, usually painless, circular tumour on the scalp (of children) or on the beard (of adults). Neighbouring glands are not manifestly enlarged, although they may contain the fungus, and constitutional symptoms are very rarely present.

The gumma of luetic origin, which might conceivably be mistaken for kerion, is far slower in its development, and is not associated with the presence of stumps or other evidence of a mycotic infection.

PLATE LI



LICHEN PLANUS
(Acute)

(PLATE LII)

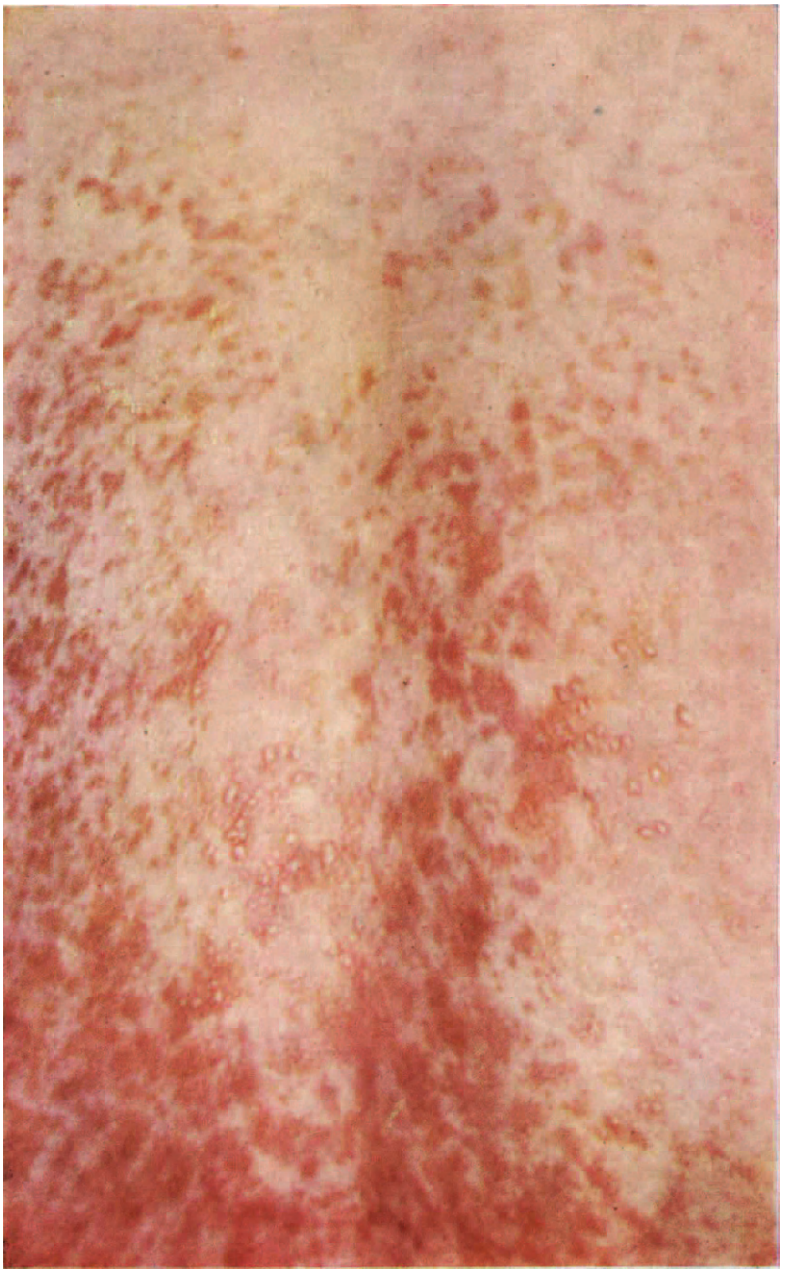
THIS illustration conveys all the characteristic features of the acute eruption on the back of a middle-aged woman. The most typical polygonal, flat-topped, shiny papules are seen to the left of the middle line at the junction of the middle and lower thirds of the plate. When these are observed, as they nearly always are, the clinical picture could hardly be mistaken for that of any other dermatosis. Intense itching is the rule, and sometimes there is a marked association of nervous excitement which lends some support to the view of a nervous or emotional aetiology comparable to that pertaining to the causation of alopecia areata.

The widespread acute cases usually run a rapid course and tend to involute in from five to six weeks. Sometimes they pass into the chronic relapsing type with its discrete violaceous or brownish lesions, and its tendency to superficial atrophy and pigmentation.

Aetiology.—The cause of lichen planus has still to be proved. An attractive theory for which there is some evidence attributes the eruption to a virus which can be activated (cf. HERPES ZOSTER, p. 102) by a variety of stimuli, including emotion and shock, or arsenic by the mouth or injection. Goldsmith quotes Jacob and Helmbold (*Arch. of Dermatol. and Syph.*, 1933, xxvii, 472) who describe a Gram-negative anaerobic bacillus which they cultured from papules of lichen planus in 25 out of 28 cases, and which on inoculation into normal subjects reproduced lesions that in some cases resembled the original both clinically and histologically. Confirmation of this work would be of great importance.

Treatment.—Rest in bed is the paramount indication in acute and widespread cases. Large and generous applications of an indifferent dusting powder, sedative baths, and the oral administration of salicin, wine of antimony ℥v t.d.s. or liquor hydrarg. perchlor. ℨj t.d.s., soporifics, and nerve sedatives such as chloral and the bromides are useful. X-ray treatment of the spinal ganglia, and even lumbar puncture, have been applied, sometimes with dramatic success, in unusually resistant cases.

PLATE LII



LICHEN PLANUS (Acute)

LICHEN PLANUS
(Subacute)

(PLATE LIII)

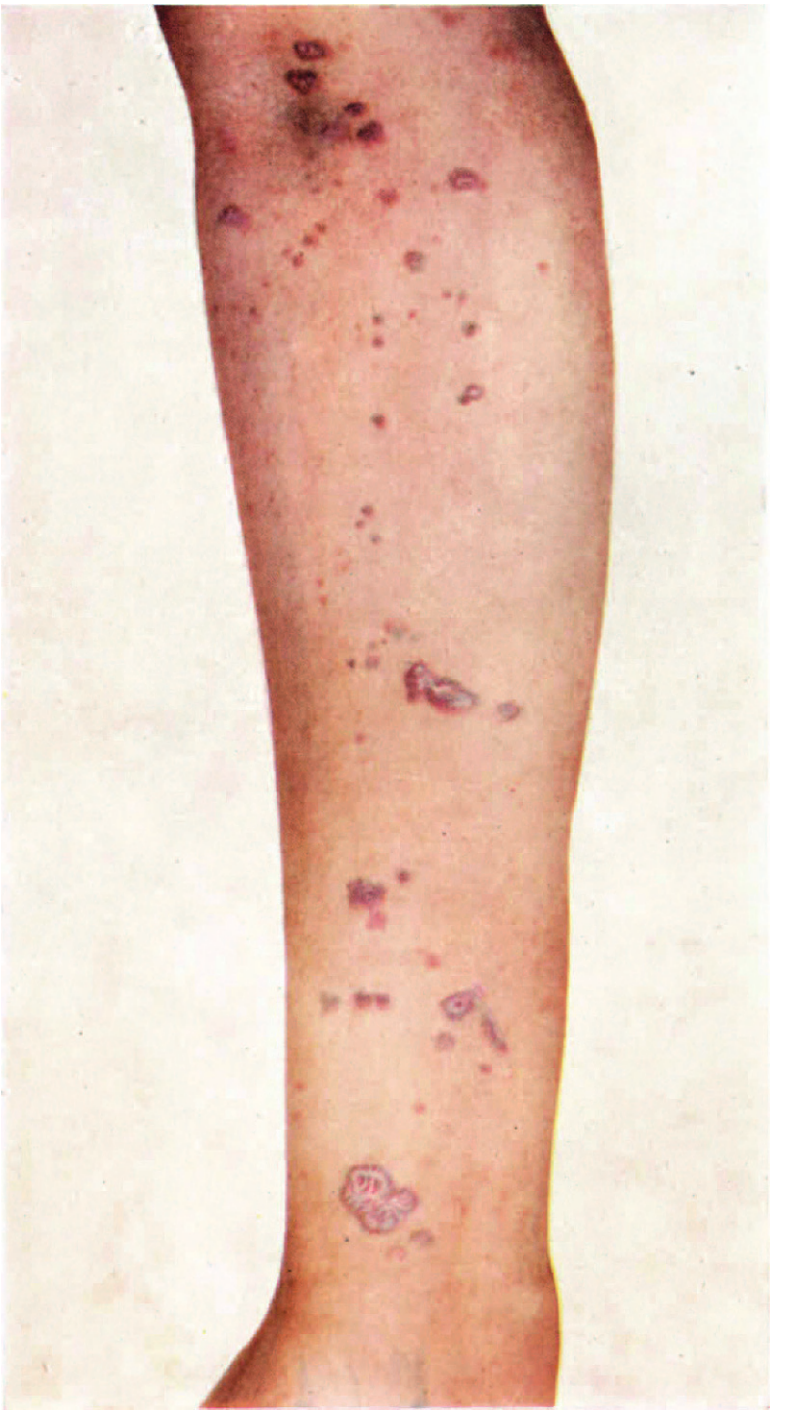
THE typical localization on the front of the wrist, and the typical raised shiny violaceous polygonal papule, admirably illustrate in this plate the salient features of the subacute variety of lichen planus. The three lesions over the wrist-joint should be carefully studied and memorized. The lower two are primary isolated papules. Several of these oval or polygonal lesions have aggregated in the larger to form a broche or gemmate pattern, on the surface of which can be seen with the aid of a pocket lens the delicate white lines or striæ first described by Wickham. The other visible lesions are modifications of those above described, and the eruption involved both upper and lower extremities more or less symmetrically. Irritation was present but not pronounced. The buccal mucosa was not affected.

Treatment.—In such a case as this the therapist should content himself with recommending rest and change when possible, and prescribing such antipruritics as 1 to 2 per cent menthol or phenol in a varnish base, e.g., pellanthum. Injections of some arsenical preparation, e.g., enesol, acetylarsan, are better than oral administration, and should be persisted in for three or four weeks at a time. Nervous irritability and (or) exhaustion seems to lie more frequently at the root of most cases than any other definable cause, and for this reason alone rest—in bed in the acute type—is the main indication in treatment.

In resistant cases germanin (Bayer 205) may be given a cautious trial, as lichen planus cases are said to be rather hypersensitive to it, and may develop renal complications. One quarter of the 1 c.c. ampoule is recommended as the initial dose, and a feeling of tension in the palms and soles should be regarded as a warning signal (Scherber).

There is some evidence to support the theory that lichen planus is due to a specific neurotropic virus, which, as in the case of herpes zoster can be activated by intercurrent factors, such as shock or emotional stress.

PLATE LIII



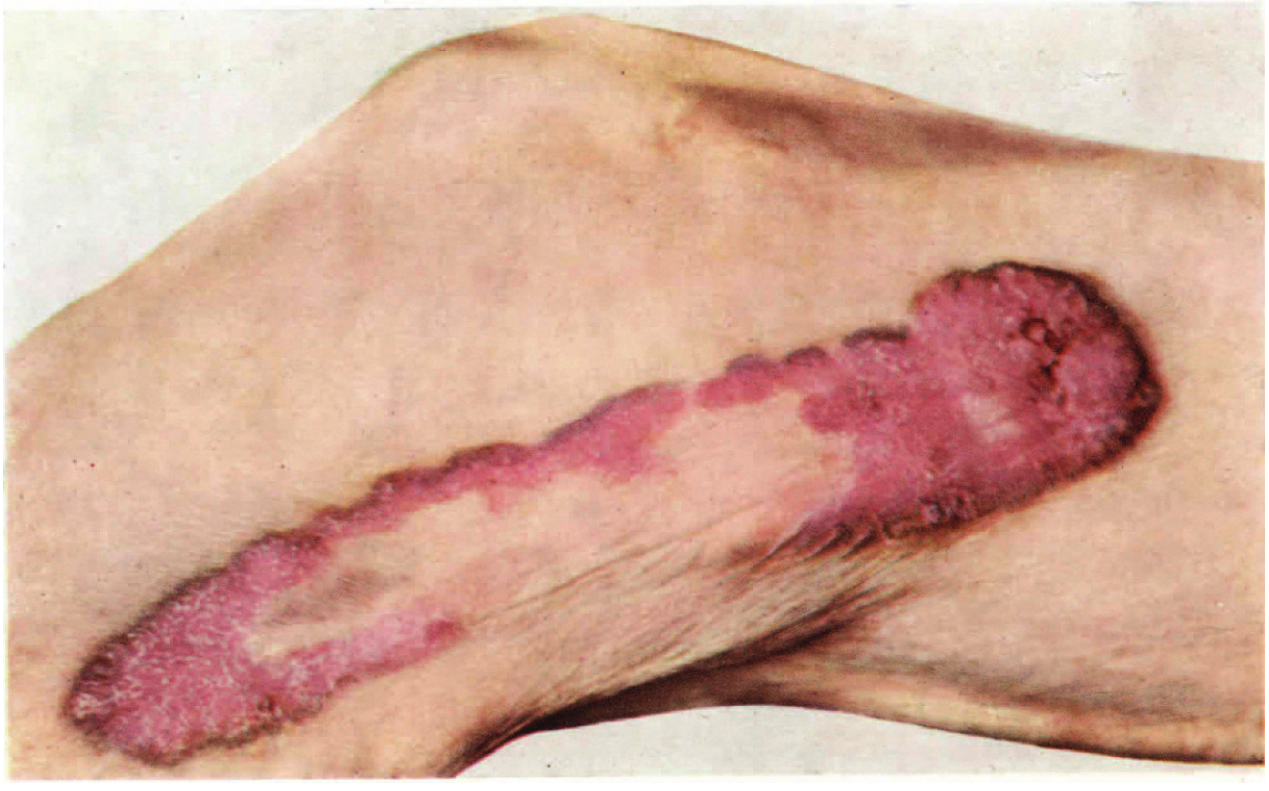
LICHEN PLANUS (Subacute)

LICHEN PLANUS
(Chronic Hypertrophic)

(PLATE LIV)

THE peculiar lesion here depicted on the internal aspect of the left thigh and knee-joint of an elderly woman had been present for some five or six years. The pronounced atrophy of the central area and lower margin confirms the history, and the violet or lilac tinge is very characteristic for the diagnosis of lichen planus. She complained of severe irritation at times, which further supports it. There were no other patches of any kind to be found, and the possibility of lichen simplex chronicus has to be considered in the diagnosis. The colour is, however, definitely against this view, and a small portion of the lesion was excised and confirmed the diagnosis of lichen planus.

The extreme hypertrophy at one extremity gave rise to the suspicion of malignancy—a possible complication in any very chronic irritable and isolated patch such as this—and the case was referred to the surgeon for excision.



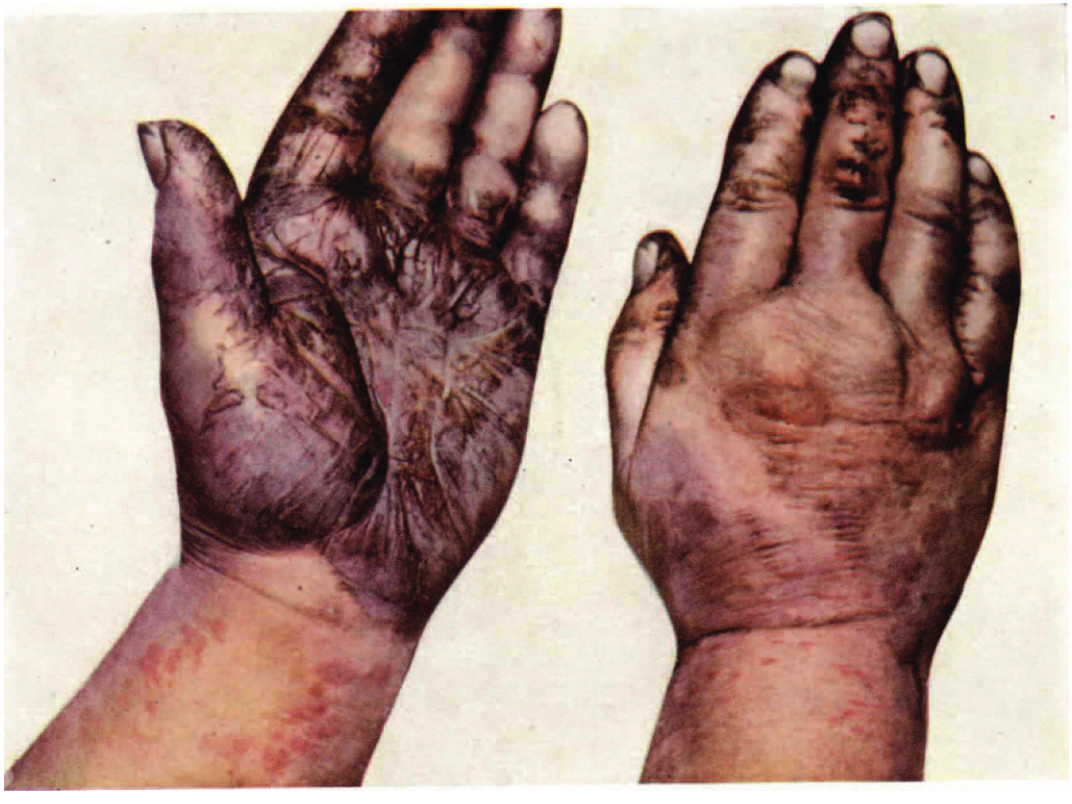
LICHEN PLANUS
(Chronic Hypertrophic)

LICHEN PLANUS PALMARIS

(PLATE LV)

THE somewhat exaggerated violaceous colour of the palmar eruption, which was symmetrical in this instance, will serve to emphasize the feature which permitted of the diagnosis of lichen planus. This was confirmed by the presence of the typical flattened papules of that disease to be seen in large numbers on the front of the left wrist. It will be further observed that as a result of the thickening and infiltration of the palmar skin, deep cracks and fissures have been produced. Their appearance may complicate the clinical picture of any disease which involves the palms and soles, and we have therefore to differentiate this case from psoriasis, tertiary syphilis, mycelial (tinea) infection, and from cases in which only thickening and fissuring without eruption is present, e.g., chronic palmar eczema. These chronic palmar eruptions are often a source of diagnostic difficulty even to the experienced dermatologist.

Treatment is that of the causal factor—in this case, chronic lichen planus. Local applications of the subacetate of lead ointment were found of some value, but most relief was given by small graduated doses of X rays, supplemented by an arsenical mixture.



LICHEN PLANUS PALMARIS

LICHEN URTICATUS

(PLATE LVI)

LICHEN URTICATUS, papular urticaria, strophulus, simple prurigo, 'gum-rash', and 'heat spots' are the same disease and incidentally a glaring example of the multiplication of terminology with which dermatologists are sometimes justly charged.

The patients are almost always infants and young children up to the age of 6 or 7, and the disease is far commoner in the hospital out-patient department than in private practice.

The aetiology is obscure, but most authorities incline to the view that allergy, either gastro-intestinal, or some external agent most active at night (R. Hallam), plays a prominent part in causation.

Nocturnal itching is invariable, and frequently severe enough to cause loss of sleep for weeks at a time. The lesions on which the diagnosis is based consist of raised urticate papules, surmounted in acute cases with a small vesicle which is promptly scratched off and replaced by a scab under which the streptococci and staphylococci flourish, and establish a clinical picture which may be confused with that of impetigo contagiosa or scabies.

The localization is not characteristic, as is that of scabies, pediculosis, varicella, and small-pox, with all of which confusion has at some time arisen. The trunk, face, scalp, and limbs, especially the buttocks, are variably affected in different degrees and at different times.

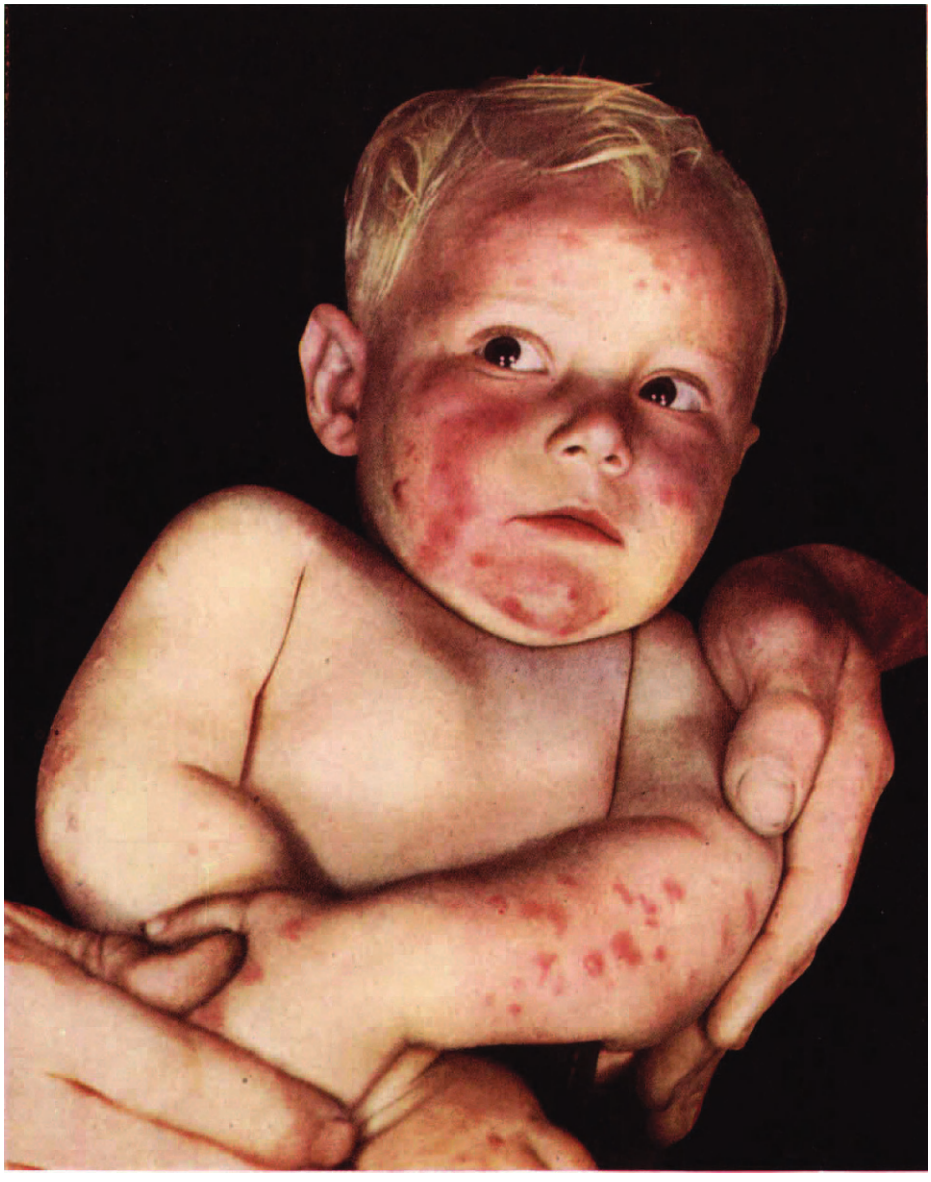
In the case depicted—an otherwise healthy-looking boy of 19 months—the forehead, face, and extensor surfaces of both upper and lower extremities, including the buttocks, bore the brunt of this particular attack. The lesions are clearly urticarial papules and there is no tendency to impetiginization or even to crusting. It should be noted that the skin between the papules on the forearms is normal, and there is no follicular prominence such as is frequently seen in scabies (cf. *Plate LXXX*), especially when sulphur has been excessively applied.

The prognosis in lichen urticatus is always good, although relapses are common.

Treatment is mainly symptomatic. Carbohydrates should be restricted in fat subjects, and attention given to digestive disturbances. Eggs, bananas and sweets—the staple diet, and in my opinion associated factors in poor families—are reduced or interdicted, and a simple rhubarb and soda mixture given thrice daily after meals. In widespread cases a nightly warm bath containing cyllin (potassium permanganate in septic cases) does much to relieve the nocturnal exacerbations. Their effect is enhanced by a zinc and starch dusting powder, or calamine lotion containing up to 5 per cent of liquor picis carbonis.

In cases which do not yield to these simple measures, I have found the Pasteur-Vallery-Radot treatment—administering 1 drachm of Witte's peptone, exactly one

PLATE LVI



LICHEN URTICATUS

hour before each meal—occasionally of striking help, but for the overworked mother with several children it is rather difficult to carry out.

Urbach's propeptans are used successfully sometimes on much the same basis. In very obstinate cases I have found the addition of 1 to 2 minims of Fowler's solution to the rhubarb and soda mixture distinctly helpful.

Table of Differential Diagnosis

Lichen Urticatus	Scabies	Pediculosis	Varicella and Variola
Age— Infants and young children.	Any age.	Any age.	Any age.
Infectivity— Nil.	One or more cases in family.	Occasional.	Highly infectious.
Localization— Face, scalp, trunk, buttocks, limbs.	Between the fingers, wrists, anterior axillary folds. Peri-umbilical — lower buttocks, and round ankles and on soles in young children. Frequently on prepuce.	Posterior scalp, shoulders, pubic and axillary hairs.	Forehead, face, backs of wrists. Trunk.
Lesions— Urticarial papules, with or without vesicles. Superficial pustules, or blood-crusted papules and crusts.	Burrows. Erected follicles due to scratching or sulphur.	Linear scratch marks. Presence of parasites or ova on hairs.	Deep or superficial papules, vesicles, and papules which are umbilicated in variola. Few or no scratch marks.

LUPUS ERYTHEMATOSUS

(PLATE LVII)

THE chronic fixed type of the disease is well illustrated in this plate. The slightly mauve or violaceous tinge is highly characteristic. The patch is of irregular shape, and is slightly raised above the surface. It extends over both zygomatic arches almost symmetrically backwards to the temporal regions and post-auricular and mastoid areas. The eruption has been in evidence for about two years, and is spreading, as frequently happens, to the bridge of the nose, eventually to complete the typical 'butterfly' localization so frequently described in this disease.

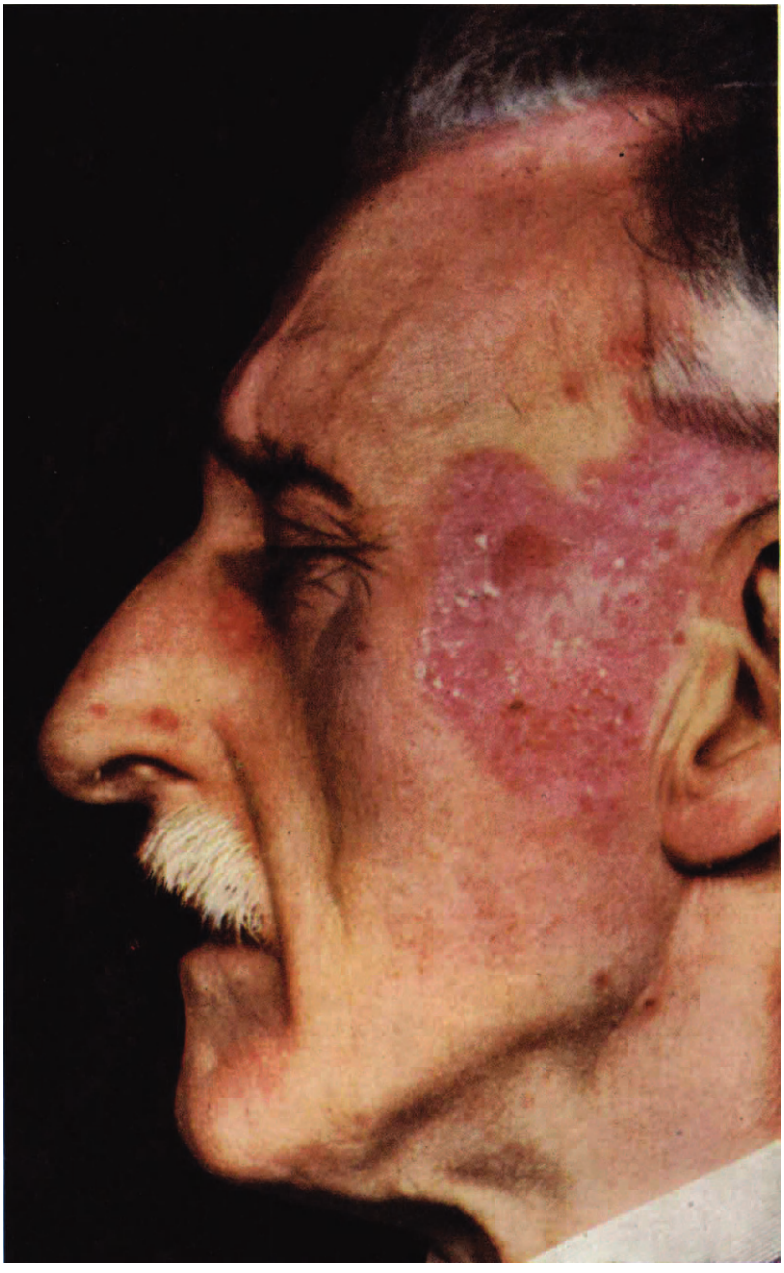
If, and when, and by whatever means, the case is cured, there is certain to be residual atrophic scarring, which is already apparent in the centre of the large patch. This feature is common to all types of the disease and is a valuable aid in the diagnosis. Other points to be observed are the constancy with which the sebaceous follicles are involved, leading in many instances to the deposition of a tenacious scaly pellicle or crust at the mouths of the oil-ducts ; the tendency to bilateral symmetry, whether involving the cheeks only, or, as in this case, the temporal and post-auricular areas ; and the occasional involvement of the lips (*see Plate LIX*) and buccal mucous membrane.

The aetiology is not firmly established, but a considerable percentage have suffered from tuberculous adenitis in childhood, while in some the removal of infected tonsils or carious teeth has effected great benefit, pointing to the septic or streptococcal factor as a possible association in the causation.

Spontaneous evolution sometimes occurs, but may take years, and may leave unsightly white or brownish pigmented scars in its train.

Treatment includes the removal of any obvious and accessible focus of infection in the mouth or pharynx, and the intramuscular injection under careful control of bismuth or gold compounds. The ever-present danger of aggravating existing lesions, of flaring up a chronic case and rendering it acute, or of precipitating an attack of nephritis or acute exfoliative dermatitis by gold injections, should always be borne in mind. Local treatment with caustics such as lactic and carbolic acids, X rays, or the Kromayer lamp, is not in favour among dermatologists at the present time, but the uncertain effects of and at times dangerous reactions to aurotherapy have influenced a return to the safer local application of carbon dioxide snow, which formerly held priority of place in the treatment of this most intractable condition.

PLATE LVII



LUPUS ERYTHEMATOSUS

LUPUS ERYTHEMATOSUS

(PLATE LVIII)

LUPUS ERYTHEMATOSUS of the hands is rare and exceedingly difficult to diagnose if the typical 'butterfly' appearances of the face and the root of the nose are lacking.

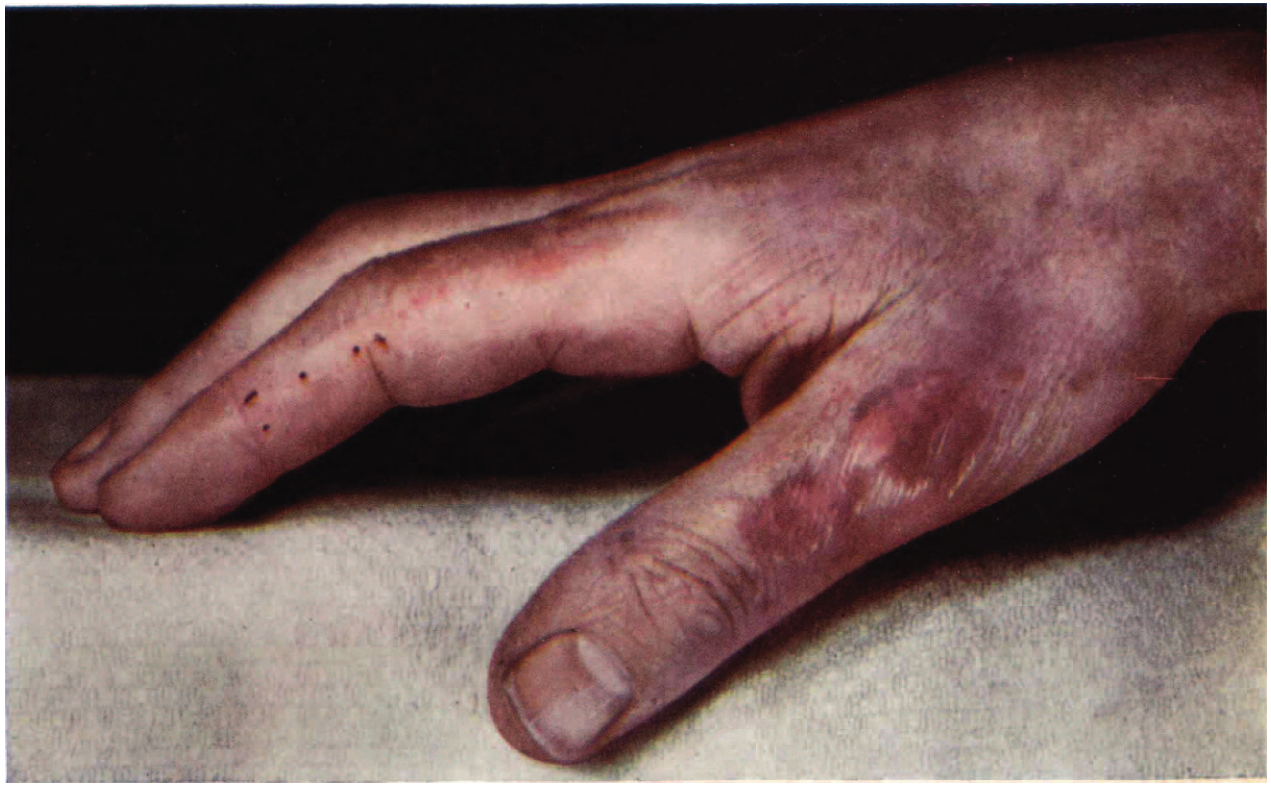
The brownish-violaceous lesion here depicted on the radial border of the thumb is slightly atrophic and sunk below the surface. At this somewhat late stage the originally follicular site of the condition has been obscured by atrophic scarring of a delicate character, without which a diagnosis would not have been possible. It is a feature which sharply differentiates the condition from chilblains, which if they ulcerate eventually produce much smaller and less evident puckered cicatrices.

The aetiology is still undecided and opinions are still divided between a tuberculous and a focal septic causation. Until the point is settled we are not likely to make much progress in our therapeutic endeavours, and it should be borne in mind that the disease is often capricious in its reactions to local applications, and that great harm can be done if the early signs of intolerance, such as increased erythema, spreading of the lesions, pyrexia, etc., are ignored. Even strong sunlight may be dangerous, and I have records of a case in which after a four hours' exposure of the face and neck to the direct rays, the patient, an unmarried woman of 24, developed the acute disseminated variety of the disease, and after four months in hospital with severe general symptoms, eventually died with all the manifestations (including positive blood-cultures) of a streptococcal septicæmia.

The frequently pernicious effect of sunlight is not, I think, sufficiently emphasized by contemporary writers on the subject. The common localization of lesions on exposed areas, e.g., the face, ears, and backs of the hands is significant, and it is further interesting to observe that some of the patients have been previously engaged for years in occupations in which artificial (electric) light has had to be substituted for natural daylight. (A recent case of mine had been working for over twenty years in a slaughter-house in which the main source of illumination was an arc lamp.) They have thus been only vicariously exposed to sunlight at week-ends or on holidays—criteria which would seem particularly favourable to the development of sensitization to ultra-violet rays.

It is further significant that most of the patients declare themselves more comfortable in winter than in the spring or summer months.

PLATE LVIII



LUPUS ERYTHEMATOSUS

LUPUS ERYTHEMATOSUS

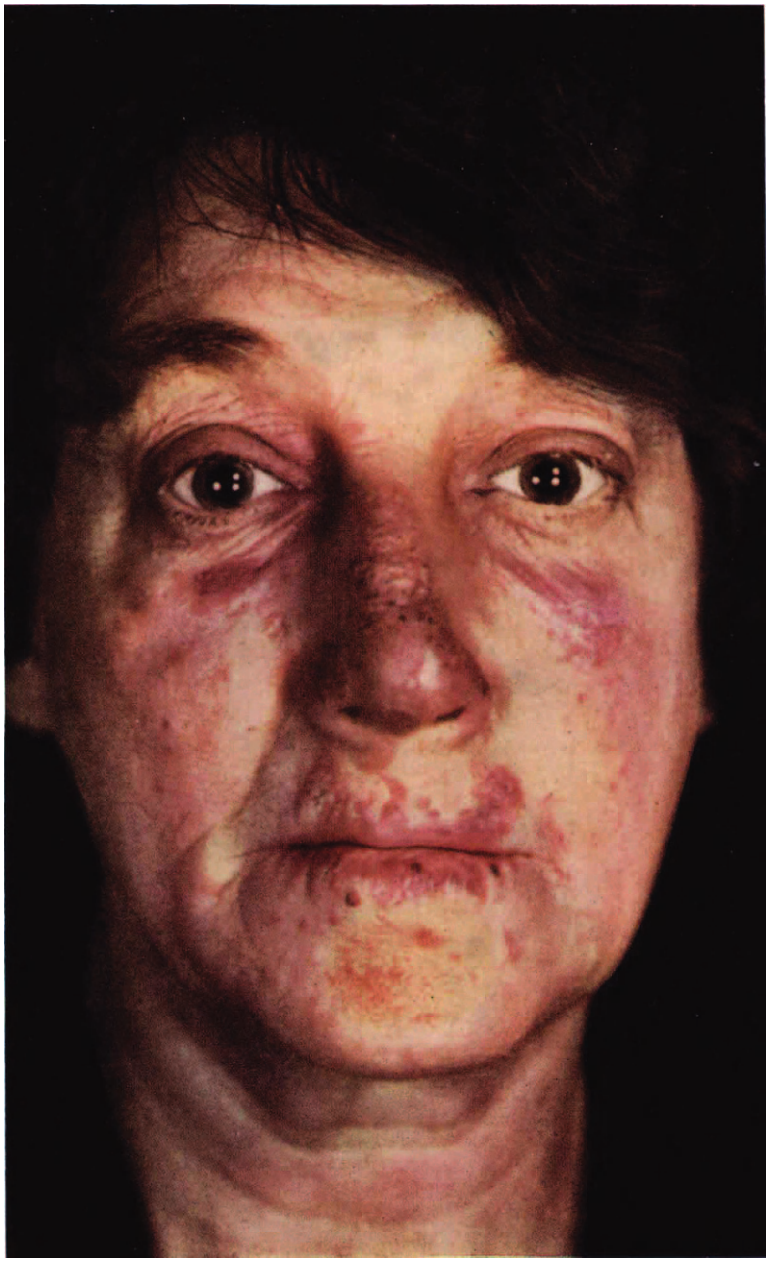
(PLATE LIX)

THE well-developed ' butterfly ' type of the disease is decidedly less common than it used to be before the last war. The reason for this is probably that cases are seen and treated earlier and with much greater success by present-day methods. The following points in the diagnosis are apparent: (1) The distribution on the nose, cheeks, and lips; (2) The characteristic slightly violaceous colour and the presence of the peculiar adherent follicular plugs in the centre of the nasal patch. Cicatrization or atrophy, another constant feature, is not present here because the eruption has been only three or four months in existence.

The reader is referred to p. 130 for treatment, etc.

Those further interested will do well to consult Goldsmith's *Recent Advances in Dermatology*, chapter ix, which he has devoted to a complete summary of modern views on the aetiology and treatment.

PLATE LIX



LUPUS ERYTHEMATOSUS

135

LUPUS VERRUCOSUS

(PLATE LX)

THE verrucose type of cutaneous tuberculosis is distinguished by its extreme chronicity and the marked tendency to recurrence even when apparent local eradication has been completed. Certain occupations are especially exposed to the possibility of infection—e.g., butchers, and the workers in post-mortem rooms—by reason of the actual handling of infected tissues. Such persons present the warty granuloma on the knuckles or backs of the hands. Nodules such as are met with in lupus vulgaris form the basis of this infection also, but are seldom demonstrable because they are obscurred by the fibrous and papillomatous overgrowth, which is a characteristic feature, and sometimes leads to the erroneous diagnosis of simple wart. The differentiation is not difficult, for in lupus verrucosus there is usually scarring, and a spreading edge of proliferative dark-red violaceous or purple granulation tissue, sometimes of low vitality, and prone to ulcerate.

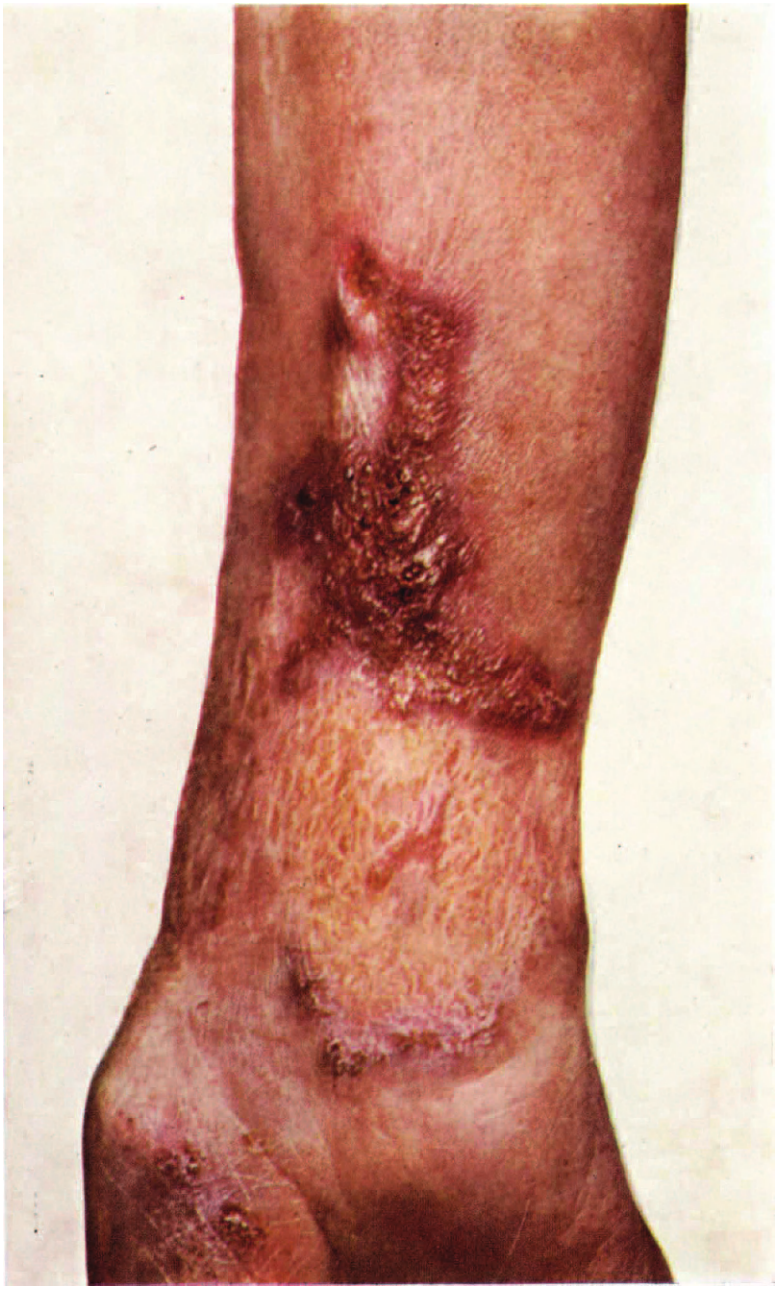
These points are clearly visible in the plate, which presents the flexor aspect of the forearm in a man of 65 who had had the disease for many years. The roughly circular depigmented scar is bordered at its lower edge by a narrow rim of brownish nodules. The disease is relatively stationary here, but is obviously spreading along an irregular line above, where a combination of hypertrophy, scarring, and ulceration affords a clinical picture not easily forgotten.

The features of tertiary syphilitic ulceration (*see Plate XCII*) differ notably from these. The progress is far more rapid (months instead of years), the outline of the ulceration is circular or circinate, and the ulcers are ' punched out ' in appearance.

Treatment of lupus verrucosus is mainly surgical—by the sharp spoon, or radical excision when possible. In the former case it should be followed by the application of pyrogallic acid ointment (10 per cent) for as long as the patient can stand it—or by salicylic acid and creosote plasters (Beiersdorf No. 78). Supporting treatment by diet (salt-free), carbon-arc light baths (the grenz rays, but *not* X rays), or tuberculin injections is also indicated.

It should always be borne in mind that many cases of this disease have pulmonary tuberculosis as well, and careful exclusion of this more serious condition is advisable before any drastic operative procedures are begun. I have twice seen hæmoptysis ensue after scraping a patch of the disease.

PLATE LX



LUPUS VERRUCOSUS

LUPUS VERRUCOSUS

(PLATE LXI)

INFILTRATED verrucose lesions about the knuckles, always characterized by extreme chronicity and highly resistant to all forms of treatment, are the leading features of lupus verrucosus.

The patients are often butchers, a fact which suggests the bovine tubercle bacillus in the aetiology. But I have been struck with the frequency of an associated pulmonary tuberculosis which may be latent when the patient presents himself, and which can be flared up by injudicious treatment, especially ultra-violet light, when given as a general irradiation.

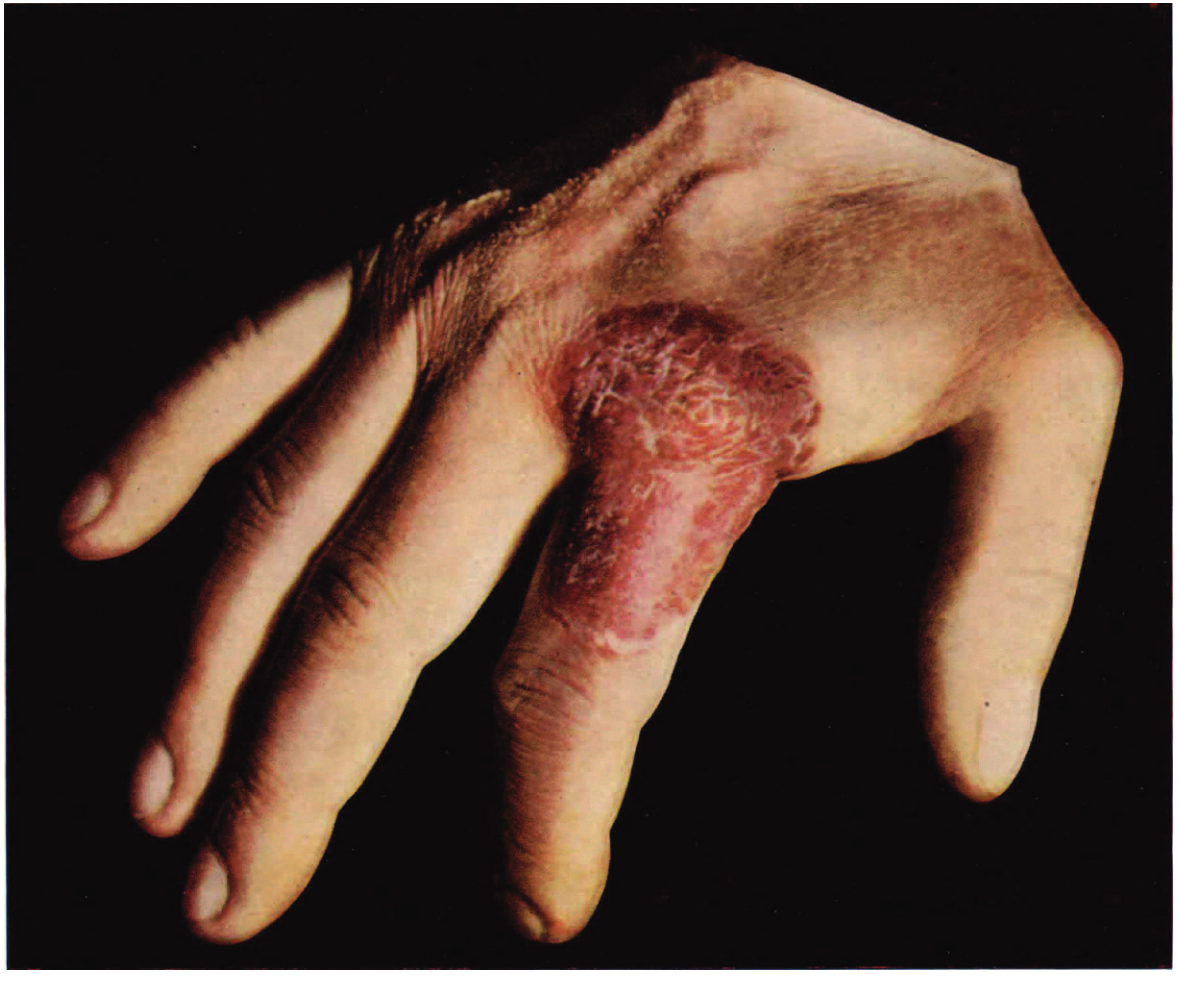
It follows that all cases of lupus verrucosus should be examined by auscultatory, radiographic, and other means for evidence of a more serious infection.

The patient with the lesion illustrated had been treated for chronic pulmonary tuberculosis some ten years previously and had developed the cutaneous manifestations after discharge from a sanatorium four and a half years later. The tuberculin test was strongly positive as it usually is in such cases, and on pressure with a glass slide the 'apple-jelly' nodules, such as characterize lupus vulgaris, were clearly demonstrated. They are rarely seen when a marked verrucose reaction has occurred.

Differential Diagnosis.—In this case the verrucose element is not conspicuous, and we should have to consider the possibility of a syphilitic aetiology. Such would be negatived by the long history, the presence of apple-jelly nodules, and a negative Wassermann reaction. Other granuloma due to mycotic infections, etc., hardly need consideration. Tuberculosis is almost the only disease that could produce such a picture over so long a period, but I once saw a rodent ulcer in a similar situation in a woman of 45, in whom the diagnosis was proved by a microscopic section, and the result of treatment by radium was completely successful.

Treatment.—This must not be too vigorous for fear of lighting up the pulmonary lesion, and for that reason general ultra-violet-ray baths were barred. Similarly I was averse to the curette, which is a rapid and useful method in uncomplicated cases, if it is followed up by pyrogallic (10 per cent) ointment applications for a time. The patient is having a course of tuberculin injections for a month or two to raise his resistance, and later we shall have to make a decision between local treatment with the grenz rays, the Finsen light, or some form of caustic application such as the creosote-salicylic acid plaster (Beiersdorf No. 78).

PLATE LXI



LUPUS VERRUCOSUS

LUPUS VULGARIS

(PLATE LXII)

THESE typical 'apple-jelly' nodules on the inner side of a young woman's arm have been present without any other evidence of a tuberculous diathesis since childhood. In colour, in size, and in conformation they present all the features of this all-too-common variety of tuberculous infection—which since it is rarely seen in private practice may be justifiably called a disease of the poor.

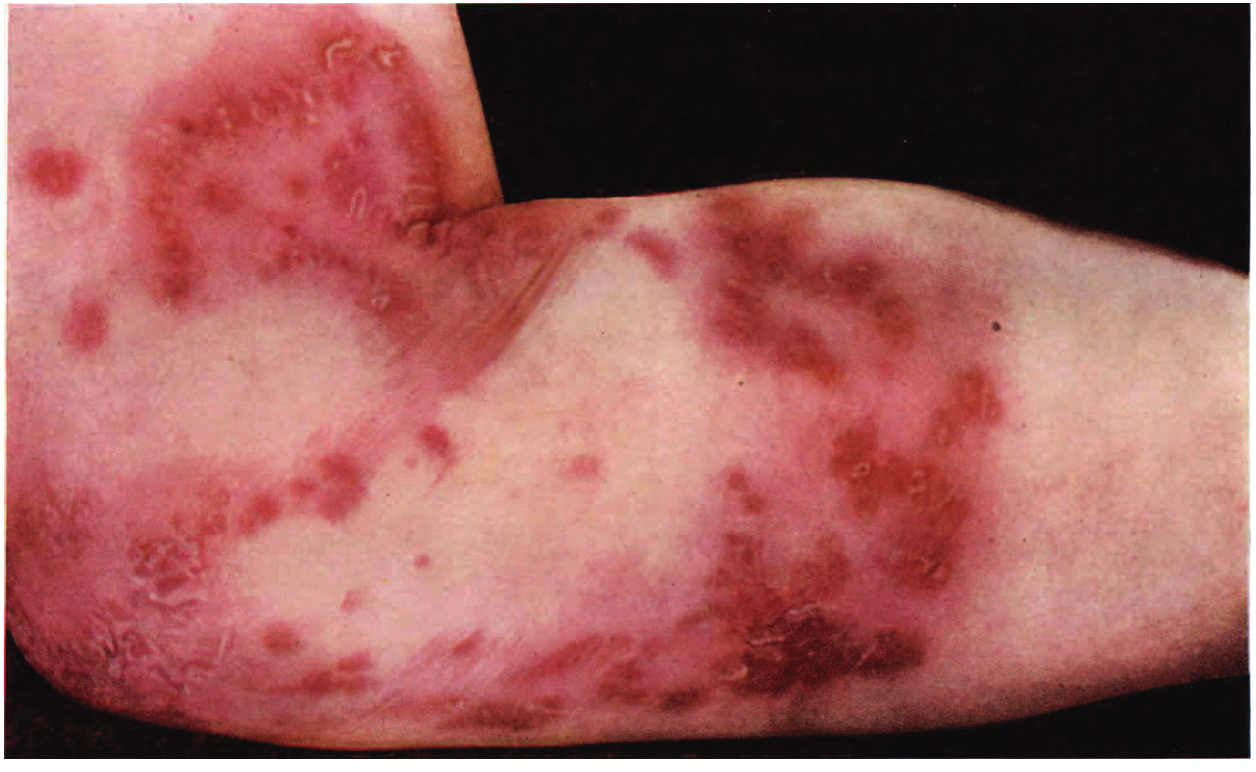
The case has been treated by carbon-arc light baths and local caustics for the last five years, and is now undergoing a course of tuberculin injections while awaiting the installation of a new Finsen-Lomholt lamp. It will be noted that the infection is spreading in a circinate form both above and below the joint, where the apparently isolated nodules—the spread is by lymphatic invasion—are gradually becoming aggregated and will presently form a patch in which ulceration is liable to occur at a later date. The scaling, which is most marked at the elbow, is a common feature, as also is the *tendency for recurrence of nodules in areas previously scarred* by the infection.

The diagnosis, which in this case is easy, is made on the colour, the consistency of the nodule, which is very soft and easily perforated by a sharpened match, the recurrence of nodules in the scar tissue, and the long duration.

Treatment.—The Finsen lamp is still the best individual local therapeutic measure, but it demands an infinity of patience, by both the operator and the subject. The best lamps are expensive to install and maintain, and not infrequently need skilled mechanical repairs or overhaul.

Bearing in mind that the principles of treatment for this most chronic of skin diseases are (1) the destruction of the tuberculous nodule and (2) the raising and maintenance of the patient's resistance, it should be possible for a keen practitioner to treat the majority of patients at his surgery, and without recourse to surgical procedures or those involving the more elaborate and costly methods now available in a few large towns of the United Kingdom. He can destroy isolated nodules by weekly insertion of a sharpened match dipped in pure acid nitrate of mercury (Adamson), or by injecting into or just under them 0.1 c.c. of ethylphenyl hydnocarpate—a derivative of sodium morrhuate—also at weekly intervals, and not more than 2 or 3 c.c. at any one session. If the nodules are aggregated into large patches he can cover them for a week at a time with Beiersdorf's creosote and salicylic acid plaster, until destructive ulceration has occurred, and then dress with boric ointment during the rapid healing which always ensues. Such measures consistently and carefully carried out will often suffice to effect a local cure in all but the most extensive and inveterate cases and those in which cartilage is involved. They should be associated with graduated exposures of the whole body to the sun or the carbon-arc light bath, and further supported by resort to the 'H.S.G.' (Herrmannsdorfer-Sauerbruch-Gerson) diet, the main principles of which are exclusion of sodium chloride, restriction of

PLATE LXII



LUPUS VULGARIS

water, plenty of uncooked fresh vegetables and their juices, raw eggs and milk, cod-liver oil, and a low carbohydrate proportion.

In my own experience the best, most rapid, and most lasting results are obtained by graduated exposure of the whole body to the sun, *with protection of the affected areas*—as practised at Leysin in Switzerland in Prof. Rollier's clinic. He uses no local treatment whatever, advises no special diet, and seems to obtain favourable results in almost every case, no matter how deeply involved or how long the duration. It is interesting and significant that in only one (out of five) of my cases *in which previous X-ray treatment* had been applied, did he fail to clear up the local manifestations of the disease. The most extensive, in which there was complete destruction of both nasal and aural cartilages, and the whole face was disfigured by granulomatous and ulcerating patches, cleared up completely in 11 months and the patient has remained free of all but very minor recurrences during the 14 years he has been under observation. It is cogent to observe that the treatment compares most favourable as regards cost with any method in which hospitalization is involved, while home-sickness is efficiently counteracted by giving the patient occupation of a light kind, and where possible in his own trade or employment.

LUPUS VULGARIS: X-RAY PIGMENTATION

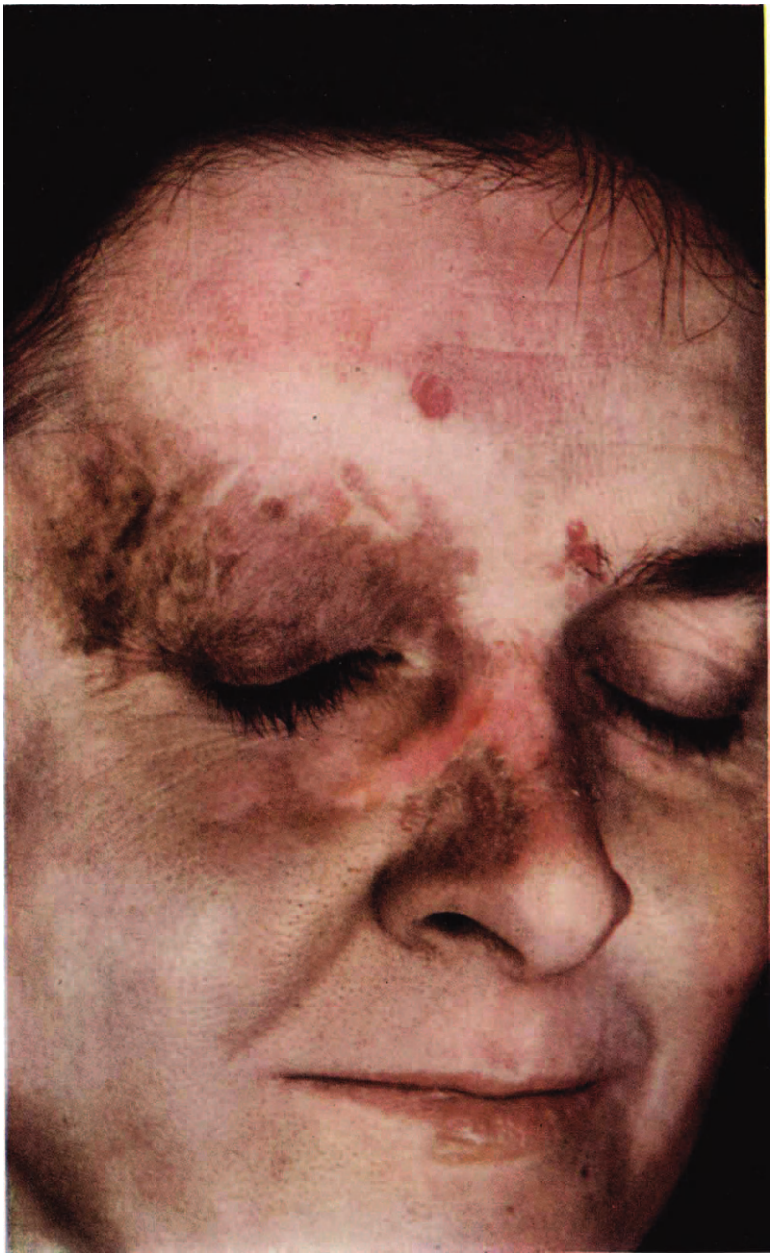
(PLATE LXIII)

THE case illustrates the effect of treatment as much as the ravages of the disease. It will be noted that the hairs of the right eyebrow have entirely disappeared, and while their destruction can be effected by the tuberculous process it is a much more common effect of excessive X-ray therapy. Unmistakable evidence of the latter is afforded by the mass of pigmentation at the outer orbital angle, and the telangiectatic condition of the skin on the bridge of the nose. The delicate white cicatrix is the result of Finsen light treatment, and at its left and central upper margin are two active lupus nodules. These are present in considerable numbers on the right side of the nose below the reddich scar, and demand early and energetic treatment, preferably by the Finsen lamp, if further destructive effects are to be prevented.

The treatment of lupus by X rays has been almost universally abandoned. Not only are the results frequently disfiguring, but X-ray ulcers and the late development of epithelioma have been recorded by several authors.

It may be that in the grenz or borderline rays with which Mr. Anthony Green is treating some selected cases at the radiotherapeutic department of the Royal Northern Hospital, we shall find an equally powerful and much safer weapon to add to those which time and experience have proved effective and reliable.

PLATE LXIII



LUPUS VULGARIS: X-RAY PIGMENTATION

MOLLUSCUM CONTAGIOSUM

(PLATE LXIV)

THE typical lesion is a small raised pearly or opalescent papule, with a depressed centre, from which the wax-like constituents can be easily expressed. The central dimpling is characteristic, and is indicated in the lowest of the lesions on the plate an inch from the posterior axillary border. In the early stages and in untreated cases there is no inflammatory areola such as is noted in some of the papules, most of which have been partly destroyed by the application of a caustic. The patients may apply this themselves, and the diagnosis has frequently to be made, as in this example, on one or two typical lesions alone. Left untreated the papules may spread widely, and are commonly seen on the face, genitals, and any other part of the body.

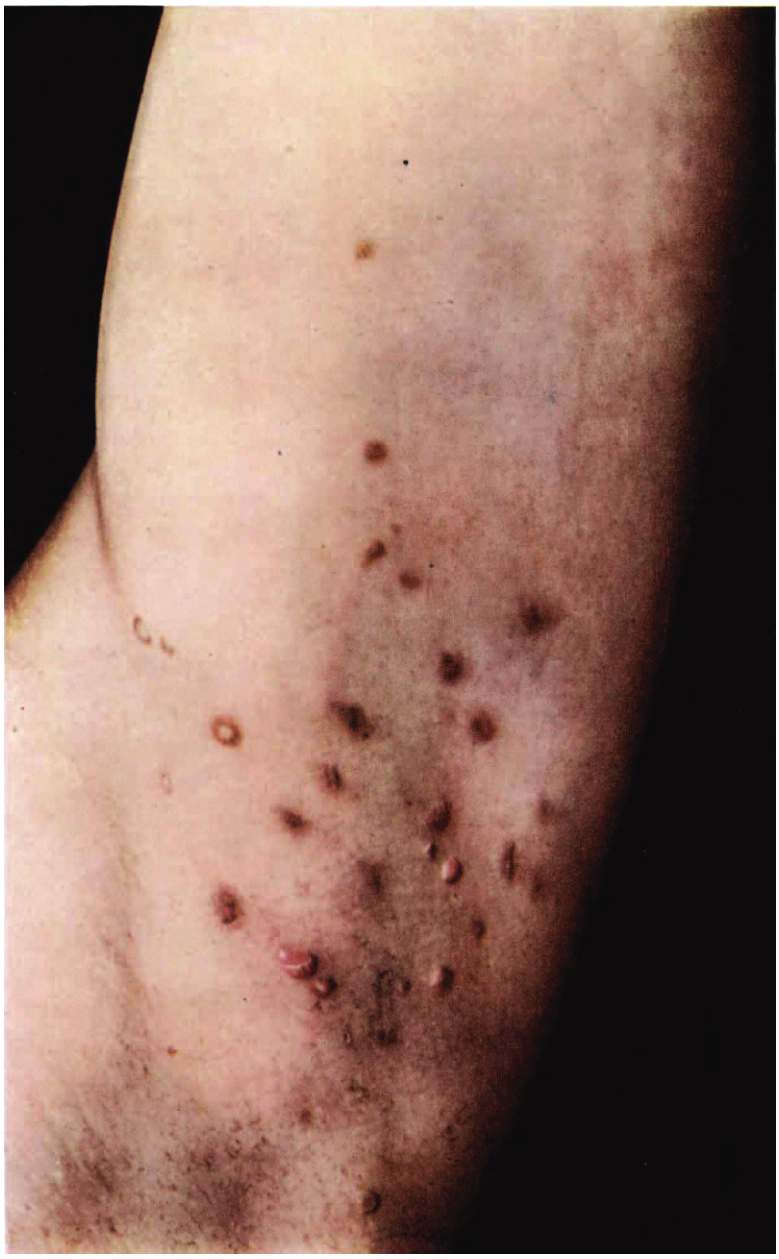
A cure may be brought about by spontaneous or induced suppuration, or, on the other hand, the lesions may persist indefinitely. In some cases there may be a local conglomeration leading to the formation of quite alarming tumours (*see Plate LXV*), the nature of which will be difficult to diagnose unless one or two typical lesions can be seen in the vicinity. A further aid to diagnosis is the presence of the so-called molluscum bodies, easily seen in the expressed cheesy detritus, under a low-power objective.

Aetiology.—There is no doubt that the infective agent of molluscum is a filterable virus. It was the first proved connection of a virus with any human dermatosis (Juliusberg, 1905). It is pathognomonic to man only, the incubation period is 5 weeks, and there is strong presumptive evidence that the Turkish bath is the most frequent source of contagion.

Treatment.—The contents of the lesion should be squeezed out or curetted, and the interior cauterized with pure carbolic or a saturated solution of salicylic acid in spirit, on a pointed wooden match. The stronger caustics ought not to be employed. In cases affecting the eyelids, as occasionally occur in children, the point cautery may have to be used under general anæsthesia. (N.B.—On account of the risk of explosion ether must never be employed.)

Goodman claims that sparking with a monopolar high-frequency current is a more effective and a cleaner procedure than curetting or the application of caustics.

PLATE LXIV



MOLLUSCUM CONTAGIOSUM

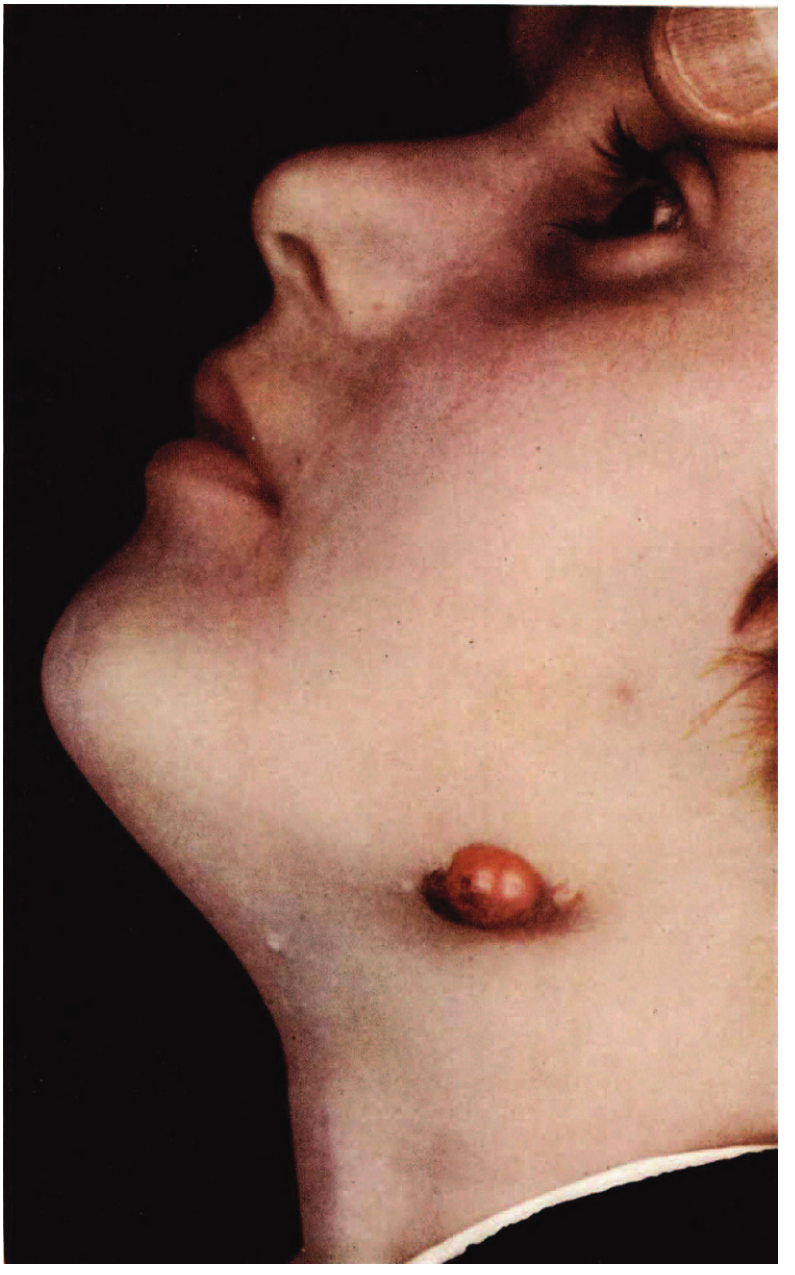
MOLLUSCUM CONTAGIOSUM
(Giganteum)

(PLATE LXV)

THE diagnosis of this remarkable variety of the condition termed molluscum contagiosum giganteum is afforded by the two small pearly white molluscum lesions anterior to it. A little less than life-size, this tumour is probably the result of superinfection with the staphylococcus. Under digital pressure the typical cheesy material was expressed from it, and molluscum bodies were demonstrable under the microscope.

One treatment with the cautery sufficed to effect a clean and uncomplicated cure, both of the main tumour and its satellites.

PLATE LXV



MOLLUSCUM CONTAGIOSUM (Giganteum)

149

MONILIASIS
(Thrush)

(PLATE LXVI)

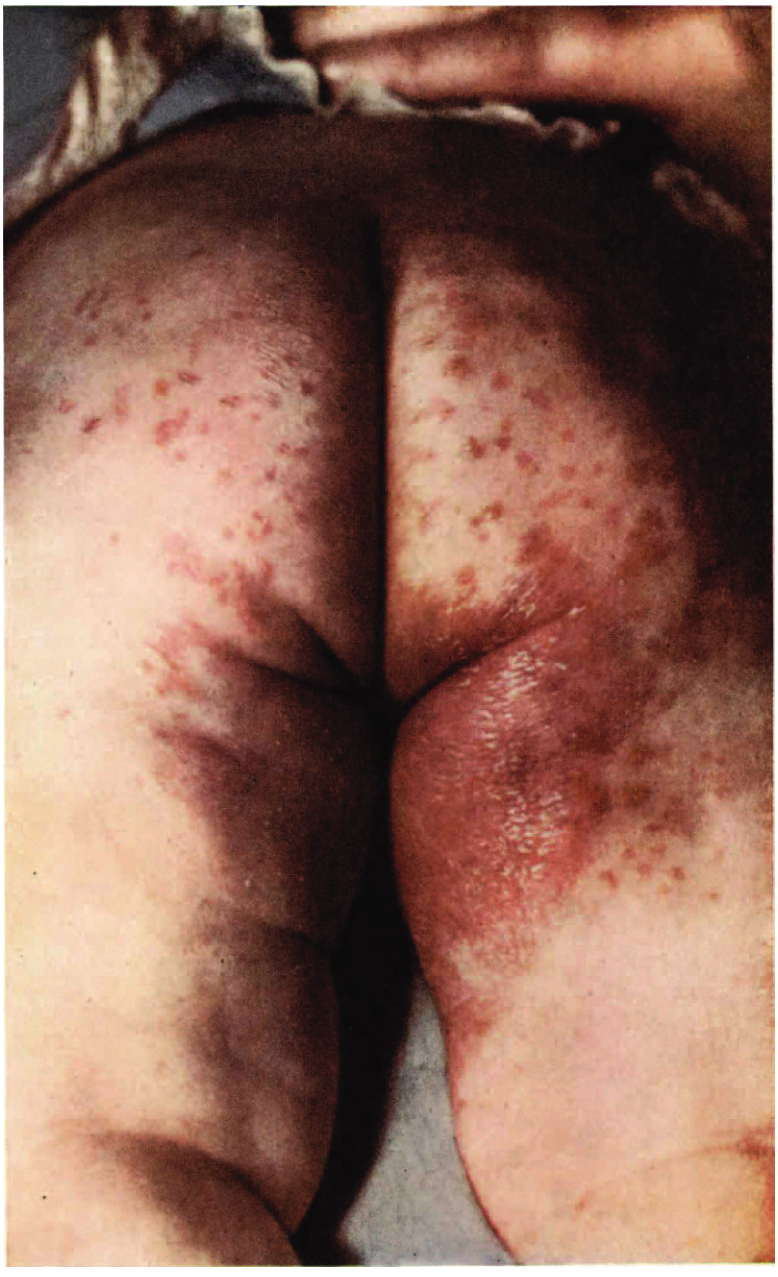
MONILIASIS or thrust infection of the skin is usually obscured very soon by secondary streptococcal or staphylococcal superinfection. We were led to the diagnosis in this infant by the discovery of buccal thrush lesions, and the demonstration of a delicate branching mycelium in potash preparations from the minute vesicles on the skin of the buttocks. The eruption would otherwise have been regarded as a streptococcal intertrigo, from which in fact it is indistinguishable clinically.

Attention to the mouth by hourly cleansing with glycerin of borax, the administration of grey powders, and the local application to the skin of lotio nigra with calamine lotion in equal parts, had a rapid curative effect.

It is essential to differentiate the condition from an acute maculopapular syphilide. This would be composed of more discrete, copper- or raw-ham-coloured lesions, which might have been found also on the palms and soles, together with pallor and marasmus, anal condylomata, snuffles, splenic and hepatic enlargement, and the other signs of the luetic state, in which a positive Wassermann reaction in both the mother and the child would have been decisive.

Treatment.—I am indebted to Dr. Bernard Schlesinger for the information that in resistant cases swabbing with dilute solution of mercurochrome (1–1000) has proved most effective in both cutaneous and buccal localizations.

PLATE LXVI



MONILIASIS (Thrush Buttocks)

NÆVUS VASCULARIS

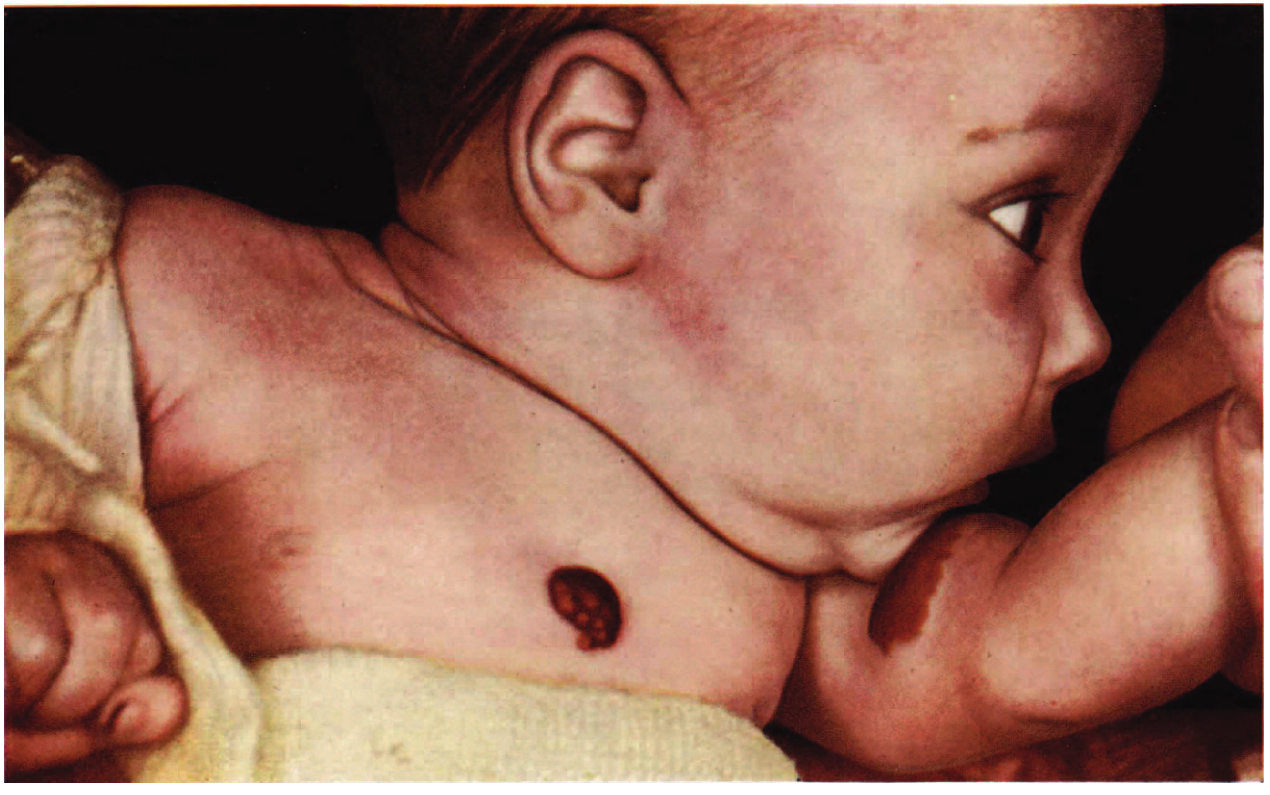
(PLATE LXVII)

Two examples of this, the 'strawberry mark', the commonest type of birth-mark, are here illustrated. From the practical point of view it is the most important, for it is the easiest to cure. Such nævi may occur on any part of the integument (most frequently on the head and neck), and the sex incidence is about equal, although female children are more frequently brought for treatment.

The structure of vascular nævi varies with their depth. The superficial type or 'port-wine' stain is a simple capillary plexus; the 'strawberry marks' may contain deeper vascular dilated intercommunicating channels, which have given them the name 'cavernous'; and finally there is the single dilated vessel with enlarged communicating capillaries—the spider nævus—the aetiology of which is certainly not always congenital, for in telangiectactic form it may occur in any scar, and especially in that following an X-ray burn.

Treatment of the raised vascular superficial strawberry mark has been practically standardized by the use of the carbon-dioxide pencil. This should very slightly overlap the cross-section diameter of the lesion, and should be applied with moderate pressure for not more than 12 seconds. It should be remembered that whereas insufficient effect can always be amplified in a subsequent session, too deep or too extensive a treatment cannot be so easily remedied. This assertion applies with special significance to the application of X rays or radium. They should be used by the expert only, and the interested reader would do well to study the special technique described in Molesworth's *Introduction to Dermatology*, 1937, 395–7 (London: J. & A. Churchill, Ltd.). For vascular nævus (hæmangioma) he claims better results by correct X-ray treatment than by any other method. It would certainly be indicated in cavernous types, i.e., with underlying and interconnecting vascular channels up to half a centimetre or more in depth, in preference to freezing by CO_2.

It should be noted that the strawberry type of vascular nævus frequently disappears spontaneously, a fact which accounts for its rarity in the adult, and one which should be allowed due weight in considering treatment.



NÆVI VASCULARES

PARONYCHIA

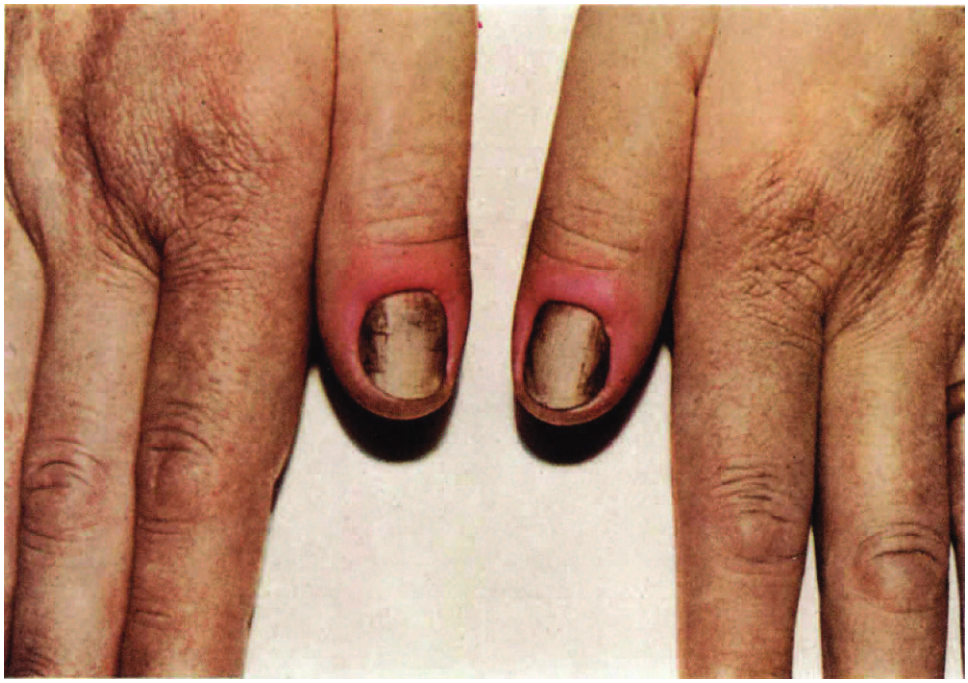
(PLATE LXVIII)

PARDO-COSTELLO, in his excellent text-book, *Diseases of the Nails*, 1936, 159 (London : Baillière, Tindall and Cox), tabulates the occupations in which diseases of the nails are common. In forty-three of the trades or occupations listed, paronychia occurs no less than thirty-two times. This I think is conclusive evidence that occupations must play a very important part in the causation of the condition. In seeking a common factor among the trades tabulated it will be noted that with few exceptions they are all connected with water or moisture in some form, and several of them with soap or soda as well. Thus bottle-washers, bar-tenders, bakers, battery workers, book-binders, cooks, chemists, dyers, dish-washers, engravers and etchers, fruit canners, fishermen, houseworkers, laundry workers, nurses, physicians, etc., all have to bear the brunt of constant or intermittent immersion of the hands in water, with or without soap, throughout the day. Is it surprising that as a result of the maceration so caused a chronic infection of the nail-bed at its most exposed part, the quick or nail-fold, should occur ? While monilia and staphylococci may be concerned in the protraction of the malady, it seems quite obvious that the primary or causative factor is the unnatural environment to which the finger-tips are being subjected in nearly 100 per cent of the cases. In London hospitals the majority of the cases are middle-aged women engaged in their manifold household duties, and it is easy to visualize how frequently they are exposed to the special traumatic factors concerned.

It is curious how rarely these are realized, and the plate, which hardly needs description, admirably illustrates the points I have stressed. The brown staining of the thumb-nails is due to daily immersion in hot permanganate solution for ten to twenty minutes twice daily, over a period of five months. As the patient, a middle-aged housewife, showed no improvement under this treatment, removal of the nails had been suggested as the only likely means to a cure. It is amusing to reflect that, although these hot soakings had been ordered, the patient was at the same time instructed *to keep her hands out of water*, so that she had done none of the household washing for all the time she had been under treatment.

Treatment.—It should follow from the above that antiseptics *per se* are of little avail unless the cause is recognized and avoided. In practice this will be found correct, and in my experience none of the many remedies, including the various dyes recommended as a local application, are equal to the drying or desiccating effect of surgical spirit, dusting powders, and avoidance of soap and water, and realization of the moisture that collects inside rubber gloves, if these are worn as a protection. For several years I have used 10 per cent solution of monsol in surgical spirit applied twice daily to the nail-fold with a camel-hair brush, with consistent success. Fomentations should never be used and ointments are equally contra-indicated. Only as a prophylactic in recovered cases ought we to apply grease to the nail-fold, and then with discretion. In the few cases in which these measures fail to restore the tissues to normal, X rays with the usual precautions have proved of great value.

PLATE LXVIII



PARONYCHIA

PITYRIASIS ROSEA

(PLATE LXIX)

FIRST recognized as a clinical entity by Gibert in 1860, and still of unknown aetiology, it is of the utmost importance to differentiate this disease from the roseola of secondary syphilis (*see Plate LXXXVI*). The eruption is rose-coloured, and consists of circular and oval macules from pinhead to finger-nail size, but slightly infiltrated, and in well-developed cases displaying a delicate collarette of fine scales at the periphery and sometimes a fawn-coloured 'crinkly' centre. The typical scaling is well marked in the lesion over the ensiform cartilage on the plate. Another characteristic feature is the stream-line arrangement in the cleavage-lines of the skin, so that the long axis of each macule is more or less parallel to that of the ribs. The outbreak is often 'heralded' by an initial ringed macule (which in the case illustrated may well have been the lesion above indicated) and the ensuing lesions first appear in a satellite fashion around it, and spread symmetrically over most of the trunk and upper portions of the limbs. The vest area is therefore the site of election, and involvement of the face, scalp, palms, and soles is rare. The mucous membranes are never affected characteristically (cf. syphilis), though a simple pharyngitis with slight transient enlargement of the cervical glands is sometimes associated in the early stages.

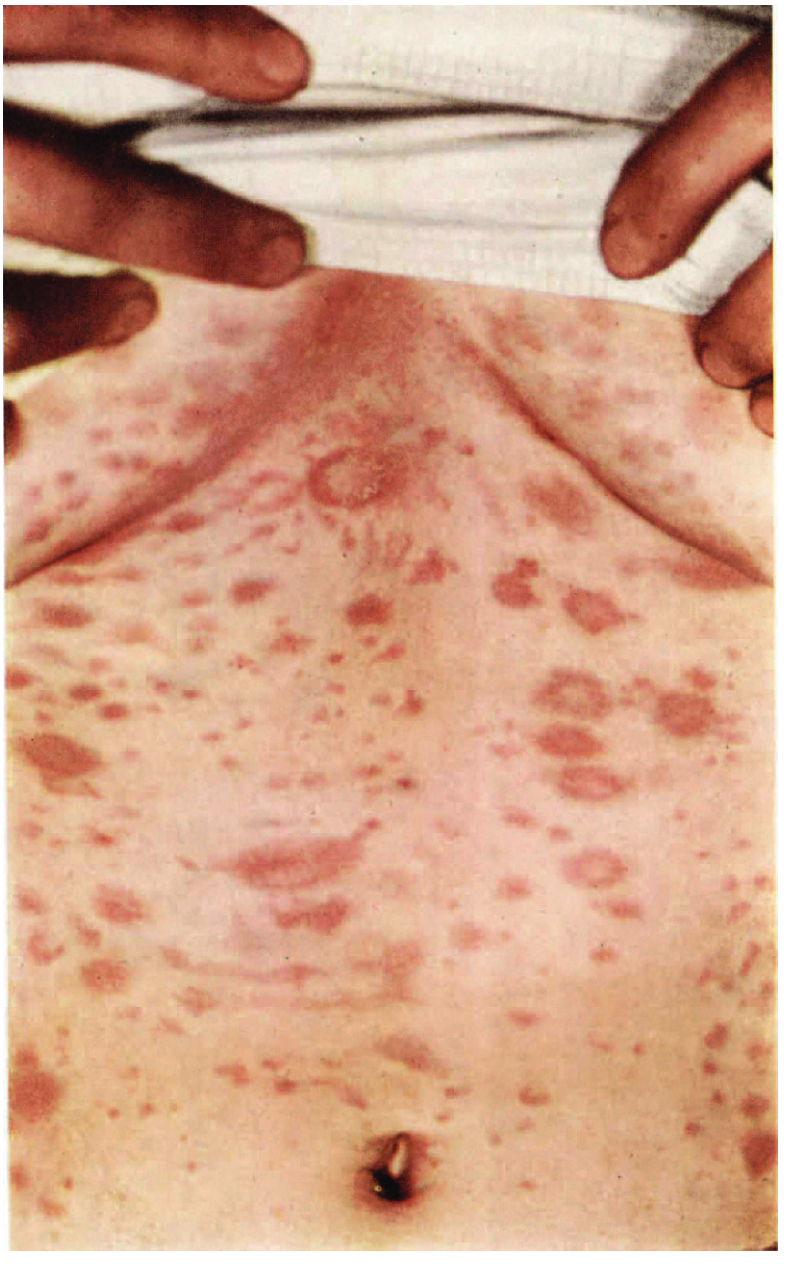
The prognosis may be given with certainty, for involution always occurs in from four to eight weeks, and second attacks are of the utmost rarity.

Symptoms other than occasional itching are rare, and this is best treated with weak permanganate baths and dusting powder, or if greasy applications are not objected to, by a $\frac{1}{2}$ per cent salicylic acid ointment or paste. *Strong applications must not be used*, as they increase irritation and risk aggravation of the exfoliating tendency of the disease. Although the general features suggest an infective cause, we cannot indicate prophylactic measures until we know its nature and source.

Table of Differential Diagnosis

PITYRIASIS ROSEA	ROSEOLA OF SYPHILIS	TINEA CIRCINATA	SEBORRHŒIC DERMATITIS	PSORIASIS
'Herald' patch. Rose colour. Scaly collarette. Fawn-coloured centre. Absence of infiltration.	History or persistence of primary sore. Polymorphic (macules and papules), infiltrated, coppery or raw-ham colour	Reddish squamous rings, with vesicles in periphery. Marked tendency to eczematization, especially on extremities. Few in number	Plaques tend to become larger, and are often irregular in shape and distribution (mid-sternal and inter-scapular sites favoured). Scales greasy and cover more yellowish lesions	Dry typical scales easily removed, leaving red oozing points. Elbow and knee localization common
Mucous membranes escape	Mucous membranes & glands typically involved			
Slight itching	No itching	Itching usually severe		
	Wassermann reaction always positive	Microscopic test		
Symmetrical	Symmetrical	Asymmetrical		

PLATE LXIX



PITYRIASIS ROSEA

PITYRIASIS VERSICOLOR

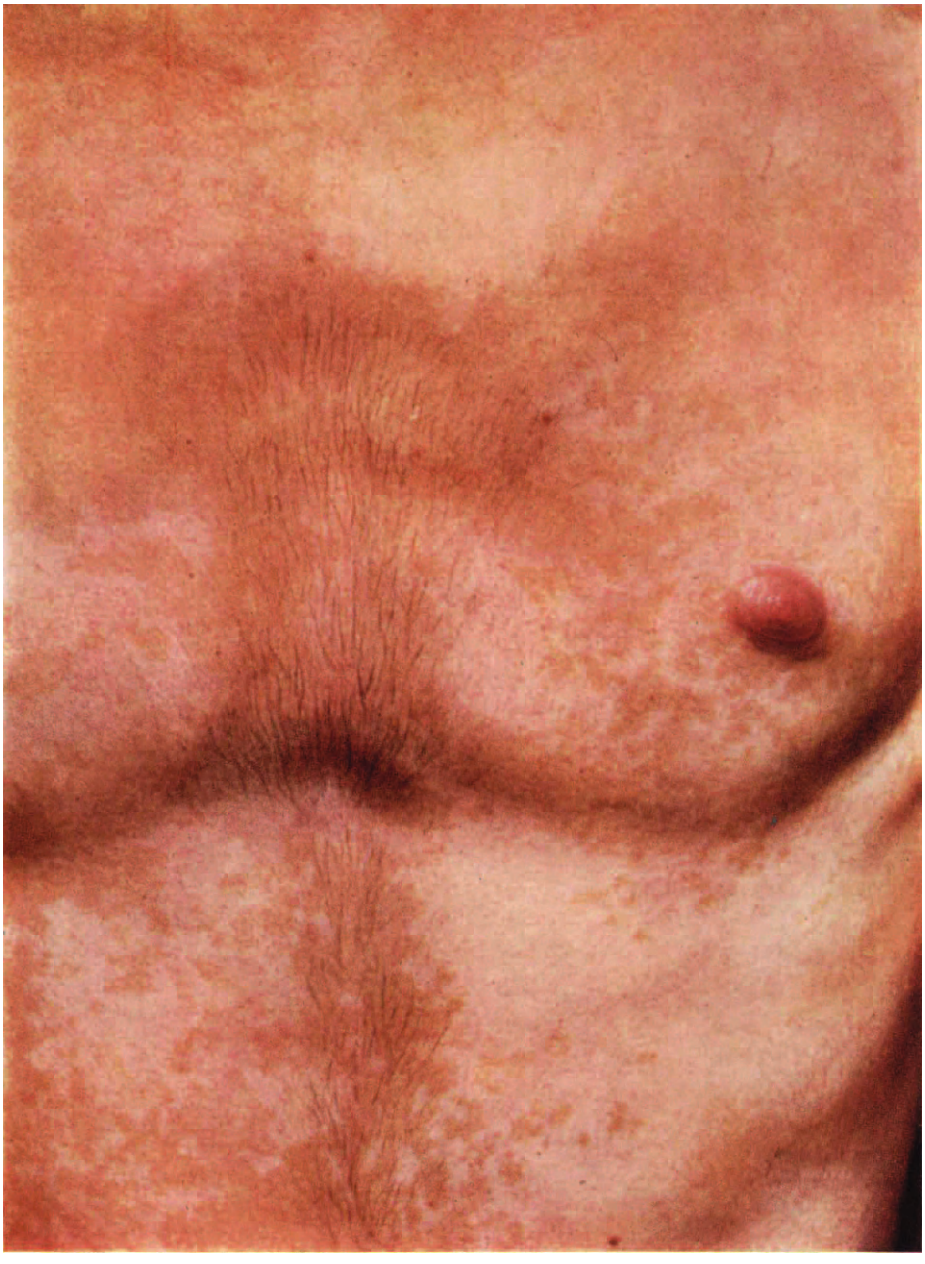
(PLATE LXX)

THE delicate brown or coffee-coloured patches of this entirely benign affection are most frequently seen on the chest and back in persons who perspire freely. For this reason, doubtless, it is sometimes met with in cases of pulmonary tuberculosis, and was once regarded as a manifestation of this disease. It is in fact the result of invasion of the horny layer of the epidermis by the *Microsporon furfur*, which can be demonstrated under a 1/6 objective in scrapings in liquor potassæ. This procedure differentiates it also from pigmentation due to Addison's disease, arsenic, and leucoderma or vitiligo. Pityriasis versicolor never gives rise to inflammatory complications like tinea, although its surface may be slightly scaly, and very slightly irritable in hot weather.

Treatment.—It is easily cured by mild applications of salicylic and sulphur or beta-naphthol ointment (1 per cent), but readily recurs, possibly owing to reinfection from the underclothing. One of the antiseptic soaps containing mercury, sulphur, ichthyol, or salicylic acid should be used for a week or two after clearance.

For both this infection and erythrasma I have found mitigal (Bayer) a most effective, unirritating, and agreeable application. It should be rubbed into the patches once daily and covered with an absorbent powder. Three or four days is usually sufficient to effect a clearance. The areas prone to infection should be swabbed with spirit occasionally and dusted with talc powder.

PLATE LXX



PITYRIASIS VERSICOLOR

PSORIASIS

(PLATES LXXI, LXXII, LXXIII)

THE cause of this widespread disease is unknown. It affects the sexes about equally, and no age is immune, although first attacks are rare at the extremes of life.

While the extensor surfaces, especially the knees (*Plate LXXI*) and elbows are most frequently attacked, no part of the integument is exempt. Psoriasis of the mucous membranes does not occur, and when it is suspected syphilis should be considered in the diagnosis. When special areas, such as the palms and soles (*Plate LXXII*), the umbilicus, and the internatal cleft, alone are involved the diagnosis may be difficult. The nails should then be examined for characteristic pitting, which if present is strong confirmatory evidence (*see Plate LXXIV*).

In moist areas sepsis and fissuring may complicate the picture, and will require alleviation before specific treatment can be undertaken.

It is doubtful if a permanent cure of the disease has ever been accomplished by treatment, as it is subject to spontaneous remissions and recurrences for no apparent reason. Intermittent disease, especially if associated with pyrexia, may initiate a clearance (usually only temporary). Itching is not a feature of the eruption, but sometimes occurs. It is rarer than the rheumatic associations of which some patients complain bitterly.

The initial lesion is a small, dry papule, of a reddish-pink colour. If not under treatment the surface is invariably covered with silvery white imbricated scales. These if peeled off carefully can be removed in two or more layers (imbrication), eventually exposing the summit of the underlying papilla as a small reddish point which tends to bleed.

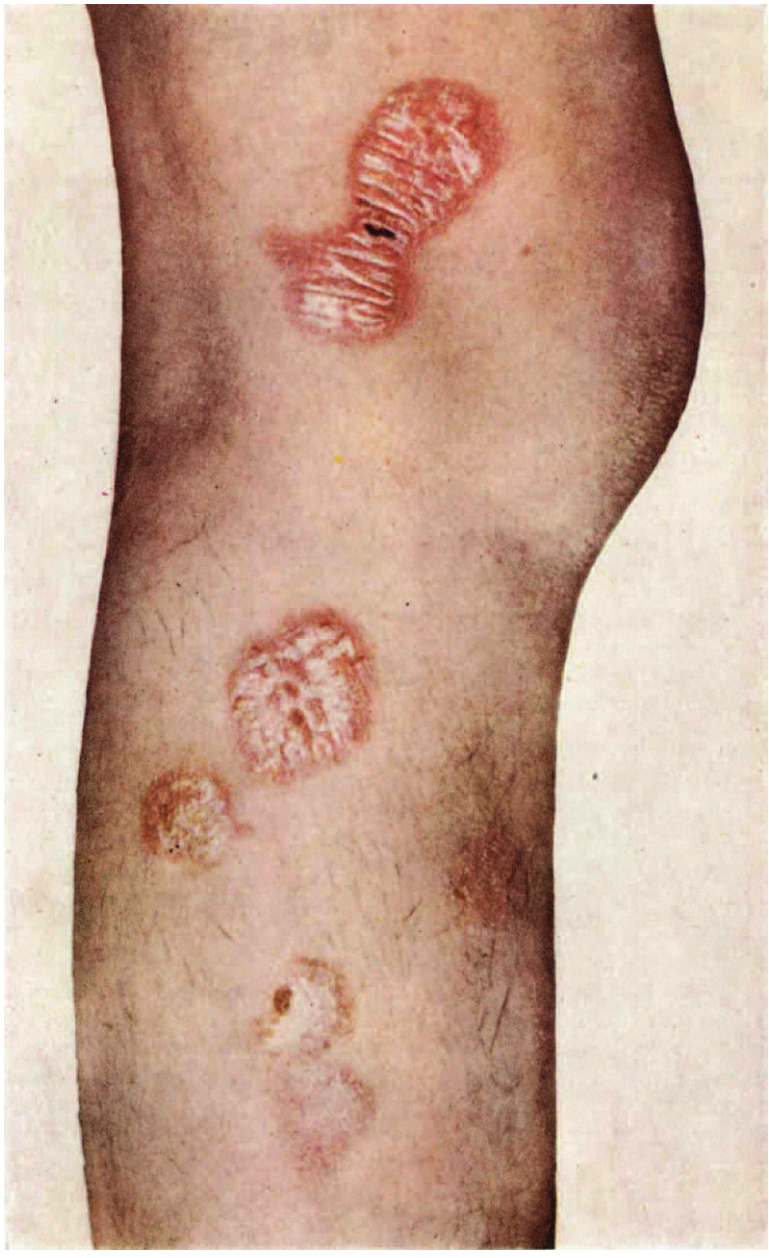
Peripheral extension of the papule gradually adds to its size until it reaches that of about a shilling, when it remains stationary or becomes confluent with other papules to form sheets or patches of various dimensions and outline. Two such, the circinate and gyrate, are depicted in *Plate LXXIII* as they appeared on a woman's back. The small, dry, scaly circular papule almost overlying the inferior angle of the left scapula, and near the middle of the left margin of the plate, is a very typical lesion. Both the colour and scaly silvery surface are true to the original.

Other clinical types (of which two common varieties are presented in *Plates LXXI, LXXII*) differ mainly with the peculiarities of the skin on which they appear. Discoid or coin-shaped patches are the features accurately portrayed in the former.

The symmetrical plantar involvement shown in *Plate LXXII* could hardly be mistaken for the other dermatoses which tend to affect the palms and soles, viz., epidermophytosis (*Plate XXXIII*), tertiary syphilis (*Plate LXXXVIII*), eczema, and lichen planus (*Plate LV*). The small, dry, yellowish, scaly lesions have the appearance of epidermal pustules.* In this case the picture was part of a general eruption, but occasionally it may be localized to the palms or soles alone and difficulties may arise in the diagnosis (*see above*). In some cases the lesions may have a more moist

* Cf. 'PUSTULAR' PSORIASIS (*Plate LXXVI*).

PLATE LXXI



PSORIASIS OF LEG

appearance, and although sterile or nearly sterile on culture, have been labelled ' pustular ' psoriasis (cf. p. 168). When they are isolated or asymmetrical the chances of confusion with a pustular form of plantar or palmar ringworm are considerable. Note that in *Plate LXXII* the lesions have appeared mainly along the lines of greatest pressure.

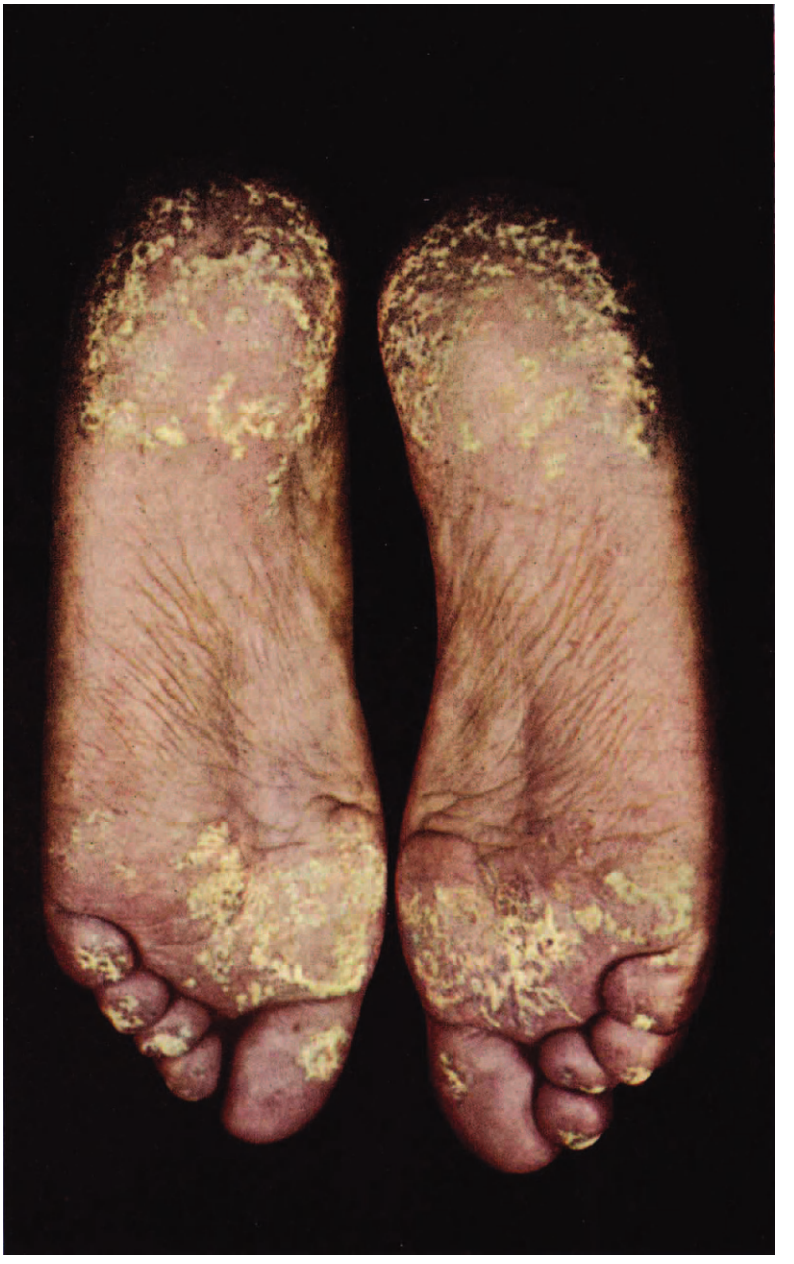
Table of Differential Diagnosis

PSORIASIS	SYPHILIS	ECZEMA
Itching Absent or rare	Absent	Invariable
Localization Extensor surfaces (with exceptions stated)	Any surface. Glands, etc.	Flexor surfaces
Mucosæ escape	Mucous involvement common	Mucosæ not involved
Scales Silvery, dry, invariably present. Red oozing point on removal	Dirty yellow. Leave indurated papule on removal	Sparse and powdery
Type of Eruption Always dry and sharply defined. One type in each case	Polymorphous, i.e., maculo-papular, pustular, etc., in same case. Positive W.R.	Diffuse, papular or vesicular, and sometimes weeping

Treatment.—Depends on the stage and extent of the disease. In acute spreading cases avoid strong applications for fear of provoking generalized exfoliating dermatitis, closely resembling that which may complicate arsenobenzene therapy, and equally serious. Rest in bed, protein-sparse diet, salicylates, and emollient soothing applications are indicated. Mild alkaline baths may prove useful when tolerated. As the condition improves and approaches the more common chronic variety, treat as for this. Never prescribe arsenic to acute cases.

The so-called ' Guelpa ' cure has helped me in more than one case of the acute type, or in those threatening the exfoliative tendency. One ounce of Epsom salts is given per os in a pint of water (if preferred in divided doses, with a cup of weak sweetened tea intervening), on waking. The patient, especially if elderly, is advised to stay in bed and submit to the attentions of a nurse with a bed-pan, for the rest of the day. A reclining posture in case of faintness is always desirable, and for the next 48 hours no solid food of any kind is allowed. Bland fluids, such as weak tea, lemon barley water, orange juice sweetened with glucose, vegetable soup (no meat stock), or Vichy water, are administered copiously. The point is that at least 4 pints of fluid should be taken every 24 hours during this period of starvation, which may be extended, if well tolerated, to 72 or even 96 hours. It is curious how well this apparently drastic treatment is tolerated and how often it is rapidly followed by a deturgescence of the inflamed and dilated skin capillaries, and an ensuing return of the skin as a whole to a less abnormal state. In my experience the patients never

PLATE LXXII



PSORIASIS OF SOLES (in a Generalized Case)

complain of hunger, a fact which is probably due to the temporary disturbance of normal digestive cycles by the free purgation. A Guelpa cure can be repeated if desired after an interval of ten days, and with due regard to its effects on the circulation. As however it is prescribed in France as a means to disembarrass the congestion of vital organs, such as the lungs or liver, there is probably no real contra-indication to its use or repetition.

In chronic cases remove scales with soft soap, frequent baths, and salicylic (2 to 5 per cent) ointments, to which tar is added in increasing percentage, and vigorously inuncted night and morning. For example :—

℞	Ol. cadi	℥xxx–℥iss
	Acid. salicyl.	℥xv–xx
	Ung. hyd. ammon.	℥ij
	Paraffin. moll.	ad ℥j

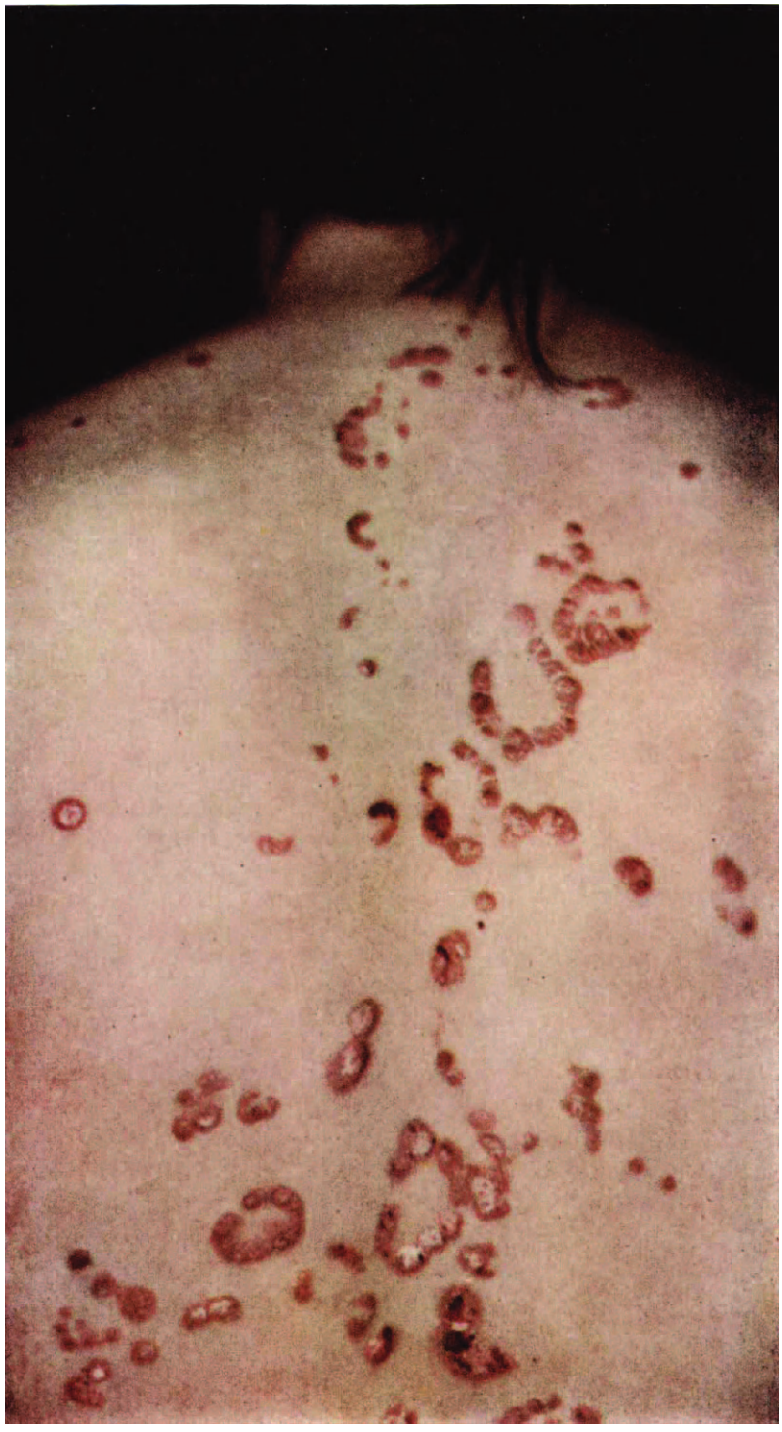
This ointment may safely be given to the patient for home use, and may be combined with arsenic administration per os, or by subcutaneous injection, which latter affords the physician the opportunity of controlling results.

For rapid and effective clearance there is nothing to compare with the application and inunction of the modern chrysarobin substitute, cignolin (Bayer). This is relatively innocuous when inuncted by a skilled nurse, gr. 2 to 5 in Lassar's paste. The patches are cleared in from eight to fourteen days, with inflammatory reaction of the surrounding skin, which must occur before a favourable result can be obtained. The patient should be kept in bed, and baths are best avoided for the time being. Treatment with tar ointment should be continued for some weeks after clearance.

Subcutaneous or intramuscular injections of thymocrine have proved valuable in some cases in my series, and enesol (mercury and arsenic) has been advocated by more than one author. When all else fails, treatment by carefully graduated doses of a typhoid-paratyphoid vaccine (pyrotherapy), given intravenously and repeated according to the reactions on the patient's temperature and general condition that follow, is well worth a trial. The patient must of course be put to bed and carefully guarded against ensuing collapse. It follows that renal and cardiac disease, unless fully compensated, are absolute contra-indications.

Prognosis.—This is frequently demanded by patients, and is a source of continual difficulty to dermatologists. According to a statistical inquiry by Dr. R. Hallam (*Brit. Jour. Dermatol. and Syph.*, 1934, xlvi, No. 5, 221), only 1 in 10 can look forward to ultimate freedom.

PLATE LXXIII



PSORIASIS (Circinate and Serpiginous Types)

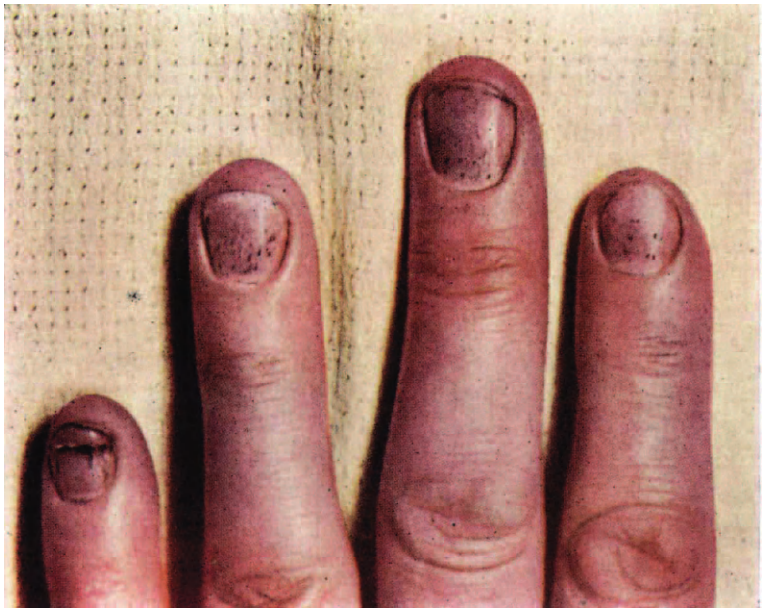
PSORIASIS OF THE NAILS

(PLATE LXXIV)

PITTING of the nail surface as illustrated in the plate is pathognomonic of psoriasis, and in this form is not seen in any other disease. It is therefore an exceedingly valuable diagnostic point, and often helps the physician to a realization of the true nature of a patch of infiltrated, smooth, or scaly dermatitis in such places as the internatal cleft, the scrotum, or the umbilicus. It is therefore important to examine the nails for such evidence in any case of suspected psoriasis in which the appearances are not typical.

Treatment.—The treatment of ungual psoriasis is that of the general disease. The author finds that arsenic by the mouth, or preferably by injection—cacodylate of soda (Clin), 1 c.c.—twice or three times weekly, is of value in such cases. No visible result can be expected under six months, and the patient must be kept under observation in case of arsenical complications. X-ray therapy is often valuable, but great care must be exercised to prevent any subsequent development of radiodermatitis. If local remedies are used they should be applied where they have the best chance of success, viz., *under* the nail and not on its dorsal and highly resistant surface. Of many advocated I prefer those which are colourless and leave no stains, such as salicylic acid 5 to 10 per cent in Lassar's paste, or one of the new almost colourless tar ointments, as strong as can be obtained. They are inserted nightly under the free edge of the nail and cleaned out next morning with an orange stick, together with the epithelial debris softened and macerated in the process.

PLATE LXXIV



PSORIASIS OF THE NAILS

'PUSTULAR' PSORIASIS

(PLATES LXXV, LXXVI)

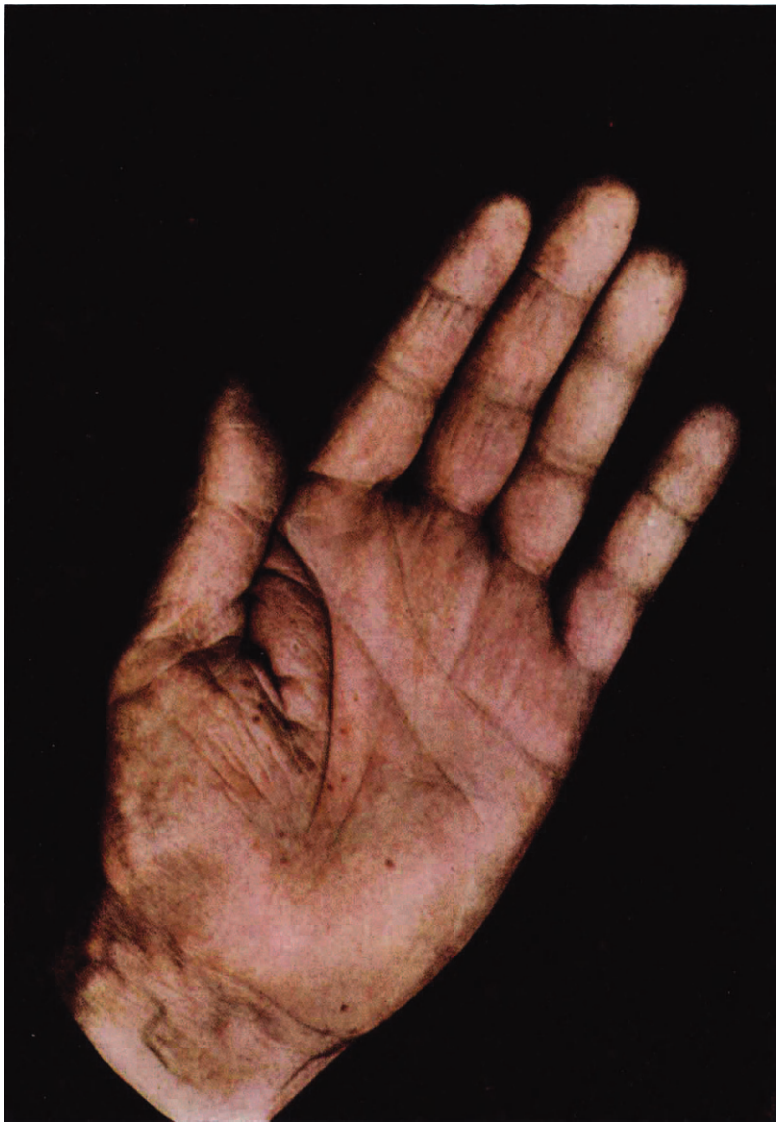
THE nosological position of this troublesome dermatosis has not as yet been definitely determined. Dr. J. M. H. MacLeod originally suggested the term for a pustular complication of the characteristic plaques of psoriasis, but the type here depicted, while conforming histologically to that common disease, differs both clinically and in its evolution in the majority of cases. It is a disease of the extremities and commonly begins symmetrically on the palms or soles on their inner aspects as erythematous, scaly patches in which the characteristic small dry, brown, intra-epidermal 'pustules' develop. Barber and Ingram (*Brit. Jour. Dermatol. and Syph.*, 1930, lxii, Nov., 500) were among the first to draw attention to its main features and to differentiate it from the pustular bacterial acrodermatitis perstans of Clinton Andrewes, which always follows trauma, usually of a nail-fold, is unilateral and definitely infective in origin, and from mycotic dermatitis with which it may also be confused. These three conditions have always to be considered before pustular psoriasis is diagnosed. The exclusion of mycelial infection by the microscope and cultural methods is often an indispensable adjunct in coming to a decision. If typical psoriasis of knees and elbows, or of the nails, can be demonstrated, or if a history of that condition can be elicited, there should be no difficulty. If a biopsy is done the diagnosis can be determined with certainty. Bacteriology, as in other cases of psoriasis, completely fails us, and the 'pustules' are practically sterile in every case.

Barber believes that focal sepsis plays an important part in the aetiology, and in two cases of my own, in one of which the patient was completely unable to walk or use her hands for ordinary purposes, dental extractions were remarkably effective in promoting recovery, while in the other enucleation of septic tonsils effected a cure.

The plates illustrate the disease in its earliest form on the left palm (*Plate LXXV*), and in a very characteristic squamous erythema with the epidermal pustules on both feet, in a man of 60 (*Plate LXXVI*).

It will be noted that there is no erythema or desquamation on the palm, only brownish, superficial, dry, pinhead-sized, discrete 'pustules' on the thenar and central palmar areas. A very different picture is presented by the soles, although the 'pustules' are still clearly in evidence. It is obvious that with such a degree of inflammatory reaction walking must have been painful, and complete rest an essential in the treatment. It will be noted that there is no sharp line of demarcation. The

PLATE LXXV

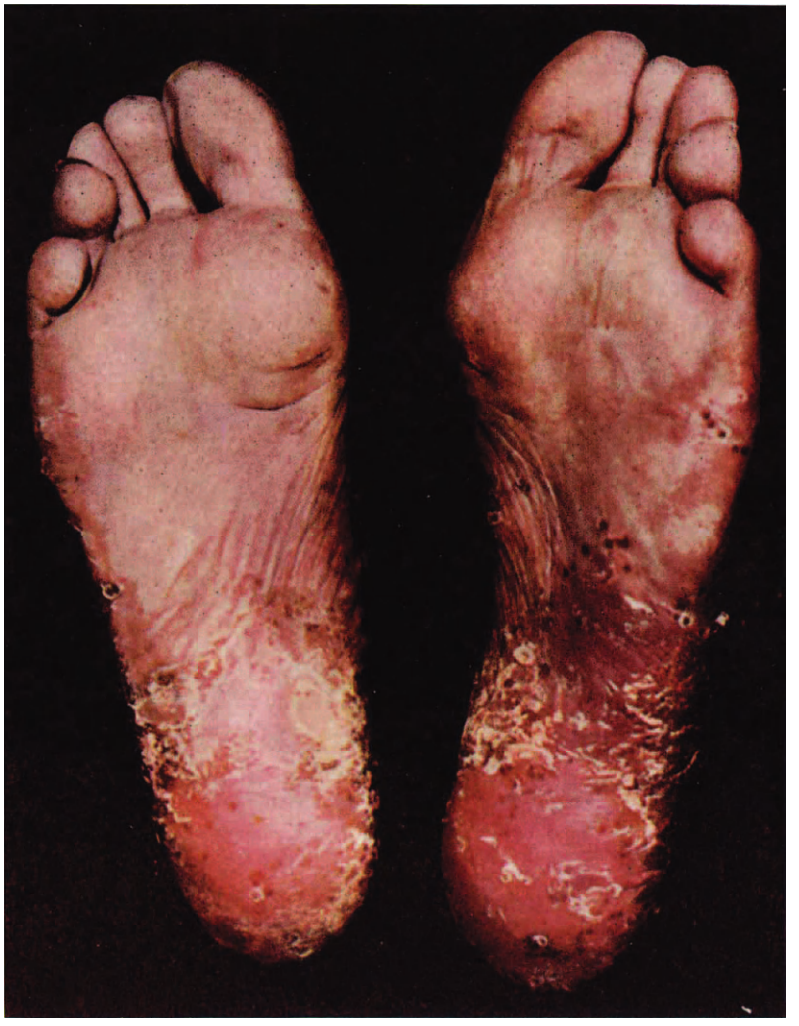


'PUSTULAR' PSORIASIS

inflamed areas fade insensibly into the normal tissues. The scales are drier, psoriasiform in type, and much less macerated that we should expect in a case of ringworm. There are no glassy vesico-pustules at the spreading edges, as are usually to be found in untreated examples of the mycotic infection.

Treatment.—These cases are always intolerant of strong applications and are usually aggravated by the ordinary stock remedies used in psoriasis. Neither X rays nor ultra-violet light have afforded relief in any of the cases under my care. I agree with W. N. Goldsmith (*Recent Advances in Dermatology*, p. 481) that rest in bed is a valuable aid to recovery, and with Barber that focal sepsis often plays an important part in the aetiology. The most satisfactory local application seems to be a weak coal tar paste, such as that prepared by Martindale, in a colourless form.

PLATE LXXVI



'PUSTULAR' PSORIASIS

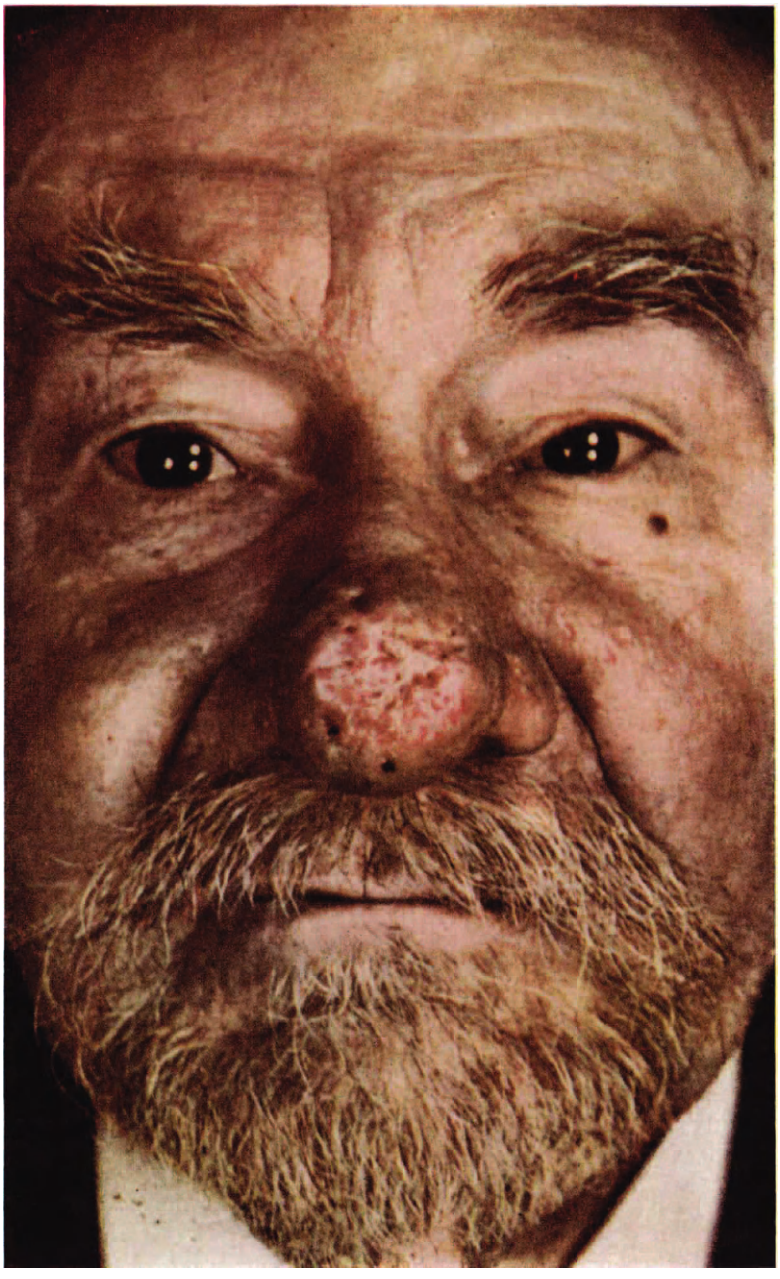
RHINOPHYMA

(PLATE LXXVII)

SIMPLE chronic and recurrent inflammation of the many sebaceous glands in the nasal skin sometimes ends in fibrous hyperplasia and the so-called 'potato nose'. The condition is certainly rarer than it used to be, because the antecedent factors of chronic alcoholism and exposure to the weather, as in the old coaching days, no longer coincide. But it is by no means always the result of alcoholic indulgence. More frequently it follows on long-continued and intractable rosacea, in which recurrent congestion of the superficial capillaries and veins ultimately leads to a sort of vascular fatigue or paresis, and ensuing characteristic symptoms. Besides the general hypertrophy, there is usually marked dilatation of the sebaceous follicles and telangiectases, which combine to form a serious distortion of the whole organ. The condition is practically unknown in women.

Treatment.—The only satisfactory treatment in well-established cases is ablation of the fibrous and sometimes pendulous masses on surgical lines. Healing and re-growth of epithelium from the dilated crypts is rapid, and grafting unnecessary as a rule. In early and milder cases X rays would be indicated and treatment for rosacea (*see* p. 174) must be instituted at the same time.

PLATE LXXVII



RHINOPHYMA

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ROSACEA

(PLATE LXXVIII)

A MORE classical example of the appearance of this common and unsightly condition it would be difficult to find.

The case is that of a woman in the middle forties, approaching the menopause, and the continual flushing of the cheeks, chin, and bridge of the nose have led ultimately to a chronic stasis in the venules and capillaries of the areas concerned. Such vascular stasis results in local infection of the sebaceous glands, and a number of these can be seen as raised red papules, particularly to the right of the symphysis menti and on the chin itself. Protraction of the infection with the formation of pustular elements sometimes leads to appearances even more repellent, and extension to the eyelids may cause blepharitis, styes, and Meibomian infections of varying degree (a mild degree of infection can be seen in the right lower eyelid).

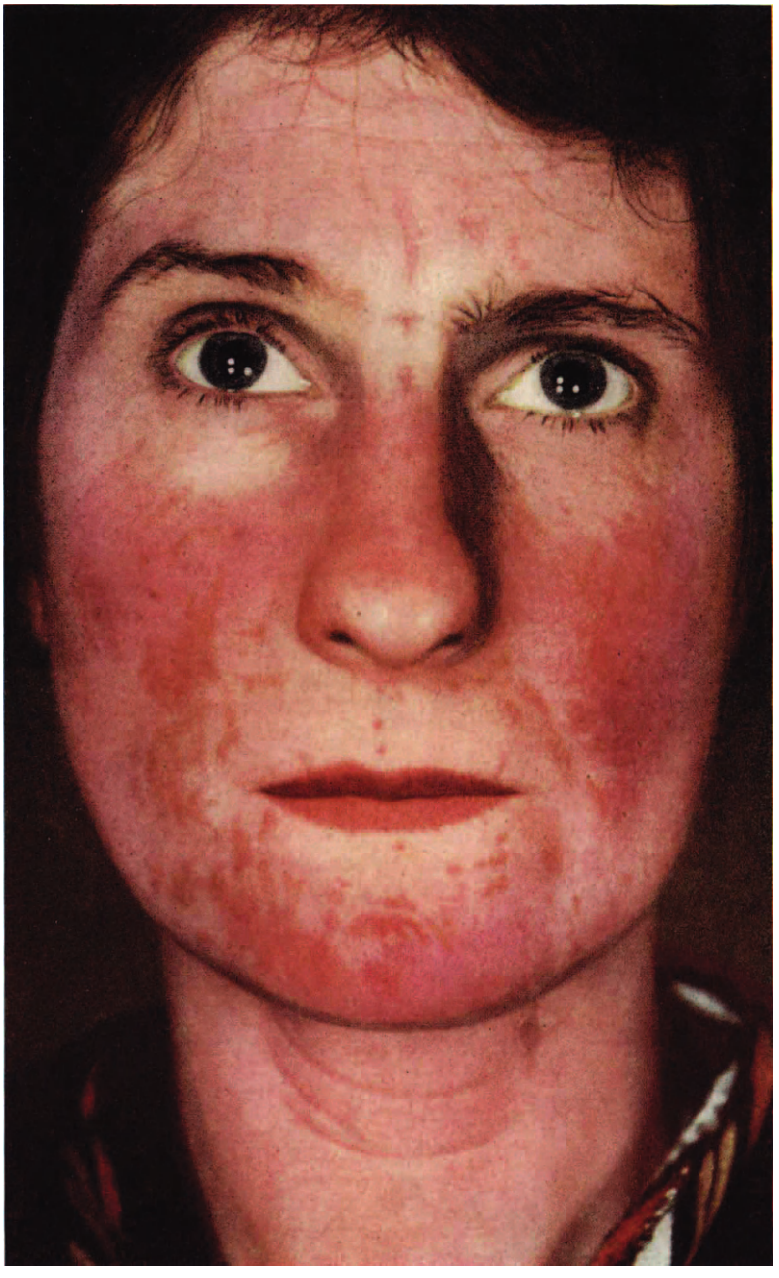
The most serious complication of rosacea is keratitis, which may lead to permanent impairment of vision. Another is rhinophyma (*see Plate LXXVII*), which seems to occur only in men.

Treatment of the local condition alone is unlikely to lead to a cure, although applications containing 1 per cent ichthyol in lead and calamine lotion for the acute cases, and a 1 per cent sulphur-calamine combination for the most chronic cases, are helpful. Every effort must be made to discover the cause, which is usually a disordered gastric reflex,* and all alcohol, strong tea, and coffee are forbidden. Spices and condiments, and anything which increases the tendency to flushing, must also receive attention. The administration of hydrochloric acid in dilute solution, given during or after meals, has been of undoubted benefit in many cases, while others respond better to a mixture of bismuth and carbonate of magnesia, especially if flatulence and constipation are present. Mild doses of X rays are beneficial in the more obstinate types.

*Dr. Sybil Eastwood (*Brit. Jour. Dermatol. and Syph.*, 1928, xl, 91, 148) believes that the flushing in rosacea is due to a *motor disturbance* of the stomach, and that the 'acidity' or otherwise is a relatively unimportant feature in the pathology. She advises hydrochloric acid with meals, and a bismuth mixture one and a half to two hours after meals to coincide with the normal alkaline tide of digestion.

A little bromide or luminal is a useful adjunct in cases in which excitability or 'nerves' seems to be playing a part.

PLATE LXXVIII



ROSACEA

SCABIES

(PLATES LXXIX, LXXX)

A PARASITIC cause should be suspected in every irritable and uncharacteristic dermatosis. This is probably the best way of avoiding an error of diagnosis which is seldom forgiven by the patient. By far the most common parasite in this connection is the acarus, and the recognizable and typical lesion is the run or burrow made by the female of the species. In it she lays the ova from which the young are hatched out in from three to six days. The burrow lies in the epidermis and can be seen on the surface as a slightly raised greyish or dirty black ridge, often with a minute vesicle at one extremity. With a small lens it is seen to have a zigzag outline, and with care the acarus itself can be extracted with a blunt needle. Its demonstration (under a 1/3 objective) as the actual cause of the symptoms is one of the most satisfactory and conclusive achievements in out-patient or consultative practice.

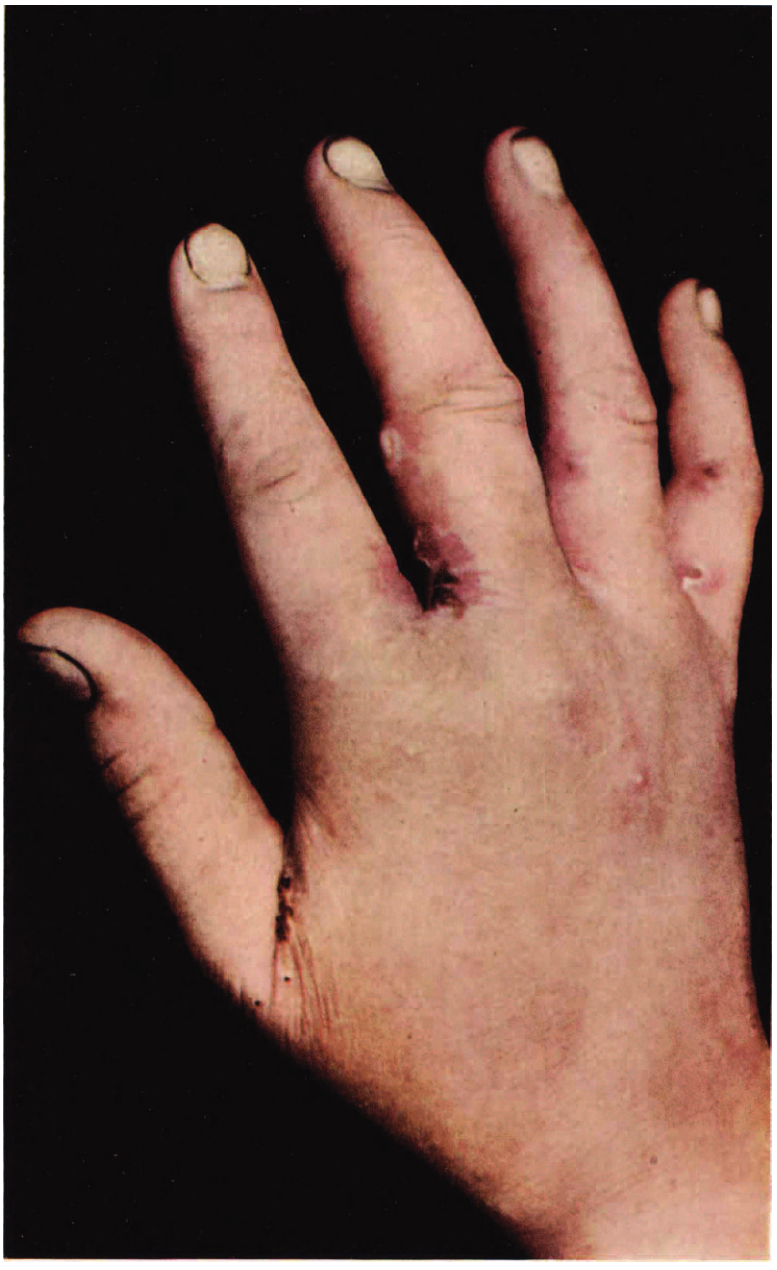
With a consistency astonishing in so predatory a parasite, the burrows are tunnelled in the interdigital clefts of the fingers (*Plate LXXIX*), the ulnar borders of the wrists (*Plate LXXX*), the glans and prepuce in men (*see Plate LXXXI*), and the circum-mammary area in women. In small children and infants the inner aspects of the ankles and the palms and soles are a favourite site.

Scratch marks, usually running in a linear fashion in the long axis of the limbs, are common on the fronts of the thighs, the forearms, the lower part of the buttocks, and the periumbilical region.

Treatment.—The irritation, which may be very severe, occurs mostly at night, when the parasites are active, and ceases in a dramatic fashion after the first application of the curative sulphur or beta-naphthol ointment. Care is necessary in its use, for a sulphur dermatitis and subsequent furunculosis, as were so common in the war, are complications at least as troublesome as the original infestation. Blankets and bed linen should be steam-sterilized after the customary three inunctions, for there is no doubt that bedding and underclothes can harbour the parasite for several days and may cause reinfection after cure.

My experience has taught me that, whenever the small expense can be borne, mitigal (Bayer) should be ordered in preference to the ordinary parasiticides for all

PLATE LXXIX

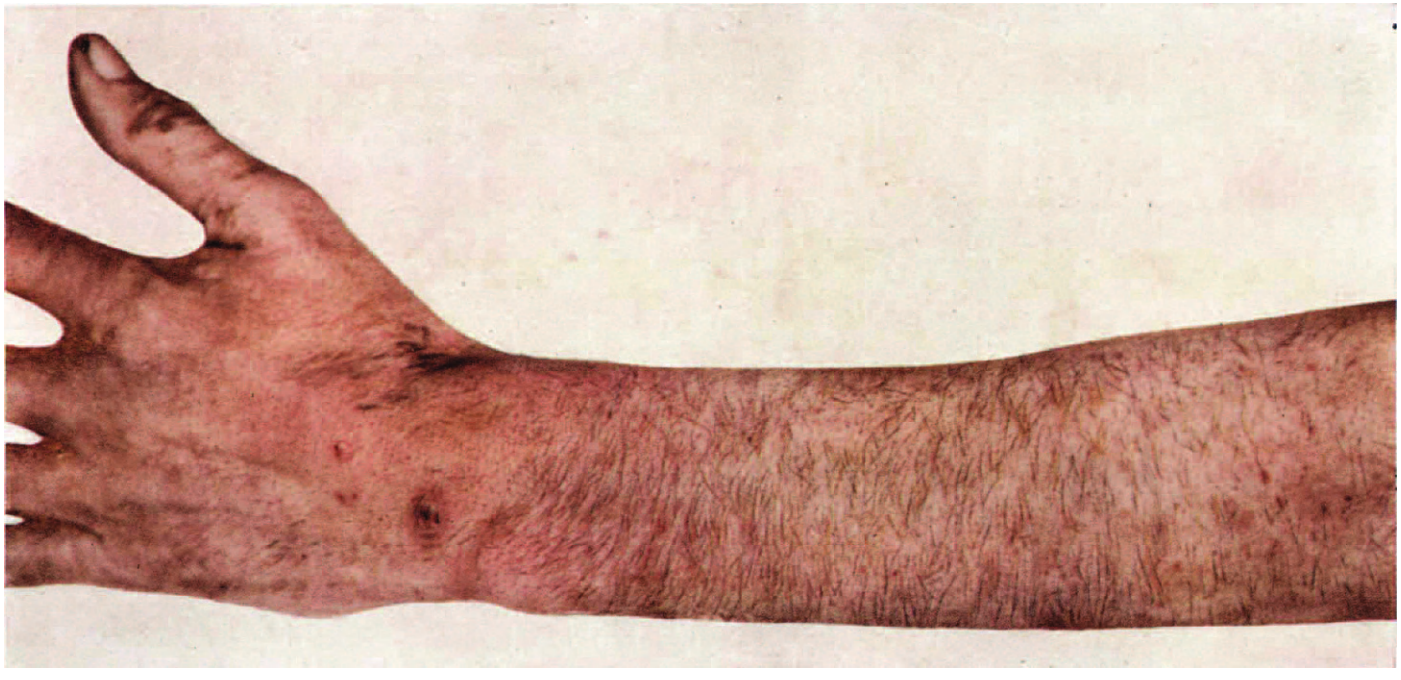


SCABIES

cases of scabies and pediculosis, and if only as a diagnostic measure, on all occasions when a parasitic cause is suspected. I have yet to see a failure or mischance in its application.

The most common complication is the dermatitis due to sulphur (*see Plate LXXXI*), but secondary pustular infection both of the burrows (*Plates LXXIX, LXXX*) and the scratch marks are apt to occur, especially about the fingers and buttocks, and may give rise to appearances of a polymorphic character which may obscure the true nature of the underlying cause. Nocturnal itching, the occurrence of other cases in the same household, and the characteristic localization of the burrows and scratch marks, are nearly always sufficient to suggest the correct diagnosis. In cases of doubt it is justifiable to put the patient through one course (no more) of the sulphur treatment.

PLATE LXXX



SCABIES

SCABIES AND SULPHUR DERMATITIS

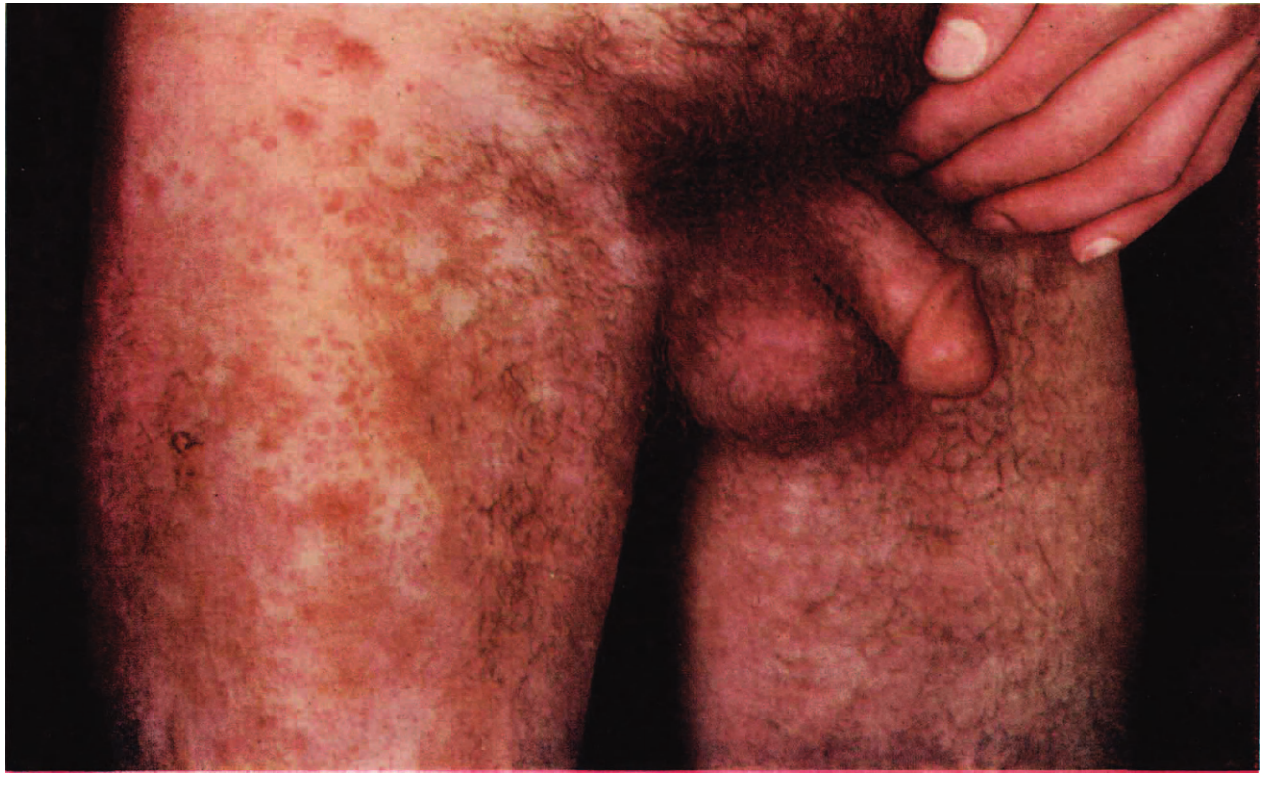
(PLATE LXXXI)

AMONG the many cutaneous conditions which constituted a disability during the war, the combination of scabies with a dermatitis due to over-treatment with sulphur was one of the commonest. The association, which is still by no means a rarity, is well illustrated by the plate. Patches of raised and inflamed follicles and a slight abrasion due to scratching, on the anterior surface of the right thigh, constitute the typical aspect of sulphur dermatitis, while on the right under-surface of the glans penis can be seen two raised, somewhat urticated papules, the irritated sites of acarine burrows. From one of these the live inmate was subsequently extracted with a needle.

The presence of small papules on the penis, prepuce, or scrotum, associated with an irritable rash on the trunk, usually worse at night, and with or without the characteristic lesions on the wrists, etc., is practically diagnostic of scabies, though the proof can be made only by demonstrating the acarus or its ovum. When this fails it is justifiable to order the appropriate treatment for scabies. It cannot be too strongly emphasized that over-treatment, or the B.P. sulphur ointment (which is too strong) wrongly applied, may not only fail to eradicate the disease but may set up a dermatitis from which the patient may not recover for weeks or months.

This case was treated with a 1 per cent beta-naphthol ointment for three nights in succession to destroy any residual parasites, and the irritation and dermatitis were finally subdued with calamine cream.

Mitigal (Bayer), which is an organic sulphur combination in olive oil, does not set up dermatitis, and is a real specific both for scabies and pediculosis.



SCABIES AND SULPHUR DERMATITIS

SYCOSIS BARBÆ

(PLATE LXXXII)

THE group of facial infections collectively termed 'barber's rash' are frequently autogenous. The patient may never have been shaved by a barber. The name should therefore be given up, for like so-called 'dhobie itch' it casts an unmerited slur where it is seldom deserved.

Two organisms can give rise to sycosis, and two main types of the condition are described—the commoner coccogenic, due to the staphylococcus, and the much rarer mycotic ('tinea barbæ'), which must obviously be contracted from an external source (sometimes a barber), and is due to a fungus, the endothrix or ectothrix trichophyton.

Coccogenic sycosis may arise *de novo* as the result of the irritation of a blunt razor, or secondarily, as after impetigo contagiosa or in the course of seborrhœic infection of the face and scalp. There is no doubt that seborrhœic subjects are much more liable to the complaint than those with normal skins, and the sycosis in such cases is often only a special localization of a general hair-follicle infection, in which the scalp, axillæ, and groins are also involved.

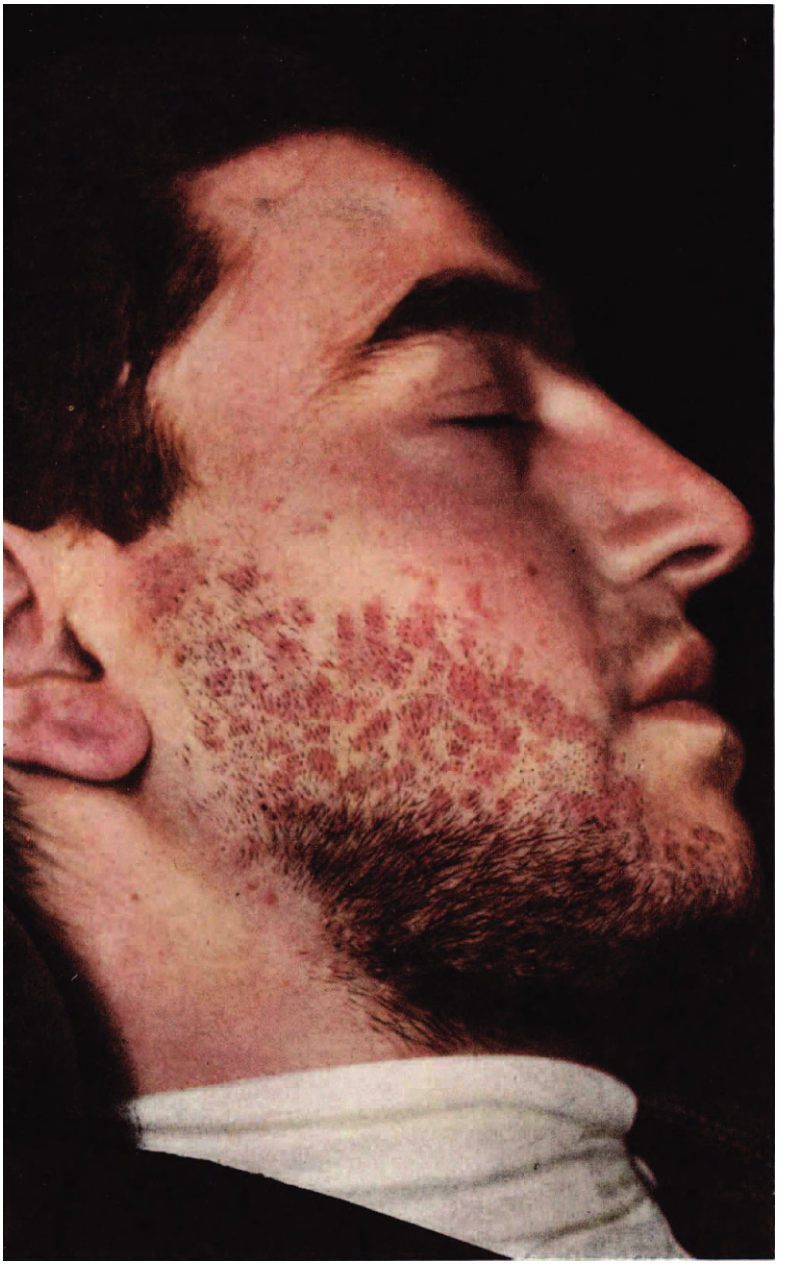
The prognosis and treatment vary greatly with the duration and type of the infection, and the outlook is particularly gloomy in cases of seborrhœic aetiology, for these are difficult to treat, and tend to early and frequent relapses.

In the case illustrated it will be noted that there is not much swelling or pustulation, and that the whole of the shaving area, and that alone, is involved. It is a very typical example of the common type of staphylococcal sycosis, in quite an early stage (three weeks' duration). It is easy to see that the primary lesion is a perifollicular erythema, indicating infection of the hair follicle, with commencing suppuration in the follicles below the angle of the jaw. There is no suggestion of a ring-formation, marked swelling, or localized pustulation, which usually accompany the mycotic infections in this situation.

To shave or not to shave, is the most pressing problem in every case. In general terms it may be said that the answer depends on the duration of the infection. In an early case such as this, it must be strictly forbidden, for each contact with the razor obviously infects new follicles. When all the follicles are infected, as in the chronic seborrhœic cases, nothing is gained by withholding permission, provided the razor is sharp and prolonged lathering with a mild antiseptic soap precedes its use.

Treatment.—The case here depicted rapidly improved on allowing the hair to grow and *epilating manually* such follicles as were suppurating. Strong antiseptics should never be used in any case of sycosis. In the acute stages a weak lead and ichthyol (1 to 2 per cent) lotion should be constantly mopped on with a cotton-wool swab. Two other disinfectant and sedative lotions are worthy of mention: (1) perchloride of mercury 1–4000 (or oxycyanide), valuable where there is much suppuration,

PLATE LXXXII



SYCOSIS BARBÆ

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and (2) a 1 per cent solution of resorcin in boric lotion. This is useful in the seborrhœic cases and can also be applied for blepharitis. The more resistant cases will sometimes yield to similar applications of eau d'Alibour ($\frac{1}{2}$ to 1 per cent zinc and copper sulphate solution); and if, as in the more chronic examples, scaliness is a feature, an ointment or paste containing 1 to 2 per cent ammoniated mercury, resorcin, ichthyol, or sulphur and salicylic acid ($\frac{1}{2}$ to 1 per cent) should be rubbed in at night. Vaccines, preferably autogenous, are sometimes useful in the chronic cases, and according to some authorities are best given in minute doses, intradermically, and at intervals determined by the degree of reaction observed locally. Ultra-violet rays, especially the general carbon-arc bath, help to raise the patient's general resistance. X rays should be reserved as a last resource and with full comprehension of the dangers involved. A temporary epilation by a skilled operator is frequently successful in early cases, but relapses are the rule in the more chronic types. Permanent X-ray epilation should never be undertaken without a signed declaration by the patient assuming all responsibility.

SYPHILIS: CONDYLOMATA

(PLATE LXXXIII)

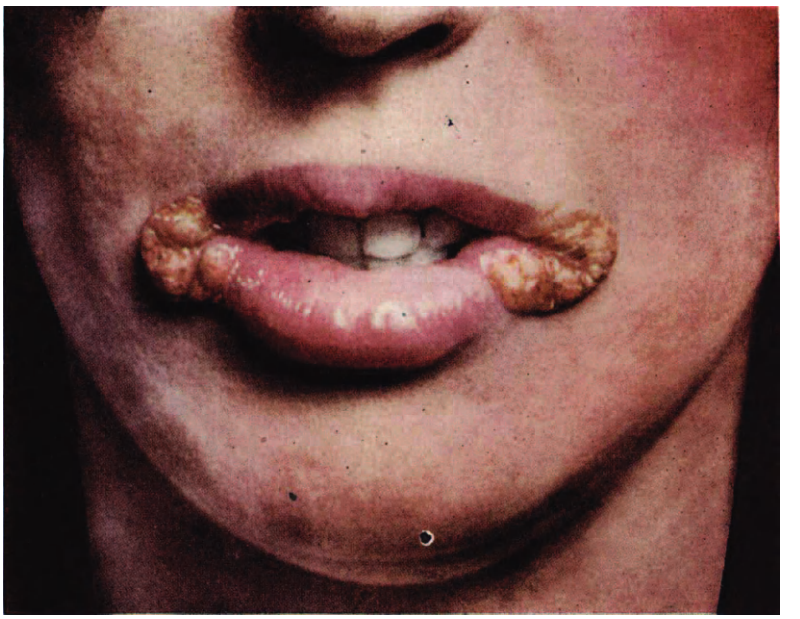
THESE may occur in untreated syphilis at any time after the first three months of infection. They are commonest in the late secondary stage, and owing to their tendency to arise in moist situations and at muco-cutaneous junctions, are apt to be mistaken for soft corns when they appear between the toes, or warts when they occur at the anal margin, the subpreputial, or the peri-vulval areas. At the labial commissures they not infrequently suggest the diagnosis of congenital syphilis in the infant, and may then be associated with 'snuffles', enlargement of the liver and spleen, a papulo-macular rash which besides appearing on the trunk may involve the palms and soles, and a positive Wassermann reaction. This latter is never absent in the case of condylomata, and must therefore be regarded as the crucial test in a doubtful case.

Glandular enlargement as a result both of the specific and a secondary septic infection is always present in some degree, but does not compare with that accompanying the primary chancre. It was not notable in the case depicted. This clearly demonstrates two hypertrophic granulomatous growths at the mouth angles of a young woman in the late secondary stages of the infection. A rather circinate tendency suggests an approach to the third or gummatous stage of the disease. It will be noted that the lower lip is definitely œdematous, and the lymph block responsible sometimes leads to serious permanent disfigurement if the cause is not recognized and the case is allowed to drift (cf. *Plate LXXXIX*).

The treatment is that of syphilis, which must be carried through and persisted in on the lines advised in modern text-books.

It is pertinent to add that a case of this kind is highly contagious. The moist secretion on the surface of the lesions would be swarming with treponemata, and the saliva itself is doubtless contaminated.

PLATE LXXXIII



SYPHILIS: CONDYLOMATA

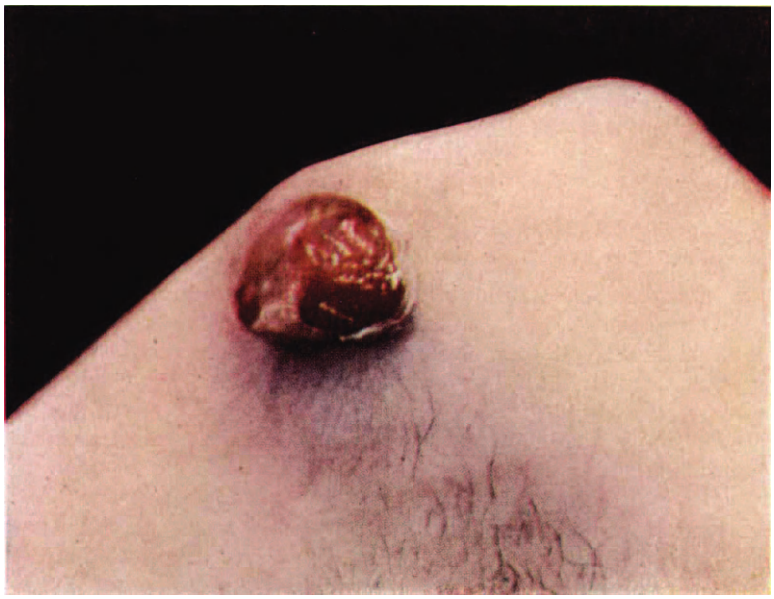
SYPHILIS: GUMMA

(PLATE LXXXIV)

THIS oval, raised, granulating, painless lump made its appearance on the outer side of the left knee-joint in a man of 48, without causing any pain or disability. The absence of inflammatory reaction in the surrounding skin is a point which should have aroused the observer's suspicion, for any septic cause must certainly have produced an areola of hyperæmia. The little tumour, furthermore, had developed from a " lump under the skin ", i.e., it was subcutaneous in origin, and had given rise to no trouble in that situation until necrotic processes intervened. Our suspicions were confirmed by a positive Wassermann reaction, which should always be determined in any case of unrecognized tumour or eruption, especially in this situation.

A few injections of N.A.B. and iodides by the mouth induced rapid healing and involution.

PLATE LXXXIV



SYPHILIS: GUMMA

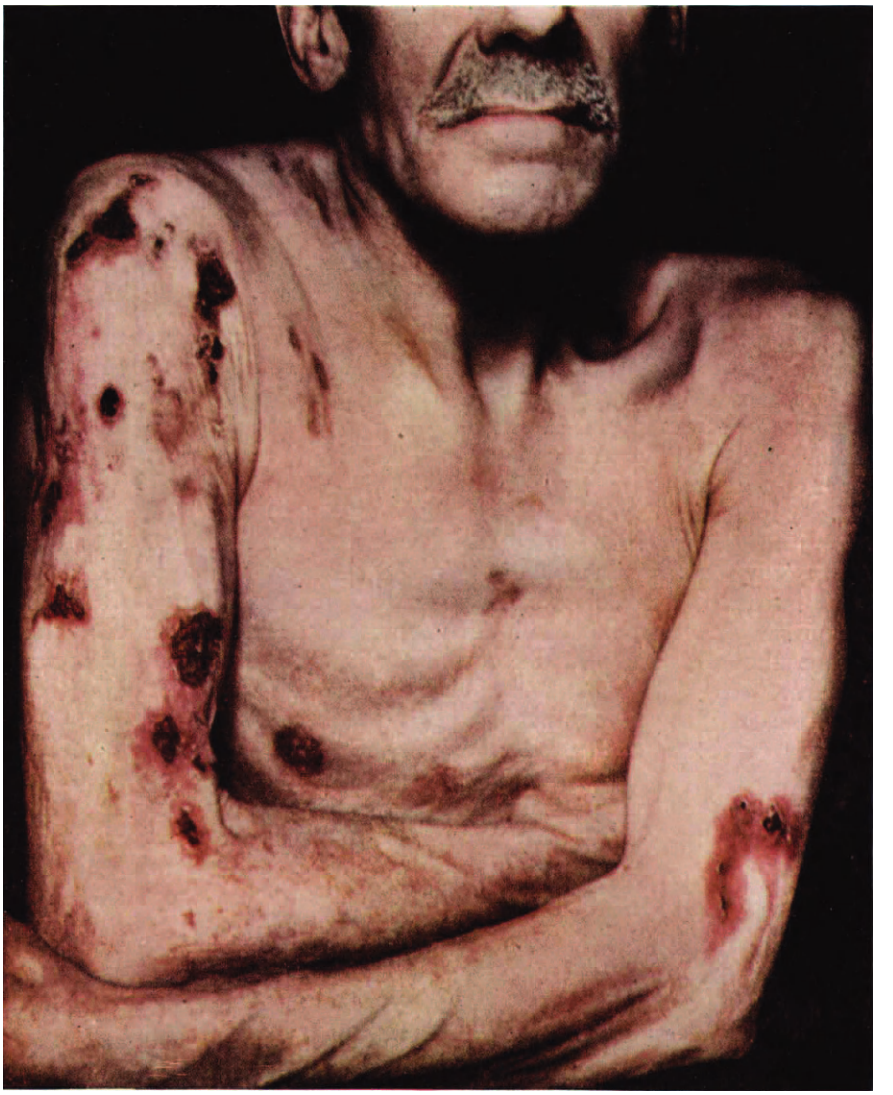
SYPHILIS: GUMMATA
(Multiple Cutaneous)

(PLATE LXXXV)

THE patient, a labourer of 61, presented himself for the treatment of the lesion seen above the outer aspect of the left elbow, which he stated had been present for about six months. He said nothing about the rest of his cutaneous disability which was only discovered when he was told to strip. He then admitted that he had had a chancre as a youth, and that the first signs of ulceration on the trunk had developed over thirty years ago. The back exhibited many cicatrices and a few crusted ulcers of similar type, and over the left scapula there was an enormous cystic swelling of diffuse outline, which he confessed rather troubled him when he had to carry weights over it. On evacuation it proved to be a necrosing gumma of the deep fascia and promptly yielded, together with the cutaneous lesions, to potassium iodide by the mouth and small injections of a salvarsan derivative intravenously. The Wassermann reaction was found to be strongly positive, and after so lengthy a history is not likely to be influenced by treatment.

Such cases were common enough before the introduction of salvarsan, but are rarely seen to-day. In this instance the patient had never consulted a doctor, as the lesions were not painful and were entirely covered by his clothing. They consist of scattered crusted ulcers and cicatrices involving the outer aspect of the left upper arm and the front of the chest. The most recent lesion above the left elbow has an obviously crescentic outline, typical of the chronic cutaneous gumma.

PLATE LXXXV



SYPHILIS: MULTIPLE CUTANEOUS GUMMATA

SYPHILIS: SECONDARY MACULAR AND PAPULAR ERUPTION

(PLATE LXXXVI)

THIS early maculo-papular eruption is one of the commonest manifestations of general invasion, and usually makes its appearance about ten weeks after the date of the infection. It is always associated with enlargement of axillary, antecubital, and posterior cervical glands. Fever, headache, and mucous patches in the pharynx are frequent associations, and diffuse alopecia may also occur at this stage.

The characters of the eruption vary a little with its duration and the presence or otherwise of seborrhœa. In the main the colour is pink with a *coppery* tinge, and the *non-scaly* smooth elements are slightly raised and often palpable to the finger, according to the degree of infiltration present—a feature which also determines whether the lesion shall be a macule or a papule, and is responsible for the *polymorphic* character of most secondary syphilitic eruptions.

The importance of differentiation from other generalized eruptions such as pityriasis rosea (*see Plate LXIX*) cannot be too strongly emphasized. The two plates should be compared and the table of differential diagnosis on p. 156 carefully studied.

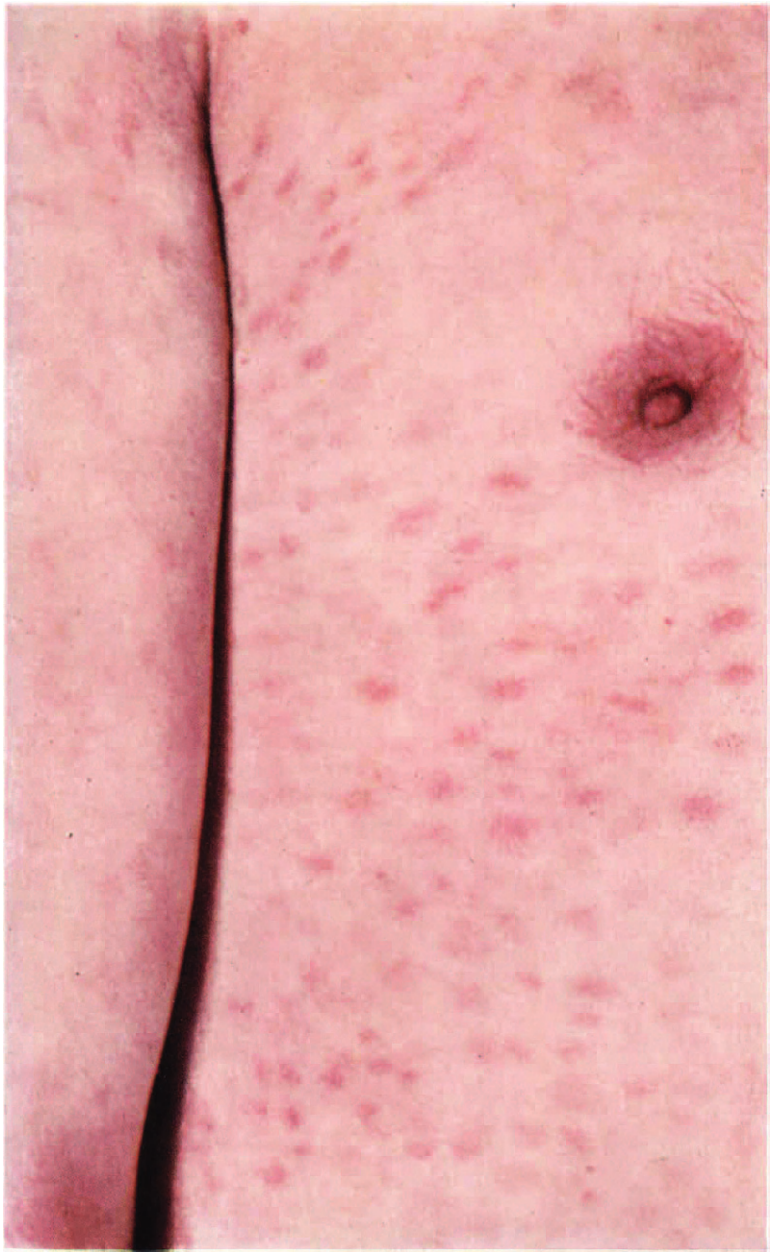
The increasing rarity of secondary syphilis, owing of course to early diagnosis of the primary chancre, renders it incumbent on the practitioner to exercise the greatest caution whenever he is faced with a generalized eruption the appearance of which is not familiar to him. I have always found it a valuable rule to ask myself at every consultation: (1) Is this syphilis, and (2) Is it scabies ?

Merely remembering the possibility of either is the surest protection against a lapse which can, in the former case, have far-reaching and serious consequences.

Incidentally the double infection has occasionally crossed my path, and I well remember a case in which an acarine run on the prepuce became indurated and eventually developed into a primary chancre. One should never forget to examine the buccal cavity, the pharynx, and the anterior faucial pillars. The patient with syphilis seldom complains of a sore throat or mouth, but in the eruptive stage unmistakable confirmation can be obtained in these situations in a large percentage of the cases. For the same reasons one should not neglect to examine the anal margins and the genital area in both sexes. (D. Lees has stated that the commonest situation (40 per cent) of the primary chancre in women is the cervix.)

The Wassermann reaction is always strongly positive in this stage of the disease.

PLATE LXXXVI



SYPHILIS: SECONDARY MACULAR AND PAPULAR ERUPTION

SYPHILIS: SECONDARY PAPULAR ERUPTION

(PLATE LXXXVII)

A LUETIC eruption as profuse and typical as this is rare in these days of early diagnosis and efficient treatment. The primary lesion must have antedated its appearance by at least three to four weeks, but was not observed, probably because it was on the cervix uteri. The frequent concomitants of headache, malaise, or a mild pyrexia were absent, and the diagnosis was made purely on the rash, and immediately confirmed by a strongly positive Wassermann reaction.

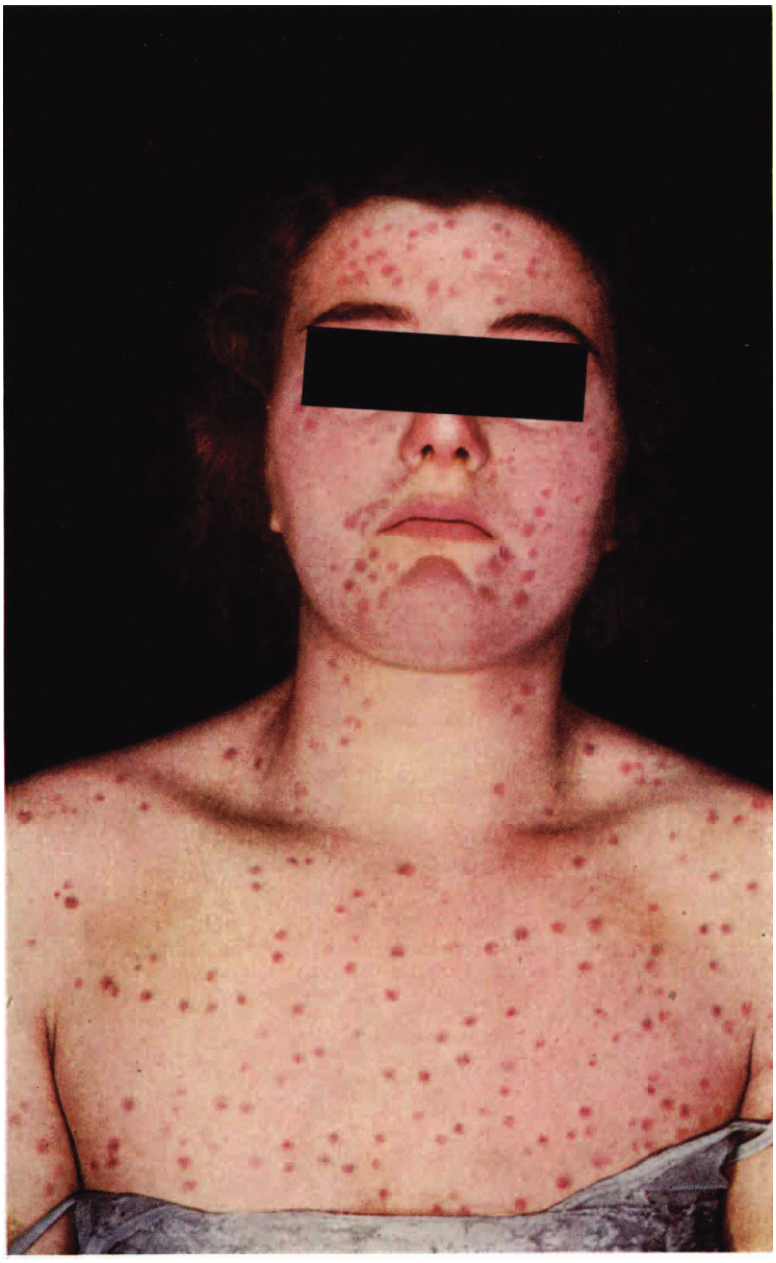
The most characteristic points are, firstly, the distribution. The forehead (corona veneris), the chin, and paralabial sulci are favourite localizations in the papular type, and this led to an examination of the trunk, the whole of which, particularly the abdomen, was covered by the raised, discrete, firm, coppery-red papules so faithfully reproduced in the plate. There was no irritation, no sore throat, which on examination revealed only some congestion, and no mucous patches, and the amount of adenitis was small (chiefly in the posterior occipito-cervical region), considering the extent of cutaneous involvement.

It will be noted that there is only one type of lesion present, the papule. This is perhaps the reason why the case had escaped diagnosis; for secondary syphilitic eruptions are characteristically *polymorphic*, and there was no trace of a roseolar admixture, though it may have preceded this purely papular type.

It is difficult to see what other disease could have been suspected in this case. A papular psoriasis would have been typically scaly and not nearly so well marked on the face. Acne vulgaris would not have appeared so widely and so suddenly in a woman of this age (25) for the first time, and acne rosacea is limited to the face and associated with capillary and venous engorgement. The appearances might have been mistaken for a bromide or iodide eruption, but the symmetry and general arrangement, the colour, the adenitis, the history, and the strongly positive Wassermann reaction would not sustain the suspicion of a drug eruption for long.

The treatment was of standard type and resulted in rapid involution. Cases with such intense cutaneous manifestations are said to afford a better prognosis in regard to relapses and ultimate cure than those in which the secondary eruption is slight or absent.

PLATE LXXXVII



SYPHILIS: SECONDARY PAPULAR ERUPTION

SYPHILIS: TERTIARY PLANTAR HYPERKERATOSIS

(PLATE LXXXVIII)

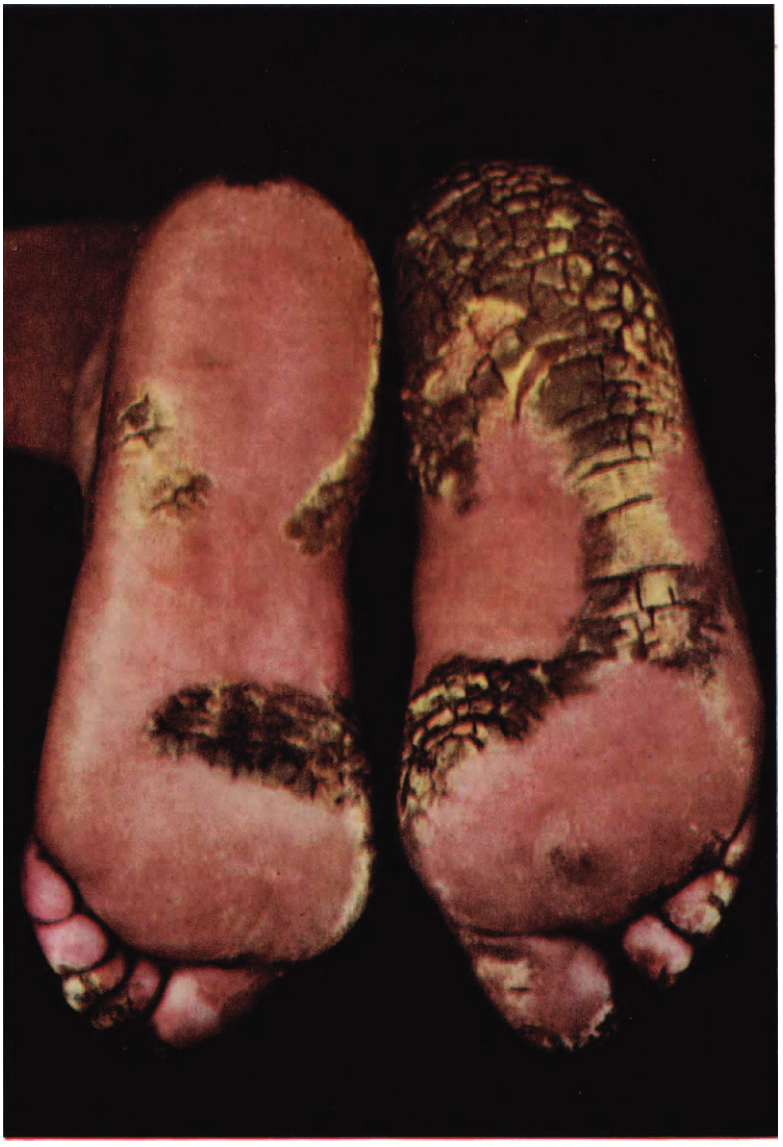
THE plate should be compared with those illustrating psoriasis and epidermophytosis (*Plates LXXII* and *XXXIII*). It will be noted how very much more *superficial* the latter conditions are. Here we are dealing with a much more deeply seated, infiltrating process, which, if sections could be made throughout its entirety, would reveal inflammation and cellular reactions far below the level of the epidermis.

It will be observed also that the tendency on the left sole is somewhat towards a circinate outline—a very characteristic feature in all cutaneous syphilides in the tertiary stage. The horny carapace proved extremely resistant to all local attempts at removal, for it persisted for quite six weeks after specific antiluetic treatment and large doses of iodides had been instituted.*

The Wassermann reaction was a strong positive, and has remained entirely unaffected by the treatment so far given. It is unlikely to show much change for years, and the patient—an elderly woman in a poor state of health—will probably cease to attend as soon as the local manifestations have been relieved. They are not likely to relapse.

* The symmetry and general appearances suggested the possibility of gonorrhœal hyperkeratosis, but no evidence of the presence of this disease was forthcoming.

PLATE LXXXVIII



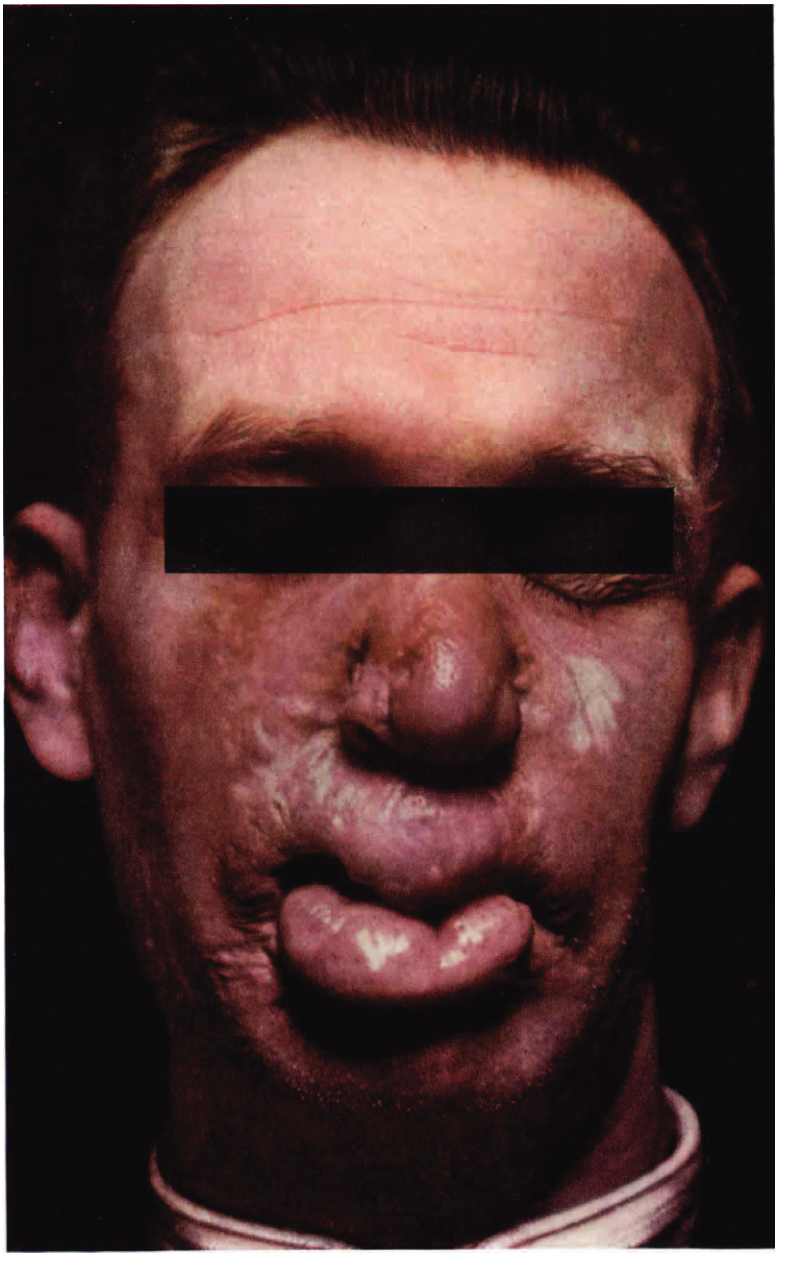
SYPHILIS: TERTIARY PLANTAR HYPERKERATOSIS

SYPHILIS: TERTIARY SCARRING AND ELEPHANTIASIS OF LIPS

(PLATE LXXXIX)

THE repellent disfigurement that resulted in this case from a failure to appreciate the nature of the disease for a period of over two years, is fortunately extremely rare in these days of the Wassermann reaction and treatment by salvarsan. In pre-salvarsan times, however, such pictures were commonly seen in hospital out-patient clinics, and the younger generation of physicians are scarcely cognizant of the debt which the world owes to Ehrlich. It is for this reason perhaps that the diagnosis was overlooked for so long and the patient treated fruitlessly with ointments and lotions. When first seen the scarred areas were ulcerated deeply and the massive elephantiasis of the everted lower lip even more pronounced. The rapid progress of the ulceration and destruction, and the complete absence of lupus nodules—the only disease with which this condition could be confused—pointed no uncertain finger to the cause, and a Wassermann reaction promptly confirmed it. The patient had been under antiluetic treatment for over a year when the photograph was taken, and plastic procedures for the repair of the lower lip—the buccal aspect of which presents three small but distinct patches of syphilitic leukoplakia—were considered but ultimately rejected by the patient.

PLATE LXXXIX



SYPHILIS: TERTIARY SCARRING AND ELEPHANTIASIS OF LIPS

SYPHILIS: TERTIARY ULCER

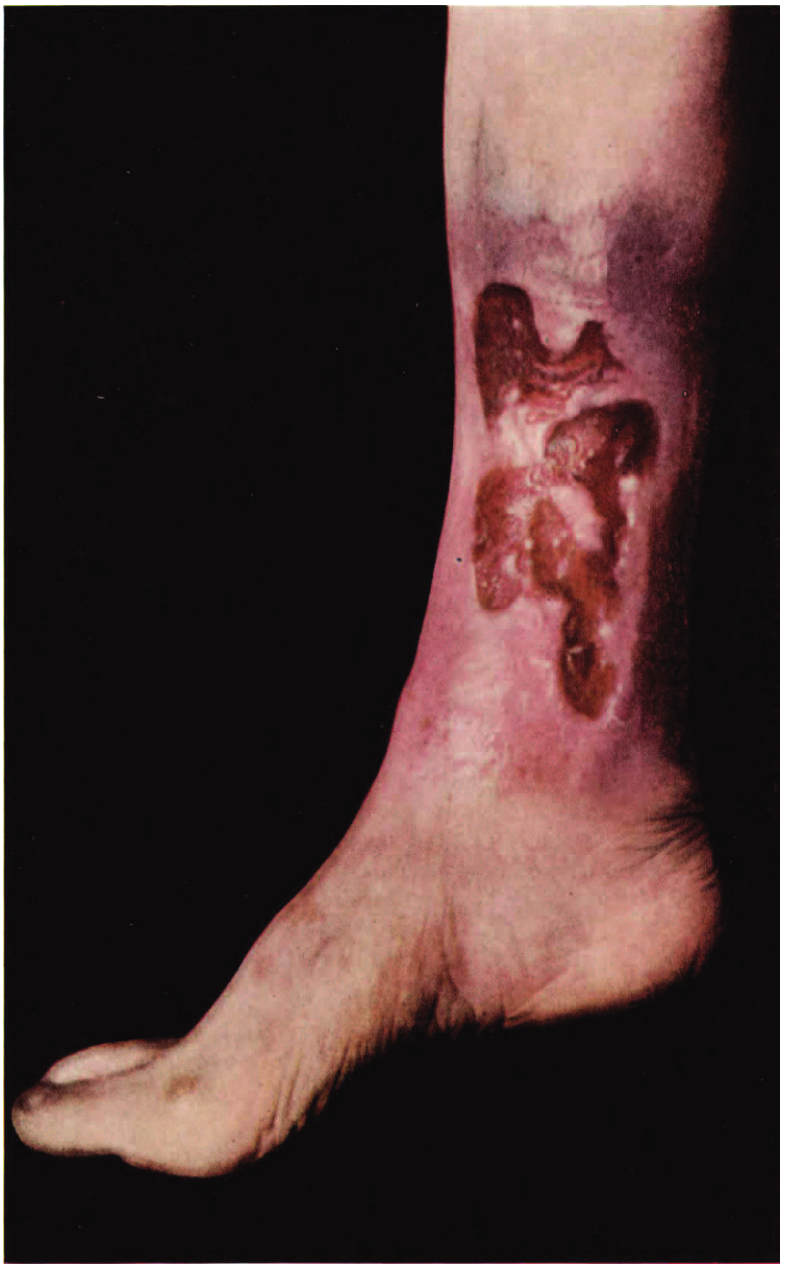
(PLATE XC)

A COMPARISON of this plate with that depicting a varicose ulcer in almost the same situation (*Plate XCVIII*) should prove interesting and instructive, for in the differential diagnosis of these two conditions confusion frequently arises. Apart from the depth and irregular circinate outline of the former, it will be noted that the edges are 'punched out', and that there is no visible effort to replenish or restore the necrosed tissues. Such ulcers are more common in the upper third of the leg.

A syphilitic ulcer is often rapid in its action, and there is hardly a limit to its destructive activity, in which the cutis, underlying cartilage, and bone may be involved, so that a perforation of the hard palate is practically diagnostic of the cause. Circinate or crescentic outlines are a further feature, and are well marked in this case, as was also the absence of severe pain—invariably complained of in those due to vascular stasis only.

Treatment is that of syphilis in its tertiary stage, and iodides should be given a large share in it. The patients are often elderly women in a poor or debilitated state of health, and do not tolerate with any degree of comfort the drastic injection methods at present in vogue. This may account for the irregular attendance of such patients when they are referred to a venereal clinic for treatment.

PLATE XC



SYPHILIS: TERTIARY ULCER

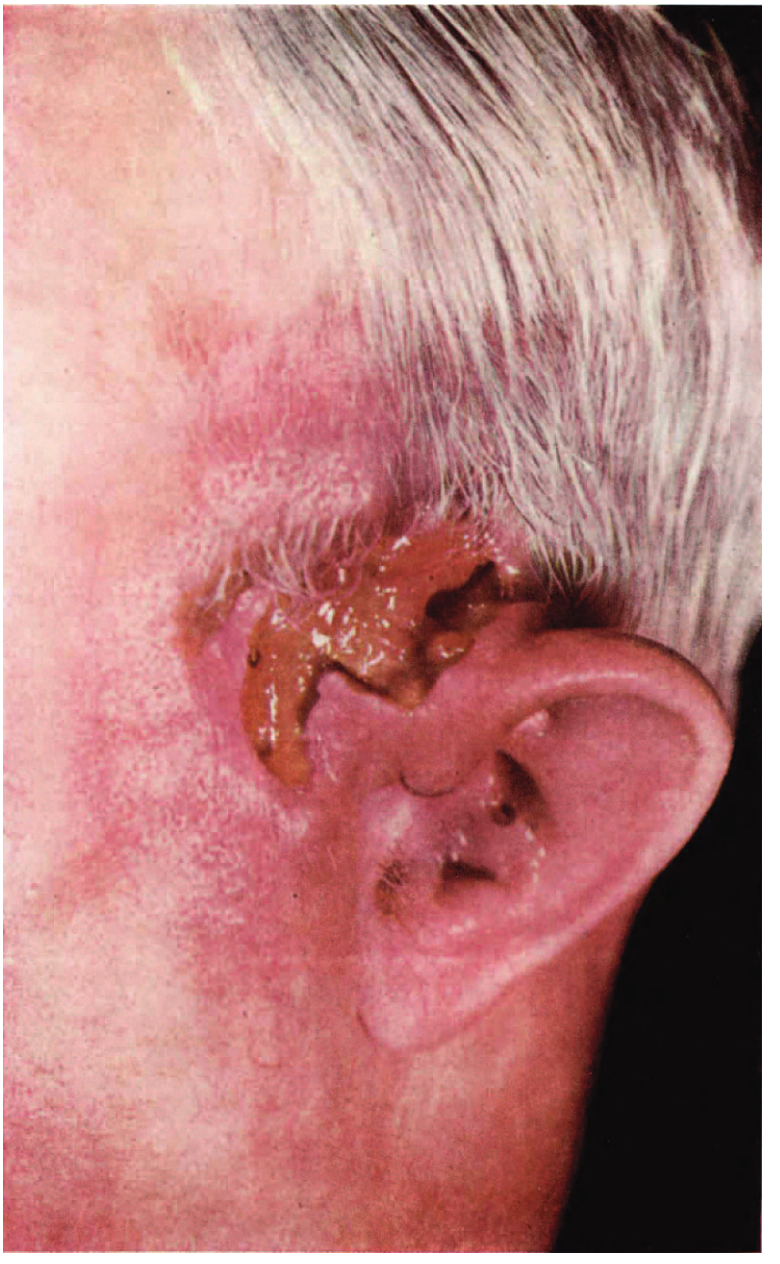
SYPHILIS: TERTIARY ULCER

(PLATE XCI)

THE necrotic slough here shown is about to separate, and the margins of the ulcer are beginning to heal. The patient had an instructive history. He had been referred from the aural department about six months previously with the suggested diagnosis of acute rodent ulcer (ulcus telebrans). The situation, clinical appearances, age of the patient (62), and duration of the disease (5 months), made such a view likely, and a small piece was excised for pathological report. No malignant cells were demonstrable, and a diagnosis of tuberculous ulcer was put forward as the most probable. The case was tested by tuberculin (Mantoux method) and gave a doubtful positive reaction. He was thereupon treated, with a group of definitely tuberculous cases (lupus, etc.), with tuberculin injections for a period of three and a half months. Alone out of the group he failed to show the slightest sign of improvement; in fact the condition had deteriorated. Another biopsy resulted in a similar pathological opinion, and a Wassermann reaction, which should have been requested when he first attended the skin department, was returned strongly positive. He was then referred for treatment to the V.D. section. The result of one injection of 0·45 g. of N.A.B., with a week's iodide of potash, is clearly depicted on the plate, and the ulcer was completely healed in a month from the commencement of the correct treatment.

A blood-test for syphilis should, whenever possible, precede any other investigation into the cause of cutaneous ulceration.

PLATE XCI



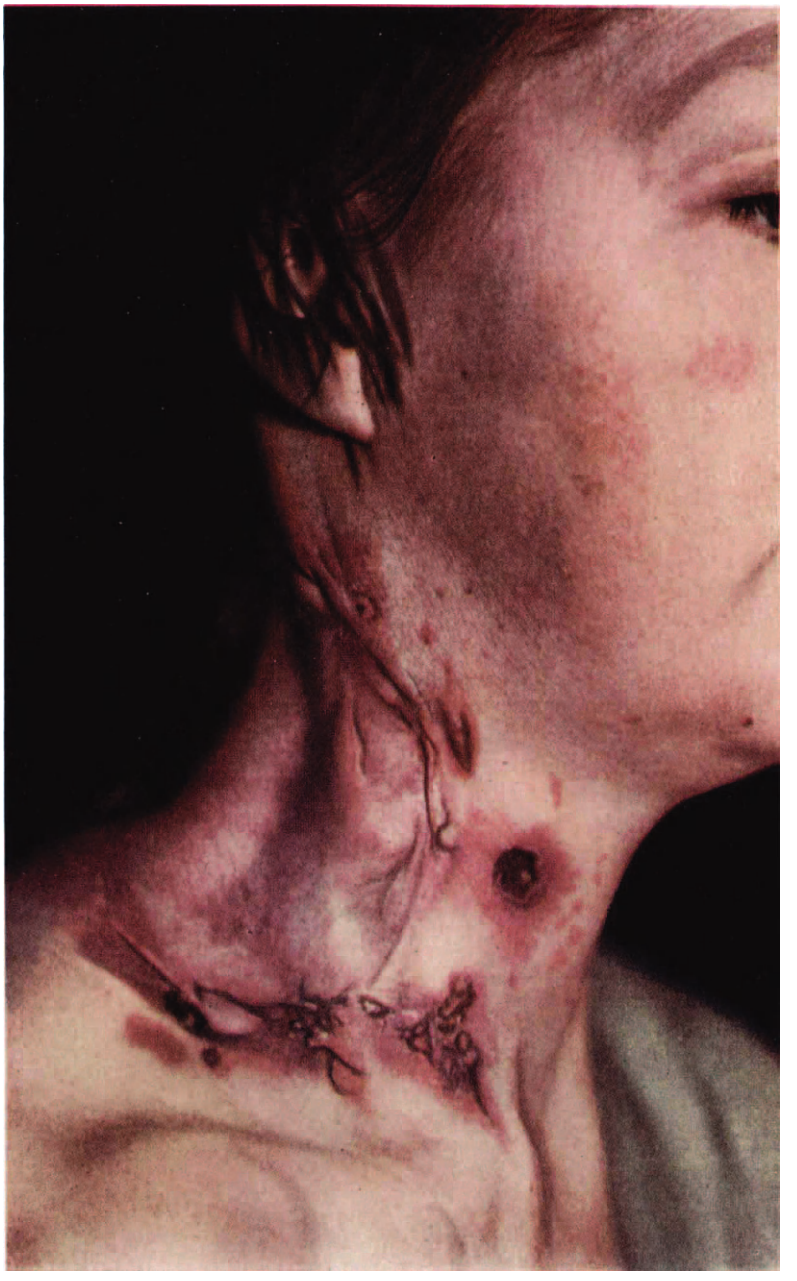
SYPHILIS: TERTIARY ULCER

SYPHILIS: TERTIARY ULCERATING SYPHILIDE

(PLATE XCII)

THE eruption followed removal of glands in the posterior triangle for presumed tuberculosis in a woman of 43, and was considered to be a case of lupus vulgaris. In the differential diagnosis, which is of the greatest importance in the treatment, the time relations are often of assistance. Only three months intervened between the operation and the developments here depicted. Lupus vulgaris would take as many years for a spread of this extent. It should be further noted that there are no 'apple-jelly' nodules. The colour of the affection is more coppery than the reddish-yellow translucent tint we are accustomed to associate with a characteristic patch of lupus. Finally there is the gummatous, superficial, painless ulceration. The neck is a not uncommon situation for this to occur. It is more acute, and much more defined, than the tuberculous. The edges are described as undermined or punched out, and tend to be circular in shape, as in this case. The Wassermann reaction was strongly positive, and the lesions cleared up rapidly after a short course of N.A.B.

PLATE XCII



SYPHILIS: TERTIARY ULCERATING SYPHILIDE
(Resembling Scrofuloderma)

TINEA BARBÆ

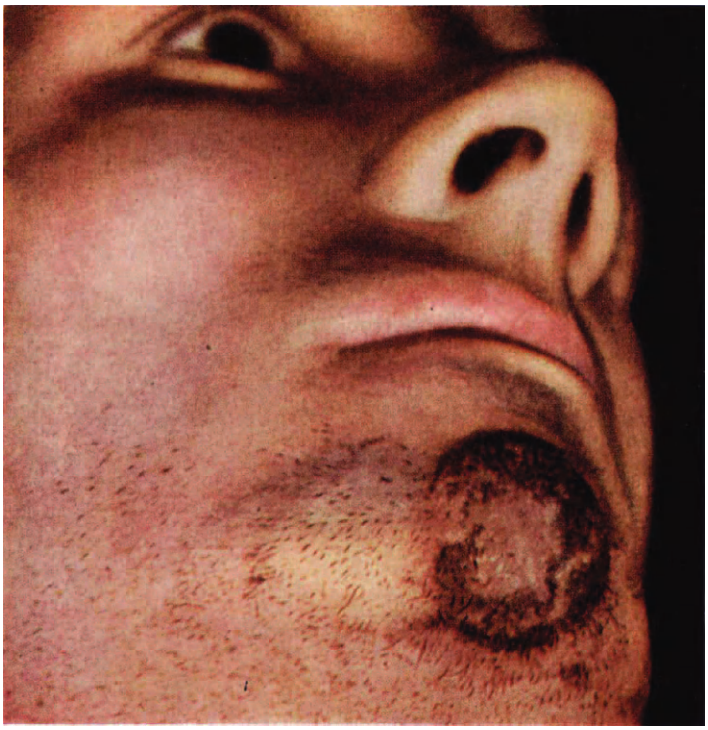
(PLATE XCIII)

MYCOTIC infection of the hair-shaft *in adults* in this country is practically confined to the shaving area, and the infecting agent is usually a tricophyton derived from an animal. The groom and cowherd are relatively the most likely sufferers from an otherwise rare infection. Two clinical types are met with—an acute suppurative perifollicular (kerion type), and a more chronic, scaly, usually circinate variety.

Although usually circular in outline the infection may have a quite irregular shape and be widely distributed over the whole face, in which case the diagnosis may be difficult. The proof lies in the demonstration of the causal mycelium, either microscopically or by culture, in the epilated hair, which when infected is very easily removed with forceps and tends to fall out spontaneously. Such was the case in the patient exhibited (the lesion has been painted with tincture of iodine)—a very mild case which soon yielded to manual epilation and the local application of an ichthyol and salicylic acid (5 per cent) ointment. Sometimes, however, the infection resists all attempts at cure, and I can recall a South African example (horse infection) which in spite of all local applications, including X-ray epilation, persisted and spread from follicle to follicle for a period of eleven months.

The plate should be compared with *Plate LXXXII*, which demonstrates a case of the much more common coccogenic variety of sycosis. Confusion might conceivably arise in a case of tertiary syphilitic ulceration, covered by crusts. A starch poultice would be advisable in all such crust-covered cases, and would probably reveal definite ulceration and the inevitable cicatrization ensuing. The Wassermann reaction would decide in any doubtful case.

PLATE XCIII



TINEA BARBÆ

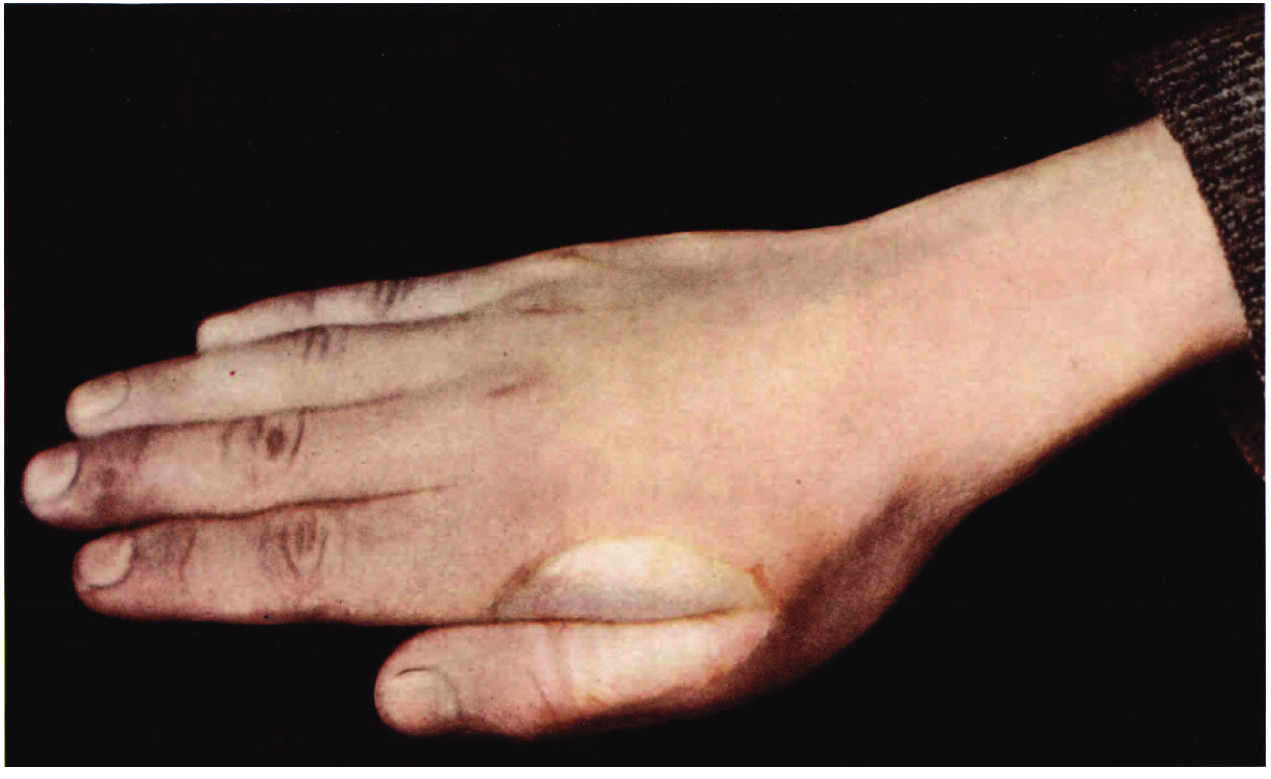
TINEA CIRCINATA

(PLATE XCIV)

THIS somewhat unusual localization, and the slight local disturbance caused, are interesting features of a common infection. There was but little irritation and no visible secondary contamination with pus organisms. Examination with a lens, however, revealed a line of small vesicles at the upper and radial border, and from one of these a delicate mycelium was demonstrated in potash. The very superficial and non-inflammatory character here present is rarely seen on the glabrous skin, and the case reminds me of one in a small child in which the upper eyelid was involved by a scaly eruption almost identical in appearance with that here shown. In that case also we succeeded in demonstrating the mycotic origin. The infection, as in this case, was probably contracted from a cat.

The diagnosis of tinea circinata should rest on the recent history, the itching almost invariably present, the superficiality of the lesion, the spreading, often pustular margin, the clearing centre, and, above all, the slightly raised edge containing small vesicles, in the delicate roof of which the mycelial cause can usually be demonstrated.

Treatment of so superficial a case is easy. A 3 per cent benzoic and salicylic acid ointment, or the application of tincture of iodine, would suffice to eliminate the infection in a few days.



TINEA CIRCINATA

TINEA CRURIS

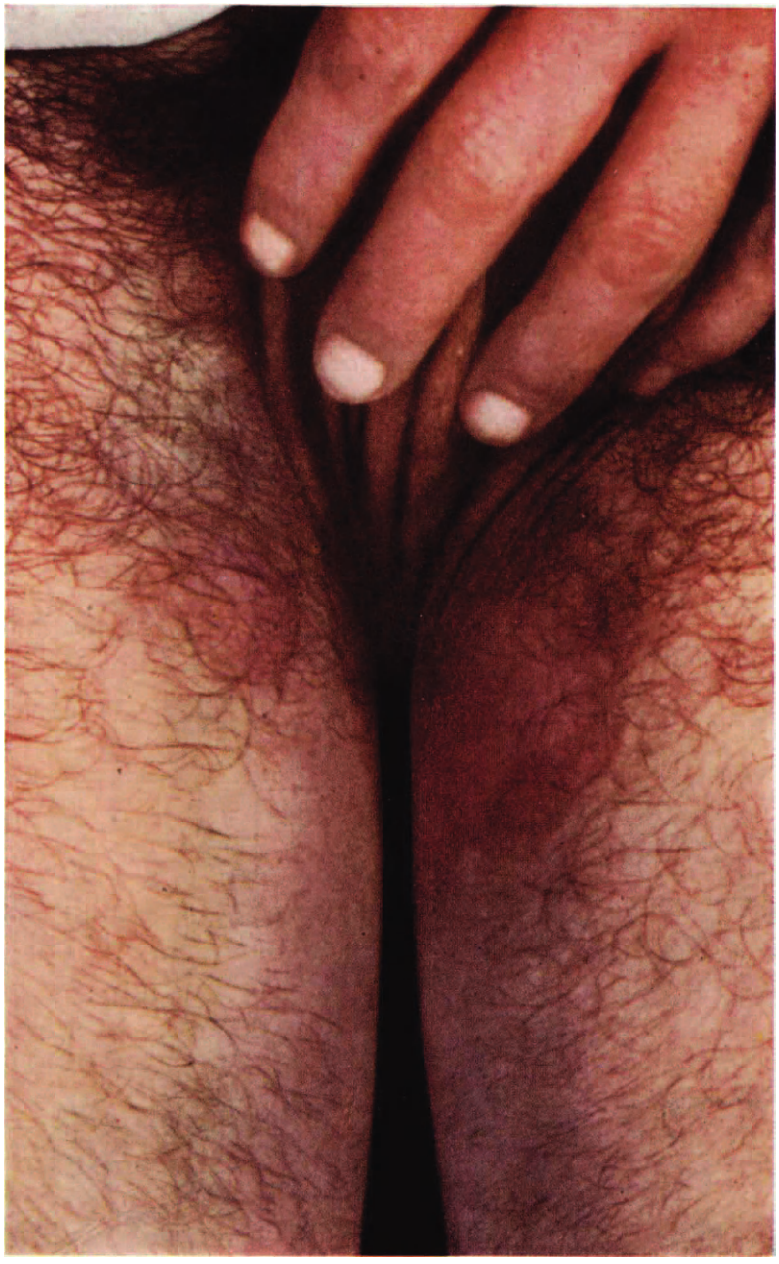
(PLATE XCV)

THIS irritable infective mycosis of the groins, inner aspects of the adjoining skin of the thighs, and scrotum, and sometimes spreading thence to the internatal and perianal regions, and even to the axillæ, is caused by the *Epidermophyton inguinale*. This fungus also infects the interdigital skin of the feet (*see Plate XXXIII*), notably the cleft between the 4th and 5th toes, where it may lie dormant as a tendency to peel, or to cause slightly painful fissures, for many years. The nail substance of adjoining toes may also be infected, and assume a yellowish opaque colour and a friable or brittle consistency. Infection is conveyed from the feet to the groins, especially in tropical countries or during hot spells in Europe, probably by the bath-towel, and never, as has been so long assumed, by the dhobie or Indian washerman. Lavatory seats, etc., are equally suspected but unproven as a source of conveyance.

The appearance of the (mostly) symmetrical patches varies with the degree of the patient's reaction, and often with unsuccessful attempts at therapy. Usually they are scaly, very irritable, and sometimes, in the acute stages, vesicular or even pustular. The important diagnostic feature is the sharply defined border, which led Hebra to name the condition ' eczema marginatum '. The differential diagnosis of this condition from other forms of groin ringworm (trichophytic) is not important, and can only be made microscopically or by cultures. Erythrasma, which is also due to a fungus, is never acute, and itches but slightly if at all in hot weather. It is often present unnoticed by the patient for years.

Treatment is simple. Washes of 2 per cent salicylic acid in spirit, or a 3 to 5 per cent salicylic acid ointment, or, in very resistant cases, a cignolin paste ($\frac{1}{2}$–1 gr. to 1 oz.), will usually suffice to clear up the eruption in about ten days. But relapses from residual mycelium or infected clothing are not infrequent, and it is advisable to persist with treatment for about ten days after all symptoms have subsided.

PLATE XCV



TINEA CRURIS

TINEA UNGUIUM

(PLATE XCVI)

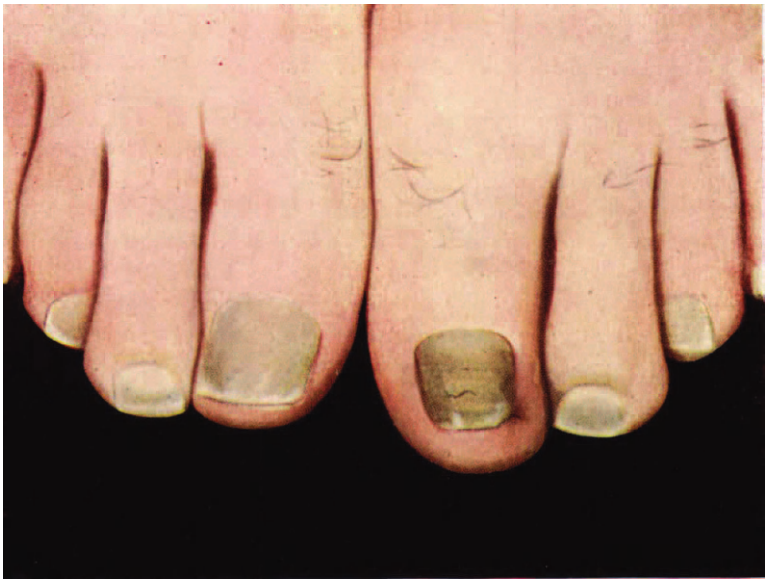
IN the case illustrated the left big toe-nail has been invaded by the epidermophyton fungus and has lost its normal contour, colour, translucence, and plasticity. On the fibular side the free margin displays a tendency to ' grow inwards ', and the infection can therefore produce the well-known and troublesome disability termed ' ingrowing toe-nail '. The fungus has been recovered and grown from the nail substance on two occasions, and it flourishes between the fourth and fifth toes (cf. *Plate XXXIII*) and in both little toe-nails. It has also spread backwards from these situations and invaded the whole of both soles, setting up chronic erythema and a tendency to exfoliation. The feet are always hot and tender, especially in the summer months.

In such cases there is the ever-present possibility of an acute local exacerbation (cf. *Plate XXXII*), or of ' dysidrotic eczema ' of the hands, which is nowadays regarded as an allergic manifestation, due in most cases to a mycelial infection. The reaction may be justifiably compared to that which may occur in certain tuberculous infections of the skin in which some form of tuberculide has developed. Neither in the tuberculide nor in this manifestation, the epidermophytide, are the causal organisms generally recoverable, although they are usually present in considerable numbers in the primary focus. Under certain conditions the organisms of both may be cultured from the blood.

A comparison with psoriasis of the nails (*Plate LXXIV*) will impress the observer with the salient differences, although in well-advanced cases the differential diagnosis may be difficult, and only possible by microscopic or cultural methods.

The prognosis is not good as a rule, for the causal factors, heat, moisture, and darkness—just as in an incubator—are ever present in the boot or shoe, and favour recurrences even if surgical ablation of the nail is advised. This is probably the best treatment for such a case as is here presented. It must be followed up by the continued and persistent application of antiseptics, of which salicylic acid is probably the best (5 to 20 per cent in an ointment base). Such an application should also be introduced with an orange-stick on wisps of cotton-wool twice daily under the free margins of infected nails in any situation. The chances of cure would be greatly increased if sandals—permitting of the free spread of all the toes to the light and air—could be substituted for shoes, at least during the summer months.

PLATE XCVI



TINEA OF THE NAILS

URTICARIA

(PLATE XCVII)

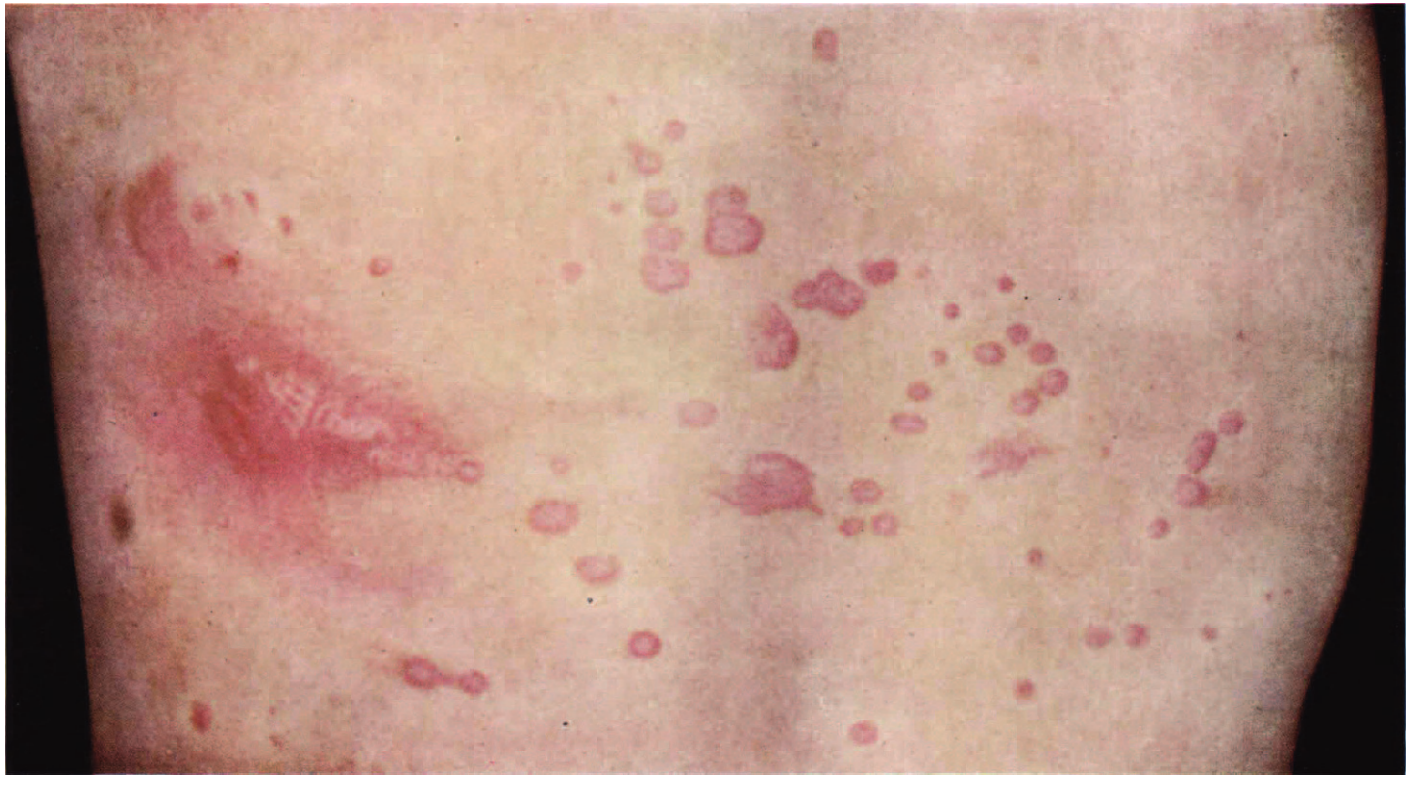
NETTLE-rash or urticaria, of which we were fortunate in securing the accompanying illustration, is characterized by the evanescence of the eruption. This consists of raised papules, macules, or wheals on any part of the skin area. Pruritus is almost always severe, and as the attacks are prone to occur at night, is frequently associated with insomnia.

There are two main types of the disease : an acute, which may follow a single indiscretion in diet or the ingestion of some article of food to which the patient is susceptible, either from birth or at a later date ; and a chronic variety which may last for months or years without the exact cause being discovered. The appearances are the same in both, but the plate happens to illustrate the latter in a youth of 16, who had suffered from the symptom almost continually for a period of three years. The lesions are pale pink macules, raised above the surface of the skin of the back, and exhibiting an erythematous flush or ' flare ' towards the left margin of the plate at a point where they had been rubbed just before the picture was taken. This flushing is a very characteristic feature of urticaria, and can usually be elicited round a recent lesion by rubbing, and not infrequently in the form of so-called ' dermographism ' in cases otherwise devoid of symptoms—a not uncommon occurrence at the time of the examination. The production of wheals, either by purposive rubbing or spontaneously, is therefore a very valuable aid to diagnosis. A study of the larger flushed lesion reveals a dotted or grained appearance. The dots are the mouths of œdematous follicles around which exudation of serum has taken place.

Treatment of an acute case, which may or may not be associated with fever and gastro-intestinal symptoms, is simple. The patient is put to bed, purged with calomel, and kept on a strict milk diet for two or three days. A local application of 2 per cent liquor carbonis detergens in lead and calamine lotion is usually effective in soothing the irritation.

In the chronic case we must endeavour to determine the antigen responsible for the allergic manifestations. Sometimes the patient has acquired a susceptibility to a specific protein—e.g., eggs, wheat, shellfish, tomato, or even milk, and may be aware of his peculiarity. At other times the abnormality has been inherited and has been present from birth. Attempts at desensitization are rarely successful and at best only temporary. The causal substance must be avoided in the diet, as far as that is possible. While the digestive tract is most frequently the site of absorption, causal antigens can be manufactured in septic foci in any part of the body, and cases of urticaria have been permanently cured by draining an infected gall-bladder or antrum, or by removing septic teeth (apical abscesses) or an appendix. A rare cause is the presence of intestinal worms or hydatid cysts. When all these possibilities have been exhausted there remains a group of cases in which no cause can be ascertained, and in these a line of empirical treatment based on protein shock injections is frequently successful. The mildest should be tried first. A course of

PLATE XCVII



URTICARIA

intramuscular injections of the patient's own blood (autohæmotherapy), 2 to 12 c.c., is given weekly or biweekly in the buttock. Intravenous peptone injections on an ascending scale are supplied by the larger chemical firms for the same purpose, and van Leeuwen, whose work on the treatment of allergic symptoms generally is well known, uses suspensions of sulphur by the intramuscular route. After warning the patient that he must expect some local pain and fever, 1 c.c. of a 1 per cent colloidal sulphur preparation is injected into the buttock. If during this reaction there is improvement in the allergic urticarial syndrome (itching and eruption) the treatment is continued weekly, but *in doses below* 1 *c.c.*, i.e., 0.2 to 0.5 c.c., until a cure or alleviation results. If after this a relapse should occur, further injections at a much lower level (0.1 c.c. of a 1–1000 suspension) may be resumed. The method is said to have succeeded after peptone treatment had failed. (Goldsmith, *Recent Advances in Dermatology*, p. 256.)

When all else fails the patient should be subjected to treatment by pyrotherapy. A typhoid-paratyphoid vaccine is usually employed for the purpose, and temperatures of 103° to 105° F. are quite frequently obtained. It follows that weakly and cardiac or bronchial cases, diabetics, and others are definitely excluded from the procedure.

Immediate relief in a severe attack which may involve the mucous membrane of the larynx or epiglottis and threaten asphyxia can be obtained by subcutaneous injection of adrenaline (5 to 10 min.), or by evatmine (1 c.c.), a useful combination of adrenaline and pituitary extract.

VARICOSE ULCER

(PLATE XCVIII)

WE see here an example of an indolent long-standing ulcer on the left leg in the typical situation—lower third, internal aspect. A similar condition has long since healed up and formed a firm pigmented cicatrix on the right leg. Sepsis, as evidenced by crusting, dermatitis, and offensive discharge—a common feature—was not a complication in this patient, and the ulcer is a good example of what has been termed 'gravitational' effect—i.e., venous stasis and back-pressure in tortuous or dilated valveless veins.

The points which can be studied in this life-like portrayal are the bluish congestion above and below the ulcer, the brownish pigmentation, and the whitish macerated and slightly raised—i.e., infiltrated—edge, which shows no tendency whatever to assume the healthy white-blue-red (from without inwards) zones indicative of the normal process of healing. The ulcer itself has a sodden brownish or purplish colour and is totally devoid of the bright-red protuberant granulations which must precede sound and efficient re-growth of the epithelium.

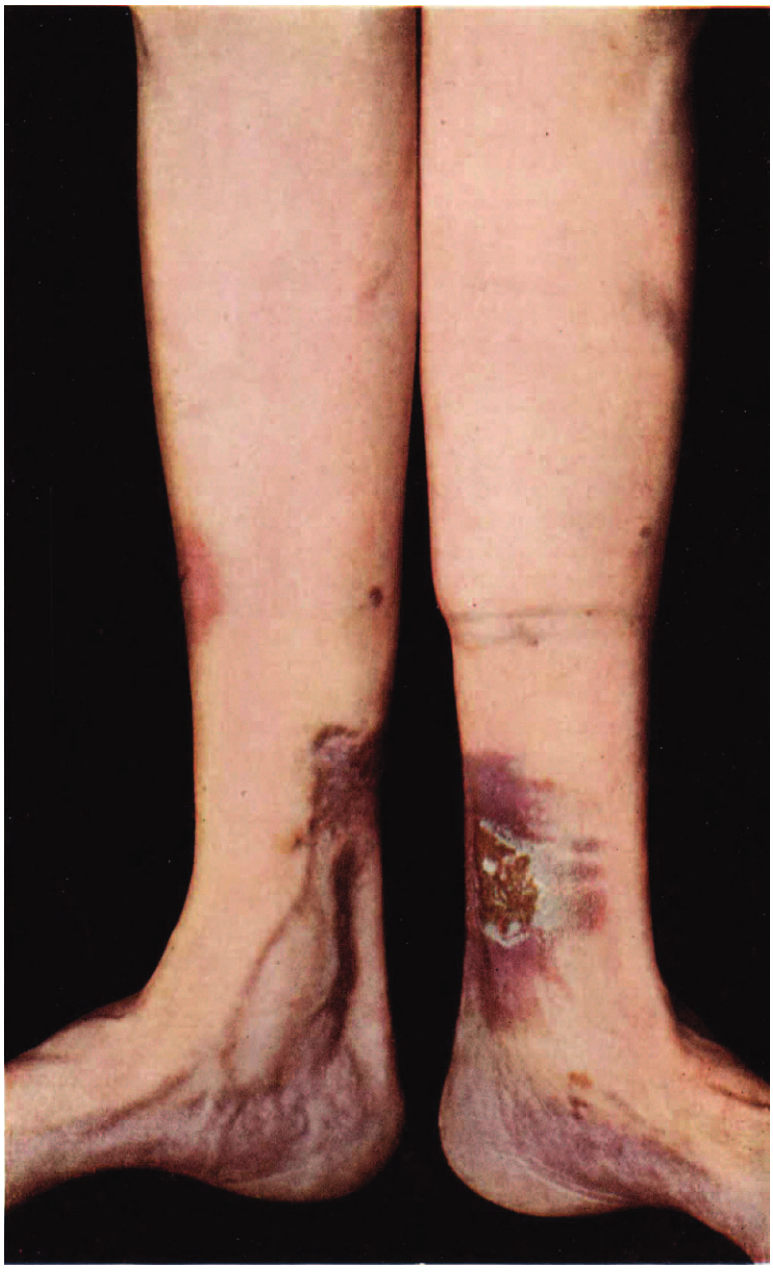
The varicose veins responsible for the condition in this case are lying under the ulcer itself, and must await injection until all danger of septic thrombosis and phlebitis by too close an association with the ulcer has been removed.

A diffuse circular patch of commencing varicose dermatitis can be seen on the right leg at the junction of the middle and lower thirds of the antero-external surface.

In the differential diagnosis it should be remembered that tertiary syphilitic ulcers of the leg (*see Plate XC*) are frequently multiple, more circular or circinate in outline, mostly in the upper third of the leg, and tend to have an excavated or overhanging edge.

Treatment.—A rapid cure was attained in this case, as in so many others, by the application of elastoplast bandages over a modified Unna's dressing (varicosan bandage) just sufficient to cover the ulcer itself. This precaution has in my experience reduced to vanishing point the incidence of dermatitis following application of elastoplast direct to the surface of the ulcer, and has certainly had no untoward effect in retarding the cure.

PLATE XCVIII



VARICOSE ULCER

VITILIGO

(Acquired Leucoderma)

(PLATE XCIX)

TYPICAL lesions and the most common situation are here represented in a married woman of 33. The characteristic feature is a patchy depigmentation or bleaching of the epidermis, symmetrically localized, and tending to spread slowly and centrifugally from quite small circular lesions. The larger white circles so formed frequently coalesce and thus account for the peculiar segmental shapes and figures of the fully established clinical picture. There is no inflammatory stage in its production, but slight pruritus is sometimes present when new areas of depigmentation are appearing. The margins of the white patches are definitely hyperpigmented, especially in the summer months, as if the receding pigment were being heaped up at the periphery of the advancing patches. In well advanced cases in which the skin of the whole body has been affected (sometimes even the hair, which may be bleached in streaks), the residual pigment grouping may present grotesque shapes and possibly lead to the erroneous diagnosis of melanoderma. The mistake can be avoided by remembering that a leucodermic patch is originally always a circle, and that therefore the white area wherever it touches the hyperpigmented must have a convex border. The figures of hyperpigmentation on the backs of the hands in this plate exhibit this convex indentation very characteristically, and afford thereby an immediate clue to the diagnosis of the case. Next to the hands, the neck is most often affected, but no part of the body except the palms and soles is immune, once the process has started, although spontaneous arrest and improvement may occur. The cause is unknown, but is suspected to be associated with the endocrine and sympathetic systems.

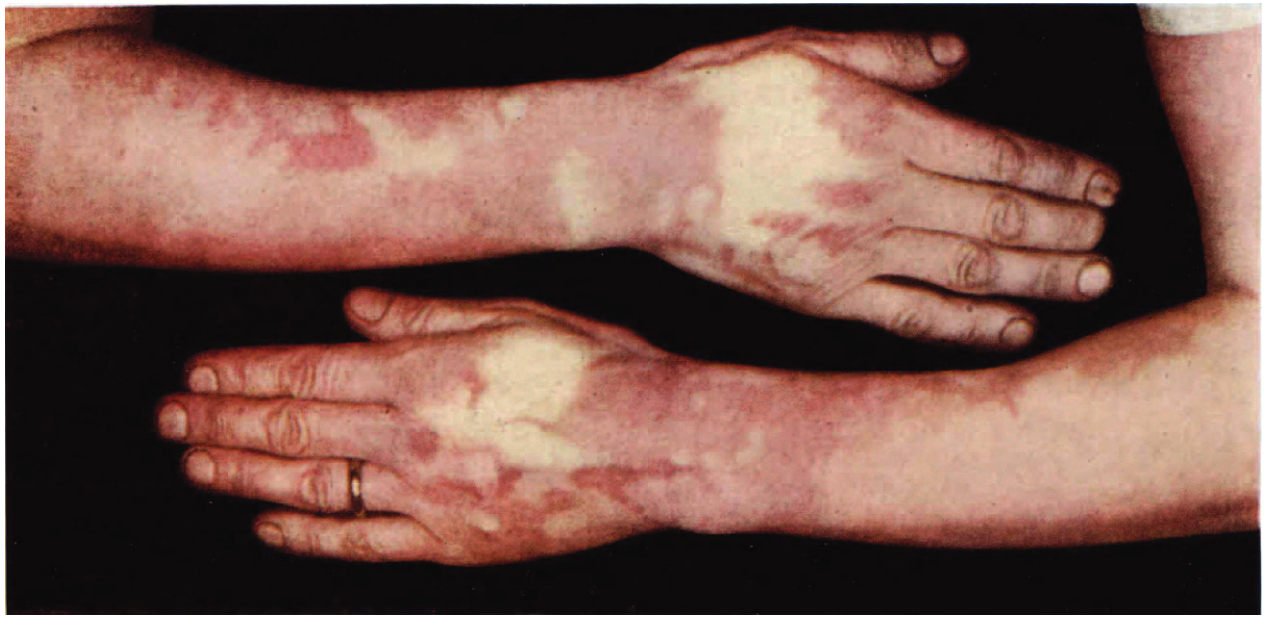
In the differential diagnosis it is well to remember that vitiligo is a progressive symptom, and that although temporary stasis occurs sometimes, universal depigmentation may eventually ensue. This progressive feature is of importance in distinguishing it from leucodermic patches of congenital or syphilitic origin. Nothing is known for certain regarding its causation, but there have been many cases in which the hyperthyroid symptoms of Grave's disease were conspicuous, and Goldsmith reports (presumably post mortem) some in which suprarenal damage was observed (*Recent Advances in Dermatology*, p. 62).

Treatment.—No treatment, hitherto, has been of much value, and recourse must be had—especially in the summer months, when the hyperpigmented areas are most prominent—to artificial stains and dyes, of which various shades and colours can be concocted to suit the individual complexion.

There is still no specific treatment available, but a modified success is claimed for irradiation with the grenz or 'borderline' rays (Bucky and Wolffenstein), the resulting erythema from which is usually followed by pigmentation.

Dr. Norman Burgess, of Bristol, has reported a successful result following the local application of a 10 per cent alcoholic solution of oil of bergamot twice daily and the mercury vapour lamp, and intravenous injections of sanocrysin 0·05 g. once weekly. Repigmentation was complete in seven weeks. (*Brit. Jour. Dermatol. and Syph.*, 1934, xlvi, July, 313.)

PLATE XCIX



VITILIGO (Acquired Leucoderma)

WART

(Verruca Vulgaris)

(PLATE C)

THE actual cause of the common wart has never been demonstrated, but experiments have proved that it is a filter-passing virus. The incubation period may be as long as six months. Uncovered areas are affected as a rule, and the face and hands are the usual sites, although the plantar wart (*see Plate CII*) occurs on the under surface of the sole. No age is exempt, but children from the age of 3 to puberty are the usual subjects.

The plate illustrates a case of warts which affected both hands in a boy of 14, and the colour, shape, and localization are highly characteristic of the various phases through which a wart may pass. The small yellow papules on the back of the hand may ultimately attain the size of the papillomatous excrescences depicted at the roots of the fingers and the ulnar and radial borders.

No other affection causes lesions so defined and multiple. The tuberculous wart is usually single, more infiltrated, tends to ulcerate, and may persist throughout life, leaving scars as it progresses. The untreated common wart never ulcerates, never leaves scars, and eventually disappears spontaneously without leaving a trace.

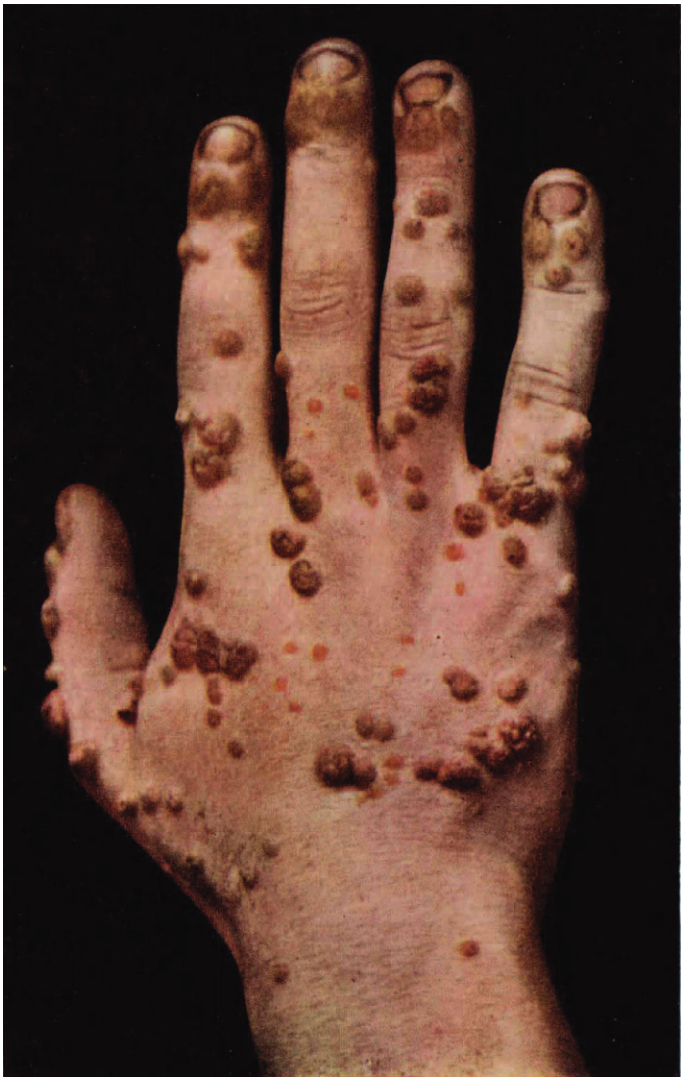
Treatment.—The only reliable means of treatment are the destructive, and these, considering we have to deal with a benign affection, should be as localized as possible. The actual cautery, which is the safest caustic we possess, is the most rapid means of effecting a cure. It is the only one at all satisfactory for the peri- and sub-ungual varieties of wart illustrated in the plate, and a local anæsthetic is to be preferred to a general. Liquid caustics, of which trichloracetic acid is probably the best, all share the disadvantage that it is exceedingly difficult to confine their action to the parts to be treated, and that with ensuing treatment the surface of a wart seems to become more compact and resistant. X rays should not be used except by an expert in the estimation of dosage. Radium, even in the most experienced hands, may leave a permanent stigma.

Dr. A. Whitfield suggested the following formula to me. I have frequently found it effective :—

R	Hydrarg. biniodidi	gr. v–x
	Acid. salicyl.	ʒi –ii
	Surgical spirit	℥ i

Recent warts, especially in children, and the soft papillomatous variety at mucocutaneous junctions and in the scalp, are the main indications. A pointed match-stick is moistened with the liquid and applied twice daily.

PLATE C



COMMON WARTS

WART

(Pedunculated)

(PLATE CI)

IN this type of pedunculated wart, the infection is conveyed and perpetuated indefinitely by shaving. In one such case recently under treatment the condition had been present for over a year, and the affected shaving area converted into a closely packed mass of hundreds of these small papillomata, which appeared to spring up from the individual hair follicles.

The diagnosis should offer no difficulty. The small isolated warts on the left cheek are pinhead-sized flat sessile papillomata, those on the chin are tending to become stalked or pedunculated. There is no other disease with which this condition could be confused except molluscum contagiosum (*see Plate LXIV*), and in the more succulent, slightly larger, glistening pearly bodies of the latter, there is always umbilication to aid the diagnosis.

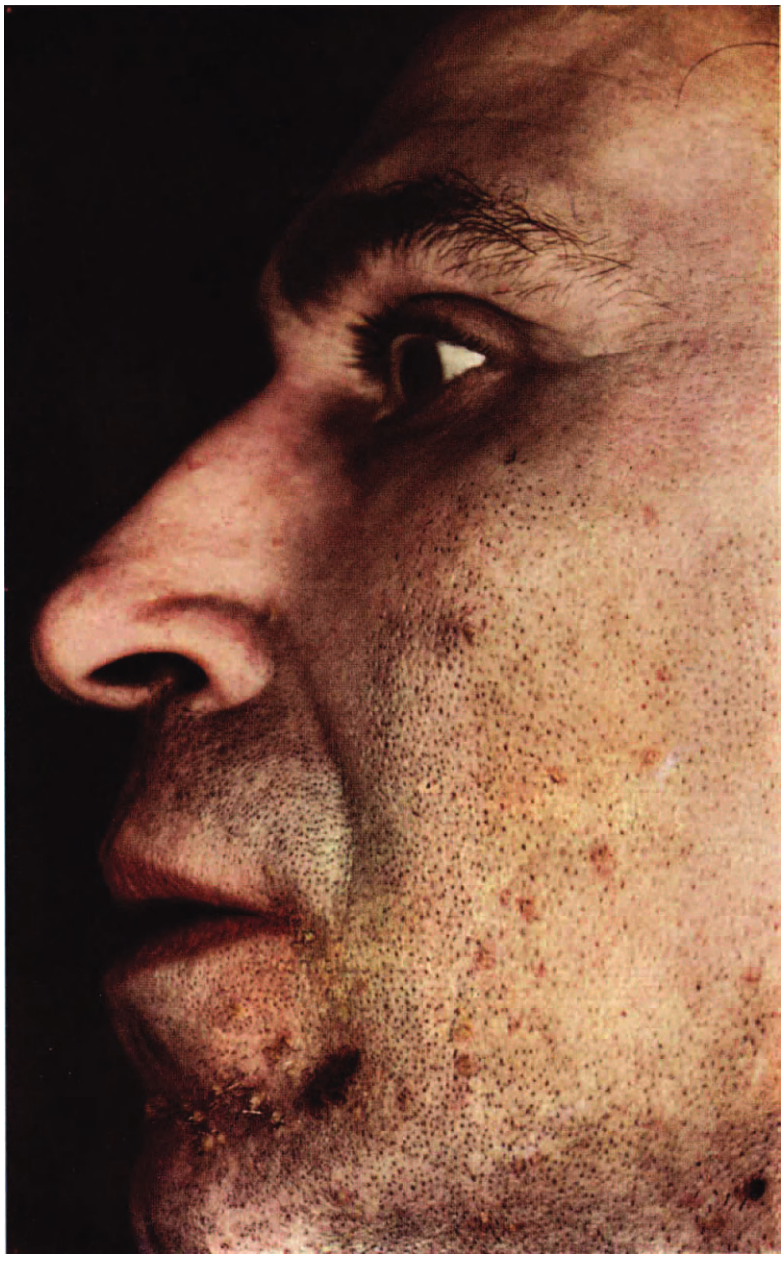
Treatment.—Very considerable doses of X rays would be necessary before a cure could be achieved, and the author rarely uses them in this infection. A safe and reliable method is to forbid shaving absolutely, and to destroy each lesion as it matures with careful applications of the actual cautery. Several sessions are usually required, at weekly intervals.

The following paint has also proved curative :—

℞	Hydrarg. biniodidi	gr. v
	Acid. salicyl.	ʒ i
	Surgical spirit	℥ i

It is applied to each lesion individually twice daily for ten to fourteen days on a pointed match-stick, and can do no harm as it does not produce scarring.

PLATE CI



WARTS (Pedunculated)

WART, PLANTAR

(PLATE CII)

THIS, the verruca of the chiropodist, appears to be getting more frequent than it used to be, and by reason of the pressure to which it is subjected may cause quite a severe degree of pain and disability. Young persons of both sexes seem to pick up the infection—which is the same as that which causes the common wart—more frequently than adults. The plate illustrates a common localization over the ball of the great toe, and the diagnosis is easy, for pain on pressure is never absent, and the appearance is very characteristic and quite different from that presented by a corn. It will be noted that the surface is dry, irregularly oval in shape, and dark in colour. This dark central verrucose point is highly characteristic, and represents the apices of the proliferating warty papillæ, which are prevented by pressure from developing into the warty protuberances of the more common hand and knuckle infections (*see Plate C*).

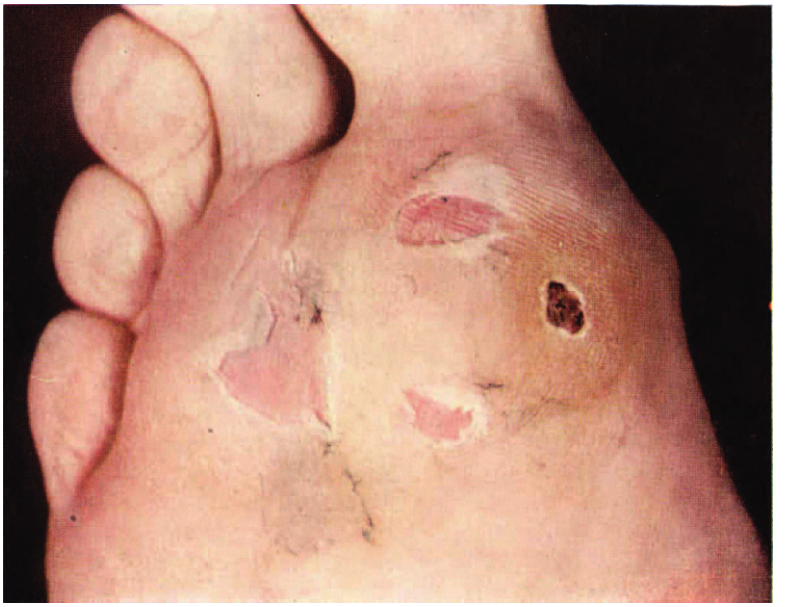
Treatment.—The treatment adopted generally is by X rays or radium, but it should never be applied except by an expert, for the necessary dose verges on the danger zone, and I have seen exceedingly painful and sometimes long-delayed radio-dermatitis (five years in one case) of an overdose on four separate occasions. Not infrequently the first dose (of 1½ to 2 pastilles) is found insufficient, and it is repeated too soon because the patient is in pain, which the X rays undoubtedly relieve. In my opinion the use of X rays in maximal or super-tolerance dosage is only justified in cases of rodent ulcer or other malignant conditions, and certainly not for a banal infection like the common wart.

My standard treatment for a plantar wart like the example illustrated (which was cured in this way) is to inject a little novocaine into the base of it, and then curette it out thoroughly with a sharp spoon, until no more warty substance is left. The little wound heals rapidly, in a week as a rule, and neither the physician nor his patient has anything to fear in the future from the effects of treatment.

Roxburgh advises plugging the cavity after curetting with a gauze strip soaked in 2 per cent solution of nitrate of silver. This procedure may tend to prevent the occasional relapses which I have seen even after a most drastic curetting.

Before either X rays or curetting is decided upon it is well worth while to try the effect of a strong salicylic acid (60 per cent) plaster fixed accurately over the wart and kept in position by strapping, day and night, for a week or two. The macerated warty substance is removed at each visit with forceps and the plaster reapplied. In children especially I have been much gratified by results. This treatment is safe and practically painless.

PLATE CII



PLANTAR WART

XANTHOMA PALPEBRARUM
(Xanthelasma)

(PLATE CIII)

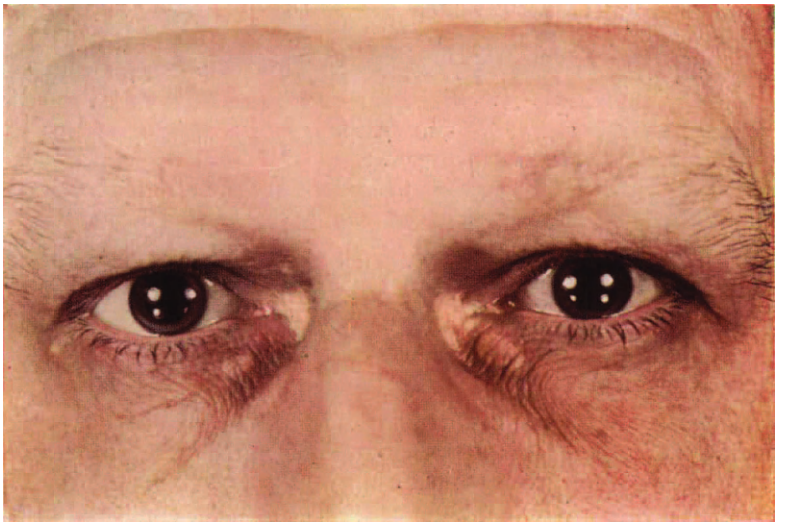
SLIGHT degrees of this disfiguring but otherwise harmless condition are by no means uncommon in middle-aged and elderly persons of both sexes. It is not to be confused with xanthoma diabeticorum, for the blood-sugar excess so common in the latter is neither a cause nor an association.

The exact aetiology is uncertain, but many of the cases have some liver disturbance, such as gall-stones, or an excess of cholesterol in the blood. The raised soft ' wash-leather ' patches or plaques never ulcerate or give rise to any local symptoms, although once they have appeared they may slowly extend along the eyelids (upper or lower) for some distance before they become stationary. Left alone they are never absorbed.

The patient here shown, a man of 48, had noticed the two nodules at the inner canthi for about five years, and thought that latterly they had begun to extend. His blood-cholesterol was normal and no symptoms of hepatic disease were present.

The little stigmata were excised by the ophthalmic surgeon under local anæsthesia, and this is probably the best and safest procedure in competent hands. Other measures, as by freezing with CO_2 snow, radium, X rays, or electrolysis, are seldom entirely successful and should not be undertaken in preference to the little operation, which owing to the laxity of the skin over the tarsi very seldom presents any difficulty to the ophthalmologist.

PLATE CIII



XANTHOMA PALPEBRARUM
(Xanthelasma)

XERODERMIA OR ICHTHYOSIS

(PLATE CIV)

IN its milder degrees the condition is by no means uncommon and may underlie certain types of recurrent seasonal eczema of the face or limbs as an unsuspected basal cause. It is practically always congenital and a recessive hereditary tendency seems to be the rule. The cause is unknown, although faulty endocrine (? thyroid) metabolism has often been impugned. The main symptoms are dryness or harshness of the epidermis, especially on the extensor surfaces (knees and elbows) of the limbs, with a tendency to branny scaling, which in some cases may lead to painful fissures as on the palms and soles. In severe cases the face may also be involved and induce a condition of 'pinched facies' with ectropion, scaling, and patchy eczema not unlike that seem in some cases of scleroderma.

Histologically there is increase in keratin formation (hyperkeratosis), and marked decrease in the normal number of sebaceous glands which accounts for the characteristic dryness present in all cases. The skin is thus robbed of one of its most potent defences—its normal oily sebaceous covering.

While the mild case (xeroderma) is the rule, there are all grades of severity, the most severe—ichthyosis fœtalis gravior (harlequin fœtus)—being incompatible with life.

The case illustrated is that of a man of 19, otherwise in perfect health, refused for the Army on medical grounds. The features depicted: dryness, scaling, and exaggeration of the normal furrows, were present in a greater or lesser degree on most of the covered body surfaces—extensor more than flexor. A younger brother was stated to be similarly affected, while his only sister suffers from recurrent attacks of asthma—a recognized occasional association either in the same individual or in a blood relation.

The military medical authority was well justified in his decision. Such a skin would handicap its owner in the normal routine of barracks and the parade ground, and almost certainly land him in hospital in the early stages of any campaign.

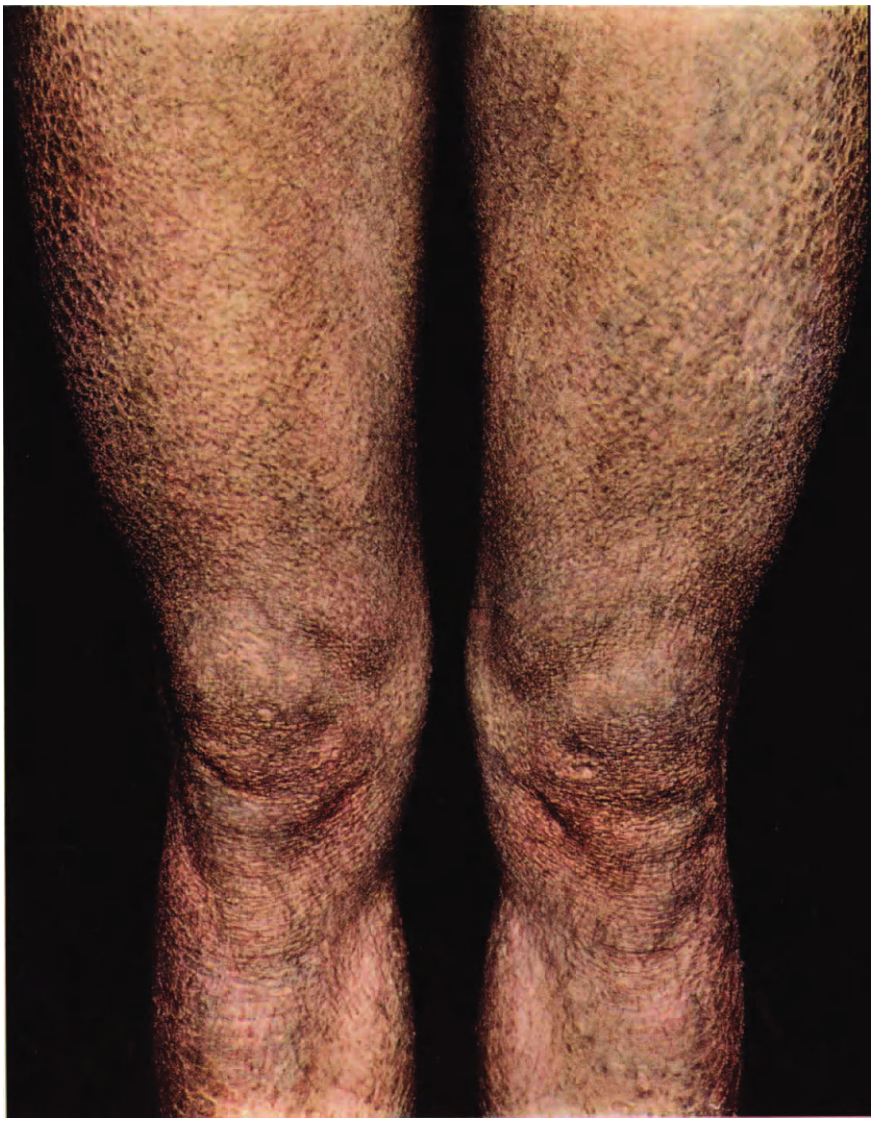
Diagnosis.—This is easy in the established case, and could hardly be confused with any other dermatosis. It is in the mild ill-defined variety complicated with varying eczematous manifestations that we must be on our guard for the 'dry skin', of which these patients sometimes forget to complain, and which may require specially selected therapeutic measures in relation to the underlying dyscrasia.

Prognosis.—While most cases improve at puberty a complete cure can never be promised. Some degree of xeroderma is likely to persist through life.

Treatment.—I have not been able to convince myself that thyroid or any other oral medication *ad hoc* is of the slightest permanent value. The chief reliance has to be placed on local applications, which in my experience are most usefully inuncted every night after a hot bath, using only the best superfatted soaps to remove the debris of scales and old ointment. The basis of all formulæ used in ichthyosis is lanoline, and to it may be added, in variable proportion, vaseline, lime water, glycerine, and salicylic acid (½–1 per cent) to loosen scales and prevent rancidity, for example:—

℞ Lanolini ʒ ii; Acid. salicyl, gr. v; Glycerini ℥ xv; Ol. olivæ ʒ ½; Vaselinum ad ʒ j.

PLATE CIV



XERODERMIA OR ICHTHYOSIS

X-RAY BURN

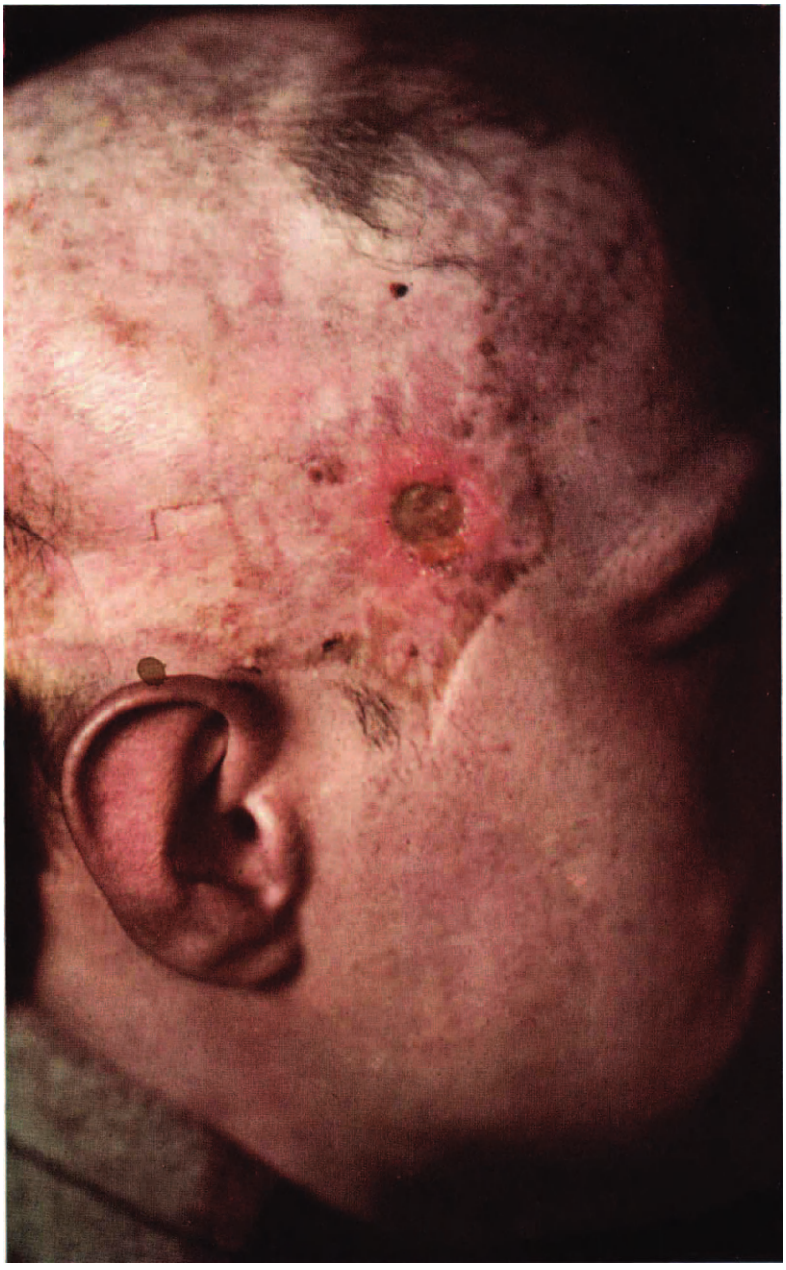
(PLATE CV)

THE picture here shown presents all the most characteristic features of chronic radiodermatitis, and is recognizable as such at a glance. Briefly summarized these features are—permanent destruction of the hair-follicles and consequent baldness, atrophy and marked dryness of the affected area of skin, depigmentation and abnormal distribution of pigment, seen well at the lower margin of the affected area, and small telangiectases (dilated venules), indicated at the centre of the area. Lastly there is a very typical chronic ulcer with slightly raised indolent edges, a yellowish base, and a hyperæmic areola. Further worthy of note is the sharply demarcated angular limitation of the damage on a line joining the tip of the pinna to the orbital margin. This is obviously a highly artificial outline, and could only have been caused by the shape of the shield used to protect the cheek from unnecessary irradiation when the patient was being treated for ringworm, some ten years previously.

Prognosis and Treatment.—The X-ray damage here shown is permanent and irremediable. The clinical manifestations are the outward and visible signs of a marked degree of atrophy and destruction of *all* the constituents of the epidermis, including the blood-vessels, lymphatics, hair, sweat, and sebaceous follicles, fat and elastic tissue (evidenced by the obvious depression of the damaged area below the surrounding surface), with permanent disorganization of the pigment-forming function.

Beyond applying some indifferent salve to counteract the lack of sebaceous secretion, practically nothing can be done for the affected skin. The invariably painful ulcer, however, must not be left untreated or a malignant transformation may supervene. If it does not heal under such modern remedies as the infra-red ray or thorium X ointment, it will have to be deeply excised and grafted, or some skilled plastic procedure invoked to repair the deficiency.

PLATE CV



X-RAY BURN

ALOPECIA

(Cicatrizing Type)

(PLATE CVI)

THE plate demonstrates an advanced example of the condition, which is fortunately very rare, for it is most irresponsive to treatment. The early case is sometimes mistaken for alopecia areata, but differs from it in the permanent and irretrievable destruction of the affected hair-follicles, with ensuing patchy baldness. The progress of the disease is very slow—it had taken twelve years to effect the changes seen in the illustration of the scalp of a middle-aged woman.

The cause is unknown, but is probably a toxin, as the follicles at the margin of the advancing patch are often erythematous and irritable. Besides the well-marked atrophy of the skin in the bald area one frequently sees brush-like relics of the original covering at points where a few follicles have escaped destruction. This is a helpful diagnostic feature, and is noticeable in the case illustrated The other possibility to be thought of in the presence of such a case is tertiary syphilis. In this disease the scarring is deeper and more irregular and may affect the bone. It is much more rapid and dramatic in its progress. The Wassermann reaction would be decisive in a doubtful case.

Treatment is, as has been stated, most unsatisfactory, and although spontaneous arrest sometimes occurs, regrowth of hair in the affected follicles never does. Possible sources of focal sepsis in tonsils, teeth, bowel, etc., should be sought out and eradicated when possible, and mild antiseptic ointments of mercury, salicylic acid, sulphur, and camphor persistently inuncted.

PLATE CVI

ALOPECIA
(Cicatrizing Type)
237

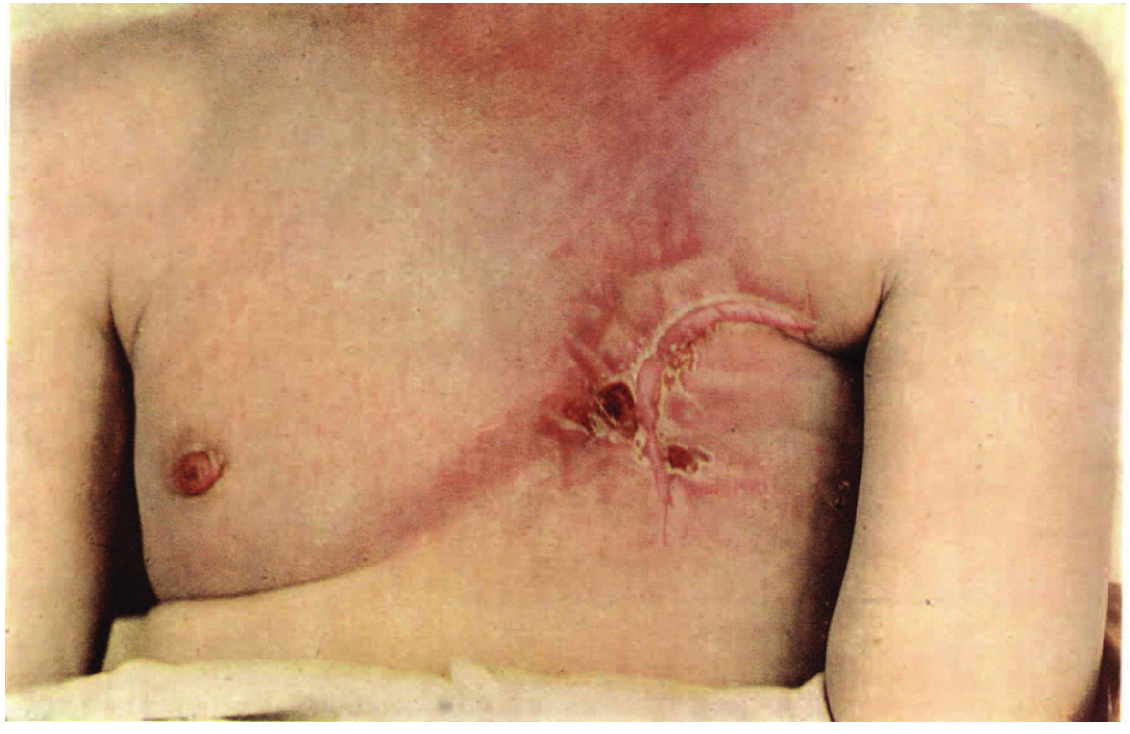
CANCER-EN-CUIRASSE

(PLATE CVII)

ANY eruption occurring in the neighbourhood of a carcinoma of the skin, or near a point at which a radical removal of, e.g., a breast, has been done—no matter at what interval of time—should always be suspected as of malignant nature. A tendency to invade the skin is particularly to be noted in Paget's disease of the nipple, but may occur in almost any type of cancer, even in those of glandular origin from the intestine or the prostate gland. Once developed it is a sign of evil augury, for it implies invasion of the lymphatic channels, and with them the lymph-glands whose deep connexions cannot be estimated.

The features of such a condition are a peculiar board-like hardness of the affected epidermis, in which pitting on pressure is but slight, a rather diffuse raised edge, a smooth surface, and a colour which may vary to a considerable degree between brick-red and purple. These points are well brought out in the plate, which also depicts a somewhat hypertrophic scar and an irregular nodular ridge or bar of new growth above it, in the lower extremity of which two small points of commencing ulceration have occurred. The epidermic invasion is not sharply defined, but has extended from the scarred area outwards into the left axilla, and upwards as high as the left clavicle and whole of the left half of the chest wall. A further extension can be seen extending downwards and to the right under the fold of the right breast.

Treatment of such a condition is wellnigh hopeless, although a good deal can be done by carefully dosed X-ray applications or radium-seed implantations to relieve pain and tension and promote healing (temporarily) of incipient ulceration.



CANCER-EN-CUIRASSE

EPITHELIOMA: MULTIPLE RODENT ULCERS

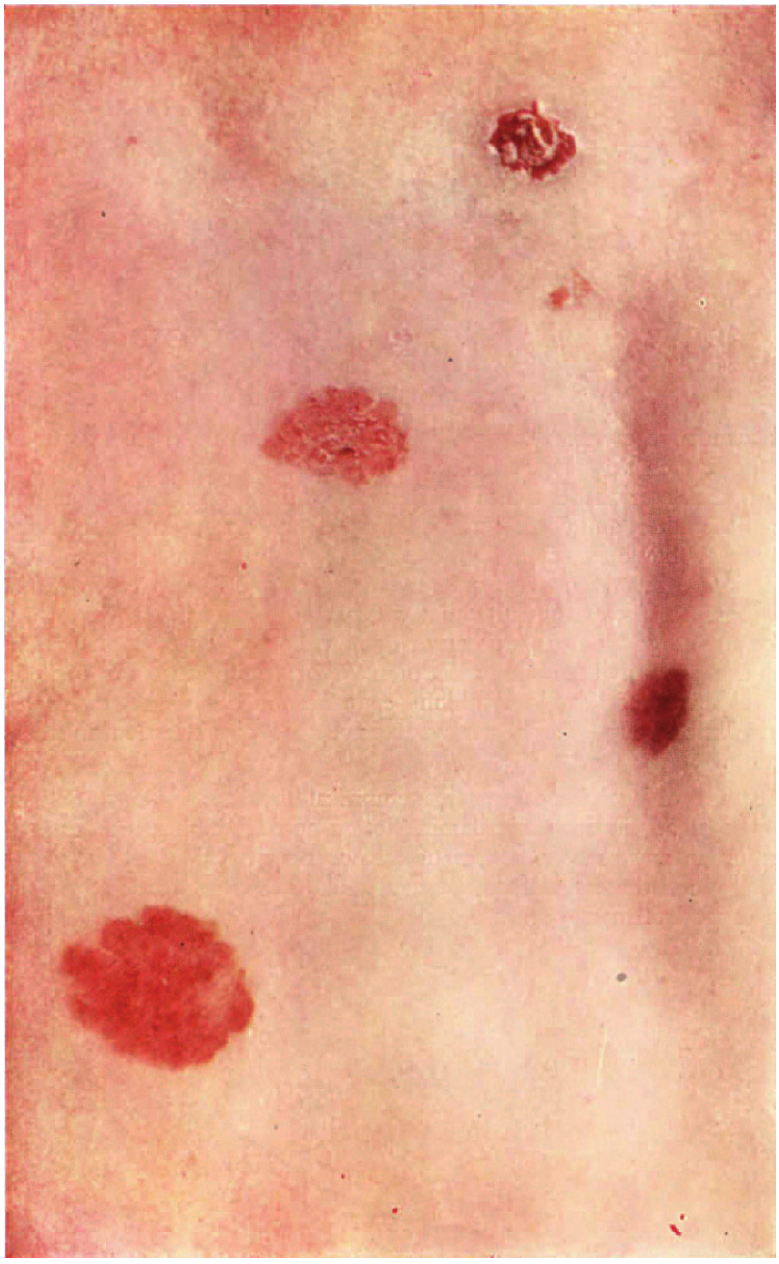
(PLATE CVIII)

PSORIASIFORM patches of long duration, of various sizes and shapes, occurring usually on the back and abdomen in elderly subjects, with a tendency to superficial ulceration, are the main features of this rare and interesting variety of malignant skin disease.

The plate demonstrates four such patches, all differing slightly in size, colour, and evolution. That in the right upper corner is exfoliating, while the lesion below and to its left is not unlike a small scaly patch of psoriasis or seborrhœa. The largest patch in the left lower angle of the plate resembles an early patch of lupus vulgaris. Careful examination of the margins of such patches with a lens will usually reveal the 'rolled' edge (which is the most characteristic clinical feature of this type of cutaneous neoplasm) at one or more points along the line of extension. A biopsy is necessary in the confirmation of the diagnosis of such cases, and not infrequently reveals cells partaking both of rodent ulcer and squamous carcinoma (mixed-cell) types. Generalization and metastases, however, do not occur, although local ulceration may become a source of pain and discomfort in situations exposed to friction—as, for example, under a truss.

The plaques are usually radiosensitive and yield to X rays or radium in suitable dosage.

PLATE CVIII



MULTIPLE RODENT ULCERS

241

ERYTHEMA, PERSISTENT CIRCINATE

(PLATE CIX)

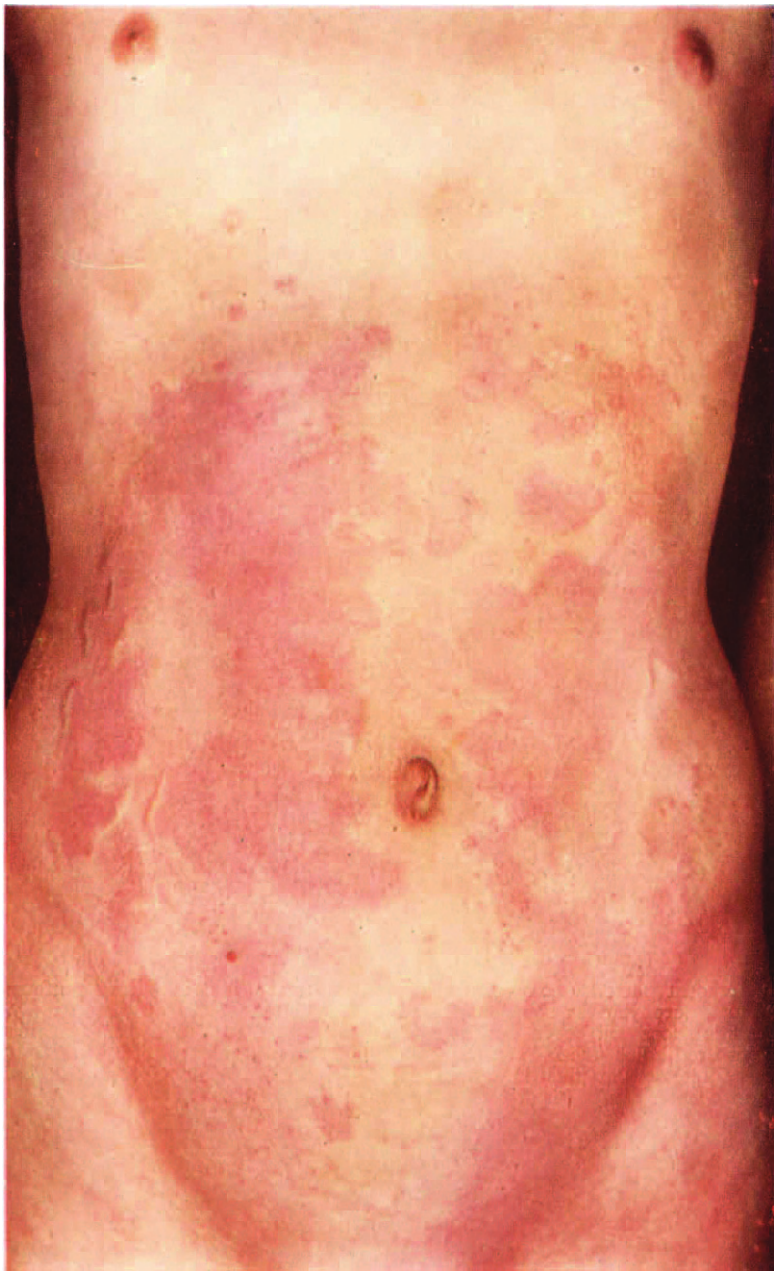
THE fixed exudative erythemata are a not very accurately classified group of benign dermatoses of which this plate is offered as an unusual example. Other members of the group resemble erythema multiforme exudativum on the one hand and granuloma annulare on the other, and clinical examples are frequently presented at dermatological meetings, where they offer scope for prolonged and usually indecisive speculation.

The lesions here present were quite symptomless and hardly itched at all—a point which distinguishes them from urticaria, which moreover is not a fixed eruption, but tends to come and go from day to day or hour to hour. The case had been sent for an opinion and was only seen on one occasion. No definite cause was elicited.

The possibility of 'drug' eruption—e.g., from phenolphthalein, or a member of the barbitone group—should always receive due consideration in this type of manifestation.

Treatment of such cases remains empirical for the present. Salicin by the mouth and local applications of calamine lotion and an indifferent dusting powder, with attention to any obvious source of oral or pharyngeal infection, are the usual indications. When these measures are ineffectual, resort may be had to some form of protein shock treatment.

PLATE CIX



PERSISTENT CIRCINATE ERYTHEMA

HYDROA PUERORUM

(PLATE CX)

HYDROA PUERORUM, for which at least three other names are still in use, belongs to the group of eruptions in which the sun's rays appear to play a causative part. It occurs more frequently in boys than in girls, and affects mainly the uncovered areas of the body, as exhibited in the plate. This youth at the age of 16 has been subject to more or less severe recurrences every spring to the middle of August, since early childhood. He has two brothers both of whom are similarly affected, though the older of the two (now 19) has greatly improved in the last year or two. The condition is therefore of congenital and familial type, a fact to which Bazin first drew attention, and clears up spontaneously about the twentieth year. Non-familial cases of sun-sensitivity, of a milder type, are common in both sexes.

Intense irritation is almost always present, and in this case it is evident that the primary papule or papulo-vesicle has been scratched and disorganized as soon as it appeared. In severe cases with deep-seated lesions, necrosis sometimes occurs, and results in vacciniform scars which should always be looked for as they are a reliable help in the diagnosis. Erythematous patches (seen on the cheeks in the plate) may accompany the papules or vesicles, and in some cases are markedly raised and urticate in type. Hæmatoporphyrinuria,* which has been demonstrated in some of the cases —it is believed that hæmatoporphyrin is the 'sensitizing' substance—was not found on several repeated examinations in this instance.

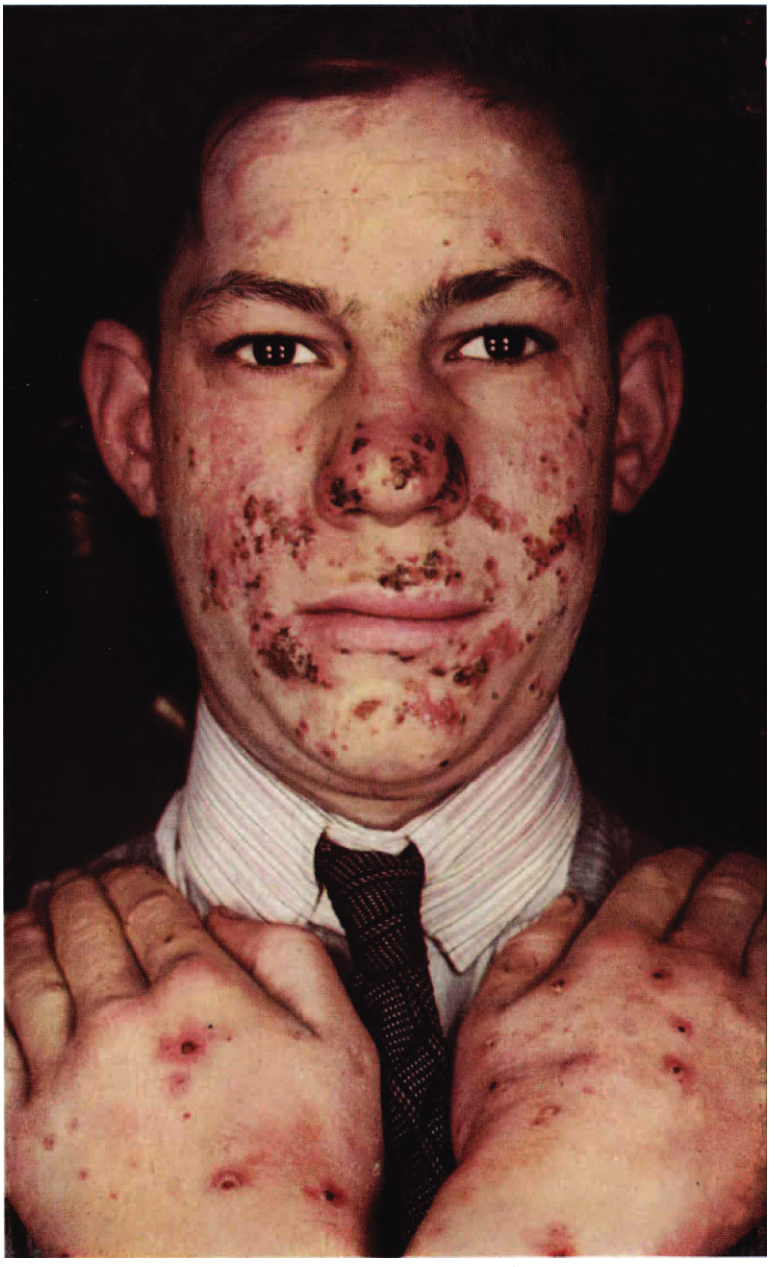
Treatment.—No treatment except protection by yellow vaseline, ichthyol, tannic acid in 10 per cent solution, quinine ointments, or the 'ultra-zeozon' (oxyæsculin derivative) cream, is of much value.† Graded intravenous injections of peptone (Martindale) have effected improvement in some of the milder, non-familial cases of light dermatosis. In these, too, it is important to investigate for hepatic dysfunction.

* In a recent personal communication, Prof. Urbach (late of Vienna) informed me that he had found porphyrin or some combination of it in the *fæces* of cases in which repeated urinary examinations had been negative. In general, he finds a 2 per cent resorcin paste, coloured with red bolus, the most efficient local protection against solar rays.

Those interested in this important subject should consult Goldsmith's comprehensive summary in chapter xiii of his *Recent Advances in Dermatology*.

† One case of the author's responded remarkably well to an autogenous fæcal vaccine.

PLATE CX



HYDROA PUERORUM

(Hydroa Æstivale, Hydroa Vacciniforme, or Hutchinson's Summer Prurigo)

LUPUS PERNIO

(PLATE CXI)

THE name allocated to this rare combination of chilled extremities, bluish congestion, and infiltration, with a variety of subjective sensations, is misleading, for it has little in common with lupus vulgaris, except a presumed tuberculous aetiology. Ulceration never occurs, the localization is symmetrical—fingers, toes, nose and sometimes the ears—and the modern tendency is to regard it as related to lupus erythematosus and the so-called sarcoids, the aetiology of which is still *sub judice*, although many authorities favour a tuberculous association.

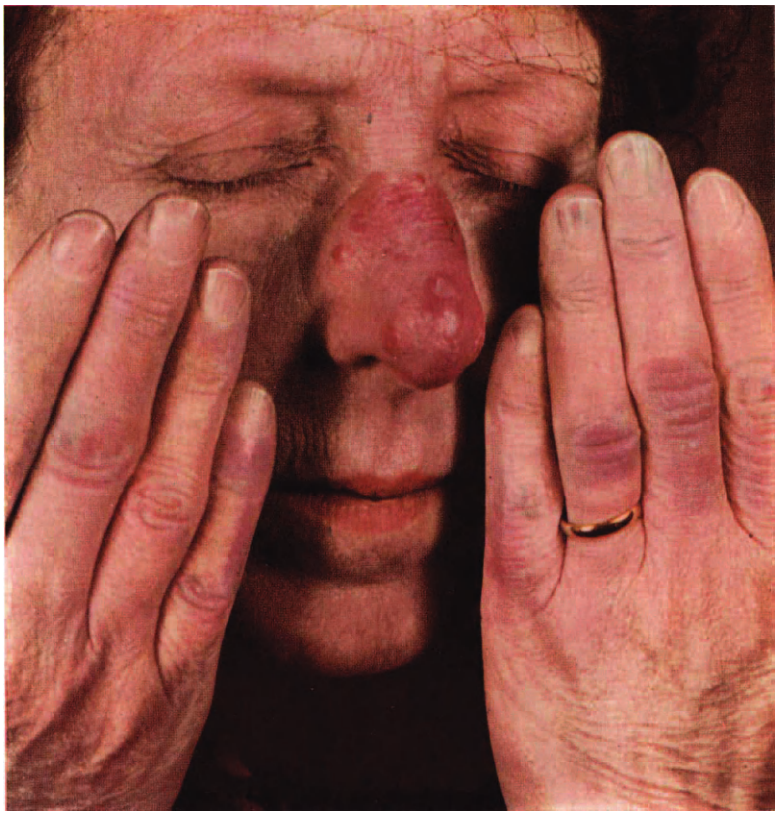
The patient is a married woman of 67 who has suffered from a cyanotic nasal congestion for many years, the knuckles having been affected quite recently. The ears (another site in which this condition is seen) have escaped. It will be noted that two fairly typical ' apple-jelly ' nodules are present on the nose on its right upper lateral border. Nodules of this kind can sometimes be made out on vitro-pressure of the affected nasal skin, and may substantiate the diagnosis in doubtful cases.

Lupus pernio practically never ulcerates, and it is permissible to surmise that the chronic congestion associated may act in some protective manner. A history of some tuberculous manifestation either in the patient or her family can usually be obtained. This patient's two brothers had been sent, the one to Australia, the other to Canada, in their youth, for ' weak lungs ', and there is a history of consumption in her father's family.

The differential diagnosis from lupus erythematosus is rarely difficult, for both scaling and cicatrization are absent.

Treatment should be directed towards avoidance as far as possible of cold and damp during the winter, assurance of good and suitable diet, including cod-liver oil at all times, and a trial of the salt-free diet. The general arc bath (latest model is the ' Universal ' lamp—a special type of carbon electrodes is used) and local applications of the Finsen or Kromayer lamp are also indicated.

PLATE CXI



LUPUS PERNIO

MYCOSIS FUNGOIDES

(PLATE CXII)

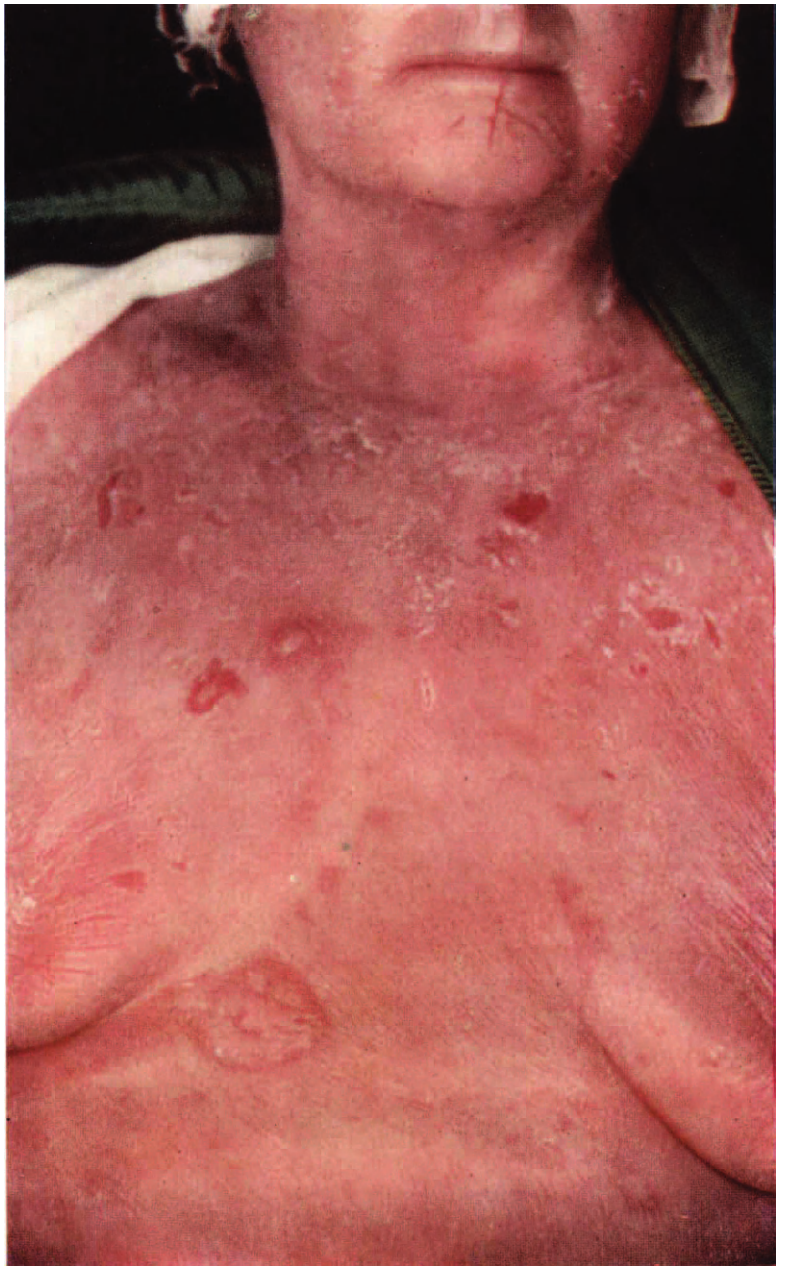
THE plate here shown should be compared with that depicting the condition termed exfoliative dermatitis (*Plate VII*), for the illustration is from the same subject, a married woman of 38. The exfoliation, for the treatment of which she had been admitted to hospital, gradually in the course of three months gave way to a diffuse but generalized infiltration of the whole integument, including the face and scalp, and the fissures seen on the chin are the direct result of the ensuing loss of normal elasticity and disorganized function. The whole epidermis has in fact been invaded by infiltrating round cells of various shapes and sizes, resembling those seen in sarcoma. These may become aggregated and form tumours (one has ulcerated at the right breast margin) which in some cases present a superficial resemblance to tomatoes ; hence the soubriquet ' tomato tumours ' of mycosis fungoides. Ulceration is the rule, and septic complications frequently ensue and lead to a fatal issue with symptoms of high pyrexia and bronchopneumonia.

The prognosis, although partial improvement and even a temporary disappearance of the symptoms may occur spontaneously, is invariably fatal, and this patient has since died. The disease, of which the cause is unknown, is fortunately very rare. It is usually preceded by a ' premycotic ' stage, in which intractable dermatitis, eczematous, erythematous, exfoliative, psoriasiform, or urticarial eruptions over months or years, may precede and eventually usher in the appearance of the tumours.

Treatment.—Until recently the only effective treatment of the tumour stage was by X rays, under which the tumours rapidly involute and the ulcerations heal. There is in fact no pathological tissue more radio-sensitive than these infiltrations, and their involution after only one moderate dose of X rays is a therapeutic test of recognized value in diagnosis. Unfortunately, however, their effect is only temporary, and directly comparable with the vicarious results obtained by the irradiation of the metastases of deep-seated cancer in the liver and other vital organs. Recurrences are the rule, and although they usually resolve to further X-ray treatment, the patients eventually succumb to exhaustion or intercurrent complication within three or four years of the diagnosis being made. It must be remembered, too, that X rays have a devitalizing effect on the blood-forming red marrow, and that caution demands control of every case by frequent blood-counts.

This applies with equal force to the new treatment introduced by Dr. Henry MacCormac, by malaria. The results by this method are encouraging enough to warrant further trial, and in a recent case of my own both the premycotic infiltrations and the tumours, and the intense associated pruritus of the entire integument, were favourably controlled for a period of four months.

PLATE CXII



MYCOSIS FUNGOIDES

PARAPSORIASIS

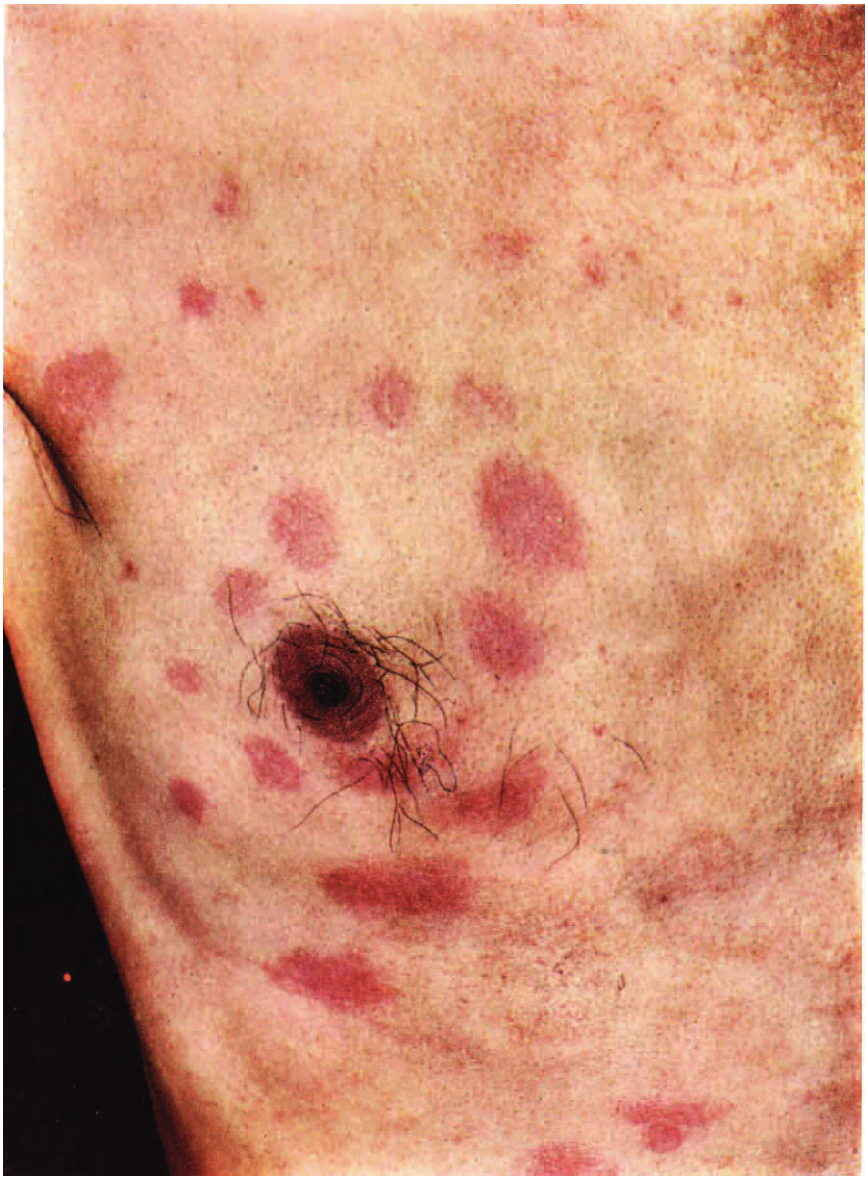
(PLATE CXIII)

THE name is one of several allotted to a group of uncommon dermatoses characterized by *chronic* scaling and erythematous patches or papules. Slight itching is sometimes present, but as a rule the rash is symptomless, and being usually on covered parts is rarely seen at its onset by the physician. We are entirely ignorant of the cause. The case presented here illustrates all the essential features in a typical manner. The patient, an otherwise perfectly healthy man of 34, had noticed the eruption for about eighteen months, but as it did not inconvenience him he did not report it to his doctor. He was very vague as to how it began, whether as a single spot or in several. Only the trunk is involved and the lesions are scattered widely over it both back and front, in the form of pink to brownish macules, slightly scaly on the surface, hardly elevated above the skin, and not perceptible on palpation. Their variations in shape and size can be clearly pictured from the samples displayed on the front of the right chest wall. Posteriorly there is some tendency to a streamline effect over the lower borders of the trapezii and latissimi dorsales, a point of interest in the differential diagnosis from pityriasis rosea.

The type here described is called ' parapsoriasis en plaques ' (Brocq), and is probably commoner than either the guttate or retiform varieties, to mention but two of them.

Treatment is not satisfactory. I have found a 2–5 per cent lenigallol paste useful and it has been temporarily effective in this case. Good results have been reported with the mercury vapour lamp, and also with gold injections, e.g., sanocrysin or krysolgan in small doses intravenously or intramuscularly. Spontaneous involution undoubtedly occurs, although it may be delayed for many years.

PLATE CXIII



PARAPSORIASIS

PEMPHIGUS VEGETANS

(PLATE CXIV)

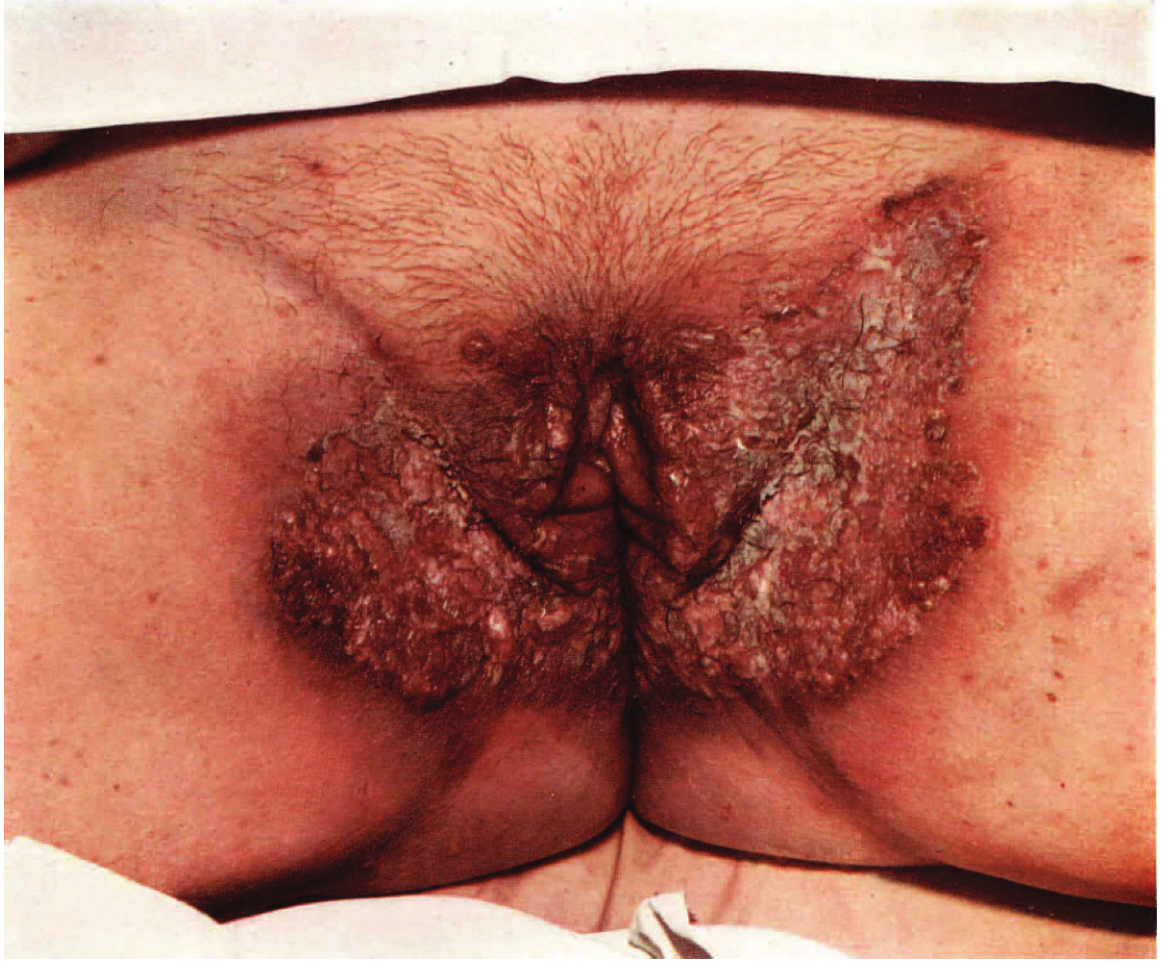
THE subject of this illustration, a single woman, of Jewish extraction, aged 63, first observed an eruption in the groins about three years before consulting me in August, 1937. It was associated with some irritation at times and a purulent discharge, and the appearances suggested the possibility of monilia infection. She was carefully investigated both by direct smears of the discharge and by cultural methods on more than one occasion but no yeast-like bodies were ever demonstrated, and on the bacteriological findings, streptococci and staphylococci, a provisional diagnosis of intertrigo was suggested to her doctor, with recommendations for estimating the blood-sugar and the application of mild disinfecting lotions and powder.

A year later she again reported. The eruption, which consisted of aggregated vesico-pustules, had spread outwards, and had involved the mucocutaneous area round the anus and in the internatal fold. The discharge had become exceedingly offensive and the patient's general condition had deteriorated. She complained of insomnia and severe irritation at night. She had also noticed 'ulcers in the mouth', and there was advanced dental sepsis, for which extractions had been advised. More recently she had had some bleeding from the nose, and remembered a similar symptom last year. During her three weeks in hospital the groin lesions assumed a condyloma-like appearance and eventually became so hypertrophic as to constitute 'vegetations'. The diagnosis of pemphigus vegetans of the vulvo-inguinal and perianal regions was no longer in doubt, and although no characteristic buccal lesions had been noted it was more than probable that the 'ulcers' complained of and the nasal bleeding had the same aetiological background.

The symptoms of this very rare and dreaded disease are fully covered by the foregoing account and are typically illustrated by the plate. The fungating character of the lesions is well brought out in the right groin, and their mucous relations by the œdema of the labia minora. The aetiology is just as obscure as that of pemphigus vulgaris (q.v.) from which it may sometimes develop. The diagnosis in the fully developed case is easy, but may offer difficulties if not preceded by the ordinary variety of the disease, as in this case, and if the localization is not in the groins or the axillæ and the buccal lesions are absent. A bullous syphiloderm, granuloma inguinale, or even erythema multiforme bullosum might conceivably present a somewhat similar picture and should receive due consideration before the more serious disease is diagnosed. A fourth possibility which was primarily envisaged in this case is moniliasis, but here there is no difficulty in demonstrating the fungus, the lesions although sometimes condyloma-like are limited to the groins, and fungation does not occur.

The prognosis is always grave, and although remissions frequently give rise to the hope of eventual cure, a fatal issue from intercurrent sepsis, pneumonia, or renal complications is the rule.

(*Continued on p.* 254)



PEMPHIGUS VEGETANS

Treatment.—Until we know the cause we are not likely to find a reliable remedy. The best to date appears to be germanin (Bayer 205), given intravenously on alternate days, and beginning with half the prescribed dose, viz., $\frac{1}{2}$ g. to $4\frac{1}{2}$ g. in all. It is a hepato-toxic drug, and in this case had to be discontinued after the second dose, as insipient jaundice supervened and albumin made its appearance in the urine. Local measures include X rays and efforts to counteract sepsis with permanganate hip baths, mercurochrome 1–1000 applications, and compresses of sulphate of zinc (gr. v ad 1 oz.) which were preferred to all other applications in this case.

The above treatment having failed, malarial infection was introduced after consultation with Dr. MacCormac. The lesions cleared up after a few hyperpyrexial attacks, but the patient became comatose and they had to be interrupted by quinine. On recovering consciousness her mentality had seriously deteriorated and it was obvious that a fatal issue could not be delayed for long.

PEMPHIGUS VULGARIS

(PLATE CXV)

THIS is a rare disease, and more frequently diagnosed when some other bullous condition is present than missed. Any suspected case should be watched for some time before the diagnosis is made, for the prognosis is serious though not necessarily fatal. The insidious and painless appearance of isolated (not grouped) bullæ and vesicles on any part of the integument is suspicious, and more so if the mucous membranes are also involved. They arise with or without slight local itching on normal skin—i.e., without inflammation or infiltration—and their contents are quite clear at first, and sterile or nearly so. Sepsis usually occurs and rupture takes place within a few days. The raw surface resulting is always slow to heal, but in the great majority of cases does so eventually with the local deposit of pigment but without a scar. Very occasionally a proliferation of the raw areas may occur (pemphigus vegetans—*see* p. 252), with the copious discharge of foul-smelling pus and an eventually fatal issue after great suffering, especially if the buccal and pharyngeal mucosæ are much involved.

The three unruptured bullæ seen on the inner side of the left foot in a man of 39 were all that remained of a much more extensive eruption on the trunk and upper limbs, and the condition had not recurred some two years later. Sepsis was not a marked feature, there was no itching, and the mucosæ (mouth) were only slightly involved. Although no recurrence has taken place to date, the prognosis must be guarded.

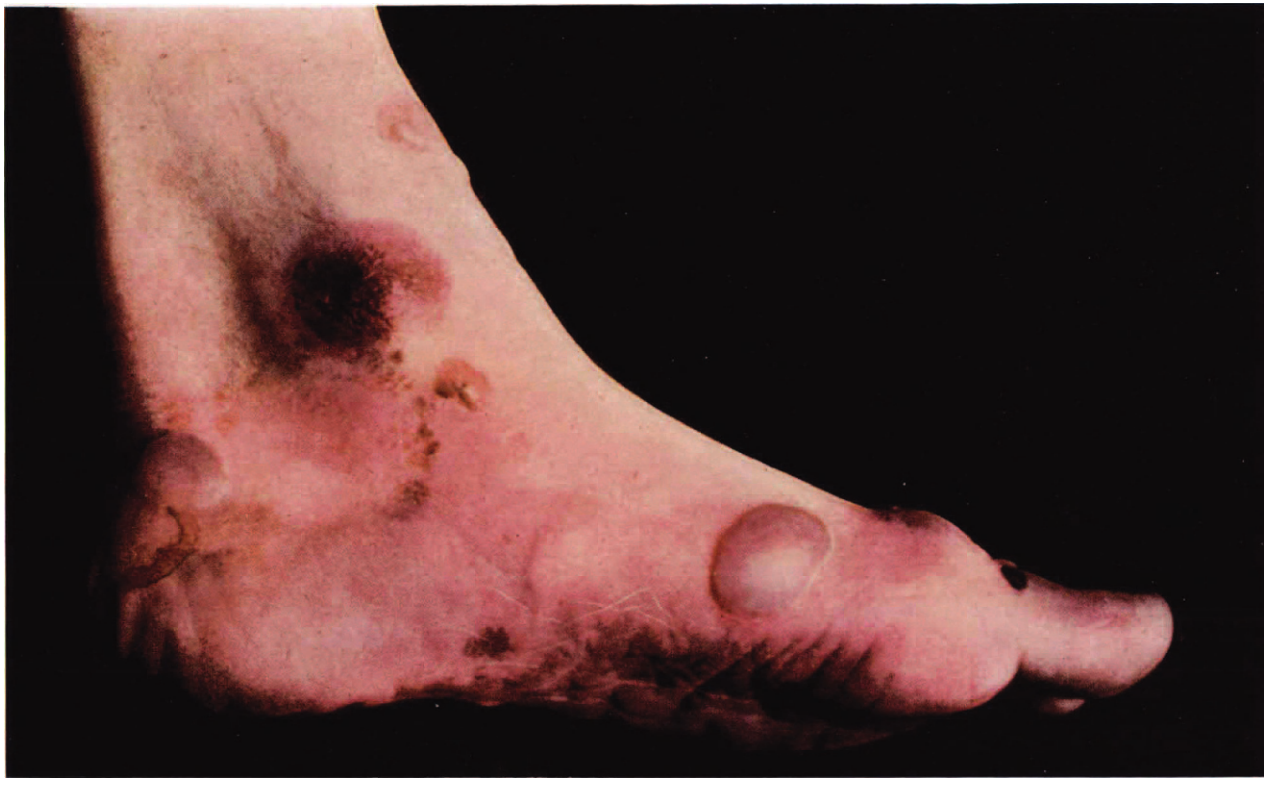
Yet a third variety of pemphigus is described, pemphigus foliaceus. Exfoliation of a dry type may set in instead of or in the course of the evolution of bullæ, and the skin may then peel off in large flakes, and the individual lesions spread peripherally and coalesce to form large raw areas from which a sticky and offensive serum is discharged. The course is usually very chronic, but the prognosis is as serious as in the vegetating type. Sepsis and exhaustion precede the fatal issue.

Table of Differential Diagnosis

PEMPHIGUS	DERMATITIS HERPETIFORMIS	BULLOUS ERYTHEMA MULTIFORME
No itching, or slight only	Itching always intense	Itching slight or absent
Bullæ isolated. May coalesce	Vesicles and small bullæ in groups	—
Vesicles or bullæ only	Eruption polymorphic: vesicles or bullæ with urticate or erythematous patches	Bullæ form on infiltrated, often raised, and target- or iris-marked patches of erythema multiforme
Sepsis and rupture and indolent healing	Rupture rare, unless scratched	—

(*Continued on p.* 258)

PLATE CXV



PEMPHIGUS VULGARIS

Two other bullous eruptions are sometimes diagnosed as pemphigus : drug rashes due to quinine, arsenic, iodides, and bromides ; and impetigo contagiosa, especially in the newborn infant—pemphigus neonatorum—which when widely distributed is usually fatal.

Treatment.—We have no specific treatment for pemphigus in any of its forms, and we do not know the cause of it. Opinions vary as to whether arsenic or quinine should be given. The former should be pressed to the limit of tolerance in increasing doses. Success has been claimed in America for injections of coagulen and iron cacodylate, given subcutaneously on alternate days, but the results are probably no better than arsenic in the form of Fowler's solution per os. The bullæ should be punctured and then treated aseptically with a dusting powder. If the denuded surfaces are extensive and there is much sepsis, the continuous saline or boric bath is comforting, and prevents the added torture of friction and decubitus.

Injections of germanin (Bayer 205) find considerable support in the recent literature.

SARCOMA, MELANOTIC

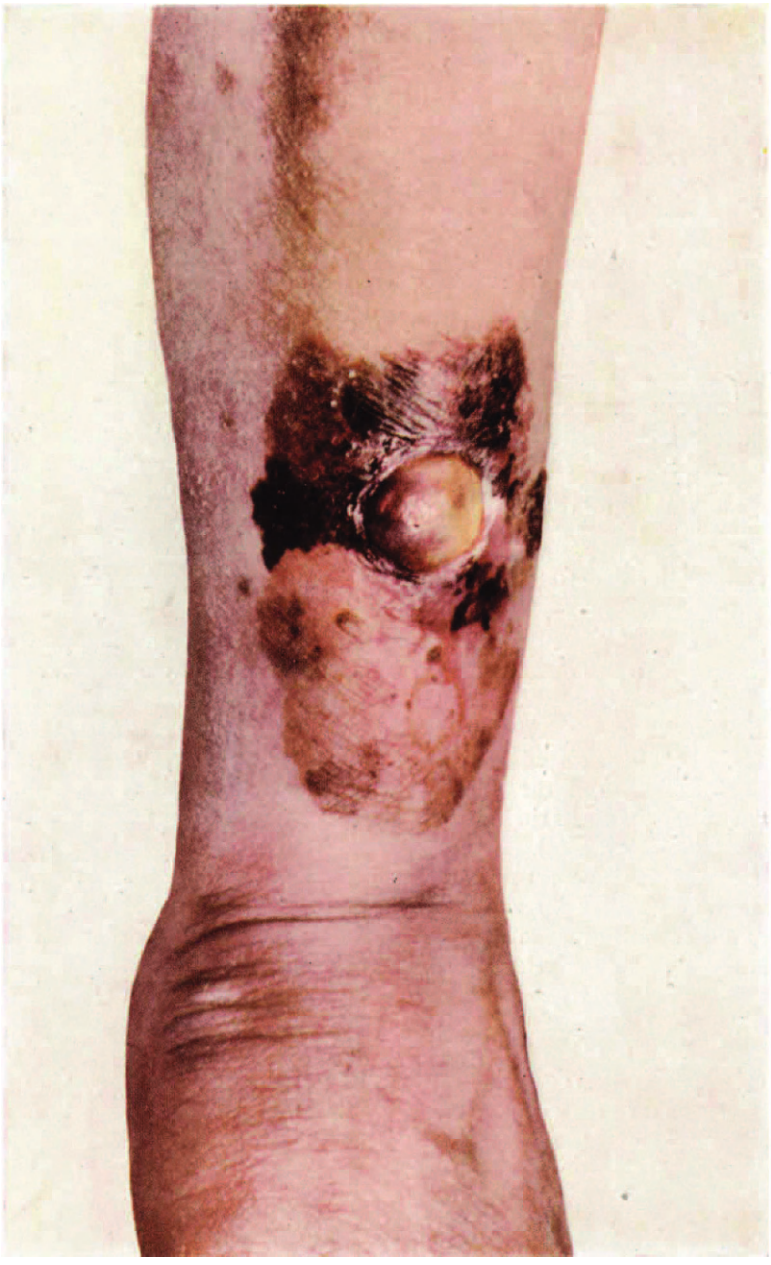
(PLATE CXVI)

THE histological characters of an excised portion of the globular tumour that protrudes from the pigmented patch in its upper half were regarded as sarcomatous by the pathologist, for the cells were definitely rounded in outline and resembled the mononuclear type of large lymphocyte. Mitotic nuclear figures, an accepted evidence of malignancy, were present in considerable number, and much intercellular pigment further supported the diagnosis.

The patient was a young woman otherwise in good health, and the patch on the front of her forearm had developed round a small dark brown mole in about six months. No glandular or other tissue involvement could be ascertained, and the whole patch was destroyed by diathermy and the scar subsequently treated by radium. No recurrence had been noted a year later, but if the diagnosis is correct it is to be feared either locally or more probably by lymphatic infection in glands, or at a later date in the bones or lungs, with an ultimately fatal issue.

Melanotic malignant growths, the majority of which are nowadays regarded as carcinomata, for moles are derived from the epiblast, are among the most virulent of all cancerous neoplasms. Fortunately the malignant transformation of a pigmented mole is exceedingly rare, and scarcely justifies the suggestion that all such should be excised (or preferably, destroyed by electrolysis) at an early age.

PLATE CXVI



MELANOTIC SARCOMA

SARCOMATOSIS

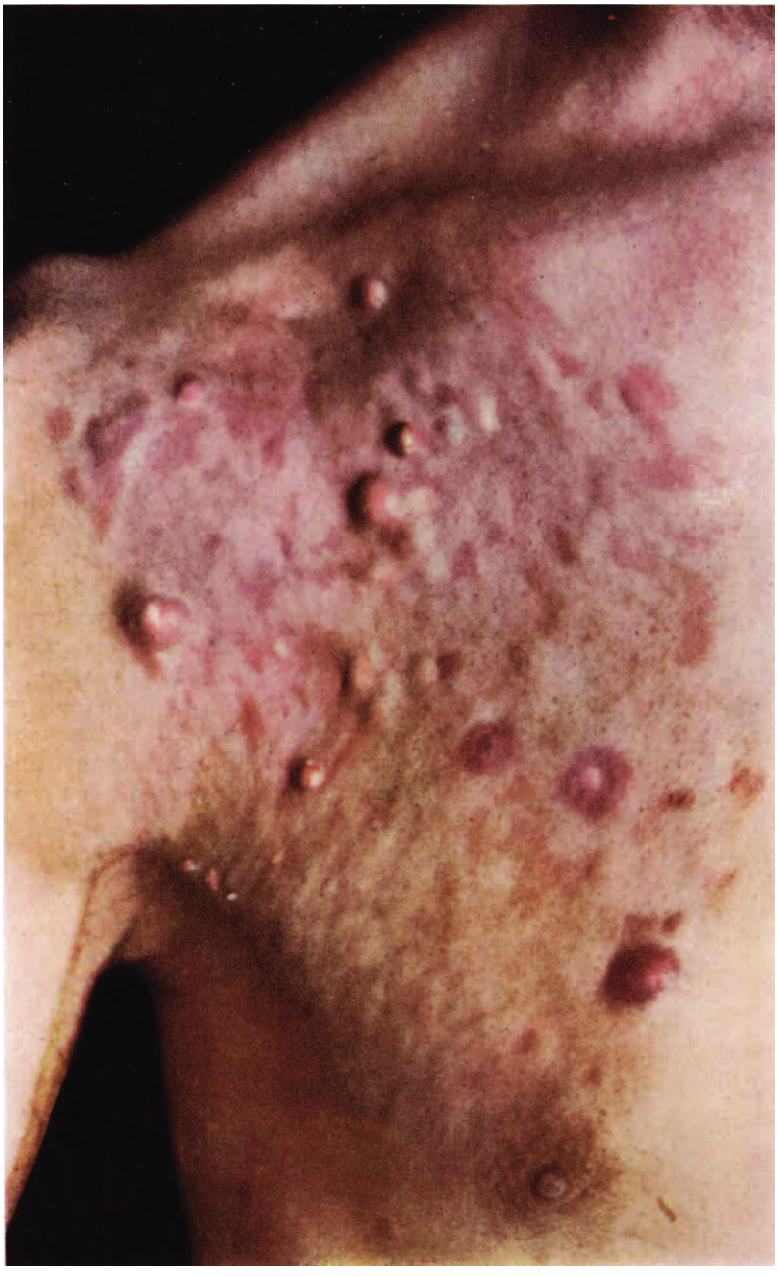
(PLATE CXVII)

THE plate of this very rare and usually fatal type of malignant disease is included because of its photographic excellence and its clinical value. The patch depicted has been present in this man of 55 since the age of 30, and has advanced slowly and without the production of any subjective symptoms from an original small lesion just below the clavicle which had been regarded as a birthmark, which it probably was. Clinically there is soft diffuse infiltration, both of the epidermis and underlying cutis. Slight brownish pigmentation is also present, and in places small raised, rounded and conical tumours have developed. Ulceration is said to take place from time to time, and can be seen in one of the nodules on a level with the axillary apex. Cicatrization is not a marked feature, but can be just appreciated in the upper half of the growth where the colour is lighter and the surface appears to be slightly depressed.

There has been no complaint of axillary pain, and glands have not presented evidence of infection at any time during the three years the patient has been under observation. The diagnosis of such a case could be made only on the histological features of a section, and the clinical resemblances to carcinomatosis—which not infrequently occurs in the skin as a secondary extension of breast cancer—may be considerable (*see Plate CVII*).

Treatment by X rays has not appreciably affected the rate of extension, and a trial with radium (needle insertion) has been refused. The prognosis, considering the already lengthy history, would appear to be favourable as regards life ; but the further history, related on p. 264, no longer supports this view.

PLATE CXVII



SARCOMATOSIS

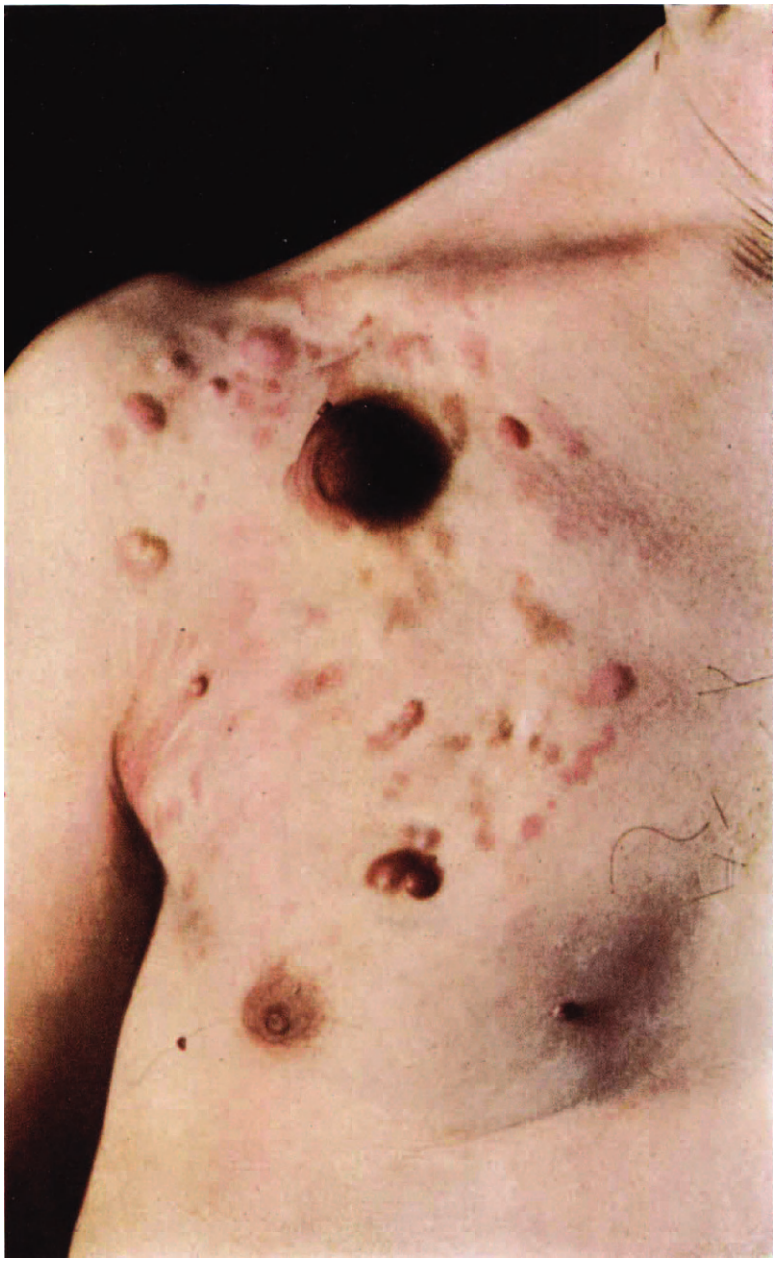
SARCOMATOSIS

(PLATE CXVIII)

THE picture represents a more advanced stage of the condition described in *Plate CXVII*. It is true that some of the smaller nodules there shown have involuted with slight cicatrization and pigment deposit, but a large plum-coloured ovoid tumour had developed under the outer end of the right clavicle and has falsified the prognosis given some six months previously, when the first photograph was taken. A prolonged clinical and X-ray investigation for secondary metastases in the lung or bones was negative, but there is increasing loss of weight and cachexia.

The patient having at last consented to admission, the whole area was subjected to radium emanation by implantation of needles, and subsequently to the surface irradiation of a specially prepared radium plaque. It is to be feared that this procedure, which might have been effective some three years previously, is too late, and his doctor wrote a month later that although the local symptoms had improved his general condition had deteriorated.

PLATE CXVIII



SARCOMATOSIS

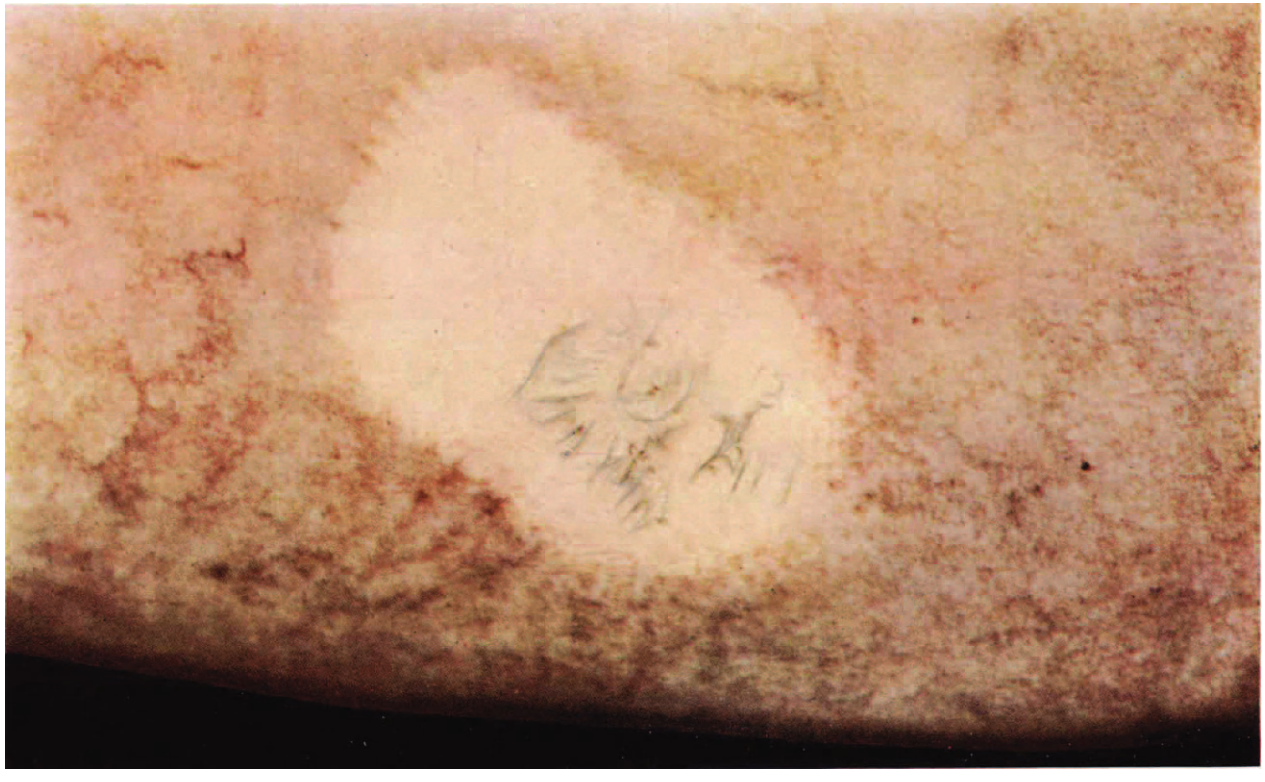
SCLERODERMA
(Morphœa)

(PLATE CXIX)

THE china- or ivory-white, circumscribed, indurated, and very chronic patch here depicted on a middle-aged woman's thigh could hardly be confused with any other condition. These patches—fortunately rare—are of cicatrizing type, and are therefore nearly always depressed below the surface—a feature which immediately differentiates them from leucoderma, in which there is no atrophy or destruction of the cutaneous tissues.

Such patches may occur in any part of the integument. Their cause is unknown, and treatment is purely symptomatic, although beneficial results are claimed following the use of thyroid gland. The disease may occur in a more or less generalized form; when it envelops the chest wall it may threaten life by impeding respiration. Patches of scleroderma sometimes ulcerate spontaneously, and they may undergo malignant degeneration like an X-ray or chronic lupus scar.

PLATE CXIX



SCLERODERMA
(Morphœa)

TYLOSIS

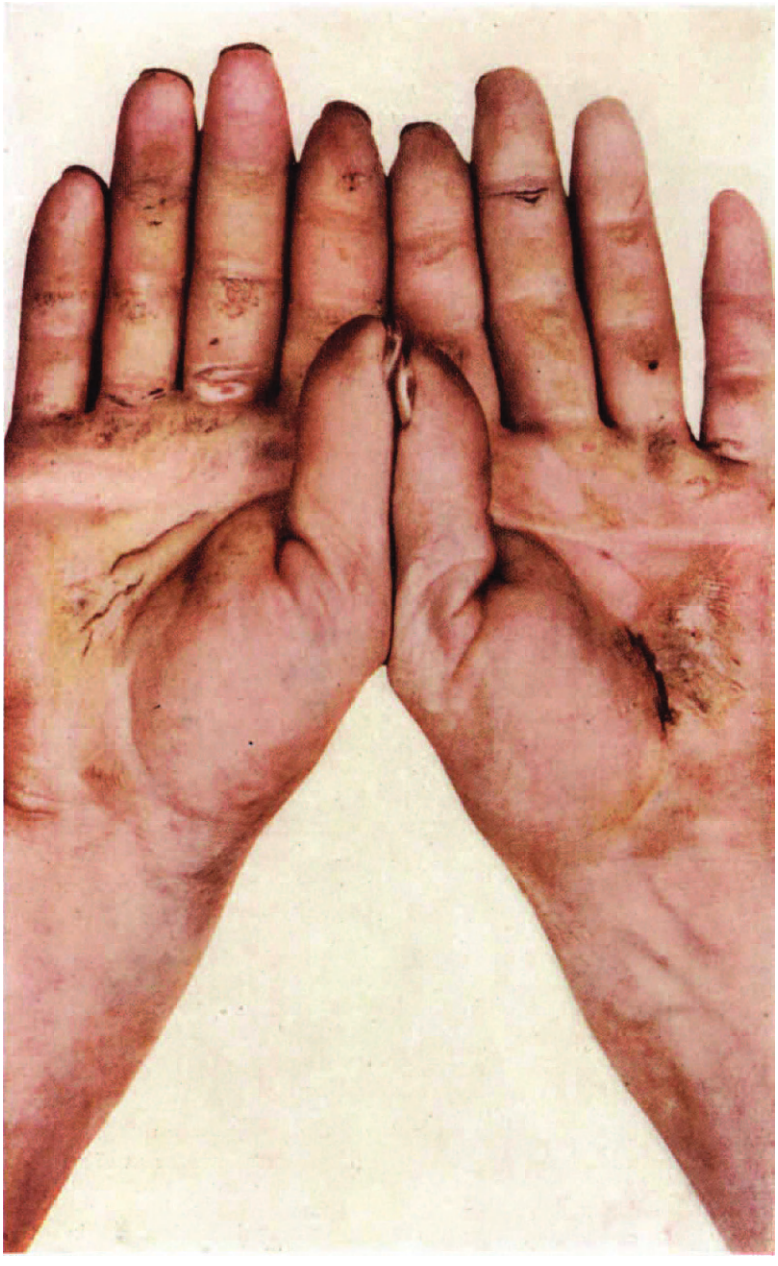
(PLATE CXX)

THIS rare condition is a bilateral and symmetrical congenital horny thickening of the skin of the palms and soles. Inflammatory symptoms are absent, and this is an important point in the differential diagnosis from the common and acquired abnormalities of cornification. The dirty yellowish bands and areas of hyperkeratosis are not the result of manual pressure or labour, for they occur at birth or soon after, and persist throughout life quite irrespective of the patient's occupation. In cases more marked than this, movement and tactile sensation may be restricted, and owing to the deprivation of the normal elasticity of the skin, deep fissures may develop, as has occurred in this case, in the lines of flexion.

The cause is unknown, but there is a strong familial tendency, and cases in four or more generations (both men and women) are on record.

No treatment has any permanent effect. All that can be done is to protect and soften the affected areas as far as possible, and this can best be effected with salicylic acid plasters (trichoplast—Beiersdorf) of various strengths, 2 to 10 per cent, as tolerated. X rays are of very temporary benefit only, and must not be persisted in.

PLATE CXX



TYLOSIS (Keratosis Palmaris et Plantaris Hereditaria)

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