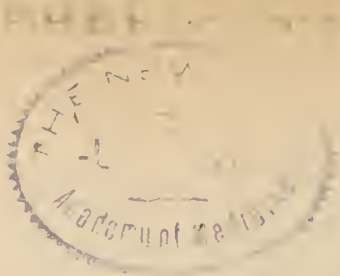


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Disseminated Cancer of the Skin.

H. BENDKE, LITH. N. Y.

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Original Communications.

DISSEMINATED LENTICULAR CANCER OF THE SKIN: CANCER EN
CUIRASSE.

REPORT OF A CASE BY

P. A. MORROW, M.D.

(With Plate.)

NORAH D., multipara, æt. forty-three, a clear-complexioned, healthy-looking woman, presented herself at my class in the Bellevue out-door department, April 22, 1883. She gave the following history: About three years previous, she first noticed a tumor in the left breast, which rapidly grew larger. It occasioned no pain, and the only inconvenience she suffered was a dragging sensation consequent upon the increased size and weight of the breast. The entire breast was removed on October 22, 1880, and the incision healed nicely in about three weeks. She says that she was told by the surgeon that the growth was a "fatty tumor," but I have since been informed, by inquiry of Dr. Varick, who did the operation, that it was a scirrhus.

After the operation, her general health continued excellent, and there was no evidence of further trouble, until June, 1882. About this time, coincident with the menopause, she noticed that the skin in the neighborhood of the scar became reddened and extremely itchy. Upon this reddened skin, there shortly afterward appeared a number of "red and white pimples," about the size of a pin-head. She was accustomed to open these pimples with the point of a needle and squeeze out "little white worms," which she likened to the grub worms occurring upon the nose and face. These pimples rapidly increased in size, and in the vicinity of the scar ran together, forming small lumps. This redness,

with the characteristic pimples, gradually extended over the skin of the right breast, the sides of the chest, surface of the abdomen, and down the left arm.

She observed about this time that the left hand and arm became much swollen and very hard. The arm felt heavy and lifeless, and free movement was interfered with. Soon afterward, the right breast began to enlarge.

There have been at no time sharp, lancinating pains; the only subjective symptoms complained of have been sensations of burning and intense itching and, latterly, a feeling as if the chest were firmly bound down, preventing expansion, and causing more or less difficulty of breathing. The patient was well-nourished, and there was no suggestion of cachexia in her appearance; on the contrary, her face was noticeable for its fine color and aspect of perfect health.

My notes of the appearance and distribution of the eruption at that time were as follows: The cicatrix, indicating line of incision, is seen extending from the sternum to margin of left axilla. Along the furrow of the cicatrix are a series of nodules of variable size, which, at its sternal portion, are grouped together, forming a patch of irregularly-shaped tubercles, from the size of a bean to that of a filbert. This patch is one inch by one and one-half inches in diameter, and elevated unevenly above the surface. Scattered irregularly over the left chest, both above and below the cicatricial crease, are a large number of nodules, from the size of a small shot to that of a coffee grain, some as large as a half-cherry. In two or three places, the larger tubercular prominences are closely aggregated and form patches, with a number of smaller outlying tubercles irregularly disposed; some in the shape of clusters, others arranged in a linear series.

The left breast is considerably enlarged, but no well-defined tumor or nodular mass can be felt imbedded within the gland. The nipple shows no tendency to retraction. Its summit is eroded and covered with a thin brownish scab. Similar eroded spots covered with brownish crusts are observed within the pigmented border of the areola; the crusts, on being detached, leave a reddened and oozing surface.

The skin covering the breast and also a considerable portion of the chest, is infiltrated and thickened, giving a hard, brawny feel. Upon this reddened surface are seen a large number of closely-set, small, shining red papules, very suggestive, both in their outline and firm consistence, of the papules of lichen planus. The apices of some of these papules have been torn off by scratching, giving them a glazed appearance; in other places, large portions of the epidermis have been detached, leaving excoriated, discharging surfaces, as seen in eczema ichorosum.

From the base of the right breast extending upward, and encircling

the neck, are seen tolerably distinct, broad bands of reddened skin studded with innumerable small mollusoid bodies. These whitish bodies are strikingly suggestive of the milia so often encountered on the face of certain individuals; they are not so rounded or globular, but more elongated, suggesting in shape and size grains of wheat; many of them are larger and quite irregular in outline, and the superimposed epidermis appears thinner, as if they were more superficially imbedded in the skin. On incising the summit, a semi-confluent, comedo-like mass is readily extruded by a slight lateral pressure. These milia-like bodies, consisting of masses of epithelial cells, are found abundantly scattered over the upper chest, arms, certain regions of the back, and over the entire abdomen as well; in fact, they seemed to constitute the most characteristic feature of the advancing disease.

Upon certain spots, or rather regions, more especially those most recently invaded by the eruption, are seen, interspersed among the milia-like bodies, a number of pinhead-sized, reddish, brownish, and blackish deposits, the latter suggesting a melanotic element, probably due to the commingling of pigmentary granulations with the epithelial masses.

On the summit of the left shoulder, there are a number of sparsely disseminated nodules of variable size, which manifest the peculiarity of not being situated upon a reddened base, the skin between and around them being apparently quite normal in tint and texture. Over the left deltoid region, and down the anterior aspect of the arm, continuing below the elbow, the eruption presents the characters of a broad, elongated patch, brawny to the feel, and made up of infiltrated skin and closely-set papules. Here also are observed a number of the pigmentary or melanotic deposits above-described, only larger, some of them the size of a silver three-cent piece.

The entire surface of the abdomen extending down to the pubes, with the exception of a few islets of healthy skin, is the seat of a mottled eruption, the redness not so diffuse or uniform as on the chest, and upon this mottled base are developed the milia and papules above-described. The characters of redness and congestion are much intensified around the waist. In this situation, a belt or zone, corresponding to the tract of irritation produced by pressure of the clothing, extends entirely around the body, the skin is intensely red and itchy, as seen in eczema of this region.

Upon my proposing to make one or two sections for the purpose of microscopical examination, the patient disappeared from observation, and I saw her no more until October, when she again presented herself at the out-door department.

In the six months' interval, quite a series of appreciable changes has occurred in the appearance of the eruption. There has been an exten-

sion of the area involved in the disease, more especially noticeable on the right arm and dorsal regions, besides an accentuation of its more characteristic features.

The general health of the patient is not so good. She has lost flesh; her face wears an anxious expression, but no distinct evidences of cachexia are observed. The intolerable itching has been a constant condition. She complains more of the binding sensation around the chest, of difficult breathing, and suffocative sensations, especially when she lies down. She has also suffered from frequent, copious hemorrhages.

In April, when I last saw the patient, the left arm was much swollen and measured from four to six inches larger in circumference than the right. During the summer, the swelling disappeared from the left arm, and the right became swollen in its entire length, and the tissues of the back of the hand became puffed up. The arm feels stiff and numb, especially in the morning, and she cannot readily bend it. This interference with free movement is, no doubt, due to infiltration of the skin and cellular tissue, which is especially marked over the flexure of the elbow.

The extent and distribution of the eruption on the front aspect of the body is seen in the plate. Its dorsal distribution may be thus described: It extends over right side of the neck in the shape of two broad bands of reddened, infiltrated skin, studded with milia, one commencing above, the other below the clavicle—the upper one ending at back of the neck, the lower one broadening out over back of the shoulder, and diffusing itself over entire right scapular region. The distinction between these two bands is now partially effaced from diffusion of the eruption over the interspace of healthy skin which at first separated them. On the left side it extends under the arm from the lateral side of the chest over the left scapular region to the median line. It also spreads over left buttock in broad ribbon-like prolongations. A patch from the upper arm extends over the left deltoid region and the supra-scapular space.

Over the left scapular region the eruption presents certain features nowhere else seen. The patches are made up of closely aggregated subcutaneous nodules, which may be readily grasped and raised up, but which are not elevated, and only show on the surface by a brownish-red discoloration of the skin; thirty or forty of these nut-sized subcutaneous tumors may be counted.

Returning now to the mammary region, we find that the skin over the right breast has become much thicker and the infiltration deeper—it feels tense, hard, and renitent, like the rind of pork or recently tanned leather. On grasping the gland with both hands, there is a sense of increased heaviness, due to the dense, board-like structure of the cutaneous

envelope, and the hypertrophy of the glandular tissues—the breast measuring twenty-three inches in circumference; its precise weight it is of course impossible to estimate.

The patch of massed tubercles at the sternal portion of the cicatrix has grown much larger, and now measures two and a half by three inches. Some of the tubercles forming the patch have broken down and become ulcerated. A number of tubercles in other portions of the surface have become deeply excoriated. The floor of the ulcer thus formed is of a grayish or brownish red, with a scanty secretion—the sides cleanly cut, as if gouged or punched out with an instrument. Some of the more superficial excoriations are covered with thin, brownish, closely-adherent scabs. Within the past month a number of the ulcers have healed over, presenting thin, depressed, pigmented cicatrices.

A number of blackish crusts, seen upon the larger tubercular patch, mark the points from which hemorrhage has recently taken place. Hemorrhages, more or less abundant, occur with comparative frequency, and may be caused by the opening of superficial veins through the breaking down of the tissues. The blood, as she describes it, is first dark and afterward of a brighter red, but thinner and more watery in consistence than normal. The blood has lost its coagulability to a certain degree, as I have found by the application of powdered persulphate of iron as a styptic. The flow can only be checked by the application of cold wet cloths. The impendence of a hemorrhage is always announced by a hot, burning sensation in the parts, and a sense of what the patient terms “inward fever,” which is relieved by the flow of blood.

To briefly sum up the changes evident within the last six months: The disease has invaded new portions of the integument, the extension of its area being especially marked on the right arm and dorsal surface of the trunk. From careful observation I should say that the disease appears to advance by the thrusting out of tongue-like bands of reddened skin, which soon become studded with epithelial and pigmentary deposits, and the later development of cancerous nodules. There has been an increase of the nodular masses both in number and volume; the malignant character of the disease is manifest in the softening and breaking down of the infiltrated tissues, causing exhaustive hemorrhages. The infiltration of the skin, especially over the anterior and lateral sides of the chest, has increased both in hardness and extent, and now forms a sort of inextensible cuirass which encases the chest, limiting its expansion and interfering with free respiration. On the other hand, certain favorable features may be remarked. In addition to the reparative tendency manifest in the cicatrization of many of the ulcerative lesions, there appears to have been a retrogression of the disease on the left arm, evinced by the more or less complete disappearance of the

swelling and the partial involution of the surface lesions. The skin is much less infiltrated than it was six months ago, the redness is fading out, and the papules and tubercles are not nearly so prominent.

As is well known, the implication of the general integument as a secondary phenomenon, after removal of primary cancer of the breast, is comparatively rare. The tendency of the disease in its recurrence, is almost always to localization in the internal organs. The conditions which in rare cases cause a determination of the morbid deposits towards the cutaneous surface escape recognition.

The chief points of interest connected with the case are: the widely disseminated character of the eruption, the multiplicity and variety of the lesions, the absence of glandular enlargements, and the excellent general health of the patient, with entire exemption from what is recognized as the cancerous cachexia. The number and variety of the eruptive elements is perhaps the most conspicuous feature. We have at the same time an erythematous redness, miliary and pigmented deposits, hard papules, tubercles variable in volume, mostly elevated, nodular masses imbedded in the subcutaneous tissues, and as secondary lesions, broken-down tissues, ulcers, crusts, and cicatrices.

Appended will be found a report of the histological characters of sections of the diseased tissues, submitted to Dr. A. R. Robinson for examination.

ANATOMY.—Two portions of skin were removed from the anterior surface of the thorax. One portion comprised a recent nodule and some surrounding normal skin. This recent nodule was about one-eighth of an inch in diameter, and its central portion appeared to consist of a whitish substance. Microscopical examination of sections of this nodule showed that it was formed of a collection of epithelial cells in different stages of vitality. Its peripheral part was composed of epithelial cells of the most various size, from that of the ordinary embryonic corpuscle, to the fully developed epithelial cell. In shape they exhibited every diversity of outline, and contained one or more nuclei. As the central part of the nodule was approached, the cells began to show signs of diminished vitality, and in the most central part had already undergone complete fatty degeneration, with loss of their outline, so that nothing was to be observed except a granular mass. In Fig. 1 is represented a section made through the centre of the nodule, and examined with a low power. A considerable portion of the epithelial mass has fallen out of the section. Beside this large central epithelial mass, there were both in the papillæ and in the corium several small collections of active epithelial cells in lymph channels (*d*). The fibrous connective tissue of the corium was normal, except directly around the epithelial collection, where it was denser from compression by the new structure. There were

no embryonic corpuscles or dilated blood-vessels, or any signs of inflammation in this tissue. The epidermis was normal, except in a small area, where the protoplasm of the rete bodies was breaking down and leaving free nuclei. The sebaceous glands, sweat glands, and hair follicles were normal.

This nodule therefore represented a new formation, consisting of cells of an epithelial type grouped together in spaces between the connective tissue bundles (lymph channels). The walls of the spaces were formed of the previously existing tissue of the part, as shown by the normal condition of the corium, consequently the epithelial collections were situated in lymph spaces. The nodule from its structure was therefore carcinomatous in nature, and from its situation in the lymphatics was a secondary growth, the result undoubtedly of a primary cancer of the mammary gland.

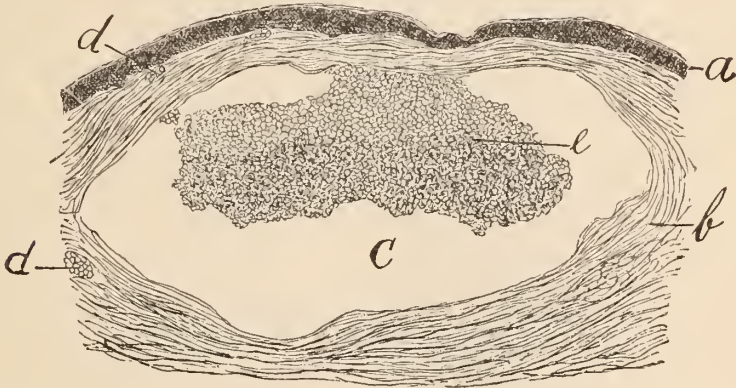


FIG. 1.—Section of a recent nodule magnified about 25 diameters; *a*, epidermis; *b*, corium; *c*, seat of the nodule; *d*, nodules of epithelial cells; *e*, degenerating epithelial cells.

The second nodule which was removed was a much larger and older formation than the nodule above described, and did not present the opaque centre. Sections of this growth showed a great number of epithelial cells of various sizes and shapes grouped together in the lymphatic channels of the papillæ, corium, and subcutaneous tissue. The cells showed all stages of growth, from the round embryonic corpuscle to the fully developed and variously shaped epithelial cells observed in carcinoma. In the central part of some of the large cell collections a commencing fatty or mucoïd change was to be observed. Many of the cells had two or more nuclei, and some were producing embryonic cells by the process of vacuolation. The amount and direction of the pressure to which the new cells were subjected exerted a marked influence upon their shape. The largest cell groups were in the upper part of the



K.R.R.

FIG. 2.—Section of a secondary carcinomatous nodule of the skin; *a*, epidermis; *b*, cell collection in a papilla; *c*, cell group, some of which have fallen out; *d*, corium; *e*, space from which cells have fallen out.

corium (Fig. 2, *c*). Within the papillæ they always occupied its central portion, leaving more or less connective tissue between them and the rete (Fig. 2, *b*). There never was any connection to be observed between the epithelial cells filling the lymph spaces and the endothelial cells of the lymphatics. With the exception of a small area in the papillary region, there were no signs of abnormal nutrition changes in the connective tissue proper of the papillæ, corium, or subcutaneous tissue. There were no changed blood-vessels, no emigration of white blood-corpuscles, no changed connective-tissue corpuscles, no signs of new fibrous connective-tissue formation, consequently the boundaries of the spaces occupied by the new epithelial cells (the alveolar wall) was not a new formation, but the previously existing connective tissue of the part, the size of the alveoli depending upon the amount of the cell collections. The corneous layer was normal. The rete was considerably hypertrophied in many of the sections, the hypertrophy affecting principally the interpapillary projections. The sebaceous glands, sweat glands, and hair follicles were normal.

In this nodule, also, the kind of new cells, their arrangement and situation, showed that the growth was a secondary carcinoma. The normal condition of the corium tissue and the endothelial cells of the lymphatics showed that the alveolar wall was not a new formation, and that the tumor cells did not arise from the fixed elements of the part. That in a group of the new cells all stages of growth, from the round embryonic protoplasmic mass to the fully developed epithelial cell, could be observed, and that in many of the epithelial cells two or more nuclear-like bodies were present, some being situated at the very periphery of the cell, justifies the view that the new bodies arise from the pre-existing epithelial cells either by division or the endogenous mode of formation.

NOTES ON TWO CASES OF SO-CALLED "ERYTHEMA GANGRÆNOSUM."¹

BY

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THESE two cases of so-called *Erythema gangrænosum* occurred in the practice of the late Dr. Tilbury Fox, but as I had opportunities of seeing both the patients on more than one occasion, and as the cases are of considerable rarity and certainly of much interest, I have thought it well to record them in some detail.

¹Notes of these cases were read during the past session to the Royal Medico-Chirurgical Society of London.

CASE I.—Mrs. C., aged forty-five years, was sent in June, 1877, to Dr. Tilbury Fox, suffering from the chronic evolution of large rounded or oval patches of *gangrenous* inflammation of the skin of the neck and arms. The patient was a stout, florid woman, with muddy, yellowish conjunctivæ. She complained of feeling weak, of losing flesh, and of constant flushings, severe palpitations of the heart, and violent throbbing of the vessels of the head and neck, especially when in the prone position. The menses were regular and there was no organic disease; and no evidence of syphilis. The eruption commenced in November, 1876, after the patient had been subjected to prolonged worry and trouble of a trying nature, and had given way to intemperance. The first patch appeared on the left supramammary region and, as this healed, another came out on the corresponding right region, and then another on the right and left forearms in succession. In this manner the patches continued to evolve, one patch appearing as its predecessor was in process of healing, and further patches would form for a time about one arm, then about the other, then about the chest, and so on. The arms would swell considerably after the formation of several of these gangrenous areas. Whilst under observation, the chest and arms only were attacked. Both arms were never or very seldom involved simultaneously, although on one occasion both sides of the chest and one forearm was so. There was a certain semblance of periodicity in the attacks, but the intervals of freedom were very short; indeed, the longest up to the summer of 1878 was about three weeks. During the illness two phases of lesion were noticed, which, however, were linked together by intermediate stages; the milder lesion appearing at the beginning of the illness, and the more severe one later on when the health was much deteriorated. The milder lesion was described as beginning in a dull-red, painful, more or less rounded, superficial inflammatory patch, which quickly, but very slightly and imperfectly, vesicated, *i.e.*, the amount of effused fluid collected was very small, and the walls of the bulla were flaccid, thin, and rapidly collapsed; moreover, the rising of the bulla was not uniform, but only little islands here and there vesicated. The rupture of the bulla and escape of the fluid disclosed a raw red (often hemorrhagic), surface, slightly weeping and crusting over and undergoing some ulceration, which healed tediously (two to four weeks), and occasionally left faint scars. The graver lesion was described as beginning by an intense local burning pain, lasting one to two days, and accompanied by nausea and some malaise. Then a redness appeared over this painful area, and in a single day or night afterwards became yellowish like parchment, anæsthetic, and surrounded by a hyperæmic areola. Sometimes on these patches there was evidence of abortive vesiculation. The slough which formed dried up, hardened, darkened in color, and gradually separated in two or three weeks, leaving an ulcerated surface which healed tediously (often taking nearly another month), and left indelible scars, with which the arms and chest were covered. These gangrenous patches, like the less severe ones, varied in size from a florin or crown to the palm of the hand. It would be wearisome to trace the progress of the case in detail, suffice it to say that in spite of multifarious and persistent treatment, the patches continued to form frequently for many months, when the lady was got into a better state of health and the frequency of appearance and severity of the eruption were less. Several relapses, however, occurred during the year 1878.

In 1879, she had an attack of paraplegia lasting two or three months, and probably of an hysterical character. In 1880, the lady, who had been considerably better for some time, was subjected to renewed trouble and anxiety, and her health and the eruption were worse again. In September of 1882, the medical practitioner in charge of the case kindly informed me that "since 1878 she has had periodic attacks about once a year, but less severe in their nature than formerly, and at no time to the same extent. She has been temperate for the last few years." Malingering was never brought home in this case, and though the idea was discussed, Dr. Tilbury Fox came to the conclusion that the affection was a genuine one.

CASE II.—Belongs to the same category, but here no distinctly gangrenous patches appeared, and the inflammation was of a slighter and more superficial character. Miss F., aged seventeen years, was sent to Dr. Tilbury Fox in October, 1878. There was but little of importance to be gleaned about the family history excepting that the father was very gouty, and the patient's sister¹ had erythematous lupus. The young lady was tall, spare, with a somewhat phthisical aspect and a poor circulation, but her menstrual, urinary, and gastro-intestinal functions were in fair order, and her appetite was good. She suffered from chorea when ten years old, and ever since remained "very nervous" and subject to marked nervous twitchings and jerkiness of her movements. This was noticed several times when she was under examination. Of late she had become subject to well-marked hysterical attacks, and her sister observed that the skin was often very hyperæsthetic. Her illness consisted in the chronic evolution in the skin of painful inflamed areas of a *severe erythematous type*, looking and feeling like severe scalds. This distressing state of things had been going on for five months, and during most of this time she had been at a seaside school at Scarborough. There had been as many as a dozen patches out at a time, and they occurred with fair symmetry over the body and extremities, the corresponding eruptions evolving simultaneously or within a few hours of one another. There was, however, as in the other case, a marked tendency for the inflammation to recur over and over again about the site of former lesions. The eruption began on the chest, then involved the neck, and finally the arms and legs. The patches occurred throughout on the front of the body, but according to the young lady's unsupported statement, they appeared at an early period of the illness between the shoulders. The inflammatory areas were mostly rounded or oval in shape, and varied in size from a florin piece to the palm of the hand, and the largest were always about the legs. When seen in October, 1878, there were vesicating patches on each mamma, on both arms and forearms, the thighs and legs. It appeared from personal examination and notes taken by the young lady's most intelligent and careful sister, that the patches appeared mostly in the night and reached their full development in a few hours, so that it was suggested that excessive heating of the body influenced their formation. Several patches evolved day by day in different regions, and it is remarkable that, as one healed, which was the case in three to seven days, a fresh one took its place on almost the same site. The history

¹ This young lady afterwards suffered from commencing *phthisis*, and has recently died from *tubercular meningitis*.

of the lesions was as follows: After some precursory local pain or irritation, an erythematous, more or less rounded, area appeared, in size generally about that of a florin or half-crown, but occasionally larger, hardly at all raised, and painful enough, it was said, to disturb sleep. The color soon became dusky, and sometimes the patch would be even slightly hemorrhagic. There was, as a rule, no increase in size after the first appearance. The surface then rapidly vesicated, but imperfectly and slightly, and the transparent contents oozed away. The flaccid and collapsed thin wall of the bulla was often with difficulty detected, and rapidly disappeared, displaying a reddened raw surface sometimes surrounded by an angry areola, and discharging a thin ichorous fluid. A dull-red macule was seen after the healing, for the inflammation was too superficial to leave a scar. The only treatment that was of any good effect was a generally supporting one of cod-liver oil and sulphate of iron, and gradually the general health improved and the patches formed less frequently. In January, 1879, after three months' treatment, the sister wrote that "the sores still break out in the old places on her chest, arms, and legs; but as a rule, they are not so large, do not look so inflamed, and heal more quickly than they did six weeks ago. It is thirty-three weeks since the eruption first began." In May, 1879, after nearly seven months' treatment with cod-liver oil and ferruginous tonics, the sister again wrote "now she has only one small sore place on her leg. That heals and breaks out over and over again. She is much stronger and stouter, and less jerky in her movements than she was three months ago." The girl shortly after returned to school, and has since been quite free from eruption. It may, however, throw light on the case to mention that at school she afterwards suffered from a remarkable illness which was probably simulated, for she vomited or pretended to vomit considerable quantities of blood without any detectable cause, and without any marked coincident ill-health. Her morbid desire to attract attention at this time was surprising, and with this object she did the most extraordinary acts, which it is not necessary to particularize here. At the present time she is in improved health, but she suffers more or less from the choreic movements, and is extremely shy and furtive. Throughout her illness those in attendance were thoroughly alive to the question of malingering, and many efforts (though not of an exhaustive kind) were made to eliminate this possibility, but the girl was never detected.

REMARKS.—The question to be answered is whether there exists an idiopathic malady characterized by the formation of patches of inflammation of different degrees of intensity, affecting special sites, having a peculiar mode of evolution, etc., such as have been described above; or whether these cases are not in reality *always* due to malingering? Much difference of opinion exists on this point. Many leave it an open question, and others think that there is an idiopathic disease of the kind which is closely simulated by artificially produced patches, and that each case, as it presents itself, must be treated on its merits. Leloir, for example, is not only convinced of the genuine character of the affection, but determines that the eruption is due, not to a central, but a primitive lesion of the peripheral nerves. In trying to reach a definite conclusion

I have made a careful search for the records of similar cases, which I will very briefly summarize; but I will first mention that the cases reported of late years under the name "Multipler Kachektischer Hautgangrän" by the late Oscar Simon, of Breslau, by Eichhoff, of Breslau (*Deutsche Med. Wochenschrift*, 1880, No. 34), and by Cæsar Boeck, of Christiania (*Norsk Magazin f. Lægevidensk*, 1881, and *Vierteljahr. für Derm. und Syph.*, ix. Jahrg., 1882), appear to be examples of what is known in England as *varicella gangrenosa*. I can only collect five cases as affording any kind of support of the opinion that there may be an idiopathic eruption of the kind. In Dr. Morley Rooke's case (*Lancet*, vol. ii., p. 486, 1864), erythematous and gangrenous patches appeared in an hysterical and wayward female for several months with a fair kind of symmetry, but evolving singly as a rule, about the breasts and thighs, the front of the trunk, and the arms. This case in many features corresponds closely with case I. of this paper. In Dr. Fagge's case (*Brit. Med. Journal*, 1870), recurrent attacks, spread over several years, had occurred in a servant girl, aged eighteen years, in whose conduct there was nothing noted that specially suggested malingering. During the attack witnessed by Dr. Fagge, the erythematous and gangrenous patches formed about the breasts, side of neck, the forearms, and thighs, but ceased to appear soon after admission to hospital. In Mr. Stockwell's case (*Brit. Med. Journ.*, Feb. 12, 1870), there was a somewhat similar condition of things, only on the legs and thighs, of a girl twenty-two years old. In a case described by Dr. Tilbury Fox (*Lancet*, Oct. 30, 1875), a small crop of gangrenous patches was said to have suddenly appeared in a servant girl on the left cheek, the left mamma, the back of the left hand, the left forearm, the outer side of the right thigh, and on the left shin; but none formed after admission to hospital. Lastly, Leloir¹ mentions a girl aged eighteen years, in whom gangrenous patches evolved for over two years on both sides of the face, neck, front of body, and extremities, but mostly on the left forearm, the left parotid and sub-maxillary regions, and behind the left ear.² Now these five cases, presenting differences of detail in the intensity of the inflammation, etc., belong undoubtedly to the same category as those I have recorded, and in every one of them the suspicion of malingering is almost irresistible, although no fraud was actually demonstrated. Thus all the cases occurred in *females*, and several of the patients, if not actually hysterical, were in a lowered or neurotic condition of health in which simulated disease was not improbable. *The character and the history of the patches* were perfectly compatible with their production by

¹ *Recherches Cliniques et Anatomico-Pathologiques sur les Affections Cutanées d'origine nerveuse*, 1882 (with chromo-lithograph).

² See also, "Observation d'hystérie avec Troubles Trophiques" (Courbis in *Lyon Méd.*, 1875, pp. 408-514).

friction, powerful irritants, or caustics of different kinds, and not otherwise easily explicable. *The selection of the attacked sites* is remarkable in several particulars, *e.g.*, (1) the front of body was always involved, or if some other part, then the outside of the right thigh, the sides of the neck, the back of the hand, or some part easily within reach; (2) there was in some cases a preponderance or almost a restriction of the patches to the left side of the body, and even where a fair approximation to symmetry was kept up, the patches had a curious tendency to recur for a time first about one locality and then about another; (3) the patches had a great tendency to evolve singly, one appearing as another was in process of healing and further to recur over and over again about the same site; (4) the breasts were frequently the first regions attacked, and here the patches tend to take a transverse direction, and not longitudinal, as on the limbs. In fact it may be said that in every one of the cases there was some striking fact or group of symptoms in the mode of development of the patches, in their shape, in the site of attack, or in the disposition and conduct of the patient which excited suspicion. Then there was an entire absence of any enfeebling condition sufficiently grave to account for the occurrence of gangrene, and in contrast with the latter there was the healthy reparative process which went on in the sores after separation of the sloughs and in one case in a bed-sore. Dr. Tilbury Fox observed that "it is impossible to suppose that gangrenous spots could spring up idiopathically and extensively over the surface unless there were serious disturbance of the nutrition of the body to account for it." For instance, Dr. Hilton Fagge recorded in the Guy's Hospital Reports and in the Catalogue of the Skin Models in Guy's Hospital the case of a man in whom there occurred extending purpuric spots on the knees, thighs, legs, and forearms. The knees became purple and stiff and the centres of the patches superficially gangrenous and anæsthetic. Almost all the central portion of the purpuric spots on the legs became gangrenous, but the hæmorrhagic portions on the arms faded away. This man, however, was in the last stage of tubercular phthisis. Dr. Pietri also (*Berliner Klin. Wochenschr.*, 1879, p. 509) described a curious and severe febrile illness from which he suffered, and in which, after six weeks' suffering, and when much exhausted, superficial gangrene attacked both arms over a double hand's breadth. This case, however, is quite unlike those described as erythema gangrænosum. Leloir draws attention to formation of the acute bed-sore of Charcot, first pointed out by Samuel, and by some English physicians. This lesion, it will be remembered, is described as an erythematous patch, on which vesicles and bullæ are rapidly developed, and terminating often in gangrene of the skin and subjacent parts, usually occupying the sacro-gluteal region, but appearing indifferently on all parts of the trunk and limbs, and following any continuous, or sometimes

very slight pressure, or exceptionally arising independently of pressure. They may be multiple and form in a few days or hours. These *acute bed-sores* occur, however, in gross cerebral and spinal lesions, and the prognosis is grave. Moreover, superficial, localized, gangrenous patches, seated generally about the legs, are now and then seen in various states of ill-health. I have recently had under observation a marked example of symmetrical gangrene of this character in an elderly man suffering from heart disease. Such patches do not, however, recur over a long period. On the other hand, a healthy reparative process does go on in these patches after separation of the slough, and an enforcement of the argument drawn from the entire absence of any marked general enfeebling condition is rather begging the question. In this connection I would refer to the gangrenous patches supervening in the remarkable affection of the distal blood vascular system known as *Reynaud's disease*. Leloir takes his case further, and brings forward evidence to show that gangrenous patches may occur in the skin following injury to the peripheral nerves, and quite independently of any disease of the cerebro-spinal centres. The only other circumstance I would mention in this connection is the fact that the gangrene in varicella and vaccinia gangrænosa is said to occur unassociated with any marked cachectic condition.

On the other side, we have the telling body of evidence derived from cases of proved malingering. It is well known that erythematous patches may be produced by mustard (Startin, Flower, *Brit. Med. Journ.*, 1870), vesication by preparations of cantharides (Startin, *loc. cit.*), intractable ulceration by caustics (Startin, *loc. cit.*), or the repeated use of irritants, such as cantharides (Guy's model of Birkett's case), and that patches of inflammation of different degrees of intensity, which may be even gangrenous, may be occasioned by the application of acetic, nitric, and sulphuric acids. The notable feature of many of these malingering cases is that the same class of females is affected as in the first series of cases I mentioned, similar sites are attacked, and in nearly all particulars the symptoms are indistinguishable. I will allude to four cases very briefly to illustrate this. In the *Lancet* for December 17, 1864, p. 706, Dr. Oswald Copland, of Chelmsford, mentioned the case of a young female servant on whom for months large white patches suddenly made their appearance on different parts of the body, followed by sloughing so deep as often to expose the tendons. These patches occurred on the face and backs of the hands, and only one or two appeared at a time. The case excited much attention in Colchester, University College Hospital, etc., but the suspected malingering was never detected until one day the house surgeon at the Brighton Hospital exposed the fraud by carefully testing the washings from recent patches and afterwards finding a bottle of sulphuric acid concealed in the bed. The girl committed suicide from cha-

grin. In the same issue Dr. Livett, of Wells, related a case where the acetic acid in some aromatic vinegar accidentally and painlessly produced two dead patches surrounded by an inflammatory halo on the breasts. The cuticle here, it is well to note, was intact. In the *Brit. Med. Journ.* for February 12, 1870, Dr. Hilton Fagge described the case of a healthy, well-nourished, but very impressionable and excitable girl of eighteen years, in whom some inflammatory patches appeared on December 8, 1869, about the neck. On the following day several formed on the cheeks and forehead, and on the 12th, one on the chin. These patches were anæsthetic, yellowish-white in color, with an inflammatory halo, and a little blistered at the margins. On December 14, two or three areas were beginning to form on the upper part of the chest, and then staining from nitric acid was detected on the fingers of the right hand. No fresh patches appeared after admission to hospital. I have quite recently recorded in the *Lancet* a case¹ where a girl produced multiple excoriated, more or less oval patches, on the front of the chest and legs, *by persistent rubbing*, and I would here suggest whether it is possible that in certain depraved states of nutrition in hysterical females the skin may take on inflammatory changes or become excoriated with unusual readiness. However, there is no doubt that an excoriated patch or blister may be excited by continued rubbing even with the finger alone. Such patches are usually oval, a little broader than the finger, and with rather irregular edges.

The conclusion forced upon me is that the eruption in the two cases now placed on record was produced by artificial means, however unlikely such a fact might appear to the friends and others about the patients. It is often useless to inquire the why and wherefore of malingering. Such patients are often apparently in good health, and the fraud is not always practised to excite sympathy, notice, pity, or to attain any particular end, but sometimes seems quite motiveless.

P. S.—Since these notes were written, a report has been published of a very interesting discussion on this subject, which took place at the Imperial Society of Physicians, at Vienna, in 1882. Neumann, Kaposi, and Auspitz thought the gangrene spontaneous, whilst the surgeons, such as Billroth and Weinlechner, thought not.

¹See somewhat similar cases reported by Dr. Sangster in Vol. xi. of the *Clin. Soc. Trans.*, 1878, by Dr. Stelwagon, of Philadelphia, in the *Archives of Derm.*, Vol. viii., p. 236; and by Dr. Murrell, *Lancet*, Sept. 15, 1883.

LEPROSY IN MINNESOTA, 1869-1883.

A REPORT TO THE STATE BOARD OF HEALTH OF MINNESOTA,

BY

CH. GRÖNVOLD, M.D.,

Chairman of the Standing Committee of the Board on that Subject.

THERE has lately been written much about a centre of leprosy in the Northwest, from where the disease is said to be spreading. It may be interesting to see how facts support this statement.

As early as in 1864, the condition of the lepers among the immigrants to the Northwest has been an object for the attention of medical men from their old country. In that year Dr. J. H. Holmboe, surgeon in charge of the Hospital for Lepers in Bergen, Norway, visited this country, to study the influence change of climate and other relations had on the development of the disease.

He found 12 cases, of which 2 had originated in this country, while one, who came here leprosy, had got well. His impression was that their condition of health was better than it would have been if they had stayed in the old country.

In 1869-70 the settlements were again visited by a medical gentleman from the old country, the late Professor William Boeck, of Christiania, Norway, well-known in medical literature for his writings on leprosy and syphilis. The result of his investigations in the Northwestern settlements may be read in "Nordiskt Medicinskt Archiv," Band iii., No. 1.

He found in the three States, Wisconsin, Iowa, and Minnesota, 18 cases of leprosy, all which had come from those parts of the Norwegian Western seacoast where the disease is endemic.

Nine cases had the anæsthetic form, 3 the tubercular, while in 6 cases both forms were represented at the same time, or one superseding the other.

In regard to the time of the appearance of the disease, in 9 it commenced already in the old country, and of these, 5 had lepers in their family, while 4 did not know of any leprosy relation.

In the other 9 cases the disease first commenced in this country. Of these 8 had lepers in their family, and the disease broke out respectively 2½, 3, 3½, 5, 6, 8, 9½, and 10 years after their arrival. These 8 cases that were developed on American soil may depend upon heredity; or they may have been caused by contagion in the old country, the only place where it is possible that they could have met with other lepers; or the disease may have developed from a miasma in the old

country. Either of the last two suppositions being right, the time of the incubation will for two of the cases be $9\frac{1}{2}$ and 10 years. Professor Boeck considers them all as depending upon heredity, in direct or lateral line. If he had any doubt, he says, in regard to propagation of the disease by heredity, these cases would have convinced him.

As an instance, here is one of the cases described in the above-named medical *Archiv*:

“S. S., forty-five years old, came fourteen years ago to America to the place where he now resides, and he was in every respect perfectly well. His father had died, about 50 years old, in the lepers’ hospital at Bergen; his brother and sister died leprous in the old country, one and four years ago; his father’s sister had also had the disease. S. continued to be in good health after his arrival in this country for nine and one-half years; four and one-half years ago he commenced feeling heavy and drowsy, and two years later, after a violent cold, tearing and fleeting pains announced themselves in hands and feet, and from there in the upper and lower extremities, and at the same time swelling set in in the same parts and in the face, and an eruption of red spots appeared. The pains were so violent that he was obliged to stay in bed from January to May, and when he was able to get out of bed his strength was gone, and he discovered that his sensation was much lessened along the peroneal side of the feet and legs, and on the ulnar side of hands and arms. Since that time he has always suffered from fleeting pains in the extremities, and feels heavy and drowsy. ‘I will never have a day of health any more,’ he says.

Sensation is at present very weak in hands and feet, as well on the outer as on the inner side, from the hands along the arms to the shoulders, and from the feet along the legs and thighs until the neighborhood of the hip. The muscles of the right hand, between the first and second finger and those of the fifth finger, are considerably wasted.”

This patient left the old country in good health, and continued to be well for nine and one-half years after his arrival in this country, in a place where there were no lepers before, and where it is not known that he has had communication with any.

The last of the nine cases developed on American soil, did not know of any leprous relation, and may possibly be referred to contagion. The case is, in short, as described in the above-named *Archiv*: “B. I. is thirty-nine years old; came to this country fourteen years ago; has for twelve years suffered, and is yet suffering, from rheumatic pains in the extremities. Recently, after a day’s hard work, she had, in the evening, a violent chill, and the next day there appeared spots on the arms, and successively on the lower extremities, chest, back, and face. These spots are distinctly morphea spots, in some places slightly elevated. In

them there is either complete anæsthesia or very little sensation; outside of them the sensation is normal, except on the external side of the feet and legs. Her appearance is very good; she is fleshy, has good appetite, the bowels are a little constipated, menstrual flow scanty. She does not know of any leper in the family. She has once, six or seven years ago, been in the house of a leper. By others, it is said that she for some time has taken care of a leper." Prof. Boeck has his doubts whether this person does not also belong to a leprous family, and the disease then due to heredity.

The professor is of the opinion that the lepers here are better off, as regards their disease, than they would have been in the old country. "They have come away from the places where we see leprosy may originate spontaneously, and which certainly will favor its development, when the disposition is there by heredity. They have settled on fertile lands, where they certainly have to work hard to make a living, but they, generally, never undergo hardships, as we, in Norway, understand the term. Here is no work that can be compared with that done at the midwinter's fisheries in open sea off the Finmark coast, or the hardships suffered while tending the cattle on the high mountains plateaus, which causes so often bring out the latent leprosy."

Since Professor Boeck's visit in 1869-70, investigations have been continued in Minnesota regarding the occurrence and character of the disease in that State. At present, six cases and their whereabouts are known, all immigrated from that part of Western Norway where the disease is endemic.

None of them are confined to bed, and most of them are able to perform their daily duties.

The following table will show some of the particulars of the cases:

		AGE.	HOW LONG LEPROUS.	HOW LONG IN THIS COUNTRY.	FORM OF DIS- EASE.	LEPROUS RELATIONS.
Case I ¹ ...	Male...	58 y'rs.	18 years.....	27 y'rs.	Anæsthetic.	Father, father's sister, brother, sister, cousin.
" II.	"	29 "	7 "	20 "	Tubercular..	Father, 2 broth's.
" III.	Female.	29 "	7 "	16 "	Do.	None. (?)
" IV.	Male...	35 "	16 "	12 "	Anæsthetic.	None.
" V.	"	67 "	Prodromata in the old country	17 "	Do.	"
" VI.	"	44 "	10 years.....	15 "	Do.	Probably a broth- er.

¹ Case No. I. is described by Prof. Boeck—his No. 1—and is the one described above as S. S. It is the only case yet alive, of those he saw in Minnesota. He has, since the Professor saw him, been tolerably well until of late years, when the disease has made a quicker advance.

It will be seen that 2 of them have the tubercular form, while 4 have the anæsthetic; in 2 of these, IV., VI., a little complicated with the tubercular.

Two of them, IV., V., had the disease already in the old country, but one of them did not suffer much from it before 7 years after the arrival to this country.

Of the other 4, 3 know of leprosy relations, while 1 (III.) denies that the disease has ever been in her family. She is from a district where there are many lepers, Balestrand, in Sogn. The main features of the case are:

Case III. came to America when she was thirteen years old, in company with a sister of her mother, sixteen years ago, and has all the time since lived near the place she first went to. The first two years she lived with her aunt, but after confirmation she served as housemaid in the families in the neighborhood until she, seven years ago, discovered the first signs of the disease. After a severe illness, she says, caused by cold, the legs swelled, and some vesicles appeared, first on one, later on both ankles, followed by sores. At present, she exhibits the tubercular form of the disease, and presents a very repulsive appearance. The complexion is pale, or rather a dirty white, the skin of the face thickened and rough. Tubercles, some suppurating, and some torn by scratching, are seen over the eyes and on other places of the forehead, on the right nostril, and on the cheeks and chin; also on the ulnar side and back of both hands, where as well as on the outside and back of the feet, and lower part of the peroneal side of the legs there is some anæsthesia. The voice is hoarse and rough. The nose seems flattened on account of the alæ spreading out. The lobes of the ears and lips, especially the upper, are very much thickened and elongated. The eyebrows and eyelashes are gone; conjunctiva a dirty white, with a troublesome secretion; cornea somewhat opaque; her eyesight is very much impaired. She denies having any discoloration of the skin, any sores or tubercles in other places than those above named, and on the ankles where there are deep ulcers, laying the bone bare. She does not suffer much; only once in a while she feels a little oppression, and some slight pain in the chest and back, but this, she believes, is only caused by weakness. Appetite is irregular; the sleep is commonly good. Menses commenced being scanty when the disease broke out, and stopped soon. She feels worse spring and fall, but is seldom confined to bed. She takes cold easily. Like almost all lepers here, she ascribes her disease to cold. "She suffered so from cold," she explains, "in a place where she was working, that she, then and there, got the disease." It is not known by herself, or anybody else, that she ever met with a leper in this country.

She must have carried the germ of the disease with her from the old country, whether it has been communicated by contagion or miasma, if

she is right in her statement that the disease has been neither in her father's nor mother's family. The disease became evident when she was twenty-two years old, and had lived in this country nine years. She will not remember any prodromes; has probably tried to conceal her condition as long as possible. She tries yet to put the best appearance to her miserable condition.

Ten lepers of the immigrants are known to have died in Minnesota since the settlement of the country, all of them males. Of these, seven have died in the last seven years, and the following table will show some of the particulars of the cases:

	AGE AT TIME OF DEATH.	HOW LONG LEPROUS.	HOW LONG IN AMERICA.	FORM OF THE DISEASE.	LEPROUS RELATIONS.
Case I...	49 years ...	24 y'rs..	19 y'rs..	Anæsthetic	Brother of mother's father.
“ II.	56 “	14 “	24 “	Tubercular.....	A cousin.
“ III.	35 “	10 “	9 “	Anæsthetic	Father's brother.
“ IV.	About 30 yrs	3 “	13 “	Tubercular.....	Brother's father and brother diseased.
“ V..	“ 30 “	12 “	15 “	Do.	Do.
“ VI ¹	62 years ...	30 “	21 “	Tuberc. 1st 7 y'rs., afterwards anæsthetic; disease stopped before death.	Brother and father's brother.
“ VII.	30 “	....	10 “	....	Mother's brother.

It will be seen that 3 of them had the anæsthetic form, and died 24, 10, and 30 years after they got the disease. The last case, No. VI., Boeck's observation 2, is an instance of one form changing into the other; the disease commenced in the tubercular form, and continued so for 7 years; after a violent fever it changed into the anæsthetic. Three had the tubercular form, and died after having had the disease 14, 3, and 12 years. Case II. got the disease 10 years after his arrival in this country, when he was 42 years old.

All of them had lepers in their family; 3 of them had the disease in the old country, 3 got it here—2, 10 years and one, 3 years after their arrival.

Four of the lepers—2 of them living yet—have full-grown children

¹ Cases II. and VI. were seen by Prof. Boeck in 1870, and described by him in the above-named journal, as observations 3 and 2. Case II. got steadily worse until death, 8 years after the professor saw him, but in No. VI. the disease made no advance years before his death, which occurred 30 years after he was attacked, 7 years after Prof. B. saw him, and described his case. He was, in the last years of his life, since Prof. Boeck's visit, in good health, with the exception of the anæsthesia in the already attacked places, and an always open and discharging ulcer under one foot. When this discharge stopped, about fourteen days before his death, vomiting set in, which became more and more distressing, so he could keep nothing in his stomach. He was not confined to bed, but moved about as usual, until just before death.

born in America; 2 have also full-grown grand-children. One, No. VI. of last table—Boeck's observ. No. 2—has 15 grand-children, aged from 2 to 22, and 2 great-grand-children, and in none of them has any sign of the disease been discovered. The other, No. I. of the first table—Boeck observ. No. 1—who belongs to a family strongly infected with leprosy—his father and father's sister, his brother and his sister were lepers—has full-grown children and many grand-children of an age up to 17, all in good health.

The suggestion of the above facts, as far as they go, seems to be that the disease is not so easily acquired here in the Northwest as in the old country, be it by heredity or contagion. The dry climate is, possibly, not so favorable for the development and the communication of the disease that at present mostly belongs to the sea-coasts and islands. The chances of contagion are decidedly less here than in the old country; there is greater cleanliness, as a consequence of the greater economical prosperity, and the new-built houses of the first settlers in a new country furnish no filthy nests for contagion.

But, once acquired, the disease seems to run its regular course without abatement.

Society Transactions.

NEW YORK DERMATOLOGICAL SOCIETY.

140TH REGULAR MEETING, November 27, 1883.

DR. P. A. MORROW, *President, in the Chair.*

PRESENTATION OF CASES.

DR. FOX presented four cases of

LUPUS ERYTHEMATOSUS.

CASE I.—A woman, *æt.* forty-seven, married. In June of this year, the end of her nose became red, with a little itching at first, but this soon passed away. Her bowels are constipated; otherwise her health is good. The end of the nose, as far up as the bridge, is red, smooth, and shiny. The color fades under pressure.

CASE II.—A woman. The disease began in May, 1880, as a red spot upon the forehead. Two years ago, when first seen, there were a number of smooth red spots upon the forehead resembling an erythema. Subsequently, similar spots appeared upon other parts of the face. For one year, she was kept on iodide of starch without any effect on the disease. The chrysarobin pigment was also used, which proved beneficial, but not curative. Last March, she was given phosphorus in one-fiftieth gr. doses, three times a day, with sudden amelioration of disease. The spots were also touched with pure carbolic acid, resulting in continued steady improvement. The phosphorus was continued, at intervals, and

the patient was seen irregularly. The redness has faded, and the patient now presents a number of pitted scars where the old lupus lesions were.

CASE III.—A woman, about thirty years old. Was first seen one year ago. Began at inner angle of left eye, and ran along under the eye to the outer angle. She was treated with the iodide of starch internally, and ethylate of sodium externally, with no effect. Pure carbolic acid and phosphorus, as in the previous case, have caused rapid improvement.

CASE IV.—A man, thirty-five years old. Began three and one-half years ago upon both sides of the face, forming large irregular patches. First used chrysarobin pigment, which seemed to aggravate the disease. The oil of ergot also used without effect. In April last, painted with pure carbolic acid, with improvement, which has continued.

DR. TAYLOR presented a case of

LUPUS ERYTHEMATOSUS

occurring in a woman, aged twenty-five years, and married. During last summer, a little red spot appeared below the right eye, and shortly after its appearance another came below, and on the same side of the face. Dr. Taylor first saw the case in September. Applications of pure carbolic acid have caused some of the disease to disappear.

In the discussion of the above cases which was made to turn upon the treatment of the disease,

DR. TAYLOR said that he looked forward to good results from the treatment by pure carbolic acid. The iodide of starch had proved, in his hands, inert.

DR. STURGIS agreed with Dr. Taylor as to the iodide of starch.

DR. PIFFARD thought that the treatment of lupus erythematosus should be considered as to the relative value of two methods. First, by the method of inducing inflammation with secondary absorption. This was the effect of the German green-soap method, and also, he believed, of the carbolic acid, which, in these cases, was not caustic. Both the green soap and its tincture will cause the disappearance of some of the lupus lesions; but it must be remembered that, in the older portions, there was always a tendency to spontaneous disappearance. He had abandoned the soap treatment, because he had seen rapid extension of the disease following its use. Secondly, the method of rapid destruction of all the infiltrated tissues. For this purpose, all the potential caustics might be used. Nitric acid would be effective, but we would hardly think of using it. Vienna paste, and other caustic pastes, and the alkaline caustics, will destroy, but we would use them only on small spots. The pure potassa caustica is rapidly destructive, but unmanageable, while the weak solutions of it are only stimulating. The operative procedures most in vogue are by multiple punctiform or linear scarifications, erosion by the sharp spoon, and by the actual cautery. The latter, unless of extreme power, does not burn deep enough, and is apt, therefore, to be inoperative. Personally, he first removes the growth with the sharp spoon, and then uses the actual cautery with strength enough to burn about 1 mm. beyond the growth. Linear scarifications are very excellent, and may be considered as involving a third method, that of inciting an intense dermatitis. This may act by destroying the bacteria of lupus, if bacteria there are, upon the same principle as the destruction of the chancre virus by the hot douche, the bacteria not being able to survive under the intense heat. We know that an intercurrent attack of erysipelas will sometimes cure lupus, and probably in this way. He believes that, while the first method may be followed by as much success as the second, yet the latter is to be preferred, as it occupies but one-fifth to one-tenth of the time. The third method is also tedious.

DR. BULKLEY said that he was decidedly in favor of phosphorus as it had a marked effect upon the disease. In recent cases of lupus, scarifications were very effective, and sometimes he applied pure carbolic acid to the cuts. He had tried chromic acid, but had not found it of much use. A very good application for the disease was a lotion composed as follows:

℞ Potass. sulphuret.,
 Zinci sulphat. āā ʒ i.-iss., or 4.0 to 6.0
 Aquæ rosæ. ʒ iv., or 120.0

DR. KEYES was in favor of the internal use of phosphorus.

DR. SHERWELL said that carbolic acid had, in his hands, caused the disappearance of the little granulations of lupus. He believed that it acted as a mild escharotic. He preferred the acid nitrate of mercury, and sometimes applied it after scarification.

DR. TAYLOR drew attention to a form of lupus which was very irritable to heat and cold, and crept on under any form of treatment.

DR. FOX said that there may or may not be a difference between lupus erythematosus and lupus vulgaris, but there certainly was a difference in regard to treatment. The curette and scarification were good in lupus vulgaris, but he did not use them in lupus erythematosus. The former left too much scar. The carbolic acid acted differently from green soap. The latter will not remove a large patch, and when there is a tendency to congestion, will increase the trouble. Carbolic acid acted on the vascular supply, reducing congestion. The indications for treatment were to lessen the redness and congestion of the patch. In most cases, indigestion was present, and this must be subdued before local treatment would do good. Phosphorus in many cases produces sudden effect on the vascularity of the part. He has used ethylate of sodium, nitric acid, etc., which destroy the tissues. He has seen the disease return after the use of the Paquelin cautery. The patient must decide whether to go slowly and leave small scar, or quickly and leave large scar. Phosphorus internally and carbolic acid externally will cure in a reasonably short time. He has seen benefit from linear scarification.

DR. MORROW said that scarification left a more supple scar than the curette. It had been suggested by Dr. Piffard that phosphorus caused fatty degeneration of the infiltration.

DR. KEYES presented

A CASE FOR DIAGNOSIS

in the person of a medical student, twenty years of age, who all his life has had upon his left leg some dry papular lumps, about one-third of an inch in diameter, located over the ham-string tendons. These itch very much, especially at night. He has had several attacks of lichenoid eruption over the knee. Three of these papules are located above, and two below.

DR. PIFFARD thought that they were papules of a chronic dry eczema, which had been irritated and enlarged by constant scratching.

DR. TAYLOR agreed with Dr. Piffard.

DR. FOX proposed salicylic acid and chrysarobin in collodion for treatment.

DR. SHERWELL thought that they were produced by mechanical irritation.

DR. KEYES said that the patient had the habit of constantly rubbing the lesions.

DR. KEYES presented a case of

UNILATERAL HYPERIDROSIS OF THE FACE.

The patient, Mr. S., æt. 32, married, has had the trouble for some time. Otherwise he is perfectly well, with the exception of a slight cystitis. No localized neuralgia. The sweating is on the right side of the face, and the sweat drops stand out prominently. No other points of sweating. Upon exertion he sweats naturally on other parts of his body. From six to ten years of age, he had chorea on the other side of the face. One uncle died at thirty-eight years of age of rapid tuberculosis. The sensibility of the sweating side is diminished, but is more affected by cold than the other side.

DR. MORROW had had a case of unilateral hyperidrosis in a young woman, which disappeared spontaneously in a few years. He had another case in a medical student, which was attributed by the patient to a blow on the bridge of the nose, causing a deflected septum. A portion of the deflection was recently removed, resulting in a reduction of his catarrh, and a decrease of his sw

DR. BULKLEY had a case occurring upon one thigh, which passed away under tonic treatment.

DR. BULKLEY presented a case of

DERMATITIS PHLEGMONOSA,

with the following history. A. K., æt. $7\frac{1}{2}$ years, German. In August last, while on the way to this country on shipboard, there appeared a swollen point like a furuncle, upon the upper and anterior part of the right thigh. Before this the child had been in good health. The furuncular mass, instead of coming to a head, spread, and soon a second spot developed, which was smaller. While yet on shipboard, suppuration took place to slight extent. On September 27th, the patient was seen by Dr. King. The child was then, and had been, suffering a good deal of pain. The limb then looked like a diffuse phlegmonous erysipelas. On November 14th, the patient was first seen by Dr. Bulkley. The disease occupied a space three by two inches, and was thick and brawny. The affected thigh measured nearly two inches more than the other. The diseased part was bright red in color, and painful on pressure. Deep pressure over the back of thigh, where there was no inflammation, was painful. The left cheek was red, and showed a lump about the middle portion. The right arm was swollen and red, with red and yellowish points, with depression in the centre. Dr. King stated that under the treatment he had instituted (iodine and soothing ointment), the thigh had improved, and lost its tenderness upon pressure. About the 1st of November, when he was about to stop treatment, a swelling developed below the original one, involving the lower third of the thigh, and extending towards the back. This was followed in a few days by the appearance of a lump in the middle of the left cheek, which felt somewhat like a boil, or as if there was an enlarged gland on the inside of the cheek. At the same time on the radial side of the right arm near the elbow another lump appeared, the tissues in the neighborhood being thickened and tender to pressure. The arm improved under the use of the lotio plumbi et opii. The lump on the cheek did not become larger, but about one week ago the cheek became red and tender. Dr. Bulkley ordered magnesia and iron, and $\frac{1}{4}$ gr. pills of sulphide of calcium three times a day. Locally diachylon ointment. On the 27th of November, all parts were worse, excepting the leg, which was a little softer. The arm was more swollen, the skin broken at the outer side, and exuding a little serum. The left cheek greatly swollen and red. The lump in the middle was deep in the mucous layer. Soon after last visit some new spots appeared upon left lower leg, which were red and painful, but improved under diachylon ointment. Temperature of affected arm at fold of elbow was 102° F.

DR. SHERWELL thought that the case resembled one of lymphatic stoppage.

DR. TAYLOR would not be satisfied until he had ascertained the history of both parents, and of the child from birth. An elevated temperature was not common in a gummatous syphilide in a child of that age.

ZONA OF THE SUPERIOR EXTREMITY.

1st. ZOSTER of the superior extremity is much more frequently observed at the present day, since trophic lesions consecutive to diseases of the cerebro-spinal system have been studied with more care.

2d. The eruption follows the arm in a longitudinal direction, always the same at the external and internal portion of the limb.

3d. The cases of zoster of the upper extremity constitute a new proof in favor of the nervous origin of this cutaneous affection.—DR. A. STOPIN, *Th. de Paris*, November, 1882.

Reviews.

THE PATHOLOGY AND TREATMENT OF VENEREAL DISEASES. By FREEMAN J. BUMSTEAD, M.D., LL.D., and ROBT. W. TAYLOR, A.M., M.D. Fifth Edition, Revised and Rewritten, with many additions by Dr. Taylor. With 139 woodcuts and 13 Chromo-lithographic figures. Philadelphia: Henry C. Lea's Son & Co., 1883. Pp. 906.

The demand for a fifth edition of this standard work affords the most gratifying evidence of the high esteem in which it is held by the profession. Upon the first appearance of Dr. Bumstead's book, it at once received recognition as the most systematic and comprehensive treatise on venereal diseases that had yet appeared. This high standard has been maintained in succeeding editions by constant revisions and additions, embodying the latest researches, and all important advances made in our knowledge of the subjects of which it treats.

The fourth edition was practically a new book. Dr. Bumstead, having associated with him in its preparation Dr. R. W. Taylor, with the view, as told in the present preface, "of producing a treatise on a level with our present knowledge, which, though the work of two men, should be as coherent as if written by one."

As is well known, the major portion of the part relating to syphilis was rewritten by Dr. Taylor, whose large experience, trained observation, and practised powers of analysis, peculiarly fitted him for the task of weighing and sifting the large mass of new material which had been developed respecting the pathological relations of syphilis, and presenting all the essential facts in a concise, yet sufficiently comprehensive manner.

The character of this standard work is so well known that it would be superfluous to here pass in review its general and special features of excellence. The verdict of the profession has been passed; it has been accepted as the most thorough and complete exposition of the pathology and treatment of venereal diseases in the language; admirable as a model of clear description, an exponent of sound pathological doctrine, and a guide for rational and successful treatment, it is an ornament to the medical literature of this country.

Only the additions which have been made in the present edition shall claim our special notice. We find, upon examination, that while these additions have not been material as regards the space occupied, they are eminently judicious from the standpoint of practical utility. Many new and important suggestions in regard to the treatment of particular conditions have been introduced. The section devoted to the treatment of the chancroid has been amplified from four pages to ten. A number of new remedies whose value as local stimulants experience has recently demonstrated, are noticed and commended, such as salicylic and pyrogallic acid, resorcin, bromine, etc.

In the light of recent researches respecting micro-organisms, and the prominence given to the germ theory in the pathogenesis of disease, no study of the nature of syphilis can be complete which does not consider its possible bacterian origin. With a conservatism which cannot be too much commended in the presence of mooted and theoretical points, our author does not commit himself upon this question. He gives a succinct *resumé* of modern investigation in this direction, detailing the observations of Klebs, Aufrecht, Morison, Birch-Hirschfeld,

Neisser, and other experimenters, and without questioning their accuracy, leaves the reader to draw his own conclusions. He gives a guarded assent to the possibility of the transmission of syphilis to animals, while readily admitting their susceptibility to the action of the chancroidal poison. The importance of the determination of this question in its bearing upon the distinction between the virus of chancre and chancroid is obvious. He gives in detail the experiments of Klebs and Martineau, in which they claim to have successfully inoculated syphilis in monkeys and pigs, from hard chancres. He summarizes thus: "The gist of the whole matter is this: That with the secretion of a hard chancre which has been irritated naturally or artificially, chancroids may be produced in animals, and that with the unirritated secretion, or with portions of the chancre, we may produce something, perhaps syphilis, and perhaps tuberculosis." In this connection we may be pardoned for contrasting this admission with the positive statement on page 371, that "inoculations of animals with the true syphilitic virus have invariably failed," which may, however, have been overlooked in the revision.

More space has been devoted to the consideration of excision of the chancre as a means of aborting syphilis. With most authorities he unqualifiedly condemns the procedure as a failure from a prophylactic point of view.

In the local treatment of the cutaneous manifestations of syphilis, especially the scaling syphilides, salicylic acid in ointment is highly spoken of. In the papular and tubercular syphilides, especially those attended with much scaling, chrysarobin is regarded as the most efficient local remedy. In hypertrophic vegetating, or tubercular syphilis, the best results have been obtained from a combination of salicylic acid with chrysarobin.

A new plan of treatment is introduced for severe ulcerating gummata—a modification of Schiele's method of treating wounds. An illustration represents an ingenious appliance adapted for local mercurial fumigations. Many new and valuable suggestions as regards improved modes of treatment are found scattered through the various sections devoted to the manifestations of syphilis in different organs.

Special prominence is given to the virtues of a new adjuvant, the Erythroxyton coca, in the constitutional treatment of syphilis, which he regards as one of the most valuable agents at our command. While not claiming that the drug is a specific for syphilis, "its marked tonic effect upon the heart, nervous system, and capillaries, and its power to invigorate the system, to improve nutrition, and to sustain life, is so great, that its use in syphilis, secondary to that of mercury and the iodide of potassium, is attended with results which no other agent known to us possesses. It is especially useful in the anæmia and cachexia of the secondary period, etc." He then goes on to particularize its great value in "marked debilitated and cachectic conditions." It is to be hoped that a more careful and extended proving of this drug will verify its possession of the remarkable remedial virtues which Dr. Taylor ascribes to it as an adjuvant in the treatment of syphilis. Reference is made to a number of new agents of vegetable origin, such as *Cascara amarga*, *Berberis aquifolium*, and also to the combination of sarsaparilla, stillingia, and other plants, which has been introduced to the profession by Dr. Sims as a new treatment for syphilis, the virtues of which, however, have long been known to the Southern and Western physicians of this country.

The work concludes with a new chapter on Syphilis and Marriage—the brevity of which is disappointing. This subject has not, it seems to us, received the recognition which its importance demands. There is no point of view from

which syphilis can be contemplated that embraces so many considerations of vital interest as its relations with marriage. The marriage of a syphilitic man involves the possible transmission of the disease to an innocent wife; it may condemn his offspring to death *in utero*, or entail upon them a patrimony of lifelong debility and disease, and in this aspect it assumes the character of a social crime. It is important that the physician should fully appreciate the great responsibility which, in his protective relation to society, he assumes in allowing a syphilitic patient to marry. While it is not possible in a general work of this kind to consider in detail the various complex and delicate social problems which may arise, yet it should indicate with precision the line of the physician's duty in the difficult situations which may present themselves. We think that Dr. Taylor has not laid down sufficiently stringent rules: too much latitude has been given to "the force of circumstances," which oftentimes compel the physician to give "a reluctant consent to the marriage of a recently syphilitic man or woman." "If possible, it is always well to delay the marriage of a syphilitic person until the end of the second year of infection," it being understood that the patient has been regularly and systematically treated during that period, and at the end of that time is apparently free from the disease. It will be seen that these conditions are much less rigorous and exacting than those formulated by Fournier, which demand a treatment vigorously pursued during several consecutive years—*three or four years* at the minimum, and in addition, the absence of existing specific accidents; a certain period of absolute immunity consecutive to the last specific manifestations; and the non-menacing character of the diathesis.

The difficult task of bringing a book covering so wide a range of subjects "up to the level of our present knowledge," has been in the main so creditably performed by Dr. Taylor that it may seem invidious to point out possible shortcomings.

From the cursory examination we have made of the new material introduced into the present edition, we perceive that it is principally of a practical character, chiefly to improved means and modes of treatment. No material revision has been made of doctrinal points, which remain essentially unchanged. But, it must be borne in mind that, since the last edition was put forth, there has been a constant accumulation of new facts which have tended singularly to modify our knowledge upon many points connected with the pathological relations of syphilis, of the highest practical interest. In no field of special study has there been such an extraordinary activity displayed as in investigating the morbid states impressed upon the organism by the syphilitic diathesis, and especially its late hereditary manifestations—the varied and complex relationships of which we are now only beginning to appreciate. In the light of these new developments, the true scientific spirit is best shown by a judicious conservatism respecting questions still unsettled.

We will refer briefly to a few points upon which the teachings of science are by no means fixed and definite, yet which Dr. Taylor has disposed of in a manner, it seems to us, too absolute and dogmatic—such, for example, as certain phases of syphilitic heredity, the duration of the period of its manifestations, its possible transmission as rickets, the relations of syphilis to tabes, etc.

In opposition to the views held by the great body of syphilographers, Dr. Taylor contends that syphilis in the mother, contracted at any time during pregnancy, cannot be conveyed to the child *in utero*, on the theoretical ground that infection of either mother or child cannot take place through the utero-placental

circulation—a theory which, of necessity, also precludes the possibility of “syphilis by conception,” or *choc en retour*, as this mode of infection has been termed. The period during which hereditary manifestations may occur is limited to the twentieth year, thus ignoring the numerous, well-authenticated cases recently placed on record, in which incontestable manifestations were observed twenty-four, twenty-six, and twenty-eight years after birth, and even at a later period.

As regards the possible syphilitic origin of rickets, he characterizes the statement that syphilis may be transmitted as rickets as utterly untenable. While few authorities accept the radical proposition of Parrot, that syphilis is the sole cause of rickets, yet we cannot ignore the statistics of this eminent observer, who found among one hundred rachitic children, indubitable evidence of hereditary syphilis in ninety-one; of Kassowitz and other German observers, who found that nearly every syphilitic child became rachitic; of Fournier, whose opportunities for clinical study in this direction have been unrivalled, who concludes, that while syphilis is not the unique cause, it is one of the affluents of rickets.

Again, as regards the relations of syphilis to tabes, Dr. Taylor asserts that syphilis is never the cause of locomotor ataxia. We cannot here refer to the eminent authorities who believe in the existence of syphilitic ataxia. Dr. Taylor's teaching is opposed to the opinion of the distinguished specialist, Prof. Erb, who asserts that sixty-one per cent of all ataxics are syphilitic; to the conclusions of Fournier, who boldly affirms that “the enormous majority of cases of locomotor ataxia constitute a manifestation of syphilitic origin and nature.”

In laying down this valuable book, in which we find so much to commend, and so little to criticise, we must congratulate the publishers on the taste and judgment displayed in its style and general get up. The type is larger, heavier-faced, and more distinct, and the book is altogether handsomer and more imposing in appearance than its predecessors. The present edition is enriched with two chromo-lithographic plates, with thirteen figures, representing the principal venereal lesions.

Selections.

THE TREATMENT OF NÆVI.

Two papers on this subject were read at the recent meeting of the British Association, and are published in the *British Medical Journal*, Aug. 18, 1883. In that by Wm. Martin Coates, F.R.C.S., a treatment of superficial venous nævi discovered and perfected by Dr. Marshall Hall, but now almost forgotten, is commended as “painless, safe, scarless, and certain.” Dr. Hall's object was to excite just so much increased action in the growth as to cause deposition of lymph and occlusion of its vessels. He, for this purpose, introduced a cataract-needle, at about a line from the circumference of the nævus, and passed it from the point of its entrance to the opposite extreme edge of the growth, keeping, in all its course, as near as possible to the surface. The needle was then withdrawn, almost to its point of entrance, and pushed again through the nævus, at about the sixteenth of an inch from the line of the first puncture, and so on until the lines of puncture took a fan-like shape. It is desirable to keep the needle as close

as possible to the surface, though, should it penetrate the thin covering of the growth, a piece of adhesive plaster arrests the bleeding immediately.

There is no need of breaking up the *nævus*, as has sometimes been recommended.

One operation has invariably succeeded in the superficial venous *nævus*.

Now that we have safe anesthesia, there need be no pain in the treatment of such cases.

The bright scarlet or arterial *nævus*, appearing as a small, bright spot, as a patch measuring one or two inches in diameter, or again as one or two minute arterial branches, the author has successfully treated on the same principle—stimulation, not destruction of tissue—as follows:

A large needle made for the purpose, with a blunt, flat end, is passed, with the flat end at right angles to the skin, and tears through the vessels. An *echymosis* takes place which is soon absorbed, and the red spot disappears permanently.

This treatment has been applied in the broad superficial arterial *nævi*, with invariable success; but they require the proceeding to be repeated two, three, or four times, at intervals of three or six months. In these cases, numerous white spots occur over the whole *nævus*, after a few weeks. These, spreading slowly, join together; and, in a space of time varying from six months to two years, the *nævus* has disappeared, leaving in its place a portion of white skin, but neither scar nor depression.

When a *nævus*, venous or arterial, exceeds a thickness of one-sixteenth part of an inch, the needle operation is not applicable. In such cases, the author resorts to hypodermic injections of undiluted tincture of iodine, and, since 1861, has treated them all in this manner.

The little operation he describes is very simple. Wood's syringe, with a very fine needle, is the only instrument required. Sufficient tincture of iodine having been drawn into the syringe to fill the *nævus*, the needle is introduced through the skin, at about a line from the circumference of the *nævus*, and passed to its centre. The piston is propelled slowly home, so as to force the tincture into every part of the growth. This is facilitated by moving the point of the needle into every part of the *nævus*. On withdrawing the instrument, pressure is made on the small puncture, for a few seconds, and the proceeding is complete.

Dr. C. has practised this treatment many times, since the year 1861, with complete success. One injection generally succeeds; sometimes several are required. Usually, a slight vesication occurs on the surface of the *nævus*, then a white spot, or spots, appear, which spread in all directions until the vessels are obliterated; a slight depression of the surface alone remains.

This treatment, it is admitted, is not heroic; but the author believes that its bloodlessness, painlessness, and freedom from danger will be an additional recommendation.

The other communication was by Mr. Edmund Owen, F.R.C.S. The *nævi* to which it related are vascular tumors, varying in size from a dried raisin to a ripe fig, and which, situated in and beneath the skin or mucous membrane, are growing steadily, usually to the alarm of the parents, and sometimes to the embarrassment of the medical attendant.

After stating the objections to other methods which have been employed in these cases—*i. e.*, snares and ligatures, setons, scalpel and forceps, and electrolysis—the author remarks:

“When a *nævus* is large and growing, some prompt and effectual treatment is demanded—one on which thorough reliance may be placed. It is a great point

if the surgeon can almost promise that a single operation—and that not of a cutting nature—will be all that will be necessary.

“In my experience, all the demands are supplied, and most of the objections avoided, by the treatment of large *nævi* by that useful instrument, the thermo-cautery of Paquelin. I show you the two blades which I employ; the larger the *nævus*, the larger the heated point. This small needle-blade is very efficient in dealing with small *nævi*, or *nævoid* stainings. The vapor of benzine, pumped through the hollow stem, with the India-rubber hand-ball, is ignited at a low temperature, and keeps the point of the blade at any desirable heat throughout the whole operation.

“Having been heated to a dull redness, the blade is thrust through the skin in as many places as may be considered necessary, and the point directed to all the regions of the vascular mass: central, deep and peripheral; each district must be searched out and invaded. The skin punctures should be made well within the limits of the tumor, as the effects of the cautery necessarily extend beyond the limit of the tissues actually traversed. By the slow and cautious withdrawal of the blade, the small eschars are permitted to remain, sealing the wounded vessels, and thus not a drop of blood need be lost. A few black sinuses, surrounded by a ring of skin, which has been reddened by the scorching, remain after the operation, and the tumor is found smaller and firm from coagulation having taken place throughout the entire mass. Oiled lint may be used as a dressing.

“For the next few days, the part looks angry and swollen, and is evidently painful. Then a slight amount of sloughing takes place, and, in a few days more, some small clean ulcers mark the dwindling mass. The ulcers heal, and cicatricial contraction, taking place throughout the entire mass, determines the process of shrivelling. The integument does not perish, except where wounded; but it loses its old purple staining, from the obliteration of the vessels which formerly brought to it the unsightly injection.”

In the discussion which ensued, Mr. Thomas Darby said that of course it was understood that different kinds of *nævus* required very different treatment. With regard to those larger *nævi* occurring on the face, which mothers call “raspberry marks,” he had seen them successfully treated by hypodermic injections of absolute alcohol, without leaving a mark.

Mr. Silcock advocated painting capillary *nævi* with collodion.

Mr. Coates remarked that the treatment of Mr. Edmund Owen, by what was really the external cautery, produced sloughs and subsequent ulceration. This must be followed by scars, which were not desirable on the face, neck, or upper or lower arm of a girl. Mr. Coates had only once seen the result of vaccination, done by a very eminent London surgeon on a child of high rank; and that left scars, but did not cure the *nævus*.

IMMUNITY OF ANIMALS FROM SYPHILITIC CONTAGION.

THE author first passes in review the attempts made by previous investigators to inoculate animals with syphilis, all of which he shows to have been unsuccessful, and then gives a detailed account of his own recent experiments having the same object.

These were made with the greatest care, the virus being taken directly from the diseased person, and introduced into the body of the animal. The animals experimented upon were kept under observation for a considerable period of

time after the inoculation. In no case were any results obtained other than those local and short-lasting affections which would naturally follow the introduction of an irritating material into the tissues. Nothing that bore any resemblance to a chancrous tumor was observed. The subjects of the experiments were three apes, three rabbits, a horse, a hare, a white rat, a marten, and a cat. The total number of inoculations was fifty-four. The author concludes from these investigations that syphilis must be henceforth regarded as a disease of the human species only.—I. NEUMANN, *Wien. Med. Wochenschrift*, February 21, 1883.

Received.

Die krankhaften Veränderungen der Haut und ihrer Anhangsgebilde mit ihren Beziehungen zu den Krankheiten des Gesamtorganismus, dargestellt von DR. H. V. HEBRA. Wien, Friedrich Wreden, 1884.

Atlas des Maladies de la Peau par le DR. SILVA ARAUJO. 1r et 2me Fascicules. Rio de Janeiro, 1883.

Item.

INTERNATIONAL MEDICAL CONGRESS.—The eighth session will be held at Copenhagen, from the 10th to the 16th of August, 1884. The following list of subjects is proposed for communications and discussions in the section of dermatology and syphilis:

1. On the Syphilitic Origin of Tabes.
2. Treatment of Syphilis with Mercurial Injections.
3. Excision of the Initial Induration as Abortive Treatment.
4. The Etiology of Leprosy.
5. On a New System in Skin-Pathology.
6. The Etiology of Lupus vulgaris.
7. The Pathogeny of Gonorrhoeic Rheumatism.
8. The Term of the Infectiousness of Gonorrhoea.
9. The Significance of Micro-Organisms in Skin-Diseases, formerly considered as Non-Parasitic.

DR. A. HASLUND,
*President of the Organizing Committee for the
Section of Dermatology and Syphilis.*

DR. E. PONTOPPIDAN, *Secretary.*

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Original Communications.

ACNE INDURATA; ITS TREATMENT.¹

BY

HENRY W. STELWAGON, M.D.,

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LOCAL treatment may remove acne, and in a sense the acne may be said to be cured. Once removed, however, does not signify a permanent freedom. On the other hand, constitutional treatment alone is rarely capable of causing a disappearance of acne papules and pustules, although, when removed by local means, it may and will frequently prevent a return of the eruption.¹ In no other class of acne cases is the futility of internal medication alone so forcibly illustrated as in the indurated variety. The patient may be purged, toned up, or subjected to a course of alteratives, and yet the eruption remains about the same, or at the best is only slightly modified. To remove the existing lesions, local treatment is always necessary, and even then the eruption may at times prove exceedingly obstinate. In ordinary acne various plans of local treatment are equally efficacious, and simple in character. This cannot be said of acne indurata. At times it will yield somewhat to lotion and ointments, but in the greater number of cases, and in fact in nearly all, either operative measures will be called in requisition, or strong applications be found necessary.

There are several of the so-called operative methods, although they

¹ Read before the Northern Medical Association of Philadelphia.

are essentially the same, or at the most modifications. Standing first is scarification by puncture. This is a favorite plan and the one most generally practised. Each lesion is punctured to a sufficient depth with an instrument specially made for this purpose, or with a thumb lancet, or what I have found as useful, and which is certainly more convenient, the sharp-pointed tenotome. Every pocket case contains this and hence it is always in readiness. If the acne indurations are somewhat flat and broad, several punctures may be made in each at the one sitting. Every lesion should be so treated, varying from a single puncture in the small induration to several in those of a larger size. In these cases there seems to be very little tendency to pus evolution. The punctures, therefore, rarely liberate any pus, but are usually followed by some hemorrhage, which should in all cases be encouraged. The application of hot water, by means of a sponge or piece of flannel, favors the bleeding, and at the same time allays the irritation produced by the scarifications. It is a valuable adjuvant of the treatment and should when possible be employed. After four or five days the scarifications should be repeated. One or two scarifications will generally suffice for the smaller lesions; the larger indurations may require several repetitions. If the eruption is copious, it is best that only a proportion of the lesions be punctured at one visit, unless the patient gives himself over entirely to the treatment; in which case all may be operated on at the one time, and thus shorten somewhat the period of treatment. During the time between the scarifications, a stimulant lotion or ointment may be used on the parts not operated upon, and in cases in which the scarifications cause but little irritation, may be applied to the whole face. Although such a lotion or ointment has only a trifling influence on the nodules themselves, it may serve to stimulate the glands as yet but slightly involved to a healthy action, and prevent to a certain extent the formation of new lesions. An excellent stimulant to the glands, and one that prevents the hardening of the sebaceous plugs, or when such has taken place, softens them, is hot water. It should be applied freely at bed-time for several minutes. It is invaluable in the treatment of all forms of acne. To be efficient, the water should be as hot as can be borne and applied from five to ten minutes, or even longer. Lotions or ointments if used should be applied in the evenings, after the hot-water applications. In the greater number of cases of acne indurata the plan above detailed will be adequate for a removal of the eruption. The length of time required will vary according to the conditions present. The milder varieties yield, as already stated, after a few scarifications; others may require prolonged treatment. The scarifications to be efficient should be thorough and should penetrate the full depth of the nodules.

Of the lotions and ointments that may be advised in conjunction with

the operative measures, or at least during the intervals, the following will be found most useful: ℞ Sulphate of zinc, Sulphuret of potassium, each one-half to two drachms; Water, four ounces. ℞ Corrosive sublimate, two to four grains; Alcohol, one fluidounce; Water, three ounces. ℞ Washed sulphur, one to four drachms; Ether, four fluidrachms; Alcohol, three and a half fluidounces. ℞ One to four drachms of precipitated sulphur; Benzoated lard, one ounce. ℞ Sulphuret of potassium, thirty grains to two drachms; Benzoated lard or eosmoline, one ounce. For persons with sensitive skin the milder strength should be ordered; others may require the strongest. There are other well-known lotions and ointments, many of which are of unquestionable value, but the formulæ just given answer all the requirements.

Another method of treating this form of aene is a modification of the above. The scarifications are practised the same as already described, but after the bleeding has ceased, each papule and pustule at the point of puncture is touched with dilute acid nitrate of mercury, one part of the nitrate to from five to eight parts of water. Excepting the hot-water applications, adjuvant measures are not employed, being in a degree forbidden by the irritation caused by the acid nitrate. Frequently the irritation is slight, and in these instances the use of an ointment or lotion may be advised as in the former plan of treatment. The scarifications and the subsequent application of the acid nitrate are, however, usually sufficient without the employment of any other measure. If the irritation is marked, then an ointment of oxide of zinc, cold cream, or vaseline may be ordered. The acid nitrate should never be used undiluted, as searring may occasionally result. It is far safer, and equally efficacious, to use it in the strength of one part to eight of water. In this strength its action is sufficient for a therapeutic effect, and the unpleasant sequence of searring will not ensue.

Another modification of the method by puncturing is similar to the last, except that carbolic acid is used instead of the acid nitrate. I have always used the ninety-five-per-cent solution. Sears have never followed and the therapeutic result has been satisfactory. It is much superior to the acid nitrate of mercury, having all the latter's merits and none of its disadvantages; it is not so painful and the irritation is less, while the effect is always more striking. The best method of applying it, as may also be advised with the acid nitrate of mercury, is with an ordinary matchstick, made somewhat tapering at the end. The point should not be small enough to penetrate the puncture, just sufficiently small to touch it superficially. A lotion or ointment may be used in the intervals of active treatment if not contraindicated. The punctures and subsequent application of carbolic acid should be made about every fifth day, the

same as in the treatment with simple scarification, and in that with scarifications and acid nitrate of mercury.

These three methods, if they may be so-called, will generally be found sufficient to remove the lesions of indurated acne. If simple scarifications are not adequate, the application of dilute acid nitrate of mercury or of carbolic acid may be superadded.

In those cases in which the acne indurations are capped with a small pustular centre, as in all other cases, another operative method is sometimes employed. It is that in which the curette is employed in place of the scarifying knife. The tops of the lesions are thoroughly scraped out, and the case may go on without any further measure, or it may be necessary to repeat the operation, although this is seldom required. The acid nitrate of mercury or the carbolic acid may in some instances be applied as in the method by puncture; the scrapings are, however, usually sufficient without anything else superadded. There is much more irritation caused by the scraping than by puncturing, and in cases so treated it is advisable to prescribe a mild soothing ointment. This method, moreover, as may readily be understood, produces during the time of treatment more disfigurement, and patients will not so willingly submit to it on this account alone. It is besides much more painful and terrifying than puncturing, although it must be admitted that it is thoroughly effective.

Another operative method which may, upon extended trial, commend itself is electrolysis. So far I have only had a few opportunities of trying this plan, but in these few instances the result was such as to warrant its employment in other cases. The needle, the same as used for the removal of superfluous hair or an ordinary sewing needle of small size, is attached to the negative pole of a galvanic battery, introduced deep into the lesion and the connection made by patient grasping the sponge of positive pole. The current should be continued a fraction of a minute, depending upon the amount of electrolytic action excited. The appearance of slight frothing at the point of insertion is evidence that the action has been sufficiently long. From five to fifteen cells of a recently charged battery are generally required; ten cells are most generally applicable. A great deal depends upon the amount of action excited, and the number of cells, as also the period of contact, should be gauged accordingly. Unfortunately this operation is painful, even more so than scarifications, although it is not so terrifying. The pain is not so severe, however, as to forbid its employment, and after a few sittings, a degree of tolerance is established.

Occasionally patients are seen who are alarmed by the sight of a knife and in whom even a needle causes more or less apprehension. Such persons positively object to all operative procedures, it matters not how trifling the operations themselves may be. In these cases other plans of

treatment must be adopted, although much slower and less satisfactory in their results. Time is usually wasted with the use of the ordinary lotions and ointments successfully prescribed for simple cases of acne, so that from the start resort should be had to strong applications. The three substances which in my hands have yielded the best results are, the acid nitrate of mercury, corrosive sublimate, and carbolic acid. These cause slight destruction of the acne surfaces and with the resulting dermatitis more or less exfoliation takes place, and if repeated, the lesions will gradually be made to disappear. The improvement is of course much slower than by the methods by scarification. The acid nitrate of mercury has been used in its undiluted state, and is still so employed, especially by English dermatologists. It may be done in some cases with good effect, but extreme care is necessary lest scarring results. It is far better to use it diluted with four or five parts of water, even if it requires a greater number of applications, and consequently a longer period of treatment. Here again I can testify to the equal efficacy of carbolic acid and its absolute freedom from unfortunate accidents, provided that only an amount of care that all such remedies demand, is exercised in its employment. The carbolic acid should be used pure or nearly so (95%). The applications should be made with an ordinary match-stick, somewhat rounded or pointed at the end. Any similar contrivance can of course be employed; a match-stick is always at hand and requires but little time for preparation, and after the sitting may be thrown away. The point should be broader than that used when scarification has preceded, as a greater surface is to be touched and acted upon. The application, as a rule, should be made every third or fourth day. If the irritation is marked, a soothing ointment should be prescribed. Applications of hot water should be made at bed-time, as in the former methods. Corrosive sublimate, if employed, should be used in solution, and applied in the same manner as the acid nitrate and carbolic acid. Instead of making an application every few days, however, it should be applied several times during the day, and after forty-eight to seventy-two hours, omitted for a day or so. Considerable exfoliation follows its use, and in this way mainly improvement is effected. It should be applied only to the lesions, and care should be taken that it does not run beyond, or a violent dermatitis may ensue. The strength of the lotion required varies according to the sensitiveness of the skin and the action excited, from five to twenty grains to the ounce of water, or preferably alcohol and water. The weaker lotion should be tried first.

This plan—non-operative—of treatment will, if persisted in, effect considerable improvement and frequently remove the eruption entirely. It is not, however, comparable to that in which scarification plays the principal part. As in the method by puncture, so in this plan a mild ointment or

lotion may be used at the same time, although not essential to the success of the treatment. Each case, in fact, demands special attention, and every peculiarity, its due consideration. If one plan of treatment does not answer, another must be tried. The amount of irritation caused, and the effect produced, must gauge the activity and persistence of the treatment. Positive rules for collective cases cannot be laid down, as each case is a study in itself, and may require some modification in the treatment which would not apply to other patients.

The local management of these cases having been mapped out, the constitutional treatment remains to be considered. It has already been intimated that, although external treatment may remove this as well as all other forms of acne, it will not prevent a relapse, and the cropping up of new lesions. Constitutional treatment is called for, and should, in fact, be instituted as soon as the case comes under observation. A combination of external and internal treatment will frequently effect a permanent cure, or at least so close to it, that only a few evanescent or insignificant lesions appear from time to time. Here again, for a successful result, each case demands special study. Acne is something more than a local affection and depends, in part at least, upon some systemic irregularity or fault. To discern this is not always an easy matter, and yet upon its recognition depends the permanent success of the treatment. Each case should be carefully considered, and every suspected etiological factor thoroughly investigated.

In general it may be stated that there are three great causes of acne: dyspeptic troubles, functional (occasionally organic also) diseases of the sexual apparatus (this cause applicable mainly to females) and scrofulosis. Acne indurata may be provoked by any one of these three, but in the greater number of cases seems to be an expression of a scrofulous diathesis, although other evidences of this condition may not always be present. These patients are either decidedly cachectic in appearance, or are somewhat heavy with flabby flesh and pasty and leaden-looking skin. Such persons are always weak and debilitated, and this fact affords a key to the best plan of constitutional treatment.

Among the tonic remedies indicated, none stand higher than cod-liver oil. If it can be taken and assimilated, it will invariably be of advantage. Iron, preferably the bitter wine of iron, or if well borne the syrup of the iodide, should be prescribed, and also a preparation of malt. These three remedies should be given separately, rather than in combination; the malt during the meal, the iron immediately after eating, and the oil thirty to sixty minutes later. Further on in the treatment, arsenic may be given in small doses, a minim of Fowler's solution in each dose of the wine of iron.

If dyspepsia is the sole discoverable cause, remedies directed toward a

palliation and cure of that condition are to be advised. A good combination, especially if constipation coexists, is one consisting of two fluidrachms each of fluid extract of cascara sagrada and dilute muriatic acid, and two and a half fluidounces of the compound tincture of cinchona; a teaspoonful in a wineglassful of water at meal-time. The cascara sagrada may be increased or lessened according to the effect produced. Even in what may appear as purely dyspeptic cases, after the symptoms of indigestion have abated, cod-liver oil, if well borne, should be advised. So far as my experience goes, there is no single remedy which is so uniformly of advantage in the permanent cure of this form of acne as cod-liver oil. It is not necessary that the dose should be large; beginning with a teaspoonful, it may be rapidly increased to a dessertspoonful, and in some cases to a tablespoonful. It is seldom advisable to exceed a dessertspoonful, as a greater quantity is rarely digested and absorbed, and is more apt to produce nausea and eructations.

Some cases in women are ascribed to menstrual irregularities and uterine diseases, and such really appear to be the operative cause. These conditions are frequently expressions of the same cause which is more or less responsible for the acne. Be this as it may, such irregularities disappear along with the tendency to acne formation as the general health is brought up to par. Tonic remedies, such as already indicated, should be prescribed and continued for a long period.

Finally, it may be added that an indispensable prerequisite of a successful result in the treatment of acne, and especially acne indurata, is a proper regulation of the habits and the diet of the patient. Indiscretions and excesses of all kinds are to be positively interdicted. The diet should be simple and nutritious. Milk may be advantageously substituted for drinking water and taken freely. All indigestible and innutritious substances are to be avoided. Open-air exercise is of advantage, and should always be advised. In short, everything calculated to improve the physical and mental health is of benefit, while that which saps the strength, disturbs the mind, or interferes with the proper performance of the various functions is to be carefully guarded against.

CONTRIBUTION TO THE STUDY OF HERPES OF MUCOUS MEMBRANES AND HERPES OF THE LARYNX.

1st. THE existence of herpes of the larynx, suspected indeed before herpes of the mucous membranes had been definitely demonstrated, has been placed beyond all doubt by the laryngoscope.

2d. It may, with propriety, then, be assigned a place in the study of acute affections of the larynx.

3d. The demonstrated existence of this herpes strengthens the hypothesis that certain benign croups may be due to the development of herpes in the larynx.—M. DAVY, *Th. de Paris*, Nov., 1882.

AN UNUSUAL CASE OF HERPES FACIALIS.

BY

GEORGE THOMAS JACKSON, M.D.,

New York.

ON the first of August, 1883, Christ T., æt. 21, born in New York, and a case-maker by trade, presented himself at the New York Polyclinic for treatment. Previous to his present disease, he had always been in good health. About fifteen months ago he had a sore on his privates, which apparently was not followed by any secondary symptoms. His build is rather of the phlegmatic order than the neurotic.

Four days ago he was playing ball in the heat of the day. He sweated freely, was exposed to a slight shower, drank beer to excess, and went to bed intoxicated. The next day he was in bed till 3 P.M., with chill, fever, and derangement of the stomach. On the morning of the third day he woke with a burning pain in his face and found a number of vesicles upon the upper lip about the median line. During the day the vesicles kept appearing in crops, so that by evening the right side of the face was well covered. During the night he could not sleep on account of the pain in his face, and the next morning he found the whole of the left side of his face involved in the eruption.

The eruption occupies the entire anterior part of the face included between two lines drawn perpendicularly through a point about one half inch beyond the outer canthus of each eye. It is formed of confluent vesicles completely covering, like one large patch, the lower part of the face below a line drawn through the alæ of the nose. On the rest of the face the vesicles are isolated or arranged in various-sized groups. Above the eyebrows there are only four groups, three of these over the left eye, and one anterior to and above the left ear. The vesicles are full of cloudy serum and unbroken. Around the single vesicles and about the patches is a slight zone of redness.

The patient's bowels are regular. His gastric disturbance has passed away. He complains of the burning pain in the face, and of sleeplessness on account of it. The lower lid of the right eye is swollen and the conjunctiva slightly reddened.

He was put upon a protective powder, and cautioned against rupturing the vesicles. He was given opium to procure sleep.

Aug. 3.—Reports himself as feeling a good deal better. Vesicles are beginning to desiccate. His right eye is now markedly inflamed. Left eye normal. He was ordered the ointment of the oxide of zinc for his face, and a saturated solution of boracic acid for his eye.

From this time on his progress was rapid, his last appearance having been on Aug. 8th.

In connection with this case the question arises, What is the etiology of herpes facialis? A glance at the anatomy of the skin may aid us in giving an answer.

The sensitive branches of the cerebral and spinal nerves, together with the motor and vaso-motor nerves enter the skin from below, take a horizontal direction, repeatedly branching, till with the blood-vessels they pass through the cutis. Some of the nerve filaments end in the tactile and Paenian corpuscles, but more pass on to again take a horizontal direction close under the papillary bodies and form a true nerve plexus. Some observers claim to have found in these plexuses minute ganglionic cells. From these plexuses branches enter into the epithelial layer of the skin. Some end in the endothelium of the papillary blood-vessels, but the majority pass between the epithelial cells and terminate in the nuclei of the granular and prickle cells, two nerves going to each cell. (Unna, Ziemssen's Handbuch der Speciellen Pathologie und Therapie, Bd. xiv., Heft 1, 1883).

From this we learn that the conditions for reflex disturbance of the skin are all present, that is to say, the skin is very richly supplied with nerves, and is in direct communication with the sympathetic system, markedly so if we recognize the presence of the ganglionic cells in the lexuses.

The neuro-pathology of the present time teaches us that the nutrition of the body is regulated by the trophic nerves, and the circulation is controlled by the vaso-motor nerves. Both sets of nerves belong to the sympathetic system. The production of a vesicle is due to a local change in the nutrition of the skin, which may arise from change in the circulation of the part, or to a pure tropho-neurosis.

The face is richly supplied with blood-vessels and nerves. It is markedly subject to reflex disturbances in its circulation, as illustrated by flushing of the face from emotional, digestive, and other causes. Herpes facialis so frequently comes in the course of general fevers, and of local inflammations as of the lungs, or even of the mucous membrane of the upper air passages, as to win for itself the popular names of "cold sore" and "fever blister." To account for its occurrence it does not seem necessary to believe with Bärensprung that it is a mild form of zoster due to irritation of the peripheral ganglia of the nerves; nor with Gerhardt, that it is due to the compression and irritation of the branches of the trigeminus nerve in the bony canals by the rapid dilatation of their accompanying blood-vessels. We need not seek its cause with Eulenberg in the rapid dilatation of the small arteries of the face, nor assume with the French the presence of an arthritic or dartrous diathesis. But re-

membering the anatomy of the skin and the so far known facts of neuropathology, I believe we may regard herpes facialis as due to a reflex tropho-neurosis, depending upon derangement in the organs of digestion, respiration, and circulation. Such cases as occur without implication of these organs, and they are infrequent, are probably due to some local insult and a consequent neuritis or perineuritis.

In the case presented in this paper, the appearance of the eruption in successive outbreaks, its limitation to the branches of the trigeminus nerve in their distribution, and the conjunctivitis would suggest a double zoster. But the eruption was not accompanied, preceded, or followed by true neuralgic pain, it had not the characteristic distribution of a zoster, it ran its course inside of two weeks, showed no tendency to the formation of ulcers, and left no lesion. Its history justifies us in regarding it as a tropho-neurosis of reflex character depending upon gastric disturbance.

NOTE ON THE TREATMENT OF ECZEMA MARGINATUM AND OF RINGWORM IN GENERAL.

BY

R. W. TAYLOR, M.D.

I HAVE always placed much confidence in the parasiticide virtues of bichloride of mercury in the treatment of the various forms of ringworm, and have generally used it in alcoholic solution, being in accord with Cayley in the opinion that, thus used, its efficacy is much enhanced. Even thus combined, its action is not always certain, particularly in cases of eczema marginatum. This fact was very forcibly brought to my mind in the treatment of the case of a young lady during the past summer. She had this affection, severely involving the integument of the hypogastric, pubic, erural, and gluteal regions. The diagnosis was confirmed by the discovery of the parasite in the scales, but the appearances of the eruption were thoroughly typical. I ordered a two-grain solution of the bichloride of mercury in one ounce of alcohol, which was used for about a week, when I increased the strength to four grains, as the progress was not satisfactory. Though the parts were carefully sopped with this solution, three or four times a day, and care was taken that the underclothes would be frequently changed, the rings of eruption advanced, in many parts being preceded by outlying papules. The pruritus was only relieved for a limited period after each application. In this state of affairs, it occurred to me that, if I could find some vehicle by which the parasiticide could be kept continually over the morbid surfaces, and not be rubbed off, I could soon effect a cure. It happened one

day, when the progress of the ease was thus at a stand-still, that I had on my office table a bottle of tincture of myrrh. The thought occurred to me that, if the liquid was painted over the surface, a very thin, flexible layer of gum resin would be left which would retain the bichloride of mercury in contact with the skin. I, therefore, first thoroughly bathed the parts with a four-grain-to-the-ounce alcoholic solution of the bichloride, and, when dry, painted the whole surface with the tincture of myrrh. The lady reported, the next day, that she was much better and had not scratched very much since the application. I then gave her a prescription containing four grains of the bichloride to the ounce of tincture of myrrh, with directions to thoroughly paint the parts twice daily. The effect was simply wonderful. In a few days, the patches and rings became less red, the papules less salient, the pruritus was relieved, and, within a fortnight, the disease was wholly cured. I have since used the simple and compound tinctures of benzoin in the same way, and find that they are equally as valuable in affording a vehicle for the parasiticide and a protective film to the integument. The discomfort of the application of these tinctures is very slight; patients simply complain of a little drawing or tight sensation of the parts, for a few moments after the application—inconveniences which are more than counterbalanced by the relief of the pruritus. I have thus far used this method in three cases of eczema marginatum and two of tinea tonsurans capitis; in all with most excellent results, namely, a prompt and perfect cure. Whether the gum resins have any therapeutic effect I am unable to say. I think that these tinctures can be still further used with benefit as a vehicle for other agents in the treatment of skin affections.

Society Transactions.

NEW YORK DERMATOLOGICAL SOCIETY.

141ST REGULAR MEETING.

DR. P. A. MORROW, *President, in the Chair.*

DR. BRONSON introduced the subject of

THE PRURIGO OF HEBRA,

for the purpose of discussing the question of its occurrence in this country. He claimed that it did occur, and by no means so unfrequently as commonly supposed. Its presence had often been overlooked here, he believed, for the same reason as that given by Morant Baker before the International Congress in London to account for the apparent rarity of the disease in England, namely, that too much stress had been laid upon the so-called essential lesion of the disease, the alleged primary papule. The importance of this "papule" had been exaggerated by Hebra and other German authorities, and, moreover, its precise

character was somewhat uncertain. The prurigo papule described by Hebra had been clearly shown by later writers to be simply an inflammatory product, not differing essentially from inflammatory papules that occur in other diseases. Auspitz had recently maintained that the characteristic papule of prurigo was identical with that of lichen pilaris. It was his opinion that the disease was in the nature of a sensory neurosis combined with a motory neurosis affecting the arrectores pili. Too little attention had been paid to this disease in its character of a neurosis, and too much to what was presupposed to be its characteristic eruption. The eruption differed greatly in different cases, and no one form of efflorescence could be regarded as necessary or pathognomonic. Prurigo was simply a peculiar form of nervous irritation affecting certain particular regions, and invariably exempting others. Any chronic pruritus that was always most pronounced upon the peroneal aspects of the legs, the outer surfaces of the thighs, and the extensor surfaces of the arms, and which invariably avoided the flexures of the joints, might with propriety be called prurigo. The skin lesions—the wheals, the papules, the eczema, the horny thickening and roughness of the surface—were all inconstant symptoms or secondary effects. Whether the neurosis were purely a sensory neurosis, or, as Auspitz claimed, both sensory and motor, or, as maintained by Schwimmer, a tropho-neurosis, the speaker would not venture an opinion. He would only urge that any itching cutaneous disease, whether pruritus without pronounced lesions, or eczema, or urticaria, or a disease with very marked trophic changes of the surface, which begins in infancy, persists for a long time, and always occurs in the above-mentioned situations, is essentially the prurigo of Hebra.

The following case was presented by Dr. Bronson before the Society as an example of

PRURIGO ASSOCIATED WITH ECZEMA.

Chas. McC., *æt.* three years. The patient first came to me at the New York Polyclinic, February 7, 1883. The father stated that the child had suffered from disease of the skin since he was four or five months old. At first the disease appeared in the form of elevated spots "about the size of mosquito bites" (which the father called "water-blisters," but which probably were urticarial wheals). The condition gradually became worse, and the character of the eruption changed. When first seen, the patient presented a woeful appearance, with a sad, fatigued expression of countenance, a large head, with an ill-nourished body, while the skin was almost everywhere affected with eczema of various forms and grades. The face and head were covered with crusts, erosions, and pustules. There was a papular eczema over the body, while upon the extremities the following appearances were presented: The surfaces of both arms and legs, especially upon their outer aspects, were rough, dry, and horny. Scattered over them were numerous deep-seated pustules of about the size of small peas. There was considerable thickening of the skin, with deepening of the natural furrows, which at the same time were wider apart than normal. The flexures of the joints were, however, perfectly smooth and free from disease. Moreover, the flexor aspects of the extremities were less affected than the extensor. The glands below Poupart's ligament were somewhat, though not greatly enlarged. Under treatment, the cutaneous affections rapidly improved, and following an attack of measles, in March, the improvement was still more decided.

When the case was presented, the eczematous element seemed quite under control, but still persisted, to a slight extent, in a few isolated spots. By far the

most marked feature of the cutaneous condition was the thickening and roughness of the peroneal surfaces of the legs and the posterior surfaces of the forearms, in which regions there was still decided itching, especially at night.

Dr. Bronson next referred to a class of cases which he had observed among children, in which successive crops of urticarial wheals persisted in recurring in the situations affected by prurigo. The efflorescences of ordinary urticaria were quite as apt to occur upon the flexor as the extensor surfaces of the limbs, but these cases were marked by the invariable exemption of the joint flexures, and by the more common occurrence of the spots upon the extensor than upon the flexor surfaces. From this peculiarity, as well as from the fact that the disease occurred usually in puny, ill-nourished children, and was of long continuance, they were believed to depend upon a neurosis of the same nature as prurigo and, hence, were essentially the same disease. Sometimes, in noting these cases, they had been described as *prurigo*, sometimes as *urticaria*, and again as *prurigo urticata*. For illustration, the following notes were presented :

Prurigo urticata. L. A., æt. six and one-half. Female. When eighteen months old, she began to have eruptions of "hives" (spots elevated and like "mosquito bites"), which came out especially on the outer aspects of the arms and legs, and on the abdomen. She has been subject to similar eruptions ever since. They are much worse in summer, in winter seldom very noticeable. The patient always has had an itchy skin, scratching much at night. She was a very puny baby, an eight-months child, and has never appeared well-nourished, though her appetite and digestion seem always to have been good. The child is not irritable or nervous, and has a good disposition. It has been carefully nurtured, the parents being in affluent circumstances.

January 30, 1882.—On examination to-day, when first presented, there were found scattered over the body little red or pigmented spots (the sites, probably, where wheals had been), most abundantly on the outer surfaces of the arms, forearms, legs, and thighs; also, but to a less extent, on the chest, back, and abdomen. On the outer aspects of the legs, and on the extensor surfaces of the arms, the surface is roughened, and of a somewhat darker shade than elsewhere. There is also perceptible thickening of the skin in these situations. On the left side, the glands of the groin were a little enlarged.

Dr. Bronson called attention also to another form of cutaneous disease observed in immigrants to this country, the most essential feature of which he had found to be recurrent eruptions of urticaria, and for this reason he had styled the disease

URTICARIA OF IMMIGRANTS.

He had observed it most commonly, though not exclusively, among the Irish, more particularly in young women and children. On examination, the eruption usually appeared polymorphic in character, with papules, vesicles (eczema), wheals, patches of erythema, pustules of impetigo, and even bullæ figuring in greater or less abundance in different cases. He believed, however, that it was always urticaria that formed the basis of the disease, and that the eczematous, impetiginous, and other lesions were the result of general cutaneous irritation, caused by scratching. He did not see how any one who saw much of skin disease in New York could have failed to remark the prevalence of the eruptions mentioned in newly-arrived immigrants, and thought it strange that no special mention had been made hitherto of the disease. As to its cause, he believed that it was chiefly related to the dietetic and climatic changes in the patient's habits. Attention

was particularly called to the fact that in Ireland most of these patients had lived upon an almost exclusively vegetable diet, while in this country they usually eat meat twice and often three times a day.

DISCUSSION.

DR. TAYLOR took exception to the diagnosis of the case presented as one of prurigo with eczema, and believed it to be only a case of eczema leaving a roughened skin. He did not find any symptom of prurigo present in the case. He mentioned three cases of prurigo in children which he had seen; one, especially, in the person of a friend's child, which he had had under observation for a number of years. For three years this child had suffered with chronic urticaria arising from gastro-intestinal disturbance from use of starchy food, which left great itching of the skin. He regarded the signs of prurigo to be a dirty brownish color of the skin, an increase of the furrows, thickening, and papules. In his case there was marked thickening of the skin, especially upon the extensor surfaces over bony prominences and subcutaneous brownish papules. The papules were not diagnostic. The neurosis and the scratching produced the thickening of the skin. In adults, also, in prurigo there was first a chronic urticaria, which passed away, leaving an itching more continued than in pruritus. The cases of prurigo in children which he had seen also involved the flexor surfaces, as bends of the elbows, knees, etc. The urticaria and prurigo do not occur together, but the urticaria runs its course and ceases, and then prurigo develops. According to his experience, the disease spoken of by Dr. Bronson as urticaria of immigrants took rather the form of erythema papulatum, or multiforme. These often co-existed with urticaria. He had seen it also in the higher walks of life, and even in the person of an American who had returned from Europe.

DR. ALEXANDER saw but little resemblance between the case presented and the real prurigo as seen in Vienna. He would regard it rather as a case of eczema. As to the urticaria of immigrants, he had seen many cases of the disease, especially in women, many of whom were Germans. In his experience, the disease took rather the form of erythema, which was apt to be general, and, as a rule, did not itch much. Recovery usually took place in three or four weeks. Most of the women had suffered from amenorrhœa during the voyage and afterwards.

DR. PIFFARD said that there was nothing in the history or appearances of the case presented other than in eczema. It was not uncommon to have chronic papular lesions in urticaria and eczema, the papules being secondary to the constant scratching to relieve the itching. But he never called this papular condition prurigo. The term "prurigo" was made use of by Willan in a very broad manner, and most of the English authors, down to a very recent period, had followed his usage. Hebra's prurigo was very rare in this country and in England. He had seen two cases, both in adults. It was well to use the term prurigo in the sense used by Hebra, a disease occurring in the form of papules which is almost incurable. We see many cases with papules only which are cured in a short time and are not prurigo. As to the occurrence of buboes, these were not uncommon in diseases of the lower extremities accompanied by chronic itching, lasting till the lesion of the skin below is cured.

As to the skin lesions of immigrants, they were of many kinds. He had seen one case of hydroa, an eruption of fine bullæ, in an immigrant. Most of the cases were urticaria accompanied by a persistent lesion, a papule, which ran its course in one month or so. The papules were the result of scratching. Not long ago, he saw a recently arrived immigrant with an eruption of papules accompanied by scaling. The patient had used a lotion of carbolic acid. Later the papules increased in size and number and were quite scaly.

DR. FOX thought that prurigo in the German sense was not so rare in this country as it had been said. We must remember that the cases presented in Vienna were marked cases, and we had naturally formed our idea of prurigo from them. They were examples of prurigo ferox, with characteristic papules and swellings in the groin. The most marked case he had seen in this country was under the care of Dr. Campbell. He himself had had two cases occurring in boys which in Vienna would probably have been called prurigo. Hebra describes a prurigo mitis, and that is the form of the disease as found in this country. He has met with an urticarial condition occurring with this form. He had met

with some half a dozen cases, mostly in women, where there was an intensely itching eruption upon the arms, neck, and face, the body being slightly if at all affected. It consisted of hard, shotty, subcutaneous papules, which sometimes contained serum. Excoriations were often present, and these, in badly-nourished subjects, would leave pits. The papule would appear, would generally be immediately scratched, and would run its course in two or three weeks. The disease was always chronic and intractable.

He had rather more frequently met with a papular erythema in immigrants than an urticaria. As to the causation of these eruptions, he thought that sudden changes of temperature had more to do with it than dietetic change.

DR. MORROW had met with a papular erythema in immigrants more than any other lesion. He asked if season had any effect upon the frequency of the trouble.

DR. ALEXANDER had noticed no such connection.

DR. TAYLOR was inclined to believe that it was more common in the spring, though that was only an impression.

DR. BRONSON said that most of the gentlemen evidently took a more restricted view of the disease (prurigo) than he did. He believed the disease to be a neurosis, and that it differed from a papular eczema in its location, in its increase in severity from above downwards, and in its sparing the bends of the joints. The case he presented was as characteristic as any that were presented at the last International Medical Congress in London as cases of true prurigo (in which there were no papules present), and so pronounced by the Germans. At least there was nothing absent from his cases that was present in those. All the cases he had described had occurred in children, and those with urticaria had always avoided the flexures of joints. In one case there was thickening and slight melasma, and there was some pigmentation in the case presented this evening. He thought that Dr. Taylor's cases could not be considered as examples of prurigo, as that disease *always* avoided the joints.

As to the urticaria of immigrants, he believed that a history of the presence of urticaria was ascertainable in every case. In the daytime an erythema is the prominent lesion, the erythema being usually a small papular one. He had seen a bullous urticaria, and frequently impetiginous rashes. His cases had all complained of great itching.

DR. FOX remarked that his experience was in accord with that of Dr. Bronson, that is, that the flexor surfaces of the joints were free in all cases of true prurigo, even in prurigo ferax. This exemption is the distinguishing feature. All follicular diseases of the skin exempted the joint flexures.

DR. BRONSON then presented a

CASE FOR DIAGNOSIS,

occurring in the person of a woman twenty-seven years of age. The disease began six or seven years ago in the form of little crusts upon the scalp. When first seen, about three weeks ago, the scalp presented the appearance of a squamous eczema, being red and scaly, with some points of excoriation and crusting upon the upper part, while posteriorly and below there was a large amount of scaling not unlike that of seborrhœa. The hair of the upper part of the head is very much thinned, absolute alopecia being present in places. The scalp appears slightly atrophied in some parts. No favus crusts are to be found. The hair is very brittle and dry, and under the microscope showed bulbous enlargements but no fungus. Had been treated like a case of eczema, and improved under it. Epilation had also been practised with benefit.

DR. PIFFARD drew the attention of the society to some

VERY RARE CASES.

He had recently seen two cases of *erythema* in puerperal women which resembled scarlatina. There were no throat symptoms, and the fever was moderate. The eruption began above, and took one week to reach the lower ex-

tremities, and one month before desquamation ceased. The possibility of these being drug rashes was excluded. He had also seen two cases of *dermatalgia*. One in a woman thirty-five years old, in which for fifteen years there had been a localized spot tender to the slightest touch upon her back just below the neck. The other was in a man, who had a shifting *dermatalgia* over the back. Morphine relieved him for several days, but the excessive pain would soon return. This patient had been examined by competent neurologists and the central nervous system pronounced all right.

DR. MORROW suggested for treatment in this last case the use of a hot-water bag along the spine. By this treatment he had cured two cases of neuralgia following zoster.

Correspondence.

DERMATOLOGY AND SYPHILOGRAPHY IN GREAT BRITAIN.

(*Special Correspondence.*)

URTICARIA PIGMENTOSA—ACUTE CIRCUMSCRIBED OEDEMA—PURPURA—PELJOSIS RHEUMATICA—RHEUMATISM—VACCINAL ERUPTIONS—ANTIMONY—TRICHORRHEXIS NODOSA—SCRAPING AND SCARIFICATION—BACILLUS OF LEPROSY—PRIMARY VENEREAL SORES.

THE curious affection called "URTICARIA PIGMENTOSA," formed the subject of a communication to the Royal Medico-Chirurgical Society on June 12th, by Dr. Colcott Fox. He gives a summary of previously recorded cases, describes an additional one, and furnishes an account of the later history, extending over ten years, of three of the original cases described by his brother, the late Dr. Tilbury Fox. It seems that in these latter the special eruption is now no longer produced, although ordinary urticaria occurs in two of them, and the old stains in all three are fading. He considered the affection to be a very chronic urticaria commencing in infancy, the wheals being persistent, and having a special tendency to pigmentation. In the discussion Dr. Thin stated that he considered Duhring's explanation of these cases the only satisfactory one; viz: that there were two classes of an entirely different character, one with no cell-growth which was urticarial, and the other with a new cell growth which was non-urticarial. The present writer has no doubt that this view is correct.

Under the title "ACUTE CIRCUMSCRIBED CUTANEOUS OEDEMA," Dr. Allan Jamieson (*Edinburgh Med. Journal*, June, 1883, p. 1,090), gives an account of two patients who presented symptoms corresponding to the description recently given by Quincke under the above name. *Case 1.* A single lady, age sixty, suffered seven years ago from pains in the nape of the neck and shoulders; these soon subsided, but subsequently the right wrist and fingers and both feet were attacked by rheumatoid arthritis, which afterwards invaded the other hand and both knees; the disease was now quiescent, but many joints remained swollen, stiff, and distorted. Simultaneously with the onset of arthritis she was attacked with swellings of the face coming on suddenly and irregularly, usually about the eyelids, but occasionally on both lips. These attacks gradually increased in frequency and came on in the following manner: there was first headache and slight fever, soon followed by a feeling of tension at the outer canthus, and then a gradually

spreading swelling, so that in twenty-four hours the whole of both eyelids, and even a part of the skin beneath them became distended with serum; the eyes were completely closed, and the watery-looking skin had a faint purplish tinge; there was no itching or smarting, but a feeling of tightness accompanied the œdema, which subsided gradually in from three to five days. When the lips were involved the attack came on at night, and half or the whole lip was enormously swollen on rising. Occasionally one or other cheek was affected in the same way, and once or twice the throat. The attacks had latterly occurred about once a fortnight, without marked disturbance of the general health. *Case 2* was that of an elderly lady who had sudden swelling of one lip, which came on at night; the lip was painless and not tender, but stiff; the œdema subsided in a day or two and never recurred. Dr. Jamieson thinks the affection may be the same as that described by Milton as giant urticaria, in which itching and tingling were not prominent symptoms; he refers to other cases apparently similar, published by various authors, and concludes that, as in his first patient the œdema and arthritis both appeared at the climacteric period, the affection is probably of nervous origin.

The subject of PURPURA has recently attracted some attention. Dr. Bristowe, in "CLINICAL REMARKS ON PURPURA. DEATH FROM CEREBRAL HÆMORRHAGE," (*Med. Times and Gazette*, July 28, p. 87), gives an account of two fatal cases. He notes that blood extravasations beneath the skin, in solid organs and tissues, and serous and mucous membranes are not infrequent in many different maladies accompanied by profound constitutional disturbances, or a mechanical impediment to the venous circulation; *e. g.*, small-pox, typhus, rheumatism, scurvy, leuchæmia, idiopathic anæmia, obstructive disease of heart, and affections of the liver; but he considers that true purpura is an idiopathic disease, of which the cause is as obscure as the causes of leuchæmia, and idiopathic anæmia. It attacks persons of all ages and both sexes, the apparently healthy as well as the ailing; it appears to be independent of local sanitary conditions and diet, and has a tendency to recur. He goes on to describe simple and hæmorrhagic purpura, but points out that the distinction between them is purely artificial, and that they are linked together by intermediate cases.

The able paper read at the meeting of the British Medical Association, "ON THE NATURE OF PURPURA," by Dr. Stephen Mackenzie, has been already fully noticed in this JOURNAL (Nov., p. 440). At the same meeting Dr. W. Russell communicated an account of four "CASES OF PURPURA HÆMORRHAGICA" (*Brit. Med. Journ.*, Sept. 1, p. 414), which are especially valuable for the report furnished by Mr. Watson Cheyne, of his examination of a portion of the heart with hæmorrhages from one of the cases. He found many of the capillaries at the deeper part of the hæmorrhages plugged with small bacilli, and small colonies of these organisms here and there among the effused blood; the capillaries were not merely blocked by the plugs, but their walls were distended, and in some cases ruptured; there was no evidence of inflammation in the tissues around the blood-masses. The bacilli were best shown by an alkaline solution of methylene blue, and Mr. Cheyne concludes that the hæmorrhages at least were due to them, whether their relation to the disease be a causal one or not.

In a "CLINICAL LECTURE ON PELIOSIS RHEUMATICA" (*Brit. Med. Journ.*, June 9, p. 1,103), Dr. McCall Anderson gives a general account of the disease, with a description of three cases, in one of which bullæ formed as well as hæmorrhages (purpura pemphigoides), while in another the extravasations were preceded by papules (purpura papulosa), and also accompanied by bullæ; the latter case

is somewhat aberrant. The administration of oil of turpentine and ergot is recommended.

Dr. Thomas Barlow read some valuable "NOTES ON RHEUMATISM AND ITS ALLIES, IN CHILDHOOD," at the recent meeting of the British Medical Association (*Brit. Med. Journ.*, Sept. 15, p. 509), in which he enunciates the following views on affections of the skin in this disease. As to erythema nodosum, he has never obtained evidence of an organic cardiac murmur, nor of any intercurrent arthritis; it seems possible that the pains in the limbs may be accounted for in great measure by the frequent occurrence of the effusions in spots which do not readily yield, as the front of the shin, and thinks that we should hesitate before saying that this affection is closely related to rheumatism, much less convertible with it. But erythema marginatum and papulatum do occur simultaneously with pericarditis, when joint affection is slight or absent. He gives an instance of a girl with previous rheumatic endocarditis, who was admitted with *E. marginatum*; within three days she developed subcutaneous nodules, then had chorea, and finally fatal pericarditis, but no joint affection. Urticaria and purpura also appear to have an occasional relation to rheumatism.

"VACCINAL ERUPTIONS" are treated of by Dr. Napier (*Glasgow Med. Journ.*, June, p. 424). After referring to the views of Hervieux, Behrend, and others, he relates five cases of general eruption, *i. e.*, eruption appearing at a distance from the point of vaccination. (1.) A healthy child vaccinated with calf-lymph; normal course until the tenth day, when a plentiful crop of papules appeared on the lower limbs, lower part of trunk, and arms: they disappeared in three days. (2.) A child was vaccinated with lymph taken from a child that had been vaccinated with calf-lymph eight days before; normal course until the eleventh day, when large rings of erythema exudativum appeared on arms and thighs; on following day spread and changed from purplish to yellowish red; faded on the third, and completely disappeared on the fourth day. Two other children vaccinated with the same lymph showed nothing abnormal. (3.) A sister of the preceding; calf-lymph was used; normal course to the tenth day, when a vivid red papular measles eruption appeared over the whole body, face, and head; faded greatly in twenty-four hours, and completely in two days. (4.) Calf-lymph vaccination; normal course to ninth day, when eruption precisely resembling the last appeared, and had faded by the evening of the next day. (5.) A doubtful case, as the interval was very long. A healthy child was vaccinated with human lymph; on the *twenty-eighth* day an eruption of crescentic blotches like measles appeared on the scalp and face, and less on the neck, chest, and upper arms; it disappeared in five days. There was no catarrh, and no other member of the family was affected. Dr. Napier refers fully to the published experience of American physicians, and notes that the eruptions observed by them have been nearly without exception after calf-lymph. He concludes that these eruptions, which appear pretty constantly from the eighth to the tenth day, are really specific, being due to the action of the vaccine virus, and not simply, as held by Behrend, to a foreign material circulating in the blood; on this point we miss any discussion of the precisely similar eruptions caused by drugs, which seem to the present writer strongly in favor of Behrend's views.

Mr. Malcolm Morris has drawn attention to the "USE OF ANTIMONY IN CERTAIN SKIN DISEASES" (*Brit. Med. Journ.*, Sept. 22, p. 572). In acute eczema and eczema rubrum he gives *vin. antimon.* ℥ iv. to v. t. d., gradually increasing to ℥ viij., and finds that the exudation ceases, and the local irritation is much relieved after a few doses; but treatment should be continued until all traces of eruption have

disappeared. In acute eczema of children $\text{℥}\frac{1}{2}$ may be the dose up to the age of six months, and $\text{℥}\text{i}$. up to a year old. In subacute forms similar doses should be continued for a longer period, but in chronic eczema the remedy is said to be less successful. In certain erysipelatous affections of the face, with low temperature, called by Mr. Morris relapsing erythema, the use of antimony is said to shorten the attack and diminish its severity; but the present writer's experience is that such cases are very mild from the beginning, and subside in a few days with simple local treatment, or no treatment at all. In prurigo antimony is said to allay the itching and prevent eczematous outbreaks while it is taken. One out of five cases of sycosis is reported to have perhaps improved slightly under its use; in psoriasis it is admitted to be of doubtful benefit, while in urticaria attacks are said to be checked during its continuance.

In a paper "on an unique case of hereditary TRICHOORRHEXIS NODOSA" (*Lancet*, July 28, p. 140), Dr. McCall Anderson points out that in the *fragilitas crinium* of Wilson, which most frequently involves the hair of the face only, there is an apparent, but not a real nodosity of the hairs; the little whitish spots being found to be partial fractures of the shaft; but in the condition to which he would restrict the name trichorrhexis nodosa the hairs are really nodose as well as brittle. In these cases the greater part, but not the whole of the head is affected; the parts are not bald, but the hair is thin and short, dark and crisp, the scalp being scurfy but free from irritation. The hairs break off at variable distances from the surface, and are twisted and bent at acute angles; by the naked eye the hairs are seen to be studded at intervals with little glistening dots, like beads, and are very apt to break at the internodes; these dots are shown by the microscope to be fusiform swellings, opaque and darker than the internodes, while in *fragilitas crinium* the apparent nodosities have a white appearance. The internodal fracture in trichorrhexis is sharply pointed, while in *fragilitas* breakage takes place at the seat of the partial fracture which gives rise to the nodular appearance, and the extremity is expanded and brush-like. Trichorrhexis occurs almost exclusively on the head, while *fragilitas* generally affects the beard and moustache, and the head occasionally; both are rare, especially the former. The case, in which heredity has been noticed for the first time, was that of a boy, three years and a half old, with defective growth of hair, congenital or nearly so, over the greater part of the head, which possessed the characters of true trichorrhexis. The boy's father, and one of his sisters, were similarly affected. Subsequently a brother of the father brought a daughter affected, and was himself found to be so; finally it appeared that many other members of the connection had the disease (or rather abnormality) which was traced to the great grandmother. A genealogical table is given, showing that out of twenty-nine members belonging to five generations, as many as fourteen showed this peculiar condition. The paper is illustrated by a woodcut showing the difference between trichorrhexis and *fragilitas*.

In a communication to the British Medical Association, on "The comparative advantages of SCRAPING AND SCARIFICATION in the treatment of LUPUS VULGARIS," Mr. Malcolm Morris admits the excellent results of erosion by Volkmann's method; but considers that on the face, where the appearance of the scar is a matter of importance, scarification is preferable. He describes the operation, which usually has to be repeated several times, but leaves a smooth supple scar, little if at all depressed; no anæsthetic was required. Dr. Thin agreed that scarification yielded the best result as regards the cicatrix in lupus of the face, but pointed out that treatment often required to be continued for a very long time; one case under his care was not complete, although it had been scarified once a

week for more than a year. Mr. Bickersteth had latterly employed a 'strong' solution of bisulphate of calcium, applied on lint covered with waterproof tissue, and cod-liver oil with iron internally; improvement took place in a few weeks, and cure in a few months, at most.

At the meeting of the Royal Medico-chirurgical Society on June 12, Dr. Thin read a valuable paper "On the BACILLUS OF LEPROSY." It had hitherto been found in leprous tissues of Norwegian, South European, and South American cases; he himself had met with it in cases from China, India, the West Indies, and in one patient who died in Australia. In the skin the bacilli are always contained in cells, which are sometimes to be found in the unbroken rete mucosum, and are probably leucocytes which have migrated. He had also found a lymph-corpuscle containing bacilli in a lymphatic vessel of the cutis, and groups of bacilli on its border; he therefore considered lymph-cells to be one mode of their conveyance. In the skin the parasite chiefly occurs in the deeper part of the corium, which is least richly supplied with blood-vessels. The bacillus is rather smaller than that of tubercle.

Dr. Armand Bernard, in a paper "On PRIMARY VENEREAL SORES," read to the British Medical Association (*Brit. Med. Journ.*, Sept. 23, p. 563), repeats his previous conclusions as to the seat of the lesion, already noticed in this JOURNAL (May, p. 254). He then examines the period of incubation, which was found to vary in sixty-nine cases from one to fifty-six days, the former being probably due to a mixed inoculation. He points out the preference given to multiples of seven, as the most usual dates for the first appearance of the lesions; in cases recorded by Fournier this was true in twenty out of forty-five inoculations, in cases observed by Mr. Lowndes twenty-five out of forty-seven times, and in his own cases forty-three out of sixty-nine. Induration is best marked when the sore is situated on the inner surface of the prepuce and furrow, and is absent when it occurs on the body of the penis; in the female it is best marked on the nymphæ; it appears, therefore, that induration is most distinct when a mucous membrane is involved.

CAVAFY.

LONDON.

Reviews.

EPITOME OF SKIN DISEASES WITH FORMULÆ FOR STUDENTS AND PRACTITIONERS, by the Late TILBURY FOX, M.D., F.R.C.P., and by T. COLCOTT FOX, M.B., M.R.C.P. Third American Edition, Revised, with Additions by T. COLCOTT FOX, B.A. (Cantab.), M.B., London, Physician for Diseases of the Skin to the Westminster Hospital, etc. Philadelphia: Henry C. Lea's Son & Co., 1883, pp. 240.

The favorable reception accorded to the former edition of this Epitome of Skin Diseases by the profession in this country has led to the issue of a third edition which has been "much amended and rewritten" by Dr. T. Colcott Fox. While we regard such a work, which, from necessary limitation of space, can only give a superficial idea of the subjects treated, as of limited utility, either to the student or general practitioner, yet it supplies the wants of those who have neither the time nor inclination to consult fuller and more exhaustive treatises on diseases of

the skin. From this point of view, we can commend this little book as one of the best of its class.

In this compendium, the diseases are arranged in alphabetical order, their more salient features clearly described, and the treatment concisely given. The pharmacopœia appended gives a list of the drugs generally employed in cutaneous therapeutics, and the combinations in which they have been found most valuable. Due recognition has been given to the nationality of skin diseases in a short chapter on the "Peculiarities of Skin Diseases in the United States," which embodies the conclusions of Dr. J. C. White upon this subject, presented before the International Medical Congress in 1876. "To increase its interest for American readers," we are told in the preface, "there has been introduced the classification of dermal diseases, adopted by the American Dermatological Association." The insertion of this classification must be accepted as a sop to the Cerberian prejudice which is supposed to guard our portals against the entrance of foreign dermatological literature. We hardly think that the introduction of this classification, which is by no means accepted as authoritative by American dermatologists, and the defects of which none more thoroughly appreciate, will materially enhance its interest or value in the estimation of American readers. We could have wished that a more creditable contribution from American dermatology might have been chosen.

THE HYGIENE OF THE SKIN, by J. L. MILTON, Senior Surgeon to St. John's Hospital for Diseases of the Skin. Second Edition. London: Chatto & Windus. 1883.

The object of this little work, as the author sets forth in the preface, "is to offer a set of rules for preserving the skin in a high state of health, and assisting the restoration of it to a proper standard, when the reader is under treatment for disease affecting this part of the frame." The fact that the first edition "sold not only faster, but a great deal faster, than any work of the kind ever yet did," is conclusive evidence, to the author's mind at least, that such a book was much needed.

The book is divided into three chapters. In the first chapter, all the essential facts relating to the Structure and Functions of the Skin are presented in language sufficiently plain for the comprehension of the lay reader, for whom it is principally intended. In the second chapter, Disordered States of the Skin are considered; and in the third, The Management of the Skin.

In considering the conditions necessary to maintain the skin in a healthy state, a special importance is given to "due nourishment of the frame." We should judge, from the prominence given to the question of diet, occupying, as it does, fully one-third of the entire volume, that the author regarded the *materia alimentaria* as much more important than the *materia medica* in its influence upon the skin.

Considerable space is devoted to the merits and demerits of the different kinds of soaps, with an analysis of thirteen samples of toilet-soaps.

In laying down hygienic rules for the skin, he strongly protests against cold bathing, especially sea-bathing and saline baths, when the skin is tender or irritable. It is evident that balneology occupies a subordinate place in our author's esteem. He says: "While sulphur fume baths will often take away itch and sometimes liver stains, and occasionally the Turkish bath answers in a rare form of disease called prurigo, beyond these there is not a single form of cutaneous affection known to myself which can be cured by any kind of bath." He refers to the old Roman baths only to condemn them as haunts of profligacy and vice, and the anointing with oil, which formed a part of the system, as a filthy practice.

He continues thus : "If Socrates really said that men should smell of oil, he simply showed that, in addition to being what most men in Athens considered him to be, a perverse, contradictory old nuisance, he was also an old pig." In the matter of clothing, he protests against the use of excessive clothing, especially the wearing of flannels in warm weather, as a sort of national evil, which, so far from protecting the wearers against bronchitis, consumption, and rheumatism, distinctly makes them more liable to such complaints. He takes an optimistic view of the future, however, in the thought that "perhaps when society succeeds to its inheritance of common sense, we shall revert to the more manly habits of our ancestors."

We have quoted sufficiently to give our readers a general idea of the character of the book.

Selections.

GLYCERIN-JELLY AS A CONSTITUENT OF DERMATOLOGICAL REMEDIES (GELATINÆ GLYCERINATÆ MEDICATÆ).

GLYCERIN-JELLY (Leimglycerin) is made by boiling together one part of gelatin and three or four of glycerin, until they form a translucent mass. Of this as much is taken at a time as may be called for by any prescription, and is dissolved by steaming. The medicinal ingredient, having meantime been finely rubbed up when requisite, with water or glycerin, is then added to the liquefied jelly, and the resulting compound well shaken until it becomes a tenacious fluid, which may be either moulded into tablets or poured into a vessel, the former mode of preservation being suitable for the soft, the latter for the hard jellies.

The remedies best adapted to be used in this manner are divided into the two following classes :

1. All volatile agents (tar, carbolic acid, acetic acid, mercurial sublimate, iodine, iodoform, camphor, camphor-chloral, chrysarobin, ichthyol, the balsams, certain narcotic extracts).

2. Those solid substances whose superficial action only is desired (oxide of zinc, lithargyrum, alumina, acetate of alumina, acetate and carbonate of lead, iodide of lead, salicylic acid, sulphur, arsenic, pyrogallic acid).

Jellies with which medicines of the latter class are combined possess the decided advantage of exerting a less degree of pressure on the skin than is produced by collodion, so that they never give rise to erosions, intertrigo, etc., and permit the complete and easy passage of the perspiration. This pressure has also a beneficial exsanguinating and absorbent action in many cases. Glycerin-jellies are soon found to be superior to the fatty ointments in two other respects—they cause but little soiling of the patient's linen, and they cover the affected surface with a smooth artificial cuticle, which is desirable in all pruriginous complaints, in lichen ruber, etc., as reducing the friction of the clothing to a minimum.

With regard to the precise constitution of these medicated jellies, it is evident that the combining proportions of their several ingredients must fluctuate

considerably, according to the condition of the remedial agent when thus incorporated, and according to the amount of alteration which it produces in the remainder of the compound. These variations are too numerous to be retained in the physician's memory, since, even if the percentage of the active ingredient be taken as the same in all cases, the three remaining quantities will vary considerably among themselves, the formation of a jelly being impossible if these arbitrary relations are not exactly preserved. Thus, a small addition of gelatin will cause a decided hardening of the mixture, which may be again softened to a certain extent by the addition either of a little glycerin or a large amount of water. An excess of glycerin will completely prevent the formation of a "jelly," but the same effect will not be caused by even a large surplus of water. Consequently, we can only say, in general, that, if a fixed percentage of any medicine be united with two, three, four, or five per cent of gelatin, there will be an ascending and descending, but still constant relation between the proportions of water and glycerin belonging to that particular "jelly." That is, if the proportion of the active ingredient remains the same, it may be combined with either two, three, four or five per cent of gelatin, making four series of the jelly; and for every other percentage of the medicine, another quadruple series will be formed in like manner.

The question now arises, whether it is absolutely necessary to employ only such glycerin-jellies as will harden rapidly after being applied in solution to the skin. As a matter of fact, it has been ascertained by repeated experiments that when a jelly had to be used which could not be manufactured in strict accordance with the prescription, the persistently moist artificial surface it produced could be promptly dried by simply covering it with a bandage which could then be removed at any moment with the aid of a wet sponge. By this method it was found that the patient's clothing was still better protected, and the patient himself more effectually prevented from scratching. It will in many cases be advantageous to resort to it, even when a well-made jelly is employed, if we do not wish to wait for the drying of the latter.

Not content, however, with recommending this substitute, the authors have endeavored, by accurate experimentation, to facilitate the task of finding practically correct proportions to be employed in all these cases. The results of their labors are presented in the following tables. The jellies prescribed in Table A, are of the consistency of a gelatin bougie; before being used they are changed into the form of a liniment by placing them in hot water, and being then applied to the skin soon harden into a pellicle. They are denominated *gelatinæ glycerinatæ molles*.

Table B comprises those medicines to which a ten-per-cent addition of gelatin is advised, and which are therefore entitled *gelatinæ glycerinatæ duræ*. These are used in the same way as those of Table A; but their much greater solidity admits of another mode of applying them. A few drops of boiling water may be poured upon the mass and the skin painted over with a camel's hair pencil dipped in the rapidly-drying solution thus obtained. This method is exceedingly economical, and perhaps more convenient than the other. It is recommended be used in policlinics generally, and especially when it is more important for the physician to keep the case in his own hands than to maintain the exact strength of the remedy.

Lastly, Table C exhibits a shorter list of jellies containing twenty per cent of gelatin. Like those of Table B. they can be employed as either hard or soft compounds.

TABLE A. GELATINÆ GLYCERINATÆ MOLLES.

Medicine, Pr. Ct.	Gelatin, Pr. Ct.	Glycerin, Pr. Ct.	Water, Pr. Ct.	Used in
5 iodoform.....	5	20	70	} Ulcers, bubo.
10 ".....	5	20	65	
10 sulphur.....	5	20	65	
5 camphor.....	5	25	65	
10 sulphur.....	5	25	57	} Acne.
2 camphor.....				
1 calc. carb.....				
10 sulphur.....	5	25	59	}
1 calc. carb.....				
10 ox. of zinc.....				
10 ox. of zinc.....	5	20	70	}
1 calc. carb.....				
10 alumina.....	5	30	55	}
10 alum. acet.....				
10 lithargyr.....	5	20	65	}
10 plumb. acet.....	5	20	65	
10 " carb.....	5	20	65	} Bubo, Epididymitis.
10 " iod.....	5	25	60	
10 ox. of zinc.....	5	30	45	} Erysipelas.
10 alum. acet.....				
5 naphthol.....	5	25	65	} Psoriasis, scabies.
5 arsenic.....	5	25	65	
5 arsenic.....	5	25	65	} Tumors.
0.01 merc. sub.....				
5 chrysarobin.....	5	90	..	} Psoriasis, mycoses, hemor- rhoids.
10 ".....	5	85	..	
5 pyrogall. ac.....	5	80	..	

TABLE B. GELATINÆ GLYCERINATÆ DURÆ.

Medicine, Pr. Ct.	Gelatin, Pr. Ct.	Glycerin, Pr. Ct.	Water, Pr. Ct.	Used in
0.1 merc. sub.....	10	50	40	} Mycoses, acne, syphilides.
0.1 merc. sub.....				
5.6 carbol. ac.....	10	50	25	} Lichen ruber, mycoses.
10.0 ox. of zinc.....				
10 chloral-hyd.....	10	40	40	}
5 chloral.....				
5 camphor.....	10	40	35	} Antipruriginosa.
5 chloral.....				
5 camphor.....				
5 carb. ac.....	10	45	40	}
5 carb. ac.....				
10 carb. ac.....	10	40	40	}
5 acet. ac.....				
5 salic. ac.....	10	40	45	} Condyl. acum., verruca.
10 ".....				
10 ".....	10	45	35	} Mollusc. contag., calli, clavi.
10 ".....				
5 extr. narcot. fluida.	10	40	45	}
10 extr. narcot. fluida.				
5 extr. narcot. fixa...	10	50	35	}
10 extr. narcot. fixa...				
5 pix. liq.....	10	60	25	} Eczema, psoriasis.
5 bals. peruv.....				
5 styrax.....	10	60	25	} Scabies.
5 ichthyol.....				
10 pix. liq.....	10	50	30	} Eczema, } acne, acne rosacea, psoriasis, } chilblains, ulcers.
10 ichthyol.....				
20 adeps.....	10	40	30	}
5 pyrogall. ac.....				
10 pyrogall. ac.....	10	85	..	} Psoriasis, tumors, ulcers.
10 pyrogall. ac.....	10	80	..	

TABLE C. GELATINÆ GLYCERINATÆ DURÆ.

Medicine, Pr. Ct.	Gelatin, Pr. Ct.	Glycerin, Pr. Ct.	Used in
10 ol. cadini.....	20	70	Eczema, psoriasis, etc.
10 ol. rusci.....	20	70	
20 ol. cadini.....	20	60	
20 ol. rusci.....	20	60	
20 pix. liq.....	20	60	
20 ichthyol.....	20	60	
10 ichthyol.....	20	60	
10 pix. liq.....			
10 ichthyol.....	20	60	
10 ol. cadini.....			
30 adeps.....	20	50	Psoriasis, tumors, mycoses, ulcers.
5 tannin.....	30	75	
5 pyrogall. ac.....	20	75	
10 ".....	20	70	
20 ".....	20	60	

The durability of both the hard and soft jellies admits of their being kept constantly in stock by druggists, and since so large a number of dermatological remedies can be compounded in this way, they can undoubtedly be used in conjunction with other approved modes of application. It will be an interesting study to determine the nature of the cases in which they are practically of most service. Certain agents—as chrysarobin—and certain very mobile bodily parts—as the elbow and the palm of the hand, already seem excellently adapted to this kind of treatment. On the other hand, it is obvious that glycerin-jellies will never come to be so speedily incorporated as the fatty ointments, or so powerful in their effects as the rubber plaster, or so handy of application to less accessible regions as the ether-spray. Yet, equally with the fatty ointments, they are superior to the other two methods, in extensive or universal skin affections. — UNNA and BEIERSDORF, *Monatsh. f. Prakt. Dermatologie*, Vol. II., No. 2.

ELECTRICITY IN DERMATOLOGICAL PRACTICE.

ELECTRICITY as a remedial agent has thus far failed to answer the highly-wrought expectations which were at first aroused on its behalf. Not, of course, that its claims can be entirely set aside, but, having been extravagantly lauded by enthusiastic advocates on the one hand, and on the other almost overlooked by the majority of regular practitioners, it has suffered the usual fate of powerful remedies while neglected by science, in being largely utilized for the benefit of quacks. Hence the discredit into which it has undeniably fallen, but which should not prevent a recognition of its absolute worth.

Nevertheless, as was recently remarked by an American physician, Dr. Hardaway, to his colleagues of the Missouri Medical Society, electricity has certainly been found wanting, at times, in those very disorders where it seemed likely to prove most serviceable. Take, for instance, the diseases of the skin. The superficial location of these disturbances, their usually easy diagnosis, and the clear indications which most of them present for the selection of remedies, would seem to offer a peculiarly inviting field for the employment of electricity. It is probably as much the fault of the experimenters themselves as of the means employed, that the results so far have been comparatively meagre.

By applying the different forms of electricity, under different conditions, to the various cutaneous maladies, Dr. Hardaway has obtained favorable effects, both medical and surgical, in a certain number of instances. Here, as elsewhere, it is necessary to success that the chosen agent be applied with skill and discernment. Has this rule always been observed?

In electrical treatment, galvanization and faradization fulfil different indications. In skin diseases accompanied by nervous disturbances, both these methods are of equal advantage; the application should be made both directly to the nervous centres, and also at the seat of the superficial symptoms. A third procedure, electrolysis, is of great value for the destruction of tumors, hypertrophies, and cutaneous neoplasms of various kinds.

Piffard and others have employed faradic currents in the treatment of *acne rosacea*. Hardaway's method is to place the positive electrode on the back of the neck, and the negative over the affected region. When galvanization is used, he advises to apply the former pole upon the temporal region and the other to the seat of the eruption. Electrolysis has been recommended in order to coagulate the blood in the varicose veins. The needle forming the negative pole is inserted into the vascular tumor, the positive pole being held in the patient's hand. A battery of eight or ten cells is employed, and the electropunctures are repeated several times along the course of the enlarged vessels. Dr. Hardaway, however, admits that this procedure, though superior, in his opinion, to any other local measure, is insufficient without the aid of constitutional treatment. We must not be misled by Bartholow's enthusiasm into regarding electrolysis as a sovereign remedy, which enables us to disregard the restrictions of diet and regimen.

In *seborrhea of the scalp*, the functions of the glands may be restored, and the morbid process partially controlled, by faradization. The hair having been previously moistened, the negative pole is applied upon it, while the positive is held in the hand of the patient. Care must be taken to employ only a feeble current, which should not be kept up longer than ten or fifteen minutes at a time. In this disease, also, constitutional measures are indispensable.

Faradization and galvanization, especially the latter, sometimes exert a palliative influence on the course of *urticarial eruptions*, especially those of reflex origin. Continuous currents here give the best results—in accordance with the physiology of the case.

In the treatment of *pruritus* by electricity, no marked or permanent effects have been obtained.

In *eczema*, galvanization produces an amelioration and sometimes an entire cessation of the itching; but this effect is temporary, and is even of shorter duration than when brought about by other remedies. Electricity, on the whole, is of doubtful efficacy in this complaint.

In the acute stage of *herpes zoster*, continuous currents have proved successful in checking the eruption, and relieving the accompanying neuralgic pains. The various distressing sequelæ of this disease have also yielded to weak and prolonged applications of the same kind.

Alopecia in all its varieties is benefited by electricity, but a moderately strong current, according to Hardaway, is especially serviceable in *alopecia areata*.

In *scleroderma*, favorable results from the employment of this agent have been reported by Feber, Piffard, *et al.*, but as yet its virtues in this direction do not seem to have been fully determined.

The surgical uses of electricity are divided between the process of electrolysis and that of galvanocausty. Each of these in its own sphere is of undoubted

value; but electrolysis produces a strong chemical effect upon the tissues, while galvanocauty, acting only by heat, has of late years been to some extent superseded by thermocauty, which is more convenient of management.

One of the most frequent applications of electrolysis is for the *destruction of superfluous hairs*. This electro-surgical triumph appears to be most warmly appreciated on the other side of the Atlantic. Some American authorities exalt it as "a genuine boon to humanity," and discourse touchingly upon the evil effects of too much hair on the upper lip of individuals belonging to the beardless sex. We are told that it tends to degrade them in the social scale, and sometimes even leads to madness.

To Dr. Charles Michel, of St. Louis, belongs the glory of having first made known to his fellow-citizens the latest and most approved method of correcting this melancholy state of things. Piffard, Hardaway, Fox, and Duhring have since united in sounding its praises. A fine cambric needle, fitted with a handle, is inserted into the hair follicle which it is designed to extirpate. This needle communicates with the negative pole of a galvanic battery of eight to twelve cells, whose opposite electrode is a moistened sponge which is held in the hand of the patient. The pain caused by the process is trifling, and the scars disappear entirely in the course of a few weeks.

The electrolytic treatment of *nævi* and of erectile and pulsating tumors has long been familiar, and the superiority of this method for the removal of *taches vineuses*, especially, has been acknowledged by numerous English and American surgeons. Galvanocauty has been employed for the same purpose, but has now given place in both hemispheres to the thermocautery.

Lupus erythematosus has been successfully treated by galvanocauty. Kaposi however, prefers Paquelin's cautery in this disease, while Besnier and Doyon regard linear scarification as the better remedy. Hardaway, in one case, effected a cure by electrolysis.

Electrolysis has been resorted to for the removal of *pigmentary nævi* and of *small fibromata*. Trial may be made either of this process or of galvanocauty, against *xanthoma*, *warts*, *condylomata*, *horny excrescences*, *molluscum*, and epithelioma in its early period. Hardaway thinks it would be well to test the advantages of the former in the treatment of *keloid*, especially since permanent good, results have so rarely followed the use of caustics and the knife in this complaint. Indeed, electrolysis would seem decidedly indicated in all affections where great effusion of blood or lasting cicatrices have to be avoided.

On the whole, it must be admitted that electricity has hitherto played but an unimportant part in relation to dermatology. If it is ever to enter into every-day practice in this department, its results must be more generally appreciated than at present by the profession, and its legitimate advantages must cease to be monopolized by a few experts, however indisputable their abilities.—CH. ELOY, *L'Union Médicale*, September 13, 1883.

CUTANEOUS ERUPTIONS IN DIPHTHERIA.

VERY little attention has hitherto been paid to this subject, if we may judge from the paucity of references to it in recent medical literature. This is the more remarkable, because, first, the exanthemata which mark the course of other contagious diseases, as, *e. g.*, abdominal typhus and cerebro-spinal meningitis, have received due consideration, and, second, cutaneous eruptions of various kinds are by no means infrequent accompaniments of diphtheria. Oertel (Ziems-

sen's Cyclopedia, 2d ed., vol. ii., part 1, p. 650, 1876) makes brief mention of an erythema on the face and breast, as occurring in rare cases of this disease, and as making it easy to confound it with scarlatina, and Mackenzie expresses himself to the same effect in his work on Diseases on the Throat. "The diphtheritic eruption," he says, "bears more or less resemblance to that of scarlatina, and consists of small, red, isolated spots, disappearing on pressure. It is distinguished from the scarlatinal exanthem by the absence of desquamation." Mackenzie, however, maintains, in opposition to Oertel, that this phenomenon has been noticed in many epidemics of diphtheria, especially among children, and directs attention to a fact which I also have observed, viz., that such eruptions are generally met with in very severe cases of the disease. But so far as I am aware, no stress has been laid by any authority on their importance as a prognostic sign, when thus occurring.

According to my own observations. *petechiæ constitute by far the most frequent cutaneous manifestation of diphtheria.* They make their appearance either shortly after the commencement of the complaint, or else at a later stage, sometimes only a few days before the death of the patient. The extravasated spots are of different sizes; quite often they are very small, hardly more than points, so as to be easily overlooked without close examination, which, perhaps, is the reason why they have so frequently escaped notice. Sometimes, however, I have found scattered over the skin slightly prominent bluish-green spots as large as a half-dime which might readily be mistaken for contusions caused by the pressure of the bed at particular points, were it not for their number and their presence on all parts of the body and extremities. I have never observed petechiæ on the conjunctiva of diphtheritic patients: but, in cases where they have existed on the general integument, post-mortem examinations have always disclosed similar appearances on the serous membranes, especially the pleura and pericardium, and on the mucous membrane of the pelvis of the kidneys, less frequently on that of the stomach.

The number of these petechiæ on the living subject is generally small, and I have never seen them in groups; they are uniformly dispersed at a considerable distance from each other, in consequence of which the above-described bluish-green contused-like spots are less numerous than the more minute red ones.

As to their mode of origin, the results of Oertel's inoculations of rabbits with diphtheritic virus appear to confirm the opinion that these eruptions are due to the presence of bacteria—probably in the lymphatics of the skin—such objects having been frequently detected in the extravasated organs—especially the kidneys—of human subjects.

Diphtheritic erythema is of far less frequent occurrence than the above, and I have but few observations of my own to report respecting it. The JOURNAL OF CUTANEOUS AND VENEREAL DISEASES for April, 1883, contains a paper on this subject by Dr. Robinson, to which, on account of its late reception, I can scarcely do more than allude in passing. The author distinguishes between the scarlatina-like erythema of no prognostic importance, because occurring in both slight and severe cases, which appears in the earliest period of diphtheria, and the eruption resembling *erythema multiforme*, that sets in several days later, and forebodes an unfavorable issue. The origin of these symptoms he attributes to hyperæmia dependent on vaso-motor irritation of the cutaneous nerves, which irritation, in the case of the second variety, is caused by a toxic material in the blood.

In addition to petechiæ and erythema, there is a third species of eruption con-

nected with diphtheria, of which, so far as I know, the following example is the only one on record.

On May 5, 1877, a male patient, a cattle tender by occupation, came under the care of Dr. Goldschmidt, laboring, since March 2, under a cold and sore throat, with running from the nose and eyes, to which was added, two days afterwards, an eruption partly of papules, partly of pustules, chiefly on the backs of the hands and dorsal surface of the forearms. This, when at its height, was more thinly scattered on the upper arms, in the palms of the hands, and over the body, and there was one prominent pustule, like a small-pox pustule, on the left shoulder. The patient succumbed to a continued high fever, after the development of the eruption and the spread of the diphtheritic membrane in the throat. The autopsy revealed diphtheria of the posterior pharynx, a pseudo-membranous deposit on the tongue, epiglottis, larynx, and trachea, ecchymoses of the pleura, parenchymatous degeneration of the cardiac structure, and swelling of the spleen and liver.

No reasonable doubt can be entertained that the case presenting the above-described cutaneous features, whose like has never previously been observed either in diphtheria or in any other contagious malady, was a case of genuine pharyngeal diphtheria.

I am unable to offer an exact explanation of the exceptional phenomenon, but would call attention to the fact that the disorder which produced it was remarkably severe, and very rapidly fatal; and in this we have another confirmation of Mackenzie's maxim already quoted. *The prognostic meaning, and hence the clinical importance, of the various eruptions we have spoken of, are consequently obvious.* Cases of pharyngeal diphtheria accompanied by petechiæ are almost always fatal. In all such cases, therefore, even when the patient's general condition is not unfavorable, we should be cautious in our predictions as to the final issue, with a readiness to foresee the worst. So, too, when erythema is the form presented, however encouraging may be the general symptoms, death, in all probability, is to be looked for within a few days. With regard to the papulo-pustulous eruption of which the solitary example has been given, we cannot say positively that every attack of diphtheria similarly complicated will terminate in the way described, but our judgment under like circumstances in the future must, of course, be influenced by the recollection of that unprecedented case.—EUGEN FRAENKEL, *Monatshefte f. Prakt. Dermatologie*, Sept., 1883.

LEPROSY IN NEW BRUNSWICK.

IN order to gain a more accurate knowledge of leprosy as it exists in the Maritime Provinces of Canada, the writer spent some days at Tracadie and the immediate neighborhood.

There are now in the Lazaretto twenty-four patients, whose names and histories were recorded. At the end of 1882, there were twenty-six patients—eleven males and fifteen females. There was one death during the year, and four patients were admitted. There have been no admissions since the commencement of this year. Two deaths have occurred, leaving the present number. On looking over the hospital records, it was found that the average length of time of residence in the hospital of those who died was about five and a half years. The average length of residence of those who are now in the hospital is four years and ten months. This includes one who has been twenty-four years and another fourteen years in the Lazaretto.

The history of Margaret Sonier, née Robicheau, is cited as a remarkable one. She contracted leprosy forty years ago, being now seventy years old. She was admitted to the Lazaretto on Sheldrake Island in 1844, when it was first established. During five or six years' residence there, she lost all the fingers of both hands, leaving only the first phalanges of the thumbs. She was then sent out cured. She married into a leprous family, and had three children, one of whom is now twenty-four years in the Lazaretto. The other two never contracted the disease. In the writer's opinion, the disease has not really returned since she first left the hospital. She is quite as well, and appears much more active than most women of her age.

During the short time that the writer remained at Tracadie, he heard of four cases outside of the Lazaretto. In some instances, the disease is concealed as long as possible, but new cases are constantly watched for, so that, as a rule, they do not long remain unrecognized.

The writer spent the greater part of his time in attempting to discover the manner in which the disease commenced and spread. On this point, he arrived at the following conclusions:

1. The origin and early spread of the disease cannot be explained on the theory of hereditary transmission, although this theory may account in part for its further propagation.

2. Although endemic influences, such as climate, mode of life, diet, etc., may be strong predisposing elements, they are in no case the sole cause of the disease.

3. Leprosy at Tracadie was imported from without, and, finding there favorable conditions, was propagated from one person to another by contagion.

Finally, leprosy may be regarded as one of the least contagious of diseases, and one which will only spread under a combination of favoring circumstances such as were found at Tracadie. In all probability, the disease is communicated solely by means of inoculation, and opportunities for such inoculation are very few indeed unless there has been long and intimate contact with diseased persons.—J. E. GRAHAM, *Canada Med. and Surg. Journal*, October, 1883.

ON THE CONNECTION BETWEEN SYPHILIS AND DEMENTIA PARALYTICA.

THE materials for this paper were derived from the author's personal and continued observation of one thousand insane patients, all belonging to the higher walks of life, one hundred and seventy-five of whom were affected with unmistakable progressive paralysis.

The result of his study was to convince him, despite his previous disbelief in such a connection, that syphilis is to be ranked among the most frequent causes of the above-mentioned disorder; in other words, that *dementia paralytica must henceforth be included among the symptoms of tertiary syphilis*.

It is, however, a fallacy, he thinks, to regard dementia paralytica as always, or nearly always, originating in this way, or as capable, when thus produced, of being distinguished, like a separate form of disease, by positive and well-marked signs.

The nearest possible approach to a differential diagnosis between ordinary progressive paralysis and the disease as resulting from syphilis (except when the history of the case renders a mistake impossible) is made by attending to the following points:

1. The early appearance of the paralysis. Coffin, quoted by Fournier, speaks

of a *paralysie générale précoce* occurring between the twenty-fifth and thirtieth years of life which is usually caused by syphilis. Progressive paralysis, when not related to specific disease, generally sets in after the age of thirty-five, very seldom before thirty. Moreover, *tabes dorsalis* from syphilis seems often to be met with in comparatively youthful subjects.

2. An abnormal condition of one or both pupils is a familiar symptom of progressive paralysis. When the pupils are of unequal size, it must be ascertained which of them is the subject of disease. Unnaturally dilated pupils most often result from syphilis, while contracted ones are frequently met with where no suspicion of its existence can be entertained. Sometimes, indeed, though very rarely, the reverse condition may obtain.

3. An indication is sometimes afforded by the results of anti-syphilitic medication. Undoubtedly, many cases of progressive paralysis arising from syphilis have not only improved, but have completely recovered under such treatment. It is quite natural, therefore, that iodide of potassium, or some similar remedy, should be resorted to in desperate cases of the kind even when unconnected with syphilis. Nevertheless, it would be a mistake to suppose that the non-success of such measures proves that syphilis had nothing to do with the cerebral disease. Cases of the latter uncontestedly originating in syphilis have bid defiance to energetic specific treatment, which is not surprising in view of the fact that in the advanced stages of progressive paralysis the loss of nerve substance consequent upon the sclerotic process has gone too far to permit the return of functional equilibrium.—H. OBERSTEINER, *Wien. Med. Wochenschrift*, Aug. 25, 1882.

PROPOSITIONS CONCERNING LEPROSY.

THE following are the ten propositions submitted as a result of the combined investigations of Drs. Fox and Graham:

1. Leprosy is a constitutional disease, and in certain cases appears to be hereditary.

2. It is, undoubtedly, contagious by inoculation.

3. There is no reason for believing that it is transmitted in any other way.

4. Under certain conditions a person may have leprosy, and run no risk of transmitting the disease to others of the same household or community.

5. It is not so liable to be transmitted to others as is syphilis in its early stages. There is no relation between the two diseases.

6. Leprosy is usually a fatal disease, its average duration being from ten to fifteen years.

7. In rare instances, there is a tendency to recovery after the disease has existed for many years.

8. There is no valid ground for pronouncing the disease incurable.

9. Judicious treatment usually improves the condition of the patient, and often causes a disappearance of the symptoms.

10. There is ground for the hope that an improved method of treatment will in time effect the cure of leprosy, or, at least, that it will arrest and control the disease.—*Trans. American Dermatological Association*, 1883.

CHANCROIDAL BALANO-POSTHITIS.

SIMPLE chancres developed upon the mucous surface of the glans or the internal face of the prepuce may produce a balano-posthitis, most often accompanied with phimosis.

Phimosis and balano-posthitis symptomatic of simple chancres may be divided into three categories, which correspond to three grades of severity and extent of the accidents: inflammation, abscess, gangrene.

Gangrenous balano-posthitis is the gravest of all; it may destroy not only the prepuce, but also the glans, the corpora cavernosa, and even the entire penis.

The appearance of gangrene in balano-posthitis almost always coincides with general symptoms, characterized by high fever, gastric disturbance, prostration of strength, and sometimes even by ataxo-adyynamic phenomena.

The gangrenous inflammation converts the purulent secretion into an ichorou serosity of gangrenous odor, but deprived of all contagiousness.

From the moment that gangrene is established, the morbid products which escape from the glando-preputial cavity are no longer inoculable.—DR. A. PETIT. *Thèse de Paris*, December, 1882.

Received.

La Dermatose de Kaposi (Xeroderma Pigmentosum). Par EMILE VIDAL. (Reprint.)

Du Lupus scléreux. Par E. VIDAL. (Reprint.)

Lichen Ruber and Lichen Planus. By A. R. ROBINSON, M.B. (Reprint.)

Les Syphilides. Par les DOCTEURS TOUSSAINT BARTHELEMY et F. BALZER. (Reprint.)

On the Pathology and Treatment of Gonorrhœa. By J. L. MILTON. Fifth Edition. London: 1883.

Item.

THE DERMATOLOGICAL AND SYPHILOLOGICAL SOCIETY OF LONDON.—The committee, at their last meeting, held on Thursday, the 6th inst., decided to name this Society the "Willan Society of London," after Willan, the father of English dermatologists. It was also decided that the objects of the Society should be the exhibition and demonstration of patients, drawings, models, specimens, microscopic and otherwise, illustrating disease of the skin and venereal diseases, and the reading of papers and discussions of subjects on dermatology and syphilis.—*Brit. Med. Jour.*, December 15, 1883.

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EXPERIMENTS WITH RECENTLY RECOMMENDED REMEDIES IN GON-
ORRHŒA.

BY

E. L. KEYES, M.D.

HOT water has become one of the therapeutical modes of the day, and irrigation and drainage, as surgical principles, have been brought to bear upon a number of maladies formerly treated in other ways.

How long ago these methods were introduced into the management of gonorrhœal maladies I have not sought to find out, but doubtless investigation would prove them to be very ancient.

I remember that in 1865, in the Hôtel Dieu, at Paris, Maisonneuve had an apparatus consisting of a suspended pail of water and a rubber tube working as a siphon with a special terminal nozzle capable of being made large near its proximal end, by which he attempted to cure specific vaginal inflammation in women by the principle of moderate distention of the vagina associated with incessant irrigation, night and day.

The method did not find favor or success, as I observed it.

Somewhat later I devised a retrograde urethral irrigator for the male urethra, but nothing came of it. Reginald Harrison, of Liverpool, two years ago published a method of prolonged deep urethral irrigations by mild astringents as a certain method of relief in gleet conditions of the urethra, a method which I have employed in several instances without success.

In any case of urethral inflammation in the male, hot water irrigation, intermittently applied, is a part of the treatment instituted by nature,

for every act of urination performed by the patient washes out the urethra with a hot fluid, generally rendered bland and alkaline by the alkaline diuretics prescribed, yet as a curative means this natural irrigation has little value.

In these modern days of hot-water therapeutics, however, the tendency is for the surgeon to take the initiative. The hot-water cure of dyspeptic and intestinal derangements, headache, and constipation has a large corps of adherents among the laity as well as in the profession, while hot water douches in- and external have acquired a just popularity for the good they effect in various morbid conditions of the stomach, vagina, uterus, bladder, and rectum.

It is but natural, therefore, that hot water should find its way into urethral therapeutics, and the subject seems now to be receiving general attention in this city, notably since a paper was published upon the subject recently by Dr. Curtis, in the *Medical Record*, in which hot irrigation followed by an astringent application of tannin was advocated for the abortion of a commencing gonorrhœal attack.

Dr. Otis, in his latest publication, speaks kindly of the hot-water method without claiming any personal results from its application in his own practice.

Besides the use of hot water by deep irrigation, a claim is made for its efficacy when repeatedly used by the ordinary method of syringing as customarily practised by the patient.

I have come into contact with a few cases in which both these methods have been used, and my impression of them based upon these few cases is that they are not only useless but dangerous in many instances, especially in fresh gonorrhœa in a virgin subject. In the case of old sinners, whose urethral canals have been toughened by several previous inflammatory attacks, they appear to be harmless, sometimes even efficient.

The first case I have to record as bearing upon the subject is that of a young gentleman with his first urethritis, apparently a mild attack, certainly not a specific gonorrhœa.

He was referred to me by his physician after a failure of the hot-water method, to which, however, a mild stimulant had been added.

The history is the following:

Three weeks after exposure, a very mild urethral inflammation manifested itself to the patient by a moderate discharge. For this he was advised, commencing at the thirty-sixth hour of the mild discharge, to remain at home and inject his urethra hourly with water as hot as he could comfortably tolerate, and twice a day to employ an injection containing one-quarter of a grain of nitrate of silver to the ounce.

The injections always caused pain. After the first injection a little blood began to flow and the urethral orifice to swell moderately. The

process was continued until the tenth day, when the patient was sent to me with considerable redness and œdema of the prepuce (especially in the region of the frenum) and a swollen painful gland in the groin; great pain on making water, very moderate urethral flow, frequency of urination, and moderate cystitis of the vesical neck.

This was a year ago. He recovered under six weeks of methodie treatment without further accident, and remains well.

After this, upon reading the paper by Dr. Curtis already alluded to, I determined to test the method of deep urethral irrigation followed by an astringent in a few cases personally.

My experience covers five cases, in the management of which I was assisted by Dr. Blackwell.

Case I.—A gentleman, an old offender, with a tough urethra, came to me within a few hours of the commencement of his urethral discharge, which was very mild.

His urethra was irrigated and the tannin solution applied according to the method advocated by Dr. Curtis. Twenty-four hours later he returned in considerable pain with swollen meatus, a faint watery discharge, pain on urinating, and considerable inflammation and œdema of the entire foreskin and a portion of the integument covering the penis. He declined further injection. His penis was wrapped up in a hot lead-and-opium solution and an alkaline diuretic with an anodyne was ordered. The swelling promptly declined and in a few days he became and remained well without further local treatment. He had been drinking freely before this attack and I therefore concluded that he had not had a gonorrhœa, but an irritation of some of his old tender urethral spots.

However, both the patient and myself were inclined to think well of the method since the ultimate result had been good.

As it so happened, some weeks later, again after drinking and suspicious sexual contact, he once more appeared with slight pain on urination and a distinct urethral discharge. I urged him again to submit to the irrigation, but he declined on the score of some pressing duties and asked for a mild injection to be applied in the usual way, stating that after a few days, if the discharge continued, he would have performed his pressing duties and would then again submit to the hot irrigation.

I ordered a mild sulpho-carbolate of zinc injection and he improved from the very first application, so that after a few days he was so manifestly on the high-road to recovery that he declined to allow the hot irrigation to be used. He recovered entirely in a few days, thus justifying his wisdom in refusing the harsher method, and proving to my satisfaction that neither of his attacks had been truly gonorrhœal.

CASE II.—A gentleman, past middle life, was treated by the Curtis

method for his first gonorrhœal attack. No inflammation of the urethral or surrounding structures followed. The injections were repeated a number of times during ten days. Each one was followed by a temporary subsidence of the discharge, which promptly recurred. At first the injections were repeated daily, then at longer intervals. After ten days they were stopped and ordinary treatment instituted, under which he slowly recovered, the entire time being about five weeks.

CASE III.—The first injection in this patient, who was a young man with a pale face but in good health, and suffering from true gonorrhœa, caused the penis to swell along its entire length, increased the pain and (after twenty-four hours) the discharge to such an extent that he refused further trial of the method and went on with an aggravated gonorrhœal attack lasting about three months, and more or less complicated by mild gonorrhœal cystitis.

CASE IV.—Was a fresh case of true gonorrhœa in a mulatto. But little swelling followed the irrigations. The discharge was temporarily arrested by each injection, and then went on as before. After three weeks the method was given up, and a slow cure effected by ordinary means.

CASE V. was a counterpart of Case II.

In these five cases the utmost care was used in making the injections, which were done without any violence, a very small rubber soft catheter being used and a fountain syringe.

My experience comprises two other cases treated primarily by other physicians.

CASE I.—During the summer of 1883 I was called in consultation by a gentleman having charge of a case which had been under the care of still another medical man. I was informed that the patient had been submitted to the deep urethral hot-water irrigation method for the cure of a gonorrhœa.

When I saw the patient he was confined to his room in bed with a high fever and great perineal pain. His discharge was better than it had been, but his prostate by the rectal touch was found to be very seriously congested, hot, tense, throbbing, and all the indications pointed toward probable prostatic abscess.

By methodical treatment he slowly improved, there was no abscess, the urethral discharge came back—as is its wont—when the prostatic swelling subsided. When I last heard from his physician, recovery was assured. I cannot state the exact number of weeks during which this patient's discharge lasted.

CASE II.—This case is the most brilliant of all. The patient is now on his back in bed at the end of the eighth week with a free urethral discharge.

The history is as follows: In July, 1883—one year ago—this patient came to me with his first attack of gonorrhœa.

I knew that the family was (urethrally speaking) an inflammable one. The patient had only three brothers. One had twice been under my care with bad attacks of gonorrhœal rheumatism. The second, with a prolonged gonorrhœa of many months' duration, treated in the country, had had an inflamed inguinal gland which required many months for its dissipation without suppuration. The third had a sharp urethral discharge which lasted him the better part of a year.

With such knowledge I treated the patient most carefully, avoiding injections. He recovered in about two months, with no complication greater than a little urgency upon urinating toward the close of his treatment.

Eight weeks ago, while sitting in Delmonico's, he became conscious of a slight urethral discharge. He confided the fact to a friend sitting beside him; and his horror of the disease which had been two months in getting well a year before. The friend said to him that there was no need of being so long as that getting well of gonorrhœa, that he would take him to a doctor who would "fix him in a week." True prophet, alas! for in a week the patient certainly was "fixed"—upon his bed, where he has remained ever since. The doctor, be it understood, was a thoroughly competent practitioner.

The method was as follows: Every hour while awake during the day the patient was told to inject his urethra—with an ordinary syringe—with water as hot as the urethra could tolerate, and three times a day he was to take a full hot bath, and while in the bath to inject his urethra under water with the hot water of the bath *as many times as possible*. This he faithfully did for a week. On the fourth day he began to feel pain on urination deep in the perineum. His calls to urinate became frequent and urgent. The doctor said that this was not important, and ordered him over and above the hot water to use an astringent injection. This the patient did, and, his sufferings steadily aggravating, he sent for me on the eighth day. He said that the treatment had certainly been effective in stopping the discharge, but he had the piles frightfully, and the doctor had given him an ointment to apply outside. He was, however, growing suspicious of the treatment, so he sent word to the doctor that he was well and would call upon him shortly, and then hurried a messenger to me. Possibly he may yet come to be recorded by his physician as a cure of gonorrhœa by hot-water injections in a week.

I found the temperature 104° , intense perineal pain and urgency of urination, no pus flowing from the urethra, but plenty of it in the urine—in short, the case was one of gonorrhœal cystitis and prostatitis of a high grade, induced by the peculiar treatment I have detailed above.

The cystitis to-day—seven weeks later—is well, the prostatitis nearly so. There has been no abscess, but the patient has had active epididymitis, which has relapsed three times, the patient being all the while kept flat upon his back in bed. A new wave of inflammation, without known cause, would seem to pass over his prostatic sinus and vesical neck, and shortly there would be a relapse of the inflammation in the testicle. Now the testicle is reasonably quiet, and the urethral discharge has, naturally, returned in creamy abundance. Dr. Samuel Alexander two days ago found an abundance of gonococci in the urethral pus.

As for other methods of aborting gonorrhœa. I have not tried eucalyptol, but I have experimented with iodoform suppositories, and with frequent injections of weak corrosive sublimate solutions.

The iodoform bougies have failed me totally, but have done no harm. I have used those of Kelley and Durkee, two grains, coumarin one-twentieth grain each.

With corrosive sublimate injections I commenced with one-quarter grain to the ounce of water, but found it too strong for frequent use in a virgin case. Some old staggers liked it and confessed moderately good results as having followed its use in their cases of spurious gonorrhœa. I then reduced to one-sixth grain in the ounce, but was totally disappointed in its use. With such a solution injected three or four times a day, I did not succeed in aborting a single case of gonorrhœa out of several in which it was tried.

On one occasion, after a plastic operation upon a healthy urethra to close a fistula in the scrotal portion, I attempted to irrigate the urethra by a small rubber catheter passed beyond the point of the former fistula with a one-in-two-thousand (one-quarter grain to the ounce) solution of corrosive sublimate, a solution with which I had washed the wound thoroughly and with which surgeons freely irrigate ordinary wounds without causing irritation.

The soft-rubber catheter could only be passed once beyond the scrotal point where the fistula had been. The urethra swelled so much that it became temporarily occluded at that point, and after two days an abundant creamy suppuration occurred under a continuance of the injections which persisted for a number of days after the injections had been suspended.

My conclusions, therefore, are—my temporary conclusions, I should say, for they are based on too imperfect data to allow accurate generalization—

- 1st. A mild bichloride of mercury solution irritates the mucous membrane of the urethra more than it seems to irritate an open wound.
- 2d. It appears that an abortive treatment of true gonorrhœa is yet to be discovered.
- 3d. The hot water treatment of gonorrhœa is unreliable.

THE TREATMENT OF ACNE.¹

BY

HENRY G. PIFFARD, M.D.

THERE are few affections of the skin that are easier to cure temporarily than acne, each lesion thereof being, as a rule, self-limited, and going through a regular and definite course of evolution and decline. This course may sometimes be aborted, often shortened. The abortion of an acne papule or the hastening of its maturation or resolution affords the patient, however, but little real advantage, and brings but little credit to the surgeon. Repeated relapses annoy the former and discourage the latter; and after an ineffectual conflict of perhaps months' duration, the victim of acne seeks advice elsewhere, and again undergoes the same routine of standard and time-honored prescriptions, and with the same result as before. It is this that has given the affection its bad name, and has led many physicians to inform their patients that the affection is practically incurable except by time. This is partly true, as time alone in many instances, in the simple acne of youths, will be sufficient without medication. Time, however, in this connection, is not to be measured by weeks or months, but rather by years.

The relapses of acne, the continual development of fresh papules, pustules, tubercles, etc., constitute the chief features against which treatment should be directed. Before undertaking it, one fact should be thoroughly appreciated, and always borne in mind: that acne never commences, and that relapses never occur, without some sufficient cause. He, therefore, who would hope to successfully combat the affection, should at the very beginning seek to unravel the etiological skein, however tangled it may seem to be. The principal etiological factors of acne have already been considered (this *JOURNAL*, September, 1883). Ascertain, if possible, which one or more of them are implicated in the special case under examination, and then carefully determine whether they are remediable. If curable gastric, intestinal, uterine, or genital affections are present and appear to constitute the underlying causes, first attack them. How this is to be accomplished it is not the province of this paper to indicate, for that belongs to the realm of general medicine. More than once we have been personally helped out of difficulties of this sort by those whose experience in these directions was greater than our own. A few years ago, I presented at a meeting of the New York Dermatological Society a case of acne that by common consent was

¹Read at the meeting of the Amer. Dermatological Association, Aug. 29, 1883.

regarded as the worst case of this disease that any then present had ever seen. The patient was a young lady, the daughter of a physician. A year of persistent and painstaking treatment had yielded no result, and it was not until her uterus was propped up and retained in position by some species of gynecological scaffolding, that the treatment specially directed against the cutaneous lesion began to prove of service. In this instance a uterine specialist accomplished the first steps that led toward a cure. Concerning the cases, fortunately in the minority, in which the cause of the eruption is irremediable, I have very little to say, other than to refer to a single illustrative case. A lady, now well advanced in life, has been a martyr to a severe acne for the past thirty years. She has been at different times under the care of Hardy, of Paris, Wilson, of London, and the late Dr. Bulkley, of this city, without benefit. She has several times requested me to prescribe for her. This I have declined to do, knowing her to be a chronic sufferer from organic uterine disease of an incurable character. Each exacerbation or moderation of the uterine irritation was plainly indicated in the face. Two eminent gynecologists of this city diagnosed a fibro-cystic tumor of the uterus, and gave an unfavorable prognosis as to life. Curiously, the lady has survived them both, but the tumor is slowly increasing and the acne still persists. This is an example of a class of cases that the writer greatly prefers not to treat, as temporary alleviation is at most all that can be expected.

The clearing away of etiological underbrush brings us next to a consideration of the special treatment of the cutaneous lesions themselves. These lesions usually embrace papules, pustules, tubercles, and more or less infiltration of the peri-follicular tissue, and sometimes, in addition, comedones and rosacea. The lesions mentioned are not usually encountered all together in the same case; and as a rule, the acne of early life, the acne *vulgaris*, *simplex*, or *juvenilis* of writers, will exhibit papules and small pustules only, with comedones, while the acne *tuberculata* or *indurata* of more advanced years consists of tubercles, pustules, and dermic infiltration, with often a touch of rosacea.

In either early or late acne, the acuteness of the process, and the degree of inflammation varies. In some, the evolution is active, and the fresh crops of eruption succeed each other rapidly. In others, the entire process is sluggish, both as to the degree of the inflammation and the frequency of outbreaks and relapses. Between these extremes there are all shades of difference, due not to any essential differences in the disease so much as to differences and peculiarities in the individual.

We would naturally expect, then, that the treatment of these different cases will vary; and if we expect even moderate success, the proper modifications and allowances must be made. In systematizing the treatment, it is impossible to more than state the general rules and principles

that should govern the use of the various drugs and other measures that may be employed, and to indicate their special application to the principal typical forms of the affection. These forms and their chief remedies will now be indicated.

ACUTE ACNE VULGARIS.

Internal Treatment.—The drug which, in the writer's opinion, outweighs all others in usefulness in this form of the affection, is *calx sulphurata*, given in small doses at not too frequent intervals, and discontinued as soon as its good effects appear to be manifest, and to be resumed as soon as they seem to flag.¹ Next in usefulness is bromide of arsenic, given in doses of from $\frac{1}{100}$ to $\frac{1}{50}$ of a grain. A one-per-cent solution in alcohol is a very available method of dispensing it, and the dose will be one or two minims² (not drops) in a wine-glass of water two or three times a day. If any gastric irritation should ensue, the dose should be lessened. The repetition of the dose, and the continuance and discontinuance of the drug, are to be governed by the same rules that apply in the case of *calx sulphurata*. As regards the choice between the two drugs mentioned, I can say but little, other than that it has been my custom to use the former drug in cases of a lymphatic character, and the latter in those of a more florid type.

External Treatment.—When a papule first appears, immediate incision will usually cause its abortion, perhaps through the agency of depletion which should be encouraged by applications of warm water, which also act after the manner of a poultice, and hasten resolution. The incision may be made with point of an ordinary old-fashioned lancet, but more conveniently with an acne lance that I devised some years ago.



In suitable cases I puncture a few papules, direct the patient to do the same, and afterward leave this part of the treatment in his or her hands, with orders to puncture each fresh papule as soon as it appears. Another method of dealing with the acute papules is the twice or thrice daily application of very hot water, as hot in fact as it can be borne. The effect of very hot water on congestions is well known, and its utility in this respect can be profitably availed of in these cases.

If pustules are present, they should be punctured, their contents squeezed out, and the face thoroughly washed, and hot water applied to

¹ I have so recently written in full (this JOURNAL, January, 1883) concerning *calx sulphurata*, and its use and dosage in this disease, that I deem a repetition unnecessary.

² The patient should obtain a minim dropping tube.

reduce the congestion. Beside these measures, soothing applications of various sorts are of decided service. My own favorites are belladonna and stramonium. An excellent formula for the former being:

℞ Linamentum belladonnæ ʒ i.
Adeps benzoinatus..... ʒ i.

the camphor in this preparation being, I think, a useful ingredient. A little of this is smeared over the eruption on retiring, avoiding as much as possible any direct transfer to the eyes, and the patient being warned to discontinue its use if dilatation of the pupil occurs. To this a little ammoniated mercury or oxide zinc may sometimes be added to advantage.

The preparation of stramonium that I altogether prefer is a fluid extract made from the fresh leaves gathered in the fall. This is to be incorporated with benzoinated lard or with white precipitate ointment in the proportion of one drachm to the ounce.

SUBACUTE ACNE VULGARIS.

Internal Treatment.—Among the remedies specifically useful, calx sulphurata deserves the first place. As elsewhere pointed out, it should be given in much larger doses than in the acute form, and its action pressed until a semblance of acuteness is apparent—that is to say, until its physiological action is manifested by increased activity and perhaps increase in the number of the lesions, with a more decided tendency to suppuration. When this point has been reached, there should be a temporary cessation of the internal treatment and the institution of soothing external applications. If the acne fails to yield to a few courses of this sort, arsenious acid may be commenced, beginning with a dose of $\frac{1}{100}$ of a grain and gradually increasing to $\frac{1}{3}$. If, however, amendment should be apparent before this latter dose is reached, no advantage will be gained by increasing the dose to the maximum. Occasionally both mercury (preferably the corrosive sublimate) and the iodide of potassium, given as an intercurrent remedy for two or three weeks in obstinate cases will be of service.

External treatment.—In subacute acne the principal indication for external treatment is the employment of such applications as shall stir up the sluggish circulation and increase the activity of the pathological process. To this end, green soap, tincture of green soap, sulphur, iodide of sulphur, mercury, and biniodide of mercury and corrosive sublimate are most in vogue. These drugs all act in substantially the same manner, namely, as irritants, and their use is followed by increased hyperæmia and swelling. When, after a few days, this has reached a proper limit, the applications should be discontinued and the parts permitted to return toward a healthy state. If the drugs employed have been sufficiently active, or

their use kept up for a sufficient length of time, the horny layer of the skin will loosen and desquamate. When this process is finished, the entire surface acted on will, as a rule, be found with fewer and smaller lesions, smoother, and in every way better than before. A similar course is again pursued, and this is repeated as often as may be necessary. The dosage or strength of these applications must be guided by the effect produced, and there is a very wide range of susceptibility to reaction exhibited by the skins of different persons. As a rule, it is well to commence with applications of very moderate strength. For instance, green soap may be simply smeared over the surface once a day, but if this is not found sufficient, it may be thoroughly rubbed in night and morning. The tincture of green soap may be rubbed on with the finger or well rubbed in with a bit of flannel once, twice, or thrice daily. In like manner, precipitated sulphur, diluted with some inert powder, or used pure, may be very conveniently applied with the aid of an ordinary lady's toilet puff. The bichloride and biniodide of mercury and the iodide of sulphur should be mixed with lard, in a strength at the beginning of not more than two or three grains to the ounce, to be increased if necessary. The action of these different agents is essentially the same in principle; it is simply the destruction of an existing irritation or inflammation by the superimposition of another one. Dermatology affords us several illustrations of this principle, even in cases where drugs take no part in the action. For instance, psoriasis sometimes assumes a form characterized by rings of infiltration covered with scales, the integument within the rings being quite healthy in aspect. These rings exhibit a tendency to increase in size, and if two of them are close together they will ultimately unite, forming a figure of eight. Now, one might naturally suppose that at the point or line of junction we would find a double thickness of infiltration and an increased amount of scaling. On the contrary, the reverse happens, the infiltration and the scales disappear at the seat of junction, while they are maintained in full vigor at all parts of the circles that do not touch. This same phenomenon is witnessed where two spreading circles of common ringworm (*trichophytosis*) unite, and is also sometimes observed in connection with annular syphilides. These examples of two morbid actions meeting on one spot and destroying each other should not be lost sight of, as they furnish useful hints regarding the therapeutic management not only of acne, but of several other cutaneous diseases. The useful applications of this principle in dermatology are far from being limited, as we very frequently find that subacute and chronic irritations of the skin readily improve after being made temporarily worse by some active irritant. It is on this that most of the cutaneous therapeutics of the German school at the present day is based.

On this very point the latest French dermatological writer, the eminent and venerable Hillairet (recently deceased), speaks as follows:

“*Irritant or substitutive* medication is of very frequent utility in dermatology. It is by this means that we modify locally the superficial layers of the skin, in chronic inflammations, as psoriasis, chronic eezema, lichen, etc. It is indicated in a general way in all dry papular and squamous affections, accompanied by thickening and induration of the skin.” He then goes on to indicate oil of cade, pyrogallie acid, chrysarobin, nitrate of silver, iodine, etc., as agents that may be used to this end.¹

It will be observed that we have drawn attention to two classes of drugs, those for internal use, and those for external use, that are capable of producing local irritation and exciting a substitutive inflammation, both apparently capable of fulfilling the same end. It may then very properly be asked which class of remedies is to be preferred. On this point there is very naturally a certain difference of opinion. The Vienna school is a unit in favor of the external applications, and any one in that city who would propose to cure acne by internal medication would be regarded almost a fit subject for a commission *de lunatico inquirendo*. The French school, though united on many important points, are much divided as to the treatment of this affection. In England there is no settled school of dermatology, the traditions of Willan, Wilson, and Tilbury Fox being the supreme guides with some; while with others the teachings of Hebra are omnipotent. In America there is as yet, very fortunately, no school of dermatology, each practitioner being allowed to pursue his own methods of investigation unhampered by the traditions of the past. Consequently, each pursues the method that his fancy dictates, and the probabilities are that before many years the exact truth on this point will be known.

One other important drug in this connection remains to be considered. This is ergot, recently introduced as a remedy for acne by Dr. Denslow,² of New York. It is commonly prescribed in doses of twenty or thirty grains twice or thrice a day, and continued for several weeks. Instead of the powder, the extract or fluid extract may be employed, the former being five times the strength of the latter. In several very obstinate and severe cases of acne, we have seen gradual but unmistakable amendment follow the use of this agent. As to the theory of its action, I can say nothing, as I am not prepared to accept the one advanced by Dr. Denslow in his original paper, and have not been able to frame one that is at all satisfactory. I am equally uncertain whether the dose mentioned is really the best one for most cases. An experience of but three years, in

¹ Hillairet: “*Traité théorique et pratique des maladies de la Peau*,” Paris, 1881, p. 184.

² New York Medical Journal, February, 1881.

not above twenty-five or thirty cases treated with ergot, is too limited to warrant any general inductions.

In the place of drugs, certain mechanical procedures have been recommended in the treatment of acne. Of these crasion with the sharp spoon or dermal curette claims the first notice.



This method was advocated by Hebra (the younger)¹ and by Wigglesworth,² and affords a very certain and prompt way of removing acne. All that is necessary is simply to scrape off the lesions with the instrument, and presto, the patient is free from his acne; but *alas*, the benefit is but temporary.

Another procedure equally effective was proposed by Ellinger.³ It consists in rubbing off the lesions with a handful of fine sand.

Complications.—There is one very frequent accompaniment or complication of both acute and subacute acne vulgaris. I allude to comedones. These insignificant but annoying pests yield, so far as my own experience goes, to but one direct method of treatment, namely, mechanical. They must be removed by pressure on the surrounding skin. This may be done with the finger-nails or a watch-key, or far more satisfactorily with an instrument specially constructed for the purpose.



If the sebaceous plug does not readily exude on gentle pressure, the mouth of the follicle may be enlarged with a fine glover's needle.

TREATMENT OF ACNE INDURATA.

Acne indurata, whether acute or subacute, may be briefly defined, though not with perfect strictness, as an aggravated acne vulgaris, in which the lesions are larger, and the tissues immediately surrounding them are more extensively involved. The principles that should govern their treatment are substantially the same as in acne vulgaris. The etiological conditions should be first studied, and provided for. After which the direct treatment may be undertaken with the weapons that have already been mentioned.

It is in acne indurata that we have seen the most striking results

¹ Wien. Med. Wochensch., No. 51, 1875.

² Boston Med. and Surg. Journ., 1876.

³ Wien. Med. Wochensch., No. 45, 1876.

from the employment of ergot. This drug, however, should be used, we believe, with a certain amount of caution, lest excess be followed by serious and even dangerous ergotism.

Society Transactions.

NEW YORK DERMATOLOGICAL SOCIETY.

142D REGULAR MEETING, JAN. 22, 1884.

DR. P. A. MORROW, *President, in the Chair.*

The meeting was opened by DR. KEYES, who read a paper entitled,

EXPERIMENTS WITH RECENTLY RECOMMENDED REMEDIES IN GONORRHOEA.

In the discussion of the paper, DR. OTIS said that he had used the injections of hot water as recommended by Dr. Curtis shortly after the appearance of the latter's article. The first case treated in this manner was that of a man who had had repeated attacks of epididymitis. He first made the injection when the patient was almost well of his discharge. The operation was carefully performed, the tube carried to a depth of four inches, the water having a temperature of 120° F., the amount of water used being one quart. The next day the patient had a fresh epididymitis. He tried the method again in a case of profuse gleet, and continued it every night for several weeks, using one or two quarts at a time. He saw no marked benefit from its use. In another case, he used the method faithfully for three or four weeks without benefit, and finally cured the case by division of a small stricture near the orifice. In another case of very profuse discharge of one year's standing, the discharge gradually decreased under the hot water after using it for one month, but it still continued. In one acute but mild case, the hot water seemed to allay the pain, but did not markedly affect the discharge. In all these cases, he had made use of mild astringent injections after using the hot water. Altogether, he had tried the method in twenty-five to thirty cases. In some acute cases, it gave relief; in some cases, it had no effect, while it aggravated others. On the whole, he had been disappointed in the results, as he had only seen one virgin case improve under it, and that a very mild one.

DR. PIFFARD had not had any experience in the use of the hot water, but thought that probably the water had been used too hot. In an acute inflammation, the temperature of the water should be lower than in a subacute inflammation. He thought that Dr. Keyes' bichloride of mercury solution was too strong (it was from one-quarter to one-sixth grain to the ounce). He had used the bichloride of mercury for gonorrhœa several years, but gave it by the mouth. In the acute stage, he gives it in one-fiftieth to one-one hundredth grain doses, t. i. d., till the acuteness is passed, and then stops it. In the early stage, it markedly diminished the ardor urinæ.

DR. OTIS remarked that the case he mentioned as one with very profuse discharge and very chronic did well with the water at a temperature of 130°. (The doctor being requested by the Society to give his views on the treatment of gonorrhœa spoke as follows :) He believed that all cases of the disease, whether treated by baths, copaiba, cubebs, injections, or subjected to no treatment, got well in about the same time, and that was within one month. He had gradually stopped using copaiba, cubebs, and the like, and contented himself by putting the patient in the best possible general condition, giving demulcents, such as flaxseed tea, using hot water externally, and insisting as much as possi-

ble upon rest. Under this method, he never has any complication in the way of swollen testicle, and was more successful in his results than by the old method. He gives neither specific nor injection, and by the avoidance of the former he does not derange his patient's digestion. He believes that the disease is self-limited, and that there is no such thing as a specific for it. Whenever his patient has not recovered within five or six weeks, he has never failed to find a urethral impediment.

DR. WEISSE agreed with Dr. Otis in his experience. He does not give specifics. Injections of hot water, of a temperature under 120° , by means of an ordinary urethral syringe, do good. He had never used hot water in chronic cases, as there was always some mechanical impediment in these cases to be removed.

DR. TAYLOR thought that one month was the usual duration for a virgin attack of gonorrhœa. Quiet and rest were good, but he believes in the use of catharsis to a moderate degree in the early stage. He thought it was better to give a cathartic like the Pil. cathart. co. than a saline one, as the latter often made the disease worse. In the early stage of an attack, he gave alkalies with hyoscyamus by the mouth, and had the patient soak his penis in hot water. Copaiba, cubeb, and sandalwood, he thought, were good at the end of the acute stage. As to hot water, he had many years ago used it in urethral inflammation, employing a reverse-current syringe, and always had bad results in the form of chordee, prostatic pain, and the like. Lately, he had used the Curtis method in two cases of gonorrhœa of twenty to twenty-five days' standing, using it every night with the hot water at a temperature of 110° to 115° . Both cases were made much worse, with pain and tenderness in the prostate. In four cases after treatment of stricture with dilatation and operation, he had good results with deep injections of one quart of warm water containing one grain of bichloride of mercury. In using the bichloride of mercury injections, he thought that a strength of one grain to the quart did best. If used as strong as one grain to eight ounces, it causes trouble.

DR. BRONSON said that if the chloride of sodium was added to the bichloride of mercury, it would reduce the irritability of the latter, and make it better tolerated.

DR. KEYES, in closing the discussion, said that the natural life of a gonorrhœa was four weeks. He believed that balsamics did good if they were well-digested. If they caused indigestion, then the urine would be, naturally, more irritable, and they should be stopped. He made use of injections at the beginning of the attack and late in the disease, of mild strength, and often repeated. Alkaline cathartics did harm if the wrong ones were used, and this was due to their rendering the urine more concentrated.

DR. FOX presented a case of

LUPUS ERYTHEMATOSUS,

which had existed for eighteen years. Sixteen years ago, the case was operated on as one of cancer. Three years ago, it began to spread rapidly. One year ago, when the doctor first saw the case, the nose and right side of the cheek were covered with a thick scale. The disease is now disseminated, and located in patches upon nose, cheeks, and chin. Under the local use of pure carbolic acid, the case improved, but the improvement was more rapid when phosphorus was given internally. Last May, he burnt the diseased patch upon the right cheek thoroughly, and now the skin is soft, and of almost normal color, and the scar hardly recognizable.

DR. TAYLOR reported that the case of lupus erythematosus occurring in a woman, which he had presented to the Society in November, 1883 (see number of this JOURNAL for January, 1884), had entirely recovered under the carbolic acid local treatment.

DR. BULKLEY presented a case of

GENERALIZED LUPUS ERYTHEMATOSUS.

The patient, a woman twenty-five years of age, has had the eruption for four years. The disease first appeared upon the scalp in the form of a number of disseminated vesicles which gradually enlarged and became blebs filled with a lymph-like fluid, and finally underwent ulcerative changes. About one year ago a papular eruption appeared on the face, and has continued to spread. At about the same time a number of livid macules appeared on both arms, some of which from time to time ulcerated. The patient never had any eruption as a child, and gives no history of syphilitic infection. Her teeth are regular and sound. The eruption does not itch.

At present the scalp is smooth, hyperæmic, atrophied, and almost perfectly bald. On the occiput there is a large, irregular, and ragged-edged ulceration. It is not deep, has a red base, secretes a thick, yellow pus, and emits a foul odor. The face, ears, and a large portion of the neck present a dappled red appearance, the skin being thickened and crusted. The eyes are œdematous, the ears are swollen and tender, with excoriations on the inside of the concha. Upon the flexor and extensor surfaces of both arms there are scattered a large number of irregularly and variously shaped and sized livid spots. Upon the left arm there is one ulcer about the size of a ten-cent piece. Upon both palms there are numbers of copper-colored patches from one-half to one inch in diameter. These patches come out in crops, at first of bluish color, and soon begin to desquamate.

DR. BRONSON would not venture a diagnosis. He saw no evidence either of lupus or syphilis; the ulcers had not the appearance of syphilis. He thought that the disease was probably due to a general neurotic condition.

DR. FOX considered the disease to be lupus erythematosus, but the appearance of the hands was different from anything he had seen.

DR. BULKLEY said that Kaposi described lupus erythematosus as in some cases ulcerating, and giving rise to swelling of the face. In this case he (Dr. B.) had arrived at a diagnosis by eliminating all other eruptions. The patches on the hands showed the congestive period of the early stage of lupus. On the arms there was a formation of an acne-like eruption similar to what we see in this disease as occurring on the face. As another element in the diagnosis of lupus is the fact that the disease leaves scars. The patient was under treatment by phosphorus.

DR. BULKLEY then showed a case of

SUPPOSED GUMMOUS SYPHILIDE OF THE SKIN.

The disease had existed for seventeen years in the form of thickened deposits in the skin, which always remained superficial and discrete. They appeared from time to time, became excoriated or superficially ulcerated, and healed with cicatrization, leaving a scar. At present he has a number of these dark reddish spots, about the size of a ten-cent to a twenty-five cent piece, with well-marked inflammatory areola, scattered over his body, and found upon face, neck, legs, and buttocks. Upon the side of the neck there is a superficial ulcer. Numerous pigmented spots are also found where the lesions have been. The patient says that the disease is itchy.

DR. BRONSON saw no evidence of syphilis.

DR. KEYES said that there were certain suggestions of syphilis in the grouping of the rounded scars behind the ears, excepting that they were too shallow and bevelled.

DR. FOX observed that at a hasty glance the grouping of the lesions on the neck with the small, round cicatrices, and the occurrence of the lesions at the periphery of the patches, looked like syphilis. He would not, however, apply the term "gummatous."

DR. BULKLEY remarked that the course of the disease was a good deal influenced by specific treatment. When the patient took the medicine regularly, he always improved.

DR. BULKLEY presented a case of

CHRONIC LICHEN,

with the following history: Joseph D., æt. thirty-three, M. Has had the eruption for eighteen years. It first appeared on both knees in the form of a pustular eruption which lasted for one year. Next a scaly eruption appeared on the extensor surfaces of the joints, evidently of tuberculous character, which on disappearing left scars. Then came a crop of vesicles near the joints with a few upon the trunk, lasting about two years. Three years ago a crop of large boils came on the nates and the lower part of the back. Since that time the eruption has come and gone with varying intensity at different times, following the types mentioned till six weeks ago a rash like prickly heat appeared upon the trunk. It has always been very itchy, especially at night, keeping him awake, and is worse in the winter. His body is now covered with a coppery maculo-papular eruption, in places appearing in patches, at others in individual points, in some places resembling the excoriated points of scabies or lichen. It is rather more abundant anteriorly than posteriorly. On the arms and legs there are many small excoriated or crusted points. They increase in both directions towards the elbows and knees, and are principally upon the flexor surfaces. His hands, face, and feet are free.

The patient smokes and chews a great deal. His bowels are regular. He drinks about two pints of beer each day.

DR. BRONSON thought that this case belongs to that class of cases distinguished by hyperæsthesia of the skin, and would not call it lichen. In the way of treatment he would endeavor to relieve the neurotic condition, and in the first place he would stop the patient's wearing of red flannel.

DR. ALEXANDER considered the case to be one of papular eczema.

DR. WEISSE observed that an eruption lasting eighteen years must have some internal cause. As to irritation due to wearing flannel, it was the red dyed cotton flannel rather than dyed wool which caused the trouble.

DR. KEYES considered the case to be due to a neurosis, and in no way dependent upon the dye of the flannel.

DR. FOX said that these cases were quite common. He regarded it neither as a papular eczema nor as a lichen, but a neurosis. It is possible that the wearing of flannel irritated it, but the main cause was internal, and could not be cured until the neurosis was relieved.

DR. BULKLEY was sure it was not due to any external cause. The internal exciting cause was probably tobacco, as the patient was an inveterate smoker. There was present a marked urticarial element. He believed that lichen was a different disease from papular eczema.

Correspondence.

DERMATOLOGY AND SYPHILOGRAPHY IN FRANCE.

(From our Special Correspondent.)

THE NATURE OF LUPUS.

THE subject which at the present time most deeply interests French dermatologists is, without doubt, the question of the nature of lupus. Certainly, it is by no means a novelty since, for many years past, they have discussed it without being able to arrive at a solution of a problem so interesting in general pathology. Some regard it as an essential disease, others as one of the accidents resulting from hereditary syphilis, others again as one of the cutaneous manifestations of the scrofulous diathesis, while others, finally, look upon it as purely and simply a localized tuberculosis. But, it must be recognized that this question has become now, more than ever, the order of the day, and under an entirely different form, since we now possess for its solution efficient means of analysis heretofore unknown: the microscope, with the perfected processes which enable us to color the microbes, and experimentation by the cultivation of the microbes and their inoculation in series.

In 1881, apropos of the memorable discussion which took place in the *Société Médicale des Hôpitaux de Paris* upon the relations of scrofula and tuberculosis, certain partisans of the identity of these two diatheses considered lupus as a cutaneous manifestation of scrofula, thus tending to make of this affection a local tuberculosis.

M. le Dr. Vidal protested against this view, which was entirely erroneous in his opinion. He asserted that lupus is not tuberculosis; he had observed true tuberculosis of the skin and it is altogether different from lupus in its symptomatology. The same is true of tuberculosis of the mucous membranes which could not be confounded with lupus of these surfaces. The lupus ulceration is granulating, vegetating, indolent, slow in its evolution; while the tubercular ulcer is always quite painful, ragged, sinuous, surrounded by a crop of small yellowish tubercles; its progress is quite rapid and it is often accompanied with laryngeal tuberculosis, always with pulmonary tuberculosis. Lupus of the tongue is never seen, while tuberculosis of this organ is quite common.

The pathological anatomy of lupus has many points of analogy with that of tubercle, as Messrs. Vidal and Leloir have so well demonstrated in a communication made in 1882 to the *Société de Biologie*, but its identity is far from being complete; thus the giant cell and the follicle termed tubercular, are often found in lupus, but there have never been demonstrated, as in cutaneous tuberculosis, the characters of the miliary tubercle of Laennec. Lupus may be in process of evolution during several years in the same individual, without occasioning the slightest infection, the least tubercular adenitis, the least alteration of the general health. Practically it is never hereditary. Auspitz and Pick have inoculated it without success upon the patients themselves, as well as healthy subjects. Vidal has made numerous unsuccessful inoculations upon himself. Also the venerable physician of the Hospital St. Louis remains absolutely unshaken in his opinion as to the non-identity of lupus and tuberculosis. And we should add that his opinion carries immense weight, for without doubt he, of all French derma-

tologists, should be considered the most authoritative upon the subject of lupus, as he has had the largest practical experience.

Nevertheless, these views are now assailed by another of our most distinguished dermatologists, Dr. Besnier. In the endeavor to elucidate this difficult question, Dr. Leloir set himself to work to make inoculations and histological researches. Taking as a basis the results obtained by Koch, Cornil, Hippolyte Martin, who demonstrated that when a tubercular product is introduced into the peritoneal cavity it uniformly develops a peritoneal tuberculosis which rapidly becomes generalized, he said to himself, if lupus is really a local tuberculosis, one should obtain identical results, that is a peritoneal tuberculosis, in introducing fragments of lupus in the peritoneum of animals. This is what he has endeavored to do. He has very justly remarked in his first memoir upon the question (*Société de Biologie*, December 30, 1882) that it is necessary, in order to eliminate every cause of error, 1st, To be assured that the subject, from which one takes the fragments of lupus which are to serve in the experiments, is not the subject of tuberculosis of the lungs or other organs. 2d, To take a lupus in process of evolution which has not been treated. 3d, To not place the inoculated animals in contaminated cages or by the side of other tuberculous animals.

These are conditions quite difficult to fulfil, and we comprehend how difficult it may be to say, if a rabbit or a cobaye should become tuberculous from an intraperitoneal inoculation, whether they became so because the fragment inoculated was true tubercle or simply because the animal was predisposed to tuberculosis, because it had suffered a traumatism, because it became infected from another source than the experiment, or because it was shut up in the vitiated surroundings of the laboratory or hospital. . . . Thus we believe that every fact of negative inoculation should be regarded quite as probatory as a fact of positive inoculation.

Dr. Leloir has not confined himself to the attempt to inoculate lupus in animals, he has sought also (*V. Comptes Rendus de la Société de Biologie*, July 28, 1883) to find in lupus the microbe which, according to the researches of Koch and Baumgart, would appear to be the specific element of tubercle, and if the bacillus, admitting that it exists, would reproduce tubercle after culture. The results which our distinguished confrère has thus far obtained are far from being confirmatory. He has already sacrificed or lost ten cobayes which he inoculated with tubercular lupus, and among these ten cases he found seven animals perfectly free, two presented acute generalized military tuberculosis, and the third, two small military nodules in the spleen and three tubercular mesenteric ganglia.

Of four rabbits inoculated in the anterior chamber of the eye with tubercular lupus, one alone carries in the cornea a sort of neoplasm which developed around the point of inoculation. Finally, of two cobayes inoculated from erythematous acneiform lupus, one died of generalized acute military tuberculosis, the other is still quite well.

MM. Cornil and Leloir have made numerous histological examinations of lupus in twelve patients, in order to find the bacillus of tuberculosis; they have not found it except in a single case, and further they have discovered only a single bacillus! They explain, moreover, that the patient in question was tuberculous. They also affirm that if bacilli exist in lupus, they are extremely rare. M. Mallassez has never been able to find them. We are then quite far from the results obtained by Pfeiffer (*Berl. Klin. Wochens.*, July, 1883), by Doutrepoint (*Monatshefte für prakt. Dermatol.*, June, 1883), by Demme (*Berl. Klin. Wochens.*, No. 19,

1883), who found bacilli in large numbers. The first in a lupus of the conjunctiva, the second in seven cases of lupus of the face, the leg, and mucous membrane of the nose, the third in three other cases of lupus.

MM. Cornil and Leloir cannot refrain from comparing the result of their histological researches, of the great inconstancy of the success of their inoculations, and the long period which elapsed between the appearance of the tubercles and the date of the inoculation in positive cases, which does not happen when inoculation is made with true tuberculosis; so they conclude that if lupus is a local tuberculosis, it is in every case a very attenuated tuberculosis. It is quite evident that the foregoing results cannot yet decide the question; so we think it prudent to wait before pronouncing upon it positively. For our part, we could wish nothing better than to believe in the unicity of lupus and tuberculosis; but we should prefer to know of a large number of positive inoculations; we should prefer to have found in lupus, free from every superficial lesion, the bacilli which are now considered characteristic of tuberculosis. We should demand, finally, that the true bacillus of lupus be cultivated, and that, after cultivation, it should produce by inoculation true tubercle. We cannot forget, indeed, that there exists a bacillus in leprosy, precisely as in tuberculosis, and that these two micro-organisms are so similar that many authorities, notwithstanding the latest researches of Dr. Babes, regard them as being morphologically identical. There is, however, no pathologist who could possibly entertain the idea of identifying leprosy and tuberculosis. Why then should not lupus also have its special microbe? It will not then suffice to say that there are bacilli in lupus in order to prove that lupus is a local tuberculosis; it will be necessary to prove in addition that the bacilli of lupus react upon the organism in the same manner as the bacilli of true tuberculosis.

Dr. Besnier has recently published in the *Annales de Dermatologie et de Syphiligraphie*, August 29, 1883, a very important article upon this question. Already one of his pupils, Dr. Bonneau, had given, in an inaugural thèse (July, 1883), the ideas of his master in a historic exposition of the treatment of lupus. According to the eminent physician of the Hôpital St. Louis, lupus is a scrofulus lesion, a scrofuloderm, and, consequently, a local tuberculosis. A partisan of this idea, he endeavors to establish it, and combats the principal arguments of those who do not admit it. The non-heredity of lupus in his opinion proves nothing, since at the same epoch the heredity of tuberculosis is questioned. He recognizes that there are differences between lupus and true tuberculosis of the skin and mucous membranes from a symptomatic point of view, but he demands if the same disease may not take on quite different forms, and he finds, for example, that between acute miliary tuberculosis, simulating typhoid fever, and a slow phthisis there is at least as much difference as between lupus and tuberculosis of mucous membranes. Lupus, which is, in his opinion, quite probably a tuberculosis of accidental and extrinsic origin, developed in subjects lymphatic, but still quite vigorous, cannot have the same symptomatology as secondary tuberculosis of the skin or mucous surfaces, occurring in subjects already infected and debilitated.

Dr. Besnier endeavors to prove that lupus conduces to visceral tuberculosis, and that a general infection is imminent in those who are attacked. He shows that among thirty-eight lupus patients taken without selection among those he treated, eight were manifestly tuberculous. We may remark, however, that it would be quite strange not to encounter tubercular disease in lupus patients, even though lupus may not be a local tuberculosis. Such patients, are, indeed,

peculiarly predisposed to be infected ; their morale is quite impaired; they perceive that they are subject to an excessively chronic and obstinate disfiguring affection, which often obliges them to change their vocation and reduces them to misery; they live in a perpetual apprehension, dreading the aggravation of their disease, or the painful operations which they are compelled to undergo; they dare not go out, they remain confined during long years in habitations often unhealthy or in the wards of hospitals. Is it strange that they should not all escape contagion, especially when they have quitted their homes in order to be treated and have come to reside in the centres of infection, such as the hospitals or large cities ?

Dr. Besnier uses the experiments of Leloir as a basis for his conclusions as to the inoculability of lupus and its identity with tuberculosis; he claims that the investigations of Demme, of Dautrepoint, and of Pfeiffer have proven that the bacillus of tuberculosis exists in lupus, etc., but we shall not return to the observations we have already presented upon these different points.

The eminent dermatologist remarks that the special seat of lupus is upon uncovered parts, and that its development appears to be favored by any slight traumatism, pathological or accidental, of the skin and mucous membranes, which would seem to prove that it is primarily the product of inoculation. The lupus element comes then from without, and it is at first quite superficial; it may remain localized through life, but at other times, according to Besnier, it passes from the state of an indolent local tuberculosis to the state of an infecting tuberculosis, and leads to a fatal termination by causing a development of tubercles either in the lungs or in other organs of the economy. In his opinion, this general infection is facilitated by the bloody operations to which the lupus patient may be subjected: as he expresses it, *one may thus auto-inoculate the patient*, introducing into the blood-current the bacilli which, carried to a distant point, may give rise to the development of tubercles in the viscera. This theory of auto-inoculation will doubtless find many opponents, and, indeed, the arguments which may be opposed to it are quite numerous: first of all, the experimental fact that numbers of lupus patients treated by scarification are cured without the least accident, and, likewise, another fact of experience, that when a lupus patch is methodically scarified, the incision extends beyond its borders, consequently, if the lupus be auto-inoculable, the patch should always enlarge, while it is just the contrary that happens: it actually becomes smaller. However this may be, Besnier radically condemns the method of quadrillated linear scarifications, of scraping, and, in a word, every bloody operation on account of their possible fatality to the patient, and he proposes a new method, consisting of punctate or linear cauterization made with the thermo-cautery, or, better, with the galvano-cautery; a method which, according to him, does not present the same dangers of infection as the bloody operations, is more rapid in its effects, and gives equally good cicatrices.

Mathieu, of Paris, has constructed for him a number of small, quite ingenious instruments in the form of points and blades, which may be carried to any desired temperature by regulating a battery. A dull heat should be employed in order to avoid hemorrhage, and the projection of a false light upon the parts to be operated upon. It is necessary to pass one or two millimetres beyond the limits of the neoplasm. The surgeon employs punctures with the electro-caustic needle or scarifications with the galvano-caustic knife, according to the circumstances of the case. It is necessary to proceed carefully, to extinguish, so to speak, the heated point in the pathological tissue. The pain, which is quite

acute, ceases immediately after the operation, and local anæsthesia is not necessary. Most often there is not the slightest hemorrhage, and a subsequent dressing is not required. Still, in certain cases, there may be a slight bleeding which may be arrested by fine sponges, lint or compresses dipped in water. The following days the parts treated may be covered with the *emplastrum de Vigo*, cataplasms of starch, or bits of tarlatan dipped in starch or borated water. In about eight days the little dry eschars, consecutive to the action of the galvano-caustic, separate and fall, and beneath them are found minute depressions with a red and dry base. Sometimes, in the case of granulating, tumefied, ulcerated lupus, the eschar does not remain dry, and the cauterized surfaces soon become covered with yellowish crusts. The operations are repeated every eight days. The results obtained by Besnier have been so satisfactory that he considers this method as the most certain means of cure in all varieties of lupus, "and as the most rapid and inoffensive of all methods that may be applied to local tuberculoses."

BROcq.

PARIS.

Reviews.

DIE KRANKHAFTEN VERÄNDERUNGEN DER HAUT UND IHRER ANHANGSGEBILDE, mit ihren Beziehungen zu den Krankheiten des Gesamtorganismus dargestellt von DR. H. V. HEBRA, Docent an der Universität Wien. Braunschweig: Verlag von Frederick Wreden, 1884.

To one who years ago listened to the uncompromising, strictly objective teaching of Ferdinand Hebra, it is a pleasant thing to find, on taking up a work on skin diseases written by the son of that great man, that it is entitled "the morbid changes of the skin, and their relations to diseases of the general system." This feeling is, however, to a large extent, annulled on reading the book, and finding that the author attaches but little, if any more importance, to the morbid relations between the skin and the rest of the body than do other experts of the school of dermatology to which he belongs. In speaking of *acne vulgaris*, *e. g.*, he says that "the cause of the disease is the very great increase in the formation of epidermic substances such as occurs at puberty, with simultaneous swelling of the sub-epidermic connective tissue at the neck of the hair follicle." Not a word is said about the possible predisposing causes, such as anæmia, plethora, disorders of innervation, uterine or gastro-intestinal disturbances, external irritation, etc. Cases of *sycosis* are divided into three classes, due respectively to chronic nasal catarrh, previously existing eczema, and to unknown causes. Other illustrations of this want of consistency between the book and its title might be given.

Another respect in which this work might be said to fall short of the standard of a model text-book, is the superficial and hasty manner in which the all-important subject of therapeutics is handled, a poverty in resources being manifested which is surprising in one with so large a clinical experience behind him. In the preface the author alludes to the limited space allowed him by the publisher, and yet when we find that he has devoted nearly sixty pages to measles, scarlatina, variola, and vaccination, diseases which are more appropriately treated in

works on diseases of children, and a very respectable number to the anatomy and zoology of the various parasites which may affect the skin, one cannot help feeling that he might in this regard have made a better use of his space.

The classification followed is that of Auspitz, the reasons for adopting which are given at length in the extremely interesting chapter on "Systematik," with which the work opens. The description of each class of diseases is preceded by a separate introduction which furnishes the reader valuable assistance in grasping the point of resemblance between the different members of the group, in systematizing his knowledge of the subject, and in explaining the meaning of the various terms used, many of which will doubtless sound strange to one familiar only with the nomenclature hitherto in vogue.

A few unimportant adverse criticisms which occurred to the writer during a hurried perusal of the work may here be cited. From the definition given of eczema no one would imagine that the occurrence of moisture during its course is a striking characteristic of the disease. Allusion is casually made to the fact a number of pages further on.

Beginning ectropium of the lids is said to be the most common cause of eczema of the face in old people, a statement which is certainly not borne out by the cases which come under observation in this country at least.

In the section on prurigo it is stated that the papules, which have hitherto been usually regarded as characteristic of the affection, are of a purely inflammatory nature, entirely secondary to the scratching by the patient, and that they appear only very late in the course of the disease, which, in fact, is defined as a purely sensory neurosis.

Chrysarobin, which is so highly prized in this country and in England, is spoken of in a flippant, derogatory manner, the impression being given that it is, on the whole, a dangerous, not very efficient remedy, which had better be neglected. The author does not seem to be familiar with any of the various pigments of which it forms the chief ingredient, and by means of which the unpleasant effects of the drug may be almost entirely gotten rid of.

Impetigo contagiosa is dismissed with the statement that it is a bullous form of herpes tonsurans. This will scarcely meet with general acceptance.

In speaking of hypertrichosis, he mentions the "electrolytic" method of treatment "recommended by C. Heitzman, of New York." This passage, like several others in the book, evinces a lamentable want of familiarity with recent dermatological work in this country, which prevents him from giving credit where it belongs, to Michel, Hardaway, Piffard, Fox, and others. In this connection he makes the amusing admission that he had used the method only once, and that then it caused such extensive ulceration that he abandoned the instrument.

Dr. Denslow, who was the first to recommend the internal use of ergot in acne, is spoken of as "Legrand D'Eustache," and even then whatever credit is due him is divided with Heitzmann.

Space is wanting to give to the book the careful analytical review to which its many merits entitle it. Aside from its shortcomings in an etiological and therapeutical respect, it seems to contain a judicious, well-arranged representation of the latest doctrines of the most erudite school of modern dermatology in the world. About one hundred and ninety distinct diseases are treated of, including even œdema, myxœdema, and gangrene. It is an extremely interesting and learned work, far more instructive than the average text-book, and its pro-

duction reflects great credit upon the industry and scholarly attainments of its author, who, although doubtless more or less handicapped by the associations which cluster around the great name he bears, has worthily maintained its reputation.

The work is neatly printed on good paper, and contains a number of well executed new woodcuts.

Selections.

THE THEORY OF THE PERSPIRATION.

DURING the last few years astonishing progress has been made in this department of inquiry, especially as relates to the nerve-tracts which serve as exciters of the perspiration, so that a superficial observer might suppose it to be now completely explored and capable of direct pathological application. And yet, every student by whom this application has been attempted, is aware that even those familiar phenomena known as "cold sweat," and "dry heat" of the skin, are at this moment as inexplicable as they were ten years or a century ago, since they require the solution of problems which thus far have hardly been grappled with.

Medical opinion respecting the sources of human perspiration has been constantly alternating between two extreme conceptions. According to one of these, it is the product of special secretory organs, while the other regards it as derived in all its forms from a mere physical evaporation of transuded liquor sanguinis. This latter was the theory which universally prevailed until Malpighi's discovery of the sudoriferous glands. Under the influence of Haller, the physical hypothesis temporarily regained its sway, but more advanced anatomical knowledge caused the sensible perspiration to be again ascribed to the action of the sudoriferous glands; but as to the origin of the insensible perspiration opinion still remained divided, until the era of Krause's observations.

One of the chief services rendered by this inquirer was his clear demonstration (in 1844) of the fact that the deposition of sweat in drops upon the surface cannot possibly take place by evaporation through the epidermis; but that, on the other hand, watery vapor may make its way through the latter, as indeed it is constantly doing in large quantities. He found that sweat is also formed by the precipitation and condensation of this transuded vapor, but that the amount thus produced is exceedingly small when compared with that which he supposed to arise from direct action of the glands, and which, moreover, may itself likewise be recondensed and returned to the surface after evaporation.

But the question arises, why did Krause and his contemporaries, and why do we, assume that the sensible perspiration is produced solely by the sudoriferous glands? Only one reason can be given, and this is founded on the familiar fact that on the palm of the hand drops of sweat can be seen by the naked eye issuing from minute funnel-shaped pores, and that these pores are the terminations of the excretory ducts of the sudoriferous glands. But though this is true, it does not necessarily follow that the secreted fluid must always proceed from the convolutions of the sudoriferous glands and from them alone. On the contrary, it is shown

by the latest anatomical researches into the subject that the tissue-juice which circulates freely in the space included between the spinous cells and the granular layer, easily passes over, under the pressure caused by its accumulation at this level, into the lumen of the excretory duct, and coming out at the above-mentioned pores of the epidermis, is readily mistaken for a glandular secretion.

Questions like this, however, would be of little consequence, if the common supposition that perspiration is the product solely of the contorted tubes of the sudoriferous glands could be brought into harmony with all the other facts of the case, or even if it had never been seriously controverted.

But Krause's views soon met with a powerful opposition. George Meissner, in 1856, contended that the actual perspiratory function—the production of sweat—belongs not to the contorted tubes of the sudoriferous glands, but to the entire papillary body. Meissner founded his position upon the following facts: 1, that all sudoriferous glands periodically contain fat; 2, that the axillary and ceruminous glands, which are histologically most closely allied to the sudoriferous glands, specially and constantly secrete fatty substances; 3, that in the lower animals structures precisely similar to the sudoriferous glands are evidently designed for the lubrication of the skin. As the matter now stands, no one has yet succeeded in tracing the passage of water from the fundus of a sudoriferous gland to the surface through its excretory duct, as has actually been done in the case of the fatty secretion.

As already stated, then, the only foundation which is left for the current theory is the simple fact that drops of sweat can be seen emerging upon the skin, and this, it has been shown, is entirely inconclusive.

Meissner is not alone in the maintenance of this view. Kölliker, in 1855, came to a like conclusion as to the similarity in structure and function, between the sudoriferous and the axillary glands. In a case of so-called *ichthyosis congenita* he found the canals of the former completely filled with white fat. My own observations have led me to a unitary conception of the convoluted glands of the human skin. Like Kölliker, I find that, taken together, and including the smallest and most rudimentary glands of the trunk, those of the palm and sole, and the anal, papillary, axillary and ceruminous glands, they exhibited an uninterrupted and almost imperceptibly graded ascent in the scale of development. Their special constituents, *viz.*, *fatty drops, pigment-granules, and the mucous, shining debris of cells*, are those which are found in every drop of sweat when freshly exuded upon the palm of the hand. In the sudoriferous glands, as in many of the salivary glands, two different kinds of secretion appear to be formed, dependent, probably, upon different conditions of the organs, according as they are acting after rest, or in a state of partial exhaustion from fatigue. The clear, glassy kind of secretion produced under ordinary circumstances is quite different from the profuse, watery sweat called forth by a vapor-bath, or by pilocarpin.

Evidence of another kind has been adduced from *the distribution of the sudoriferous glands in the human body, when compared with that of the most easily perspiring localities*. But the facts in this case are not favorable to the popular theory. The face, the throat, and the back of the neck sweat very easily, the palms of the hands much less so (except in the subjects of hyperidrosis manuum). Yet (according to Krause) the last-named region contains 2,716 sudoriferous glands to the square inch; the neck (front and side), only 1,303; the forehead, 1,258; the cheeks, 548; and the back of the neck, only 417.

The axillæ and the perineum are the only places where both these conditions—an abundant supply of sudoriferous glands, and profuse and easy perspiration—are found to co-exist. But here another factor comes into account—the *warmth produced by surfaces in continuous contact*—which deprives these in stances of their importance. As to the idea that an abundance of sudoriferous glands may be connected with a *thickness and consequent dryness of the epidermis* in particular parts, it is one that has a seeming probability only with regard to the plantar surfaces of the hand and feet. The very reverse is what generally obtains; the thickened epidermis of the back and of the anterior portion of all the limbs coincides with a small number of sudoriferous glands, while the thinner investment of the breast, abdomen, and posterior portion of the limbs is accompanied by a much larger supply of those organs. On this point, it is sufficient to remark that if it be considered with reference to the latest scientific doctrine of human development, we shall find that *the favorite localities of the sudoriferous glands are the contact-surfaces of the body*, in the widest sense of this term. By *contact-surfaces*, I mean the soles of the feet, the posterior aspects of the limbs, the bends of the joints, the cleft of the anus, the genital and mammary regions, and, finally, the folds of the groins, the breast, abdomen, and palms of the hands, although these last are no longer in constant contact with other surfaces. All these surfaces require, on the one hand, to be kept well lubricated, and, on the other, represent so many places for the production and storing up of certain odoriferous materials which discharge a more important office in the economy of the inferior species than in that of man. I regard the collections of convoluted glands in the human axillæ as surviving representatives of similar scent-producing and lubricating organs extensively met with throughout the animal kingdom at large. The predominant fatty and pigmentary contents of the ceruminous glands may also be looked upon as resulting from a functional modification induced by their having remained in a state of permanent repose—of freedom from all disturbing nervous influences—a state which is likewise caused by senile involution even of ordinary small sudoriferous glands, since, under this condition, we find the epithelium of the latter stuffed full of fatty and pigmentary granules.

If it cannot at present be positively proved that the convolutions of the sudoriferous glands furnish fatty and odoriferous materials as special constituents of their secretion, we shall, at least, not err in regarding them as the source of the fatty acids to which the sweat owes its *acid reaction*. Trumpy and Vuchsinger have lately endeavored to show that the doctrine of the essentially acid reaction of the perspiration is incorrect, and that this effect is due to a mixture of decomposed secretion from the sebaceous glands; *the normal reaction of pure sweat*, they contend, *is alkaline*. But this, in my opinion, is putting altogether too much on the sebaceous glands, and is physiologically untenable.

A large number of experiments on both healthy and morbid perspiration have yielded varying results as regards this condition. Sweat produced by pilocarpin after a thorough cleansing of the skin from oily deposits was at first neutral, but soon changed to alkaline. In a case of tic douloureux, accompanied by long-lasting perspiration confined to the right half of the entire body, I found the reaction, in numerous trials, after careful drying of the skin, to be acid, neutral, and alkaline, in confused alternation.

Anatomy and chemistry being thus seen to be unfavorable to the derivation of the sensible perspiration from the sudoriferous glands, let us now consider the

testimony of physiology. All authorities have concurred in ascribing to *nervous influence* a direct and important share in the excitement of all kinds of perspiration. It would have been attempted to compensate for the absence of special nerves of the sudoriferous glands by vaso-motor action, had it not been observed that the perspiratory secretion was still maintained in a part which had been completely cut off from the general circulation. This surprising fact, however, seems to me to prove no more than that this secretion is entirely independent of the pressure and velocity of the blood-current. I cannot admit that *the occurrence of sweat has no connection with the circulation in any case*. Even supposing a limb in which the phenomenon in question was displayed had been *absolutely deprived of blood and lymph* after amputation with the Esmarch bandage, still I should first have to be converted to a belief in the existence of genuine secretory nerves, which would make it possible for *perspiratory fluid to be produced from the epithelium of the glands*. Until then, I prefer to believe that the surviving glandular epithelium was left, after amputation, floating in a sufficiency of lymph to permit a maintenance of the secretion, under maximal irritation, for a considerable period. Luchsinger does not assert in this connection what Haidenhein supposed to be the case with the epithelium of the salivary glands, viz., that the cells themselves are induced to secrete by nervous irritation. Yet only on this assumption is it possible to explain the production of sweat by the agency of the vaso-motors

Hörschelmann and Ranvier's investigations have resulted in the discovery of smooth muscular fibres between the tunica propria and the epithelium of the sudoriferous glands. Hitherto, no special office has been assigned to these fibres. I believe that they are intended to maintain a greater or less degree of tension of the glands, which tension more or less compresses the glandular epithelium. Under slight tension, the lymph-current washes out from the glands a secretion poorer in organic products; under strong tension, one laden with such products, and even with cellular substance. "Clammy sweat" is that which is secreted under maximal compression by the glandular elements, and, since energetic co-operation on the part of the sympathetic is requisite for such compression, it is not surprising that during the effusion of this sort of sweat the blood-vessels of the skin contract, and the mucous membranes become pale.

To this extent, therefore, I admit a considerable and quite specific participation of the epithelium of the convoluted glands in the production of certain kinds of sweat. But I cannot grant that *every sort of perspiration must be accounted for* in the same way. I consider it as yet an open question, to be decided by future investigators, whether the *profuse, watery, and long-continued sweats* caused by vapor-baths and those produced by pilocarpin should not be regarded as derived from the capillaries of the excretory ducts, or of the papillary body. These sweats are especially combined with a superficial cutaneous hyperæmia; they are promoted by a degree of heat which leads to vascular relaxation; in them, the activity of the sympathetic is diminished, and that of the vaso-motors brought prominently into play.

I believe that this supposition of the *participation of different organs in the perspiratory function* affords the only satisfactory explanation of all the various kinds of hydrosis, while not excluding the co-operation of other influences; on the contrary, it is physically necessary, in carrying out the theory, to suppose that an especially powerful flow from one of the sources of sweat sustains and promotes that which may be furnished by another, since in all cases the secre-

tion is poured forth upon the surface through the same capillary channels. Above all, it provides an easy solution of that primary puzzle, *cold sweat*, and even of clammy sweat; the increased alkalinity of forced sweats is accounted for by exhaustion of the glandular constituents, leaving behind the epidermal; long-continued repose of the glandular epithelium permits a ripening of its specific products—fat and pigment—which are plentifully supplied to the perspiration. The problem presented by a *dry, hot skin* is the only one which remains unsolved. Here, pathological observations must come to our aid, and we are fortunate in being able to avail ourselves of Bouveret's copious and carefully-arranged monograph on the subject of Morbid Perspiration (Paris, 1880). I have more particularly in view his *position that hyperhidrosis* is, almost to a certainty, connected, on the one hand, with *irritation of the cerebro-spinal nerves*, and, on the other, with *paralysis of the sympathetic*. Every case of excessive perspiration of peripheral origin may undoubtedly be traced to one or the other of these causes, although it is well known that the converse does not universally obtain, *i. e.*, cerebro-spinal irritation or paralysis of the sympathetic is not uniformly accompanied by sweating, but is often associated with anhidrosis.

Although the connection between the above-mentioned phenomena is firmly established, yet conditions necessarily arise which render them in many cases inoperative, and these conditions are not yet precisely determined.

The sweat-producing influences proceeding from the *nervous centres* are involved in still greater obscurity than those which operate peripherally. Experiments on the lower animals have given no results which can be brought into correspondence with pathological facts. But these latter sometimes affords us hints which partially compensate for the lack of precise physiological indications. Thus, if it be asked, Are the profuse sweats which occur so often in the course of acute meningitis signs of an irritation or of a depression of the cerebral forces? we may reply that it is *not irritation*, but *inactivity of the brain* which, as in the cases of sleep and coma, causes the disposition to perspire.

As to the relations between circulatory and secretory influences in the production of sweat, the real problem here is to determine the causes of their *complete disconnection*, as it is sometimes observed in diseased conditions, while yet, generally, hyperæmia and perspiration go hand in hand. The most familiar example of this disconnection is exhibited in *intermittent fever*; but, furthermore, all such disorders as pyæmia and other fevers from absorption, in which the bodily temperature rises and falls with great abruptness, belong to the same category. In them, the skin, at the height of the pyrexia, is hot, turgescient, and strongly hyperæmic, but absolutely dry; it only begins to sweat at the approach of defervescence, and perspires the more freely the more rapidly the fever declines. We find this symptom (outbreak of sweat accompanying defervescence), in a less pronounced degree, in the most-varied forms of fever. Conversely, there is a well-marked correspondence between high fever, heat of the skin, and vascular congestion on the one hand, and the formation of sweat on the other, in those more continued, slowly rising and falling, slightly remitting catarrhal fevers, of which acute articular rheumatism is the type. Here there takes place, owing to the constant connection between fever and transpiration, a considerable reaction of the latter upon all the symptoms of the former, which imparts to these disorders their well-known and peculiar character. I believe that the essential difference between the two kinds of fever lies in the fact that the skin is *heated very rapidly* in the first, and *much more slowly* in the second. By noticing these fea-

tures, we obtain an important analogy with certain skin diseases, in which a similar observation may be easily made. In exanthematous affections where local cutaneous hyperæmia appears on an inflammatory basis, as particularly in erysipelas, no sweat occurs until defervescence of the affected portions of the skin sets in, and after the return of heat it is again completely absent. The same has long been known to be true of scarlatina. In both these diseases, the general hyperpyrexia, of course, considerably increases the heat of the skin induced by the local inflammatory process. Aubert has found that in many simple erythemata the perspiratory function is not affected, or is affected in the direction of hyperhidrosis; while, on the contrary, many of the most superficial inflammatory processes are connected with anhidrosis. It is very probable that the *overheating of the skin*, or of certain of its elements, which takes place in quickly-rising fevers accompanied by cutaneous inflammations, is what prevents the usual increase of sweat by heat. This effect I conceive to be brought about by means of a third factor, hitherto unnoticed, viz., *the expansion of the epidermis by heat*.

This expansion is familiarly exemplified by the corrugated condition of the hands which is caused by immersing them in hot water, but still more unequivocally by the rapid formation of blisters under the application of dry heat. This would be impossible, did not the momentary overheating of the surface give rise to a sudden and considerable increase in the volume of the epidermis. In the case of blistering from a burn, the *very high degree* of heat at once destroys the *elasticity* of the epidermis—just as, by heating a piece of whalebone, we can cause it to assume permanently any shape desired. Under a lower temperature, as that of a merely warm hand-bath, the epidermis retains its elasticity, and on cooling off, at once returns to its former dimensions. Now there is a point within the epidermis at which the effect of an increase in its volume is greater than at any other—and this is *the fissure-like opening formed by the passage of the spiral canal of the sudoriferous gland through the basal epidermis*—Oehl's stratum lucidum. It must very easily happen, whether through a swelling of the epidermis caused by long soaking, as in chronic eczema, etc., or through its rapid overheating and expansion, that first of all this narrow slit in the stratum lucidum contracts until it becomes impermeable. This alone will account for the dryness of the skin in scarlatina and erysipelas, and in rapidly-rising fevers; and the fact that contemporaneously with the subsidence of the local affection in the first-named diseases, and with the decrease of fever in the latter, sweat again makes its appearance, is evidence to the same effect. Thus also we can explain the formation of blisters and vesicles on erythematous places, at the height of these complaints (scarlatina miliaris and pemphigoidea, erysipelas bullosum and vesiculosum). All those eruptions denominated miliaria or sudamina, which have hitherto been the subjects of such conflicting opinions in regard to their etiology, may be similarly accounted for, and this leads me to the final topic of the present discussion, viz., *the effect which altered ideas respecting the sources of the perspiration must have upon our judgment of certain skin diseases*.

First, as to the *sudamina* (which I regard as identical with *miliaria alba* and *rubra*), it is known that they do not originate from the sweat after it is effused upon the skin, but that they make their appearance suddenly, over large extents of surface, along with a profuse outbreak of perspiration. They correspond not to the sweat pores alone, but occupy portions of the spaces between them, often become confluent, and moreover clearly display a hyperæmia of the papillary body. He

who derives the sweat from the sudoriferous glands alone, must concede, with Hebra, from the spread of this eruption over every part of the surface, a general participation of the papillary body in its production. But to him who recognizes the important share which the latter takes in the normal play of the transpiratory function, sudamina are only the necessary result of profuse perspiration accompanied by great heat of the skin, and partial or complete closure of the sweat pores, a conception which on clinical grounds certainly deserves the preference.

Miliaria crystallina, on the other hand, consist of cysts formed in the spiral canal of the sudoriferous glands, and situated quite superficially in the epidermis. They do not coalesce, arise without over-heating of the skin, and are due, not to a swelling up of the pores of the stratum lucidum, since they are located above them, but to an occlusion, however caused, of the external apertures of the excretory ducts. So slight is the inflammation accompanying them that the papillary body takes no part in the morbid process.

So also, with respect to certain local hyperhidroses, especially *excessive perspiration of the feet*, nothing would be more wonderful than that we can cure this unpleasant affection so easily by astringent remedies (alum, tannin, salicylic acid), or anti-eczematous applications (Hebra's ointment, powders for sprinkling), if it were actually a disease of the contorted sudoriferous glands buried deep in subcutaneous fat; and no explanation is simpler than that which makes it consist essentially in a certain penetrability, as yet imperfectly understood, of the spinous layer by the normal tissue juice, whereby, even though appearing on the healthy epidermis, it closely approximates to eczema.

I venture to predict no slight revolution of ideas in relation to diseases of the sebaceous glands, especially the so-called *seborrhœa*. We are accustomed to attribute excessive lubrication of the skin to the action of the sebaceous glands. I can here only express my conviction that the oily, as well as the dry form of seborrhœa has nothing to do with the sebaceous glands. The former exhibits a pure hypersecretion of the sudoriferous glands, the latter a superficial catarrh of the skin, with formation of scales, which are more or less lubricated by the normal secretion of the same glands.

In *acne*, which essentially depends upon a pure keratosis confined to certain regions of the skin, the excretory ducts of the sebaceous glands are attacked by excessive cornification; the secretion of these glands is demonstrably inclosed in sacs between the horny lamellæ, and yet the skin is always well lubricated, never brittle or eczematous. It is lubricated from beneath by the sudoriferous glands—a function which these glands would still be able to fulfil even if, as is frequently the case in acne, all the sweat-pores between the outermost horny layers were likewise obliterated. Every freshly-caught sweat-drop which contains fat, but is without large epithelial cells undergoing fatty degeneration, must be derived, not from the sebaceous, but from the sudoriferous glands.

I believe I have now proved that the conception of the secretion of sweat as a process confined to the glands must be abandoned in favor of a theory more complicated indeed, but more in accordance with actual relations—the theory, namely, that various organs take part in the performance of the perspiratory function.—P. G. UNNA, *Schmidt's Jahrbücher*, vol. cxciv., part. 1, '82.

A SPECIES OF GRANULAR CELLS (EHRlich'S MASTZELLEN), AND ITS RELATIONS TO SYPHILIS, LUPUS, RHINO- SCLEROMA AND LEPRO.

WHILE studying the effect of aniline dyes upon cells, Ehrlich found a species of the latter which was acted upon only by particular colors. These cells retained their normal constitution, and were chiefly met with around the blood-vessels, and the circulatory organs in general, of parts which were apparently in a state of exaggerated nutrition. They were most numerous in certain diseases associated with the latter condition, and on this account were called by Ehrlich "Mastzellen." [I do not coincide with this view, believing that the cells in question bear an active part in the development of blood-vessels.]

These cells have quite a peculiar appearance; they are larger than (sometimes twice the size of) the migratory cells, but their arrangement is almost the same as that of the latter, especially around the blood-vessels, and occasionally at a considerable distance from them, among the connective tissue-fibres, *e. g.*, within the substance of the derma. They penetrate also among the papillæ. They exhibit a great variety of forms—rounded and elongated—and sometimes send forth prolongations resembling those of the pigmentary cells—in the meninges, for example. They were mostly colored by the purple of methyl 1 B, it being very difficult to demonstrate them with the aid of any other colors employed in histology. The nuclei of these cells are very slightly tinged, when compared with their protoplasm. This latter consists of a great number of rounded or somewhat oblong granules, uniform in size and closely aggregated. It is a peculiarity of these cells that they are not strictly confined to particular localities, and the same is the case with the granules of which they are substantially composed. Small round granules, well defined by aniline-purple, are sometimes met with outside the cells. Similarly, when the cell itself has ceased to exist, its place is often found to be occupied by a mass of such granules.

The best method of coloring these elements is to treat the tissues for twenty-hours with a concentrated watery solution of 1 B purple (manufactured at Basle), and preserved in Canada balsam. In this way the granules of the granular cells are colored a deep purple-red, while the other tissues present a lighter hue. The granules have a diameter of about μ 0.2; they are somewhat brilliant, and are but slightly affected by acids or alkalis. While investigating these cells, which occupy healthy tissues, I was struck by the close resemblance which their granular contents bear to the so-called "microbes." In consequence, when reading about the rounded elements found in cells in various contagious diseases, and regarded as the organism in which those diseases originate, I have asked myself whether these microbes were really anything more than granules of protoplasm belonging to granular cells. Such microbes have been described for the most part in connection with syphilis, lupus, rhinoscleroma, and lepra.

Birch-Hirschfeld has described a microbe of syphilis. He claims to have detected it in syphilitic products in the granulations and around the syphilitic embryonic tissue, as an inhabitant of certain cells. According to him, these cells, when thus infected, are filled with microbes, that is, with very short rods, like micrococci, which cannot be individually distinguished, and which are sometimes found also outside the cells. While examining, in M. Cornil's laboratory, a large number of recent syphilitic products, most of them freshly taken from living subjects, I could never discover any microbes, but almost always

found granular cells, with their granules colored as above described, and presenting the same arrangement as Birch-Hirschfeld's organisms. Hence there can be no doubt that this observer's interpretation of the phenomena is a mistaken one. I believe that syphilis is caused by a parasite, but as yet we have found no means of demonstrating the fact.—V. BABÈS, *Le Progrès Médical*, June 9, 1883.

EXPERIMENTS IN THE USE OF NAPHTHOL FOR THE TREATMENT OF SKIN DISEASES.

THE author finds naphthol one of the most efficient and agreeable remedies for *scabies* which has yet been brought forward. Both in the rapidity of its action, and in its beneficial effects upon the inflamed skin it is superior to any of the means ordinarily employed for the cure of this disease. Its exact place in dermic therapeutics remains to be ascertained, but he is inclined to think that it will not prove an unimportant one.

In eczema it has failed in his hands to give the same beneficial results as were obtained by Kaposi. In most cases of vesicular and in acute eczema generally its action is simply that of an irritant. On the other hand, it has a limited field of action in the cure of a certain number of cases of squamous eczema of the scalp.

In his opinion it is a valuable addition to our external means of treatment in *psoriasis*. Kaposi speaks well of it in *psoriasis* of the scalp in particular, and his experience would lead him to place it near chrysarobin and pyrogallic acid in effectiveness without the neutralizing disadvantages of either these drugs.

In *seborrhœa* of the scalp naphthol is a decided addition to our means of treatment. While inferior in some respects to sulphur or carbolic acid, it has a certain range of usefulness which further experience will in all probability more exactly demonstrate.

Naphthol is highly lauded by Kaposi in the treatment of *hyperidrosis*, but in the author's hands it has failed entirely, although used strictly according to his formulæ. He considers it quite valueless in this disease, so far as his experience goes.

His experience leads him to regard its effects in *ringworm* as inferior to almost all of the remedies at present used, and as almost entirely inefficient in most cases of *tinea versicolor*.

In *pediculosis* he has had no experience, but in a single case of *pediculosis capitis* its action was favorable.—VAN HARLINGEN, *Am. Jl. Med. Science*, October, 1883.

Item.

THE SYHILITIC MONKEY.—The monkey inoculated by M. Martineau with syphilitic virus developed chancres twenty-eight days after inoculation. These were followed by papulo-erosive and diphtheroid lesions of the penis, inguinal, axillary, and sub-maxillary adenitis, and loss of flesh. Later there were patches of alopecia on the head and back, and about ten months after the infection ulceration of the mucous membrane of the palatine vault.—*Lyon Médical*, December 23, 1883.

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THE "ALLIGATOR BOY"—A CASE OF ICHTHYOSIS.

BY

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AT the present time, when medical schools of various sorts are becoming so surprisingly numerous and prominent, a plea might be made for two modest, though well-established institutions which furnish exceptional facilities for post-graduate instruction. I refer to the "Dime Museum" of our cities and its provincial analogue, the itinerant "Side Show." For ease of admission, short curriculum, moderate fees, and unique advantages, these institutions stand unrivalled, and nowhere else could one enjoy the privilege of inspecting such rare dermatological curiosities as are exhibited in these halls of learning. Witness the bearded woman, the tattooed Greek, the African leopard-boy, the elastic-skin man, and the ichthyosauric youth who is the subject of the present sketch.

A year ago, I had the opportunity of presenting this child at the Skin Clinic of the College of Physicians and Surgeons, and at this time made the following brief notes.

At birth the child weighed four and one-half pounds and presented an ichthyotic condition which has since increased in severity. When about a year old, the frontal epidermis split vertically in the centre of the forehead and was cast off in two lateral pieces. The hands, at this time, "looked like those of a ninety-year-old man." The boy had never had any of the acute exanthemata, or severe illness of any sort, and, in spite of the fact of his spending most of his time in the close atmosphere of the

show room, he was said to be far less delicate than one would judge from his appearance. The muscles of the lower extremities were not at all developed, and he was scarcely able to stand alone. By means of his arms, he would creep across the floor quite readily, and, according to the father's statement, could not only swim like his namesake, but had an uncontrollable desire to get into the water whenever an opportunity offered. He had a good appetite and was especially fond of fish, oysters, and the whites of eggs. He liked fruit, but ate no meat, and I was assured that his bowels rarely moved oftener than once in two weeks.

The eruption, contrary to the rule in ichthyosis, was most marked upon the trunk, the epidermis being broken, by the movements of the body, into polygonal horny plates of varying size and of a dirty yellowish hue. In the intervening fissures, the pinkish color of the deeper skin was apparent. The scalp and forehead were also affected in a marked degree. The rest of the face was free from scales, save a slight mealy condition around the nose and mouth, and the cheeks were as smooth and soft as those of any child. The arms were but slightly affected, and the forearms, especially upon the extensor aspect, were almost natural in appearance. The legs also were almost free from scales. The parents stated that in winter the skin upon the trunk was smooth, though horny in character. In the spring, this horny integument was wont to crack and present the characteristic "alligator" appearance, while the hair of the head was almost entirely shed. In the summer, the scales would gradually lessen and the skin become much softer, though by no means normal.

This boy was born in Montreal, in May, 1879, and Dr. F. Kennedy, who officiated at his *début*, has kindly furnished me with the following information. The mother was a primipara, and claimed that it was impossible for her to have been more than eight months pregnant at the birth of the child. At four and one-half months (according to her statement to me), she was frightened at the sight of an alligator, and, a few weeks later, by seeing a dog in a fit. A tedious and irregular labor was followed by natural delivery. At birth, the child presented a most extraordinary appearance. The skin was thickly covered with vernix caseosa, and, when washed, the surface was as smooth as if polished, and of a deep red color. In fact, the surface had the appearance of being thickly varnished. There were very few fissures noticeable, and so strong was the coating that it was impossible for the child to make use of its facial muscles in its efforts to cry or suck. Its limbs were also restricted in their movements. After a few days, fissures occurred more especially along the facial lines. On the forehead were two large scales separated along the median line. On the eyelids, cheeks, and around the mouth, armor-like scales were formed. On the back the scales were very thick. There was no healthy skin, as the whole surface was more or less covered

with scales. The skin was thoroughly smeared with cod-liver oil, and the same, with iodide of iron, was given internally. Under this treatment, considerable improvement was obtained. About the second week the scales loosened and peeled off, and, about the fifth week, the skin, with the exception of the face, had become soft and pliable, though still of a deep red color and shiny. The parents and child left the city at this time. Both parents were seemingly in good health, and no history could be obtained which had any bearing upon the case.

ON THE TREATMENT OF STRUMO-DERMA.

BY

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London, England.

(From a paper read before the Willan Society, January 3d.)

UP to the present time, the internal or constitutional treatment of strumo-derma has, to the best of my knowledge, been limited to the employment of tonics such as quinine, iron, and mineral acids, the latter being usually given in combination with bitters; of medicines containing iodine in some form; and of antacid absorbents such as liquor potassæ, lime water, and muriate of lime. Some years ago a gentleman, lecturing on strumous affections of the skin, stated, in my own hearing, that the remedies for the complaint consisted of the tonics I have just mentioned, supplemented by cod-liver oil, nutritious diet, stout, and, when they could be procured, port wine, jelly, and milk.

It is more than twenty years since I last used these things in the treatment of strumo-derma, but in my early days I constantly employed them, and I may as well say at once, with one unvarying result, that of complete failure. What may have really been the success of others generally with these means I am unable to say, as no machinery exists for determining such a point. I have never read in any book or heard in conversation a single statement as to whether such treatment succeeds invariably, only occasionally, or in reality not at all. Everywhere and continually I met with the information that this is the system to be pursued, which I presume means that it is the best, but what the intrinsic value of that best is I totally failed to learn. The word being used in the superlative, I suppose we are to understand that the method is, at the lowest valuation, assumed to be several degrees better than nothing; whereas my own researches would lead me to believe that it is at least quite as much worse, seeing that while it does not contribute one atom towards the cure, it

fritters away time, money, and patience, so that the formula for it ought to be nothing plus waste.

I will take the items a little more in detail. From the employment of quinine I have never seen the least good, either in this or any other disease of the skin. Sometimes the appetite gets rather keener while the alkaloid is being administered, but generally it needs no improving, and when the improvement has been effected, the patient is not a whit nearer being cured. We are told to give iron when there is anæmia, but not unfrequently the patient is the opposite of anæmie, as was evidently the case with one of those I had the honor to show you at the last meeting; and the use, for years, of every preparation of steel which I have seen tried, constantly fails to relieve in any noticeable degree the bloodlessness of strumo-derma. Of acids I have given the nitric, nitro-hydrochloric, sulphuric, and phosphoric, and I believe there is not a pin to choose between them, for the simple reason that they are equally useless. In short, I see no choice but to conclude that the whole system is a mistake; a piece of that idolatrous credulous superstition under which medicine has so long suffered, and that it would be no great loss to therapeutics, if it were despatched on the road taken by so many long forgotten creeds. It may possess some amount of curative power which I have, for want of care, failed to notice; but after what I have noticed, I should as soon think of putting faith in some of Pliny's old remedies, the "blood of a weazill" for instance, or "a wasp hanged about the neck."

At one time I tried Lugol's treatment very carefully, and always kept his book at hand for reference. The formulæ were made up exactly as he directs, but I observed no effect whatever from their employment, and the patients, one and all, got tired of a method which even they could see was inert. In justice to Lugol, however, it must be remembered that his system deals almost exclusively with glandular struma, which, as regards practical therapeutics, differs in some degree from serofulo-derma. Cod-liver oil proved quite as useless as iodine; even Dr. Yongh's oil, which answers so very well in some diseases of the skin, showed itself powerless here. Mr. Chalk, who was one of the first to use this remedy in England, told me that the only oil to be relied on in this complaint is that which is simply expressed from the liver of the fish and used without any purification; but as I have been unable to procure it in this state, I can say nothing about the matter.

The alkaline absorbents are possibly a shade more potent; at any rate I have once or twice thought that I noticed a feeble glimmering of effect from the use of muriate of lime, and one of the best modern physicians speaks highly in its favor. But it is neither sure nor speedy in its operation, and that means having a very weak staff to trust to. Phosphate of

lime, wheat phosphates, hydrate of lime, and Parrish's food answered no better.

As to the external treatment, the difficulty is to make out, not what it comprises, but what it does not comprise. Stimulant, digestive, sedative, alterative, emollient, and astringent applications turn up in such crowds that the bare mention of their names would take up far more space than I can spare for the whole subject. I suppose they are all good and of equal virtue; certainly I never tried to find out whether one was better than another, because I thought it sheer waste of time to do so; for had any one of them possessed superior curative power, it would before this have reached the front rank, as has always happened with remedies which can really stand the sharp test of experience.

When I come to the question of diet, I get into doubt as to whether I ought to trust the evidence of my own senses. Men of unquestionable candor and ability say they have seen good done in these cases by giving bottled stout, port wine, rump steaks, meat three times a day, jellies, strong soups, and so on; whereas the effects of such diet, in the cases which I saw, were feverishness, coated tongue, constipation, headache and loss of appetite, while the disease was either not benefited or was exasperated.

The system, which has been pursued in my own department of this hospital ever since the first patient with strumo-derma entered it, is just as opposed to the tonic treatment as an opposite can well be, for it consists in the unsparing use of purgatives and the enforcement of a light diet. The purgatives employed are calomel and salines. A dose of the former, alone or with a little gray powder, is given two or three times a week at bedtime for a fortnight, after which it is withheld for two, three, or four weeks, the longer intervals being observed in cold weather; the saline is taken every morning, both being prescribed in such doses as will insure, conjointly, daily free action of the bowels. Beyond this nothing is done as regards the strumo-derma. If the appetite fall off, nitro-hydrochloric acid can be given with some bitter infusion, and occasionally towards the close a patient derives benefit from the acid solution of iron used at the hospital. As an outward application anything which promotes the patient's comfort will do; consequently this part of the course is generally restricted to water dressing and zinc ointment. So soon as the surface is healed, blistering fluid may be applied to hasten the filling up of the depressions left behind. A light unstimulating diet is ordered, and beer, brandied wines, coarse spirits, and over-free use of butcher's meat are forbidden.

The results of the treatment may, I think, be spoken of as most satisfactory. Among the medical practitioners who have at one time or other visited the hospital, several have expressed their surprise at the

control which these remedies manifestly exerted over the complaint. Strumo-derma, it will perhaps be said, always heals in the end under any system of treatment, and this may be the real secret of the success obtained; the suggestion will not hold water here. Many of the patients had been getting worse for years, and yet began to mend within a short time after the commencement of the treatment. This was distinctly the case with both of the girls whom I had the honor to bring under your notice at the last meeting. The result is too uniform and the cases are too numerous to leave very much room for self-deception. The number of strumo-derma cases entered in the books of the hospital in my department, up to the 22d of March, 1883, is, as a reference to the books themselves will show, eighty-two. All these were treated in the same way, and so far as could be ascertained, with favorable results wherever the treatment had fair play. But I need scarcely say that it is extremely difficult to secure fair play, or get at precise results in such cases; irrespective of many other causes of possible error, we have always before us the fact that a large proportion of the patients are every now and then compelled, by some exigency or other, to shift their quarters to a distance which utterly precludes their regular attendance. The patients I showed you did not labor under this disadvantage, it was possible to watch the progress of the disease without a check, and I therefore give the history of their cases, which moreover will illustrate the system pursued better than any description.

CASE I.—Kate G., eighteen years old, living at Hammersmith, was admitted as out-patient at St. John's Hospital, Sept. 20th, 1881, for extensive strumo-derma in full ulceration. It reached nearly from ear to ear, passing behind and under the jaw. The affected surface was in most parts quite an inch and a quarter in width, and over great part of it the skin was destroyed through its whole thickness, the edges being extensively undermined. The disease had existed eight years, during the whole of which time it had persistently got worse. The patient had been under the care of three medical men, and had taken among other things cod-liver oil and Parrish's chemical food. She had also painted the places with iodine, and had used some ointment the nature of which could not be ascertained. Meat diet with port wine had been ordered. The girl herself did not look unhealthy and had a good ruddy color, but she was short and her face peculiarly angular with a pointed chin.

She was ordered the saline mixture used at the hospital, a full dose, half an ounce, twice a day, and a powder, consisting of two grains of mercury and chalk and one of calomel, to be taken every second night. The use of the saline mixture was continued without any change up to 6th of June, 1882, when, her appetite having fallen off, she was ordered dilute nitro-hydrochloric acid and infusion of quassia, a fairly strong

dose twice a day. To this mixture, unless symptoms are present which expressly counter-indicate it, a small quantity of De Valangin's solution is always added. From this time forward she was directed to take only one dose a day of the saline, but it was left to her own discretion to increase this beyond half an ounce if she thought it desirable to do so. The powders were given for only a week or ten days during each month in the cold weather, and rather more frequently during the summer. No local treatment whatever was ordered during the first three months, at the end of which she was instructed to bathe the part daily with methylated spirit. In the spring of the year following her admission, the ethylate of sodium was tried, the use of it being sedulously kept up for quite nine months, during the whole of which time I was unable to trace the slightest beneficial effect to its operation; it was therefore discontinued. Later on, when the ulceration had almost entirely healed, an attempt was made to stimulate growth at the base of the ulcer by painting it with the blistering fluid of the Pharmacopœia, and apparently with considerable success, though I need scarcely say how difficult to assign to any one factor its exact share in the result. In October, 1888, the application of the mild iodized glycerin of the hospital, glycerin saturated with iodide of potassium, was begun with, and it, too, seemed to assist the process of cure.

The girl was told to observe a plain, light diet, avoiding much meat of any kind, and all heavy, rich, and stimulating meat, such as pork, goose, hare, and so on. Beer in every shape, strong soups, jellies, brandied wines, like port and sherry, were strictly forbidden; claret, however, to any reasonable extent, being allowed. She was instructed not to walk too much, and not to put any trust in change of air and sea-bathing.

According to her own account, her health began to improve almost directly she commenced taking the medicine, and it was not many weeks before the ulceration ceased to extend. Six months, however, elapsed before healing fairly set in, and I assume that, as the girl was intelligent and attentive to all that was said, those dates may be accepted as fairly representing the history of this part of the case. The great point is that the improvement, having set in, went on unchecked till about the beginning of August, 1883, when, without any particular reason, the bases of the ulcers, which had nearly all closed, reopened and for a time discharged in a way which made me fear that all the work would require doing over again. However, the relapse soon came to an end as mysteriously as it had begun, and on the 22d of November last I showed you the girl, all the places having thoroughly and firmly healed, except one small patch evidently in process of cicatrization, which has since closed, the depth of the ulcer having considerably filled up.

CASE II.—The subject of the next case, Jane S., 15 years old, presented

a great physical contrast to the other patient, for she was moderately tall, not badly featured, and extremely pale and slender. The disease in her was confined to a single patch on the right cheek, about twice the size of a half-crown and nearly circular in outline at the base, from which rose an irregularly conical mass, composed apparently of luxuriant granulations and dark-colored crusts, giving it, when seen from a distance, almost the look of a large limpet, and attracting a degree of observation which annoyed the girl excessively. When she began attending at St. John's, December 6, 1881, she stated that the disease had then existed between seven and eight years, and gave the following history of it: The beginning was a small lump about the size of a pea under the skin. As it became of stony hardness, she went to a hospital about it, but was told she had nothing to fear. Feeling uneasy, however, she went to another hospital, where the surgeon in attendance proposed to operate upon the swelling, to which she seems to have made no objections; for some reason or other, the surgeon did not put his suggestion in force. She was now taken to a hospital for children, where an operation, the nature of which I have as yet been unable to learn, was performed, with the result of total failure; and another hospital was tried, but no improvement ensued. A second operation was suggested at this institution, but objected to, and she was again taken to the second of these hospitals, and placed under the care of a colleague of the gentleman who first recommended operating. I totally failed to find out what medicines she had taken, but none of them had checked the disease in the least. Singularly enough, in all this time cod-liver oil had never been administered.

She was ordered saline mixture, half an ounce every morning, and as this did not produce any particular effect, it was increased to two doses a day; a grain and a half of calomel, with three grains of gray powder to be taken twice a week at bed-time was also prescribed. The directions were that she was to take the mixture every morning without omission, but the powder only for ten or twelve days out of each month. No external application whatever. The diet to be the same as in the preceding case, very much to the surprise of the girl, who had frequently heard that she needed "a great deal of keeping up." She soon began to improve, and by the end of the following March nearly all the crust had fallen off, exposing a mass of granulations which were evidently shrinking and dying. At this time a friend suggested trial of the ethylate of sodium, which was accordingly made, but though I believed the patient used it most perseveringly, and strictly according to the instructions given her, besides coming to the hospital once a fortnight to have it laid on, yet I could not observe that it produced the least real effect. In fact, curatively looked at, it seemed to be totally inert, and this was certainly the conviction at which the girl herself arrived, as she asked, after

a time, that it might be discontinued, on the ground that it gave her a great deal of pain and did her no good. For a very short time she took, in addition, ehloride of iron. No other medicine was given up to the end. Sometimes she evidently got tired of the saline, and a respite was allowed. Sometimes bad weather and the exigeneies of her situation prevented her attending, but on the whole she proved a model patient, and gave treatment every ehance. The shrinking of the granulations was a much slower process than the shedding of the crusts, still it did progress, and I never noticed anything that looked like arrest of the cure. It was not, however, till the summer of the next year that the surface could be said to have thoroughly cicatrized and the granulations to have quite shrunk, changes which left behind a large and very unsightly depression. With the aim of removing this disfigurement, if possible, the surface was painted with blistering fluid, and as the application was not followed by any particular degree of pain or irritation, she was, after a few trials, finally entrusted with the use of the remedy, and directed to apply it twice a week. The depression has filled up remarkably, and apparently from the base and on one uniform plane, there being no levelling at the edges. There is, however, no intention to ascribe this to the operation of the blistering, for it may have been due to continuance of the curative action set up by the medicines. On the 22d of November, 1883, I showed you the girl with the part firmly cicatrized. She had, indeed, long been well, and had only taken her medicine occasionally for several months. Neither this patient nor the other ever went to the seaside or had any ehange of air during the time of treatment. The younger patient gained flesh, strength, and a slight degree of color while taking the medicines; no ehange was noticed in the other.

A CASE OF LYMPHANGIOMA.¹

BY

J. E. GRAHAM, M.D.,

Toronto, Ont.

MISS L., æt. 21, has always lived on a farm in the northern part of Ontario. She has had very good health with the exception of the disease about to be described.

When she was five years of age, a tumor appeared in front of the elbow, which gradually extended upwards towards the shoulder and

¹ Read at the meeting of the American Dermatological Association, August 31 1883.

downwards towards the wrist. The history of the growth up to the present time has been one of constant increase, but it has grown more rapidly during the past year. Its presence has not inconvenienced her to any extent, and she has been able to attend to the work on the farm, including milking, washing, etc.

Present condition.—The left arm from the shoulder to the wrist presents the following appearance: When outstretched, on the greater part of the surface of the upper and posterior aspects the skin is normal in character. Along the anterior and lower aspect, there is an outgrowth of integument which hangs loosely down, so as to form, as it were, a deep fringed bag. The anterior surface of this growth presents in some places a dark-red and in others a light-red color. The color is deeper when the arm hangs down than when it is elevated.

On the same surface near the shoulder is a hard nodule about the size of a hazel-nut. This is the only indurated part in the whole mass. The papillary layer of the corium and perhaps, also, the epidermis, is much hypertrophied, and the skin presents deep furrows which resemble those found in the serotum when it is contracted, or those seen in the normal integument by a magnifying glass.

Near the elbow, at the margin of the growth, there is a brown pigmentation. This discoloring of the skin, so far as I could make out, always preceded the advance of the growth itself.



On the posterior aspect of the growth, the color is more normal. In parts, there is a deep-brown pigmentation similar to that above described. At about the junction of the lower with the middle third of the forearm, there is a tumor about the size of a large walnut, with a round, smooth surface, and, when felt, gives the impression of dilated vessels existing beneath the integument. Growing from the surface are a number of strong black hairs which present a different appearance from those seen in the immediate neighborhood. Near the elbow, there is a much larger, round, soft tumor, which has the same character as that already described.

The whole growth has a peculiar soft, velvety feel. There is certainly

thickening of the skin, but no induration whatever is found except the nodule above mentioned. It appears to diminish somewhat in size when the arm is held up for a considerable time. It can also be made a little smaller by continued pressure. Sensation over the surface is not so acute as in other parts of the body. She has never experienced any pain in the tumor.

The muscles beneath appear to be somewhat atrophied. She states, however, that the affected arm is almost as strong as the other.

She has a very indistinct recollection of the commencement of the disease, and it is not at all improbable that a small tumor might have existed at birth, and remained unnoticed during the early years of life.

Family history.—Her father died of inflammation of the lungs after a short illness. Her mother died after confinement. She has three sisters and three brothers, all healthy. No hereditary disease in family.

From the history of the case and the appearance of the growth, the diagnosis made was that of lymphangioma cutis. The round tumors on the posterior aspect present all the ordinary appearances of lymphatic growths.

There is certainly a relationship existing between these cases and those of elephantiasis, but this relationship exists only in the fact that we find lymphatics more or less affected in each form of disease.

It is probable that the disease in this case was congenital, and that the main pathological lesion is dilatation of the lymph channels. The hypertrophy of the skin, which is exceedingly well-marked, may have followed from increased nutrition.

This case resembles in many points some of those described by Dr. Busey. I do not think, however, that there existed in any of his so marked and peculiar a condition of the skin.

Society Transactions.

NEW YORK DERMATOLOGICAL SOCIETY.

143D REGULAR MEETING, FEBRUARY 26, 1884.

DR. P. A. MORROW, *President, in the Chair.*

DR. SHERWELL presented a case of

CHRONIC ULCER OF THE UPPER LIP,

Probably an epithelioma. The patient, a woman, æt. seventy-three, first noticed upon the middle of her upper lip a little scale or scab. This was four years ago. Since that time the scab has continued to form and fall off, superficial ulceration has taken place, which has slowly extended. From time to time the patient says

that a little "matter" will appear under the scab. The lesion is the seat of a great deal of pain. The patient has never smoked a pipe nor made any irritating applications. The ulcer occupies almost the exact middle of the lip, is partly upon the skin and partly upon the mucous membrane, is not much larger than a ten-cent silver piece, is covered by a thin fissured crust, is very slightly indurated along upper edge, and seems very painful upon contact. Upon the left cheek over the malar eminence, there is a blackish wart growth, which has also been present for about four years.

DR. FOX would not call the ulcer an epithelioma, nor at present make any positive diagnosis. He could not detect much induration in the ulcer. The growth upon the cheek is one of those peculiar sebaceous formations which are not uncommonly met with in elderly people, and are often followed by epithelioma.

DR. TAYLOR said that, when we consider the history of the case, the age of the woman, the length of time the ulcer had existed, and its general characteristics, the mere absence of induration in so small an ulcer was not enough to invalidate the diagnosis of epithelioma. He believed that the disease was of epithelial nature, and that microscopical examination would show the presence of epitheliomatous growth. In many ulcers of low grade the infiltration is of no great extent, and is always most marked when they are upon the cutaneous surface, while this ulcer was most upon the mucous surface.

DR. BRONSON thought that the history of ulceration for four years was not sufficient evidence in favor of epithelioma to offset the absence of induration. There were other causes than epithelioma capable of keeping up ulceration, and he did not think this present case one of epithelioma.

DR. SHERWELL said that when the ulcer was first seen by him, about two weeks ago, it was more typical than now, having a typical covering scale and well-defined border. He believed that the ulcer will become an epithelioma, if it is not so now, and that it certainly is epitheliomatous. He deemed the case interesting, as he did not remember ever before having met with a case of epithelioma beginning on the upper lip, and because Paget had said that the disease never occurred in that situation.

DR. MORROW would not diagnose the disease as epithelioma from its clinical appearances, if it were situated anywhere else and had not its history. It was safe to assume that any lesion occurring upon the lip in an elderly person, where it was necessarily exposed to all sorts of irritation, would be very liable to develop into an epithelioma. There was no physiological reason why epithelioma should not occur upon the upper lip, and he thought that this particular lesion would become an epithelioma, though it was not one now.

DR. BRONSON presented a case of

RECURRING ERYTHEMA PAPULATUM,

Located upon the backs of the hands. The patient, a woman, has been annoyed for the past ten or fifteen years by the frequent recurrence of an itchy eruption upon her hands. These attacks occur at all times of the year, but more especially in the winter, lasting one to two weeks on an average, and disappearing, to reappear after an interval of months or years. Otherwise her health is good, and she is not rheumatic. The eruption is in the form of isolated and grouped purplish and reddish papules, the latter forming patches in which the individual lesions are readily distinguishable. There is a complete absence of desquamation, and the subjective symptom is rather a sensation of burning than of itching.

DR. FOX considered the case to be one of papular erythema. The only other disease with which it could be confounded was lichen planus, and he never knew of a case of that affection which recurred so frequently.

DR. SHERWELL quite agreed with Dr. Fox.

DR. MORROW said that the only feature which contraindicated the diagnosis of erythema papulatum was the subjective symptoms. The evolution of the lesions pointed to an erythema, and he would arrive at that diagnosis by exclusion.

DR. BRONSON thought the case of interest on account of its constant recurrence for so many years, and because the patches formed by erythema papulatum usually are smooth and spread at the periphery, while in this case they are uneven and look not unlike those of lichen planus.

DR. SHERWELL presented

A CASE OF CLUBBED FINGERS,

Occurring in a boy, with the following history: E. A. S., æt. nine years, the first child of his parents. Primary dentition quite regular, excepting that the upper incisors came first. Secondary dentition followed the same order and was regular. The parents are apparently both well and healthy. In February, 1883, the child had an attack of pleuro-pneumonia, followed by empyæma and pyopneumo-thorax, the suppuration leading to perforation of the chest-wall. The heart was and is displaced. Under a nourishing plan of treatment the child has made good advance toward recovery, but has complained of tibial pains and some headache. About four months ago, the terminal phalanges of all the fingers began to swell, the nails to increase in size in all directions, and to become distorted and incurvated. At a later date the terminal phalanges of the toes presented a similar condition, and the ends of the long bones likewise became enlarged. The extremities of the fingers are very much thickened, and the nails are strikingly large without any other abnormality. The circulation in the fingers is sluggish, as shown by their coldness upon contact.

DR. TAYLOR would call it a simple case of clubbed fingers. He had seen a good deal of dactylitis, and two of these cases were limited to the distal phalanges. In one case, all of the fingers and toes were involved; in the second case only a few of them. Dactylitis, when due to syphilis, was peculiar in that the nails looked as if in a frame of skin, and were not so broad as in the case presented to-night. The crucial test of dactylitis was pressing upon the inner and distal aspect of a finger and twisting, when you would get the feeling of the enlarged bone under your fingers, and thus make your diagnosis. The case presented was due to interference with the circulation.

DR. SHERWELL had presented the case only as a possible case of dactylitis. It was more extreme than ordinary cases of dactylitis. It was doubtless a result of the heart having been pushed out of place, and a consequent interference with the circulation, increased nutrition, and new growth at the farthest points.

DR. MORROW presented a case of

ECZEMA OF THE LEG TREATED WITH THE GELATIN MEDICATED PLASTER,

To exemplify its good effects. The patient, a woman, was scalded nearly two years ago upon the outer surface of her leg, resulting in a sore which never healed. The surrounding tissues became œdematous and inflamed. Two months ago, when the patient was first seen, she had a general eczema most marked upon her face, arms, and neck, while the scalded leg was the seat of a severe eczema rubrum. The general eczema yielded readily to treatment, but the eruption upon the leg was very rebellious, absorbent powders, iodoform and oleate of bismuth ointment, Lassar's paste, etc., having been used without effect. On the 18th of this month, he used first application of a medicated gelatin, made after the following formula, viz.:

℞ Glycerin..	250 parts.
Gelatin	1,000 "
Water....	2,000 "

medicated with ten per cent oxide of zinc, and one per cent carbolic acid. This was left undisturbed till the 23d, when it was removed and the epidermis

was found to have been regenerated. It was reapplied on the 23d, and when taken off to-night there was no sign of exudation and the epidermis was in good condition. The patient says that from the first application the itching had been markedly lessened. In the last dressing there was no carbolic acid in the gelatin varnish. The dressing was seen to form a perfectly smooth, uniform, elastic covering.

DR. FOX was very much pleased with the satisfactory results obtained in this case. He thought that the admissibility of applying a bandage over this dressing and leaving it on for several days was a great point in its favor.

DR. MORROW said that while the collodion and gutta percha solutions in chloroform were more convenient of application than the gelatin plaster, yet there were some cases, and this was one of them, in which they could not be used on account of the excessive burning that they caused. The chloroform solutions are preferable in scaly and chronic cases, but not in acute and irritable cases. The gelatin plaster was easy of application and caused no inconvenience either to physician or patient. There was no occasion to apply a bandage over it if the patient can return every few days. He thinks that the compression caused by these elastic layers did good.

DR. MORROW then submitted to the Society for discussion the following propositions :

That the introduction of fixed, adhesive applications in the treatment of certain forms of skin affection marks a veritable advance in cutaneous therapeutics.

That they are admirably adapted for the employment of certain powerful stimulating drugs recently introduced into dermatological practice, as well as other standard drugs.

That they constitute the most effective mode of applying drugs in certain pathological conditions characterized by hyperemia of the derma with inflammatory over-growth of the epithelial elements, as in psoriasis and dry scaly eczema.

In conditions characterized by hyperplasia of the cuticle, as in callosities, corns, and over-growths of thickened, hardened epidermis, etc.

In conditions of capillary congestions of a passive character, as in acne rosacea, chronic erythema, etc.

In certain neurotic conditions, not only in essentially pruriginous diseases, as prurigo, but in the pruritus symptomatic of other affections. In circumscribed lesions generally, as tinea circinata, tinea capitis, eczema marginatum, chromophytosis, syphilitic scleroses, lupus and, possibly, epithelioma.

He then said that there had been an impression that none of these preparations were applicable where moisture was present. The case presented this evening was a refutation of this, at least as far as the gelatin preparations are concerned. In applying them it was only necessary to use a little care in order to make a smooth coating.

DR. FOX indorsed what Dr. Morrow had said in regard to the invalidity of Auspitz's objections. He had used the gelatin preparations only to slight extent and not in acute cases. He had been somewhat deterred from using them, as they were more troublesome to apply than either the chloroform solutions or ointments; but they made good impermeable and elastic coverings. In chronic eczema and psoriasis the solutions of gutta percha or collodion answered all purposes of local applications, but were not adapted to acute cases with exudation. In this latter class of cases he thought, from what he had seen to-night, that the gelatin preparations would answer well. It was claimed that the chrysarobin used as a varnish did not stain the clothing, and this was true to a great extent, but unless the varnish was very carefully applied, a little chrysarobin powder would get off and stain the clothing.

DR. TAYLOR remarked that the escape of the powder would be prevented by painting the varnish over with a little pure collodion, which was his plan.

DR. MORROW observed that Besnier recommended that a solution of chrysarobin should first be applied, and then this covered with the solution of gutta percha.

DR. TAYLOR thought that a good deal could be done with an elastic and extensible application such as this gelatin one, in places where so firm a dressing as collodion or liquor gutta perchæ was inadmissible. In this connection he would like to say a few words as to the use of balsamic gums as vehicles for applications, and this in continuation of his short paper upon "The Treatment of Eczema Marginatum and of Ringworm in General" (see this JOURNAL, Feb., 1884, p. 42). Since the writing of that paper, he had treated five new cases of eczema marginatum. As the result of his experience with these cases, eight in all, he would reduce the strength of the bichloride of mercury from four grains to the ounce to two grains to the ounce, at least at the beginning of the treatment. This strength could be gradually increased to four grains to the ounce, according to the tolerance of the patient. He had met with some cases in which the four-grain solution had proved too irritating. He would further state his preference, in the light of his experience, for the compound tincture of benzoin as a vehicle.

DR. BRONSON had not used the gelatin preparations very much, as his experience with them had been unfortunate. The trouble of getting the hot water and the waiting for them to set made them less convenient to use than the collodion or gutta percha solutions. With these latter, in dry squamous diseases, he had had far better results than by other methods of treatment. He had used Besnier's method, but did not think it so good as having the medicament suspended in the gutta percha solution. By his method you were not sure of the strength of the drug you were using, as it was apt to be a little washed off when the gutta percha solution was painted over it, and some of the first solution was very apt to escape being covered by the second. He had used the collodion and gutta percha solutions also in pruriginous diseases such as lichen planus. He had found a ten-per-cent solution of salicylic acid in liq. gutta perchæ excellent in the dry fissured form of eczema palmarum; and had used it with good effect in eczema of the face with slight exudation. He doubted if a good frank eczema rubrum would stand any fixed application. In this connection he would say that the liq. gutta perchæ was a good vehicle for the application of iodine.

DR. SHERWELL was a little doubtful in regard to the efficacy of the chrysarobin gutta percha solution in ringworm of the scalp, and would think that it would be more inconvenient than an ointment. He had not been in the habit of using goa powder in parasitic disease of the scalp. His plan was to soak the whole head for three or four hours with linseed oil after shaving or epilating the affected parts. After this he applies some ointment, preferably the oleate of mercury.

Correspondence.

DERMATOLOGY AND SYPHILOGRAPHY IN FRANCE.

(From our Special Correspondent.)

SCLEROUS LUPUS.—ZONA.—PURPURA HÆMORRHAGICA.

DR. VIDAL, of the *Hospital St. Louis*, has recently described in the *Annales de Dermatologie* a variety of lupus as yet but little known, to which he gives the name of *lupus sclereux*. It has already been mentioned by Hardy under the name of *scrofulide verruqueuse*; by McCall Anderson as *lupus verrucosus* or *scrofuloderma verrucosum*; and by Kaposi as *lupus papillaire verruqueux*. This form of lupus may develop *d'emblée*, that is, primarily, or it may be observed as a secondary phase of the transformation of a primary tubercular lupus. This lesion is unmistakably of a lupus nature, since, when it is scraped, we

observe that small soft tubercles, yellowish-red, or transparent, absolutely pathognomonic of tubercular lupus, form in the cicatrix during the process of repair. Sclerous lupus is characterized by more or less extensive patches, neatly circumscribed, of a deep-red or violaceous color, around which the derma becomes thickened and indurated; the papillæ are exceedingly hypertrophied, forming rugous, uneven, papillomatous, and, sometimes, horny projections, separated from each other and divided into irregular protuberances by furrows and fissures, which often discharge a purulent secretion. Quite frequently, the centre of the patch heals by a sort of sclerous transformation, forming a cicatrix, while the lesion advances at its periphery, pursuing a serpiginous course.

Sclerous lupus may develop upon any portion of the body, but it is most often localized upon the extremities, the fingers, toes, hands, and feet. It is extremely slow in its evolution; it shows no tendency to become grave or degenerate into lupus vorax.

According to the author, upon a perpendicular section through the entire thickness of the infiltration will be found: 1st. A superficial, papillomatous layer, simulating epithelioma, and constituted by exuberant epidermic proliferations. 2d. A middle layer of sclerous tissue. 3d. A deep layer in which will be found lupus tubercles with all their histological characteristics. Sclerous lupus would seem then to be only a tubercular lupus, the tubercles of which have undergone a fibrous transformation. In certain preparations, it is possible to witness, so to speak, this process; one may see the prolongations, more or less fine, of fibrous tissue encroach upon the tubercle by its periphery and dissociate it. Such is the common form of sclerous lupus. But within a few years past, Dr. Vidal has observed at his out-door clinic another variety of sclerous lupus in which the tubercles are superficial, sub-epidermic, visible to the naked eye, and rest upon a deep, indurated base, forming a sort of flattened tumor, involving the entire thickness of the derma, and often even the subcutaneous cellular tissue. According to the statistics of Dr. Vidal, this sclerous form is observed in about one of every eighteen cases of lupus, and men seem more predisposed to it than women—a remarkable fact, since every one knows that the other varieties of lupus are much more frequent among the feebler sex.

The best treatment is undoubtedly scraping; for this purpose, we may employ the curettes of Volkmann, Balmanno Squire, or Besnier, or the *racléur* of Vidal, which possesses the advantages over other instruments of penetrating the morbid tissues with greater facility and being much more easily cleaned. One may operate boldly, since the healthy skin, thanks to its suppleness and its elasticity, resists the action of the instrument. After having completely enucleated the neoplasm, one may apply a Lister dressing, or simply cover the wound with compresses dipped in carbolized water. As soon as cicatrization begins to take place, it may be dressed with the *emplastrum de vigo*. But it is necessary to intervene promptly with another operation if one observes, as is the rule, the small, yellowish, transparent tubercles begin to form in the cicatrix.

We may also employ, in cases of sclerous lupus of the face, the method of quadrillated linear scarifications. We may perhaps thus obtain a more perfect cicatrix than after scraping; but the treatment is infinitely more prolonged.

The recent monograph of Dr. Fabre,¹ of Commentry, upon ZONA gives the most complete exposition of the present state of our knowledge of this interesting question which has yet appeared. Want of space renders it impossible for

¹ Le Zona par Dr. Paul Fabre de Commentry. Svo de 249 pages. Paris, 1882.

me to give a satisfactory analysis of this work here, so I shall limit myself to the presentation of a few of the new points which it contains.

The author begins by establishing that it is not the herpetic vesicle which is the essential constituent eruptive element of zona; but the erythematous patches which precede the appearance of the vesicles, and which are grouped in a more or less considerable number upon the territory of the nerve. In fact, one may see the eruption rest at the erythematous stage, and it is even frequent in a zona which develops completely, and arrives, as is the rule, at the vesicular stage to see the vesicles abort upon some of the patches.

From the point of view of the classification which the author proposes for the double zonas, it is necessary to establish certain distinctions. Dr. Fabre divides the double zonas practically into three categories :

1st. Symmetrical zonas forming a complete girdle.

2d. Multiple, non-symmetric zonas, in which one may see a zona of one region coincide with a zona of another region on the opposite side.

3d. Bifurcated zonas; he terms zonas bifurcated where the eruption, situated upon the course of the second, third, or fourth intercostal nerves, occupies, on the one hand, the corresponding intercostal space, and, on the other, the neighboring part of the shoulder and the internal surface of the arm. Now, it is impossible to range these last cases among double zonas, for the eruption occupies the territory of a single nerve. We know that the second, third, fourth, and even the fifth intercostal nerves send branches to the integument of the shoulder, the axilla, the internal surface of the arm, and that some of the filaments anastomose with the brachial internal cutaneous and the accessory nerve. It appears to me necessary, in the first place, to precise what is meant by the term double zona. The majority of authors designate by this name only cases in which two eruptions of zona are observed, one upon the right side, the other upon the left. These cases are not simply double zonas; they are cases of *double bilateral zona*. It would be more logical, it seems to me, to designate as double or multiple zona every eruption of zona which occupies the territory of two or more nerves; then we may admit the following divisions: 1st. Symmetric bilateral double or multiple zona. 2d. Non-symmetric bilateral double or multiple zona. 3d. Unilateral double or multiple zona.

Dr. Fabre reports in his work the very interesting observations of Drs. Desprès, Gellé, and Ollivier, which seem to prove the existence of a lingual and guttural zona, and, apropos to which, the author adds that we should not identify with zona, herpes buccalis, facialis, labialis, preputialis, etc. I quite agree with this view, but the differential diagnosis between the two affections often appears quite difficult. At any rate, if I may be permitted to give my own opinion, I think that we should only admit the existence of a buccal zona when we have a herpetic eruption exactly limited to the right or left half of the affected mucous surfaces, preceded and accompanied with neuralgic pains, occupying the territory of the interested nerve and independent of any other fébrile affection.

From a pathogenetic point of view, I cannot entirely approve of Dr. Fabre's division of the eruptions heretofore recognized as zona into two principal classes: 1st. Into primitive or idiopathic zonas, resulting from the influence of cold, digestive troubles, mental emotions, etc. 2d. Into secondary or symptomatic zonas, depending upon a central or peripheric nervous affection. It seems to me there is a vast difference between these two classes of cases. In the first, we have an essential idiopathic affection, a kind of eruptive fever as Bossière has

termed it; in the second, on the contrary, the lesions are secondary, veritable trophic troubles. We should not forget that it is almost entirely upon cases of the second class—for those of the first category are not fatal—that the theory that zona is purely and simply the result of a nerve alteration has been constructed, and I would ask if in true idiopathic zona there may not be another pathogenetic element too much neglected at the present time.

These ideas, I am happy to say, have been recently sustained with the most distinguished ability in a clinical lecture by Dr. Landouzy. This author strongly insists, and quite properly, upon the capital fact that zona does not return, as an exception to which, there are only four known cases, one attributed to Dr. Oscar Wyss, another to Neumann, another, quite doubtful, to Kaposi, and the fourth to Dr. Fabre, of Commeny. A first attack seems then to confer complete immunity. Thus, Dr. Landouzy does not hesitate to establish a radical distinction between *true zoster* (first category of Dr. Fabre), which he calls *zoster fever*, and the vesicular eruptions which occur in the territory of affected nerves (second category of Dr. Fabre), which he terms *zosteriform exanthems*. “The fever zoster is a general affection, acute, almost cyclic, infectious, conferring immunity, with a circumscribed determination towards the nervous system, and a secondary dystrophic cutaneous expression. There is a zoster fever as there is a scarlatinial fever, and zosteriform eruptions as there are scarlatiniform exanthems. Between zoster and zosteriform eruptions there is all the difference which distinguishes a disease from a symptom.”

Dr. Fabre believes that it is sometimes useful to give a mild purgative at the debut of a zoster if it be needed; then general calmatives against the pains if they should be too acute, such as opium, cherry-laurel water, belladonna, ether, chloral, sulphate of quinine, and even injections of morphine. If the vesicles are recent and transparent, they may be aborted by covering them with thin layer of collodion, but if they are fully formed, well developed, especially if their contents are slightly hæmorrhagic, this should not be done; for deep ulcerations will take place beneath the collodion, leaving indelible cicatrices. In these cases it is much better to allow the evolution of the eruption, keeping the affected surfaces covered with inert powders, such as starch, flour, subnitrate of bismuth, talc, oxide of zinc, etc. Or the treatment recommended by Dr. Vidal may be employed, which consists in applying upon the affected parts successive layers of a soothing balsam and starch powder, thus forming a sort of protective shell which alleviates the pains.

The study of PURPURA is still continued in France. Unfortunately these efforts are not crowned with success, and the most deplorable confusion continues to reign in this chapter of general pathology. In the *Archives générales de Médecine*, April and May, 1883, Dr. Duplaix has published certain researches upon hæmorrhages of the nervous centres which occur in the course of purpura hæmorrhagica. They are rare, and the cerebral phenomena observed in this group of affections depend oftener upon cerebral anemia than upon hemorrhagic lesions of the nerve centres. When they occur, they take place in the earlier stage of the disease before the period of anæmia; they are chiefly situated upon dependent parts, and they affect rather the form of ecchymoses than veritable cerebral hemorrhages.

It may be remarked that Dr. Duplaix, in studying the cerebral lesions in his article, should have begun by defining what we are to understand by the term purpura hæmorrhagica. It is well known that the works upon this subject

which have recently appeared are far from being explicit upon this point. The study of the subject by Dr. Du Castel (Paris, 1883) shows that in the present state of our knowledge it is absolutely impossible to preserve a distinct morbid entity to which the name of purpura hæmorrhagica may be given.

In conclusion I may mention two new documents which have just been published as contributions to the natural history of purpura. One is from Dr. Rathery, and treats of a patient suffering from successive crops of purpura, who had during his purpuric attack variola, which did not take on a hæmorrhagic character, and was modified in no respect by the primary disease. The other is contributed by Dr. Hartmann, and describes a case of purpura hæmorrhagica developed as a result of traumatism. (*V. Rev. de Chirurgie*, No. 9, 1883, p. 735.)

PARIS.

BROCQ.

PULSATILLA IN ACUTE EPIDIDYMITIS.

NUMEROUS disappointments in the treatment of this disagreeable and painful affection by the usual methods and the perusal of a few brief articles published in the journals at various times by Piffard, Sturgis, and Fox, of New York, have led me to employ experimentally the tincture of pulsatilla, and I am pleased to state, to my complete satisfaction, as in using this drug I found that not only was the relief its administration afforded more prompt than by the former methods employed by me (cathartics, poultices, rest, etc.), but that it completely did away with one of the most objectionable features of that treatment, namely, rest in bed.

The cases upon which I base these few remarks are twenty-four in number, all of which have been treated within the past eighteen months, and they were all in the acute stage of the disease; hence I think I can safely draw correct conclusions.

During my hospital service in New York, I had ample opportunities for practically testing the value of the treatment of acute epididymitis as advised by Prof. Bumstead (Bumstead and Taylor, *Ven. Dis.*, 4th Edit., p. 145 et seq.), and arrived at the conclusion that the only source of benefit was the fact that rest in the recumbent posture was strictly enjoined. Now, the class of men who are liable to this disease are principally young men who prefer to suffer almost anything rather than have their troubles known, and it is with the greatest difficulty that they can be induced to go to bed. Now, here I think we have a remedy which does not require so exacting a discipline, as I never found in all my cases any necessity for complete rest in bed, the only requirement being the wearing of a suspensory bandage, and taking of the medicine. The relief from pain usually takes place within three days. The preparation employed by me is the tincture of pulsatilla manufactured by Boericke and Tafel, of New York, the dose being two drops every two hours. No benefit is derived from the use of larger doses at longer intervals.

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Selections.

MECHANICAL REMEDIES IN THE TREATMENT OF SKIN DISEASES.

THESE are : massage, compression, blood-letting, scooping, scraping, the seton, and cauterization.

Massage.—The effects, both local and constitutional, of this agent, are often very beneficial in certain morbid conditions of the integument, and at times result in a complete restoration of the part to its natural state.

It may be performed by the hands alone, or with the aid of some fatty material, a coarse towel, a hair mitten, or a brush—and also by means of the ingenious machines which have been devised for the purpose.

The most common form of massage used in the treatment of skin diseases is *friction*. This is usually applied in all directions, without regard to any rule, but is more efficacious when made either vertical or circular. For example, in manipulating a limb in this way, the upward or vertical stroke from the extremity to the trunk, following by the same downward motion, will always favor and not retard the circulation, thus giving a soothing and beneficial influence to the part.

The upward stroke should be strong and vigorous, while the returning one should be light and passive, the palm of the hand, however, still remaining in contact with the surface. The effect of frictional massage is to stimulate the lymphatic vessels and veins to augmented action and thus promote the absorption of inflammatory products, should any exist, as well as adding tone and vigor to the general system. The vessels in course of disease are not only compressed by inflammatory deposits in the tissue, but are also often filled with plasma and other material, causing stagnation and loss of their absorbing power. The object to be attained by using frictional massage in such conditions is to empty the over-distended lymphatics and veins, thus increasing their activity, re-establishing their absorbing power, and enabling them to carry off all deposits and restore the tissues to their normal state. Frictional massage can very often be advantageously combined with such movements as pinching, kneading, manipulation, rolling and percussion, more especially when the exudation is very great, the innervation of the skin marked, and the object is to obtain a more decided action upon the superficial and deep parts.

Having thus briefly described massage, I will now refer to its effectiveness in particular skin diseases. In the dry form of seborrhœa, especially of the scalp, and in thinning and loss of hair, frictional massage, used in moderation, stimulates and augments the sluggish circulation, furthers absorption, and imparts tone and vigor to the scalp and hair. In indurated acne and in glandular swellings it arouses the activity of the sluggish and choked-up absorbent vessels, and thus relieves the glandular congestion, and the skin again becomes normal in being soft, supple and elastic, and free from these lesions. It not only has a local beneficial influence upon the class of affections just named, but likewise often removes, or assists in removing, when used over the trunk, many gastric and intestinal disorders which very often keep up the cutaneous irritation. This general effect of frictional massage I have witnessed again and again in relieving and curing

constipation and other functional derangements, which are very often active factors in keeping up *acne rosacea*, *hyperidrosis*, *seborrhœa*, *urticaria*, and *eczema*.

It is often efficacious in removing scurf, and in cases in which the pigment of the skin is either excessive or deficient in quantity, stimulating to renewed activity the absorbents, and assisting in again restoring the parts to their natural state. Massage, whether made with one or more of the group of movements named, is an invaluable agent in certain neuroses, especially in neuralgia, perverted sensibility, and trophic disturbances of the skin. It exerts in these affections a delightful and pleasing local effect, relieves pain by its sedative and counter-irritant effect, increases the circulation of blood in the integument, thus lessening its activity in the internal organs, and likewise has as a result a decided tonic action upon the nervous system. Massage as a general remedy is an important adjuvant in promoting an increasing oxidation in cases of *scrofuloderma* and in *psoriasis*. It makes the skin more active, removes effete products from within as well as without, and increases the red corpuscles of the blood.

Massage thus applied in some of the sub-acute forms of *eczema*, in which the surface is dry, slightly thickened, and covered with groups of papules, will awaken the action of the dormant absorbents, increase the circulation, arrest the intense itching, and very often alone restore the skin to its natural state. But it is in some of the chronic forms of this disease that massage has been, in my experience, more efficacious than in any other affection of the skin.

In cases where the surface of the skin presents marked infiltration, is hard, dry, rough, thickened, even to a leathery state, and upon which all medication has been used in vain, it will often be found to yield under this appropriate form of treatment.

Massage not only breaks up the exudation, but likewise stimulates the absorbents, and so assists in removing the inflammatory products from the tissues, and restores the skin to its natural soft and elastic condition. In chronic vascular *eczema*, especially where the parts become covered with confluent patches of papules, and on which there is more or less infiltration, dry, and attended with persistent and obstinate itching, the judicious use of massage will often not only remove the abnormal and pent-up effete products, but will also produce a sedative action on the irritation, and give the sufferer a blissful state of repose, followed with sleep, which formerly had been constantly interrupted by the itching.

Upon an acutely-inflamed surface, massage should never be used directly ; but it can be applied in the early stages of such conditions with benefit above and below the parts, in order to afford more area for the returning circulation.

In the beginning of his employment of this remedy, the physician should see to it that certain qualities are possessed by the manipulator, such as strength, intelligence, and hands adapted to this purpose. Unless he has sufficient knowledge of anatomy and physiology, and is thoroughly skilled in medical rubbing, more harm than good may be accomplished by his means. Care should be taken, first, that the part treated is properly exposed and at perfect ease for the manipulation ; secondly, that the hair, should any cover the surface, is well shaved before beginning the operation ; thirdly, that the manipulator works from the wrists, and not from the upper part of the arms and shoulders ; fourthly, the movements should be begun moderately and gently, and carefully graduated and increased both in force and frequency, according to the exigency of the case and the ability

of the patient to bear the manipulation ; fifthly, the manipulator should carefully avoid stretching the tissues beyond their normal elasticity, which, of course, will vary in each individual, and also according to the extent and length of the disease. He should avoid, in particular, stretching the delicate and sensitive integument in opposite directions, more especially over the flexors of the joints, where the skin is often torn by this error.

Lastly, the dose of massage should, of course, vary according to the extent of surface treated, and the skill and experience of the manipulator.

Compression.—This remedy—which should receive more attention than is at present given to it by practitioners—can be applied by means of any substance which will afford rest and support to the affected structures. The means usually employed are muslin, linen, cotton, silk, and gum, used either alone and bound upon the part, or arranged in the form of bandages and plasters; or the several materials may be combined and woven to the shape of the part to which it is to be applied. The use, in the first place, of the ordinary muslin lightly bound over the surface, in many eruptive affections, will not only give rest and support to the parts, but will also exclude them from the air, which so often tends to keep up the active irritation. It will likewise retain applications upon the surface, as well as prevent friction and irritation from the clothing, assist in arresting a discharge and in limiting the disease, and keep at the same time the parts clean.

Such applications of muslin simply wound or bound around the neck, the axillary region, or the chest, in many of the eruptive affections that involve these regions, often serve as valuable aids to local medication.

Compression can be applied in the same manner to the breasts in any of the eruptive diseases, especially erythema or eczema. I know of no one remedy which is so valuable in eczema involving the folds of the nates and genital regions and the abdomen, particularly when there is considerable adipose deposit upon these parts. The use of strips of muslin, or a large abdominal support of muslin, silk, or a combination of the fabrics, made in the form of an apron, lacing either at the sides or posteriorly, will relieve the congestion, arrest the effusion, serve to keep the application on the surface, protect the parts, and prevent friction with the adjoining portions of the integument, thus limiting the disease. Further, the use of compression in this same form in the treatment of obstinate eczema of the scrotum will result in furnishing the best evidence of its value.

Compression may be applied in the local treatment of erysipelas, and to soothe and protect denuded surfaces during recovery from eruptive fevers. It is a most important adjuvant in the treatment of herpes, herpes zoster, urticaria, furuncular and glandular affections, erythema, and eczema in all its forms.

Compression can likewise be made with plasters, which usually consist of muslin, linen, or sheepskin, upon which some simple or compound medicinal substance is spread.

These are not adapted for making compression over the general surface, and can be more advantageously used upon certain regions.

Their beneficial influence is most strikingly evinced in eczema of the lips.

The mucous surface in this disease is torn open with every movement of the lips, and all the lotions, ointments, and powders will not, at times, soothe the muscular irritation and heal the parts until they are protected and placed at rest. This purpose can be fully accomplished by encircling the lips with strips of adhesive plaster whose ends are caused to meet at the nape of the neck.

In removing these strips, care should be taken to detach both ends and draw gradually to the centre; otherwise, the mucous surface may again be torn open.

While compression can be made with bandages or plasters in the treatment of persistent chronic fissured eczema, yet their lack of adaptability, their inconvenience of application, the ease with which they fall from the parts, their unsightly appearance, and interference with the use of these members, make them very objectionable means to employ. They can only be used in this situation by supplementing them with tightly-fitting gloves or stockings, of a porous fabric, woven with some gum material in it. A similar appliance is equally serviceable in eczema of the popliteal region, the knee and the ankle. Compression should always be applied, so as to support, protect, and afford rest to the tissues. Great care, however, should always be taken not to make so much pressure on the parts as to arrest the circulation.

Bloodletting. The abstraction of blood, either as a local or a general measure, is both a speedy and an efficient means of arresting morbid changes of the integument. In the treatment of cutaneous affections, topical bloodletting should be used in the great majority of cases. It may be performed by puncturing, scarification, or leeching.

Puncturing can be done either with a bistoury, a tenotome, or a sharp-pointed needle-knife, such as I have been in the habit of using, and have named the "dermatome." I have employed this method with success in inflammation of the hair-follicles of the beard, in acne, in enlargement of the blood-vessels of the face, in chronic eczema, in excess of pigment of the skin, in erysipelas, in scrofulous eruptions, in boils and carbuncles, and in neuroses.

Scarification is sometimes very useful in dividing engorged blood-vessels on inflamed surfaces in certain cutaneous affections.

Leeching is much inferior and much less frequently applicable than the preceding measure. It can be resorted to when patients are afraid of the knife or needle.

Venesection—general bleeding—is only permissible when the subject is strong, robust, and shows every evidence of a plethoric state of the system. In such individuals much good will often result from the operation.

Incisions are performed either with the bistoury or the scalpel, for the purpose of exposing or dividing diseased parts, which can often afterwards be removed by other means. It is in this way that we often deal with tumors in the skin, sebaceous cysts, and lymphatic enlargements.

Incisions are likewise made into local inflammatory patches, as in sycosis, in erysipelas, and in carbuncles, to relieve the tension of the parts, to divide sensitive nerves, or to afford free exit to pent-up inflammatory products.

Excision consists in the removal of a part, either by the knife, by ligature, or by crushing. Warts, horns, pigmentary and hairy moles are often eradicated from various portions of the integument by excision with the knife, which is also largely used for extirpation of many of both the benign and malignant tumors of the skin.

Crushing, as performed by Chassaignac, of Paris, is a very excellent mode of excising diseased parts. Although slower than the knife, it is more rapid than the ligatures.

Enucleation is a form of a vulsion, and consists in rapidly peeling out diseased structures, either with the fingers or some hard substance, generally the handle of the knife or forceps. It is a method often employed advantageously after the skin and capsule have been divided over morbid growths.

Scooping is a species of enucleation now much in vogue for removing, with a smooth or sharp spoon, broken-down products or pent-up secretions. It is an invaluable method of emptying cutaneous abscesses, sinuses, and certain kinds of strumous glands.

Scraping, also a very ancient procedure, unfortunately is not receiving, at the present time, the consideration to which it is entitled. It is but a modification of scooping, and can be done with the spoon, provided a little more force is applied. The purpose of this method is to assist the action of local remedies, by ridding the surface, or parts within the integument, as far as possible, of morbid products.

Cauterization. The mechanical cautery, as usually employed, consists simply of variously-shaped pieces of iron fixed in wooden handles. These are heated in an ordinary fire, or by a spirit-lamp or brazier, to either a white or dull-red heat, and rapidly applied to the affected integument.

The remedies just described may be used separately or combined, and may be employed in conjunction with constitutional treatment, or with the assistance of appropriate local medication. In some cases, they can be used alone, and, from the very beginning, with decided curative results. In other instances, they are the only means that can be resorted to after all medicinal remedies have utterly failed.

It is in the latter class of intractable chronic skin diseases that I wish especially to commend the mechanical remedies, as being often very curative, provided always that sound judgment be combined with great care, both before, during, and after their application.—SHOEMAKER; *Med. Bulletin*, Sept., '83.

ON THE TREATMENT OF FURUNCLE, CARBUNCLE, AND MALIGNANT PUSTULE.

Furuncle, carbuncle, and malignant pustule are affections which really differ from each other only in degree. All three depend upon the introduction of infectious matter into the circulation from without; this matter, in the two first-named conditions, belonging to the class of what are now known as septic agents in general, while malignant pustule is the product of the anthrax poison. The latter also is essentially a septic substance—although specific in its nature, like the bacilli—but is much the more powerful.

This statement embodies the rationale of the author's treatment in the diseases named. It is, of course, diametrically opposed to the antiquated, but not yet obsolete notion, founded upon the humoral pathology, that furuncle and even carbuncle are to be regarded as *critical* complaints, by no means to be suppressed, but, on the contrary, encouraged by poulticing and similar measures, as furnishing outlets through the skin for the spontaneous and generally harmless escape of accumulated impurities which might otherwise give rise to dangerous diseases.

Furuncle is a necrosis of one or more of the sebaceous glands. Through a lesion of the cuticle, some poison is admitted, which comes in contact with the capillaries of the glands, paralyzes their nerves, produces engorgement and alteration of their blood supply, cuts off their nutrition, and at last causes the death (necrosis) of the tissues which they normally sustain. The surrounding connective tissue, when once the virus has gained access to it, becomes quickly infiltrated, and, being thus subjected to increased pressure, the necrosis continues to extend in every direction, especially after spontaneous infection has set in from the suppurative nucleus or core.

The parts of the body most liable to furuncle or to carbuncle are those in which the sebaceous glands are most abundant, and the skin is most exposed to injury, of however trifling a nature. Thus, an unclean finger or nail may convey poison into the circulation from the face. The boils and carbuncles which are so common upon the *nape* and *back* are generated by a virus carried from the neck (galled, perhaps, by a stiffly-starched collar), or from the scalp, by falling hairs, and which has found a place of entrance upon the first-named regions. The fingers bring infection to the axillæ, the anus and perineum are contaminated by the fæces, and the finger itself is liable to boils through direct contact, in various trades and occupation, in cooking, dissecting, etc. In the *auditory meatus*, owing to the obtuse angle which it forms near the orifice, its anterior wall is most exposed to contact with foreign substances; therefore, it is not surprising that furuncles are most frequently met with upon this wall.

The reactive inflammation in the vicinity of the septic formation may be confined to its first locality, if the poison is only slightly infectious, or may extend to the larger lymphatics, or, through the veins, to the brain, heart, vena portæ, etc., causing coma, collapse, marasmus, and speedy death.

It is easily inferred from this pathological view that *antiseptic and abortive measures constitute the only rational mode of treating these disorders.*

During the first few hours or days of a boil's existence, it presents merely a small pimple which, being very soon scratched open, is covered with a scab of corresponding dimensions. This scab is removed with a small knife, disclosing a suppurating point—*at once the product and the source of infection—the necrotic focus of the disease.* A small wad of lint, held by tweezers, and moistened with spirits of ammonia, is pressed rather firmly upon this point. The application is repeated six or eight times, a fresh wad being used each time. If the purulent spot has attained considerable size, the surrounding skin must be stellately scarified, before the application of the ammonia, so that the latter may gain entrance on every side. At the same time, the following is administered as a disinfectant of the blood: chinin. muriat., 1.0; aq. dest., 200.0. After the local disinfection, borax ointment (1 : 30. ungt. glycerin.) is spread over the affected places, two or three times daily, and in a few days they will be completely healed, without much inflammation, unless symptoms of a malignant nature should declare themselves.

In *carbuncle*, the inflamed tissues must be relaxed by a deep crucial incision—especially if the tumor has attained considerable size and is very painful—shreds of necrosed cellular tissue removed by the curette, the purulent cavities washed out with a five-per-cent carbolic solution, drainage tubes inserted, and the sore covered with a large antiseptic bandage, over which an ice-bag may be placed for a few days, should the carbuncle show a tendency to enlarge. This dressing must, of course, be renewed every day. Internally, quinine may be given for about a week.

In *malignant pustule*, a crucial incision is made into the small, dark-red, hard, leathery, and cicatrically-thickened eschar, and the surrounding tissues are stellately scarified, especially if they are elevated like a blister. When possible, the crust is completely removed, and the edges of the small resulting sore are also scarified. Spirits of ammonia are then repeatedly applied, as directed above, and the parts smeared with borax ointment and covered with lint or a gauze bandage. In a few days, the pustule will be completely healed, leaving a small cicatrix. Here, of course, as in carbuncle, quinine must be exhibited internally, from the commencement, and kept up for a week, but in larger doses; this generally

breaks the fever in a few days. In this way, more than one hundred cases of malignant pustule have been treated in the course of a year *with the most satisfactory results*, only two deaths having occurred—one in consequence of the pustule being seated upon a large goitre, thus causing suffocation; the other attributable to delay in commencing the treatment.

In cases of furuncle or carbuncle on the neck and back, the urine should always be tested for sugar, since diabetic patients are frequently troubled with them in these situations

The so-called *epidemic furuncle* is generally regarded as the product of some mysterious miasm. It is far more probably caused by *a deposit of septic molecules from the atmosphere, during long continuance of rainy weather, or while the wind is blowing steadily from one quarter*. In cases of this kind, the above described treatment is equally effectual.

Very hard boils on the lips, and those exceedingly painful ones which occur in the *external auditory meatus*, deserve particular attention, since their virus is frequently conveyed, by means of softened thrombi or emboli, into the orbital cavities, and thence into the brain, or else, passes *directly* into that organ, from the ear, thus causing speedy death. Various kinds of phlogogenic and septic molecules held in suspension by the atmosphere are deposited at each normal inspiration upon the nasal mucous membrane, by whose secretion they are arrested in their passage to the bronchi and lungs. From this situation they are liable to be carried into the circulation through very slight lesions inflicted by the fingers, or by razors, etc., upon the surrounding epidermis, and especially when the finger itself has been previously contaminated.

The application of ammonia is easily made to the upper and under lips. Boils in the internal auditory canal, however, can be effectually treated only by means of the recently-discovered non-caustic disinfectants, which are used without injury to the membrana tympani. Such are thymolized "boracic acid," acetate of alumina, etc., which are applied to the meatus in the form of local baths, after vertical incision of the tumor, and are followed by powdering with boracic acid, iodoform, and the like.

Errors of diagnosis are of small account, since in all the three forms of disease we are considering, the same curative measures are applicable.

Under the title *panaritium* are included diffuse phlegmon, progressive tenosynovitis, extensive peripheral necrosis, arthromeningitis, lymphangioitis, metastatic abscess, gangrene, etc., *all of which originate exclusively in septic poisoning*. Panaritia are strikingly distinguished by the depth to which they penetrate the tissues, the sudoriparous glands primarily involved in this complaint extending their roots much further down than those of the sebaceous glands; they sometimes compel amputation, or may even result fatally. It is unfortunate that panaritia, at their commencement, are usually mismanaged by the employment of all sorts of poultices and plasters, so that the physician very seldom sees them until they have passed the stage in which abortive local treatment is effectual. Even when this is not the case, the patient almost always refuses to submit to a free incision of the abscesses before pus appears to have formed, and while the finger is not even stiff. Treatment, therefore, has to be directed to the established sequelæ of the disease, and must consist of suspension of the limb, etc., in accordance with general surgical principles.—RUPPRECHT HETTSTADT; *Deutsche Med. Wochenschrift*, May 23, 1883, No. 21.

VARIETIES AND TREATMENT OF WHITLOW.

WHITLOW appears to be most common between the ages of twenty and thirty-five. It occurs quite as frequently in females as in males, especially in the slighter forms, and in the former seems often to be connected with menstrual derangement. Usually the disease is traumatic, and in most cases the direct excitement is the absorption into the cellular tissue of some irritating material. The term whitlow includes those poisoned wounds of the fingers which are so frequently seen in butchers and poulterers, and which appear to be due to the direct action of a cadaveric poison, similar in its effects, though much more limited, to those produced by the inoculation of the intense virus generated in the dead human body.

The simplest of all the varieties is that in which the inflammation is entirely superficial, and is situated at the root or side of the nail—the paronychia unguialis of Abernethy. This, though a trivial affection, is, like all the others, a very painful one, on account of the tense and firm nature of the cutaneous structure of the fingers. It is in reality a skin disease, and arises most often from inflammation of an excoriation, followed by a collection of purulent serum between the cuticle and true skin. At times it is very obstinate and recurrent, arising without known cause, and requiring prolonged constitutional treatment for its cure.

The most common variety is the paronychia cellulosa, which prevails chiefly in the autumn, occasionally epidemically, and which has distinct erysipelatous characters. It may be divided into the circumscribed and the diffuse forms.

In the *circumscribed cellular* a mere abscess forms, usually on the palmar surface of the distal phalanx. The formation of pus is very rapid, usually within twenty-four to forty-eight hours. It commences and is limited to the pulp of the finger, which is composed of dense cellular fibrous tissue. In such cases there is little or no tendency for the inflammation to spread to the contiguous textures, the skin is but little inflamed, and fluctuation is soon detected. The throbbing pain is its only inconvenience, and relief is afforded at once by a small incision.

The *diffuse cellulitis* or paraphalangeal cellulitis is a much more serious disease, particularly when situated on the thumb or little finger, on account of their synovial sheath being continuous with the common flexor sac. Not only are all the tissues of the finger or fingers liable to be attacked—even to the bones, but in all cases abscesses form beneath the palmar fascia or at the back of the hand. The sloughing which is likely to occur, even when the suppuration is rigorously followed up by the knife, suggests a similarity to a parallel disease, carbuncle.

Although this cellulitis originates in a single finger, I have seen a case in which, from neglect, all the fingers were involved in the process.

In this variety the lymphatics are liable to be involved, and the supra-condyloid and axillary glands affected, although usually even in the severest cases the disease is limited to the hand. In one recorded case the pain was so severe that the patient—a blacksmith of Herculean frame—is said to have succumbed to it alone.

Thecal abscess or tendinous paronychia is found in all cases where the tendinous sheath is the starting point of the inflammation set up by a small penetrating wound. The synovial surface of the sheath inflames and the tendon is in great danger of necrosis by being separated from its vascular supply by the formation of pus. Sometimes the symptoms supervene at once after the injury, some

times not for days. The quantity of matter that gives rise to the extreme pain and to the acute constitutional symptoms may be quite minute. In this form the œdema and superficial fluctuation of the cellulitis are absent. There is but little swelling, and the extreme tenderness and throbbing alone demonstrate the formation of pus. When neglected, sloughing of the tendon and its sheath are sure to result, and at times the inflammation spreads to the great carpal bursa, and along the great flexor tendons to the whole forearm. I have seen but one such case, which terminated in necrosis of the bones of the wrist, and left the hand quite useless.

This tendinous whitlow is often complicated with cellular and periosteal inflammation, forming a true dactylitis.

When the periosteum is first affected, there is extreme tenderness on lateral pressure of the phalanx, but no marked swelling or redness, nor very intense pain at first. It often depends on the syphilitic or rheumatic diathesis, and may occasionally be resolved by leeching and internal remedies, without even puncturing with a tenotome, if seen early. The bones are not so liable to necrose as when the inflammation extends from the adjoining tissues.

The only other subdivision of whitlow is that due to a venereal poison, and which may or may not be syphilitic. It differs altogether from the dactylitis which occurs in the later stages of constitutional syphilis. I have seen but one example of the venereal paronychia. The case, though tedious in healing, got quite well. There was no systemic infection. A precisely similar case to this has been described by Pearson.

When a whitlow attacks the dorsal surface of a finger, the joints are very liable to be affected, as the extensor alone forms the posterior ligament of the joint.

The treatment of the superficial form of whitlow consists simply in improving the general health, and, locally, if the pain be very severe, in puncturing the bulla with a tenotome.

In the initial stage of the severer forms, it may be possible, if seen very early, to abate the inflammation by leeches, iodine paint, pencilling with nitrate of silver, or the application of opium and belladonna dressing. Usually, the tendency of the disease in all its forms is to suppuration.

Internal remedies have little or no effect on this local disease.

The indispensable method of treatment is incision. On this point, most surgeons are agreed. But there is not the same agreement as to the time when incisions ought to be made. In the circumscribed form, it is often of advantage to wait, as the late incision heals much sooner than the early. But in the diffuse cellulitis, the earlier an opening is made the better.

The situation, direction, and extent of the incision are more debatable points. The puncture between the joints is the plan least likely to damage the future utility of the hand. An excellent instrument for such opening is the triangular cataract knife of Beer. This treatment is not applicable to all cases, and is most serviceable in the circumscribed variety, and when a tendinous sheath requires opening, especially in the early stage. Lateral incisions give a free vent to the pus of the spreading form. In bad and neglected cases, where the inflammation has been unchecked, laying open the whole of the palmar aspect of the finger in the midline is sometimes the only method of saving it. The motion of the joint returns even after this heroic treatment, slowly but surely. Uncomplicated periostitis is best treated here, as in other situations, by the lateral subcutaneous puncture.

The treatment I always adopt after incisions is, first, rest on a splint, and second, the application of strong opium dressings. Large poultices enveloping the hand and arm are said to be beneficial. The application of an extension apparatus to a partially disorganized joint will sometimes prevent ankylosis. The test for after-amputation is the state of the bones; should they remain sound, time and rest with extension often effect a cure in the worst cases.

There is one other method of treatment, recommended by so high an authority as Sir W. Fergusson, but which is not usually known, viz., leaving the finger to take its chance, a truly expectant plan. In the only case where I have known this treatment to be adopted, the finger had ultimately to be removed.

In the discussion which ensued, Dr. Brett remarked that the internal administration of sulphide of calcium was often efficacious in arresting the swelling.

Dr. Allen said that in paronychia unguialis it was wise to avoid incisions as long as possible, and, above all, to forbid all hot moist dressings, which encouraged suppuration, rendered the tissues sodden, and checked the tendency to heal. The best local application was a good pencilling of the surface with nitrate of silver. As to the constitutional treatment, it resolved itself into unlimited fresh air and a free administration of alcohol.

Dr. James thought that in local inflammation, free incisions between the joints were quite sufficient; he had never found it necessary to open the palm, and regarded interference with the palm as equally dangerous with complete abstention.—R. A. STIRLING, *Australian Med. Journal*, June 15, 1883.

TREATMENT OF SEBORRHEA AND ECZEMA CAPITIS.

THE treatment of seborrhœa and eczema capitis presents at times so many difficult points to the dermatologist that it is with a feeling akin to despair that he turns to anything new on the subject. The obstinacy of these diseases depends largely upon the locality which they occupy. The interference, however, of the hair with satisfactory treatment does not in the least justify the cutting or shaving of it off. Nothing is looked upon by a dermatologist as more ill-judged than the reckless removal by scissors or razor of a large suit of hair. Alopecia following seborrhœa or eczema is only serious when these diseases remain untreated. The length of the hair does not retard or hasten its falling out, as the cause lies in the skin, and not in the hair itself.

Eczema of the head appears in three forms—eczema rubrum, impetiginosum, and squamosum. The latter is the most common, and usually becomes chronic before advice is sought. Perhaps, at the suggestion of a barber or some one else, numberless remedies have been applied. In such cases, it happens more frequently than is supposed that, besides the quite easily recognized eczema, there is a form of cryptogamic growth engrafted upon it which, coming from the air or from some other external source, serves very much to aggravate the symptoms and to retard the cure. It is by no means rare to notice somewhat inflamed slightly-raised reddish spots which are covered by minute white scales following the course of the hair which has been scratching a chronic eczema of the scalp. This is a form of tinea, but differs from the usual form of dermatomycosis or so-called herpes tonsurans in that it has no regular outline. Whatever may be the nature of this parasite, it has been noticed that wherever it has become firmly fixed upon the skin, owing to the irritation which it causes, and the consequent scratching, a spot of eczema appears and there remains, and increases as long as

the parasite flourishes and grows. This explains the frequent appearance of scalp eruptions in the different members of the same family.

It is a requisite of the successful treatment of eczema capitis to apply a medication in such a way that it will come into actual contact with the scalp. It may be stated, as a general maxim, that salves, oils, or washes should not be applied with the hand. Some intermediate instrument must be used instead, and to supply this want the present instrument has been made. It consists of a small comb with perforated teeth, the openings of which lead to a reservoir on top. This is connected with a can similar to those used in oiling sewing machines. The can unscrews from the rest of the instrument, and into it is poured the medicament to be used. Then the two parts are screwed together, and the teeth turned downwards. The oil flows from the can into the reservoir at the top of



the comb, and from this into the various canals perforating the teeth. These openings are similar in size to those at the end of the ordinary sewing machine oil can, and the whole action of the instrument is quite the same. When it is inverted so that the teeth of the comb point downwards, there is no flow of oil through the openings unless some pressure be used upon the bottom of the can. The quantity of the flow is regulated by the amount of pressure used.

In cleaning the instrument, there are covers at either end of the reservoir which can be removed by unscrewing, and which have washers to make them completely tight. This admits of a free opening and the introduction of any cleansing fluid. The instrument is of solid silver, excepting the can, which is of hard rubber. One comb suffices for any number of cans, since it can be screwed on or off at pleasure, and can be cleansed with great ease.

The instrument recommends itself from the fact that the oil first touches the scalp before getting into the hair, and also on account of the cleanliness with which it can be used. There are no greasy fingers to wash, and no oily brushes to be looked after. The application is made in a minute, and so thoroughly done, it need not be as often repeated.—MORISON; *Maryland Med. Jour.*, Nov. 10, 1883.

A CONTRIBUTION TO THE GENERAL KNOWLEDGE CONCERNING THE PRURIGO PAPULE.

THE author considers that the papule is formed by an infiltration beginning around the upper layer of vessels of the corium, and that this infiltration extending upwards surrounds the papillary vessels, enlarges the papillæ, thus pushing

up the epidermis, which becomes thickened at an early stage above them, and at last penetrating it, forms within its layers a small vesicle containing serum, blood, and lymph-cells. The signs of infiltration surrounding the hair-sheaths and sweat-ducts are secondary, and they play no especial part in the process. Their presence in the papule is accidental, and it is certain that the primary changes in the skin are not in connection with them.

The color of the papule at first does not differ from the rest of the surrounding skin, on account of the depth of the slight infiltration with which it begins. For the same reason, it is at first only felt, and not seen, as the infiltration has not extended high enough to push up the epidermis perceptibly, but is sufficiently great to give a feeling of knot-like hardness underneath it. He considers the whole process due to an inflammation, and that all the signs of chronic dermatitis follow regularly, according to the length and duration of the disease, and the amount of scratching, which the itching, as a secondary symptom, causes.

Clinically, the formation of the papule coincides with this description, for there is always noticed in the beginning of the disease, after careful investigation of the skin, a slight roughness, and a sensation as of running the hand or finger over small knots, covered with an intervening membrane. At this stage, there is no itching. In fact, the itching does not begin until the infiltration has so far advanced that the papules are more distinct. If, before this occurs, the treatment is begun, no itching appears. This proves, as Kaposi says, that all the symptoms of the disease go hand in hand with the increase or decrease of the papules.—MORISON; *Am. Jour. Med. Sciences*, Oct., 1883.

CONTRIBUTION TO THE STUDY OF THE TREATMENT OF TINEAS.

1st. THE tinea being recognized as parasitic dermatoses, the rational treatment in this class of affections reduces itself to indications directed against the parasites. The two indications realizing these conditions are divided in favor among dermatologists:

1. *a.* Epilation which destroys the parasite in suppressing the organ which serves as its asylum.

b. Applications of a cosmetic of croton oil, which accomplishes the same end by inflaming, without destroying, the derma and hair follicles, and thus provoking the fall of the infested hairs.

2. A cure or a notable amelioration is the rule when the disease is not too inveterate. This result may be obtained in a period which varies from three to eight months, and which necessitates from three to five frictions.

3. This method of treatment, extolled by M. Descroizelles, has been reproached with exposing to a greater liability to recurrence than the process of epilation. The observations related in our thesis prove that this reproach is, to say the least, exaggerated.

4. As to the inconveniences of the croton treatment in causing intense folliculitis, inflammations of the hairy scalp, and even the occipito-frontal aponeurosis (Kaposi), erysipelas, etc., the object of the topical application in the form of a cosmetic is to suppress them. The croton treatment has also been accused of having caused permanent alopecia as the result of inflammation. We can truly affirm that such severe accidents have never yet been produced in our young patients.

5. The only real inconvenience which we have witnessed has been the transfer of the application to other surfaces, such as the conjunctiva; but this inconvenience is readily obviated if one takes the precaution to cover the hairy scalp with a protective envelope. Furthermore, we have never observed serious ocular accidents; sometimes a slight conjunctival hyperæmia, but nothing more.

6. As to erysipelas, the statistics which we have reported in our chapter of treatment of tinea tonsurans show that this accident occurred only four times in a thousand frictions, and that it was always followed by a cure. These inconveniences are nothing compared to the violent and intense pain caused by epilation and the inutilité of this procedure in the treatment of tinea tonsurans, since the hairs almost always break.

7. To sum up, we would say that the treatment by the croton oil cosmetic has given us the most satisfactory results in tinea tonsurans, and is encouraging in tinea favosa and in certain cases of alopecia.—DR. A. MASSAY, *Th. de Paris*, 1882.

Received.

Zur Syphilis-Behandlung. Von PROF. DR. A. NEISSER. (Reprint.)

First Annual Report of the Skin and Cancer Hospital, New York.

Affections Parasitaires en général et sur leur traitement. Par M. ERNEST BESNIER. (Reprint.)

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Syphilis Héritaire Tardive. Dents Syphilitiques. Par le PROF. ALFRED FOURNIER. (Reprint.)

Item.

Removal of Warts by Internal Treatment.—DR. ET. GUÉNOT reports (*Bull. Gén. de Thér.*, Mar. 15, '83) that he removed a large crop of warts from the hands of a patient by means of daily ten-grain doses of calcined magnesia, taken in the morning before breakfast.

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ECZEMA OF THE AURICLE AND EXTERNAL AUDITORY CANAL.

BY

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ECZEMA affecting these parts is very similar to the disease occurring elsewhere, except that the hearing is apt to be affected, especially when the auditory canal and membrana tympani are involved. The varieties that occur here are the erythematous, vesicular, pustular, and squamous. The disease may be acute or chronic, although the former is the more usual; it may attack all ages and sexes, but it is more frequent among children and females. Eczema developed in these parts may be idiopathic or secondary to that occurring about the head or face. In the acute idiopathic form, one or both auricles may be affected, or the disease may be limited to one side of the auricle. The auditory canal may or may not be involved.

In the acute stage, the cars are usually swollen, the seat of much burning and itching, covered by vesicles or pustules, which may become dry, and so envelop the auricle with unsightly crusts. The auricle becomes deformed and unshapely, and the meatus may be closed by the collection of crusts or swelling of the parts, and in this way the hearing may be impaired to a serious extent. A sense of fulness about the ears and noises are often complained of. We may find vesicles on the meatus and mem. tympani, but usually only a red and moist skin is seen, from which the epidermis is separating. Painful rhagadæ may be found behind the ear. In chronic cases, there may be considerable thickening of the parts, due, according to Schwartze, "to inflammatory hypertrophy of

the corium," which can produce stenosis of the meatus, deformity of the auricle, and thickening of the cutis of the mem. tympani. In chronic eczema, when the parts are dry and scaly, the patients usually complain of intolerable itching. It is very apt to be the case that these patients have naso-pharyngeal catarrh and catarrhal changes in the middle ear.

In children, eczema is often caused by uncleanness, picking at the ear, by unsuitable head coverings, indigestible food, or anything which tends to impair the health. Dentition may act as an exciting cause in those patients predisposed to the disease. Other causes are the instillation of improper ear drops, an excoriating discharge from the middle ear, the effects of heat and cold, and, especially in children, pediculi about head, and consequent scratching, which may produce an artificial eczema. When occurring in adults, and not due to local causes, it is generally found that the patients are not in their usual health.

CASE I.—Acute eczema of the auricle and external auditory canal.—Mary K., æt. eight, presented herself January 16, 1882. About two months ago, she put a brass earring in the left ear and wore it part of one day only. A blister appeared on the posterior surface of the lobule at the point of puncture, which spread rapidly and finally covered the entire auricle. She applied to a doctor who cured her. Last week, however, the external auditory canal began to be sore, and another physician made an application to the canal, which became very much inflamed, and the auricle was affected as before. When I first saw her, the left auricle was covered with crusts and scabs; the auditory canal sodden, and the mem. tympani macerated. Right mem. tympani retracted and dull; hearing but slightly affected. Pulv. acid. boracic. insufflated in canal, and Ung. zinci oxid. to be applied to the auricle after removing the crusts. January 19, ear very much better, less moisture about auricle and auditory canal. Canal filled with scales, and itches very much. Powder composed of equal parts of zinc oxid. and boracic acid dusted over auditory canal, and Ung. zinc. oxid. to be continued.

CASE II.—Acute eczema of auricle and ext. auditory canal.—Catherine K., æt. forty-seven, came to the Infirmary October 30, 1883. She had discharge from the ear and deafness two years ago. Ten days ago noticed she was deaf and had pain and itching in the left ear. Hearing very much affected. Examination showed right mem. tympani thickened, congested, and perforated just below umbo. Left mem. tympani macerated, reddish, inner end of auditory canal congested and shedding epithelium, canal very much narrowed. Eczematous eruption over auricle and on parts behind it. Pil. Calcii sulphid. gr. $\frac{1}{16}$, one every three hours, and ung. zinci oxid., to be applied to auricle.

November 2. Watery discharge from the ear yesterday, less to-day; considerable itching; canal still somewhat occluded. Fl. ext. viola tri-

color \mathbb{N} x., to be taken three times daily, and ung. zinci oxid. to be continued.

November 9. Eczema better; calibre of canal restored. Perforation seen now in left mem. tympani. Acoumeter, right ear, 12"; left ear, $\frac{1}{2}$ ".

November 16. Eczema has almost entirely disappeared. Auditory canals normal; mem. tympani on either side still perforated. No discharge now from either ear. Continue *viola tricolor*, acid. boracic. insufflated in left canal.

CASE III.—Chronic eczema of both auricles.—Eliza N., æt. fifty-seven, Irish, first came to my clinic February 21, 1882. Twelve years ago, first began to have trouble with her ears, following a cold. She came to this Infirmary then, with same trouble as now. She recovered entirely, and remained well for four or five years. Auricles were then normal in size and hearing good. She had some kidney disease about a year ago, and her health has never been good since then. She has had several attacks of eczema of the auricles, but they have never been perfectly well since the second attack. Right meatus almost closed, and whole of auricle very much thickened, reddened; thin, watery discharge from concha. Left auricle in about the same condition. Meatus very much narrowed, but auricle not as much inflamed. Both ears discharge water, and the least cold she takes causes her ears to swell up and then she hears nothing. Ung. tannin, \mathfrak{z} i.— \mathfrak{z} i., to be applied to parts.

October 20. Ears were cured in about a month; only a certain amount of thickness remained. Another attack followed in six weeks, which was cured as before.

February 13, 1883. She again returned with both auricles in the same condition; both auricles very much enlarged, thickened, and both auditory canals almost closed, so that the hearing is much affected. Watch, left ear, C.; right ear, 1"; hears loud voice only. She has some œdema now of lower limbs, and eczematous spots on upper lip and lower eyelids. \mathfrak{R} Acid. tannic, \mathfrak{z} i.; Vaseline, \mathfrak{z} i. M.

CASE IV.—Chronic eczema of both auditory canals.—J. Y., æt. seventy-three, porter, came December 18, 1883, to the Infirmary. Had an attack of deafness many years ago, but he has always enjoyed good health. Five years ago, right ear began to itch, then left one; some slight watery discharge from both ears. The itching has gradually been getting worse. Hearing, watch, right ear, 3"; left ear, 15". Tuning-fork placed on vertex heard with about the same intensity in both ears. There was no improvement until December 21, when I ordered him to apply \mathfrak{R} Ol. cadini, \mathfrak{z} i.; Alcohol, \mathfrak{z} ss., to both canals, and to take Fowler's solution, gtt. iij. three times daily. The itching has been much relieved since he has been under this treatment. Examination with otoscope showed right mem. tympani lustreless, parchment-like; congestion

along handle of malleus; calibre of canal smaller, which is congested and scaly; scales also about concha. Condition of affairs about the same in the left ear.

January 25. Almost no itching since; canals less scaly. In this case the itching was very annoying, but was relieved at once by the application of tar.

CASE V.—Chronic eczema of both auditory canals.—Thos. C., æt. thirty-six, Irish, January 29, 1884. For about ten years he says he has had dry scales in his ears; canals have itched more or less, and have gradually grown worse. Had syphilis fifteen years ago; he has some scaly eczema about the face, and he has probably had eczema on other parts of the body at times. There is a watery discharge from the ears when he picks them; he takes cold easily and has naso-pharyngeal catarrh. ℞ Ol. cadini, ʒi.; Alcohol, ʒss., applied to canals and to be used twice daily by means of camel's-hair brush. Given arsenic in small doses.

February 5. Hearing distance 15" for both ears after scales have been removed from both auditory canals. Tuning fork, placed on vertex, heard about the same in both ears; the itching has been much relieved; only once since he was here has he been obliged to scratch his right ear. Tarry matter and scales removed from both ears with the syringe and curette, and same treatment as before.

February 8. Watch, right ear, 10"; left ear, 12". Left canal not so scaly; mem. tympani dull, lustreless, and somewhat congested and retracted; few scales in right canal; right mem. tympani similar to left one. Same treatment continued.

Constitutional treatment is very important in these cases. Dyspepsia or constipation should be corrected. The urine should be examined for Bright's disease—diuretics and alkalies are often required for those of a gouty or rheumatic diathesis. In children who are scrofulous, cod-liver oil will be found beneficial, or iron and the phosphites. In chronic eczema, arsenic in small doses should be given. Piffard, several years ago, called the attention of the profession to the use of *viola tricolor* in cases of eczema capitis, acute or chronic, and especially occurring in children of a lymphatic nature. I have used the fluid extract in x.-xx. ℥ doses with apparent benefit in several cases. Any naso-pharyngeal catarrh or middle-ear disease should have appropriate treatment, and the condition of the mouth should be noted to see that there is no dental irritation. As regards local treatment, in acute cases I have found the officinal zinc ointment generally all that is required. The crusts should first be removed, and then the parts rubbed well with the ointment several times daily. When the auditory canal is invaded, the crusts and scales should be gently removed with the curette, and then the zinc ointment applied, or what is better, the parts may be dusted with a powder composed of equal

parts of zinc. oxid. and boracic acid, or ℞ Zinc. oxid., ʒ ss.; Amyli, ʒ i. No water should be used. Other useful remedies are the ungu. diaehyli of Hebra, or applications of cod-liver oil. Should the disease show a tendency to become chronic, especially if there is any thickening, the following salve will answer well: ℞ Acid. tannic, ʒ i.; Vaseline, ʒ i. In making applications to the external auditory canal, great care should be employed not to injure the mem. tympani. In chronic eczema, when there is much thickening and the parts are dry and scaly and attended with much itching, tar should be used. Besides the eurette, it will often be necessary to syringe the ear in order to remove all scales before making applications. I use the following preparation of tar, as recommended by Burnett in his Treatise on the Ear: ℞ Ol. cadini, ʒ ij.; Alcohol, ʒ i. M. The parts may need more stimulation, when acetum cantharidis may be gently applied, or solutions of potassa and then tar used afterwards.

THE NATURAL HISTORY AND THE TREATMENT OF SYPHILIS.

BY

DR. SCHUMACHER, JR.,

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DR. P. DIDAY, of Lyons, for many years has distinguished a decreasing and a progressing syphilis. Against the former he employs hygienic remedies, and avoids specifics; but against the latter he uses mercury or iodine and hygiene. It is of great consequence to distinguish these two forms, and to wait at least twelve to fifteen months after the appearance of the chancre. If, during this time, the symptoms of syphilis are only of a secondary nature, and if the recurring symptoms are the same as the former, the "decreasing" syphilis exists, and for a cure the expectant treatment ought to be followed. But if, after this time, severer symptoms, that is, if the so-called tertiary symptoms (gummata), mixed with secondary, appear, one must surely apply specifics, namely, *mercury*.

In similar manner, Diday expresses himself in his history of syphilis (Paris, 1863), declaring that he has seen that syphilis, in spite of methodical specific treatment, lasts very long, and causes later affections of the skin, iritis, diseases of the testicle, and lastly the so-called tertiary affections, and may, in this manner, reappear without any limit; even if the patient is apparently cured, still the inclination to engender enfeebled children remains. This being the form of strong syphilis.

More frequently, he has also observed the contrary, and that was when syphilis, although treated without specifics, restricts itself to

superficial lesions, to two or three cutaneous eruptions without importance, and diminishing by degrees; then the health is entirely restored, as the children of such patients, later engendered, will prove. This combination of symptoms constitutes a picture of what is called the mild form of syphilis.

About a discussion on the same subject in the Parisian Society of Surgery, which appeared in the *Gazette des Hôpitaux* in 1867, Diday says: "Although mercury cannot prevent the secondary symptoms, it tends to weaken the disease, but it neither prevents recurrences, nor does it destroy the diathesis; children of syphilitic parents are less liable to infection in course of time." He gives no mercury to patients that have indurated ulcers, or to those who have light secondary symptoms, nor to those who have psoriasis palmaris and moist papulæ, but does give it to those affected with scaly and pustular exanthemata, or iritis, onychia, and dysphonia.

In the month of September, 1872, at the Medical Congress of Lyons, Diday read statistics of seventy-four cases of syphilis. Of these, during the time of the appearance of the infecting chancre till the first appearance of the secondary symptoms, forty-nine cases have been cured without the use of mercury and twenty-five directly with mercury, the pills of the iodide of mercury having been given throughout. To give greater demonstrative power to these conclusions, drawn from three observations, he has now these seventy-four cases, of which he later excludes one-quarter on both sides, on account of too short duration of observation, but the rest he pursued as rigidly as possible for ten years, that is, till 1882, and published the result of his observations in the *Annales de Dermat. et Syphilis*, 1882, Nos. 10-11.

After the declaration of Diday, separating, as he does, the cases in easy and difficult ones, I propose to give you his exact views, and give his statistics in the following table, in which the combination with the figure Hg. denotes the sum of the cases which, after the breaking out of the secondary symptoms, were treated by him with hydrargyrum.

A.

Cases not treated with mercury before the appearance of secondary symptoms.

	TIME OF OBSERVATION TILL THE YEAR.	AFTER THE YEAR OF OB- SERVATION; NO SYMPTOMS OF SYPHILIS.	SYPHILIS STILL EXISTING.
Mild syphilis.	1 — 7	2 — 1 Hg.	5 — 1 Hg.
	2 — 6	2 — 1 Hg.	4 — 1 Hg.
	3 — 7	6 — 3 Hg.	1 — 1 Hg.
	4 — 3	2 — 2 Hg.	1 — 1 Hg.
	5-10 — 3	3 — 2 Hg.	.. — ..
Sum total,	26	15	11

	TIME OF OBSERVATION TILL THE YEAR.	AFTER THE YEAR OF OB- SERVATION NO SYMPTOMS OF SYPHILIS.	SYPHILIS STILL EXISTING.
Strong syphilis.	1 — 6	.. — ..	6 — 5 Hg.
	2 — 2	1 — 1 Hg.	1 — 1 Hg.
	3 — — — ..
	4 — 1	1 — 1 Hg.	.. — ..
	5-10 — 2	2 — 2 Hg.	.. — ..
Sum total,	11	4	7

B.

Cases treated with mercury immediately after the appearance of the chancre.

	TIME OF OBSERVATION TILL THE YEAR.	AFTER THE YEAR'S OBSER- VATION NO SYMPTOMS OF SYPHILIS.	AFTER THE YEAR'S OBSER- VATION SYPHILIS STILL EXISTING.
Mild syphilis.	1 — 5	1	4
	2 — 1	..	1
	3 — ..	..	..
	4 — 1	..	1
	5-10 — 1	1	..
Sum total,	8	2	6

	TIME OF OBSERVATION TILL THE YEAR.	AFTER THE YEAR'S OBSER- VATION NO SYMPTOMS OF SYPHILIS.	AFTER THE YEAR'S OBSER- VATION SYPHILIS STILL EXISTING.
Strong syphilis.	1 — 7	..	7
	2 — 1	..	1
	3 — 1	..	1
	4 — 1	1	..
	5-10 — 1	1	..
Sum total,	11	2	9

From the history of his cases of syphilis, Diday now suggests five points of controversy:

(1) Does mercury, given on the appearance of the chancre, prevent the appearance of the secondary symptoms?

The answer is no, judging from the results of his observations.

(2) If mercury does not prevent the breaking out of the secondary symptoms, does it not at least weaken the further progress of syphilis?

Hereupon Diday also answers that the success of the expectant treatment, and that of the treatment with Hg. immediately after the appearance of chancre is the same in both cases.

(3) Is mercury as powerless against relapses, as it is powerless to prevent the first breaking out of the secondary symptoms?

Although Diday for many years has proclaimed the inefficacy of Hg., and although his cases mentioned in previous years proved now and then the failure of Hg. as a curative agent, yet it did not prove this failure to be a general rule. Nor do his present statistics appear to him as

decisive for No. 3 as for Nos. 1 and 2. Nor does it include any clinical facts which could be a support to his adversaries; although, indeed, the comparison of the history of the disease now demonstrated by him shows, as regards the gravity of the symptoms, an almost absolute resemblance between the relapses which appear after a longer or shorter treatment with mercury with those in which an expectant, hygienic treatment had been used. On the contrary, the physician has not a better chance to study the influence of a drug than at the beginning of the disease, when its course is with all patients the same. If one considers that during this time the physician has the full control and the possibility of giving mercury to its full capacity, yet that this preparation deserves by no means the title of a specific, what can then mercury do against the further progress of syphilis, if it cannot prevent the beginning of the disease?

(4) For twenty years Diday has maintained the view that there is a consistency between the gravity of the first general appearances, that is, of the primary and secondary symptoms, and the gravity of the later symptoms of syphilis. The eruptive form (erythematoso) of the first syphilitic promises a quicker decline, and is easier to control; syphilis which appears immediately with papulous exanthemata presages, besides a long duration, a deeper infection of the organism, and then iritis, onychia, and dysphonia are to be foreseen. Finally, the squamous and pustular forms are followed by lasting and strong headaches, by persistent sleeplessness, and, after short duration, by purulent processes, impetigo, ecthyma, and rupia.

The old maxim as to syphilis is entirely wrong—"Nimum ne crede colori." On the contrary, the color of the first breaking out is our best guide. The darker it is, the worse the prognosis.

(5) Diday considers syphilis in most cases a mild disease, as the following sentences, given in questions, prove. May one consider syphilis incurable? Are there not mild and difficult cases? Does syphilis as frequently and as early lead to visceral diseases or to particular lesions of the nervous centres as is asserted? Ought one to adjudicate to syphilis so long a time of expiration; might not one adopt rather a middle degree for syphilis, such as it appears most frequently, say a middle duration, until it is finally cured?

(6.) Finally Diday concludes, for the use of the practitioner, that he, without disapproving in the slightest of mercury, only recommends its application in the sphere of its power and its benefits, that is, to soften with it every severe breaking out of syphilitic process.

So far the views of Diday. I have considered it my duty to follow closely the experiences of the author, which contain much truth. But it may also be allowed me, though briefly and temporarily, with-

out statistical documents, of course, only in mean proportion, to communicate the results of my own experience, made during the last ten years in Aix-la-Chapelle, which in important points are not at all parallel with the views above reported. I directly point out by this that in Aix-la-Chapelle, in consequence of the peculiarity of our professional work, only difficult cases of syphilis are met with.

The works of Diday show doubtless that, besides the necessary and important regard for hygiene, with him also mercury has become the principal remedy in the treatment of syphilis, as soon as the disease takes a serious form, whether it be in the secondary or in a later stage. Indeed, he makes many dialectic turns, in a diplomatic style, to find fault with mercury, but as the tables alone may prove, he has, in group A, in most cases resorted to mercury as soon as the secondary symptoms made their appearance.

The success of the group A also speak in the favor of mercury. For the number cured at the end of the observation grows by so much more the longer the observation, that is, the cure of the disease was made possible by the faithfulness of his patients. Diday may by no means be counted among the antimercurelists, as he tries to make one believe in many places.

To my conviction, in syphilis appearing with severe symptoms, the application of mercury in the form of embrocation or inunctions of the blue ointment will, above all others, give the physician the best results.

A CASE OF SYPHILITIC PYREXIA.

BY

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THE subject of this short history was a young man of twenty-eight or thirty, who, up to the time of contracting syphilis, enjoyed good health. He had been, for several years, a student, and was remarkable for his quiet habits.

About the middle of October, 1882, he consulted me regarding a sore on his penis. He stated that when he noticed it first, a few days before he came to me, he cauterized the sore with nitric acid. For this reason, I told him I was not quite certain as to the real nature of his disease; and also, as he had been exposed on two occasions, the one six, and the other twenty-seven days previously.

In a few days, under a cleansing treatment, it became quite apparent

what the real nature of the trouble was. Antisyphilitic treatment was ordered; but he could not, or would not, take this medicine. In the course of two weeks, the glands in the groin became enlarged. At this time, there was severe headache.

The cachexia became very great. There was utter loss of appetite. The feature of the case deserving special mention, however, was the continuous high temperature, which, on one occasion, reached 105.1. This symptom varied from 102.5 to that just given as the highest, falling in the morning and rising in the evening, for a period of over three weeks, when a macular, followed by a vesicular, rash came out fully over the body and head. The emaciation and sleeplessness were pronounced.

Owing to the inability of the stomach to tolerate mercurials, a solution of corrosive sublimate was given hypodermically. Under this treatment, he improved well; and, about six weeks from the date of commencing this treatment, he left the city, with strict orders to continue his medicine. This he did not do.

He gradually became deranged mentally, and, in April, 1883, was quite insane, with religious convictions and a strong suicidal tendency. He was now put on potassium iodide, one drachm, and corrosive sublimate, one-fifth grain a day. The mental condition began to improve. He was sent to the country to live on a farm, where he was fed mainly on milk, being all the time under careful watch. The iodide and mercurial were occasionally dropped, for a week during the treatment.

At the present time, he is almost himself again; and, were it not for a reticent manner, those who know him best would not recognize any great difference between his condition now and previous to the attack.

Society Transactions.

NEW YORK DERMATOLOGICAL SOCIETY.

144TH REGULAR MEETING, MARCH 25, 1884.

DR. P. A. MORROW, *President, in the Chair.*

DR. FOX presented a case of

SCLERODERMA AND MORPHEA.

The case was kindly sent by Dr. W. G. Robinson, of the Bellevue Bureau of Out-Door Relief. The patient was a woman. The disease began fifteen years ago as a purple spot upon the outer side of the left leg, about midway between the knee and ankle, from which it spread so as to involve the whole of the left leg, and to a less extent the right one. The affected parts are reddened, hard to

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the touch, and the patient complains of great stiffness of the left leg. The skin has a tense look, and there is a line of cicatricial tissue running down the left tibia from below the knee to half-way down the leg. There are numerous irregularly shaped, atrophic, white spots upon the left thigh and upon the right buttock, which are extremely painful upon contact. These spots have no lilac border, and are devoid of any lardaceous feel. They were first noticed about fifteen months ago.

DR. ROBINSON would agree without question in the diagnosis of scleroderma, but did not feel so sure of morphœa also being present. The white spots were atrophic, and probably were so from the beginning, in that respect differing from morphœa, which is hypertrophic. But we know that scleroderma may run into morphœa, and so it would probably be correct to allow the diagnosis of morphœa.

DR. FOX said that Dr. W. G. Robinson asked whether electricity would be of benefit in this case. He (Dr. F.) had seen galvanism do good in one case of scleroderma.

DR. MORROW said that the patches did not look like morphœa; they lacked the lardaceous appearance, and their color was rather a grayish-white than the characteristic white of morphœa. The fact, however, of their development with sclero-derma was strong evidence of their being morphœa. He had never seen any good result from treatment.

DR. CAMPBELL, on behalf of DR. BULKLEY, presented a case of

LEUCODERMA.

The patient was a young man, twenty-one years of age. His general health is and has been good. Last winter, his hair began to turn gray in tufts, and shortly afterwards he noticed numerous apigmented spots on his body. Upon examination, there are found some twenty white spots scattered over the trunk of his body. In the centre of most of these spots there is a red vascular point. The patient says that the white spots come first, and the red points afterwards. One or two old pigmentary nævi are seen to be fading.

DR. FOX considered this to be a very unique case. Were there not some patches of ordinary leucoderma, he would have thought that the central red spot was primary in each case.

DR. OTIS then read the paper of the evening, entitled

CONTRACTIONS OF THE MEATUS URINARIUS AS A SOURCE OF REFLEX IRRITATION IN THE BRAIN AND SPINAL CORD.

Civiale was the first surgeon who divided the meatus urinarius as preparatory to the operation for stone, allowing the meatus to heal before proceeding to the main operation. In some cases in which he had divided the meatus, he observed that some symptoms attributed to the stone disappeared when the contraction of the meatus was relieved, even before the operation for stone was performed. In consequence of this experience, he formulated the saying that "division of the meatus often caused a sudden and remarkable change in the nervous condition of the individual, and the general condition of the patient often improved without other treatment."

As an illustrative case of the nervous symptoms caused by a contracted meatus, that is, any narrowing of the meatus below the size of the urethra behind it, Dr. Otis related the following: A patient, a physician himself, complained of irritation at the end of the penis, which came on whenever he was in a reduced state of system from overwork, either physical or mental, the latter being apparently the chief and immediate cause of the irritation. At the same time that this came on, he became very despondent without apparent cause. He

did not associate in his mind the irritation with the despondency, but attributed the latter to his general debility. The despondency was so great as to render all his mental processes unreliable, and to make him feel as if he did not care to live. He never had had any venereal disease. There was some dribbling in urination. Upon examining penis, the meatus was found about the average size, No. 24 F. or thereabouts. There was no stricture of the urethra, as the urethrometer discovered no contraction except at the meatus. This was dilated to the extent of three or four millimetres. Division of the meatus was advised, but not accepted by the patient. After several weeks, the patient again called upon Dr. Otis, and stated that as soon as the smarting from the passage of the instrument on his previous visit was over, his mental atmosphere cleared up, and there was no irritation at meatus till now, when he applied for another dilatation. This was done, and with the same effect of relief of symptoms, so that there was no doubt as to cause and effect. The dilatation was repeated at periods of from one to four months for a year or more, when the patient began dilating his own urethra. He would never permit himself to be cut, and now for five years he has occasionally dilated the urethra, and always with the same prompt relief.

Another physician applied to Dr. Otis some five years ago, the subject of attacks of profound mental depression, coming on without apparent cause. He stated that he was always a thin-skinned, nervous individual, and that he could not endure any great strain either nervous or physical. He had always had a long prepuce, and a troublesome fossa navicularis from which he had to shake out the last drops of urine. There was no smarting or scalding of the urine, but only the feeling of an unemptied urethra till the fossa was squeezed out. The *coup de piston* was good. He bore these difficulties until he was past forty years of age, when to them were added various reflex nervous difficulties, among these a feeling of wetness in the urethra and a bearing-down in the perineum, great discomfort, and hyperæsthesia. The meatus only admitted a No. 12 F. sound, which was passed, to his immediate relief, which continued for several weeks. After about one year, Dr. Otis divided his meatus, and kept his glans uncovered, with the effect of permanently removing his nervous trouble.

Dr. Otis has seen many cases in which a contracted meatus seemed to be the determining cause of epileptic attacks, in illustration of which he cited the following case: A. B., æt. eighteen. In only fair health, and of nervous disposition. When about eleven years old, he began to masturbate on account of irritation at end of penis, and for several years he did so almost daily. At sixteen years he had his first epileptic attack without recognized cause. In the next few months he had two similar attacks, both during much mental worry. No digestive trouble present. Each attack preceded by distinct aura, and they were of the character of "petit mal." About three weeks before coming to Dr. Otis, the attacks became more frequent, occurring almost daily. The usual remedies having no effect upon the epilepsy, the genito-urinary condition was inquired into. It was ascertained that the patient had no functional difficulty, but prolonged waiting before urination, and dribbling after it. The meatus measured No. 26 F., the estimated normal urethral calibre being 34 m. There was great sensitiveness at the contracted portion. Upon the emergence of the urethrometer there was an attack of petit-mal lasting for three minutes; and during the rest of that day there were three more slight seizures. There was no further trouble for five days, when there was another attack. On the 15th October, 1877, the meatus was cut up to 34, the size of the urethra behind the contraction. No attack until the 31st October; hesitation in urination completely

removed. From then to 7th December he was free from attacks and mental fatigue and worry; when he had a slight faint. On December 10 a slight recontraction was found, and divided up to No. 35 F. During the next three months he improved in every way, and only had two slight attacks under great fatigue. A slight recontraction at one-half inch was found, which was divided to No. 36 F., the size of urethra before and behind the contraction. No further trouble for five years, during which he was a hard-working student. In 1882 he contracted a gonorrhœa, and within a few days he had a slight attack of petit mal. From that time till now (March, 1884) he has had no trouble, and is in excellent health. During the entire time from October, 1877, there has been no medication for the epileptic trouble.

Within the past three or four months, Dr. Otis has had a case with the history of frequent attacks of petit mal coming on only at night, and always preceded by irritation in the fossa navicularis, this followed by a desire to urinate, which grows more and more frequent for fifteen minutes to one hour, when he gets a thrill over the region of the liver, sometimes accompanied by eructation of gas from stomach, then soon lapses into a state of insensibility, continuing for ten or fifteen minutes. These attacks are sometimes as often as twice a week, and the violence of the precursors are increased by errors in diet. There is no evidence of organic disease in the man. Examination shows circumference of penis, $3\frac{1}{4}$ inches. The normal calibre estimated at 32 mm., and contraction of the orifice to No. 25 F., the meatus was stretched 5 mm. with the urethrometer. The patient was not again seen for four weeks, when he reported great relief from low spirits and irritation of the penis for over three weeks. The attacks of epilepsy have come on several weeks apart instead of semi-weekly, as before. The operation for dividing the meatus is decided upon, but up to this time postponed.

There is yet another class of cases in which the reflex irritation falls more particularly upon the spinal cord. Case —, child, æt. three years. First seen by Dr. Lewis Fisher, of this City, in October, 1881. The child when an infant did not improve satisfactorily; and a wet-nurse was obtained for it when six months old. He was weaned at eleven months. The child was then restless and fretful, had frequent erections, and troublesome enuresis. The physician then in attendance examined the child's penis, and pronounced it free from any trouble. When the child was two and a half years old, it was still in the same general bad condition, and suffered from bilious attacks. The parents then took the boy to Europe, and he was shown to several leading physicians there. In London, circumcision was advised, on account of enuresis and erections. This was done on child's return home, with relief to the enuresis, and almost entire stoppage of erections during the day, though still troublesome at night. He often waked from sleep screaming, and was very hard to quiet. When first seen by Dr. Fisher, October 15, 1881, the child was found to be growing thinner, and more irritable, stumbling in his walk with his right foot turned in, and subject to violent outbursts of temper. The child constantly fumbled with his penis while in bed so that his hands had to be tied. Upon examining the penis, the prepuce was found to have been circumcised, and the meatus was not much larger than an ordinary probe. Dr. Fisher believed this small meatus to be the possible cause of the troubles, and consulted Dr. Otis, who quite agreed with him. A few days afterwards Dr. Otis saw the child, and failed to find any evidence of spinal disease. The difficulty of locomotion was marked, the child falling every few steps. Erections almost constant during sleep. Upon examining the penis, it was found to be $1\frac{3}{4}$ inches in circumference; the meatus measured No. 9 F., was red and

pouting. The normal calibre of urethra was estimated at not less than No. 22 F. The urine was examined but found to be normal. It was reported that the acts of urination during the day were accompanied by escape of flatus from the bowels on account of straining. On November 8 the meatus was divided to No. 17. After the child recovered from the immediate effects of the ether, it slept quietly without handling the penis. After the operation there was no trouble in urinating and no escape of flatus; a marked improvement in gait, and no disposition to be carried as before. The sleep during the night following the operation quiet, and without erections. Subsequent treatment by separation of wound by means of a bent probe. Improvement in sleep and temper till the seventh day, when erections returned, sleep disturbed, and in the morning stumbling in the gait. The meatus was found recontracted 4 mm. It was carefully divided to No. 22 F. without producing hypospadias. No. 22 F. bulb passed easily along whole urethra. Relief was as before. Improvement to December 22, when again persistent erections. Recontraction was found to No. 13 F., which was divided to No. 20 F. with immediate relief of irritation and improvement in gait. Subsequent treatment as before. In four days recontraction to No. 18 F., with return of erections and stumbling. Divided up to 20 F. on 29th December, and on 30th December dilated up to 21 F. Doing well up to January 23, 1882, when there was a return of the erections and of the stumbling, and a recontraction to 19 F. was found. Divided the cicatricial stricture up to 20 F. with prompt relief to symptoms. After-treatment as before. Improved in general health, and no irritation or erection up to February 22, when a recontraction to 15 F. was found and divided with same prompt relief. On March 3, reflex symptoms and recontraction again present, and Dr. John T. Metcalfe was called in consultation. He found no spinal difficulty, and coincided in a suggestion previously made, to examine for stone. This was done with negative result. He then advised a continuance of the cutting as long as relief of the symptoms followed and relief through other means failed. Again divided up to No. 22 F., without enlarging the orifice, with immediate and complete relief up to March 18, when erections recurred and gait became unsteady. Recontraction found to No. 19 F., which was divided to No. 23 F. After twelve days, during which the child steadily improved in health, there was a recurrence of reflex symptoms with a recontraction, which was divided with complete relief for twenty-eight days. Child was well and improving up to April 28, when No. 22 F. passed with slight catch, there was some return of erections, and slight unsteadiness in gait. Divided again, but still some slight catch on withdrawing bougie. On May 3, 1882, divided again, on account of incomplete disappearance of symptoms. No. 24 F. passed easily. From this time the child remained well, dilatation being continued by means of a specially constructed dilator, somewhat like a glove-stretcher, capable of being dilated up to No. 24 F., at first every other day for one month, and then every week, two weeks, and one month for two or three months, then stopped. Child to-day, nearly two years from date of last operation, fat and well without any noticeable deformity of penis, and has been well of all genito-urinary troubles up to this date, March 28, 1884.

In the discussion of the paper

DR. KEYES said that he had had no experience in the direction of Dr. Otis' paper. He believed that dividing the meatus was exceedingly useful in cases of deep irritation of the urethra. From cutting of the meatus alone, he had not had good results. He has seen spasm of the urethra relieved after cutting in various ways, but not by cutting of meatus alone. This was useful to allow the passage of a large instrument into the deep urethra to stretch it. Vesical irrita-

bility may be relieved by cutting the meatus if under No. 26 F. He thinks it very extraordinary, in the light of Dr. Otis' cases, that No. 26 F. being the average size of the male urethra, there is no symptom complained of in the great majority of male subjects. There was no reason why irritation of the meatus should not be the cause of epilepsy any more than scar tissue may be, and if so, relief of the irritation should relieve the epilepsy. He considered the child's case to be very extraordinary, as there was no sexual element in it, nor any chance for moral effect of treatment. He had only had one case in which he cut the meatus for the relief of reflex nervous troubles centering about the urethra, and with decided cure of the case. After eighteen months, the patient had a return of the trouble, and then the neurosis took another tack, and he had some other form of insanity. He considered the first effect of cutting in this case as purely moral. He remembered another case which illustrated the change of neuroses under moral influences. The patient was a very much over-worked man with many responsibilities, who had an intense pruritus scroti. His first illness took the form of dyspepsia, which he cured, according to his own story, by living upon fried oysters. When his dyspepsia left him, he became insane, and for two years was confined in an asylum. When he recovered from that, he developed this pruritus scroti. Treatment failed to relieve him, and Dr. Keyes advised him to leave work, and asked him to report to him when he found anything to cure him. The patient went to Hot Springs, and reported that they cured him. In considering these cases, he was led to ask himself if some of the cases reported as cured by cutting the meatus might not be shifting neuroses.

DR. SATTERLEE had seen several cases very much relieved by Otis' treatment. One was a man with severe pruritus of scrotum and penis without any particular cause. His meatus was found to be No. 20 F., and was enlarged to No. 32 F. Within a half-hour, he experienced relief from his itching, which lasted six hours, and gave him sound sleep. He had never had syphilis. His urine was normal. Every day his urethra was dilated, which always relieved his itching for from six to ten hours. He had had other cases like this one. He had also had another case with small meatus, associated with loss of power in the legs and a feeling of numbness. The meatus was enlarged, and subsequently dilated, with great relief to the symptoms, and now the patient walks with comfort. The patient had also partially lost the sight of one eye, and after the cutting of the meatus his eyesight improved. The eye had been pronounced normal by a distinguished ophthalmologist.

DR. TAYLOR had cut scores of meati for deep urethral and vesical troubles, and with varying success. He did not believe that cutting of the meatus would relieve itching of the scrotum, except in so far as the sore penis took the mind away from the pruritus.

DR. DENSLOW had had several good results from Dr. Otis' plan of treatment. The first case was that of a man who had been sent to the Adirondacks for his health, he having been growing thinner and more wretched for some time. He came to the doctor in New York. His meatus was so small as hardly to admit a knitting needle. It was cut, and the patient's health immediately began to improve. After some four or five months, he felt badly again, and his meatus was found recontracted. He was cut again up to No. 20 Eng., and regained his health. The second case was a man who had a persistent pain in his back between the shoulders; he was losing flesh, and was unable to attend to his business. His meatus was found to be small, and was cut up to No. 18 Eng., with the result of a perfect cure of all his symptoms.

DR. WHITE, by invitation of the President, said that he had seen some cases considerably relieved by this operation. One case he had in which the patient was troubled with disturbance about the prostate. His meatus was about No. 24 F., and was cut up to No. 40 F. Result, perfect cure.

DR. BANGS, by invitation of the President, corroborated all that Dr. Otis had said. The cases narrated by Dr. Otis he had seen, and considered them as reflex irritations cured by operation.

DR. OTIS, in closing the discussion, said that the cures may have been the result of the operations upon the patients' mind, but that did not invalidate the operation. If we can do our patients good by any operation, we should practise it. He had no theory, psychological or otherwise, as to the operation. His impression was that there were nerve connections with the meatus throughout the entire system. The track between the brain and the penis was perfectly clear,

at least as to sensuous thoughts. We know that from any cicatrix we may have nerve disturbance, and why not from a cicatrix of the meatus? A contracted meatus is a common cause of neuralgia testis. There is no reason why a nerve disturbance originating from one point should not manifest itself reflexly upon any part of the body. Many years ago, he had a case of neuralgia of the toes in a woman who had an ulcer on the os uteri, and this case was not unique.

DR. MORROW asked if Dr. Otis could give any group of symptoms which would be an indication for the operation.

DR. OTIS replied that there was, properly speaking, no such group of symptoms. The highest type of urethra is one in which the meatus is of the same size as the urethra behind it. In any case of obscure nervous trouble of any part associated with contracted meatus, he would feel justified in dividing the meatus.

DR. FOX said that it was his custom in nearly all cases of pruritus ani or scroti to examine the meatus. In many cases, he had found a slight stricture, and relief from the itching by passing a sound.

DR. TAYLOR did not doubt but that pruritus ani et scroti might be relieved by dilating a stricture; but he did not think it could be if the pruritus was associated with infiltration of prepuce and scrotum.

DR. KEYES said that patients often felt better after the passage of a sound, but he thought it was merely the effect of the passage of a smooth instrument through the urethra, and not the stretching of the canal.

DR. FAITHFUL, of Sydney, Australia, by invitation of the Society, presented some specimens of medicated chalk and starch powders. They were medicated with various substances suspended in ether, chloroform, and alcohol. He then read a short paper upon the preparation of these powders, as follows:

A NOTE ON THE USE OF MEDICATED POWDERS IN MOIST SKIN AFFECTIONS.

Most physicians are aware of the difficulty of getting medicated local applications for moist skin diseases, which are:

- 1st. Non-irritating.
- 2d. Cleanly.
- 3d. Beneficial.

It occurred to me that by medicating starch or French chalk, these requirements could be met.

The difficulties presented in the matter were:

1st. To get the medicant sufficiently finely powdered and thoroughly mixed, so as to get a uniform strength, and be at the same time non-irritant.

2d. Many substances or drugs required could not be obtained in a powdered form.

The idea then suggested itself, that by first dissolving the medicant in alcohol, ether, or chloroform, and then carefully and thoroughly mixing the solution or tincture with the starch or French chalk, and then allowing the alcohol, ether, or chloroform to evaporate, these difficulties could be overcome.

I tried this, making the solutions or tinctures from Dr. Squibb's and Messrs. Schieffelin & Co.'s fluid extracts. Each minim of a fluid extract equals about a grain of the powdered leaf or root of the drug from which they are made, so a pretty uniform medicated starch or chalk can be prepared by pouring the solution or tincture over a given amount of starch or chalk according to the requirements of the case.

No artificial heat should be used to cause the evaporation of the alcohol, ether, or chloroform.

Should the preparation dry too rapidly, a few lumps may be formed, but these can be entirely disposed of by the use of a pestle and mortar.

I have used these medicated powders in several cases of *eczema vesiculosum*,

intertrigo, herpes progeneralis, moist warty growths, ulcers, etc., with the most marked results.

The advantages claimed are:

1st. The starch or chalk absorbs the moisture, and the medicant is brought in direct contact with the diseased surface.

2d. It is easy to apply, cleanly, cooling, non-irritating, and effective.

3d. It can be applied to the most irritated surface without causing any pain or inconvenience.

4th. It can be easily removed if necessary.

5th. Any substance or drug which is soluble in alcohol, ether, or chloroform may be used.

Correspondence.

DERMATOLOGY AND SYPHILOGRAPHY IN GREAT BRITAIN.

NETTLE-RASH—CHILBLAINS—LABIAL HERPES—HERPES ZOSTER—THICKENED EPIDERMIS—MYXEDEMA—DIAGNOSIS OF SYPHILITIC ERUPTIONS.

DR. MCCALL ANDERSON, in "A Lecture on NETTLE-RASH" (*British Medical Journal*, Dec. 8, 1883, p. 1,107), gives a good account of the various forms of this affection, and, after full consideration of the etiology and diagnosis, recommends treatment to consist primarily in removal of the cause; if this is undiscoverable, ether, as recommended by Trousseau, may be tried in doses of twenty to forty drops, or quinine in full doses, or arsenic, which is only exceptionally useful. But the most useful drugs are atropia, beginning with one one-hundredth grain subcutaneously, and bromide of potassium in doses of ten grains, three times a day. "In either case, the dose should be gradually increased, either until the disease begins to yield, or until the supervention of the usual physiological effects renders it unsafe to push the experiment further." Occasionally, good results are got by electrical treatment, change of air and scene, and alkaline waters. Locally, carbolic-acid lotion and camphor-chloral are useful, and occasionally a lotion of tar, soft soap, and rectified spirit, not only gives temporary relief, but permanent benefit.

In the same number of the above journal (l. c., p. 1,124), Dr. Kingsbury reports a case of "ACUTE URTICARIA," in which the temperature reached 102° F. The whole body was covered with wheals, and the affection subsided in three days. Dr. Cullingworth (l. c., p. 1,234) suggests that this was a case of *Rötheln*, with urticarial complication.

"The Prevention and Treatment of CHILBLAINS," forms the subject of a short paper by Dr. Dawson Williams (*Brit. Med. Journal*, Dec. 22, p. 1,233. See also editorial note on same subject, l. c., p. 1,145). He doubts whether chilblains are local congestions, but thinks they are rather inflammations with a tendency to ulceration, the combination of superficial and very vascular ulcer, with extensive underlying and surrounding inflammation, being most characteristic of their later stage; at that time, they are extremely tender, the slightest touch giving pain; poulticing, until the inflammation has subsided, is the best treatment, as the ulcer afterwards heals readily. Occasionally, a limited slough forms, in-

volve the whole thickness of the true skin, and leaving a deep ulcer, with sharp edges, but without much surrounding inflammation; this is much less painful, but heals much more slowly and, of course, leaves a scar. The first or erythematous stage is most amenable to treatment; counter-irritants do no good, except, perhaps, iodine. Collodion is worse than useles, as it cracks in drying. The most trustworthy treatment is careful packing in cotton-wool, after the application of a little calamine lotion, which is allowed to dry on. Chilblains are especially apt to occur in damp, cold weather, as during a thaw, owing to the air being so heavily charged with moisture that boots, gloves, etc., cannot be kept dry. He recommends the wearing of woollen stockings, and armlets to the axilla, washing the hands with *very hot* water, and rapid drying with a dry, absorbent towel, and great care in drying boots and gloves before use. Tonic remedies are beneficial; but not cod-liver oil, or high feeding.

An instance of "the relation between LABIAL HERPES and rigor," which occurred in his own person, was communicated to the Clinical Society, on December 14, by Mr. C. I. Symonds. After unusual exercise and fatigue, he had a severe rigor, lasting five hours, and followed by profuse sweating; the temperature reached 105° F. Next day, the health was as good as usual; but, on the day after, an abundant crop of herpes appeared on the lips and tongue, unaccompanied by any other symptom. He thought the factors producing the attack were fatigue, exposure to the sun, and a feeling of fear when about to plunge into water from a boat, followed by undue chilliness. Other cases in which rigor preceded herpes were ague, operations on the urethra, and erysipelas, showing that there was nothing peculiar to the form of the disease; for instance, the eruption had no special connection with pneumonia, but only indicated that the disease had come on suddenly and severely after a rigor. The accompanying fever was not alone sufficient to produce herpes, which was absent in many febrile affections, nor did herpes appear after every rigor, so that some other factor seemed to exist; but what this was was doubtful. It was equally difficult to explain why the second and third divisions of the fifth nerve should be especially selected, its occurrence over the distribution of the first division being rare. Perhaps, where herpes existed without catarrh, fatigue might have acted, or the eruption might be a disease of itself, with its own fever and rigor. He referred to the traumatic herpes described by Verneuil, and finally suggested that rigor was necessarily related to labial herpes, but that some other factor, besides pyrexia, was associated with it; it was a question how far simple fatigue might be a cause of rigor, or more severe affections. In the discussion, Dr. Hale White remarked that the connection between rigor and herpes had a bearing on the question of a heat-centre. Physiologists agreed that in the dog an area in the region of the sulcus cruciatus, in some way, presided over the heat of the body, whether by vasomotor or trophic influence; now, herpes was obviously a trophic lesion, and there might be some close anatomical connection between the fifth nerve and the heat-centre; perhaps, an inhibitory influence was suspended, as in hysterical hyperpyrexia. Dr. Sémon had watched an epidemic of relapsing fever in Berlin, a disease in which rigors were constant, frequent, severe, and long-lasting. Altogether one hundred and sixty cases were observed, and, assuming only one relapse and one rigor in each attack, this would amount to three hundred and twenty rigors; in reality, there were many more. Notwithstanding this, herpes labialis had occurred in only four instances, and these were not severe cases. Mr. Jonathan Hutchinson said he had taught for twenty years that herpes of the lips was symptomatic of rigors, and thought there was undoubted truth in the general doctrine that herpes was connected with shivering.

A case of "paralysis of the right facial nerve with HERPES ZOSTER of the second division of the fifth nerve" was brought before the Ophthalmological Society, on December 13, by Mr. Waren Tay. A man, aged fifty-eight, found the right side of his face swollen, on awaking one morning, and the right eye was sore and red; on the following day, the eruption of zoster came out, occupying the area of distribution of the second, and, to a slighter extent, of the first division of the fifth nerve; the cornea was ulcerated, and there was well-marked paralysis of the right facial nerve, but faradic contractility was retained; there was slight diminution of sensibility of the parts supplied by the second division of the fifth nerve. Dr. Stephen Mackenzie remarked that the disease of the eye came on contemporaneously with the facial paralysis, and therefore clearly could not be due to exposure of the eyeball. The association of herpes zoster with paralysis of a motor nerve was unusual. Mr. Jonathan Hutchinson said it seemed pretty clear that, in a certain number of cases, paralysis of motor nerves followed herpes zoster; he had seen this occur in the third nerve, the facial nerve, and in certain muscles of the arm.

A paper read to the Clinical Society, on November 23, on "Cases of THICKENED EPIDERMIS Treated by Salicylic Plaster," by Dr. Thin, is a valuable contribution to the therapeutics of an obstinate and troublesome condition. CASE I. was that of an adult man, with hereditary tendency to extreme tylosis of the soles and palms; they were covered with very thick and hard epidermis, and had been so for many years, resisting the usual treatment. Dr. Unna, of Hamburg (the originator of the remedy), recommended the application of salicylic plaster made with gutta-percha, and the treatment was continued by Dr. Thiu. The plaster was kept constantly applied by bandages, and changed every third or fourth day. Ultimately, the hard layer came off in one mass, leaving a delicate, rose-colored epidermis behind; there was no pain or inconvenience of any kind. CASE II.—A gentleman, aged seventy-two, had been unable to walk, for about six weeks, owing to sciatica; he then rather suddenly took to walking much on a hard pavement, and the soles of both feet became hot and tender, and, after a few weeks, the skin of the ball of each foot became hard and horny. When seen by Dr. Thin, this condition was of seven years' duration, and there was much pain and discomfort; the salicylic plaster relieved for several months at a time. CASE III.—A gentleman, aged forty-three, had the palmar surface of his right forefinger covered, for years, with thick fissured epidermis; this was removed by salicylic plaster, and the part remained normal nine months afterwards. CASE IV.—A gentleman, aged forty, had thick epidermis of the heels, for many years; potash and scraping gave only temporary relief. The salicylic plaster got rid of the horny masses, but did not stop the tendency to their re-formation. Dr. Thin regards the above condition as essentially allied to eczema, the formative power of the epidermis being injured; salicylic acid, by its solvent power on horny epidermis, freed the skin from an adherent irritating mass, and the deeper layers of the rete were thus placed in a more favorable condition for regaining their physiological properties. In the discussion which ensued, Mr. Butlin said that Mr. Thomas Smith had used salicylic acid with success for warts, and it had also been applied with some benefit in ulcerating carcinoma, rodent ulcer, etc.; but he had known of no real example of epithelioma cured by it. Mr. Morratt Baker had used the remedy with success in a case of syphilitic warts, and mentioned that the "cornsolvine" of the shops consisted of a saturated solution of salicylic acid in collodion. (Compare this JOURNAL, vol. i., p. 256, "Gezou's Corn and Wart Cure," to the value of which the present writer can testify.)

At the same meeting of the Society, "A Case of MYXŒDEMA" was brought forward by Dr. Drewitt, which led to an interesting discussion. The patient was a woman, aged forty-five, in whom the disease was of twelve years' duration; she presented the usual and now well-known characteristics of the complaint; slow and indistinct speech, slow, weak movements, waxy œdema of the eyelids, swollen, purple lips, congested cheeks, raised, scanty eyebrows, swollen, awkward hands, with dry, scaly skin, subnormal temperature, etc.; in fact, she was practically a repetition of previous cases, all of which present a close resemblance to each other. The discussion was opened by Dr. Sémon, who gave an account of Professor Kocher's paper on "Extirpation of the Thyroid Gland and its Consequences," based on personal experience of partial or total extirpation of the thyroid in 101 cases. Out of these, 34 came under subsequent observation, of which 16 were partial extirpations, *i. e.*, of one lobe, with or without the isthmus; in these latter the result was good, without any affection of the general health. In the 18 total extirpations, only 2 showed non-deterioration or even improvement: the remaining 16 showed a more or less considerable progressive derangement of the general health, in the following order: a few months after the operation there was fatigue, with weakness and heaviness of the limbs, sometimes preceded by pains, and soon afterwards coldness, especially of the extremities: in winter the hands and feet swelled, became bluish-red and cold, and chilblains appeared; mental activity decreased; thought, speech, and movement became slower, and swelling came on, usually first about the eyelids, then of the nose, lips, hands and feet; the skin became dry and scaly, the hair was lost, and there was considerable anæmia; growth was arrested in growing patients, and occasionally there was slight dysphagia, giddiness, and headache. Kocher, who was not acquainted with myxœdema, called this condition *cachexia strumipriva*, and exactly similar observations had been made by Reverdin. In these cases every symptom was present which had been found in myxœdema, and we might therefore say that there were three closely allied conditions, having in common either absence or complete degeneration of the thyroid, *i. e.*, cretinism, myxœdema, and the state after removal of the thyroid, in each of which absence of the thyroid was the common factor; it was possible that absence of this body caused a lower form of connective tissue (with excess of mucin) to be developed, but any speculation on the *modus operandi* must be premature. Sir Andrew Clark (President) had noticed a curious variation in the quantity of urea in myxœdema; as a rule, it was under two per cent, but occasionally more than four per cent was excreted. Sir W. Gull (who first described the disease) thought that Dr. Ord's investigation of the connective tissue of the skin was important, but it might be questioned whether the disease had a peripheral origin, or whether the myxœdematous change was secondary to an affection of the nerve-centres; many facts pointed to the latter view, which was supported by Kocher's cases, as they seem to prove that the thyroid had a general influence on nutrition, either direct or indirect, through the nervous system; that the latter was the case was rendered probable by the changes following removal of the ovaries or testes, and by the arthritic lesions of ataxia described by Charcot. He was at present disposed to refer the disease to the class of tropho-neuroses, but it could not yet be decided whether it was produced by primary changes in the areolar tissue of the skin and its nerve-expansions, or through wasting or morbid changes of the thyroid, or independently of either of these conditions. Dr. Ord had written to Kocher, comparing his cases with myxœdema, and sending him some photographs of the latter, which he recognized as closely resembling *cachexia strumipriva*. He was

more and more convinced that total extirpation of the thyroid was necessarily followed by the cachexia, and did not think it was due to neuritis of the sympathetic, unless it were shown that this nerve had a peculiar relation to the thyroid; there were many facts pointing to the probability of atrophy of the thyroid being in some way or other the cause of myxœdema, but there was still much to be investigated. Dr. Burney Yeo had seen a case of disease of the thyroid in which there was entire loss of the eyebrows and eyelashes, a condition which was also met with in myxœdema; with regard to variations in the urea excreted daily, he thought they would be found in many conditions of ill-health, in women especially. The present writer thought the natural history of the disease deserved attention, the course being apparently not one of uniform deterioration, but with intervals of quiescence and improvement; he mentioned two cases in which improvement to a very marked degree had followed childbirth and ascites respectively. Dr. Crocker thought too much stress should not be laid on the fluctuations of urea, as these occurred in a very marked manner in health without apparent cause. Dr. Hadden had always found the amount of urea subnormal in myxœdema, and thought the diminution was probably due to lesion of the sympathetic; he had, however, been unable to detect any lesion of the cervical portion of this nerve in a case he had examined. Dr. Ord (referring to the present writer's remarks) said that one of his patients had borne two children after the condition was established, and there was no change whatever in the symptoms; he agreed that there were periods of seeming amelioration in most cases, but until lately he had seen a tendency to progress from bad to worse; he had now found jaborandi to be very beneficial, and gave it to all his cases; they all got better, and one patient declared herself well. He gave 30 drops of the tincture three times a day, gradually increasing to 60, 90, or 100 drops, and continuing the treatment for months. Dr. Whipham had seen improvement in one case from pilocarpium. Sir Andrew Clark had lately seen a clergyman who was dying of myxœdema four years ago, and was now quite well, and had seen many cases improve under merely rational treatment.

At a subsequent meeting of the Society the President appointed a committee of physicians and surgeons to examine and report upon the disease.

In a "Clinical Lecture on the Secondary SYPHILITIC ERUPTIONS, with Points in Diagnosis" (*Lancet*, December 1, p. 939), Dr. A. Sangster, after remarking on the occasional difficulty of diagnosis, especially when eczema or scabies are present as complications, adopts the following scheme of classification of syphilitic eruptions, modified from that of Bäunler.

- I. Circumscribed hyperæmia with slight infiltration.
 - Macular syphilide.
- II. Marked infiltration of the papillary body.

Lenticulo-papular syphilide.	{	a. Squamous. b. Moist (coudyloma). c. Early circinate.
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- III. Especial implication of the immediate vicinity of the hair-follicles.
 1. Miliary papular syphilide (infiltration).
 2. Miliary vesicular syphilide (exudation).
 3. Miliary pustular syphilide (suppuration).
 4. Acneiform syphilide.
- IV. Infiltration with subepithelial suppuration and superficial ulceration.
 1. Varicelliform or varioliform syphilide.
 2. Ecthymatous syphilide

{	a. Superficial. b. Deep.
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3. Rupia.

V. Gummatous infiltration with ulceration.

Tubercular syphilide.

This classification is undoubtedly good and comprehensive, but seems to the present writer to have the fault of not allowing sufficiently for transitional and mixed forms; no doubt the same want may be felt in any classification of all diseases of the skin, but it is, perhaps inevitably, more marked in any attempted arrangement of the protean manifestations of syphilis.

The description and differential diagnosis of the above eruptions is clearly given by Dr. Sangster, and his account of the early circinate modification of the lenticulo-papular syphiloderm, with its delicate linear tracery, may be especially singled out as worth attention.

LONDON.

CAVAFY.

Selections.

ON THE NATURE OF ACUTE PEMPHIGUS.

HEBRA, as is well-known, denied the actual existence of this malady. He had never been able to recognize it with certainty during the whole course of his experience in skin diseases, embracing nearly a million of cases. Yet so many descriptions of acute pemphigus have been furnished by various authors—some of them referring to it as an epidemic—that the fact of its occurrence among the newly-born, and sometimes even among adults, can no longer be regarded as doubtful. This, indeed, is admitted by Kaposi, although he had never actually seen the affection, and although, in his opinion, many of the cases called by this name were not instances of genuine pemphigus, but of other vesicular diseases running a similar course. As bearing upon this latter position, the following history appears to me deserving of publication: In the early part of September, 1883, a male infant fourteen days old was brought to my clinic by his mother. Six days after its birth, she had noticed on its neck a bulla somewhat larger than a hazel-nut, which ruptured spontaneously on the second night following. Soon afterwards, new bullæ made their appearance in quick succession on the back, face, and arms. Although the child nursed well, and also partook of other food, yet its sleep was broken and disturbed, and for some days it had had a greenish diarrhœa. An aphthous eruption had also broken out in its mouth. On examination of the mother, she was found to be in perfect health, presenting no traces of any eruption, and no evidence of past or present syphilis, from which the father appeared to have been equally free. Their other child, now fifteen months old, had always been well. On the forehead, cheeks, and lower extremities of the little patient appeared irregularly-scattered bullæ varying from the size of a pea to that of a pigeon's egg, and filled with a clear wine-yellow or somewhat turbid fluid, contained in an integument so thin as to rupture under slight pressure. Hence, most of the bullæ were only moderately tense, and many among them were already broken, and lay on the bright-red *rete mucosum* in shrivelled folds which, by the drying of their former contents, were partly converted into yellowish crusts. On the sides of the neck, and over the

chest and abdomen, almost the entire surface was covered with confluent bullæ, so as to resemble a burn of the second degree. The skin at the inguinal folds, of the inside of the thigh, and of the scrotum was thickly studded with the characteristic tubercles of eczema intertrigo. The internal organs were healthy; the urine contained no albumen. The bodily temperature was normal. The child could not bear to have the excoriated parts uncovered or touched, but was otherwise quiet. Under appropriate treatment, viz., powdering the affected parts, placing pledgets covered with amylum in the genital folds, and dressing the raw surfaces with a mixture of lime-water and olive oil, together with the administration of a decoction of saleg, and breast-milk for nourishment, improvement began in three days, and at the end of two weeks the skin had almost completely healed, the diarrhoea was greatly improved, and the child had increased in weight. The diagnosis of *pemphigus acutus neonati* (*pemphigus benignus*) had been made at its first examination, and was confirmed by the subsequent course of the disease. The leading symptom—the formation of bullæ on an erythematous surface—was developed very rapidly, and lasted altogether for fifteen or sixteen days; the loss of epidermis to which it gave rise was repaired by a new growth of cuticle within a week after the rupture of the bullæ. The site of the latter was marked for a few days by a reddish discoloration, which afterwards turned to yellow, and left not the slightest scar.

Microscopical examination of the remains of the bullæ, and the shreds of epidermis upon which their serum had dried, disclosed an abundance of fungous elements, whose arrangement and amount showed that they could not have been deposited by accident, more especially since their propagation within the sweat-pores and hair-follicles of freshly-prepared specimens proved that the schizomycetæ must have existed in the epidermis before the eruptive process had commenced. The bullous integument was shown to be formed from the horny layers of the epidermis and cells of the stratum granulosum, together with isolated white blood-corpuscles. The fungous elements consisted, in the first place, of irregularly shaped clusters of conidiæ, each cluster containing from ten to one hundred individuals. These were situated between the epidermic layers, for the most part surrounding the follicular openings, though sometimes they were disconnected from the latter. In many places, the hair-tubes and excretory ducts of sudoriferous glands adherent to the bullous integument were crowded with fungous elements even to the entire occlusion of their passages. The individual conidiæ bore a considerable resemblance in size, shape, and light-refracting properties to the conidiæ of *trichophyton tonsurans*. Their decided predominance in number, however, as well as their peculiar arrangement, served to bring them in closer relation with the fungous elements belonging to *pityriasis versicolor*, and, on the whole, I believe that for the present they should be regarded as constituting a class by themselves. Respecting the mode of propagation of the fungi, and the manner in which they find their way into the epidermis, the microscope gives us no reliable information, so that these questions still remain undetermined.

That children should be more liable than adults to the various forms of bullous eruption need not surprise us, in view of the greater delicacy and irritability of the infantile tissues. Thus we see slight cutaneous irritation in children give rise to bullous eczema. Moreover, a recent case in my own clinic has shown me that the growth of fungous elements in the epidermis of young subjects will sometimes set up an irritation sufficient to result in the formation of bullæ. In this instance, the disease, starting from a patch of typically developed herpes

tonsurans on the nape of the neck, extended serpigginously over the back, where, instead of the usual small and transient vesicles, it produced well-filled bullæ.

I believe, therefore, that in my first-described case of pemphigoid disease, the fungi discovered must be regarded as the real *causa morbi*, although the fact has not yet been positively demonstrated by the artificial transportation and development of a like affection.

The frequent appearance of acute pemphigus as an epidemic, and the fact that the disease, according to several reliable observers, has been restricted in some instances to the children tended by particular midwives, seem to point to the conclusion that pemphigus should be ranked as a product of infection. The non-febrile character of the complaint, its comparative harmlessness, and the very slight degree in which it affects the general system, all make it probable that its virus is confined to the skin.

Yet, notwithstanding the weight of evidence in favor of its contagiousity, the precise element of the contagion had never until now been discovered, and repeated inoculations with the contents of the bullæ (in which bacteria were detected by Birch-Hirschfeld) have been entirely unsuccessful.

The recognition, however, of a fungous vegetation—such as that discovered in the above-described cases—as the real cause of acute pemphigus would not only account for all the symptoms of the complaint, but would throw a convincing light on certain hitherto inexplicable facts connected with it, such as the absence of fever by which it is marked. Its failure to affect the constitution directly, and the spontaneous cessation of the eruptive process after the manner shown also in *herpes tonsurans vesiculosus*, so, likewise, the frequent communication of the disease by midwives and nurses, the negative results of inoculation with the fluid of the bullæ; even the fact (which has been adduced in opposition to the idea of contagion) that in adults who have the care of this class of patients, the eruption sometimes makes its appearance on the breasts, lips, and fingers, *i. e.*, in places where the epidermis is thinnest, or is most liable to slight injuries from sucking, kissing, etc., but never on the surface at large, may all be easily explained on the same theory. The delicate cuticle of a new-born infant, especially during the period of desquamation, makes its whole body a better breeding surface for fungi than the completely developed horny layer of an adult's integument. The latter can only nourish these germs in places which have been prepared for them by maceration or some mechanically produced lesion, and thus is only liable to suffer locally from bullous eruptions of this character.

Yet I would not venture to assert on these grounds alone that *all* cases of pemphigus originate in fungi. The general problem is one whose solution I must leave to those among my colleagues whose opportunities for pursuing the necessary investigations are better than my own. The present contribution should be regarded as merely an initial step in the direction indicated.—GUSTAV RIEHL, *Wien. Med. Wochenschr.*, December 22, 1883.

THE TREATMENT OF WENS BY ETHEREAL INJECTIONS.

By wens, in this article, are meant only sebaceous or "tannes" growths seated on the scalp or face, excluding lipomata, serous cysts, and epitheliomatous tumors of those parts. The annoyances caused by even benign excrescences in either of the above localities are sufficiently evident: but wens on the scalp are liable, moreover, to become dangerously irritated and inflamed by the use of the comb (especially in females), or by the pressure of the head-covering. Hence,

considerations of safety, as well as of comfort, often imperatively demand their removal. This is usually effected in one of two ways—by the knife or by the application of caustics. The former does its work quickly, and, in those frequently occurring cases where the incision heals at once, it leaves only a trifling scar. But the operation is often followed by erysipelas, in which case the risk incurred by the patient is equal to the worst which could have resulted from his original malady. The employment of caustics does not involve this danger, but there are three serious objections to this class of remedies, founded on the intense pain which they produce, the slow healing of their wounds, and the deformity caused by the resulting cicatrix. Their action is unquestionably efficacious, but it is difficult of control, and furnishes a means of cure which has justly been characterized as “brutal.”

As the surgeon's choice in the cases we are considering is necessarily restricted to these two methods, various expedients have been resorted to, in order to lessen the evils complained of in regard to caustics. Of these, the process devised by Professor Le Fort has proved the most successful in practice, and marks a decided advance in the treatment of these troublesome affections. It is thus described in the inaugural thesis of his pupil, M. Lecoq (Paris, 1877). A small, slender piece of wood is dipped at its pointed extremity into monohydrated nitric acid, and is then drawn across the surface of the tumor, so as to produce a linear cauterization. This done, the wooden point is once more charged with the acid, and the surgeon proceeds to search for some dilated glandular orifice, such as is always discoverable on the integument of the wen; having found which, he plunges the wooden lancet into it down to the centre of the cyst, where it is suffered to remain for half a minute, and is then withdrawn. During all this, only slight pain has been experienced by the patient, and none of the contents of the cyst have escaped. Not until a fortnight has elapsed, does the eschar become loose; the surgeon, then, seizing it with his pincers, detaches it completely, and, with it, the entire cyst in the form of a whitish ball.

More recently interstitial injections of chloride of zinc have been recommended for the treatment of cysts in general, on the ground that the only lesion they produce is the slight puncture caused by the entrance of the syringe-needle, and that the caustic, when thus applied, gives rise to no eschar. It was his knowledge of this procedure that led M. Vidal to attempt the cure of wens by injecting them with ether. Used for this purpose, ether acts as a caustic—but much more mildly than is generally the case—by setting up inflammation of the cystic contents, and finally inducing suppuration of the cyst itself. This it effects without producing any of the painful sensations or constitutional symptoms which are caused by throwing it into the circulation as a stimulant of the system at large. Its action is entirely confined to the structure operated upon, in which it gives rise to nothing more than a feeling of tension, if the injection be made too forcibly.

The ether employed should be as pure as possible; that at sixty-five degrees, such as is usually sold in the drug stores, answers very well. It is injected with an ordinary subcutaneous syringe, without the necessity of those precautions which have to be observed in the application of caustic solutions—since it does not corrode the metallic fittings of the instrument, or cause the formation of any deposit which can clog its piston.

As to the number of injections required and the quantity of ether to be introduced at each of them, M. Vidal has found that, for wens of the face or forehead, which are not larger than a hazel-nut, no more than five or six drops need be injected at a time. Larger tumors on the scalp may require ten drops, part of

which, owing to want of elasticity in the cyst walls, is liable to escape on the withdrawal of the syringe. As a rule, the injections should be suspended so soon as the cyst begins to suppurate.

The number of injections is of greater importance than the quantity introduced. Speaking generally, a wen the size of a hazel-nut will require two or three injections of five drops; if as large as a walnut, ten drops must be injected four or five times. The mode of treatment in every other respect will depend entirely upon circumstances as they arise. The little operation is performed as follows: The tumor is grasped by the left hand, so as to put its integument on the stretch, thereby bringing plainly into view the glandular orifices it contains; into the most dilated of these, which is often distinguishable by a fatty scab, the needle of the syringe is inserted perpendicularly. It is then, before making the injection, moved about within the cyst cavity, so as to break up its sebaceous contents, and prepare them for the complete reception of the ether; at the same time, the walls of the cyst are scraped and here and there lacerated, with the needle-point, with the object of promoting their final elimination. The succeeding injections are made in the same way and at the same opening. They are stopped as soon as the wen begins to enlarge, becomes reddened and softer, and is the seat of a slightly-painful sensation of throbbing or heaviness, which, however, never amounts to a headache. The tumor is now punctured at its base, from which issues a jet of purulent fluid; next, the contents of the cyst are discharged in the form of a whitish mass, resembling vermicelli, and mingled with the shreddy detritus of its walls. When the wen is of average size, this part of the process will be completed in six or eight days. During the ensuing days, the integument of the cyst proceeds to suppuration, and is discharged through the same puncture, together with remnants of the internal membrane. As the tumor dwindles, the skin surrounding it gradually contracts, and soon it is represented by a mere core of conjunctival infiltration, which, when the last drop of pus and the last fragment of cyst wall have made their exit, shrinks into a small indurated lump covered with healthy skin, and without any sign of the orifice by which the former mass has been evacuated. This consummation is generally reached between the fifteenth and twentieth days.

The efficacy of M. Vidal's procedure was strikingly exhibited in the case of a man of intemperate habits and debilitated constitution who came under his care in the Hospital St. Louis for an eruptive disease, and who had also been troubled, for five years, with an enormous wen which prevented him from wearing a hat or cap, and from lying on his back or on his left side at night. The incumbrance was completely removed by ten injections of ether. During the treatment, the patient suffered no pain: he took no care of himself, often exposing his tumor to the cold, without protective dressing, and in the ward which he occupied there were four erysipelatous patients. Yet nothing untoward occurred; the region operated on is now perfectly smooth and level with the rest of the scalp, and not the slightest trace of a cicatrix is left to mark the site of the excrescence.—*LERMOYEZ, Bull. Gén. de Thérapeutique, Nov. 30, 1883.*

A RARE FORM OF ITCHING VESICULAR ERUPTION (?HYDROA BULLEUX OF BAZIN).

THE condition treated of in this paper is of special interest, not only because of its rarity, but because, whilst it occupies a position on the border land of several kinds of skin disease which possess well understood diathetic relations, it cannot

as yet be definitely referred to any one of them. Four cases are described which have recently been under the author's observation—two male, and two female. The general character of the complaint, as manifested in all of them, may be briefly outlined as follows: The eruption was profuse over the trunk and limbs. It consisted of thickly-set erythematous patches, sometimes quite confluent, presenting an irregular configuration, but mostly of a gyrate or ringed pattern. All or nearly all of them were covered with closely-set straw-colored vesicles, or small bullæ.

These varied in their arrangement in individual cases, and in different relapses in the same case, occurring singly, in groups, or in circles or segments of circles, the whole complicated with secondary lesions due to scratching, viz: excoriations, urticarial wheals, and ecthymatous lesions from the inoculation of pus. Hence, the appearances presented by these eruptions were some of the most complex and bizarre it is possible to meet with. A constant and the most marked subjective symptom was the intense itching. The eruption relapsed over a period of many months.

A considerable number cases distinguished in a greater or less degree by the above features are to be found scattered through recent medical literature under various names, but chiefly under the name of *hydroa*. This is an old Hippocratic term revived by Bazin, who applied it to three varieties of diseases: 1. *Hydroa vesiculeux*; 2, *Hydroa vacciniforme*; 3, *Hydroa bulleux* (*pemphigus à petites bulles*). We are here only concerned with the first and third. Both of these, it seems, had been already described by Willan and Bateman, the former under the name *herpes iris*, the latter, probably, under that of *herpes phlyctenodes*. As to *herpes iris*, it is now included under that form of erythema, running a definite course, and showing a special tendency to affect the back of the hands and wrists, in steps, face, etc., for which Hebra, some time ago, invented the term *erythema exudativum polymorphicum*. The third variety, *hydroa bulleux*, is the one we are most concerned with in connection with the cases just referred to. Bazin's description is nearly as follows: *Hydroa bulleux* is an arthritic affection but little known. An eruption, preceded by malaise, loss of appetite, and slight febrile disturbances, is seen on the arms, trunk, insides of thighs, and occasionally the buccal membrane, the only prodromal phenomenon which seems constant is intense pruritus. The eruption consists of bullæ filled at first with clear fluid, but soon becoming opaque yellow. They occur in groups of three and four on a red surface. The bullæ are unequal in size, ranging from that of a lentil to that of a split pea, which size few exceed. While fresh bullæ are coming out, the older ones dry up and are replaced by a yellow crust. The patient retains his appetite, and nutrition is not interfered with. The disease runs a chronic course, manifesting itself by successive outbreaks and lasting altogether five or six months.

Are cases answering to this description, and to that which we have previously given, sufficiently individual in their character to constitute a group by themselves? Or is it possible to recognize in them examples of many well-known diseases, so to speak, in disguise? They seem not to be so nearly related to the erythema group, but to bear a close resemblance to other diseases, such as pemphigus, herpes, and urticaria. It must be admitted that the pemphigus bulla is, as a rule, very different from the large vesicles or small bullæ encountered in this disease. Especially may be mentioned its peculiar abrupt character or absence of surrounding inflammation. Both diseases relapse over a period of months or years; but in pemphigus a cachexia is readily established, which at times proves

fatal. None of the cases described as hydroa bulleux seem to have materially influenced the health. There is one fact (if it be a fact) that would help to link these curious cases with pemphigus, and it is the good influence on them of arsenic. The drug is not mentioned as having been tried in many cases; but what facts are noted, are favorable as to the benefit derived from it.

The cases bear a certain resemblance to herpes in the grouping and fleeting character of the vesicles. No special nerve distribution is affected, however; the grouping is not of that corymbose character peculiar to herpes zoster; nor are the attacks associated with catarrh or rigor, as is the case in catarrhal herpes. But perhaps these cases fit in with urticaria as well as with any other disease. The intense pruritus, the general distribution of the eruption, its erratic character and tendency to vary in pattern, especially to affect ringed and serpiginous types, its relapsing tendencies and probable localization, in some cases, by mechanical irritation of waist bands, garters, etc., are all points suggestive of urticaria.

There are, however, no etiological facts as yet available to support the urticarial relationship, unless the arthritic tendencies which are common to the two diseases be accepted as such. Lastly, the anatomical appearances of the eruption present but a trifling objection, when it is remembered that experience has taught us to attach but little importance to these in association with diseases presenting cutaneous lesions of a purely inflammatory type. Polymorphic exudative erythema is now recognized; would it not be as well to admit a polymorphic exudative urticaria? Cases of "urticaria bullosa" have been already described.

For such an affection, then, as that delineated above, at any rate until more is known about it, there is some reason to retain the name hydroa.—ALFRED SANGSTER AND J. MITCHELL BRUCE, *Med. Times and Gaz.*, Jan. 5, 1884.

RENAL SYPHILIS.

1st. SYPHILIS, in any of its stages, may affect the kidneys; the same is true of hereditary syphilis, in infantile or adult life.

2d. Certain renal complications are *precocious*, others *late*. The first, only studied within the last few years, manifest themselves in the first months after infection with all the characteristics of the nephritis of the infectious fevers: when the debut of the chancre dates back several months, the clinical history of the renal affection is similar to cases of glomerulo-nephritis which are observed in scarlatina for example.

3d. Syphilitic nephritides occurring in the secondary stage are always grave accidents, nevertheless they are curable, not only in the acquired syphilis of adults, but also in the hereditary syphilis of childhood. Their gravity appears to bear a certain relation to the age of the syphilis and the time which the patients have been subjected to specific treatment.

4th. Albuminuria being the principal symptom in the examination of these renal accidents, we understand how specific nephritis may pass from view before the other secondary accidents of syphilis.

5th. When œdema appears and is sufficiently marked to attract the attention of the patient and physician, another cause is generally assigned to it, so that syphilis is readily eliminated from the diagnosis.

6th. These albuminuric patients being improved under the influence of specific treatment and taking no further care of themselves after the secondary accidents have disappeared, the renal lesion may slowly pursue its course, and when, later, the patient comes under the care of the physician, it is more than probable

that his suspicions will be directed to another cause than syphilis, especially since it so often happens that the patient declines to confess to a disease which he has every interest in concealing. It is necessary, then, when a patient comes under the physician's care with all the symptoms of an acute or chronic nephritis and the etiology generally adopted proves doubtful, to think of syphilis and institute a specific treatment. If the patient bears any traces of syphilis (either upon the organs appreciable to view, or upon the viscera, nervous centres, liver, etc.), these accidents only confirm the diagnosis of a syphilitic renal lesion.

7th. Precocious syphilitic albuminuria is generally persistent and of quite long duration. There remains a question of extreme importance to be resolved: what will be the outcome, in a time more or less remote, of the secondary syphilitic nephritides considered as cured? The presumption is probable that a certain number of cases of Bright's disease may be the recurrence or latent termination of this primary disease of the kidneys (precocious syphilitic nephritis).

8th. Specific treatment gives the same results as in the other precocious accidents of syphilis. Milk diet should be regarded as a simple adjuvant, but not recognized as a necessity.

9th. Renal complications occurring in an advanced stage of syphilis (tertiary and quarternary accidents) exist, presenting sometimes the character of acute or chronic Bright's disease, sometimes the characters of amyloid degeneration; in the last case, contrary to the opinion generally held, we think with Wagner that the amyloid kidney is a consequence of syphilis, and not of a concomitant suppuration or of a mercurial or venereal cachexia, for cases occur in which there is no suppuration, and the patients, far from being cachectic, are on the contrary quite vigorous.

10th. These specific renal alterations are more grave than those which appear in the first years of syphilis. Nevertheless they may be benefited by specific treatment, the sole condition being that the renal lesion be not too far advanced; for, as in the case of the nerve centres, we cannot rebuild the tissues.

11th. Gumma of the kidneys, although quite rare, exist; but no pathognomonic symptom reveals their presence during the life of the patient, it is probable that anti-syphilitic treatment would have the same results as in gumma of other viscera.—G. NEGEL, *Thèse de Paris*, Nov., 1882.

CONTRIBUTIONS TO THE STUDY OF THE DIAGNOSIS OF OF ULCERATIONS OF THE TONGUE.

THE objective signs ascribed by authorities to the different species of ulcerations of the tongue are so variable that, in the majority of cases, a diagnosis cannot be established without recourse to the history and an appreciation of the diathetic state of the patients.

There are a number of circumstances in which the co-existence in the same patient of several diatheses renders the nature of the lingual ulceration altogether ambiguous. Thus there are found hybrid varieties, showing mixed characters from the multiple constitutional states to which the patient is subject.

Lingual ulcerations, though rare as a diathetic manifestation, are not necessarily specific. Among the tuberculous, notably, an ulceration of a simple inflammatory nature, traumatic or medicamentous, may manifest itself and be cured; on the contrary, the true tubercular ulcerations do not appear to be curable.

In the case of hybrid ulcerations occurring among tubercular syphilitics or cancerous syphilitics, not exhibiting characteristics sufficiently precise as to ad-

mit of the establishment of a positive diagnosis, it would be legitimate to institute a specific treatment as a test. But it is necessary that this be done with proper management, and it should be suspended so soon as the experimenter is enlightened by the failure of the treatment; for it seems that the use of mercury and iodide of potassium rapidly aggravates the condition of non-specific ulcerations, and impresses upon them a tendency to phagedenism.—DR. CH. DU PERRIER *Thèse de Paris*, 1883.

THE CUTANEOUS ACCIDENTS CONSECUTIVE TO THE INTERNAL USE OF PREPARATIONS OF QUININE.

1. QUININE preparations internally administered may give rise to cutaneous eruptions.

2. These eruptions, without being absolutely frequent, are not, perhaps, so rare as heretofore believed.

3. The non-recognition of the possibility of their occurrence may give rise to grave errors of diagnosis.

4. Quinine eruptions constitute an essentially polymorphous eruption which, probably, may take on almost every form of dermatitis. The only forms which have been noted, up to the present time, are, in the order of their frequency: erythema, roseola, purpura, urticaria, eczema, pemphigus.

5. The elimination of quinine by the skin explains the mode of production of five of these categories; purpura may have its source in the action of the alkaloid upon composition of the blood, and also upon the tissues, notably upon the capillaries.

6. It is quite impossible, in the present state of our knowledge, to say why the eruptions affect different forms in different individuals.

7. The influence of temperament, of age, of sex, of medicinal doses, of cold, of heat and humid cold, of malaria, etc., is more than doubtful.

8. Alcohol, injected simultaneously with quinine preparations, would appear, in certain cases, to favor the development of the eruptions.

9. Individual susceptibility and a peculiar idiosyncrasy are the only really indisputable causes of the affections.

10. This susceptibility becomes more intense when the individual has once undergone an attack.

11. Quinine eruptions are not grave in character.

12. The treatment, as simple as the prognosis is benign, consists entirely in the removal of the exciting cause and the employment of emollients.—DR. G. BOUVARD, *Thèse de Paris*, 1883.

PEMPHIGUS OCCURRING IN HYSTERIC.

THE nervous system plays an important rôle in the production of certain cutaneous affections. The lesions of the peripheral nerves which are distributed to the affected cutaneous regions precede the cutaneous disease.

Pemphigus is met with among the nervous and particularly among hysterics. It here presents a special march; it is observed especially at the time of menstruation; it affects an irregular distribution; its evolution is rapid; the bullæ leave brownish macules, which may be indelible, and which persist after the fall of the thick squamous crusts consecutive to the bullæ.

The prognosis is not grave.

As regards its pathogeny, the author admits an enfeeblement of trophic influence, direct and indirect.—DR. FRANCESCHI, *Thèse de Paris*, 1883.

A NEW DISEASE.

SOME little time ago, a man who lived in a secluded country district, consulted Mr. Treves, of Margate, on account of a number of sores, which had made their appearance on the side of the neck, and on the chest. The first sore had "come of itself," about two years ago, on the left side of the neck just above the clavicle; subsequently the others appeared, one after the other, to the number of four, in an oblique line across the chest. The largest of these, the one nearest the primary sore, was the first to appear, and the others appeared, as they were arranged, in series; there was also over the left side of the jaw, near the primary sore, another, pierced by a sinus leading down to the bone. The circumstances evidently suggested some infective process; the first sore was an excavated ulcer, with an irregular caseous-looking base, but the sores below this projected from the surface as much as half an inch in their centre, had a semi-gelatinous look, and an excoriated surface. Altogether, these latter sores rather resembled the small growths seen in some cases of sarcoma of the skin; but the case, taken as a whole, was evidently not one of sarcoma, and after due consideration Mr. Frederick Treves, of the London Hospital, to whose care the patient had been transferred, exhibited the patient at the Pathological Society, as probably a case of actinomycosis. Of this disease, which had been long known as occurring in cattle, we gave a full account in a leading article, published on April 15th, 1882, soon after the publication by Professor Ponfick, of Breslau, of his monograph entitled "Human Actino-mycosis, a New Infectious Disease." The disease has been known to veterinary surgeons as maxillary sarcoma, and the whitish tumor-substance produced was the simple embryonic structure seen not only in some sarcomata, but also in the infective new growths. Bollinger had shown that the tumors contained in cavities in their interior little yellow bodies, which consisted of matted masses of mycelium. This fungus, from the peculiar radiate appearance presented by it in sections of the growth, he named actino-mycetes. Israel, of Berlin, first described the disease in man, and attributed to a new form of fungus, but without apparently identifying it with the disease of cattle, as Ponfick did later. However this may be, there will, we imagine, be little question that this case now brought before the profession by Messrs. Treves, is the first which has been recognized in this country. that is, if the diagnosis which is at present made tentatively prove to be correct. On this point the only positively conclusive evidence is the discovery of the fungus; and on Saturday last, at the London Hospital, Mr. Treves examined the growths, which were distinctly pedunculated; and Mr. Watson Cheyne, who holds one of the Research Scholarships of the British Medical Association, will, we understand, make a complete examination.—*British Medical Journal*, January 12, 1884.

PRECOCIOUS CEREBRAL SYPHILIS.

1. SYPHILIS may invade the brain at a period not far removed from the occurrence of the primitive accident (from one year to eighteen months).

2. Among the precocious visceral accidents of syphilis, the cerebro-spinal syphiloses are certainly the most frequent and the most dangerous, by reason of the situation in which they develop.

3. All the accidents of late hereditary syphilis may be observed among the precocious syphiloses.

4. Certain symptomatic forms seem to predominate. The most frequent are hemiplegias and, among these, right hemiplegia, with aphasia.

5. We can only form very vague conjectures as to the etiology of the precocious cerebral syphiloses. In the majority of cases, the primitive accident has been quite benign, as well as the manifestations upon the skin and mucous membranes.

6. The precocity of cerebral syphilitic accidents furnishes no particular indication from the point of view of treatment.—DR. MANCHON, *Thèse de Paris*, 1883.

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THE OBJECTS OF DERMATOLOGICAL CLASSIFICATION, WITH ESPE-
CIAL REFERENCE TO AUSPITZ'S SYSTEM.

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IN framing a natural classification of skin diseases, a great difficulty arises from the fact that a large proportion of the affections of the skin are the incidental effects of processes more or less general which originate outside the cutaneous economy. To construct a classification that will exhibit all the morbid reactions to which the skin is liable in their most essential relations to each other involves the necessity of recognizing two separate and dissimilar factors, to wit: a local pathological process which is cutaneous, and also, in many cases, a remoter and vastly more complex process upon which the local process depends. To reconcile these two factors has been the chief problem of the so-called natural classifications of modern times. It would be easy to evade the difficulty by seizing one or the other horn of the dilemma. The Hippocratists who regarded all skin affections as mere out-croppings of internal disease ignored the one; while the Willanists, who were content to classify only the local lesions of the skin, disregarded the other factor. Between these extremes there lies an intermediate course which it has been the aim of modern classifications with greater or less success to pursue. Still, where diseases are concerned which are not purely idiopathic, no reconciliation is possible without the necessity of one factor taking precedence over the other. Each group must be denominated according to one or the other

principle of classification. Either the local process or the general process must be considered first, depending not so much upon which is the more essential where both constitute conditions *sine qua non*, but rather upon the intention of the classification. If it be the object to exhibit cutaneous diseases in their relations to general pathology, the general process will take precedence, while if the intention be rather to present the local conditions under which dermatoses may arise, the local process will be first considered. Which method is the preferable one is a matter mainly of expediency.

No classification since Hebra's has tended so much to advance the nosology of skin diseases as the system proposed a few years ago by Heinrich Auspitz.¹ Among the many classifications of the present day it stands *facile princeps*. None hereafter proposed can afford to ignore the work which it has accomplished. In this system, so far at least as the acuter forms of disease are concerned, a sharp distinction is made between diseases that are primary and those that are secondary. In the arrangement of the latter class of affections it is always the *general process* that is made predominant. It will be the purpose of this essay, first, to inquire in how far the method here adopted serves to fairly exhibit the most essential relations of cutaneous diseases; and second, to urge the advantages of a method that, while recognizing the remoter relations of pathology, yet gives precedence to the local process.

The first class in Auspitz's classification has received the designation of "Simple inflammatory processes of the skin—dermatitides simplices"—and is divided into "catarrhal" and "phlegmonous" dermatitides. The first division embraces "diffuse catarrhs of the skin" including simple or idiopathic erythema, and eczema; "erosive catarrhs" or "*stigmatoses*," including various superficial forms of inflammation due to erosion of the epidermis, whether by animal parasites or by other forms of traumatism; "follicular catarrhs," including *miliaria (alba et rubra)*, *acne* and *sycosis*; and finally, "engorgement catarrhs," including *ecthyma* and *ulcera cutanea*. The second division embraces "stratified" (*Schichten*) "phlegmons of the skin," including *combustio*, *congelatio*, and *pseudo-erysipelas*; "circumscribed" (*Herd*) "phlegmons," including furuncle, anthrax, Aleppo and Biskra boils; while last of all we have *phlebitis et lymphangitis cutis* and erysipelas, under the designation of "engorgement phlegmons of the skin." The inclusion of these commoner forms of disease in a separate class appears at first sight natural and proper, and had the adjective *common* instead of "simple" been used to designate them, the intent of the division could not have been mistaken. This, however, would not have interpreted the author's meaning. The diseases of this class by no means include all dermati-

¹System der Hautkrankheiten. Wien, 1881.

tides of a common type of inflammation, and, on the other hand, many of the same types of inflammation represented here reappear afterwards under other heads. The antithesis to the term *simple* must be sought in the definitions given to other classes in which inflammatory diseases appear. These are angioneurotic (Class II.), neuritic (Class III.), and engorgement dermatoses (Class IV.).

Angioneurotic dermatoses are defined to be "dermatoses having the character of a general disturbance of vaseular tension associated with a more or less pronounced inflammatory fluxion to the eutaneous surface." In other words, they are dermatoses secondary to general disease which furnishes the condition essential to their development, and doubtless also impresses upon them certain special characters.

Neuritic dermatoses are "dermatoses due to disease of sensory (and at the same time trophic?) nerve elements;" while engorgement dermatoses are "dermatoses which have the character of a passive disorder of the circulation with impairment of the venous and lymphatic absorption." These definitions clearly imply an etiological division, though at the same time suggesting incidentally certain peculiar forms of morbid activity. The groups of diseases which they define are essentially symptomatic (or at least deuteropathic) diseases. The inference is that "simple inflammations of the skin" are *idiopathic* inflammations—inflammations that are the natural and immediate effect of a local irritation sufficient in degree to disturb the normal processes of nutrition. Some exception might be taken to this division on the score that certain of the affections of this group do not always bear this simple character. Erysipelas, for example, is by no means always idiopathic, and it is not easy to see why *acne vulgaris* is not entitled to representation under the angioneuroses as well as eczema.

The characterization of the affections of the second family of this class as "erosive" catarrhs or "stigmatoses," is ingenious and, with respect to some of them, felicitous. It is questionable, however, if in all cases it is an *erosion* which is the chief element in the disease. Under the parasitic forms are included "*entomoses*" from lice, bugs, fleas, and mosquitos, and "*acarinosis*" from *leptus*, *acarus folliculorum*, *acarus scabiei*, etc., some of which erode the epidermis, some merely perforate it, while others simply enter the follicles without any disturbance of the epidermis whatever. The lesions caused by them vary in still greater degree. Some differ in no respect from the efflorescences of urticaria, some consist of a papular erythema, others assume the form of a pustular eczema; while in other cases the only effects are either the result of scratching or absolutely nil. It would seem then that the erosion could play but an insignificant part in all these diverse manifestations. In the case of the mosquito, something more than the simple perforation of the

epidermis with the fine *setæ* of the insect is necessary to account for the intense irritation and decided wheal which is almost invariably caused by the bite. Though no poison gland has ever been discovered, the possibility of a poisonous saliva has been suggested. Similar explanations may apply to others. But, however they are to be explained, the effects produced in these different forms of parasitic disease are so various that the question arises whether Auspitz, in condemning the association of *mycoses* with *entomoses* and *acarinosis* under the common head of parasitic diseases of the skin, on the score of disparity in the pathological processes, has not committed the very error he sought to escape.

The second class—angioneurotic dermatoses—embraces all the so-called *exanthemata*, all toxic eruptions, and what are termed “essential angioneuroses of the skin” including, beside *erythema multiforme*, *iris*, *et nodosum*, several varieties of herpes; “eczematous and pemphigoid efflorescences fundamentally of angioneurotic nature;” *purpura rheumatica*; *cnidosis* (chronic urticaria), and *erythema angiectaticum* (*acne rosacea*). Extensive as this enumeration is, there is apparently no good reason why the list might not be greatly augmented. Reference has already been made to certain affections of Class I. which might be included here. The angioneurotic diseases of the skin are represented as being such affections as arise in consequence of an abnormal sensitiveness to inflammatory reactions. This excessive irritability often constitutes the sole evidence of the presence of the angioneurotic condition; as, for example, in the case of chronic urticaria. Now when we see an acute or subacute form of erythematous or papular eczema breaking out suddenly without obvious provocation, and extending rapidly over a large portion of the cutaneous surface, as in certain subjects it not infrequently does, it is not easy to see in what it differs from an essential angioneurosis. In fact, I see no sufficient reason why the larger portion of the acuter forms of eczema, which tend to greatly exceed the limits of the original area of irritation, are not essentially angioneurotic. Again, with regard to *acne vulgaris*, its predisposing causes bear a very close resemblance to those which predispose to *acne rosacea*, and I fail to see why in one case as well as in the other the intermediate condition between the general sources of the disease and the local manifestation in the skin should not be an angioneurosis. Again, there are certain non-inflammatory affections of the skin which, though clearly depending upon neurotic vascular disturbance, are yet excluded from the class of angioneurotic dermatoses without obvious reasons. The affections which Schwimmer¹ terms “pure angioneuroses,” comprising certain forms of anæmia and hyperæmia of the skin, such as simple rubor and pallor due manifestly to central nervous influence, receive no mention here. In their lighter forms they might be regarded

¹ Die Neuropathischen Dermatosen. Wien u. Leipzig, 1883.

as physiological rather than pathological; but when, as is sometimes the case, they become manifestations of disease of the nervous centres, they acquire a pathological significance.

Pemphigus, psoriasis, and pityriasis rubra are classed among the "anomalies of growth" under *Epidermidoses*. One of them, pemphigus, is also represented under the *angioneuroses*, under the somewhat vague phrase "pemphigoid efflorescences with an angioneurotic basis, such as occur in "hysterical" conditions "and the like." Hans Hebra, who, in his recent treatise,¹ has adopted Auspitz's classification with slight modifications, puts pemphigus vulgaris among the *angioneuroses*, while pemphigus foliaceus appears under *akanthoses*, apparently for the sole reason that the former is regarded as an inflammatory affection, the other not. But there is nothing in Auspitz's description of the angioneuroses of the skin to imply that inflammation is absolutely essential, else why was the class not denominated "inflammatory angioneuroses of the skin," or "angioneurotic dermatitides"? Though the angioneurosis is "attended with a more or less pronounced inflammatory fluxion to the skin," it is the predisposition to inflammation rather than the inflammation itself that characterizes the angioneurotic dermatosis. It is true the affections so described are in the main inflammatory diseases. But acne rosacea is by no means necessarily an inflammatory disease, and the same is true of purpura toxica, peliosis rheumatica, and doubtless of the "pemphigoid efflorescences." The fact remains, however, that the characterization of the class leaves a certain indefiniteness as to where its exact limits should be drawn. What might be termed an "inflammatory fluxion" is present in the acuter forms at least of pemphigus, of psoriasis, and of pityriasis rubra. Moreover, when they appear, as they often do, in the form of a recurring exanthem more or less generally over the whole body, with the character almost of an acute inflammatory disease, they lack few of the characteristics which are ascribed to the angioneurotic dermatoses. A similar observation might also be made regarding certain of the *steatoses* and *idroses* which are classed with the epidermidoses, notwithstanding the vascular "fluxion" that accompanies them falls short of inflammation.

But returning to the group of affections which Auspitz has included in the Second Class we are now considering, let us inquire in how far they conform to the definition given of angioneurotic dermatoses. Some of them, more especially those belonging to the family of "essential angioneuroses," fully meet the requirements. With regard to others, the case is not so clear. Thus in the case of the "toxic exanthemata," can we be sure that there is one general condition which is essentially the same for all? Can we assert that the pustule of iodism is the manifes-

¹ Die krankhaften Veränderungen der Haut. Braunschweig, 1884.

tation of a general morbid process identical with that which causes the erythematous eruption from copaiba or the purpura from phosphorus or salicylic acid? If we have the demonstrated fact of the elimination of iodine through the cutaneous follicles to account for the inflammation of the skin, why resort to the far-fetched hypothesis of an angioneurosis? It is by no means impossible that many of the drug rashes are due to direct irritation of the skin at the moment of elimination of the drug, thus allying them to "*dermatitides simplices*." Others, such as the purpuric eruptions, might as easily be explained on the score of vitiated hæmatisis as upon the theory of neurotic disturbance.

Similarly with regard to the infectious exanthemata, admitting the presence of a general vaso-motor disturbance, it by no means follows that this disturbance is necessary to the concomitant skin disease. In this respect its importance is probably not always the same. While, in the prodromal eruption of variola, or in the diffuse redness of scarlatina, the presence of angioneurotic influence is too obvious to be denied, there are other forms of exanthem, such as the discrete follicular efflorescences of measles, or the complex trophic changes that constitute the mature efflorescences of variola, or the isolated lesion of vaccinia that are not so easily explained. The very diversity of the processes implies a cause more proximate, more immediate, more specific than a general angioneurosis. For aught we know, it is the direct action of the virus of these diseases upon the autonomy of the skin, which is the immediate cause, sufficient in itself to account for the cutaneous phenomena, without resorting to any other hypothesis. Neumann¹ found that the chief pathological changes of the skin in measles were confined to the cutaneous glands and blood-vessels, while in scarlatina the changes were chiefly in the mucous layer of the epidermis and in the cutis directly underneath. In the former case, N. believed that the implication of the glands implied that it was by these avenues that the poison sought to escape from the body, while the pronounced involvement of the epidermis in scarlatina would serve to account for the contagious properties attaching to the products of desquamation in the latter disease. Thus we have some reason to believe that the catarrhal inflammations of measles and scarlet fever have an analogy with the acne of iodism or bromism, differing in their mode of origin from the artificial eczema excited by a local irritant only in the direction from which the irritation proceeds. Something, doubtless, is to be attributed to the predisposing and modifying influence of neurosis, but how much is no less a matter of theory than the explanations offered above. One feature of these diseases, however, which is occasionally observed, namely the sudden recession of the exanthem, associated,

¹ Ueber die histologischen Veränderungen der Haut bei Morbillen und Scarlatina. Med. Jahrb., 1882, 11.

as it usually is, with an exacerbation of the disease internally, might readily be explained in the same way as is the sudden disappearance of an eczema on the occurrence of a severe internal disorder, that is, upon the theory of substitutive irritation, the neurotic influence being the same in either case.

The III. Class, designated as "Neuritic Dermatoses," presents a group of diseases whose limitations are much more succinct and clearly defined than those of the class just considered. The only objection to it, in such a system as that adopted by Auspitz, is a purely practical one, based upon the fact that it repeats many forms of disease also included elsewhere, which, so far as the local effects are concerned, are precisely identical. After "*herpes neuriticus*" (zoster) and "*herpes febrilis*" (herpes facialis, herpes progenerialis), which comprise the first family, comes "*erythema neuriticum*," under which we have almost an exact repetition of the eruptions of "*erythema essentiale*." There is also an "*urticaria neuritica*," and then come atrophic and necrotic affections of neuritic origin. The "Engorgement Dermatoses" (Class IV.) constitute another well-defined division of diseases. They include certain anæmias and hyperæmias, also a family of *transudationes* (including *œdema cutis*, *elephantiasis arabum*, and *sclerema cutis, neonatorum et adultorum*), which are all characterized by incomplete stasis, and "engorgement necroses" in which the stasis is complete. Although certain of the affections which figure in this class might perhaps more properly be included elsewhere, that is purely a matter of individual judgment which in no wise affects the general design of the author's system. Thus, Hans Hebra prefers to class Raynaud's disease, which Auspitz has included here, under angioneuroses, attaching more importance to the neurotic character of the disease than to the prevailing condition of the blood-vessels. Objection also may be made to the inclusion here of œdema which is by no means necessarily nor usually associated with engorgement. Indeed it has been conclusively shown that mere prevention of the return flow of the blood is insufficient to produce œdema unless there is also impaired action of the sympathetic nerves. Moreover, œdema takes place under many different conditions. But doubtless the author has in this case regard solely to the lymphatic engorgement incident to the impaired function of the absorbents.

In establishing a class of "hemorrhagic dermatoses" (Class V.) Auspitz takes an unlooked-for departure from the general principles of his classification. It is only with processes, he declares, "*nicht um Befunde*," that his system is concerned. Though hemorrhage may in a narrow sense be regarded as a process, it is no more so than erythema, nor œdema, nor icterus, nor argyria. It represents no definite disease condition, it implies no etiological factor. It is at the best but a secondary process,

an effect, a symptom, a *Befund*. In this class traumatism, defective hæmatisis, neurosis, engorgement, morbid conditions of the blood-vessels play the essential parts, and to them the symptom should be subordinate.

The next class (VI.)—"Idioneuroses of the skin"—is defined as "functional anomalies of the cutaneous nerves without trophic changes of the skin;" following this come the "Anomalies of growth" in two classes—"Epidermidoses" (Class VII.) and "*Chorioblastoses*" (Class VIII.)—both most admirably arranged upon an anatomical basis. The ninth and last class comprises the "*Dermatomyces*."

From this cursory review of the several classes of Auspitz's system it is easy to see that the pervading principle is an etiological one; not, however in the sense of dealing with causes that are remote and accidental or occasional, but causes that are inherent in and essential to the skin disease. The import of Auspitz's classification is very different from that of those etiological systems that divide the symptomatic affections of the skin in accordance with supposed relations to various constitutional diseases or diatheses. The relation of arthritism to cutaneous disease is a very different thing from that of a neurotic process that stands in direct physiological communication with the diseased organ. So also the ingestion of certain drugs may produce an exanthem upon the skin, but between the skin effect and the general intoxication the relation is not a constant or necessary one. It only becomes necessary when the constitutional effect calls in play a train of action capable of directly influencing the skin, namely an angioneurosis. Auspitz's method in the construction of his classes has been to regard first the sum total of the processes upon which the skin diseases depend, and then selecting from these processes those which are most essential and fundamental, to group the affections accordingly. The result has been an etiological division, rather as a necessary consequence of the method than from any original design on the author's part. The most essential pathological processes prove also to be those which stand in a proximate causative relation to the cutaneous affections. The method adopted by Hebra differed from this in that the skin affections were classified according to certain previously observed rules of general pathology. Auspitz's method reaches much farther and seeks to carry the inquiry to what may be termed the prime motives of disease.

(To be concluded.)

AN UNUSUAL PAPULAR DISEASE OF THE SKIN.¹

BY

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St. Louis.

THESE cases are reported with a good deal of hesitation, for the reason that the observations upon which they are based are more or less incomplete, and besides, I was in no instance enabled to secure a specimen for microscopical examination. However, I have been persuaded to lay my brief notes before you, because, in the first place, neither my reading nor personal experience has supplied me with any clew to the exact nature of the affection I am about to describe, and secondly, I wished, if possible, to have it determined whether the disease was one already observed by others.

CASE I.—This patient, a well-developed, and otherwise perfectly healthy brunette, aged twelve, was first seen by me about four years ago. I was consulted on account of an eruption which was situated upon the left cheek and upon both hands, and which had been in existence for at least one year. It gave rise to no particular annoyance, except from its unsightliness and some slight pruritus. The lesions were scattered over the left cheek, upon the backs of both hands, and also on and between the fingers. They observed no special grouping, were discrete, and the intervening skin was normal. The lesions were ovalish or irregular in shape, non-pedunculated, usually of the size of a split pea, a few smaller, of a peculiar dark lemon-yellow color, and gave a most deceptive appearance of liquid contents.

Upon closer examination, they were found to be solid to the touch, smooth, painless, and presenting no evidence of any aperture on the surface. Pruritus slight.

On the second visit, having in mind the possibility of molluscum epitheliale or colloid degeneration of the skin, I pricked the papules repeatedly with a needle, but succeeded in getting only a drop of blood as a consequence. Neither could I squeeze anything in the shape of contents from the lesions. They appeared perfectly solid. The color, a dark lemon-yellow, and the pseudo-vesicular character of the eruption were especially notable features. I frequently punctured the lesions, but always with the result just mentioned. Never having observed a similar case, and being somewhat at a loss for a suitable treatment, I determined to destroy the papules by electrolysis. This I did in a number of places on the hand, and I remember distinctly how resistant they were

¹ Read at the Seventh Annual Meeting of the Am. Dermatological Association, Lake George, Aug. 30, 1883.

to the passage of the needle through them, and that the patient complained much of the pain. About this time, for some reason that is not clear to me now, I ordered an ointment, consisting of one drachm of ammoniated mercury, one drachm of the "liquor picis alkalinus," and one ounce of vaseline, to be rubbed into the parts. I was delighted to discover that the eruption began to disappear rapidly under these applications, and, in about two weeks, was entirely gone, leaving no scar.

There were a number of children in the family, but this young girl was the only one so affected.

Within the past few days I purposely visited this patient to refresh my memory as to certain facts, and to ascertain whether her disease had ever relapsed. Upon examination, no trace of her former eruption could be detected, except quite small scars on the hands, resulting from the electrolysis. She told me that the papules had never reappeared. No pigment stains were to be observed.

CASE II.—D. C., a healthy blonde child, aged three, was referred to me by Dr. Brokaw, of St. Louis. The eruption had already been in existence some months. The lesions closely resembled those described in the foregoing observation, namely, they were discrete, dark-lemon colored, pellucid-looking papules. They were somewhat smaller than in the other case, and mainly uniform in size. They were situated on the right arm, both extensor and flexor surfaces, and extended from midway to the shoulder almost to the wrist. There were also, perhaps, four or five on the trunk. The rest of the body was free. On the arms, where the papules were more closely set, there was no appearance of coalescence, nor were they generally grouped on a reddened base, but, in this situation, there had been a good deal of itching, and about the elbows the integument was much irritated. This did not, however, obtain about the more isolated lesions. When the dermatitis had been overcome by appropriate treatment, it was noted that the papules still persisted unaltered. I pricked the lesions, as in the other case, expecting a free escape of contents, but only drops of blood followed the punctures. I subsequently prescribed the tar and mercury ointment, and although I lost sight of the patient, I have every reason to believe that she recovered.

CASE III.—This was a little girl of five years, put under my care by Dr. Love, of St. Louis. In this case the papules were found on the forehead, near the hair, and numbered altogether eight or ten. Their physical characters were as heretofore described. Some attempt at grouping was here exhibited, but the lesions did not coalesce, and the intervening skin was normal. They gave rise to no annoyance, except from their unsightliness. This eruption had also been of some months' duration. The child was exceedingly dark, and consequently the papules were not so bright and vesicular-looking as in the other cases, still the same fea-

tures were present in a lesser degree, and were sufficiently marked to enable me to recognize the similarity at once. The same treatment was ordered, but took effect only after much persistence. After four or five months a few papules reappeared, and were again dissipated to return no more. No other member of the family was affected.

CASE IV.—A. H., a boy, aged four years, was referred to me by Dr. E. W. Saunders, of St. Louis. Dr. S. is himself thoroughly conversant with skin diseases, but confessed that the appearances presented were entirely novel in his experience. The eruption was made up of the characteristic papules grouped upon a normal skin in a space of the size of a silver half-dollar, upon the left side of the forehead near the margin of the hair.

They were also chronic, but under the tar and mercury were made to disappear in about two weeks, and have not since returned. As in Case III. the papules did not give the deceptive vesicular look so markedly as in Cases I. and II.

CASE V.—G. T., merchant, aged thirty-five years, residing in the interior of the State, first noticed, some four years before consulting me, small pimples, which gradually made their appearance on the back of the neck, right side, about and below the margin of the hair. I first saw the patient four years ago. Upon inspection, there was to be observed in the region just mentioned, a dozen or more split-pea-sized papules. In my notes taken at the time, I find it stated that they had the appearance of *vesicles*, but that upon puncture nothing escaped but a droplet of blood. Having now seen at least two of the other cases, I noted that the color was characteristic. A few of the lesions were pierced by hairs, the majority not. In this case the papules were more closely grouped than in any of the others; for instance, while there were a few outlying, peculiar lesions, there were several places where groups of two, three, or more had coalesced; yet the separate papules had not lost their identity, and could be readily differentiated. In warm weather, the lesions, according to the patient, would become irritated and seale somewhat, and the pruritus, which generally was slight, would become severe. I destroyed one or two of the papules by electrolysis, but as the patient complained greatly of the pain, I desisted, and ordered him the salve mentioned several times above. I am not acquainted with the outcome of the case.

Whether in the foregoing brief and imperfect notes I have placed under one heading several diverse disorders I cannot presume to say. However, the fact remains that all of these cases were strikingly alike in their essential features; indeed, after the first two had come under my observation, I had no difficulty in recognizing the family likeness in the others, and placing them without hesitation in the same category.

To recapitulate: In all the patients the disease had existed a number

of months, and in one perhaps a number of years—therefore, the eruption was of a chronic type. Each and every papule presented a more or less characteristic color, viz., so far as I can describe it, a dark lemon-yellow, and in every instance to a greater or less degree a striking pseudo-vesicular appearance. The individual lesions varied in size from a grain of wheat to a split pea. They were solid in structure, non-pedunculated; gave exit to a drop of blood upon puncture; no sebaceous or other material could be squeezed from them; had no areolæ; presented no aperture at any point; were rounded or slightly flattened; and were smooth and resistant to the touch. When the lesions disappeared under treatment they left behind no stain or scar. They were evidently non-contagious.

From the description, I think it will be conceded that these cases are not examples of papillary warts, nor of xanthoma. In color and some other features, the lesions bear some relation to the colloid degeneration of the skin described by Wagner¹ and Besnier.² Wagner's patient was a woman of fifty, who had suffered with pain in the scalp for some time before applying to him. At the date of the observation, this symptom no longer existed. Otherwise she was healthy. The region involved in the process was the whole area of the forehead from the hairy margin to the eyebrows, and also the nose and upper part of the cheeks. The integument was in some parts thickened and furrowed. The region was studded with rounded, glossy, yellow projections, some larger than a millet seed and some smaller, and non-confluent.

These projections simulated vesicles, but revealed to the touch their hard consistency. Pressure exerted with the tips of the fingers or with the nails did not empty them of their contents. When pricked with a needle there was no escape of liquid, hardly a droplet of blood. Strong bilateral digital pressure extruded from the orifice left by the puncture, together with slight hæmorrhage, a transparent white, or pale-yellow colloid substance in the shape of little globes or rolls. As is well known, Wagner regarded these growths as milia with colloid contents.

Besnier's patient was a healthy man, aged forty-six. He also complained of occipital headache. The eruption was thickly grouped on the upper part of the face, and especially on the dorsum of the nose, and about the orbits and temples, which territory it overflowed in all directions, to lose itself on the surrounding sound skin. At first sight it seemed to consist of a confluent crop of lemon-colored vesicles, but their solid feel when touched or pressed, and the negative results of needle puncture, demonstrated that they were vesicles only in appearance. They

¹ Das Colloid Milium der Haut. Arch. der Heilk., t. vii., p. 463, 1866.

² Sur un cas de dégénérescence colloïde au derme, affection, non décrite, non dénommée, ou improprement dénommée Colloid-Milium. Gazette Hebdomadaire, No. 41, 1879.

were non-liquid, shining, lemon-colored, translucent elevations, irregular in shape, unlike true papules, and varying in size from a scarcely appreciable point up to a millet seed and grain of wheat. These growths were also to be observed on the ocular conjunctiva, and the lower edge of the septum of the left nostril. Besnier looks upon this condition as a colloid degeneration of the connective tissues of the corium, having its seat in the upper strata, beneath the papillary layer; the other structures, epidermis, glands, and hair follicles being involved in a secondary manner, as the result of pressure.

These two observations are here briefly recorded merely to show that there exists some superficial clinical resemblance between the cases and my own, particularly in the color and pseudo-vesicular appearance of the lesions.

I am inclined to think that the verruca-like variety of molluscum epitheliale is still more suggestive in this direction; but yet many points of clinical correspondence are lacking.

DISCOLORATION OF THE HAIR.

BY

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UNDER varying conditions of health and disease, the hair has been noted to undergo discoloration other than that of turning gray. Some of these changes are due to external agencies acting after the manner of dyes, and some to internal agencies.

Blue hair has been observed frequently amongst workers in cobalt mines, and in indigo works. *Green hair* occurs in workers in copper, the tone becoming darker from year to year till the hair becomes decidedly green. In both these cases the color is due to a deposition of the particles of the mineral or vegetable floating in the atmosphere upon the cuticle of the hair. The color can be entirely washed out, and the microscope shows that it is from without and not from within the hair.

Prentiss¹ reports a case of change of color of the hair from light blond to nearly jet black in a patient suffering from pyelonephritis with anuria, for the relief of which muriate of pilocarpine was used hypodermically. The use of the drug was begun December 16th, 1880, and the hair began to change in twelve days. The drug was not administered after February 22d, 1881, but the color continued growing darker so that by May 1st,

¹ Phila. Med. Times, 1881, xi., 609.

1881, the hair which originally was light blond with a yellow tinge had become nearly jet black. The change in the color was noted both on the head and in the axillæ, and simultaneously with it the hair became coarser and more vigorous. The color of the eye changed from light blue to dark blue. These changes were due to increase of normal pigment.

That the color of the hair may change after death is shown by a case reported by Hauptmann,¹ in which, on exhuming a body that had been buried twenty years, the hair was found to have changed from a dark brown to a red color.

Leonard² cites a case in which after death a head of red hair changed, within thirty hours, to a gray color. Other cases have been reported in which, after illness, the hair has altered its color, gradually to regain its normal hue when recovery has taken place. Smyly³ has recently reported a case of suppurative disease of the left temporal bone, in which the color of the hair changed from a mouse color to a reddish yellow. Squire⁴ reports a piebald condition of the hair of the head, occurring in a deaf and dumb boy of sixteen years of age. In this case the left side of the head hair looked like the fur of a tortoise-shell cat, with light patches of true auburn tint, and dark patches of dark-brown color, the patches being sharply limited. This condition had existed from birth. The other side of the head was covered with dark-brown hair. Exposure of the hair to the fumes of chlorine gas will bleach it.

Society Transactions.

NEW YORK DERMATOLOGICAL SOCIETY.

145TH REGULAR MEETING.

DR. P. A. MORROW, *President, in the Chair.*

DR. ALEXANDER presented

A CASE FOR DIAGNOSIS,

with the following history: Child; male; æt. 1 month. The second child of its mother, who is a stout healthy German. Its father is an Irishman, who, as far as can be ascertained, is also healthy. The mother has been exposed to all kinds of hardships, and this child is illegitimate. The child was born at Maternity Hospital, Blackwell's Island, and the labor was normal. When born, the infant's

¹ Virchow's Archiv. 1869, xlvi., 502.

² The Hair, etc. Detroit, 1881.

³ Med. Press and Circ., 1883, xxxv., 184.

⁴ Lancet, 1881, ii., 74.

body presented a glistening appearance as if it had been coated with a thick layer of amber-colored varnish; this covering showed a disposition to crack in the flexures of the joints, especially at the wrists, where there were deep fissures seemingly extending through into the corium. There was a palpebral conjunctivitis. When the case was first seen by Dr. Alexander, the whole body was covered with large thick scales or plates with deep fissures between them. The play of the facial muscles in crying was impeded by the incrustation of the face. Four large plates covered the head. These were about one-eighth of an inch thick. The plates were detached with difficulty, and presented prolongations on their inferior surfaces as in seborrhœal scales. On removing the plates from the head, the hair came away with them. The skin under the plates was slightly reddened, and somewhat thickened, otherwise normal. The microscopical examination of the plates showed them to be composed of epithelium and amorphous matter. The child was rubbed at first with cod-liver oil, but now sweet almond oil was used locally and the cod-liver oil given internally. It has been steadily gaining in weight and health. The first hard and glistening covering broke up under the oil and was entirely removed. New thin lamella-like scales still continue to form.

On presentation, the infant appeared to be of a good average size for its age. The whole surface, from crown of the head to the soles of the feet, was red, the redness readily leaving the skin on pressure to promptly return, and covered pretty generally with thin parchment-like scales, in some places, as at the toes and fingers, forming complete casts of the part.

Dr. Alexander presented the case for diagnosis. He did not think it was a case of true congenital keratosis, as all the cases of that disease reported were of infants either born dead or dying soon after birth, whereas this child was steadily improving.

DR. FOX regarded the case as a connecting link between ichthyosis and diffused congenital keratosis as described by Kyber and others, a case of which occurred in the service of Dr. Wheelock in the Nursery and Child's Hospital of this city, and was reported with plates in the *Illustrated Quarterly of Medicine and Surgery*. In keratosis the skin is amber-hued, and appears as one immense plate at birth or is broken up during the process of delivery. These cases have all died. Cases of ichthyosis lived. Between cases of keratosis and ichthyosis he knew of only two, the so-called "Alligator Boy," and this one of Dr. Alexander. He believes if this case lived, the boy would precisely resemble the "alligator-boy," which he reported in the April number of the *JOURNAL CUTANEOUS AND VENEREAL DISEASES*. If the history there given be compared with that of the one to-night presented, they will be found to be almost identical. The case as seen to-night presented no adequate idea of what it was a few days ago, when he first saw it.

DR. DENSLow had seen but one case of congenital keratosis, and that was in Hebra's clinic in Vienna. The child was three days old, and was covered with scales about the size of a twenty-five cent piece, which were curled up.

DR. TAYLOR saw the case when it was in the amber-cuirass condition, and would call it one of congenital keratosis.

DR. PIFFARD, judging from the present appearance of the case, would differ entirely from the previous speakers. He did not think it was analogous to ichthyosis or keratosis. Is the case were that of an adult, he would unhesitatingly call it dermatitis exfoliativa. The appearances presented were a markedly red skin, and about as white scales as could be met with. In ichthyosis we did not find clear red plaques, but when the scales were removed, the skin was commonly normal in color. He believed that if the child lived he would get entirely well of this skin trouble.

DR. MORROW said that in ichthyosis there was very rarely anything abnormal about the skin at birth, the change occurring often after the first few months, sometimes later. There was no reason why dermatitis exfoliativa should not

occur in an infant. But in this case there was thickening of the corium and very large scales, in some places a complete mould of the fingers being formed, which is not the case in dermatitis exfoliativa. He should regard the case as a developmental malformation in which the skin was too small for the bony development, and hence cracked.

DR. ALEXANDER remarked that he thought the redness of the skin seen now in his case was accidental, as it began as an intertrigo about the genital region on account of lack of care on the mother's part. When the case was first seen by him, it corresponded in appearance to the plate of congenital keratosis as figured in Hans Hebra's book.

DR. TAYLOR corroborated Dr. Alexander's statement that at first there was no redness of the skin.

DR. FOX said that in regard to the redness of the skin, of course, we do not find it in ordinary cases of ichthyosis, but we do in well-marked cases of keratosis, as in this one and in Dr. Wheelock's case.

The next order of business was

CLINICAL RECITALS.

DR. DENSLOW spoke of the probable remarkable effect of

BROMIDE OF NICKEL

upon a patient of his to whom he administered the drug for intense headaches to which she was subject. He ordered her to take a dessertspoonful of a solution of the medicament of the strength of two and one-half grains to the drachm. By mistake she took a tablespoonful at 10 A.M. About two hours afterwards she felt very faint, and was attacked with a violent gastro-enteritis, followed by great prostration. At 2 P.M. a flush began upon the forehead and spread gradually downwards so that by 10 P.M. it had reached the knees, and by the next morning the entire body was covered with a scarlatinoid rash. The redness was absent upon the sides of the neck and the upper portion of the chest, and in its stead were numerous petechiæ as in typhus fever. This continued all the second day, but on the morning of the third day all had vanished excepting the petechiæ, and they slowly disappeared in a few days. There was no desquamation or exfoliation. The question in his mind was: were the symptoms due to the drug?

DR. MORROW thought that they were doubtless due to the drug, and the question was whether they were dependent upon the bromide or the nickel.

DR. STURGIS asked if they might not be due to the gastro-enteritis.

DR. JACKSON presented photographs of a case of

UNUSUAL CICATRICES FOLLOWING ACNE.

The patient was a well-developed young man who led an active out-door life. The disease was so severe at its outset that he was compelled to give up his work for a couple of months. The cicatrices were upon his face, chest and back, and were atrophic and hypertrophic. Some of the atrophic places were as much as two inches by three, irregularly shaped and crossed by prominent bands. These were doubtless favored by the confluence of many small dermic abscesses.

DR. TAYLOR mentioned a case of

ERUPTION FROM EXTERNAL APPLICATION OF QUININE.

The patient, a woman, whenever she took quinine internally, was attacked with a well-marked dermatitis. This had happened so frequently that she had given up taking it. During the last month she began to use a "Rum and Quinine Hair Tonic," for alopecia, and wherever this quinine preparation touched her

skin she had a dermatitis identical with that arising from taking quinine internally.

DR. PIFFARD showed two photographs of a case of

TRICHOPHYTOSIS

of the groin, arm pits, etc. The patient, an Englishman, suffered a great deal from it, and the disease was very rapid in its development. In this case he had used with good result a solution of iodine in collodion. The strength of this solution could be either five or ten per cent, the first generally being strong enough. This solution of iodine in collodion was far more active than a corresponding tincture. He was in the habit of making his solution by mixing equal parts of collodion and tincture of iodine.

THE PRESIDENT introduced the question of

THE TREATMENT OF RINGWORM

for discussion.

DR. FOX said that he had tried Dr. Taylor's recently proposed plan of treatment (see February, 1884, number of this JOURNAL), in three cases of this disease and was pleased with the results obtained. For the vehicle he preferred the compound tincture of benzoin. In ringworm of the scalp he had had good results from shaving the scalp, and applying ten per cent chrysarobin solution in collodion with ten per cent of ac. salicylic added. He was inclined to think that this was the best plan of treatment, as it probably caused deep-seated inflammation and destroyed the spores.

DR. DENSLOW preferred sulphurous acid in the treatment of eczema marginatum.

DR. MORROW had used Dr. Taylor's method. The strength of his solution was two grains of the bichloride of mercury to the ounce of tinct. benzoin. He had not observed marked benefit from it. He had treated many cases of ringworm of the scalp with the chrysarobin pigment, and gave this treatment the preference. From it he got the best results, excepting from Coster's paste. He has the hair clipped very close, and then readily applies the remedy. He had never used salicylic acid as Dr. Fox proposed.

DR. PIFFARD said that as regards the use of chrysarobin in ringworm of the scalp, he had made use of it ten years ago, and his results had been almost nil. The drug first came to the surface as a parasiticide, especially for eczema marginatum and for ringworm of the scalp. Possibly the use of the drug in collodion would do better than in any other shape. One objection to it was its liability to excite erysipelas of the scalp. In his hands the croton-oil treatment introduced by Ladreit de Lacharrière had given the best results. This method had been purloined by an Englishman who recently wrote a book recommending it.

LEUCODERMA AND PSEUDO-LEUCODERMA IN THE ELEPHANT.

DR. PIFFARD stated that he had carefully examined the "sacred white elephant" now on exhibition, and found that it was a well-marked case of leucoderma. The ears, front, and trunk were the chief seats of the loss of pigment. The color was not white on these parts, but a pale flesh color. The rest of the elephant's skin was of the usual color. Dr. Piffard had also witnessed the experiments that were being made in bleaching the skin of an ordinary elephant by means of the peroxide of hydrogen, the substance made use of by certain belles to procure the golden locks so much in fashion. This substance has been sold under various fancy names at an exorbitant price, but being now manufactured on a large scale for commercial and technical purposes, may be obtained quite cheaply. The peroxide was applied several times a day to the elephant's skin, and at the end of four days had changed it from its natural blackish-brown hue to a light ash color. It was not believed that the white color would be permanent.

Dr. P. stated that some time since he had partially removed a melasmic discoloration from the skin with the peroxide, but having lost sight of the patient, could not state the ultimate result. He believed, however, that this drug would in the future play an important rôle in dermatology. The peroxide used was manufactured by C. Marchand & Co., of this city.

Correspondence.

CASE OF FIBROMA MOLLUSCUM.

To the Editors of the Journal of Cutaneous and Venereal Diseases.

DEAR SIR:—I send you herewith a photograph giving front and side view of the face and head of a patient under my professional care, also one of the nodules represented in the picture. (See plate.)

The patient, G. W. B., is forty-eight years of age. The nodular eruption commenced to develop twenty-seven years ago and now covers the entire body. His family history is as follows. His mother and father were subjects of rheumatism, which in the mother's case resulted in considerable deformity. One of his brothers has for many years been helpless from articular rheumatism. There is also a history of consumption on the mother's side, a number of members of her family having died of this disease.

G. W. B. is reported to have been a "foolish child" up to the age of ten years. In his childhood he was for many years affected with tinea capitis.

The nodules appeared when he was twenty-one years old, first upon the face and hands, then gradually spreading until now they are distributed over the entire body. They are never painful, but they occasionally itch intolerably, especially when he is a little warm or overheated from exercise.

Some of the nodules are as large as a pigeon's egg, irregular in outline, and are situated upon a broad base, others are smoother and attached by a pedicle. In some places it would seem that smaller nodules spring from the surface of the larger ones (see plate).

These tumors are filled with a softened atheromatous material, apparently the result of a fatty degeneration. This atheromatous material is said by some writers to be the result of a chronic parenchymatous inflammation of the inner arterial tunics. But the question which presents itself to my mind is, can there be an inflammation without an increase of heat, and could this inflammation continue for so long a period while the patient's general health remains so good? Again, in view of the bad family history, may we not suspect that it is something more than a local disease? May not hereditary influence be an important factor in its development?

Very respectfully,

GAINESVILLE, TEXAS.

J. C. MILNER, M.D.

(The specimen forwarded by our correspondent was referred to Dr. E. C. Vidal for microscopical examination. He reports that it was an ordinary fibroma. No substance of an atheromatous character was discovered.—EDS.)



To the Editors of the Journal of Cutaneous and Venereal Diseases.

As the impression seems to be more or less prevalent that the New York Skin and Cancer Hospital has abandoned the care of cancer, we deem it desirable to have the error corrected. The aim of this institution from the first has been to undertake the study and treatment of this disease, and over one-third of its beds have from the opening of the present building been set apart for this purpose.

A tract of land of nearly one hundred and fifty acres has recently been secured just beyond the city line, and the plans for cottage pavilions have already been drawn. It is proposed to erect some of these at once, and to add to the number as they may be required so as to afford unlimited accommodations for each and every case of cancer requiring assistance. Both early cases for operation are received, and those which are chronic and hopeless.

Our city hospital, No. 243 East 34th Street, will still be continued, and clinics held there as follows: For skin diseases, daily from 2 to 4 P.M. For cancer, on Monday, Tuesday, Friday, and Saturday, at the same hour.

L. D. BULKLEY, M.D.

GEO. HENRY FOX, M.D.

J. E. JANVRIN, M.D.

R. F. WEIR, M.D.

E. L. KEYES, M.D.

Selections.

SKIN AFFECTIONS CONNECTED WITH DIABETES.

VARIOUS forms of cutaneous disease are of frequent occurrence in diabetic subjects, and have therefore been regarded as standing in a causal relation to glycosuria. This relationship has been repeatedly discussed in connection with the pathology both of diabetes and of skin disease, but has never yet been made perfectly clear.

The fact that the skin affections accompanying diabetes differed very widely among themselves and, so far as observed, were devoid of special characteristics, was certainly not in favor of the view just referred to.

These affections which are partly functional and partly nutritive in their nature, and generally of an inflammatory character, may be enumerated as follows:

1. *Asteatosis* and *anidrosis* of the skin. This is obviously only a relative condition, and consists of an abnormal dryness and exfoliative state of the general integument. It is not a uniform or pathognomonic indication of diabetes, but seems to be merely a result of deficient nutrition, such as is met with in many other morbid processes involving a similar constitutional deterioration. Accordingly, it generally occurs in the more advanced stages of melituria. During the earlier period, while the patient is well nourished and preserves his adipose development, the secretory functions of the skin are usually well performed. Indeed, corpulent diabetics are, at this time, not unfrequently the subjects of excessive perspiration, leading to erythema and eczema intertrigo, affections

which, under the influence of the glycosuria, may assume a peculiar character, when localized on the genitals and surrounding regions.

2. *Pruritus cutaneus*, as a pure neuralgia, is not a rare concomitant of diabetes, under the form either of pruritus universalis, or, in females, of pruritus vulvæ. It is a most distressing complaint, sometimes rendering the patient desperate, or even impelling him to suicide. The itching comes on in paroxysms which occur several times a day, and sometimes last for hours, so that the patient is soon brought very low through want of sleep. It may accompany other diseases besides diabetes, but Hebra long ago assigned the latter as one of its causes, and his followers have made it a rule to examine the urine for sugar in every case of pruritus cutaneus. By applying this test I have often succeeded in ascertaining the existence of diabetes while the patient was still unsuspecting of his disease. Like pruritus cutaneus in general, diabetic pruritus occasions no changes in the general integument other than those which are produced directly by the scratching.

3. *Urticaria chronica* is another diabetic skin disease which I have repeatedly encountered. It consists of an eruption of small pimples which are subsequently lacerated by hard scratching and end in suppurating excoriations and pustules. I have never observed it except in reduced and debilitated patients, whose low condition, however, was not caused by the diabetes, but had existed in the earliest stages of that complaint and before its symptoms had become pronounced. In these cases, therefore, the emaciation, etc., must be regarded as resulting from the same obscure influences in which the diabetes chiefly originated. I have often observed this papulous eruption to become localized around the follicles, leading to their inflammation and the appearance of

4. *Acne cachecticorum*, occupying chiefly the extensor surface of the extremities and the nates. Thus all the varied manifestations appertaining respectively to pruritus cutaneus, urticaria papulosa, and acne cachecticorum may be found combined upon one and the same individual.

5. As to the *roseolous and erythematous eruptions* reported to have occurred as concomitants of diabetes, and to have lasted for months before taking on a marked inflammatory character, they have never fallen under my observation, and, I believe, are but rarely met with.

On the other hand, the truly inflammatory dermatoses constitute a very frequently occurring form in this connection.

First among them are certain inflammations which have really nothing to do with the co-existing blood-dyscrasia, but arise from frequent moistening of the skin by the diabetic urine, with its tendency to fermentation favoring the production of fungoid elements, and its directly irritating effects. These are due to

6. *Eczema* of various degrees, which must not be confounded with the effects of scratching in cases of pruritus cutaneus. Owing to its peculiar cause (the wetting of the skin by the diabetic urine), this kind of eczema is confined to the genitals and their neighborhood. In men, it appears only on the prepuce, and is accompanied by balanitis. Hence, an attentive observer will be led to think of diabetes, when confronted by an obstinate balanitis associated with eczema of a relaxed foreskin, and diffusing a peculiar insipid, sweetish odor.

This eczema occurs more frequently, more severely, and to a greater extent, on the female parts. The labia majora, genito-femoral sulci, and inner surfaces of the thighs then appear uniformly red, densely infiltrated, and generally moistened by sweat and urine, though rarely exuding of themselves. The affection is worse in corpulent persons. Polyuria and hyperidrosis of course favor the

production of melituric eczema, or, as the French term it, "eczème glycosurique."

The external action of diabetic urine is likewise supposed by some authors to promote a more intense degree of inflammation ending in gangrene, as also the formation of abscesses and furuncles, on the genitals and their vicinity. But it is very doubtful whether these results can be attributed to the mere presence of sugar in the excoriated integument, since this substance is known to be without injurious effect on wounds in general. Here, as in cases of urinary infiltration from other causes, it is probably the products of the decomposition of the urine, especially its ammoniates, that really work the mischief. Certain forms, however, of diffuse phlegmonous inflammation—taking their rise from particular regions of the skin directly affected by the urine—do undoubtedly occur, for which the diabetic blood-crisis must be held responsible. These comprehend the remaining diseases under our classification, viz.:

7. *Paronychia diabetica*. This complaint, though it is seldom mentioned by authors, I have often met with, chiefly on the great and little toes, these being most exposed to pressure from the shoes. It also occurs occasionally on the middle toes. It is often quite indolent and tedious, and is then very apt to produce fungous excrescences; in other cases it is exceedingly painful and obstinate. All my own cases have recovered, but I believe that gangrene has sometimes been seen as a result of *paronychia diabetica*.

8. *Furunculosis and anthrax*. These are the cutaneous affections most familiarly associated with diabetes. They have generally been observed during the incipient period of the latter, constituting, according to Seegen, one of its earliest manifestations. Since furunculosis sometimes makes its appearance before the diabetes has been discovered, it was regarded, in such cases, as having preceded for years the actual development of the latter. This was accounted for by Pick on the ground that the same influence which operates on the nervous centres for the production of diabetes, may, in particular instances, give rise to furunculosis (and subsequently, perhaps, to other skin diseases, as pruritus), instead of to glycosuria; and that, consequently, we may have a diabetic furunculosis without diabetes, or, if we adopt Kochmann's view, during this furuncular period the diabetes is latent. The same theory was applied to carbuncle. While not denying the possible validity of this explanation, I may be permitted to remark that in no one of the cases reported as bearing upon the present question does it appear that the patient's urine was examined so as to determine whether the diabetes really existed before the appearance of the skin disease. Under such circumstances I think it would be more correct to assume that the diabetes was simply overlooked than that it was latent; and hence it follows that the urine ought to be regularly tested in every case of furunculosis and of anthrax, both for albumen and for sugar.

9. *Gangrene*. This is the least recognized and understood of the diabetic complications. According to most authorities, it bears a close resemblance to *gangræna senilis*. Some of the cases reported might be regarded as coming under the head of *gangræna e marasmo*, or *atheromatosi*, but the larger number certainly present a peculiar character. Those recorded by Marchal De Calvi and Champouillon in particular, seem nearly allied to an unique case which recently fell under my own observation, of what I have ventured to designate as *gangræna diabetica bullosa serpiginosa*.

It occurred in the person of a woman fifty-one years old, and terminated fatally after lasting about seven months. The special impress in this instance was

imparted by the disseminated appearance of the complaint, its withdrawal from the outer limits of the affected surface, its restriction to the general integument, its serpiginous mode of progression, with subsequent healing, and finally by the development of inflammatory patches and bullæ upon the previously healthy skin. These characteristics were sufficient, in my opinion, to distinguish this highly typical case of gangrene as one clearly originating in diabetes.

It is well known that diabetic sugar has been discovered in all the organs tissues, juices, and exudations of the body; and it was unquestionably contained in the discharges from the gangrenous sores of the patient referred to.

The sugar deposited in the skin (or one of its elementary products) may give rise:

1. To an irritation of the secretory nerves, manifested under the form of pruritus cutaneus, although it does not follow that the latter affection in diabetes may not be sometimes due to influences emanating from the nervous centres.

2. The sugar acts likewise on the secretory and vaso-motor nerves, whence result anidrosis and hyperidrosis, asteatosis or xerosis of the skin, probably also erythema and urticaria.

3. It affects the tissues and tissue elements traversed by these nerves, as well as those of the vascular walls, *e. g.*, of the glands and corium.

Speaking generally, the alterations thus produced result in irritative processes followed by inflammation leading to death of the tissues; the skin being no less subject to these influences than are the internal organs, and we know that sphaelus of the lungs occurs nowhere more speedily than in diabetics.

Such inflammations, with their necrotic sequelæ, may be confined to circumscribed points, as in furuncle and carbuncle. Or, they may spread more widely, owing to a more extended saccharine impregnation, whence may result the diffuse forms of phlegmon and gangrene. Or, finally, the deposition of diabetic sugar in the cutaneous tissues, like its secretion by the kidneys, may take place irregularly and intermittently, both as to quantity and locality, thus giving rise to bullous eruption and gangrene.

In brief, the morbid processes brought about in this way are characterized by *inflammation terminating in tissue necrosis*, with but very slight tendency to the formation of *inflammatory neoplasms*.

Nevertheless, it is conceivable that, when the irritating influence is slowly and moderately exerted, when sugar is secreted by the skin in small quantities and during only a short period of time, or when the tissues have become gradually inured to its deleterious effects, the inflammatory symptoms may terminate in tissue-degeneration instead of absolute gangrene, and inflammatory tissue-production may also take place. This being granted, I am able to conclude my list with a hitherto undescribed form of diabetic skin disease, which I will denominate:

10. *Papillomatosis diabetica*. It is derived from my observation of a single case, that of a Brazilian medical man who came under my treatment in September, 1882. He stated that he had suffered for twenty years from diabetes, polyuria, and polydipsia; but he was still well-nourished and vigorous. His disease was entirely confined to the left forearm and hand, which were tensely swollen. The backs of the fingers were covered partly by excrescences united to the agminate glands, and varying in size from that of a lentil to that of a kreuzer, partly by ulcers of like dimensions. The ulcers were rounded or kidney-shaped, and many of them were bordered by red, glandulous, easily bleeding vegetations,

several mm. in height, and discharging a sero-sanious fluid. The forearm presented very similar appearances, but with interspaces of healthy skin, and in this situation there was no diffuse swelling. On the elbow was a growth as large as the palm of the hand, and over 2 cm. in height, deeply fissured, and having a slightly bleeding surface covered with warty protuberances.

At first sight, this case might readily have been diagnosed as one of either syphilis ulcerosa et vegetans, or of lupus vegetans papillaris, but closer examination showed that the leading characteristics of these affections were wanting. I was then inclined to identify it with that form of disease which has been so much discussed by authors under the name of *frambesia* of the Tropics, but, on grounds which it take up too much room to detail, was forced to abandon this idea also.

Under the treatment instituted—both internal and external—the affected parts, by the end of December, were nearly restored to their normal condition; the fingers were flexible, and the hands quite useful. On the first of January, however, symptoms of diabetic coma made their appearance, to which, within ten days, the patient succumbed.

Many questions connected with our general subject must here be left unanswered. What is the *modus operandi* of the sugar in the tissues? Why does this agent excite sometimes a general and sometimes only a local inflammation? And why does this inflammation, which usually terminates in necrosis, occasionally result in outgrowths of connective tissue and of vascular substance?

If the foregoing contribution to the study of the diabetic dermatoses, however unimportant in itself, shall succeed in arousing the attention and directing the efforts of my fellow-specialists and the profession at large, there can be little doubt that this missing chapter in pathology will ere long be fully supplied.—M. KAPOSI, *Wien. Med. Wochenschrift*, Jan. 5, 12, 19, and 25, 1884.

NODOSE AND PAPULAR ERYTHEMATA.

AN eruption is sometimes met with, especially in youthful subjects, consisting of red, hard, inflamed, and painful tubercles, scattered with an approach to symmetry over the legs and dorsa of the feet. It is preceded or accompanied by general malaise, some digestive disturbance, and a moderate degree of fever. Very often there are also pains about the joints or in the shafts of the limbs. In the course of a few hours the centre of the tubercles displays a purplish hue, succeeded by a changeful discoloration, such as characterizes the latter stages of a contusion.

In other cases, again, slightly raised red spots break out upon the backs of the hands, on the forearms, or on some portion of the face. They turn pale under pressure, itch, or prick, sometimes quite severely, and speedily disappear, having occasioned scarcely any constitutional disorder.

In still a third class of patients, the above-mentioned cutaneous phenomena are accompanied by general manifestations of an alarming character, by high fever, violent pains in the joints, and symptoms of internal inflammation, endocarditis or pericarditis, pleurisy or pneumonia, which, in some cases, result fatally.

The disease in the first of these categories is known as *erythema nodosum*, in the second it is called *erythema papulosum*.

What, now, is the essential nature of these affections, which, presenting always such comparatively unimportant cutaneous features, exert in some cases

so little influence on the general system as scarcely to merit the name of a disease, while in others they entail the most formidable consequences?

Is erythema nodosum really what it has been called, a mere *dermatitis contusiforme*? Is erythema papulosum nothing more than a passing hyperæmia localized on a few square inches of skin? Is there not some higher and more general influence at work beneath the changes in the outer integument? Numerous conflicting answers have been given to these questions.

The Vienna school of dermatologists, almost exclusively occupied with pathological anatomy, has troubled itself but little about the intimate nature of the diseases under consideration. Hebra, basing his opinion upon the common character possessed by their eruptions, viz., that of a hyperæmia with exudation, has included them both, with all their varieties, under the name of *erythema polymorphicum* or *erythema exudativum multiforme*, leaving entirely out of view their constitutional concomitants, a mode of consideration which must be pronounced irrational, so far at least as general pathology, prognosis, and therapeutics are concerned.

Kaposi expresses himself much in the same way, although laying greater stress than his master upon the dangerous subjective symptoms which occasionally supervene, and which seem hardly consistent with the notion of a simple hyperæmia. But this should not surprise us in writers who assign places to measles, scarlatina, and small-pox in their works on dermatology.

By all French authorities, on the other hand, erythema nodosum and E. papulosum are looked upon as local manifestations of a constitutional morbid state. Trousseau distinctly asserts that erythema nodosum is a specific disease, whose general symptoms have no more to do with its local phenomena than the fever of variola and measles have to do with *their* eruptions, and which has no better claim to be called an erythema than small-pox has to be classed as an ethyma, because its pustule so strongly resembles the pustule of the latter as to be readily mistaken for it.

But, admitting this to be the true position, our problem is not yet solved, or, at least, we have to choose among several possible solutions. Are these two forms of erythema, whether occurring separately or together, produced by one and the same pathological force? If they are so produced, is this primary morbid condition engendered spontaneously within the organism, or does it originate externally, in some specific germ, if not from positive contagion?

By way of putting these questions more precisely, let us inquire, first: Are erythema papulosum and E. nodosum *cutaneous manifestations of rheumatism*?

Bouillard, Rayer, and Bazin reply to this in the affirmative. E. Besnier and Sireday are clearly of the opinion that there exists a group of affections essentially identical, though differing in their outward manifestations, which might be called *rheumatismal skin diseases*. These present themselves more commonly in the form of papules than of tubercles, although the latter (erythema nodosum) may be considered as the type of the pseudo-exanthems associated with rheumatic or rheumatoid disorders.

It is not enough, however, for the advocates of this view to show that erythema nodosum and genuine rheumatism may occur together; they are called upon to prove that the eruption and the joint-affection are identical in their nature, and both dependent upon the rheumatic diathesis. Failing in this, their position would differ in no wise from that of an observer who should recognize no other bond than that of simple coincidence between the eruption of measles and the inflammations—conjunctival, nasal, pharyngeal, etc.—by which it is ac-

accompanied, or between the sore throat, the rash, and the albuminuria, in scarlet fever. If we admit that the supervention of heart disease upon articular rheumatism is due to something else than accident, why, it is asked, should we deny the intimate mutual relationship, the essential identity, of rheumatism and erythema nodosum? Moreover, there are many resemblances between the more striking phenomena of the two disorders respectively, which aid in sustaining this opinion.

The frequent co-existence of both forms of erythema in the same case is undeniable, and is explained by the greater liability of the lower extremities, particularly the legs, to the attacks of erythema nodosum. Patients are very often seen with a crop of papules on their arms, or just above the knees, while their tibial region is covered with tubercles.

But the converse question has also been raised—are erythema nodosum and *E. papulosum* affections *sui generis and distinct from rheumatism*? Professor Hardy thinks that they are. He considers that rheumatic symptoms, being absent in more than half the cases of *E. papulosum*, and occurring even less frequently in those of *E. nodosum*, must be regarded as merely a casual complication of these complaints, just as in many instances of scarlatina.

But how, then, shall we define this specific malady, if it is not to be regarded as rheumatic? According to the most recent authorities, it must be closely allied to the *eruptive fevers*.

It has, however, been found necessary, when surveying the erythemata nodosa from this point of view, to separate them into two varieties, one mild, non-febrile, and perhaps originating in rheumatism; the other febrile, and dangerously complicated, especially by pleurisy and pneumonia. Says M. Rondot, in his monograph on this latter disorder: "*Febrile erythema nodosum* sometimes runs its course rapidly, the first appearance of the eruption being preceded by an increase of temperature, which lasts for several days, and declines by regular oscillations, and the successive crops being ushered in by an evening rise. In other cases, the fever assumes a distinctly continued type, not altogether due to the internal inflammations, and the thermometric indications resemble those of typhoid."

"The painful symptoms are generally connected with the appearance of eruptive patches about the joints. It is these patches that give rise to the sensations in those parts which are wrongfully attributed to rheumatism. Pains in the joints themselves and in the tendons also occur, probably due to invasion of the synovial membranes by the eruption, whose influence, however, is not sufficiently energetic to produce anything like the redness and swelling which are the signs of genuine rheumatism. *Neuralgia* may extend itself even to those portions of the lower extremities which are free from the eruption."

"*Endocarditis* is the most frequent complication; next come pleurisy, bronchitis, pneumonia, pericarditis, and albuminuria. The endocarditis probably results from the same constitutional condition which calls forth the cutaneous symptoms. This condition is one of *infectivity*, and the joint-affection is similar to the pseudo rheumatism met with in the course of disorders whose contagious nature is undoubted—such as erysipelas, puerperal fever, scarlatina, variola, and gonorrhœa."

These conclusions are in harmony with those of MM. See and Telamon on the same subject, excepting that the latter would place pleurisy at the head of the list we have just cited. They state that this inflammation, though generally of a mild character, proves fatal in exceptional cases.

The question as to the essential nature of erythema nodosum and erythema

papulosum is still *sub judice*. But meanwhile its discussion cannot be devoid of interest, as bringing us face to face with those two great conceptions which are daily gaining ground in the domain of etiology—diathesis and contagion—inherent arthritic tendency, and the invasion of the microbe.—PAUL LE GENDRE, *l'Union Médicale*, Oct. 27, 1883.

MASSAGE IN THE TREATMENT OF CHRONIC FACIAL ŒDEMA CONSEQUENT UPON HABITUAL ERYSIPELAS.

I EMPLOYED massage with marked success last year in two successive cases of that rare disease, chronic facial œdema.

The first patient was a girl, ten years old, well developed and otherwise healthy, who for several years had suffered from a constant nasal catarrh with abundant discharge of mucus, and accompanied, during the last three years, by a thickened condition of the upper lip, nose and cheeks. This latter symptom appeared as a sequel to inflammatory attacks occurring several times yearly on the above localities, and marked by redness, swelling, and painfulness of the affected parts. In a few days the redness and pain would subside; the swelling, however, remained, and grew worse with every return of the inflammation. During the last year, each of these attacks had been followed by the appearance on the left cheek of a bluish-red spot about the size of a kreuzer, which lasted for weeks. The patient bled frequently from the nose, breathed through her mouth, and snored loudly when asleep. Her family history was good, residence not damp, and she herself had never had skin eruptions or glandular swellings.

On examination (eight days after an attack) the entire nose, especially its tip, the adjacent portion of the left cheek—and, to a less extent, of the right—as far as the zygoma; the upper lip, and the frontal region bordering on the root of the nose, were found to be greatly swollen, and (with the exception of the livid spot on the left cheek, which had not yet quite disappeared) of a pallid hue. The palpebral conjunctiva was deeply injected, and the left lower eyelid very œdematous. The skin about the nostrils was somewhat excoriated, causing pain on inspection of the nasal cavity, the lower portion of which was enlarged and contained collections of yellowish-green mucus, but no scabs. The Schneiderian membrane was relaxed and rather redder than natural, but presented no adenoid growths. The hearing was good.

Treatment during the first few days was directed solely against the chronic catarrh. The nasal cavity was daily injected with a solution of boracic acid, and the same agent was also introduced in powder. These measures being without effect upon the facial œdema, massage was resorted to in the following manner: the swollen parts were kneaded every day for several minutes at a time with both thumbs (well-oiled) carried downward and outward, one on each side, from the bridge of the nose to the border of the lower jaw. The process was not painful, and merely brought a short-lasting color to the pale face. Next day the bluish spot was no longer visible, and in a fortnight the swelling of the forehead, of the left lower eyelid, and of the cheeks had also completely disappeared. That of the tip of the nose and the middle of the upper lip proved more refractory. In this latter situation the condition was one, not simply of chronic œdema, but of hypertrophy, such as is so frequently to be seen in the upper lips of scrofulous subjects. Four weeks more of manual treatment resulted in so considerable a decrease in the size of this feature, and also of the tip of the nose, that the patient was dismissed, highly gratified with her improved appearance. She still remains

quite well, after the expiration of a year, and no apprehension is now entertained of a relapse.

The other case—also a girl, *æt.* 11, of a marked scrofulous constitution, but otherwise healthy and strong—though similar to the former in its essential features, was much more severe and obstinate. There was *ozæna* of long standing, and the sense of smell had been lost for three years. The recurrent inflammation, which had lasted for five years, was of a decidedly erysipelatous character, but was unaccompanied by fever, and confined entirely to the upper lip, cheeks, nose, and eyelids. The middle region of the forehead was also swollen, but without inflammation. Shortly before the present disorder set in, the patient had had an eruption on the head, to whose suppression the facial *œdema* was attributed by her friends.

The disfigurement caused by the latter was so great that she was forced to stay away from school, and had to be closely veiled when walking on the street. The upper lip was enlarged to three times its natural dimensions, of course projecting far beyond the lower, and its mucous surface was beset with numerous rhagades. The cheeks were raised by the swelling to the level of the bridge of the nose (this feature being naturally small and somewhat depressed), and the left eyelid was closed. The nostrils were filled with fetid scabs and lumps of mucus, and the turbinated bones were in a state of atrophy.

The case was treated with nasal injections of soda and chlorate of potash in solutions, and of iodoform in powder; by touching the rhagades with caustic, and by massage of the face. The improvement resulting from the last-named procedure was both speedy and well-marked. In a few days the swelling had disappeared from the right eyelid, the forehead, and partially from the cheeks. That of the left lower eyelid, however, still persisted after three weeks' steady treatment. This was owing to a recurrence of the erysipelas which, beginning at the inner canthus of the left eye, spread gradually over the left cheek, nose, upper lip, and right cheek. During this attack the patient ceased her attendance, which was not resumed until the parts had returned to their previous condition. Massage was then kept up, with a few brief intermissions, for about three months, at the end of which time the *œdema* was entirely gone, excepting from the upper lip. In this locality the process could not be applied with sufficient energy, on account of the bleeding and painful rhagades around the nostrils, and it was therefore again discontinued until these, together with the *ozæna*, could be cured. Within a fortnight this was accomplished, after which the lip was manipulated with such force and effect—by kneading it, one-half at a time, between the thumbs, followed by a rubbing movement downward and outward from the median line to the lower jaw and sides of the neck—that in six weeks the patient was discharged with hardly a trace of her disfigurement remaining.

The efficacy of massage in such cases as these arises from its accelerating action on the capillary and lymphatic circulations, and its effect in promoting the disintegration and absorption of inflammatory products. It fulfils, therefore, every rational indication for the treatment of the disorder we have been considering, and must be regarded as useless only when long continuance of the morbid process has resulted in such confirmed induration and hypertrophy of the connective tissue as to render a cure impossible. The condition of the cervical lymphatic glands is also not without its influence in this direction. The method recommended by Gerst (*On the Therapeutical Value of Massage*; Wurzburg, 1879) for catarrhal diseases of the nasal mucous membrane, and for laryngeal and pharyngeal inflammations—and which consists of manipulations directly applied

to the latter regions of the neck—was adopted in both the above-described cases, with greater advantage than could have been derived from massage of the face alone.—JOH. HABERMANN, *Prager Med. Wochenschrift*, Oct. 3 and 10, 1883.

PERFORATING ULCER OF THE FOOT.

THREE leading points are to be noticed in regard to this affection, viz., its seat, the sex of its subjects, and, lastly, their occupation.

Perforating ulcer, with very few exceptions, is met with on the sole of the foot, not, however, on every part of the surface indiscriminately, but at one or another of the points which are ordinarily subjected to the greatest pressure, *i. e.*, the ball of the great toe, the anterior extremity of the fifth metatarsal bone, and the heel. Of these three localities, the first-named is that which is most frequently attacked by the disease. In a case of club-foot, the ulcer may form on whatever part is brought, by the deformity, in constant contact with the ground.

As a rule, the victims of this malady belong to the male sex, and are found among those whose avocations oblige them to maintain a standing posture.

The progress of a perforating ulcer is divided into three stages. The first of these is marked by the existence of a *callosity*, or mass of hardened epidermis, at some one of the points above-indicated. Beneath this mass, the derma will be found dotted with red points. The period of callosity may endure for years, or the disease may never advance beyond it.

The second stage is that of *ulceration*. The condition by which it is characterized may be accounted for in various ways. As a result of long-continued pressure, the derma underlying the callosity may become gradually thinner, until it is wholly destroyed, leaving only the epidermis, which then falls an easy prey to ulceration. Or, a deposit of serum may form beneath the slowly-thickened epidermis, giving rise to perforation and ulceration of the latter. Or, if we adopt M. Gosselin's theory (undoubtedly applicable to some cases), the process should be defined as a serous dermo-synovitis, involving the formation of a synovial bursa, which inflames and suppurates. In whatever way the ulcer is developed, it presents the same form—that of a narrow excavation, looking as if a piece had been punched out of the epidermis, and surrounded by a cushiony projection of the latter. On passing a probe, a circular channel is detected immediately beneath this epidermic border.

The third stage, that of *perforation*, is characterized by those deep-seated lesions from which the malady has derived its name. The ulceration now makes its way downward, and destroys, in more or less rapid succession, the tendons, the periosteum, and finally the bone. In some instances, indeed, the morbid process does not extend beyond thickened derma, beneath which, after passing through a short perforation, we come to a serous deposit called the sub-derma. But usually the base of the ulcer is found to consist of disorganized tendons and denuded articular surfaces, to which the probe penetrates without the slightest difficulty.

In addition to these objective features of the disease, it presents some other characteristics, among which must be especially noticed the anesthesia, analgesia, and diminished sensitiveness to heat and cold that universally accompany it.

We may also meet with arterial atheroma and trophic changes, such as curvature of the nails, etc.

In brief, the course of perforating ulcer is a peculiar one in these respects; it is very slow, and proceeds by leaps, presenting intervals of improvement and

even of apparent restoration to health, followed, sooner or later, in nearly every case, by relapses, which in the advanced stages must be regarded as inevitable.

As to the mode in which it originates, only two suppositions have been advanced which, in my opinion, are worthy of more than a passing notice. These are the theory of mechanical pressure, and the nervous theory advocated by Duplay.

With regard to the former, it is unquestionably true that an individual whose occupation compels him to stand continually, or to walk a great deal, is especially liable to perforating ulcer, as a result of the unremitting pressure to which his feet are subjected. But cases sometimes present themselves in which these two causes are entirely insufficient to explain the existence of the disease; moreover, certain nervous lesions have been observed in many of its subjects. Duplay and Morat have thus been enabled to demonstrate that perforating ulcer frequently depends upon morbid alterations in the nerves, the spinal cord, or the brain; and from this point of view it may be regarded as significant that the disease has occasionally been developed in ataxic patients.

It is no easy matter, however, to detect this primary nervous lesion, which must, I think, be regarded as inadequate to the production of a perforating ulcer, excepting when combined with the indispensable predisposing influence of pressure.

The proper mode of treating this complaint follows at once from its etiology. In the earliest period, its development may often be prevented by repose and a change of occupation. When the callosity is fully formed, so as to furnish a source of additional pressure, it must be removed, by paring off thin slices, its reproduction being prevented, at least for a time, by covering the denuded surface with a piece of diachylon plaster. Should the ulcer be completely produced, it is best to touch it with tincture of iodine, and keep the part completely at rest, bearing in mind that, even when these measures have apparently succeeded, a relapse is always to be feared.

Finally, in cases where the soft parts are wholly destroyed and the bone laid bare, operative procedures—ablation, resection, or amputation—constitute our only resource.—CH. MONOD, *Le Progrès Médical*, Jan. 5 and 12, 1884.

THE TREATMENT OF GONORRHŒA BY OPEN WIRE BOUGIES.

GONORRHŒA is a specific catarrh of the mucous lining of the urethra—a condition in which there is rapid inflammatory cell-proliferation and exudation of fluid from the mucous surface. These catarrhal changes necessarily begin at the anterior extremity of the urethra, and travel backwards. The fossa navicularis suffers early and severely; and, backwards along the course of the passage, another part that is severely affected is the sinus of the bulb. These two parts are wider than the parts of the canal immediately behind each, and so small portions of fluid are apt to lodge more persistently there than in other parts of the canal.

In the local treatment of this affection it is obviously very desirable to keep separate the inflamed mucous surfaces. The condition is in many respects analogous to a moist eczema intertrigo, where cure is indefinitely postponed unless the surfaces are, by suitable dressing, maintained apart. The injections in gonorrhœa that have been most successful are those that have best fulfilled this indication of treatment, and lately Mr. Cheyne's medicated bougies of cacao-butter have given further aid in this direction. To carry out more effectually

the keeping separate the secreting surfaces, I have had made open wire bougies. These are of two forms.

The first form (Fig. 1) is for the effective administration of injections. The part *a* is a short length of catheter-tube, to which are soldered the wires of the open bougie, part *b*; and to the part *a* is also attached a short piece of India-rubber tube, *c*. This instrument being introduced until the part *a* is well within the



FIG. 1.

meatus of the urethra, the solution to be injected is introduced by a syringe, and, when quite full, the India-rubber tube *c* is compressed by a spring clip, to prevent the escape of the fluid. Within from twenty to thirty minutes, the injection will be almost wholly absorbed by the urethral walls, and then the instrument may be withdrawn. By this means, the injection is applied to, and kept applied to, any part of the urethra that may require it until entirely absorbed. By the ordinary method at present in use, the contact is at best but very brief; and, as the part of the passage that is most in need of treatment is usually the most irritable, the injection is, by the instantaneous reflex contraction of that part, at once driven from it into other portions of the canal.

The second form (Fig. 2) is an open wire arrangement throughout, and is constantly worn by the patient, so that the discharge may drain freely away, and not lie in the passage and give rise to renewed secretion, as constantly goes on in the ordinary treatment at present. These instruments are well borne in the urethra, and the patient pursues his ordinary avocations while wearing the second form.

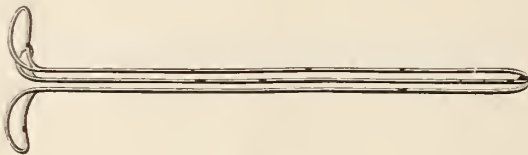


FIG. 2.

The length of the wire bougies is, of course, in proportion to the distance up the canal to which the catarrhal affection has travelled: in recent cases, an inch and one-half may suffice; in older cases, it may be necessary to have it greatly longer.

Mr. Hilliard, of Renfield street, Glasgow, can supply them to any member of the profession who may be inclined to put this method of treatment to the test.—D. C. M'VAIL, *Brit. Med. Jour.*, March 15, 1884.

CAN SYPHILIS ACQUIRED DURING PREGNANCY INFECT THE FETUS?

IN considering the etiology of hereditary syphilis, it is found that several points connected with the subject are still undecided, or, rather, that a want of agreement exist as to the inferences to be drawn from known facts. The following conclusions, however, have been reached:

- 1st. A syphilitic father may procreate a syphilitic child.
- 2d. A syphilitic mother may give birth to a syphilitic child.
- 3d. Both parents being syphilitic, their offspring will probably be syphilitic.
- 4th. The mother contracting syphilis during gestation, may transmit the disease to the foetus, provided constitutional contamination has occurred.

The first three of these propositions have been generally accepted by authors; the last has not been so favorably received. More especially, it is denied by Kassowitz, who concludes, from the study of many cases, that a mother acquiring syphilis during gestation does not transmit the disease to her healthy foetus. And he also claims that this view is much strengthened by the circumstance that his investigations in the opposite direction led him to the conclusion that a non-syphilitic mother is capable of giving birth to a syphilitic child. The foetus, he says, cannot transmit syphilis to the mother through the placental circulation, and in all cases where the mother becomes syphilitic during pregnancy, the disease originated in some other manner.

These opinions have not, however, been accepted by most writers. Their objections are based largely upon clinical observation, and it must be admitted that, owing to the peculiar nature of the investigation, there is frequently room for controversy in the most carefully reported cases.

After duly considering both sides of the subject, I am inclined to the opinion that syphilis contracted during pregnancy may be transmitted by the mother to a previously healthy foetus, provided the infection in the mother has passed beyond the initial lesion, and is made manifest by constitutional symptoms. This conclusion has been reached from a physiological and histological study, rather than from clinical observation on the subject.

It is beyond doubt that the blood of a person affected with constitutional syphilis contains the virus, and is capable, when inoculated upon a non-syphilitic individual, of producing the disease. This virus being, as I believe, a material substance, must exist in the blood either as a separate element or an organism. In either case, the inherent power possessed by the white blood-corpuscle of surrounding or incorporating within itself any material substance with which it comes in contact, leads me to conclude that these corpuscles are the chief, if not the only means, by which the virus is transmitted from one organism to the other. That a direct communication is necessary, in order that a material substance may be conveyed from mother to foetus, I do not believe.

The possibility, or rather the certainty, of the white blood-corpuscles having the power of carrying material substances from the maternal to the foetal circulation has been demonstrated by the experimental researches of several investigators. When minute insoluble particles, such as cinnabar or indigo, are injected into the blood-vessels of a living pregnant animal, and the animal killed after a varying period, it is found that an examination of the foetuses, within the uterus, shows the white corpuscles of their blood to contain some of the particles which were injected into the blood-vessels of the mother. Therefore, if it is possible for such comparatively large and appreciable particles to pass from one organism to the other, through the placenta, it is not unreasonable to conclude that it is possible, or even very probable, that the virus of syphilis, which has as yet escaped our observation when sought for with the highest powers of the microscope, may in a similar manner be transmitted.

The vital amoeboid movement, the inherent power of incorporating within itself foreign substances, and the acknowledged power of passing through the protoplasmic wall of the blood-vessels, are all attributes possessed by the white

blood-corpusele, and are, I think, sufficient to explain the manner and possibility of foetal contamination.—SIMES, *The Polyclinic*, Dec. 15, 1883.

VLEMINCKX'S SOLUTION IN ACNE ROSACEA.

VLEMINCKX'S solution is made by adding one part of lime and two parts of sublimed sulphur, or flowers of sulphur, to twenty parts of water. This is boiled down to about twelve parts, cooled, and then filtered. The result is a dark orange-yellow colored liquid, with a strong odor of sulphuretted hydrogen.

The remedy is employed externally—usually in the proportion of one part to four or five of water, though in some of the more obstinate cases it is necessary to gradually increase the strength of the lotion, even up to the pure solution. This is, however, rare. At times it is well to intermit treatment for a few days, in order that the desquamation it generally causes may disappear. The milder strengths cause very little desquamation, and, in moderate cases, are sufficiently efficacious. In most cases, the improvement would be more rapid were the lotion applied twice daily, night and morning. It is difficult, however, to get patients to make applications early in the day, on account of personal appearance. The severe forms of the disease, those in which hypertrophy is a marked feature, are comparatively rare, and as yet I have had no opportunity of testing the solution in such cases. It would probably be of little value, as the disease, when so advanced, is rarely benefited by any treatment, except those plans in which operative measures figure prominently.

Even in the moderate forms, some cases fail to respond to the application of the solution, and other treatment must be instituted, in order to secure improvement.

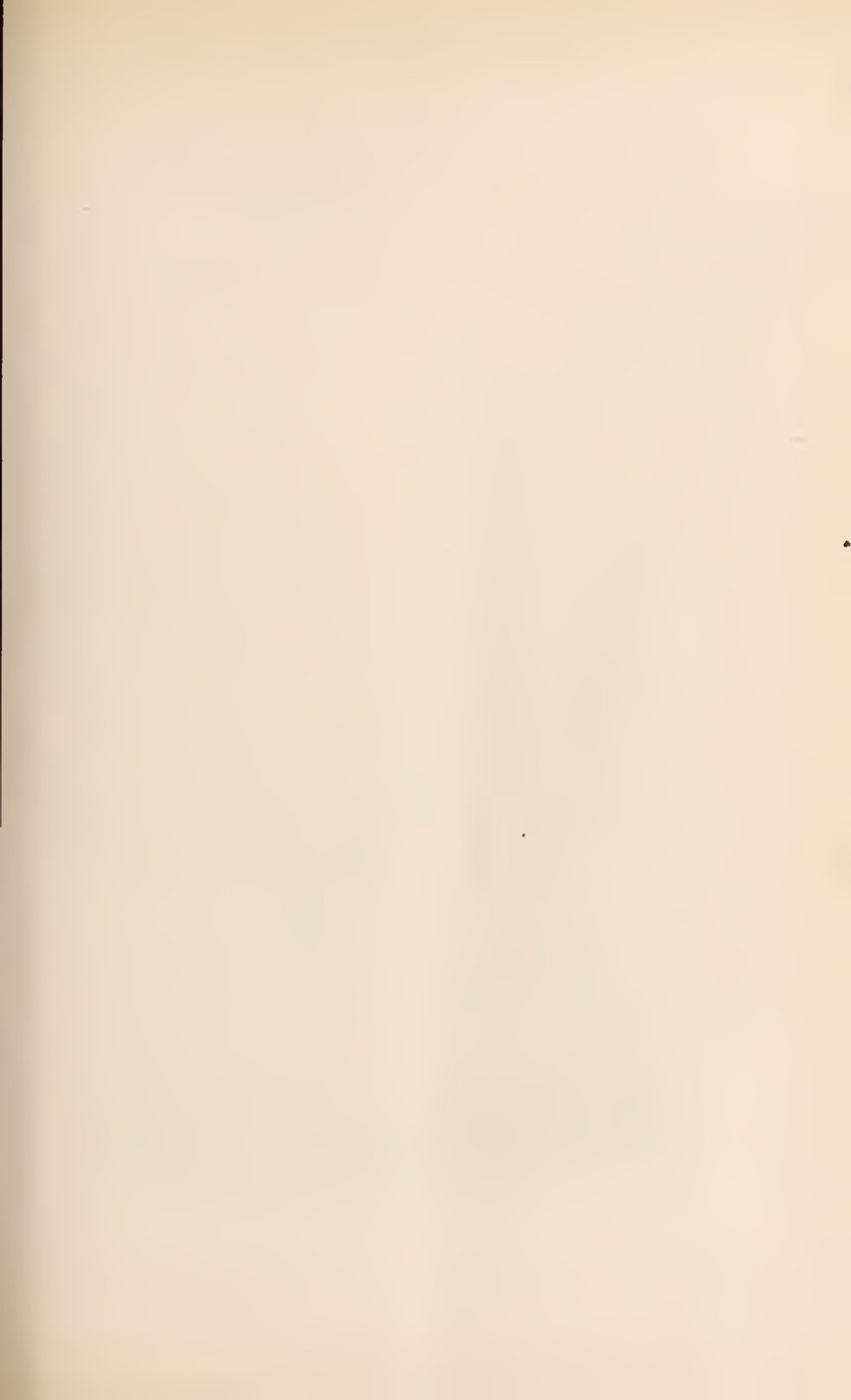
Vleminckx's solution is not, therefore, in any sense, a specific for acne rosacea—far from it. It frequently fails and disappoints. Upon the whole, however, according to my experience, it is, for the milder forms of the affection, the most reliable single remedy.—H. W. STELWAGON, *Medical News*, July 7, 1883.

NÆVUS TREATED SUCCESSFULLY BY LOCAL APPLICATION OF LIQUOR ARSENICALIS.

UNDER the above heading, Mr. W. J. Beatty, of Stockton-on-Tees, in the *Journal* for November 24th, 1883, brought before the profession a (to me) new method of treating nævus; and I am very glad, having given this mode of treatment a fair trial, to be able to say a word in its favor.

At the time his article appeared, I had been considering what would be the best mode of treatment for a large nævus on the scalp, situated over the anterior fontanelle; and, the mother objecting to vaccination, etc., I determined to try the liquor arsenicalis, with the result that my patient was completely cured in seven weeks, and that without appearing to suffer any pain, except for a short time when the nævus was ulcerating.

I had to stop the application on two different occasions, owing to severe gastric disturbance, which I attributed to the absorption of arsenious acid, and which ceased after a rest of two or three days.—JOHN BLAIR, *Brit. Med. Journ.*, April 19, 1884.



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Dr. Corlett's Case of Poriaria.

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AN UNUSUAL CASE OF PSORIASIS (WITH PLATE).

BY

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THE special regions involved in a cutaneous malady is suggestive of its nature, and points the way to further inquiry when a positive diagnosis at the time is impossible. Why certain diseases appear more frequently upon the thick, rough extensor, than upon the soft delicate skin of the flexor surfaces of the body, may not always be apparent. Constant, gentle friction will change the latter so as to resemble the rough integumentary covering of the elbows and knees. But increase this local stimulation beyond a certain, though variable limit, and it becomes a disease. Investigation at this time will show the papillæ red in color, and enlarged from a determination of blood to the part with a consequent rapid formation of tissue. Passing upward, the physiological formation of cells in the stratum mucosum has become pathological, rapidly formed and ill developed they approach the surface, and give type to the process which is named. That local irritation may be the exciting cause of psoriasis, in skins predisposed to take on a low form of inflammation, I have no doubt. But then it occurs when no such exciting cause can be detected, and upon parts of the body apparently protected from irritation. It is becoming generally accepted as a fact that irritation of the vaso-motor nerves or ganglia, as well as of the trophic centres, will give rise to cutaneous inflammation. *Herpes* is an example of this. Cut off nerve communication or by injury impair the

function of a nerve, and we get atrophic changes as a result, viz., *the glossy skin*, possibly *morphæa*, etc. May not psoriasis, which comes on at the age when functional disturbances of the nervous system are most rife, be under the same morbid influence? Does sudden or violent emotion, fear, or shock have any influence in its evolution? Or are the supposed exciting causes which one sometimes meets with, mere coincidences, and after all do we know nothing as to the etiology of psoriasis?

The case from which the accompanying plate was taken is of interest in this connection, but chiefly on account of the conformation of the eruption—the absence of the usual thick epithelial crusts, together with its distribution.

CASE.—Mr. E., aged twenty-five years, married, a native of Canada, and by occupation a stone mason, was under treatment for a slight ailment, when the attending physician noticed an eruption on the body, which the patient said had been there a long time. He had been treated for it without permanent benefit; once or twice it had disappeared, but after a few months returned again. As it gave him little annoyance, he had of late ceased treatment altogether. Soon after this, March 10, 1884, through the courtesy of Dr. Z. T. Dellenbaugh I first saw the case, and noted the following additional history.

The patient is of fine muscular development, with light hair and blue irides, a soft skin, always had excellent general health, and never had any venereal disease. Family history good. The eruption first appeared at the age of nineteen, after exposure to cold and fright. The patient was crossing a frozen river when the ice gave way, precipitating him into the water where he remained more than an hour, from which he contracted a severe cold. A fortnight later a rash appeared on his back, which was very itchy and “looked like a sun burn.” A month after this it began to fade away, excepting in certain spots which gradually assumed the ringed condition herein shown. Nothing of note occurred in the history of the case, until a scaly eruption appeared on the scalp when he was twenty-two years old.

The disease has always been limited to the trunk and scalp. At no time has it been vesicular, neither has the formation of scales been more abundant than at present. The patient says there has been no change in the spots for three years; they are in position symmetrical, slightly elevated, and of a red color, in short the usual appearance of a psoriatic patch after removing the scaly covering. In some places, however, small collections of silvery scales are seen; these are easily detached. No induration exists. Careful microscopical examination failed to show the presence of the *Trichophyton*. On the scalp it extends from the vertex forward and is more scaly, but this has not interfered with the growth of hair, which—using the patient's expression—“has always been so firm you couldn't get one if you pulled a week,” consequently we did not molest it.

Before diagnosing the case, it was necessary to eliminate two affections, which the lesion closely resembles, viz., *tinea trichophytina*, and a squamous syphilide. The former was eliminated by these facts, viz., that he had never, to his knowledge, come in contact with the disease in others; that he had slept with a brother four years, and afterward with

his wife without communicating the affection in either case; that the growth of hair had continued in full vigor, and that vegetable fungi could not be found. The history, course, and color of the eruption, together with the absence of induration, would exclude a squamous syphilide.

The treatment consisted of the internal administration of the *arsenici bromid.*, and the local application of *chrysarobin.* At the time of writing, June 9, the eruption has wholly disappeared.

143 EUCLID AVENUE.

TREATMENT OF VEGETABLE PARASITIC DISEASES.

BY

JOHN V. SHOEMAKER, A.M., M.D.

THE PRINCIPLES OF TREATMENT.

A REVIEW of the various plans of treatment of vegetable parasitic diseases would occupy the space of a good-sized volume to do justice to the subject. It is my purpose, therefore, in this short paper to point out: First. The principles of treatment in all vegetable parasitic diseases by a new method which, in my experience, can be easily pursued, and will usually be followed by effective results.

Secondly. Take up and briefly describe the treatment of some of the more common varieties of vegetable parasitic diseases. It is usually found that the majority of those having vegetable parasitic diseases are subjects that possess a suitable soil for the growth and development of the fungus. Constitutional debility in some form or another is generally present, according to my observation, especially in public institutions, and requires careful attention. In some few cases, no impairment of the system is evident, but by building up the nutritive powers of the body and by the use of suitable food tonics and fresh air, patients respond better to the local applications.

The next aim is to lessen the ravages of the parasite, and to remove and destroy it by appropriate local attention to the surface involved. This part of the treatment generally begins by interdicting the use of water to the seat of the disease. I firmly believe that the application of water to the parts places the organic carbon compound of the skin in a more favorable condition for the continued nutriment of the parasite. I usually order the diseased surface to be cleansed every day or two with sulphuric ether, or the latter with thymol, or equal parts of the ether and alcohol with a few grains of thymol.

Another useful anti-parasitic solution is equal parts of alcohol and

ether with boracic acid. Oil or oleic acid can likewise be used either alone or medicated to cleanse the parts, remove the scales and crusts, and limit the spread of the parasite. Among the most appropriate oils are crude petroleum, olive, and ergot oils.

Cutting the hair, shaving, and epilation, that are usually recommended and practised as one of the essential principles of treatment in this class of cases, I have of recent years come to the conclusion is of no especial value.

Cutting the hair, while it exposes to the view more of the diseased surface, often has the disadvantage of causing abrasions of the scalp from the scissors, and, by such a condition being present, increasing the ravages of the parasite. Cutting leaves short hair-stubbles, and the moving to and fro of them, in the endeavor to make applications, usually increases and adds more local irritation than would be occasioned from leaving the hair in the normal state. Shaving, while it fulfils to a greater extent all that can be desired from cutting the hair, often sets up even more irritation, and accomplishes from its use no special good. Epilation is a tedious, ineffective, and often painful procedure that has not, when contrasting cases side by side, been attended with any good result. It not only fails to be of benefit or assistance, by reason of the hair being brittle and breaking off, and the very attempt to extract often increases the irritation. I have for these reasons discontinued epilation, and so stated about two years ago in a discussion upon *tinea decalvans*¹ before the Philadelphia County Medical Society. Thus having briefly considered the principles of treatment, I next propose to refer to the methods in my experience which most promptly eradicate the several varieties of vegetable parasitic diseases.

Trichophytosis Capitis.

It is first necessary in ringworm of the scalp to advise proper isolation of the patient, the separation of clothing and wearing apparel from that of the healthy, separate bed and sleeping rooms, removal of woollen clothing apt to catch and carry the germs, and thus provide against all possible contagion. The spread of the contagion, at the same time, can be much lessened by the thorough washing of the heads of all the others in families or schools, etc., with sulphuric ether or a weak alcoholic solution of borax, to be followed directly with oiling the hair and scalp with a solution of thymol (about ten to twenty grains to the ounce of olive oil), or the fluid oleate of mercury. If this will be persevered with, the danger of contagion will thus be reduced to a minimum. If the patient should be out of health, which is often the case, debilitated, ill-nourished, or anæmic, I usually order in the beginning some mild aperient,

¹ Proceedings of the Philadelphia County Medical Society, vol. v., 1882-1883.

to be followed by a bitter tonic, or either the fluid extract of malt, the compound syrup of the phosphates, or one of the salts of iron or cod-liver oil. The diet should, at the same time, be nutritious; especially such articles as meats, milk, and eggs should be used; plenty of out-door exercise, and good fresh air are requisite.

The room in which the patient dwells should be airy, dry, and not overheated. Care should be taken not to allow water to stand or evaporate in the room, as moisture and warmth form the principal elements necessary for a development of the parasite. Cutting, shaving, and epilating the hair have not in my experience, from what I have already stated, been conducive of any good results. Shaving the head, which gives rise to intolerable itching with its consequent scratching, adds to the irritation already existing. To begin at once with the use of strong stimulating applications or vesicants is a measure just as cruel as the epilation would be at this period. Epilation especially is not only valueless, but in my experience is altogether impracticable, as the affected hair clasped tightly by the irritated and swollen follicles and the additional presence of the parasite which pervades it, enlarging its calibre, and rendering it brittle, will only break off short, either within or outside of the follicle and thus render the condition of the parts worse rather than better. Instead of following the old procedure, I generally have the spots sponged with a weak alcoholic solution of thymol, borax, naphthol, or corrosive chloride of mercury every day or two. To the surface thus cleansed, I immediately have applied a fifty per cent solution of boroglyceride until the entire scalp seems saturated with it. The borax I believe to be one of the most efficacious antiseptic and antiparasitic agents, and has at the same time a mild astringent action, thus tending to allay the irritation and soothe the parts. The glycerin at the same time penetrates and carries the substance into the follicles to the parasite. Glycerin has a great affinity for water and withdraws this from the tissues, thus depriving the fungus of one of its main elements of development. I cannot speak too highly of this simple application, from which alone I have observed rapid cures in some early cases of ringworm of the scalp. Boroglyceride solution is likewise devoid of any poisonous properties, and will be borne by even the most irritable scalp. This solution should be applied night and morning with a little sponge or mop, and must be well rubbed into the follicles, with the tips of the fingers. It has the advantage, besides, that it will prevent contagion, as the germs will adhere to the glycerin, which will not dry, and are not cast off to the detriment of others. I have the spots washed with one of the previously-named washes every two or three days and have immediately after the application of the solution of boroglyceride. During all this period I do not attempt to epilate, as I do not see what advantage could be gained by breaking

off the hairs. If, however, there is no amelioration of the disease within a short time, after resorting to this treatment, or if the patches extend or the implicated hair still break off or continue brittle, I next proceed to use a stronger and more decided anti-parasitic remedy; namely, copper oleate. This oleate which, to my knowledge, I was the first to employ in the treatment of parasitic skin affections, has proved in my hands one of the most valuable anti-parasitic agents that I have employed. It has no constitutional toxic effects, is a slight stimulant to the tissues and astringent, and has the power of deep penetration into the parts, especially the follicles. As prepared in its pure state, it is a salt of plaster consistence and should be diluted with either nine or four parts of a fatty diluent (I prefer the oleopalmitic acid to all others, on account of its consistence and great penetrating power) to form what I term respectively a ten or twenty per cent ointment. My attention was directed to copper oleate as a remedy for ringworm in the following manner. For several years I have had patients to tell me at the Philadelphia Hospital for Skin Diseases, and in my private practice, that they cured this or that member of the family of ringworm by putting an old copper penny in vinegar and applying the liquid to the patches. Some, however, resisted this treatment. Now, how was it that it did do in some and not in others? Judging that while this coppery liquid might destroy the fungus on the surface, if the parasite after a time passed into the follicles at its lowest depth and invaded the hair bulbs, it could not affect it in any way. I therefore reasoned that, if the copper solution had the power to kill the parasite on the surface, why could it not do the same within the follicles, providing it could be carried there? Remembering the great penetrating power of oleic acid, I had it combined with copper, and mixed with a fatty base, and applied on an inveterate and extensive case of ringworm on the scalp of a child that had been treated by numerous remedies in vain, and in six weeks the case was completely cured. Other cases of ringworm were tried with equally good results. Good effects from the use of this remedy have been reported by many in this county, as well as by Sawyer and others abroad, through the columns of *British Medical Journal* and the *Birmingham Medical Review*. The ointment of copper oleate should generally be used in cases of ringworm in the following manner. A small piece of the ointment of copper oleate should be rubbed over the affected surface. This should be repeated night and morning until all traces of the disease have disappeared. The objection urged by a recent writer to its use, owing to the parts and clothes being stained, will be found entirely unobjectionable when properly employed. It should be used in a very small quantity, the parts should not be covered as if an ordinary ointment was used. All the oleates are powerful, have deep penetration, and should be used sparingly. Employed in this

manner, it is cleanly, never produces staining, and acts rapidly and effectively. The use of water to the affected parts should be avoided, not only for the reason already set forth, but also to permit the oleate to penetrate to the lowest depth, which would be interfered with by its use.

The treatment of chronic ringworm should be conducted much in the same way as the preceding, only that I alternate the copper oleate with that of mercury oleate. That the germs in such cases penetrate to the very bottom of the follicle and into the hair is beyond doubt, and the only remedy of service in such cases must have quite as much penetrating power. While I usually prefer the copper oleate for this purpose in all cases, yet mercury oleate in some amongst the most chronic seems to do even better than the former. I have seen the mercury oleate cure rapidly the most inveterate and extensive cases which had resisted all other remedies and had existed for many years. Although I have used large quantities of the very strong mercury oleate ointment, yet I have not seen any cases of salivation follow. Mercury oleate ointment is applied in the same manner as the copper oleate ointment, the five-per-cent being preferably used in very young children, and the ten to thirty per cent in older persons. It should also be well rubbed in, and repeated the same as the foregoing. While I have seldom failed with any of the above means, nevertheless there are cases beyond our control where remedies do not have the proper effect, either by being insufficiently applied or where the treatment is not properly carried out, and thus baffle our efforts. In these cases, and these alone, do we countenance the practice of curing ringworm of the scalp by producing artificial kerion as a *der-nier ressort*, but one which seldom if ever fails. As kerion has been described as nature's attempt to effect a cure and is followed by a loosening and falling out of the hair with subsequent cure of the affection, this process is imitated with a view to produce a similar condition. The best application for that purpose is croton oil. As this cannot be applied indiscriminately, however, or to very large surfaces, it should only be painted on with a camel's hair brush to inveterate patches and may be followed by a poultice. This should be daily repeated, even if pustulation follows, until distinct infiltration and puffiness takes place and the patches have assumed an aspect as in real kerion. The scab is then to be removed and either the copper or mercury oleate ointment is to be applied to the patches, and after one spot is thus cured, others may be similarly treated, one at a time, until all of them show no further development of parasitic stumps. It may take five to six applications to produce the desired condition, but this is sure to follow if properly conducted. As this is a severe measure, it should never be lightly attempted and the parents should be duly informed of the nature of the treatment, as it might otherwise

alarm them and the case be withdrawn from the attending physician. The disseminated variety of which Alder Smith speaks should be managed in accordance with the foregoing treatment mapped out. The solution of boroglyceride should also be continuously applied and the hair should be closely examined with the lens for stumps and black dots. Where the former are found, they should be promptly treated and to the black dots the application of a drop of croton-oil to produce pustulation or, better still, the puncturing of the follicles with a golden needle dipped in that oil, and that treatment should be kept up in this manner until stumps and black dots are no longer apparent and healthy downy hair takes the place of the diseased.

In several inveterate cases in which the spots were denuded, I have brushed over the surface an infusion of jequirity, which set up an extensive inflammation and cured them.

As to the management of ringworm of the head in schools and institutions, the most important feature is isolation and cleanliness. The head of the healthy should be frequently examined and washed with one of the solutions frequently referred to.

When finally all are pronounced cured, the sick-room should be whitewashed and painted, the floors washed with a solution of *naphthol*, corrosive sublimate, or carbolized water; the clothing, brushes, combs, etc., used by the patients should be burned, so as to destroy all traces of the parasite, and prevent it from breaking out anew.

Trichophytosis Corporis.

The indications for the treatment of this affection are to employ such remedies as will cause the epidermis to be cast off, and thus tend to eliminate the parasite. Some milder cases, especially in children, may disappear spontaneously, but these are exceptions only. One of the very best remedies to be applied locally to obtain the effect just alluded to, is a solution of corrosive sublimate, which can be employed dissolved in cologne-water, about two or three grains to the ounce, to be painted on night and morning. Caustics also fulfil the same indications, and as such, carbolic acid, thymol, acetic acid, and tincture of iodine are often employed with success. Sulphurous acid and solutions of sodium hyposulphite may answer as well as chrysarobin, which yields excellent results in ointments containing twenty grains to the ounce, but have the disadvantage of soiling the clothes, staining the skin, and if accidentally brought in contact with the eyes, sets up violent inflammation. Wilkinson's ointment has enjoyed a great reputation in these cases, as also Coster's paste, the German green soap, and also the sulphur preparations. In my experience, however, no other remedy equals the copper oleate in effect, used either alone or alternated with the mercury

oleate in chronic cases. I have employed one or the other in almost all cases presenting themselves for treatment at the Philadelphia Hospital for Skin Diseases the past few years with decided good results. In some mild forms, the use alone of the thymol, or naphthol, or corrosive sublimate solutions already mentioned is sufficient to cure the cases. In others more severe, the use of a five-per-cent or ten-per-cent ointment of copper oleate acts most decidedly, and if not sufficiently active, the ointment can be increased to fifty per cent (I wish to state here that the percentage applies to the amount of pure oleate they contain). In chronic cases this ointment is alternated every few days with applications of ten per cent to thirty per cent mercury oleate ointment. Where eczematous complications present themselves, the ointment of zinc oleate with oil of cade can be applied to good advantage, or even diluted citrine ointment with birch-tar will prove of great service, but the copper oleate will generally be found sufficient to cause a change in the horny layer of the epidermis, and act as a powerful parasiticide as well. The employment of constitutional treatment in ringworm must be confined to those of strumous disposition in order to overcome the tendency to parasitic infection, and should consist principally of bitter tonics, cod-liver oil, fluid extract of malt, iron, and chlorate of potash, as their condition may indicate.

Trichophytosis Barbae.

The generally accepted treatment in this variety includes epilation, cutting and shaving of the beard, and the application of such anti-parasitic remedies as sodium hyposulphite, corrosive sublimate, sulphurous acid, etc. I fail to see the advantage of either cutting the hair or shaving, owing to the irritation that the latter, especially, occasions; the agents just mentioned above, however, often act quickly and decidedly. In this variety of trichophytosis, one of the most efficacious remedies to use is a fifty-per-cent solution of boroglyceride, applied in the same manner as in ringworm of the scalp. A ten-per-cent ointment of either copper or mercury oleate lessens the infiltration and induration and destroys the parasite. It should be applied night and morning, and persisted with until all traces of the disease have disappeared. To prevent contagion, a suitable application is a two-per-cent solution of thymol in olive oil or oil of sweet almonds perfumed and rubbed over the entire beard. If follicular suppuration and fungous granulations spring up, a weak ointment of nickel oleate will overcome and often cure the complication. In one instance I arrested the exuberant granulations that followed, and healed completely the parts with an infusion of jequirity; an enormous suppuration followed its application, which subsided with a perfect cure.

Trichophytosis Genito-cruralis.

The treatment indicated here is principally that of the other varieties of trichophytosis, as applications of such parasiticides as solutions of thymol, corrosive sublimate, also tar, sulphur, iodine, and Wilkinson's ointment. It would be well to call attention here to the fact that we have an aggravated erythematous condition in addition to the parasitic irritation. This condition would, therefore, call for astringents in connection with anti-parasitic remedies. I often prescribe one drachm of a five-per-cent ointment of copper oleate, with four drachms of the ointment of zinc oxide applied night and morning, and dust over the surface equal parts of the powdered zinc oleate and starch, in order to protect the parts and keep the contiguous surfaces separated. If any one of the very severe forms of this affection should present itself from the tropical countries, such as appear in Bermuda and Brazil, either a very strong copper or mercury oleate ointment, or the goa or chry-sarobin powder can be successfully employed. I used a few years ago upon some cases that came under my observation from Brazil, successfully a thirty-per-cent ointment of copper oleate.

Trichophytosis Unguium.

This must consist as much as possible in the removal of the diseased nail as fast as it grows, and dressing it with a ten-per-cent ointment of mercury oleate. While this will act as an anti-parasitic on the affected nail, it must be continued until a new and healthy growth takes the place of the invaded portion, which will always consume the time necessary for its natural growth from the matrix. I very often alternate with the mercury oleate the ointment of tin oleate. The latter has a slight astringent action and gives a beautiful polish at the same time to the nail.

(To be continued.)

THE OBJECTS OF DERMATOLOGICAL CLASSIFICATION, WITH ES-
SPECIAL REFERENCE TO AUSPITZ'S SYSTEM.

BY

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(Concluded.)

BUT the question may be asked, Has the proposed plan been fully carried out in the scheme presented? Do the groups of Auspitz's system take cognizance of all the morbid conditions that may be prime motives of cutaneous disease? Simple (idiopathic) inflammations.

angioneuroses, neuritic and engorgement dermatoses, idioneuroses, hæmorrhages, anomalous growths, and dermatomycoses, by no means express all the possible conditions under which diseases of the skin are liable to arise. The system, for example, might include a group of diseases due to defective constitutions of the blood (*hæmatoses*), embracing among other affections several of the cutaneous hæmorrhages; another group of affections due to abnormal blood deposits (*apostases*) including such diseases as uridrosis, icterus, and argyria, which, with questionable propriety, now appear among the *epidermidoses*; a group of zoonotic inflammations not due to general angioneurosis, but solely to the direct operation of the virus upon the tissues of the skin, and doubtless the list might be greatly increased. But perhaps Auspitz has carried out the principle as far as with our present knowledge is practicable. A more comprehensive classification might only result in confusion, and indeed while such a system might aid in more accurately expressing the etiological relations of skin diseases, the study of dermatology subjectively considered would be thereby but little furthered. The susceptibilities of the skin, its morbid tendencies, the reactions it exhibits in disease would yet remain to be classified.

This, however, is a phase of dermatology that is regarded by Auspitz evidently as of very subordinate importance. The fact is, that in his system the objects that are classified are not so much the skin affections themselves as the general morbid conditions that tend to the production of skin disease. No objection can be made on scientific grounds to such a classification; the only objection to it is on the score of its adaptability to the purposes of dermatological study. It is certainly a very liberal method of treating the subject, and tends to place the study of dermatology on a much higher plane than can any artificial classification based upon mere accidental points of similarity. Doubtless also too little attention has been paid in former classifications to the important bearing of neural conditions upon cutaneous disease. It is just and proper in those diseases of the skin that are secondary or symptomatic that we keep in view not only the local process, but also the larger process upon which the local process depends. But, on the other hand, while regarding predisposing conditions, we should not ignore those intermediate values that determine the local features and character of the cutaneous manifestations. Angioneurosis does not account for the fact that in one disease we have an erythema, in another a diffuse catarrhal affection, in another an affection of the follicles. It is admitted in the case of the exanthemata that the only immediate effect of the general vaso-motor disturbance is a certain crethism of the blood-vessels, which supplies the predisposing element for the development of the more characteristic manifestations that follow. The reactions of the epidermis in scarlatina, of the follicles

in measles, the pustular inflammation of variola, are effects between which and the angioneurosis lies an intermediate determining cause. It is just this property of the inflammatory process which unfortunately is most obscure, but which we would most desire to fathom. Moreover, the effects produced by general neural conditions often differ very slightly from effects produced by causes purely of an idiopathic nature. Thus comparing a traumatic with an essential erythema, if we confine our attention solely to the part affected, we cannot deny the marked similarity of the two processes. They differ apparently only in that one owes its origin to an internal source of irritation, the other to a topical one. In one case the angioparesis is propagated from a central or interior nervous disturbance, in the other it is the direct effect of the local injury. Auspitz's system compels us to segregate in different groups processes which, so far as the skin itself is concerned, are precisely identical. Such a system, however correct according to general principles of etiology or pathology, can scarcely be called strictly dermatological. When Auspitz compares the dermatology of the ancient humoralists to Marsyas flayed by Apollo, and calls it "dermatology robbed of the skin," we might return a reproachful "*Et tu, Brute?*"

It is doubtful if any one system is capable of giving due expression to all the matters of moment with which dermatology is concerned, and which it is desirable to comprehend in a logical arrangement. But under all circumstances it is necessary first to have in mind all the factors which make up the sum total of each disease process, and of these select as the basis of classification those that are most essential. A natural class will then consist of diseases that have the same essential factors in common. *But the factors that the diseases of any class have in common should be more essential than any factors which they have in common with diseases not in this class.* In all purely artificial systems this rule is constantly violated, as, for example, in the classifications of Mercurialis, Turner, and Alibert, where skin diseases are divided according as they affect the head or other regions of the body; the mere fact of topography being far less essential in the case of many of the diseases so divided than the characters which they have in common with each other.

But we have first to determine what the essential factors are. In an erythematous inflammation of the skin a prolonged derangement of the blood-vessels of the papillary layer is essential. In simple erythema this derangement owes its origin to a local disorder of the eutaneous nerves. In essential erythema the same derangement is the effect of angioneurosis; in *erythema neuriticum* of neuritis. In an herpetic inflammation of the skin, in addition to derangement of the blood-vessels, an implication of the mucous layer of the epidermis is essential. In one form of this inflammation, according to Auspitz, the essential factor is angioneurosis;

in another neuritis. But in both cases the characteristic feature of the cutaneous reaction is the same, namely, an implication, through what intermediate agency we do not know, of the mucous layer of the epidermis. Now comparing erythema with herpes, I submit that the anatomical factor that divides them is a more essential, a more vital one so far as the economy of the skin is concerned, so far as *diseases of the skin are concerned*, than can any factors be that divide different forms of erythema from each other or different forms of herpes from each other. The distinction, although an anatomical one, is not an artificial distinction, but inheres in the very nature of the diseases. Though it offers no present explanation, it states a vital fact which we must rely on future discovery to elucidate. The motives that determine one kind of inflammation to seat itself in the epidermis, another in the blood-vessels or their immediate vicinity, another in the cutis, another in the subcutaneous tissues remain comparatively unknown; yet it is clear that in the inception of these motives the tissues themselves play an important part. Even when the incentive to the local disturbance is central and conveyed to the skin by the nerves and blood-vessels, the character and physiognomy of the inflammation must be determined by something else, something that pertains to the autonomy of the skin and to its various anatomical elements.

The chief objection to a classification of the inflammatory diseases of the skin upon an anatomical basis is, that in inflammation anatomical divisions are rarely respected. The blood-vessels which complicate and form an indispensable part of the process undergo changes peculiar to themselves, and give rise to an exudation in their vicinity which tends to obscure the origin of the disease. If the primary seat of the inflammation be in a follicle, a peri-folliculitis soon complicates the process; if in the lymphatics, a diffuse phlegmon is the result; if, as in eczema, the disease proceeds from the mucous layer, erythema, infiltration of the cutis, and impairment of the cuticle soon evince the fact that the disturbance has overstepped its original limits. Vascular implication is a factor common to every inflammation, but where the efflorescences of a skin disease present under all circumstances a definite and more or less constant morphology, something more than general vascular or nervous disturbance is required for their explanation. Every separate structure that has a special function may also have its special inflammation. It is not unreasonable to suppose that many of the anomalies of growth of Auspitz's vii. and viii. classes, especially those attended with pronounced hyperæmia, have their counterparts in inflammatory diseases of the skin. In the one case the slowness of the process and the absence of disturbing vascular influence preserve the confines of the disease within the structure to which the disease properly belongs, while in the other the limits of the original disturbance are soon obscured or erased. But in the latter

case, though the image is blurred, certain characteristics of its physiognomy are sufficiently preserved to betray the specific character which it derives from the anatomical source of original irritation. It is clear, however, that we can take the changes observed in the pure anomalies of growth as the clue to the inflammatory diseases of the skin only in a general way. The latter often involve changes of so complex a character and so many of them are secondary and unessential that to express them in precise anatomical terms is a matter of some hazard. But, on the other hand, a number of the diseases included in Auspitz's "*Wachstums-Anomalien*" which are classified anatomically, are attended with a degree of vascular disturbance that falls but little short of inflammation; while some of them (as for example, *lupus erythematosus*, *lichen planus*, *syphilodermata*, sometimes pemphigus, etc.) are unquestionably inflammatory. The histology and physiology of the skin, normal and pathological, are yet so imperfectly known that the hope for a classification that will perfectly represent the anatomical relations of all the affections of the skin must doubtless be long deferred. For the present, we must be content if we can so classify the cutaneous reactions in disease as to indicate the general direction in which the truth lies.

It would seem to be incumbent on the writer to offer some practical illustration of the method of dermatological classification which has been indicated above. To this end the appended scheme is presented.

A CLASSIFICATION OF DERMATOSES.

CLASS I.

Telangioses of the Skin.

Dermatoses chiefly characterized by anomalies pertaining to the capillary blood-vessels of the skin.

A.

Unattended with trophic changes in the surrounding tissues.

First Family.—*Simple Angioses. Anæmias and Hyperæmias.*

- | | |
|--------------------------------|-----------------------------------|
| 1. Anæmias: | 2. Hyperæmias: |
| Anæmia mechanica, | a. Active; |
| Anæmia ex hæmorrhagia, | α. Diffuse; Rubor (idiopathic and |
| Anæmia ex angiospasmō — pallor | deuteropathic). |
| cutis, | β. Macular; Roseola hyperæmica |
| Anæmia cachectica. | b. Passive; |
| | α. General; Cyanosis. |
| | β. Local; Livor. |

Second Family.—*Non-inflammatory Angioses attended with Effusions.*—*Cutaneous Echyyses.*

- | | |
|------------------------------|----------------------------------|
| 1. Hæmorrhages : | b. Mechanical; |
| a. Traumatic: | Purpura mechanica (throm- |
| Ecchymosis, Ecchymoma, | botica, etc.). |
| Purpura traumatica, | c. Congenital—due to hæmophilia. |
| Purpura ab ictis insectorum, | d. Toxic; purpura toxica. |

- e. Neuropathic; P. neurotica,
P. neuritica.
- f. Diathetic or cachectic;
Purpura cachetica,
Purpura (peliosis) rheumatica,
Purpura hæmorrhagica,
Purpura scorbutica,
Purpura syphilitica.
2. Œdemas:
a. Œdema mechanicum.
- b. Œdema neuroticum.
c. Œdema cachecticum.
3. Adventitious Effusions:
a. Of bile;
Icterus.
b. Of matters foreign to the organ-
ism;
Argyria, etc.

B.

Attended with trophic changes.

Third Family.—Inflammatory Angioses.

1. Erythematous;
(Idiopathic.)
- a. Simple forms due to local irri-
tation:
Erythema traumaticum (inter-
trigo, e decubitu, etc.),
Erythema venenatum,
Erythema caloricum,
Erythema et urticaria ab ictis
insectorum,
(Deuteropathic.)
- b. Simple deuteropathic forms:
α. Polymorphous;
Erythema multifforme (toxi-
cum, essentielle),
Erythema iris (including
herpes iris).
β. With spasm of blood-
vessels and production
of wheals;
Urticaria toxica,
Cnidosis [Bazin, Auspitz]
(Urticaria recurrens).
γ. With deep-seated exuda-
tion;
Erythema nodosum.
- c. Symptomatic forms:
- α. Endemic form — Erythe-
ma of Pellagra.
β. Epidemic form—Erythe-
ma of Acrodynia.
γ. Leprous form — Erythe-
ma of Lepra.
- d. Characterized by angiectasis
and special localization;
Gutta rosacea:
α. Simple form—Erythema
rosaceum.
β. Pustular form — Acne
rosacea.
γ. Hypertrophic form—Gutta
rosacea hypertophica.
- e. Characterized by resulting
atrophy;
Lupus erythematosus:
2. Roseolous;
a. Simple forms:
Roseola infantilis,
Roseola toxica, etc.
b. Symptomatic forms (exanthe-
matous):
Roseola variolosa, vaccinica,
cholericæ, typhosa, etc.,
Roseola syphilitica,
Exanthem of measles.

CLASS II.

Angio-Epidermidoses.

Dermatoses characterized by trophic changes in the epidermis, together with marked derangement of the superficial blood-vessels.

First Order.

KERATOSES ANGIOTICÆ.

*First Family.—Angiotic Parakeratoses.*¹

- | | |
|---------------------------|---|
| 1. Diffuse;
Psoriasis. | 2. Follicular;
Lichen ruber,
Lichen circinatus (?). |
|---------------------------|---|

*Second Family.—Angiotic Keratolyses.*²

- Dermatitis exfoliation generalis (Pityriasis rubra),
Dermatitis exfoliativa partialis,
Dermatitis exfoliativa infantum.

Second Order.

ACANTHOSES³ ANGIOTICÆ.*First Family.—Angiotic Hyperakanthoses.*

1. Associated with marked inflammatory effusion in the papillary layer (Robinson⁴), and with parakeratosis.
Lichen planus.

*Second Family.—Angiotic Acantholyses.*³

(Idiopathic.)

(Deuteropathic.)

- | | |
|---|--|
| 1. Artificial bullous dermatoses :
Dermatitis ambustionis bullosa,
Dermatitis congelationis bullosa,
Dermatitis traumatica et venenata
bullosa. | 2. Pemphigous dermatoses:
Pemphigus acutus et chronicus,
Pemphigus foliaceus,
Impetigo herpetiformis,
Herpes gestationis,
Cheiro-pompholyx. |
|---|--|

Third Family.—Herpetic Dermatoses.

Characterized by the formation of inflammatory vesicles in the stratum mucosum and dependent upon neural disease.

- | | |
|------------------------------------|--|
| Herpes zoster,
Herpes facialis, | Herpes progenitalis,
Herpes phlyctenodes. |
|------------------------------------|--|

Fourth Family.—Eczematous Dermatoses.

- | | |
|---|--|
| 1. Idiopathic and deuteropathic Eczema: | c. With abundant mucous or mucopurulent secretion ; |
| a. With decided vascular disturbance;
Eczema erythematosum. | α. Vesicular—E. vesiculosum.
β. Pustular—E. pustulum. |
| b. With especial implication of follicles;
Eczema papulatum,
Eczema folliculare [Kaposi].
Eczema sudorale (lichen tropicus), E. sycosiforme. | γ. With erosion—E. madidans.
d. Characterized by keratolysis or parakeratosis;
Eczema squamosum.
e. Characterized by acantholysis;
Eczema rubrum, Eczema impetiginosum diffusum. |

¹ From Greek παρά, beside, and κέρας, horn, signifying diseases characterized by the development of corneous tissue of a modified character.

² From Greek κέρας, horn, and λύσις, a loosing; signifying diseases characterized by excessive exfoliation of the stratum corneum (Auspitz).

³ From Greek ἀκανθα, a prickle; signifying diseases of the prickle-cell layer of the epidermis. "Acantholyses" are diseases characterized by loosening or separation of the cells of the mucous layer of the epidermis (Auspitz).

Lichen Ruber and Lichen Planus. By A. R. Robinson, M.D., New York, 1883.

- | | |
|--|---|
| <p>f. With hyperacanthosis;
Eczema hypertrophicum epidermidis [Wilson]. (Including E. verrucosum, E. fissum).</p> <p>g. With hyperdesmosis,¹ due to vascular engorgement:
Eczema induratum seu hypertrophicum cutis, E. spargosiforme [Wilson].</p> | <p>2. Eczematous affections modified by dermatomycosis:
Eczema marginatum.</p> <p>3. Eczematous affections due to acarinosus:
a. From acarus scabiei.—Scabies.
b. From leptus autumnalis.
c. From acarus hordei, etc.</p> |
|--|---|

Fifth Family.—Impetiginous dermatoses.

- | | |
|--------------|-------------|
| 1. Impetigo. | 2. Ecthyma. |
|--------------|-------------|

Sixth Family.—Exanthematous Epidermidoses.

- | | |
|--|---|
| 1. Diffuse catarrhal exanthem associated with marked angioneurosis, and characterized by keratolysis:
Exanthem of scarlatina. | Exanthem of varicella. |
| 2. Simple vesicular or vesiculo-pustular exanths:
Miliaria (crystallina), | 3. Vesicular pustular exanths with following phlegmonous (diphtheritic) inflammation:
Exanthem of variola,
Exanthem of vaccina. |

CLASS III.

Cryptoses² of the Skin.

Diseases affecting the Cutaneous Follicles.

A.—Functional.

First Order.

STEATOSSES.

First Family.—Hypersteatoses (A³).

Seborrhœa { oleosa.
 { crustosa.

Second Family.—Asteatoses (A).

Xeroderma { congenita.
 { acquisita.

Second Order.

IDROSES (A).

First Family.—Hyperidroses.

Hyperidrosis idiopathica.

Second Family.—Paridroses.

Chromidrosis.

Hæmatidrosis.

Bromidrosis.

Uridrosis.

Third Family.—Anidroses.

Anidrosis idiopathica.

¹ Hyperplasia of connective tissue [Auspitz].

² From Greek κρυπτή, crypt, follicle.

³ Classes, Orders or Families marked (A) are the same as in Auspitz's classification.

B.—Organic.

First Family.—*Crypto-stenoses* (including *Parasteatoses* [A]).

Comedo.	Amyloid milium (<i>Molluscum contagiosum</i>). (?)
Milium.	
Atheroma cutis.	Colloid milium.
Acrochordon.	

Second Family.—*Inflammatory Cryptoses.*

1. Acne:	A. atrophica.
A. papulosa.	2. Lichen scrofulosorum.
A. pustulosa.	3. Sycosis vulgaris.
A. indurata.	4. Hydrosadenitis.

CLASS IV.

Angio-Desmoses¹ of the Skin.

Trophic diseases of the corium and subcutaneous connective tissue dependent on derangement of the cutaneous blood- or lymph-vessels.

First Family.—*Chronic angio-desmoses due to lymphatic or venous engorgement.*

Hypertrophic;	Sclerema adulatorum (scleroderma).
Elephantiasis (Arabum).	
2. Atrophic;	b. Circumscribed;
a. Diffuse;	Morphœa.
Sclerema neonatorum,	

Second Family.—*Acute or Phlegmonous Angio-desmoses due to Engorgement.*

1. Erysipelatous dermatoses:	γ. Chiefly situated in subcutaneous tissue;
a. Circumscribed;	Cellulitis (pseudo-erysipelas).
α. of veins—Phlebitis cutis.	
β. of lymphatics—Lymphangitis cutis.	
b. Diffuse, especially involving lymphatics;	2. Furunculous dermatoses:
Erysipelas:	a. Simple;
α. Superficial, involving cutis and epidermis;	Furunculus (idiopathic and neuritic),
Erysipelas simplex.	Anthrax simplex.
β. Involving cutis and subcutaneous tissue;	b. Virulent (erysipelato-furunculous);
Erysipelas phlegmonosum.	Anthrax contagiosus:
	α. Pustula maligna.
	β. Œdema malignum.

Third Family.—*Neerotic Dermatoses.*

Characterized by vascular stasis.

1. Gangrenous;	Gangræna neurotica from Raynaud's disease.
a. Idiopathic forms:	Decubitus acutus.
Gangræna calorica.	
α. Dermatitis ambustionis escharotica.	2. Ulcerative;
β. Dermatitis congelationis escharotica.	a. Simple forms:
Gangræna per decubitum.	Ulcus simplex (varicosus, etc.).
Gangræna senilis, etc.	b. Neuropathic forms:
b. Neuropathic forms:	Malum perforans pedis.
	c. Specific forms:
	Chancre.

¹ From Greek *δέσμός*, a band (and so connective tissue).

Third Family.—Onycholyses.

Onycholysis idiopathica.

Fourth Order.

ACANTHOSES.

First Family.—Hyperacanthoses.

- | | |
|--|---|
| 1. Pure; ; | toma palmare et plantare hereditarium [Unna ¹], |
| Verruca, | Tyloma, |
| Condyloma acuminatum. | Clavus, |
| 2. Associated with marked hyperkeratosis ; | Fibro-acanthoma cornificans [Unna]. |
| Cornu cutaneum (including kera- | |

Second Family.—Paracanthoses (Alveolar Acanthomata) (A).

- | | |
|---|---|
| 1. With distinct cornification of the new-formed cells; | 2. Without cornification of the new-formed cells; |
| Epithelioma: | Carcinoma cutaneum : |
| E. superficiale, | C. molle, |
| E. profundum. | C. colloides, |
| | C. melanodes. |

Fifth Order.

CHROMATOSES OF THE SKIN.

First Family.—Hyperchromatoses (A).

- | | |
|--------------------|--------------|
| 1. Congenital; | 2. Acquired; |
| Nævus pigmentosus. | Lentigo, |
| | Chloasma. |

Second Family.—Achromatoses (A).

- | | |
|------------------------|---------------------|
| 1. Congenital; | 2. Acquired; |
| Albinismus | Vitiligo, |
| <i>a.</i> partialis. | Canities præmatura. |
| <i>b.</i> universalis. | |
| Poliosis. | |

CLASS VII.

Desmoses² of the Skin. (Chorio-Blastoses³ [Auspitz].)

Anomalies of growth of the corium and subcutaneous connective tissue.

A.—Excessive development of the connective tissue of the skin.

HYPERDESMOSES.

Macrosomia.

B.—Paratypical growth of the connective tissue of the skin.

PARADESMOSES.

First Family.—Granulomata of the Skin [Auspitz]. (Chronic Infectious Dermatoses [Neisser]).

- | | |
|------------------|--------------------------------|
| 1. Lupus: | 2. Tuberculosis cutis. |
| L. maculosus, | 3. Scrofuloderma tuberculosum. |
| L. exfoliativus, | 4. Syphiloderma: |
| L. exulcerans, | S. initiale, |
| L. serpiginosus. | S. papulosum, |

¹ Vierteljahrsch. f. Derm u. Syph.," x., 1883, p. 231.² From Greek δερσμός, a band (and so connective tissue).³ From Greek χόριον, corium, and βλαστάνειν, to grow.

- S. tuberculosum, dermatitis papillaris capillitii
 S. gummosum. [Kaposi]).
5. Lepra cutanea. 7. Rhinoscleroma.
 6. Framboesia (including yaws and 8. Granuloma fungoides.

Second Family.—Desmومات of the Skin (A).

1. Fibroma cutis. 7. Xanthoma cutis.
 a. Disseminatam (pendulum). 8. Myoma cutis.
 b. Keloides. 9. Neuroma cutis.
 2. Osteoma cutis. 10. Angioma cutis.
 3. Chondroma cutis. a. Phlebangioma } Varieties: sim-
 4. Lipoma cutis. b. Lymphangioma } plex, cavern-
 5. Myxoma cutis. ma. } osum.
 6. Hyaloma cutis. 11. Sarcoma cutis.

C.—Atrophy or defective development of the connective tissue of the skin.

ADESMOSES.

1. Liodermia neuritica (glossy skin). Liodermia syphilitica.
 Liodermia essentialis (xeroderma pigmentosum). 2. Striæ atrophicæ cutis.

CLASS VIII.

Dermatomycoses (A).

Diseases of the skin and its appendages due to vegetable parasites.

First Family.—Mycosis Scutulata (Favus).

1. Dermatomycosis favosa. 3. Onychomycosis favosa.
 2. Trichomycosis favosa.

Second Family.—Mycosis Circinata (Ring-worm).

1. Dermatomycosis circinata. 2. Trichomycosis circinata (includ-
 a. D. maculo-vesiculosa. ing sycosis parasitaria and keri-
 b. D. diffusa (imbricata [Manson]). on Celsi).
 3. Onychomycosis circinata.

Third Family.—Mycosis Furfuracea.

Dermatomycosis furfuracea (Pityriasis versicolor).

Society Transactions.

NEW YORK DERMATOLOGICAL SOCIETY.

146TH REGULAR MEETING, MAY 27, 1884.

ANNUAL MEETING.

DR. P. A. MORROW, *President, in the Chair.*

DR. PIFFARD presented to the Society the

CHILD WITH CONGENITAL DISEASE OF THE SKIN

which was presented at the last meeting of the Society by Dr. Alexander. The condition of the child was greatly improved; the redness had entirely disap-

peared from over the abdomen; the skin of the whole body was quite supple, and there was a much less tendency to the formation of scales. The redness still remains, though less pronounced, upon the lower extremities. The child was improving in health, and appeared well-nourished. The treatment which had been used for ichthyosis in this case had been stopped, and the child was now upon treatment more suitable for a dermatitis. He would regard the case as one of congenital exfoliative dermatitis. In answer to a question, Dr. P. stated that the case was being treated with the local application of peroxide of hydrogen.

DR. FOX still held to his previous diagnosis, that the case was one of ichthyosis similar to the so-called "Alligator boy." The early history of the alligator boy was the same as of this child, as near as he could find out. He, too, was born with a like coating to his skin which, after a time, peeled off, and six weeks after birth his skin was free. Dr. Fox believed that in course of time this child would develop an ichthyotic skin. As to the case being one of congenital exfoliative dermatitis, we know that that disease did not disappear quickly, indeed, is difficult of cure. He would therefore think that the markedly rapid improvement in this case would argue against its being one of dermatitis, while it is exactly what one would expect in ichthyosis.

DR. DENSLow believed that the improvement had, in a measure, been due to the activity of the sweat glands, as usually is the case in ichthyosis.

DR. ALEXANDER agreed with Dr. Fox.

DR. BRONSON regretted that he had not seen the case when it was first presented. From the present appearances, he saw no evidence of ichthyosis. It was rather a parakeratosis, and corresponded to that infantile exfoliative dermatitis as described by Ritter in the *Centralzeit. für Kinderheilk.*, October 1, 1878, and quoted by Dühring in his book. The case can scarcely have any connection with the ichthyosis of new-born children of Hebra.

DR. MORROW had noticed when the case was before presented that there was no greasy feel to the skin.

DR. PIFFARD believed the case to be one of dermatitis. He would base his diagnosis upon the appearances present one month ago, viz., hyperæmia and desquamation. When he took charge of the case, about four weeks ago, it was under treatment with oil, which was well adapted to an ichthyotic condition. The treatment was changed, and marked improvement resulted. If any one who had not seen the case before looked at the abdomen to-night, which alone was under local treatment, he could find no appearance suggestive of ichthyosis. Further, in ichthyosis the epidermis is never capable of being peeled off in lamellæ, nor are casts of the fingers and toes formed as in this child was the case. He believes that if the child escapes the ordinary ills of childhood, it would fully recover from this disease of the skin.

DR. FOX presented a

CASE OF URTICARIA PIGMENTOSA.

The patient was a child of five and a half years, which had its first attack of urticaria at the age of one and a half. The wheals persisted, and acquired a café-au-lait color. The child's general health is good, it is well nourished, and apart from occasional acute attacks of urticaria and excessive pruritus of the skin when overheated in her play, she enjoys life. The whole body from neck to feet is covered with very discrete brownish spots, which vary in size up to that of a three-cent silver piece, and are irregularly round. These have been present for months, probably for years. When the skin is irritated, new wheals appear, particularly upon the pigmented spots. The child was vaccinated several times when a year and a half old, but not very successfully.

DR. DENSLow would suggest for the treatment of the urticaria the exhibition of two grains of salicylate of soda every hour till twelve or fifteen doses were taken.

DR. MORROW said that he believed the usual remedies for urticaria were without effect in urticaria pigmentosa. He thought that the development of urticarial wheals was accidental, due either to external sources of irritation, as rubbing of the clothing, or to certain forms of food. The best treatment was prophylactic. He believed that all cases of urticaria pigmentosa thus far reported had developed within the first six to eighteen months of life.

DR. PIFFARD considered the staining to be hematic, and not melasmic, and that it will slowly fade away, as all such stains do. The reason why they were so apparent was partly due to the wheals appearing again and again at the same place, and partly to an idiosyncrasy of the skin for staining under congestion. The treatment for these cases was the same as for other forms of urticaria. His favorite plan was the persistent use of the Turkish bath.

DR. FOX believed that prophylaxis was the only treatment from which we could expect much. For the staining, he would try the peroxide of hydrogen. He thought that chrysoarobin pigment touched to the spots might have a good effect. For the disease, he had made trial of salicylate of soda, as suggested by Dr. A. A. Smith, and found it to do good in some cases and to fail in others. Turkish baths he had found to be of use in many cases. He remembered one case of chronic urticaria in which one hundred grains of bromide of potassium was taken at one dose by order of Dr. A. M. Hamilton, followed up by large doses of the same drug at intervals, and was cured. He had made use of the bromide in doses of thirty to fifty grains, and had found it useful.

DR. MORROW could not agree with Dr. Piffard in thinking the staining to be hematic. In his own case, which is still under observation, there was no fading whatever of the pigment.

DR. BRONSON then read the paper of the evening, entitled:

THE OBJECTS OF DERMATOLOGICAL CLASSIFICATION, WITH ESPECIAL REFERENCE TO AUSPITZ'S SYSTEM.¹

DR. WEISSE had listened with great interest to the admirable paper. Personally he leaned towards an etiological classification, which led directly to treatment at least so far as teaching students was concerned. Such a classification, as was presented this evening would be of great use to a specialist, but was not so practical for a student.

DR. PIFFARD had been exceedingly pleased with the philosophic tone of the paper. Of course, only the general matter could now be discussed; the details required careful study, which he would be glad to devote to it. He had long been convinced of the necessity of a three-fold classification. First, an etiological one, as an aid to treatment; secondly, a Plenekian one, as aid to diagnosis; and thirdly, an Hebraic one, as an easy clue to the nature of the local processes. In 1868, he had drawn the attention of the profession to the necessity for a duplicate classification, and had presented an outline for such classification. In 1875, he had enlarged the outline of 1868. The great difficulty in classification was to arrange the details accurately. The second form of classification, the lesional, was a simple matter, and there had been no great improvement upon that of Plenek, excepting in differentiating the secondary from the primary lesions. The third form, that of Hebra, had been quite generally adopted by dermatologists for the past fifteen years, but the details in it contained more errors than almost any other classification. Where Auspitz has used Hebra's system, he has used it with greater accuracy. From the general impression he (Dr. P.) had received from hearing the paper read, he thought that Dr. Bronson had probably improved on the accuracy of Auspitz's details. As valuable as the classification is, we want also a good nomenclature.

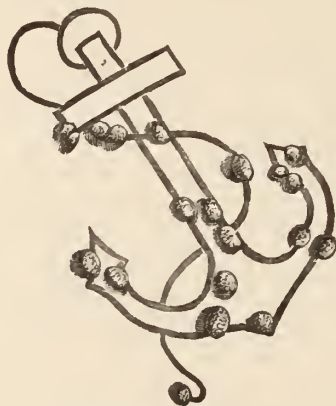
DR. SHERWELL said that while Dr. Bronson's classification might not be so practical in the lecture-room, he greatly admired it, and believes that it would be of great use to dermatology generally.

DR. BRONSON, in closing, said that he had striven to make his classification practical for teaching, as well as etiological.

The discussion of the paper, on motion, was made a special order for the next meeting of the Society.

¹ See this JOURNAL, June and July, 1884.

DR. FOX presented a photograph of a case of warts occurring on tattooed lines. A young man had an anchor tattooed on the forearm five years ago, and according to his statement the warts appeared about a year later. There were about twenty upon the forearm, and with one exception were scattered upon the indigo lines as seen in the accompanying cut.



Dr. Fox referred to the observations of Köbner, in regard to the occurrence of psoriatic patches upon tattoo marks.

DR. WEISSE presented to the secretary of the Society the first minute book of the Society, which for some time had been mislaid in the doctor's library. He said, in this connection, that recently looking over the files of the *Dublin Med. Journ.* he noticed a review of the *JOUR. OF CUTAN. AND VEN. DIS.*, in which the reviewer said that American dermatology may be said to have taken its origin from the organization of the New York Dermatological Society by the late Dr. H. D. Bulkley. While no one had greater respect for the memory of Dr. H. D. Bulkley, or a higher appreciation of his interest in and zeal for the New York Dermatological Society than he had, yet he must claim the suggestion and founding of the Society for himself. On his return from Europe in 1869, he conceived the idea of founding the Society. At that time there were not more than four gentlemen in the city specially interested in diseases of the skin, and among those was Dr. H. D. Bulkley, who was the oldest. He first spoke to Dr. Satterlee upon the subject and subsequently called upon Dr. H. D. Bulkley, and requested that he would interest himself in the Society. Dr. B. replied that of late years he had not given much time to the skin, but would heartily co-operate with him (Dr. W.) in the matter. Dr. W. then met Dr. Piffard, who warmly entered into the project. The first meeting of the Society was at Dr. Bulkley's house, by Dr. Weisse's request. He with Dr. Piffard then solicited other gentlemen, Drs. Taylor, Foster, Draper, Swift, and Zinsser. A circular was then issued to all physicians in the city who were directly or indirectly interested in dermatology. At Dr. Weisse's urgency, Dr. Bulkley accepted the first presidency of the Society, as he was the oldest member. The first meeting was called and a constitution adopted. Dr. Bulkley served as president for two years, was present at every meeting, and exhibited the greatest interest in the furtherance of the Society. He (Dr. W.) felt a just pride in the inception of this Society which has brought forth such excellent fruits, and now stands unrivalled in the work it has accomplished. The

activity of dermatology in America is due to the New York Society, and the American Dermatological Association is an outcome of it.

An election of officers for the ensuing year was then held, and resulted in the unanimous choice of Dr. A. R. Robinson, for President; Dr. E. B. Bronson, for Treasurer; and Drs. P. A. Morrow, Geo. H. Fox, and R. W. Taylor, for Executive Committee. Under the rules of the Society, Dr. Robt. Campbell, being the most recently elected member, became Secretary.

Correspondence.

DERMATOLOGY AND SYPHILOGRAPHY IN FRANCE.

(From our Special Correspondent.)

BLACK TONGUES—LINGUAL PSORIASIS—ITS PATHOLOGICAL ANATOMY—MARGINATE EXFOLIATIVE GLOSSITIS—XERODERMA PIGMENTOSUM OF KAPOSI—ZONA AND TROPHIC TROUBLES—TREATMENT OF TINEAS BY CROTON OIL—BY PYROLIGNEOUS ACID.

THE contributions to dermatology and syphilis which have recently appeared in France are so numerous and important that it is quite difficult to keep your readers posted by an occasional letter. I shall confine myself to a résumé of the most noteworthy publications.

Dr. Chas. Rayer (*Thèse de Paris*, 1883), in a recent interesting memoir, has given an exposition of the present state of our knowledge of a subject as yet but little understood, viz., *black tongues*. The author's namesake, the great Rayer, first made mention of this singular affection in his *Traité des maladies de la Peau*, 1839. Bertrand, of St. Germain, in 1839, communicated to the Academy of Sciences four cases under the title of *Blackness of the Tongue*, occurring independently of the febrile state. Eulenberg described pigmentary granulations surrounding the epithelial cells. Gubler suspected the existence of a parasite. Maurice Reymond observed in one case spores quite similar to those of the trichophyton tonsurans; he could not always find them in another case of lingual blackness, and he was forced to conclude that the lingual discoloration was not due to a parasite, but to the condensation of the epithelial elements of the tongue. This opinion was adopted by Ferol (1875), who was unable to discover the spores in one of his patients, but Lancereaux (1876), Gaveau (1876), and Dessois (1878) observed, on the contrary, in many cases of black tongue numerous spores, and they affirmed that this anomaly of coloration was due to the existence of a microphyte.

Dr. Rayer has concluded, from the researches of his predecessors and the study of a case which he publishes in his work, that there are two varieties of black tongue: one simple, the other complicated by the presence of spores. These spores form masses, which develop at first at the base of the lingual papillæ, separating them from each other. The epithelial covering of the papilla becomes hypertrophied, the spores proliferate and form a sort of nipple around the papilla, in addition they insinuate themselves between the more superficial epithelial cells and blacken them. The cryptogamic vegetation is then formed of a considerable mass of exceedingly fine sporules, in the midst of which are imprisoned the disunited epithelial cells, and it then presents a diffuse sepia tint, more pronounced at its borders. Then the entire parasitic mass is detached, carrying with

it in its fall the epithelial cells, beneath which it had insinuated itself (Malassez et Dessois).

It is quite common to observe a black coloration of the tongue display itself at certain periods, develop quite rapidly, persist for several days, then disappear. It sometimes passes through diverse alternative shades (white, yellow, brownish, black), most often respects the inferior surface and tip of the organ, forms only a slight stippling upon the borders, and is especially marked upon the dorsal surface. There is no pain, no sordes, no fœtor of the breath, no very disagreeable sensations. Sometimes the patient experiences a dryness of the mouth. The hypertrophy of the papillæ of the tongue is a constant condition. The affection is particularly prone to develop on patients debilitated by age or disease. The author has endeavored without success to inoculate the parasite upon different individuals.

The existence of lingual blackness without fungi, as Dr. Rayer admits, would seem to prove that the black coloration is not caused by the microphyte which we have described above. This abnormal tint is due, in his opinion, to a proliferation of the epithelium; but this conclusion is by no means satisfactory, and the question, it seems to us, demands further investigation. In any case, the accident is purely local and without the least gravity; it disappears ordinarily without treatment; nevertheless it has been proposed to scrape the tongue, then touch it with a weak solution of the bichloride, carbolic acid, or a solution of chlorate of potash or borax.

Dr. Leloir has had the good fortune to examine two tongues attacked with LINGUAL PSORIASIS, and he has just given the result of this examination in an interesting communication to the *Société Anatomique*, Dec. 7, 1883. The epidermis in the leucoplastic regions presented remarkable alterations. There was found a thickened horny layer, colored yellow by picric acid, and presenting at its lower portion a light rosy tint, due to the presence of small intercellular collections of diffused eleidine. Beneath this horny layer there was observed in the sections a granular layer quite marked, and constituted by four to six rows of cells strongly charged with eleidine. These alterations ceased abruptly at the border of the white patch. There is perceived in the leucoplastic regions that the mucous epidermis presents all the characters of the cutaneous epidermis in process of active keratization. The Malpighian body subjacent to this granular layer is altogether similar to the Malpighian body of a skin with thickened horny epidermis. In the epidermis, interpapillary prolongations are much less prominent than in the healthy regions of the tongue; the papillæ are flattened. The mucous derma is much thickened, doubled or even quadrupled in thickness, and these modifications resemble, as has already been pointed out by Debove, Schwimmer, Kaposi, Vidal, etc., a sclerosis of the derma in process of evolution.

Dr. G. Lemormier has just given in his inaugural *Thèse* (Paris, 1883) an excellent description of an affection which he terms *glossite exfoliatrice marginée*, and concerning which a number of memoirs have already appeared. The great Rayer first spoke of it in 1831 under the name of lingual pityriasis; Moeller, of Kœnigsberg, described it, in 1851, under the title of lingual excoriation. In 1864 Bergeron, before the *Société Médicale des Hôpitaux de Paris*, spoke of a singular lesion of the tongue which he had observed in several persons, and which was constituted by figures of irregular contour similar to geographical charts. Gubler, in 1869, gave to this sort of eruption the name of *lichenoid condition of the tongue*, and Bridon, in 1872, that of *spotted condition of the tongue*. Gautier (1878) has studied it with much care, and calls it *epithelial desquamation of the tongue*, distinguish-

ing three forms: the first with clearly cut margins; the second, in which the lingual desquamation is festooned in contour; the third, which is the lichenoid of the tongue already described by Vaulair. Finally must be cited the work of Schwimmer in 1877, and of Caspary and Unna.

The affection which Lemormier has studied in his work is only one variety of the numerous epithelial alterations of which the lingual mucous membrane may be the seat; but this variety presents special characteristics sufficiently well defined to enable one to recognize it with the greatest facility. After Professor Fournier, he has given it the name of marginated exfoliative glossitis, a name which is well adapted to the objective symptoms. This affection presents three essential characteristics. 1st, the *peripheric border*, which is slightly salient, whitish, circinate, as if constituted by a series of small elevations of a dead white, ranged lineally side by side; 2d, *exfoliation of the lingual mucous membrane*, which takes place at the concave side of the border, that is, the side which corresponds to the parts surrounded by the border, while, on the convex side of the border, the lingual mucous membrane, which is not yet involved, but is destined to be if the lesion continues to spread, preserves its normal aspect. In addition, since the lingual epithelium re-forms with great rapidity, the desquamated zone, which is of an intense red, is not well pronounced except in a relatively small extent. 3d, the *nomadic character of the lesion*; it is in fact extremely fugacious and ephemeral, so to speak. The circinations observed one day are often quite different in form, in contour, and in extent from those observed the day before. In this respect the thèse of Dr. Lemormier is exceedingly interesting, since it contains plates displaying the diverse aspects exhibited by the tongue of the same patient from day to day. These plates have been drawn from nature, and I can myself certify to their absolute correctness, as I had an opportunity the past year of observing the patient when I was chief of Prof. Fournier's clinic.

Sometimes several concentric borders are observed, most often the borders are arrested in their progress when they reach the median raphé, the alterations are effaced little by little, and the reddish color of the desquamated patches gradually disappears. It is quite rare when a patient is affected with this singular eruption that the tongue becomes at certain times altogether normal; nevertheless I have seen undeniable examples of this nature, and I cannot comprehend why Dr. Lemormier seems dubious upon this point. The color of the border may vary from a silvery white to a more or less deep yellow. The two sides of the tongue may be simultaneously attacked. The inferior surface of the organs is sometimes implicated. The affection is painless and does not produce fetor of the breath, the tactile and gustatory sensibility is not modified.

Careful microscopic examination has demonstrated the existence of numerous ordinary spores, the spores of leptothrix, spores analogous to those found in black tongues, but less numerous. The anatomical lesions may result from a very superficial inflammation of the tongue involving principally the epidermis, and probably also the more superficial portions of the derma. It does not seem that this affection is of a parasitic nature, notwithstanding its circinate disposition and its centrifugal extension. These characteristics led Prof. Parrot to regard it of syphilitic nature and that developing in children it should be referred to hereditary syphilis. Notwithstanding the great ability with which the regretted and savant master defended his opinion, he failed to firmly establish it, as it was opposed by numerous cases, absolutely irrefutable, of marginate exfoliative glossitis occurring in children entirely free from hereditary or acquired syphilis. It may be admitted that syphilitics have a special predisposition to this affection by vir-

tue of the diathesis or the irritation produced upon the tongue by treatment, but this is only a hypothesis open to discussion. Cachectics are more subject to it than healthy persons.

Dr. Lemornier terminates his excellent memoir in establishing clearly that marginiate exfoliative glossitis is quite distinct from eczema of the tongue, from the affection which has been described as lingual psoriasis or buccal leucoplasia, from the glossitis of smokers, from the glossitis of cachectics and convalescents, from mucous patches and other erosions of syphilitic nature, from superficial or dermic sclerous glossitis of specific nature.

As to treatment, the author proposes none; the sulphur preparations recommended by Unna most often fail, but, as this affection causes no inconvenience to the patient, the best plan is perhaps to leave it to its evolution.

Since we are speaking of uncommon affections, I cannot forbear calling attention to the remarkable monograph which Dr. Vidal has just published upon XERODERMA PIGMENTOSUM of Kaposi, cases of which have been observed by Taylor, Duhring, and Heitzman in America. Until recently this dermatosis remained almost unknown in France, when on the 29th of October, 1882, Dr. Vidal received in his service in the *Hopital St. Louis* a young girl eleven years of age, suffering from a strange cutaneous affection, the nature of which was at that time a problem to all who saw it. Kaposi had published a monograph upon Xeroderma Pigmentosum, a copy of which he sent to Dr. Vidal, illustrated with colored plates. I had the pleasure of witnessing the astonishment of my distinguished master when he recognized in the plate, representing the face of one of Kaposi's patients, an almost exact fac-simile of the face of his problem of the *Hopital St. Louis*. In carefully reading the observation of the distinguished Vienna Professor, he was convinced that his patient was undoubtedly suffering from Xeroderma Pigmentosum. He then ascertained that the sister of the patient had died from the same affection in the last stage of marasmus; he also learned quite accidentally that there existed three similar cases in a small locality of Béarn: he went thither, and had the good fortune to find in the same family three children affected with Xeroderma Pigmentosum. He gives a detailed statement of these five new cases in his memoir, together with a table including the entire thirty-one cases thus far observed, and two chromo-lithographs which enable any physician to recognize at a glance a case of Xeroderma Pigmentosum. Finding that the name Xeroderma Pigmentosum (Kaposi), *angioma pigmentosum et atrophicum* (Taylor), *lioderma essentialis eum melanosis et teleangiectasia* (Neisser) do not correspond to the complex processes of the disease and especially take no account of the last stage, or stage of epitheliomatous tumor, the author proposes for this new affection the name of *Dermatosis of Kaposi*, a name which has the advantage of not prejudging its nature and recalling the author who first described it.

The *Dermatosis of Kaposi* (Xeroderma Pigmentosum) is an innate or congenital disease; but it is only a certain time after birth that its first symptoms can be recognized. The influence of sex is *nil*, it almost always attacks several children of the same family, and, in the same family, those of the same sex. The solar rays without doubt act as an occasional cause, for the parts habitually uncovered, the face, neck, hands, and forearms, are first affected, and it makes its *début* during the hot season by a redness similar to that provoked by a sun-stroke. These spots of redness leave pigmented macules of a fawn color, which sometimes seem to be primitive; the macules deepen in color, enlarge and multiply. The skin is sprinkled with lentigines which are propagated from point to point, and may at length invade the parts protected by clothing, as the anterior and superior regions of the chest. This constitutes the first stage or stage of *début*.

In the second stage, the skin becomes dry and rugous, the epidermis exfoliates in fine furfuraceous scales. Trophic lesions develop, suggesting those of impetigo, the superficial exulcerations covered with yellowish or brownish crusts, beneath which are found small cicatrices, first of a vivid red, then whitish teleangiectases forming arborizations or vascular stars, are seen over the surface. The white cicatricial spots extend more and more, the skin is quite thin, tense, but non-adherent to the subjacent tissues. The diseased parts then present a mottled aspect, quite pathognomonic. This condition may persist for several years.

Then, in the third and last stage, there form upon the pigmentary spots larger verrucose projections covered with a horny epidermis. Some of them undergo a notable development, become fungous, vegetating, then ulcerate; others become pedunculated, fall spontaneously, leaving an ulceration which cicatrizes; others, finally, after ulcerating, involve the underlying tissues, destroying the cartilages, the bones, and may exhaust the patient by the abundance of the suppuration, or by the generalization of the epithelioma. The epitheliomatous tumors sometimes develop also upon the red cicatrices, or even in the thickness of the derma. It is an incurable and inevitably fatal disease, the duration of which is on an average from eight to ten years.

From a histological point of view, the horny layer is thickened and desquamating, the stratum lucidum and stratum granulosum disappear, the Malpighian layer is thinned, and its deeper cells are strongly pigmented. The derma is atrophied; the papillæ are quite apparent, and contain masses of pigment; numerous embryonic cells are met with, and a quantity of elastic fibres which appear to have replaced the connective tissue. The vessels, the smooth muscular fibres, the sudoriparous glands, and the pilo-sebaceous follicles, are diminished in number, and tend to disappear. All the fungous tumors of xeroderma pigmentosum present the histological characters of epithelioma. The most common disposition is that of a lobulated epithelioma with the fibrous stroma infiltrated with embryonic cells.

As to the pathogeny of this affection, it is most obscure. It may be asked if the epitheliomatous tumors which develop are not due to chronic irritation and the prolonged hyper-activity of the papillary layer, or, indeed, if the entire morbid process should not be regarded as a congenital variety of epithelial carcinoma.

In France, the question of ZONA and trophic troubles still occupy the attention of the profession. In a previous letter, I have already given my opinion upon the subject of zoster, and why I thought, with Fabre and Landrouzy, that it was necessary to distinguish from true zona, an altogether special disease of cyclic evolution, and but rarely recurring, the zosteriform eruptions depending upon veritable trophic troubles from direct lesion of the nerves. In the latter category must be ranged the cases recently published by Pitres and Vaillard (*Archives de Neurologie*) and Pozzi (*Gazette Médicale de Paris*, October, 1883). The first-named report a case of zona occupying the 6th to the 11th intercostal spaces of the right side in a woman thirty years of age, suffering from right pleuropneumonia and which proved fatal. The 6th to 11th right intercostal nerves presented well-marked lesions, denoted by fragmentation, by the disappearance of the myeline, and even by complete atrophy of the nerve tubes. The 6th dorsal ganglion presented a quite evident diminution in the nerve tubes, while the 11th ganglion was absolutely normal. These authors conclude that zona may depend upon alterations of the peripheric nerves, with or without concomitant lesions of the ganglia and the corresponding roots. I may remark that this case of zosteriform eruption seems to have been consecutive to inflammation of

the pleura; it is then quite probable that it was not a case of essential zona, but an eruption depending upon a simple nervous lesion, and resembling zona, while being entirely different in its nature. The same is true of the patient of Dr. Pozzi who had, after a fall, a traumatic neuritis of the right brachial plexus, and consecutively a vesicular eruption of trophic origin upon the right hand.

Apropos of an energetic attack directed against the physicians of the Hopital St. Louis by Dr. Ladreit, of Lacharrière, Dr. Besnier has again pointed out the injurious character of the treatment of tinea by croton oil. This treatment has long been recommended in France by Dr. Ladreit, who fabricates for this purpose his well-known pencils of croton oil, to be rubbed over the affected parts. They produce an intense, often a suppurative, inflammation of the hair follicles, as a result of which, according to the author, a cure is almost constantly effected. This procedure was formerly experimented with at the Hopital St. Louis, and, after numerous trials, it was rejected as inefficacious and dangerous—dangerous because the suppuration of the hair follicle may determine an incurable alopecia, an unfortunate result which tinea tonsurans left to itself never produces. It is, moreover, inefficacious, since recurrences of the disease were observed in patients treated and discharged as cured by Dr. Ladreit himself. Croton oil has been prescribed in our great hospital for cutaneous diseases, much to the wrath of the doctor, a wrath which he exhales in an article accusing the physicians of St. Louis of systematically rejecting every new therapeutic procedure. In a firm and dignified response, Dr. Besnier has corrected the erroneous assertions of his colleague. He proves that the physicians of St. Louis are ever ready to experiment with new methods of treatment. Unfortunately, all those yet proposed for tinea have given only mediocre results. This also has been found to be the case with the method of Dr. Cramoisy, which does away with epilation. He recommends for the destruction of the parasite in the hair follicle frictions with pyroligneous acid, with which he combines red oxide of mercury (HgO) and salicylic acid ($\text{C}_6\text{H}_4\text{O}_2$). These two last substances are evidently of negative value in such feeble proportions, the active substance being the pyroligneous acid. In a remarkable report read before the Academy of Medicine upon Dr. Cramoisy's method, Dr. Besnier has established, in the first place, that it is not new, and that pyroligneous acid had already been employed in various countries for tinea. He then demonstrates, by a conclusive argument, that we cannot from a therapeutical point of view assimilate vegetable and animal parasites. The latter are destroyed by parasiticides which exert no injurious action upon the integument, while vegetable parasites, which penetrate within the tissues, require the destruction even of the tissues themselves in order to obtain an immediate radical cure. Now, this destruction often provokes lesions more severe than the parasitic disease itself. It is necessary then to employ a substance which will render the living tissues unsuitable to the germination of the microphytes without destroying the vitality of the tissues. Dr. Besnier has shown that in favus the method of Dr. Cramoisy does not occasion any serious results; in the treatment of the trichophytic affections, pyroligneous acid has the advantage of not determining a profound dermatitis like croton oil, and leaving a permanent cicatrix. It clears up the diseased surfaces, but does not radically cure, a liability to the return of the disease still remaining. On this side of the Atlantic, we are still in search of a means, other than epilation, for the cure of favus and tinea tonsurans.

Review.

ON THE PATHOLOGY AND TREATMENT OF GONORRHOEA. By J. L. MILTON, Senior Surgeon to St. John's Hospital for Diseases of the Skin. London. Fifth Edition. London: Hartwick, Bogue & Co.; New York: William Wood & Co., 1884.

MILTON'S monograph on Gonorrhœa has long been known as the most voluminous and valuable work on the subject in the language. The demand for a fifth edition is an evidence of its steadily-increasing popularity. In the reproduction of this edition in Wood's Library of Standard Authors, the American publishers have shown their usual enterprise and discriminating judgment which have won for this series of publications so high a position in the esteem of the profession.

The new edition bears evidence of a thorough revision. Certain material relating to records of cases, description of symptoms, and the various methods of treatment adopted in the different hospitals of Europe has been judiciously eliminated.

The additions incorporating new ideas and theories respecting the etiology of the disease, its possible parasitic nature, etc., bring the work up to the latest advances of science in this special field, while the introduction of many new and valuable suggestions as to improved methods of treatment adds largely to its practical value.

As regards the genesis and essential nature of gonorrhœal inflammation, the author is still an uncompromising adherent of the specificity of the gonorrhœal virus. To the many arguments drawn from analogy, from experimentation and from clinical observation, which go to prove than an inflammation identical in character, in duration, and in infectious quality may be the product of simple causes, he turns an incredulous ear. He does not believe that the leucorrhœal discharge, the menstrual fluid, chemical or mechanical irritants, etc., are capable of engendering what he terms a genuine gonorrhœa—fortifying his opinion on the ground that his large practice and observation does not furnish a single well-authenticated case of such origin. He asserts that we are justified in assuming "that the matter by which gonorrhœa is communicated may be of as specific a nature as the lymph of the cow-pox vesicle, and that the supply of the infecting material is kept up in the same way in both cases, viz., by propagation from individual to individual."

The views of the partisans of the theory of the fungous origin of gonorrhœa are next given in detail. He devotes considerable space to Neisser's investigations of the micrococci of gonorrhœal pus, and, although the demonstration of the correctness of these views would go far to prove the specific nature of the gonorrhœal pus, our author does not commit himself to their acceptance. He scoffs at the idea that there is any connection between the inveteracy of the disease and diathetic states, such as gout, rheumatism, scrofula, etc.

Fully four-fifths of the entire work is taken up with considerations respecting the treatment of gonorrhœa and its complications.

The author gives the general features of the various methods of treatment which have been recommended from time to time by various high authorities

without indorsing their value. He then gives, in detail, the plan of treatment which his own practice and observation have convinced him to be the best. He submits every remedy to the rigid test of experience, "recommending nothing but what has stood the brunt, not merely of experience, but of special observation." He does not claim any marvellous results for his treatment or advocate the claim of any agent or combination of agents which even approach the character of a specific in this disease, nor does he hope for any such brilliant achievement in the future. On the contrary, he "*doubts whether man will ever discover drugs superior in their power over the disease to those already known*, and that there is accordingly more to be hoped for by trying to improve the administration of medicines already known to us than in seeking new remedies."

In concluding this brief notice of a work which is too well-known to the profession to justify careful analytical review, we may say that the book is admirably well written, the style clear and lucid, the reasoning forcible and philosophical, and the conclusions, in the main, logical and correct. The reader cannot fail to be impressed with the author's thorough familiarity with the subject, the fairness of his views, and the honesty of his convictions.

Items.

Internationaler Congress zu Kopenhagen, Section für Dermatologie und Syphilis.—Der Unterzeichnete bittet alle diejenigen Fachcollegen, welche chirurgische Instrumente zu dermatologischen Zwecken (zum Schaben, Sticheln, Injiciren, Epiliren, Spray etc., zur Galvanokaustik, Elektrolyse, optische Hilfsmittel etc.) angegeben oder verbessert haben, *behufs einer auf dem Congresse von demselben zu veranstaltenden Demonstration der neueren Verbesserungen auf dermato-chirurgischen Gebiete*, die betreffenden Instrumente in je einem Exemplar (nebst Gebrauchsanweisung, Preisangabe und Adresse des Fabrikanten) leihweise an untenstehende Adresse einzusenden oder durch ihren Instrumentenmacher einsenden lassen zu wollen.

Hieran anschliessend, würde die Einsendung solcher Instrumente zur Harnröhrenchirurgie, welche für den Dermatologen unentbehrlich sind (zur Urethroskopie, Injection, Dilatation etc.) und durch gewisse Verbesserungen ein besonderes Interesse beanspruchen, sehr erwünscht sein.

Herr Professor C. Nyrop, Instrumentenmacher in Kopenhagen, hat sich zur Empfangnahme, Aufstellung, etwaigem Verkauf und Rücksendung der Instrumente freundlichst bereit erklärt, wesshalb die Einsendung direct an Herrn Nyrop zu geschehen hat.

DR. P. G. UNNA,

Hamburg, Damnthorstrasse 31 pt.

Astronomical Observations.—Said the Syren to the student, as she Saturn her cosy couch: "Will you come in and spend an hour with Venus?" "No, thanks," said the student, "I have been there. I spent an hour with Venus last winter, and afterwards spent six months with Mercury, and don't Juno I consider this a Sirius matter."—*Exchange.*

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Original Communications.

CASE OF DERMATITIS HERPETIFORMIS, ILLUSTRATING IN PARTICULAR THE PUSTULAR VARIETY (IMPETIGO HERPETIFORMIS OF HEBRA).

BY

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THE following case of this rare disease was brought to my notice by Dr. J. H. Stubbs, of London Grove, Pa., September 28th, 1878. The patient was suffering grievously and was admitted to the hospital of the University of Pennsylvania. The notes were taken at the date of her admission.

Annie McC., American by birth, a brunette, aged twenty-seven, single; a domestic, living in London Grove, Chester Co., Pa. There is no family history bearing on the case. She is strong and robust and has always enjoyed good general health. The disease of the skin from which she is now suffering first made its appearance two years ago, previous to which time she had never experienced any cutaneous disease. It began suddenly, on the flexor surfaces of the forearms, in the form of a violent attack of itching unaccompanied by eruption. The following day "small water blisters," the size of pin-heads, appeared in clusters on either elbow. They were very itchy and were soon ruptured by scratching. In the course of a few days they made their appearance upon the hips, thighs, and knees, while new ones continued to appear about the elbows. Within three or four weeks the other regions of the body, especially the neck, shoulders, back, and buttocks, were invaded. The

scalp, ears, chest, mammae, hands and feet remained free. The lesions she describes as having been small, variously sized *vesicles*, or "small water blisters, containing a clear, watery fluid." They varied in size from a pin-head to a split pea, the majority being the size of pin-heads. They were irregular in outline, some being rounded, others quite angular, and were considerably raised above the level of the surrounding skin. They manifested no disposition to rupture spontaneously, but were in every instance scratched open, for they itched intensely. As stated, they were in clusters or groups, from three or four to a dozen or more lesions occurring together upon an area the size of a silver dollar. The grouping was irregular, the lesions showing no disposition to form into circles or other peculiar configuration; four or five would frequently be found clustered together.

The eruption continued in this form for a year, manifesting itself from time to time in distinct outbreaks, or crops of lesions, which would appear gradually or suddenly at variable intervals. At times the disease would disappear, when in the course of a week or two a new outbreak would occur, lasting days or weeks, to be again followed by another slight or severe attack, and thus the skin remained in an almost constant state of eruption. At no time was it entirely free of disease for longer than a fortnight.

About a year ago an outbreak manifested itself in which the lesions assumed a distinctly *pustular* character; the attack was of short duration, lasting only a week or ten days, and the next outbreak was *vesicular and bullous*. Within the past year the lesions have not been so numerous, but they have been larger, and the distress accompanying them greater. Not until within the present month has the disease again assumed the pustular phase. In place of the vesicular and bullous lesions which have existed almost constantly for nearly two years, distinct pustules have appeared, which will be presently considered.

The seasons have in no way influenced the disease, the eruption being quite as annoying in summer as in winter. The itching has been constant and very distressing, and at times has been almost unendurable. She states that it is impossible to describe the intensity and violence of this symptom; that were she debarred from scratching it would be altogether unendurable, for until the vesicular and bullous lesions are ruptured she cannot refrain from scratching; after they are broken down, a certain amount of relief is experienced which lasts until a fresh outbreak threatens. The recent pustules she states are much less itchy than the usual vesicular form of eruption.

Present condition. The patient is suffering with a general copious eruption, occupying the greater portion of the trunk and extremities. It manifested itself, it will be remembered, about three weeks ago, and was

at its height four or five days since. It consists of numerous, variously sized, rounded or irregularly shaped pustules in all stages of evolution. They are typical pustules, the smallest of them exhibiting a distinctly pustular state. They vary in size from a pin-head to a large pea, the greater number being of the size of small peas; when two or more have coalesced, however, a small or large finger-nail-sized lesion exists. In shape, when small, they incline to be acuminated, but as they increase in size they become decidedly flat, with an irregularly rounded or angular outline. They incline to crust in the centre and to spread in a creeping manner on the periphery, a ring of small, flat pustules, isolated or confluent, being frequently present; and where two or more are in close proximity thus almost invariably run together, forming flat, broad lesions as large as a quarter dollar and sometimes even larger, the crusting being more or less complete. A bright or deep red areola of considerable size surrounds all of the lesions. In color, the pustules are whitish and opaque, and contain a thin puriform pale-yellowish or whitish fluid. The walls of the young lesions are distended, but those of the older ones are more or less flaccid, and in many instances are ruptured, the fluid oozing forth and drying into flat, uneven crusts of a greenish or brownish color. Here and there are patches of disease, made up not only of confluent lesions but of two or more distinct groups of lesions. These areas of disease, several inches in diameter, are striking upon the arms and upon the thighs.

The distribution of the lesions is for the most part in the form of more or less distinct groups, but there are also disseminated lesions. The groups are irregularly formed, and are as a rule composed of from two to four pustules. Clusters of two and three lesions situated in close proximity, within an area of an inch in diameter, are not uncommon, while in some places as many as a half-dozen or more of various sizes may be found. On the anterior aspect of the middle of the thigh is a conspicuous group, composed of a central, unbroken, tensely distended, somewhat acuminated, pea sized, irregularly-shaped pustule, with a vivid, deep-red, "puckered" areola, around which are three similar but smaller lesions, the whole occupying an area the size of a quarter-dollar. The grouping, however, viewing it as a feature of the disease, is much less marked than in herpes zoster. In addition to the pustules, there are numerous excoriations, blood-crusts, scratch-marks, deeply-stained spots, with or without old crusts, and general pigmentation of a dirty-yellowish, brownish hue. The disease is the impetigo herpetiformis of Hebra.

October 12. The patient stated, upon her admission to the Hospital, that the disease had, she thought, passed the height of the attack, and would soon begin to subside; and so the events have proved, but there have been, notwithstanding, sufficient typical new lesions for purposes of study.

They have appeared as distinct pustules, usually the size of pin-heads, preceded by and accompanied with violent itching. Their areolæ at first are insignificant, but in the course of from twelve to forty-eight hours both areolæ and pustules assume considerable size, the latter flattening out and crusting in the centre, with a somewhat depressed, greenish-yellow, uneven crust. As the crust grows, new, small, flat, frequently indistinctly defined, whitish pustules, pin-head in size, appear in the form of an irregular broken ring just beyond the line of the crust. In the case of large lesions this process is observed to repeat itself several times, or, indeed, until the pustule ceases growing. This concentric arrangement of the lesions, while not conspicuous, not as much so, for example, as in herpes iris, is readily noticeable, and is more marked in some lesions than in others.

The itching has been exceedingly violent, and has been only partially controlled by anti-pruritic lotions. The patient has scratched incessantly by day and night, without which, she adds, the disease could not be tolerated.

November 1. At the present date the attack has almost subsided, and the patient feels that in all probability she will be comparatively well in for a brief period, until the next outbreak, which she confidently looks for, and which, according to her experience, may announce itself within a week, or perhaps not for a month.

The treatment has been directed with the view of bettering her general condition, although, as has been stated, no marked impairment of general health seems to exist. Saline laxatives, bromide of potassium, and chloral were ordered; locally, lotions of carbolic acid and tar in various combinations were relied upon. While a certain amount of relief was obtained from the lotions, the itching still persisted, and recurred from time to time with all its former violence. No benefit worthy of mention was obtained from the internal remedies.

January 22, 1879. The patient left the hospital shortly after the last note, and for the past three months has been taking a course of arsenic. Dr. Stubbs writes that the character of the eruption has changed since I last saw her, having been lately *papular* and *vesico-papular*, with violent itching. A fortnight ago, while undressing one evening, she was seized with severe itching, and in the course of a half-hour was well covered with an eruption similar to that which she now shows. It occupies the entire general surface, and consists of flat, irregularly shaped and sized, indistinctly defined herpetic *papules* and *papulo-vesicles* seated upon considerably infiltrated reddened skin, which is everywhere so excoriated that it is difficult to find lesions that have not been scratched. Excoriations and blood-crusts are conspicuous. Here and there upon the trunk and extremities, especially upon the back, arms, buttocks,

and thighs, there are distinct patches of pin-head-sized, mostly flat *vesicles*. They are small and are ill-defined, so much so that at a distance they would scarcely be detected. Some of the patches contain as many as a dozen or more, other groups not more than three or four. Smaller and disseminated lesions of the same kind exist on the forehead and neck. There are no pustules; none have formed since last October. She states that the eruption comes out and disappears every few days, the itching being most severe in the interim. She is kept awake the greater part of the night, and is exhausted from the long-continued itching.

May 16. She recovered from the attack in January in February, and remained comparatively well about ten days, when a new outbreak was announced, which appeared very gradually in the same form as before, namely, as small, flat, grouped, abortive *papules* and *vesico-papules*. She has suffered two like attacks since, from the last of which she is just recovering.

Under date of August 18, 1879, Dr. Stubbs writes that the patient is again suffering greatly from an outbreak, and that no relief is afforded by any of the remedies used. He further adds, "I do not know what to call the disease; sometimes it is pustular, at other times it is vesicular or papular, while sometimes wheals and boil-like lesions form. It is now vesicular." Two months later (October 16, 1879) the doctor writes, "Her condition now is the same as when I first sent her to you one year ago; the lesions are *pustular*. We have not had this condition from that time until now. On the fifth of this month three pustules came on her knees, others rapidly followed on other parts. She can get scarcely any sleep. She has had no appetite for two or three weeks." I subsequently saw the patient again during an attack, her condition being about the same as the last note.

Early in 1883 (Jan. 17) I received a communication from Dr. Stubbs, stating that the patient was still afflicted, although she now suffered less severely than formerly. "She has since been married, and has had one child. *During pregnancy the disease of the skin gave her no trouble, and most of that period she was quite clear.*¹ Last summer the mucous membrane of the mouth, throat, and eyes became inflamed, dry, and hot, and finally an eruption, which was the same as that on the skin, appeared. The labia and vagina have never been affected. She has not been under treatment of late for the cutaneous disease. The eruption, as before, is still confined chiefly to the back and flexor surfaces of the extremities."

I would add that no treatment used in this case seemed to exert any beneficial effect, the internal remedies prescribed including arsenic in

¹ The italics are mine.

small and large doses, quinia, iron, sulphur, saline laxatives, and alkalis. Externally, weak and strong ointments and lotions of carbolic acid, tar, and mercurials were all tried on different occasions, affording only temporary relief. The case illustrates several varieties of the disease, but more particularly the pustular (the "impetigo herpetiformis" of Hebra), which condition existed when she first came under my observation. For an account of dermatitis herpetiformis, I must refer to abstracts¹ of my communication recently presented to the American Medical Association.

TREATMENT OF VEGETABLE PARASITIC DISEASES.

BY

JOHN V. SHOEMAKER, A.M., M.D.

(Concluded.)

Favus.

CONSTITUTIONAL measures in the treatment of this disease are often very advantageous, especially in those of broken-down constitution, as the syphilitic and scrofulous, and in the latter condition I know of no better combination than cod-liver oil with syrup of ferrous iodide, or small doses of potassium chlorate with plenty of good food, good air, and healthy occupation, with clean and well-aired habitations. In reviewing the different forms of local treatment of favus, I cannot say that much progress or improvement has been made on the days of the "Calotte," or that of the "Mahon frères." Epilation, which is generally used at the present time, certainly cannot be claimed to be in conformity with modern therapeutics, and is a measure which is injurious to the follicles, and by its severity a relic of the barbarism of the past century, smacking of the pitch-cap and its torturing charlatans. The first object to be accomplished is the removal of the crusts, after which a parasiticide should be applied to destroy the fungus on the surface as well as in the hair and follicles. The best means of removing the firm crusts is by the application of oil which loosens them. In using oils, I have at all times given the preference to that of ergot, which is now a waste product, cheaply derived in the manufacture of ergot preparations. I claim for it greater penetrating power, and a mild astringent effect on the epidermis. The olive and almond oils and carbolized oils possess this property in a much less degree, and thus are not

¹ Phila. Med. Times, May 17, 1884, p. 603, and New York Med. Journ., May 17, 1884, p. 562.

as well fitted for the purpose. The crust and epidermis affected should be abundantly covered with oil for twenty-four hours before using any other remedy. The poultices of all kinds usually employed before removing the crusts are both unpleasant to the patient—not well adapted to the parts—and are positively injurious, as they cause rapid proliferation of the fungus, which by the elevated temperature they mature, as well as furnish food for it. Not only this, but by thoroughly moistening the epidermis and hair they swell it to such an extent that the hair is wedged in and entirely fills the follicles, preventing the entrance therein of any and all parasiticides. Warm water dressings and head-bandages produce the same bad result, and should for this reason be abandoned. The soap spirit of the Germans is a severe measure, not alone soaking and softening the favus crusts, but acting destructively on the epiderm, which is often cast off in consequence thereof, furnishing a rich field for the propagation of the fungus. As a detergent lotion which is parasitocidal at the same time, softens the crusts, and does not affect the epiderm, I know of nothing more suitable than a twenty-five to a fifty-per-cent glycerin solution of boro-glyceride. This solution should be sponged thoroughly over the affected surface, after being soaked in oil of ergot for twenty-four hours. After an hour or two, the crusts will readily peel off, and the epiderm will be clear and clean, ready for the parasiticide. First amongst these in order are certainly the mercurials in their many forms. To apply, however, according to the French method, a solution of mercuric bichloride (corrosive sublimate) is more than useless, for the albuminous surface is sure to be coagulated by it, and over the follicles a protective layer of mercuric albuminate is cast which allows the parasite to thrive in undisturbed security. The old salves of white precipitate are no better, for they will mechanically occlude the follicles, and will often make a cure out of question, besides congesting the skin in such a measure as to make it grasp the hair all the tighter, and render the entrance of the remedy into them a matter of impossibility. In cases of favus accompanied by pustular eczema, which occurs after scratching, I have found the naphtholized zinc oleate ointment of material advantage. After the crusts have been removed from the parts and the surface oiled for a time until the congestion is removed and the follicles open, active anti-parasitic agents of some kind can be advantageously used. The very best in my experience are the mercury and copper oleate, to the perfection of which the profession is indebted to the efforts of Dr. Lawrence Wolff, a prominent chemist of this city. I do not wish to be understood to mean by the former preparation the numerous and often worthless solutions of mercuric oxide in oleic acid, described by the per-cents of mercuric oxide they are supposed to contain, but in speaking of this preparation and of the copper oleate, I apply the term to the true and definite

chemical compounds between oleic acid and mercury or copper only. They are readily soluble in fats and oleic acids, but I prefer as a diluent for them the oleo-palmitic acid, such as is derived by decomposing olive oil and liberating it from the glycerin base. I often prescribe them as follows :

℞ Hydrargyri oleatis... .. ℥ i.
 Acidi oleo-palmitic... .. q. s.
 Ut ft. unguentum moll.

Or:

℞ Cupri oleatis... .. ℥ i.
 Acidi oleo-palmitic... .. q. s.
 Ut ft. unguentum moll.

Very little of the fatty acid is needed to render them soft, and they are the strongest of the kind that can be had. I use a little of the former ointment first, rubbing it well in with the finger-ends, and after a few days alternate with the copper oleate, which is astringent and relieves the irritation that may be set up by the former. Never have I observed in the use of these salts any constitutional effect and have noticed invariably a speedy disappearance of the fungus. The application should thus be made every day or two, and continued for three or four weeks. If after a cessation of a week or two, new favus crusts should develop and the hair does not assume its natural aspect, the treatment should be taken up *de novo*, but I have in few instances only been obliged to do so. I have, in the way just described, been able, in about six weeks' treatment, to cure several severe cases of favus. I avoid in all cases, after the crusts have been removed, the use of water as lotions or detergents, as it is a material agent necessary for the propagation of the fungus. To determine when the treatment has sufficed, I have from time to time extracted a single hair from the worst places to see if fungus were still adhering thereto, and have been guided in this manner. The alcoholic lotions of corrosive sublimate as well as iodine, while well intended to withdraw from the fungus the all-important element for its propagation—water, proves too irritant to admit of its continued use as a parasiticide. I trust that by the use of oleates the barbarous epilation will in this way be superseded, and that the treatment of favus will be rendered shorter and less severe. Favus of the epiderm on parts not covered with hair can easily be cured by removing the crusts in the manner already described, after which either the mercury or copper oleate ointments were applied.

Onycheal favus is best removed by the knife when it is circumscribed; in a total affection of the nail, in hypertrophical and perverse nutrition, by bandaging either with the mercury or copper oleate ointment and occasionally clipping with the scissors.

Chromophytosis.

The importance of treatment in this affection has always been underestimated, and the consequence is usually either a failure or incomplete cure. My experience with this disease, in private practice as well as in the Philadelphia Hospital for Skin Diseases, has led me to view the radical cure of chromophytosis as not quite as easily accomplished as one might infer from the light manner in which many authors upon this subject speak of it. I have seen patients frequently wander from one specialist to the other after being apparently cured, though ample means had been again and again persistently applied. While I cannot confirm its especial occurrence in those of ill-health, anæmic and syphilitics, yet I have seen it frequently on subjects of that description, and have found it always of first and foremost importance in such cases to institute constitutional treatment. The main part of the treatment of this affection, however, must necessarily be the local. The following mixtures have been found serviceable :

℞ Pulveris sodii biboratis..... ʒ iiij.
 Spiritus hamamelidis virginianæ..... ʒ iiij.
 M. Sig. Use externally.

Or again:

℞ Thymol..... ʒ iss.
 Spiritus vini rect..... ʒ i.
 Glycerinæ..... ʒ i.
 M.

Either of these solutions will keep the parts clean, remove all the sebaceous deposits from the surface, and act at the same time as a mild parasiticide. After this has been proceeded with for a few days, and the epidermic scales thus softened have been detached, a stronger parasiticide can then be applied. The most effective application that I have found for this purpose is copper oleate, either diluted with oleo-palmitic acid into a soft ointment or a ten or twenty per cent ointment thereof made with fat. The salts of copper, after I had experimented with the copper oleates for some time, are now confirmed to possess marked antiseptic and anti-parasitic properties, and indeed nothing else has rivalled their effects in my hands, while the oleates thereof admit of the most simple, easy, and thorough application. It not only destroys the parasite on the surface, but by its deep penetrating action will arrest its development in the epidermic cells and probably no parasitic skin trouble yields so readily to any one remedy as chromophytosis will to the copper oleate. I have succeeded with it in relieving and permanently curing many obstinate cases of this disease. In applying this oleate it should always be borne in mind that a very small quantity

will be sufficient to go over the diseased surface. The oleate will rapidly penetrate the skin and a large quantity smeared upon the surface will simply discolor the linen without being of any material advantage. I would advise in all cases that the lotions which I have above recommended should be used to keep the parts clean and avoid the spreading of the parasite until it has been thoroughly eradicated by the oleate, for I believe that, in this as in all other vegetable parasites, the fungi will propagate themselves more rapidly when water is used on the parts, and I therefore in all cases interdict the use of it, or washing the parts with it, and depend for cleanliness upon the solution already named. This treatment should be continued until coloration and scales are no longer noticeable, and a new and healthy surface has formed.

1031 WALNUT ST., PHILADELPHIA, PA.

A CASE OF FAVUS OF THE HAND.

OCcurring IN THE SERVICE OF

DR. EDWARD BENNET BRONSON,

Professor of Dermatology, New York Polyclinic.

REPORTED BY

DR. GEORGE THOMAS JACKSON,

Clinical Assistant.

GEORGE M., æt. 19, U. S., dry-goods elerk, presented himself for treatment at the Polyclinic on May 21, 1884, on account of an eruption upon his left hand. He is a man in good health, and of cleanly habits.

He stated that about one month ago a small red scaly spot appeared upon the lower and inner part of his left palm, which he picked at, and from there the eruption spread in a constantly enlarging circle. About one week after the beginning of the disease, some red pimples appeared upon the inner edge of the hand, at the outer rim of the ring, which developed into raised crusts.

Present condition.—The eruption is upon the left hand alone, and, as will be seen by reference to the accompanying illustrations, presents a well-marked circular shape, the border or rim being formed of a series of vesicles which are not fully distended by their opaque contents. The ring turns round the inner edge of the hand, running for a short distance upon the back of the hand, and also extends up between the little and ring fingers almost to the second joint of the ring finger. Everywhere the rim of the ring is composed of well-defined vesicles, excepting where it approaches the back of the hand, and here are found four perfect and one imperfect favus crusts, grouped together, occupying the site of the

just-mentioned pimples. They answer to the classical description of favus crusts, being sulphur-yellow cupped crusts, elevated above the level of the skin. The surface of the hand included in the rings is scaly, looking as if the epidermis had been roughed up; otherwise it is not much altered. Were it not for the presence of the crusts, it would be difficult to make the diagnosis from trichophytosis.



Being questioned as to the mode of his acquiring the disease, it was found that a great many mice were caught in his shop, upon the heads of which he had noticed some yellowish crusts. Subsequently he brought us three of these mice which were fine specimens of favus.

The treatment consisted in painting the whole diseased surface with a ten-grain solution of the bichloride of mercury in alcohol, which was repeated twice at an interval of two days, and resulted in a complete cure.

Correspondence.

DERMATOLOGY AND SYPHILOGRAPHY IN FRANCE.

LUPUS TUBERCULOSIS OF THE CONJUNCTIVA—ANATOMICAL TUBERCLE—XANTHELASMA—ERYTHRASMA—BACILLUS OF ERYSIPELAS—SCLERODERMA AND SCLEREMIA—INTERNAL USE OF CHRYSOPHANIC ACID IN CUTANEOUS DISEASES.

THE great question which continues to interest French dermatologists is that of the identity of LUPUS and TUBERCULOSIS. In my previous letters I have made you acquainted with the researches of Cornil, Leloir, Besnier, and others, upon this subject. A new critical review of H. Martin, upon the etiology and nature of lupus, has just appeared, and constitutes a plea in favor of the tubercular nature of this affection. Even in the Hospital St. Louis the two contrary opinions have each their partisans, counting among them our most noted dermatologists. On one side, M. Besnier, basing his opinion upon certain unfortunate coincidences which he has observed, of lupus occurring in connection with pulmonary tuberculosis, and especially the histological examination, the presence of bacilli in the lupus nodules, and certain successful inoculations upon animals; on the other side, M. Vidal, basing his belief upon the numerous negative facts which his large practice has furnished, upon the numerous negative inoculations, and especially upon the clinical features—upon the aspect; the evolution, so different, of true cutaneous tubercle and true lupus. Each side brings forward each day new documents; a thèse in support of the ideas of M. Besnier has been announced, and we now have before us one which confirms the views of M. Vidal.

Dr. Luc, during his term as interne of the *Hôpital St. Louis*, has had occasion to study LUPUS OF THE CONJUNCTIVA; he was much surprised to observe in a phthical patient who had true tubercular ulcerations of the conjunctiva, that they did not at all resemble lupus of the same region. This has been the origin of his work upon tubercle of the conjunctiva compared with lupus of this membrane, a work by so much more important as it emanates from a man who had no preconceived ideas upon the subject—M. Luc having never been a pupil of Dr. Vidal.

According to this author, the following are the clinical characters which enable us to trace a distinct line of demarcation between lupus and tuberculosis of the conjunctiva. Conjunctival tubercle occurs in patients suffering from tuberculosis of other organs, while lupus patients attacked with lupus of the conjunctiva are not more apt to become tubercular than other patients, the psoriatic, for example. Conjunctival tuberculosis makes its debut by small protuberances which, at first opaline-yellowish, then end by evacuating their softened centre and forming small crateriform ulcerations; lupus of the conjunctiva, on the contrary, takes on a slightly vegetating aspect, it is never frankly ulcerative. Conjunctival tuberculosis is characterized by depressed sinuous ulcerations with granular base, the borders punched out; they are the seat of an abundant purulent secretion, and around them are perceived here and there a crop of yellowish points. These yellowish points and this abundant secretion are never observed in lupus of this region. Finally tuberculosis of the conjunctiva is accompanied with quite intense lancinating pains, with sensations as of the presence of sand, of

engorgement of the pre-auricular ganglion, of rapid tuberculosis of other organs, and death in a short time. Lupus of the conjunctiva is indolent, it never determines ganglionic engorgement except when inflamed, it is slow in evolution, may last several years without the general health being involved, and is susceptible of being radically cured by scraping and scarification. These two clinical pictures are so very different that Dr. Luc thinks that he is authorized in concluding that lupus can never be regarded as a variety of local tuberculosis.

This question is at present still farther complicated by that of ANATOMIC TUBERCLE; this lesion, as is well known, consecutive to certain pricks which may be received either in performing an autopsy or in dissecting, resembles very much in its general aspect sclerous lupus. Dr. Vidal has suggested, in a recent article, that this lesion may result from the inoculation of a true tubercular product; I have seen, in the case of one of my friends, a dissecting tubercle develop from a puncture received in performing the autopsy of a phthisis patient. Dr. Verneuil has confirmed this opinion in a very interesting communication made to the Academy of Medicine, January 22. He reports the history of a medical student who pricked himself while performing an autopsy in July, 1877. He observed that there soon developed around the punctured point a tubercle which has since continually extended, the mode of extension being always the same in the neighborhood of the affected part: a small whitish point develops which suppurates, increases in size, becomes papular, then papillomatous, and finally unites with the principal mass. In 1880 the lesion had changed in aspect; it no longer resembled an anatomic tubercle, but rather a scrofulous ulcer; it had formed an abscess on the back of the hand presenting all the characteristics of a tuberculous abscess. Professor Verneuil amputated the diseased finger, opened the abscess on the back of the hand, and after prolonged treatment effected a cure of the several wounds. In 1883, the patient, whose health had been sufficiently re-established to enable him to practise his profession, observed in the lumbar region two cold abscesses, probably tuberculous. At the present time his internal organs remain healthy, but the same fate may be anticipated of our unfortunate confrère as of Laennec, who, when making an autopsy on a tuberculous patient, scratched himself with a saw. There developed in the neighborhood of the injury a small tumor, in the centre of which a whitish spot appeared. He cauterized it with chloride of antimony. Several years afterwards he died from tuberculosis.

All these facts seem to prove that true tuberculosis is inoculable, that when once inoculated it may remain localized during a certain time, and then become generalized. It is proper, however, to demand a much larger number of probatory facts before coming to this conclusion, and on the other hand, it is possible that anatomic tubercle, or rather certain varieties of it, may be the result of the inoculation of the bacillus of tuberculosis. Nothing proves incontestably that the same may be true of typical lupus vulgaris. It should not be thought that these questions are simply theoretical and without any practical bearing. These discussions, which seem to be purely scientific, result practically in the rejection or adoption of the methods of treatment of lupus at present most in vogue, viz., scraping and scarification.

In a previous letter I have already given the views of M. Besnier upon this subject. In the opinion of this eminent authority, the bloody method ought to be entirely abandoned as dangerous, as being likely to lead to the auto-inoculation of the disease which he regards as bacillary, and to general infection. Only topical applications and cauterization with the galvano- or thermo-cautery should be employed. Such has been the method of procedure he has employed during the

past year in his service in the Hôpital St. Louis, making, in the intervals between the cauterizations, applications of the sublimate upon the affected surfaces, and he has obtained excellent results. Formerly he practised racleage of the anatomical tubercles, and thus obtained a radical cure in a single séance. At present, he has abandoned racleage for fear of determining general infection by auto-inoculation, and cauterizes the tubercles with the galvano-cautery. He effects a cure by this latter method, but much more slowly, several séances being necessary.

There is another cutaneous malady of which one of our French histologists, Dr. Balzer, would make a parasitic affection, viz., XANTHELASMA. According to him, it is a general malady, infectious, most often appearing as small yellowish spots, first upon the eyelids, but tending to become generalized. He has based this theory upon his discovery of numerous microbes in the nodules of xanthelasma.

Unfortunately, Dr. Hanot having recently had a patient in his service suffering from xanthelasma and wishing to verify the parasitic nature of this affection, removed a number of the nodosities, and made sections which he prepared and colored in various ways; but notwithstanding the number of his preparations and the multiplicity of his procedures, he was unable to discover a single microbe. We must do this experimenter the justice to say that he does not think himself justified in concluding from these negative results the non-existence of the microbe of xanthelasma, but we must agree with him that this difficult question demands still further investigation.

Dr. Balzer, continuing his interesting micrographic studies of cutaneous diseases, has just published an article in the *Annales de Dermatologie* upon a dermatosis as yet but little known—ERYTHRASMA. It is known that this affection, already described by Burchardt in 1859, and by Bärensprung in 1862, and attributed by them to a well-defined parasite—the *microsporon minutissimum*—has since been confounded in Germany even with the trichophyton cutanei.

M. Balzer demonstrates, on the contrary, that it is a dermatosis *sui generis*, having a special symptomatology and a particular parasite. It has a predilection for the inguino-cruro-scrotal region; most often it is limited to the parts in contact with the scrotum, the thighs, the buttocks, and even the abdominal region. In certain rare cases it may be observed upon other regions of the body, especially upon the articular flexor surfaces. In the majority of cases it presents itself in the form of irregular patches, the borders of which may be diffuse or neatly circumscribed; their coloration is sometimes red, somewhat brownish or dull, more pronounced at the periphery than at the centre, and in some cases resembles the peculiar parasitic rustiness. Sometimes, on the contrary, it is of a vivid red, indicating a certain degree of inflammation of the integuments; the patches are then slightly scaly, the epidermic shreds are with difficulty separated from the surface. Ordinarily they occasion only a slight pruritus, causing the patient so little discomfort that he may be not aware that he has the affection. He only perceives it by chance, at least when the patches are not inflamed, consequently they have as a rule already attained to considerable dimensions when the physician is consulted. It is only necessary to take a few scales from the surface, wash them in ether or alcohol, then examine them in sol. potash, 40 per cent, in order to distinguish clearly the vegetable growth, the *microsporon minutissimum*. This parasite is quite abundant, and its element are arranged in the same manner as those of the *microsporon furfur* (pityriasis versicolor). The spores are very minute, rounder or slightly elliptic, grouped in irregular masses. The tubes of mycelium are of extreme fineness; they are irregular, knotty, ser-

pentine, ramified. The vegetation is found only in the horny layer of the epidermis.

This affection is without gravity; it may be the occasion of a pruritus sufficiently intense to be uncomfortable. The treatment is essentially the same as that of pityriasis vesicolor. The author insists especially upon the efficacy of soap frictions, but he recommends them to be continued for a long time, otherwise one does not succeed in entirely eliminating the parasite, and the disease recurs.

Without doubt, questions relating to parasitism in diseases are at present most eagerly studied. I cannot give in detail the interesting lectures of Dr. Cornil upon the inflammations of the skin determined by the microbes of jequirity. The subject is hardly of sufficient practical interest, and the details would occupy too much space. I will, however, say a word as to investigations of the same authority into the pathological anatomy of erysipelas. Quite recently Fehleisen has proved that this affection is caused by bacteria which he has cultivated, and he has even given erysipelas to patients by inoculating them with this culture fluid. M. Cornil has verified, at least in part, the facts advanced by this authority. According to our histologist, the primitive essential lesion consists in the presence of numerous bacteria infiltrating the inflamed tissues. These bacteria are quite minute. They are constituted of spores re-united in chaplets, which often present a sinuous form. They form groups which are situated in the interfascicular spaces, in the vessels, lymphatics, and the subcutaneous adipose tissue: in the fat globules they occupy the fatty cells themselves, and the protoplasm which surrounds the fat globule. One of their seats of predilection is the periphery of the hairs. It is probable that they likewise exist in the sheath of the hair, and this disposition affords a ready explanation of the fall of the hair so often observed in erysipelas of the hairy scalp.

At a superficial examination the bacteria of erysipelas might be confounded with certain albuminous granulations, but they may be distinguished by staining with aniline, which gives a strong coloration to the bacteria.

In an interesting note in the *Medical Weekly*, Dr. Besnier, in response to a communication of Köbner to the Medical Society of Berlin, gives his views upon the morbid groups, as yet but little understood, comprehended under the general term SCLERODERMA. He thinks it necessary to divide all cases into two principal classes, one embracing the cases in which the sclerous lesion is generalized, or at least involves considerable portions of the integument, affecting especially the face and upper extremities. It is a diffuse lesion, so to speak; it corresponds with the scleroderma of Guitrac, to the concrete oedema of Doublet, to the sclerema of Chaussier; it is the generalized sclerema of Alibert, the sclerema adutorum of Thirial, the oedematous scleroderma of Hardy. M. Besnier proposes to give to this affection, so well defined in its clinical type, the name of *sclerémie*. The second class is characterized by the fact that the sclerous lesion is localized in certain portions of the integument. It is not so well defined as the first; it is probable that it embraces several morbid types not well defined, and among which M. Besnier distinguishes morphoæas or *Sclerodermie en plaques*, the *sclerodactylie* of Ball, and the *Sclerodermies asphyxiques et mutilantes* of the extremities. He reserves for these several forms, which are all circumscribed in character, the name of *sclerodermies*.

In conclusion, permit me to say a word in regard to a work which, although published by a Belgian physician, should nevertheless find a place in this correspondence, since it has appeared in France and was written by a Frenchman. It is a note upon the internal administration of chrysophanic acid, by stomach or

hypodermically, in the treatment of diseases of the skin. The author, Dr. Stockquart, of Brussels, has treated sixty-one cases of skin disease by the internal use of chrysophanic acid, without employing any local treatment whatever. All the cases of acne except one case of inveterate papular acne, all the cases of ecthyma and impetigo were rapidly cured; the same is true of urticaria. In lichen the pruritus was quickly suppressed, even before the disappearance of the eruption. In a case of prurigo, the improvement was not perceptible for a long time; the other cases of this affection rapidly yielded to the new medication. In 32 cases of eczema he obtained 30 cures; in 5 cases of psoriasis, 3 cures. He has prescribed the drug suspended in water, the bottle to be well shaken before it is used. It may also be used in the form of powders or pills. The average dose for children is 1 centigr., and for adults 3 centigr. daily. Still, he has given it in doses of 20 to 30 centigr., without the least inconvenience. On the other hand, some patients manifest symptoms of intolerance when the drug is given in relatively small doses. It is desirable to test the susceptibility of patients by commencing with small doses, otherwise it may determine gastric troubles or intestinal irritation. Dr. Stockquart has also tried the administration of chrysophanic acid hypodermically. He has been able to satisfy himself that this method was particularly efficacious, and that the eruptions disappeared after the injections with a marvellous rapidity; one case of prurigo was cured in two days, four cases of lichen, one of eczema, one of psoriasis, and one of urticaria were cured in four days, after one or at most two hypodermic injections. Unfortunately the acid often occasions abscesses of the subcutaneous cellular tissue. This accident was observed by the author in the cases of psoriasis and urticaria after a single injection containing one centigramme of the chrysophanic acid; in a case of lichen, in which two milligrammes were used, and in another of lichen, in which only one milligramme was employed. The author thinks that this method should be restored to only in cases of absolute urgency.

From his investigations he concludes that the internal use of chrysophanic acid should be employed in the case of inveterate dermatoses, and when the eruption is situated in points where it is difficult to make topical applications. However this may be, we think that additional provings of this method are necessary, as the cases of Dr. Stockquart are not sufficient in number to justify conviction, and besides his therapeutical precepts by no means possess the precision which is desired.

BROcq.

PARIS.

A CASE OF PRIMARY SYPHILIS OF A FINGER.

To the Editors of Journal of Cutaneous and Venereal Diseases.

DEAR SIRs:—On January 25, Mr. D., restaurant keeper, a large heavily built man, consulted me for a peculiar looking sore upon the right index finger just under the nail. The appearance presented was that of a very shallow ulcer seated upon an inflamed indurated base. The amount of infiltration was so great as to give a bunched appearance about the nail and was out of all proportion to the size of the ulcer.

The patient stated, that while opening oysters he pricked his finger with a piece of shell. The surface was thoroughly treated with nitrate of silver. He presented himself again in a few days with the finger in the same condition as before, still considerable induration, and surface of sore not disposed to heal. Still regarding it as an irritated wound, the possibility of syphilitic inoculation

did not suggest itself to me. A twenty grain to the ounce iodoform ointment was now applied on general principles, and under its persistent use for three weeks the surface healed, but left behind a clubby, misshapen finger end.

Our patient did not show himself again until March 22, when he complained of a tired languid feeling, anorexia, headache, and evening fever. His tongue was heavily coated. Still unsuspecting of syphilis, and thinking he might be troubled with a torpid liver, I prescribed the usual remedies and followed them up with a tonic. He presented himself again on the 28th, saying that he felt better, but not all right yet. He, now, in a rather unconcerned manner, directed my attention to an eruption upon the arms and neck.

This consisted of numerous prominent dull-red papules, varying in size. The largest ones were found upon the neck, and a few here and there were inclined to scale. A more thorough examination disclosed the fact that the eruption was a generalized one. The outbreak was entirely of the papular form. There were no other lesions. Inquiry now elicited the fact that his throat had been sore for about three weeks. (It could not have troubled him much, as he had not spoken of it before.) The cervical and epitrochlear glands were slightly enlarged. The diagnosis of syphilis was now made, and the nature of the disease was explained to the patient. He admitted that about two weeks before he first presented himself, he had been fooling with a loose woman and had placed his finger in her vagina.

The finger undoubtedly became inoculated at the time, and the strangely obstinate sore was, in the light of what followed, plainly a true hard chancre, with more than the ordinary induration. Now, to take a retrospective glance, we have a sore which heals in three weeks under alterative applications, the induration remaining.

From the first indications of a sore up to the first cutaneous expression of the disease, we have a period of invasion of nine weeks. The malaise, cephalalgia, and slight elevation of temperature which preceded the eruption about a week, and which were mistaken for biliousness, were plainly due to the primary syphilitic fever.

This patient had a gonorrhœa and orchitis two years previously.

We sometimes learn from the mistakes of others. If the report of this interesting case will teach my medical brethren to be on their guard, or throw any light upon the early recognition of the extra-genital chancre, it will perhaps have served a useful purpose. Most respectfully yours, CHAS. P. RUSSELL, M.D.

UTICA, N. Y.

Selections.

THE TREATMENT OF SYPHILIS.

IN connection with this much-disputed topic, the only positive rule which it is possible to lay down is, that the treatment of syphilis should always be in strict accordance with what is known concerning the essential nature of the disease. As respects the latter point, our ideas within the last few years have undergone considerable change—or rather have become more settled. The most industrious and skilful investigations have hitherto failed in detecting the actual

virus of syphilis, but I entertain not the slightest doubt that it is an *organized product*, and I regard the discovery of the *syphilitic bacteria* as merely a question of time. Thus far, their existence is only an assumption; yet on such firm grounds does this assumption rest that it must necessarily exercise an influence on our conceptions of the malady. And in fact, all the peculiar features of syphilis—its infectivity, its symptoms, and its transmission by descent—can be shown to harmonize precisely with the theory of its bacterial origin.

This being regarded as settled, three questions come up for consideration in relation to our special theme. These are—When should the treatment of syphilis be commenced? What method of cure should we adopt? How long should the treatment be continued?

I. *When should the treatment of syphilis be commenced?* I reply—*not before we are quite certain of our diagnosis.* This may seem a mere truism, yet it is one which I am called upon to emphasize, in view of what we all know to be a very prevalent practice. There are many physicians who look upon every sore arising from sexual intercourse as syphilitic, and proceed at once to attack it accordingly. This is the result neither of faulty diagnosis nor of recklessness, but of too strict an adherence to a certain general theory—the theory, namely, which regards the virus of the soft chancre as identical with that of syphilis, and the difference between the symptoms of the two disorders as caused merely by a difference in the affected tissues, or by some other accidental circumstance. Now, as between this opinion and that of the *dualists*, I have no hesitation in expressing my most decided agreement with the latter—*i. e.*, with those who look upon the above mentioned diseases as entirely separate and distinct, as caused by different poisons, and their co-existence in the same subject as due to a simple coincidence. And in renouncing the unitary conception of the disease, of course I reject also its legitimate result—the immediate treatment of all venereal ulcers. Nevertheless, instances are frequently encountered in which this immediate treatment, in anticipation of a certain diagnosis, is resorted to even by professed dualists. I refer to those cases where a soft chancre is succeeded speedily by an outbreak of genuine syphilis—*i. e.*, after an incubation of three weeks, by first a primary sore, and then, in due succession, by the other characteristic phenomena of the disease. But even this occurrence does not justify a departure from the rule I have announced, for it should be considered as really due to the combined operation of two different poisons, that of soft chancre and that of syphilis, whose germs have been accidentally deposited at the same time in the same subject, and both of which have run their typical course. Therefore (if we adopt the dualistic view) the existence of a soft chancre is not to be depended upon as affording the slightest evidence that real syphilis is about to follow, or as constituting a sufficient ground for resorting to specific medication. This latter should be instituted only when unequivocal signs of syphilitic infection have manifested themselves. The observance of this precept will no doubt often result disagreeably for the physician, by obliging him to keep his patient for several weeks in a state of suspense and apprehension. *This, however, is a something which must needs be endured until such time as the demonstration of the characteristic bacteria in the chancreous secretion shall enable us to recognize the disease at once*, instead of waiting for the development of its symptoms. *After this delay, the specific induration generally makes the diagnosis clear, when the affection is situated on the epidermis—as, for instance, on the lips of the urethral orifice. But when seated on the mucous membrane, especially that of the female genitals, it can rarely be identified as a primary syphilitic phenomenon, since here the formation*

of a sclerosis is anatomically impossible. In this case our decision must be postponed until time enough has elapsed for the supervention of constitutional symptoms.

An aid to diagnosis is often afforded us by the *lymphatic glands* in connection with the part first affected, whatever its location. These glands not unfrequently become indurated almost as soon as the primary sore itself, the difference in time being only that which is required for the passage of the bacteria from the one situation to the other.

But whenever our diagnosis is made, or however we arrive at it, the same rule holds good—that our treatment of syphilis should begin just as soon as we are certain the disease is present. Guided, in this case, as already said, by our conception of the bacterial nature of the virus, our path lies plainly before us: we must, as speedily as possible, effect the destruction of the disease-producing germs. The simplest and most direct means of accomplishing this object would be by the immediate removal of the earliest focus of infection. Unfortunately, for the reasons given above, such prompt action is inadmissible. We must defer the procedure for about three weeks, until the nature of the complaint has been established by its visible manifestations.

But when these manifestations have occurred, *is it not still possible to obviate all risk of constitutional contamination by destroying the chancre itself?* This is what was perseveringly attempted in a variety of ways, until the doctrine gained ground that the local affection was merely the expression of a general disease, and that, therefore, the removal of the former must necessarily be unavailing. It is only recently that the old-time theory and practice have been reverted to, as in full accordance with the bacterial notion of syphilis, and now we direct our efforts to the extirpation of the primary sore, in the hope of thus preventing, at a single stroke, the extension of the mischief. That is, we regard the initial induration as simply *the local focus of infection, as the centre in which the syphilitic virus is developed and from which it spreads, and consequently as the chief, if not the only, source of general contamination.*

Staunch advocate though I am of this method, I must confess that its results thus far have not corresponded with our anticipations. Such excisions have been made in numerous cases, which yet have developed constitutional symptoms. How is this comparative failure to be accounted for? On the ground, oftentimes, in my opinion, that the operation did not succeed in thoroughly removing *all* the morbid germs, but left them behind, here and there, in sufficient quantity to bring about the general infection. But besides this, I believe that, in the majority of such instances, the excision has been made *too late*—constitutional contamination having already occurred, although undiscoverable by our present means of investigation. Despite these untoward results, I still regard the procedure in question as an advisable one, and I employ it myself in all cases where it is not forbidden by the localization of the sore on the glans, the corpus cavernosum, the lips of the urethra, etc. In my opinion it is recommended, in the first place, by the rapidity with which healing is established—especially under antiseptic precautions—and secondly, by the possibility (even if it is nothing more) that secondary symptoms may by this means be entirely prevented—a consideration in itself sufficient to justify a resort to harmless and locally advantageous an operation. I will also suggest that, very probably, reasoning from theory if not from practice, the progress of the disease may in this way be rendered milder, in cases where it cannot be entirely stayed.

On similar grounds, I am strongly in favor of *extirpating the lymphatic*

glands when primarily affected, although this is a measure which cannot be so safely attempted by the general practitioner as the simpler one I have just referred to. In the case of a soft chancre, on account of its extremely infectious nature, the excision, if ventured upon at all, must be preceded by a thorough destruction of the specific virus, and accompanied by the strictest antiseptic precautions, if we would prevent the wound from becoming poisoned.

Finally, in deciding upon the feasibility of this operation, we must be governed by the circumstances of the individual case.

When excision is out of the question, or when we have reason to believe that general infection has already taken place, I would advise *that constitutional treatment be at once entered upon*. And here I must express my dissent from those teachings, emanating from the Vienna school, according to which such treatment may be wholly, or almost wholly, dispensed with. Sigmund, in particular, has reported that nearly forty per cent out of his numerous syphilitic patients got along so well of themselves that they did not appear to require any constitutional treatment. This is opposed, however, to the experience of the French authorities, and particularly of Fournier, who found that the severest forms of secondary syphilis were manifested in those cases where the initial symptoms had been remarkably mild. We are not to conclude from hence that the disease showed increased malignity in its later stage, *because* the primary affection had been of an opposite character; the simple fact was that treatment during the earlier period, being regarded as unnecessary, was completely neglected, and it is this neglect that must be held responsible for the subsequent aggravation.

This is only one out of numerous instances that might be adduced to show how little confidence can be reposed in statistics with reference to the complaint we are considering. If, in judging the issue thus raised between the above-named authorities, I take the side of Fournier, it is on theoretical grounds only—since, assuming syphilis to be a bacterial disease, I infer that it is best treated by means adapted to remove the micro-organisms and prevent their reproduction without injury to the general system. It is my firm conviction that such an agent is only to be found in *mercury*, and therefore I do not hesitate to say that *every syphilitic patient ought to be brought under the influence of that drug, as soon as the nature of his case is ascertained*.

In view of the harmlessness of this remedy, the maintenance of a passive attitude in reference to the disorder appears to me to involve a positive sin of omission.

But it may be asked, why not rely upon mercury in those cases where there is only a possibility that syphilis may have been contracted—*i.e.*, in every form of suspicious erosion and ulceration? I answer that here, against the bare *possibility* referred to, must be weighed, the *probability* that the course pursued will result, not in the eradication of the malady, but in the temporary suppression of those symptoms by which alone its real character is made known, so that the latter will be merely disguised by a deceptive appearance of restored health. It is unnecessary to insist upon the dangers which may be incurred by the patient and his family through a mistaken or even a doubtful diagnosis under such circumstances. We must, therefore, adhere firmly to the principle proclaimed at the outset of these remarks: *Never to resort to antisymphilitic measures until we are assured that it is syphilis with which we have to deal*.

II. *What method of cure should we adopt?* I regard *inunctions* as the best means of obtaining the antisymphilitic effects of mercury. Mercurial baths I em-

ploy only when circumstances forbid the use of inunctions, or when the treatment has to be repeated two or three times successively in the same long-standing case. Müller and Stern's solution of sublimate with soda, or the mercurial pепtones, are preferable for subcutaneous injections. When properly prepared, the foramid, lately recommended by Liebreich, is advantageously employed in this way, by reason of its almost absolute painlessness, but has not yet been sufficiently tested as to its efficacy in preventing relapses. For internal use, I prefer corrosive sublimate in small doses. It is best given as a watery solution, with common salt and plenty of milk, so as to lessen its disturbing action on the stomach and bowels. The yellow iodide of mercury is much better tolerated by many patients, but is in great part passed off in the stools.

III. *How long should constitutional treatment be continued?* This question is easily answered as regards the cases characterized by frequent relapses. Here the use of mercury should be suspended at intervals depending upon the constitutional effects of the drug, the state of the patient's nutrition, etc.; it being also borne in mind that mercury loses its peculiar action when administered uninterruptedly for too long a period. This latter consideration led Fournier to formulate his so-called "alternate and intermitting method," according to which the mercurial treatment is kept up for at least one and one-half to two years, with gradually increasing pauses of from four to eight weeks each, during which iodide of potassium is substituted.

When the complaint has passed into the *tertiary* stage, iodide of potassium is the sovereign remedy—and it must not be given in too small doses. Experience, moreover, has recently established that a combination of this drug with mercurial inunctions is of special value in severe syphilitic affections of the brain and spinal cord. Here, too, we should remember Fournier's maxim "as well do nothing as not do enough," and administer the mercury freely.

But what shall be said of those cases in which the early symptoms are few and mild, and are apparently succeeded by a complete return to health? Does the disease in them remain latent and liable to break out at any time, or is it actually and permanently cured? To this question no general reply is possible, in the present state of our knowledge. No test can be applied, no sign discovered, which may serve as an unerring guide. This being so, I hold that every patient in whom the disease has thus manifested itself should be regarded *as still a syphilitic and a fit subject for the mercurial treatment just referred to*. This treatment, in short—assisted, when necessary, by iodide of potassium— I would employ in *every* case of syphilis, with but three exceptions, viz., when tuberculosis or severe scrofulosis coexists; when there is a decidedly anæmic or cachectic condition, and, finally when the form of specific disease presented is that known as "galloping syphilis." In this last, generally invigorating measures are alone called for, until the resisting capabilities of the organism have been so far restored as to admit of a return to direct antisymphilitic medication. Here, as always, *our plan of management and the doses we prescribe must be adapted to the patient's constitutional peculiarities, as well as the nature of his disease*.

Aside from these special conditions, I believe that Fournier's method is that which is preferable in the greater number of syphilitic cases, and this belief is founded solely upon my faith in the bacterial origin of the disease.

It need scarcely be added that, in conjunction with specific medication, the patient's strength must be supported by suitable nourishment and favorable hygienic surroundings. The *lowering diet* so frequently advised in the earlier

stages is altogether a mistake, except in the case of overfed and very plethoric individuals.

The long-continued mercurial and iodide treatment deserves to be considered, moreover, in relation to the *hereditary transmission* of syphilis. We know that when the disease runs its natural course, the liability to such transmission tends to diminish spontaneously at a certain rate: but this tendency may be decreased by the judicious administration of mercury. Now, since the degree of transmissibility has nothing whatever to do (apart from the effect of remedies) with the presence or absence of syphilitic symptoms, it follows that any course of treatment which depends upon the latter must be absolutely worthless, in this regard. Looked at from a kindred point of view, Fournier's plan of cure assumes additional importance when we consider that it demands not only a certain lapse of time between the infection of a subject and his *marriage*, but also the employment during this interval of vigorous therapeutical measures.

A word may be expected before closing in relation to Guntz's "chromwasser" treatment. This, in my opinion, does not possess the advantages claimed for it by its inventor. His own communications on the subject—especially his numerous clinical histories—are quite sufficient to prove that he is still far from having attained his object.—A. NEISSER, *Deutsche med. Wochenschr.*, Jan. 3 and 10 1884.

LUPUS VULGARIS—ITS TREATMENT BY THE LOCAL APPLICATION OF SULPHUROUS ACID.

MR. JONATHAN HUTCHINSON, in a paper recently read before the medical society, urges that the term "lupus" should not be employed in its present restricted sense, but that it ought to have a wider signification, and be made to include a whole group of diseases possessing natural and close affinities.

Mr. Hutchinson also considers that the definition of this term should be a clinical one, and supports this view with considerable power, and with his rich store of practical knowledge.

Yet it is not by a pathological light, rather than by a clinical investigation that we have ascertained the links of connection between the several types of lupus.

In the present immature state of our knowledge of the true nature of this disease, would it not be better to accept a pathological definition, perhaps the following: A new growth of the skin or mucous membranes, accompanied by active congestion, and followed by exfoliation, degeneration, and interstitial absorption or ulceration, and terminating in scar-formations. Now, although for the sake of pathological accuracy this definition is made to include mucous membranes, it is most important to bear in mind that these tissues are never primarily affected, but always become implicated by extension.

I cannot help laying great stress upon the significance of this latter point, as of much diagnostic value in discriminating between true lupus and certain of its so-called allies, more especially those associated with tertiary syphilis; and as a most interesting illustration of this point, I may be permitted to cite the following case:

Margaret A., aged twenty-five years, was brought under my notice in March last by a medical friend, who supposed her to be suffering from lupus vulgaris.

In this case there had been extensive and deep ulceration of the nostrils, lips (the upper one being almost entirely destroyed), cheeks, and forehead, where the

left margin of the ulcerated surface was very considerably thickened, and covered with rough congested skin. In addition there were swellings over the sternal end of the right clavicle and right acromio-clavicular joint; the former about the size of half a walnut, covered with thin congested skin, had some semi-fluid contents, and the latter, about twice as large, was excavated by ulceration similar to that on the forehead. There was also a large and irregular perforation of the palate.

Her family history was good; no indication of syphilis or lupus in any other member. Her parents were in a respectable position.

Feeling confident that the case was one of syphilis, we ordered large doses of iodide of potassium, with bark and ammonia. This treatment was followed by rapid subsidence of all lupoid action, and the patient gained rapidly in health, and strength. At the present time, her deformities alone mark where the disease has been.

In this case, although we had a history of keratitis at the age of sixteen, four years before the disease had declared itself, we had nothing else particularly indicating the existence of syphilis but the mode of onset, the *spreading of the disease from a mucous to a cutaneous surface*.

My chief object, however, in obtruding myself upon the notice of the profession is to present what I must humbly consider to be one of the most successful methods of treatment yet brought to light for lupus vulgaris—the local employment of sulphurous acid to the ulcerated surface.

In nine cases treated by the local application of sulphurous acid, I am able to record five distinct cures, three in which great improvement was effected, but which, unfortunately, passed from my hands before a cure could be concluded, and only one in which a negative result was obtained, this last being under treatment for fourteen days.

And this form of treatment will, I am sure, be not the less acceptable because it is free from the usual modifications of cutting, bruising, burning, etc., now so generally resorted to, and consists simply and wholly in the employment of a slightly irritating application to the ulcerated surface of the disease.

Sulphurous acid has long been recognized as a valuable disinfectant and parasiticide, and has been in frequent use for most of the local skin affections connected with the presence of living organisms. It has also been much advocated by various authorities for such general affections as tonsillitis, malignant sore throat (scarlatinal and laryngeal), diphtheria, croup, influenza, and chronic phthisis, locally applied, and internally administered, whilst in typhus and typhoid it is in great repute abroad, its advocates claiming that by its employment in large doses these fevers are diminished in both severity and duration.

Besides its germ-destroying influence, sulphurous acid also exerts a powerfully stimulating action when applied to the surface of open wounds, and I have particularly noticed its excellent effects upon certain indolent ulcers, which have resisted the influence of many other modes of treatment, including carbolic acid. In fact, my experience of its use in these particular cases compels me to consider that it is preferable to the latter in most forms of simple ulceration. It is far less irritating, and consequently may be employed where carbolic acid would certainly do harm. Its stimulating influence may account, then, to some extent, for its beneficial effect in lupus vulgaris. In gonorrhoea its effects, as an injection, are most happy, and I shall shortly publish the notes of one hundred and twenty cases of this disease treated by its local employment.

In the local employment of this remedial agent, it may be applied in the form

of a lotion, or an oil, or in the gaseous state. This last-named modification is most useful when its application is required to parts distant from the respiratory organs, and can readily be obtained by burning sulphur in a jar or open-mouthed bottle, and allowing the rising fumes free contact with the surface to be treated. The frequency and duration of these fumigations will mainly depend upon the progress made during its employment, but, as a rule, two applications daily, each for about twenty minutes, will be found sufficient to produce the healing effect of the remedy.

The lotion is best obtained by the use of the pharmacopœial preparation of the acid, either alone, or diluted to relative strengths of one in two, one in three, or one in four; the last preparation is the weakest which should be employed. It is a clean and simple mode of application, and can be applied to any part of the face without causing disagreeable effects, the great objection to its use being that it has to be constantly repeated, and evaporates much more quickly than when employed in the form of an oil.

This last-named method is my favorite form of applying the remedy. It is best made by dissolving the anhydrous acid (which may be procured at all druggists in the shape of a concentrated alcoholic solution) in castor or olive oil. I may state that I consider the former to be preferred as a vehicle, as it holds the acid in more complete solution, parts with it less readily, and forms a more perfect covering to the surface of the wound. The anhydrous acid, mentioned in connection with the sulphurated oil, may also be employed proportionally diluted as a lotion.—HERBERT COLLIER, *Med. Times and Gaz.*, April 26, 1884.

AN EXPERIMENT IN THE TREATMENT OF SMALL-POX.

THE influences chiefly concerned in the production and development of a variolous attack may be distinguished as follows: First, the organism is invaded by the specific germs of the disease. These multiply and become localized in the skin and internal organs, where they bring about necrobiotic changes at small circumscribed centres. This process gives rise to irritation and inflammation of the surrounding tissues, going on to suppuration with all its sequelæ—none of which phenomena are immediate results of the original infection. Purulent points, often in immense numbers, make their appearance on the general surface, which may coalesce, thus forming large abscesses. If all these gray and small deposits were united into one, we could better estimate the gigantic extent of the mischief.

Now, we know how much injury such a vast amount of suppuration must inflict upon the system, and accordingly we observe various morbid conditions to be produced by it, such as parenchymatous degeneration of individual organs (the liver, the kidneys), hepatic and pulmonary abscesses, etc., and, still more frequently, pleurisy—all just like what is met with in a case of pyæmia.

Another danger to the small-pox patient arising from the multiplication of pustules is, that, owing to the destruction of the epidermis over so large a surface, the latter is brought into very much the same condition as after an extensive burn.

The most dreaded consequences entailed by the suppuration are the permanent cicatrices which, in confluent cases, frequently disfigure the patient so frightfully, and which our present resources are almost powerless to prevent. Among the immediate symptoms connected with it must be noted the great pain which is experienced as soon as the skin begins to swell on the face and extremities, and which, as the disorder advances, sometimes becomes unendurable.

If now we look at these features of the disease comprehensively, we shall perceive that its foundation is laid by the infection and the necrobiotic processes immediately resulting therefrom, but that its most intractable and dangerous symptoms (excepting in the *foudroyant* cases) are those caused by the inflammation and its sequelæ.

This is shown to be a correct statement by the fact that death, in ordinary cases of confluent variola, seldom occurs before the termination of the suppurative stage.

From what has been said it will readily be seen how this complaint should be combated. Since we can do nothing to oppose the invasion of the microbes, or to prevent their increase and localization, with the consequent necrobiotic changes, it follows that we should direct our efforts towards the amelioration of the subsequent phenomena, and especially of the inflammation; succeeding in this, we shall obtain a mitigation of all the remaining symptoms.

A very good means for the attainment of this end is found in Burow's solution—a remedy which has long been successfully employed against another infectious dermatitis, viz., erysipelas. Its mode of application is a very simple one, since, for the most part, it is used only on those parts where the eruption is most developed and the pain greatest—as the face and extremities. These are dressed in the regular way, with linen rags dipped in acetate of alumina, afterwards with Brun's wadding, and covered with India-rubber paper; for the face a mask is cut out of the wadding and kept constantly wet with the solution.

I refrain from giving the history of the several cases that have thus far been treated by this method, for the reason that they all presented the same series of local phenomena, which I will now proceed to describe. The dressing having been applied in the above-mentioned manner on the parts chiefly affected, a striking alteration was perceptible within a very few days in the state of the underlying eruption. The latter looked paler, and had lost its red areola; the severe burning and itching had also subsided. The tubercles in these situations continued to increase in size and number, but still remained smaller and less prominent than on the rest of the body.

On the second or third day of the eruption, vesicles began to form, the epidermal covering of which, at first shining and translucent, soon became dull and shrivelled; the vesicles themselves were almost empty.

Here and there, the vesicles now began to rupture, discharging a clear serum the contents of the others soon afterwards became turbid; pustules lying closely together (except when very greatly enlarged) were separated by a distinct margin. Finally, the pustular epidermis dried up, often in a surprisingly short space of time.

After desquamation, the corresponding surface was scarcely at all depressed, and speedily returned to its natural level.

No scarring occurred in any of the cases. Whether this result would always be produced under the same circumstances, must be determined by further observation.

The skin was always swollen, but never to so great a degree as is usually seen in severe cases.

Even the eyelids, when attacked by the eruption, were not thereby prevented from closing, which was a source of great advantage, since the secretion caused by the accompanying conjunctivitis not being retained, the eyes could be kept clean without difficulty, and further complications in this direction as far as possible warded off.

The pain attendant on the complaint was either entirely absent throughout, or was very slightly felt.

The effect of the treatment on the average duration of the malady, from first to last, could not be accurately ascertained, but very probably it was shortened.

The only complications observed were slight bronchial and conjunctival catarrhs. The urine never became albuminous.—G. PH. BRAUN, *Prager Med. Wochenschrift*, January 16, 1884.

PRURITUS HIEMALIS.

THE affection known under this title was described by Duhring (*Phila. Med. Times*, 1874). It is characterized by a more or less violent itching of the skin, which comes on in the latter part of autumn, or the beginning of winter, continuing sometimes only a short time, sometimes during the entire cold season, but always ceasing before the advent of spring. After the age of puberty no period of life is exempt from its attacks, to which both sexes seem equally liable.

The itching is usually felt in the neighborhood of the hips and on the lower extremities, especially the calves of the legs; the hands, feet and scalp are never affected.

In some cases this symptom is only slightly troublesome, in others it becomes unbearable, so that the patient's skin is injured by the constant scratching to which it gives rise. The itching is generally most intense in the evening, especially at bedtime, when it renders sleep impossible; in the morning it is decidedly lessened, or may even cease altogether during the day.

The above-described condition may recur every winter for a period of years.

The skin in these cases presents no outward indications of disease, excepting the lesions produced by scratching.

No etiological influence other than that exerted by climate can be assigned for the production of this complaint. Conditions of regimen, clothing, etc., seem to have as little to do with it as differences in age or sex. Duhring states that pruritis hiemalis is of frequent occurrence in the United States, north of Philadelphia, while it has never been known to appear in more southern latitudes. During his residence in Europe he never met with or heard of a single case of the disease, or of anything resembling it.

In short, judging from the statements of such dermatological authorities as I have been able to consult, it might almost be concluded that this affection is exclusively confined to the northern portion of the American continent.

I know of only a single case which militates against this supposition. It was one which came under my care some time ago in the person of a gentleman thirty-seven years old and of very vigorous constitution, who resides at Cairo, Egypt. For several years he had suffered from an itching on both calves, which began regularly every October, became very intense during the winter, and ceased early in March. In the daytime it was quite endurable, but was greatly aggravated at night, and also by emotional disturbance. He had been unable to obtain relief in any way.

On examination, the patient's organs appeared perfectly sound, and he presented not the slightest indication of skin disease—for, as it happened to be the month of August, even the marks of scratching were imperceptible. The normal sensibility of the integument was also unimpaired on the affected parts.

The patient told us that he was of a healthy family, and had never been seriously ill.

Two noteworthy circumstances are embraced in this history; first; Cairo,

where the patient had lived, is situated some ten degrees further to the south than Philadelphia. The temperature of the former city never falls below 5° C. in winter, while the mean temperature in October, when, as we have seen, the pruritus commenced, is as high as 22.5° C. The winter in Cairo is marked by no extremes either of humidity or dryness. It is not likely, therefore, that the complaint, in this instance, was due to the absolute degree of cold at the latter season; it should rather be referred to the difference between the winter temperature of Cairo and that of its very hot summers. Otherwise, it might have been expected that the patient on his return to his native Vienna would have experienced the warning symptoms of his disorder towards the end of September—which, however, was not the case.

The other important fact to which I would call attention is the aggravation which was always caused in this instance by any considerable mental agitation. This I regard as confirmatory of the idea that the affection originated in a neurosis.

As regards the therapeutics of pruritus hiemalis, there is very little to be said. Duhring was unable to find any permanently effectual remedy. I am inclined to believe that treatment in this complaint with arsenic and the like can be successful only through its action upon the nervous system at large. From my patient I have heard nothing since his departure, and am therefore unable to say how he got through the following winter.

I must confess to having formed no very clear idea as to the mode in which the disease is developed, but probably its symptoms take their rise from the peripheral nerves, and especially from the terminal organs of the latter. In what precise way the nervous system is affected—whether, chiefly by lowness of temperature or by other climatic circumstances—I am without the data which would justify me in deciding.

I am in receipt of communications from a large number of my colleagues, having reference to cases similar to the one above reported, which have been observed in this country. I regard it therefore as highly probable that pruritus hiemalis is not, as we have been accustomed to think, a malady met with only in America, but that it occasionally occurs among ourselves.—H. OBERSTEINER; *Wien. Med. Wochensch.*, April 19, 1884.

NOTES ON THE REGENERATION OF EPITHELIUM AND PIGMENT.

I HAVE noticed for some time in cases of burns and scalds, and chiefly the latter, that when the injury is of the third degree (that is, when the "cutis vera" has only been partially destroyed), healing has frequently taken place with great rapidity, although the superficial extent of the ulcer after separation of the sloughs may have been very great; and further, that in such cases the rapid healing has been due to numerous foci of cicatrization, which have sprung up spontaneously, and given the ulcer the appearance of having been successfully grafted. I have never observed this rapid process of healing in cases where the injury was of the fourth degree, that is to say, where sloughing had extended down to the subcutaneous tissue.

No adequate explanation occurred to me until recently, when I had under observation an adult negro, who, ten days before I first saw him, had sustained an extensive scald, involving the whole anterior and lateral aspects of one leg. It was chiefly of the second degree, the cuticle and its pigment having been removed

by the blistering, but in the centre there was a patch about three inches in diameter, where the injury was of the third degree, superficial destruction of the corium having occurred; this portion was then a granulating ulcer. On the fourteenth day after the injury the superficial scald was of a pinkish red color, but studded with numerous black dots, of which about from sixty-five to seventy were contained in an area of one square inch; they were arranged in more or less regular lines, and through the centre of many a hair was seen to be protruding; the size of the majority of them was not larger than that of a pin's head; they were evidently the orifices of the hair follicles. On the surface of the granulating portion were seen many white spots, islets of epithelium, some of them having already a central black dot. The ulcer healed rapidly, and in a few days was glazed over and smooth, and now the black dots were as numerous and conspicuous over its surface as over the rest of the scalded area. At the end of a month from the time of the injury many of the black spots had coalesced with their neighbors, and the scalded surface had attained a general bluish-black tint, those spots which were still discrete being then about the size of a pea.

Up to the present time two views have been held as to the reproduction of epithelium in a wound undergoing repair by granulation. By some the new epithelium has been supposed to spring from neighboring epidermic cells, because it most usually spreads from the periphery to the centre of the ulcer; but by others it has been thought to be due to the transformation of the cells of the superficial layer of the granulation tissue, because islets of epithelium, such as I have described, are sometimes seen in the centre of an ulcer, which appear to have sprung up spontaneously. This latter view has the support of MM. Cornil and Ranvier, as it seems to be corroborated by the observations on skin-grafting of M. Reverdin (*vide* Cornil and Ranvier's Pathological Histology).

I think, however, the foregoing observations throw some light upon the question and serve to explain away some of its difficulties, for we know that in the negro the pigment is mainly found in the deeper cells of the Malpighian layer of the cuticle, and further, that this layer is continuous with the outer root sheath of the hair follicles, which penetrate deeply into the corium, sometimes even through it to the subcutaneous tissue; and lastly, we know that the "cutis vera" and the "epidermis" are derived from very distinct and different embryonic sources, and it is difficult to believe that epidermis, which is of epiblastic origin, can be reproduced from tissues derived from the mesoblast, whereas the hair follicles are known to be formed originally by involution of portions of the epiblast.

The conclusions I have arrived at are as follows:

1. Epithelium is only reproduced from pre-existing epithelium.
2. When the cuticle is completely removed, as by a blister, the regeneration of epithelium commences at the orifices of the hair follicles, as well as at the periphery of the blistered area.
3. That the same process of regeneration takes place in scalds and similar injuries of the third degree.
4. That pigmentation re-appears after the regeneration of the epidermis, even when the corium is destroyed to a considerable depth.—ALFRED A. LONDON, M.D., *Australian Medical Journal*, March 15, 1884.

RODENT ULCER AND ITS RELATIONS TO EPITHELIOMA.

THERE seems to be now almost an agreement among pathologists on the subject of rodent ulcer and its relations to epithelioma. But the question is not yet

entirely settled, and the investigation whose results I am about to state was undertaken with the desire to aid in definitely determining the pathology of the former disease.

Since the publication of Thiersch's atlas, the existence of peculiar cell-masses has been accepted as the distinctive pathological feature of rodent ulcer. The point on which opinions have mainly differed has been as to the genesis of these cell-masses. Thiersch considered them to be of epithelial origin, and from their general form and character he was of opinion that they took their rise from the hair-follicles. This view has been generally adopted, and among recent writers has been especially advocated by Drs. Tilbury and Colcott Fox, who traced the growth to the external root-sheath of the follicle. This sheath being an extension of the Malpighian layer of the epidermis, from which the growth in epithelioma is known to spring, this view necessarily reduces the difference between the two diseases to a minimum. On the other hand, Dr. Thin has maintained the belief that rodent ulcer is in reality a cancerous adenoma of the sweat-glands. He traces the origin of the cell-growth to the secreting epithelium of these glands, and not to any epidermic structure, and thus assigns to the disease a pathological connection altogether distinct from the epithelial cancers. Between these two views, there is no doubt that the balance of evidence is decidedly in favor of the former; but on neither side has the endeavor to trace the actual development of the new growth from its origin been altogether satisfactory.

During the past five years, I have had opportunity of examining specimens from eight cases of rodent ulcer. In the first five of these cases, the portions of skin obtained were too completely involved in the disease to admit of other than a conjectural opinion as to its origin. I therefore determined, as opportunity occurred, to obtain portions of skin as far as possible removed from the edge of the ulcer, in the hope that a methodical examination from thence towards the ulcer would yield important evidence as to the structure in which the morbid action begins.

Three cases—the correspondence of which in all particulars with rodent ulcer was exact—have afforded me material for continuing the examination in the way proposed. The facts obtained were the same in all of them, and are altogether in agreement with the result of my previous study of the disease. They seem to me, therefore, to justify certain definite conclusions. In the first place, they are entirely opposed to the view that rodent ulcer is a cancerous adenoma of the sweat-glands; the number of cases which I have examined in an exhaustive manner would certainly not warrant the position that rodent ulcer never begins in these glands. But even in Dr. Thin's investigations, the connection between the rodent masses and the sweat-glands was not traced; and it seems probable that, where morbid changes have been found in them, these have been of a secondary character, as they undoubtedly were in my own cases.

The only conclusion which seems to be borne out by all the facts, both pathological and clinical, is that rodent ulcer is a form of epithelial cancer which begins in the external root-sheath of the follicles and in the sebaceous glands. It is of the same essential nature, therefore, as epithelioma; but it differs pathologically in the mode of development of its cell-growth, just as it differs clinically in the absence of gland infection, and in its slight general malignancy.

It was suggested, some years ago, by Mr. Jonathan Hutchinson that the difference between the two forms of epithelial cancer must somehow be determined by the difference of locality in which they occur. The observations just referred to certainly go to establish the correctness of this idea. Commencing in the con-

tinuity of a skin surface, rodent ulcer is peculiarly apt to attack that part of the face—the side of the nose—in which the sebaceous glands are strongly developed and I have been able to trace clearly the manner in which the structure, when the disease begins, determines its onward course. As bearing upon the supposed influence of locality, it would be an important point to decide whether an ulcer which began as undoubted rodent ulcer in the upper half of the face may not become changed to the epitheliomatous type, when in its ravages it reaches the region of the mouth. One or two cases which I have seen in a very advanced period of their course, in which the invasion of the region of the mouth seemed to be speedily followed by glandular infection, seemed to lend countenance to this view.—G. H. HUME, *Brit. Med. Journal*, Jan. 5, 1884.

TREATMENT OF PORRIGO DECALVANS (ALOPECIA AREATA).

AMONG the selections in the July number of this JOURNAL was one relating to the treatment of a group of diseases comprehending *herpes tonsurans*, *porrigo favosa*, and *porrigo decalvans*, by the local application of croton tiglium. In *L'Union Médicale*, January 5, 1884, we find an article by Dr. Ladreit de Lacharrière, Physician-in-Chief to the Deaf and Dumb Asylum in Paris, describing his clinical experience with the same agent in the last of the above-named affections. He employs it, however, in a somewhat different form. In order to prevent the croton oil, when applied to the scalp, from spreading over too large a surface, whereby its action is much weakened, if not altogether lost, he conceived the idea of combining it, in the proportion of one-half, with cocoa butter and virgin wax, the resulting mass being then moulded into sticks, such as are manufactured for cosmetic purposes. These sticks are wrapped in lead foil, which both serves as a preservative, and renders them more convenient to handle. By their use, M. de Lacharrière is enabled to prevent the action of the croton tiglium from extending over a space of more than five centimetres square, thus obviating all risk of exciting those violent inflammatory symptoms which have been complained of by other physicians who have experimented with the remedy. When the entire scalp is affected, he marks it off into several regions, which are treated in succession.

Previous to the application, the hair of the affected parts must be cut as closely as possible; when the state of the scalp will permit, it had better be shaved. Then the diseased surface, after being subjected to friction for a few moments, is covered with a thick layer of the croton pomade, over which, to protect it from the air, is placed a linen cloth, secured by a head-band of silk. Next day, an inflammation is visible, quite active, but confined within the limits of the application, and characterized by the formation of a yellowish crust, resembling that of pemphigus. A few emollient poultices will moderate this symptom, and hasten the detachment of the crusts, which, on examination, are found to contain a great number of spores. In this way, all the morbid elements are often removed at once. Redness and swelling of the scalp are relieved by the use of almond oil or of glycerin. After this, should any remaining germs of the disease be detected, by the microscope or otherwise, the first application must be repeated.

One hundred and fifty patients, the record of whose names and addresses is open to public inspection, were treated for *porrigo decalvans* by this method at M. de Lacharrière's clinic. Of these, 25 failed to report themselves, but were probably cured. The remaining 125 were ascertained to be thoroughly rid of the

complaint within periods of time varying as follows: One month, 11; one and one-half months, 43; two months, 16; two and one-half months, 14; three months, 16; three and one-half months, 3; four months, 9; four and one-half months, 1; five months, 2; six months, 4; seven months, 4; nine months, 9; fourteen months, 1 (in this last case there were several relapses).

The average length of treatment required it would be difficult to compute on the basis of this report, owing to a marked difference between the recent cases and such as were more advanced. In the former, where the microphyte had not penetrated far into the derma, a single application for each of the patches was sufficient; in the latter, though perhaps more circumscribed in extent, it had to be repeated two or three times, at intervals of ten or twelve days, thus greatly prolonging the period of attendance. M. de Lacharrière, however, entertains not the slightest doubt as to the great superiority, in every respect, of his croton tiglium treatment over both epilation and the use of any other anti-parasitical remedy. He maintains, at the same time, that, to insure the best results, it must be carried out with a degree of care which is not likely to be bestowed upon it in a great public institution such as the St. Louis Hospital, where its trial would seem to have been attended with only a partial measure of success.

Review.

ATLAS DES MALADIES DE LA PEAU (Dermatologie et Syphiligraphie), par le DR.

SILVA ARANJO, Professor de Clinique de Maladies Syphilitiques et de la Peau à la Policlinique Générale de Rio de Janeiro, etc., etc.; Premier and Deuxième Fascicules. Rio de Janeiro : G. Senzinger & Filhos, 1883.

We have received the first two numbers of this Atlas of Skin Diseases which, although issued in Brazil, is published in the French language.

We cannot forbear expressing our surprise and gratification at the publication of a work of such magnitude and high scientific character in South America. No better evidence could be offered of the growing interest and importance which dermatology is everywhere assuming than the undertaking of a special work of this character in the Brazilian capital. It speaks well also for the enterprise and enthusiasm of our distinguished confrère whose contributions to dermatology have already gained for him favorable recognition as an active laborer in this special field.

Of the advantage—necessity even—of such a work, there can be no question. Climate, race, and social habits extend such a modifying influence over the development and character of diseases affecting the skin that their clinical features vary widely in different countries. This variation in the type of skin affections, depending upon changed external conditions, is so marked that dermatologists now, more than ever, recognize the importance of what has been termed “the nationality of skin diseases.” Dr. Aranjó has enjoyed peculiar advantages in studying the influence of race characteristics upon the clinical individuality of skin diseases. As he tells us, “the diversity of races met with here, and their intermingling, open to my observation a large field from which I may

choose the most interesting cases—Brazilian, Europeans, Asiatics, Africans, hybrids, all lend me their aid, for they are all found here in large numbers.”

Each number of the Atlas is illustrated with one or more chromo-lithographs, accompanied by a descriptive text, giving the latest views of the most eminent authorities upon the subjects treated, and reflecting the most advanced principles and methods of treatment. The diseases chosen for illustration in the first and second numbers are tinea favosa and tinea tonsurans. The author tells us that the most scrupulous fidelity to nature has been observed in reproducing the impressions. The result seems to us most satisfactory from both an artistic and clinical point of view. We cannot too highly commend the artistic taste and the typographic excellence shown in the first instalments of this work.

Received.

Étude sur une variété de Toxidermie observée chez les Plumassières par PAUL DE MOLÈNES et MARCEL LERMOYEZ (Reprint).

Étude sur les Classifications des Maladies de la Peau par le Dr. ARMAND RIZAT, Paris, 1884.

Ulcera infettante della Piega Inguino-scrotale dal Prof. CELSO PELLIZZARI (Reprint).

Ulcera Cutanea d'origine Nervosa dal Prof. CELSO PELLIZZARI (Reprint).

Sulla Elefantiasi dei Greci dal Prof. GIUSEPPE PROFETA (Reprint).

Syphilis Héréditaires—lésions du foie par le Dr. BARTHELEMY (Reprint).

Exitus letalis nach Erysipelimpfung bei inoperablem Mammacarcinom und mikroskopischer Befund des geimpften Carcinoms, von Dr. O. JANICKE und Prof. NEISSER in Breslau (Reprint).

I segni della Sifilide ereditaria tardiva. C. PELLIZZARI (Reprint).

Small-pox *versus* Pemphigus, and other eruptive diseases; being the full and Verbatim Report of the Case of Regina *versus* Dr. Wolff. Kimberly, 1884.

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Original Communications.

LOSS OF AN EYE FROM INHERITED SYPHILIS.

BY

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MISS Hattie J. B., aged twelve, was brought to us by her mother on June 5, 1880, for professional advice. Both eyes of the child were said to have been well until she was three years old, when she had two styes on the lids of her left eye. Shortly after this a white spot appeared in the pupil, and later a divergent squinting of that eye was observed. From that time on, the eye had frequently been red and painful. Latterly she had suffered from occasional attacks of redness and pain in the fellow-eye. This eye was also painful at times when it showed no external signs of inflammation.

Upon examination it was found that the left eye was the subject of cataract with old iritis, synechia posterior, and divergent squint. It was sensitive to pressure, especially in the upper portion of the ciliary region, and was without perception of light.

The right eye had vision = $\frac{20}{20}$, was hypermetropic $\frac{1}{6}$, and presented no visible lesion, ophthalmoscopic or otherwise. The use of the right eye had recently produced neuralgic pains in and about both eyes, and this had kept the patient out of school for five consecutive weeks the preceding winter.

The patient had the *facies* of inherited syphilis, with well-marked Hutchinson's teeth. She had been compelled to wear iron braces to her

legs to enable her to walk from the time she was two until five years of age. Her father, some time dead, had been subject to rheumatism, and her mother had miscarried twice previous to the birth of the patient, the first time at two months, and again at four months.

As the sight of the left eye had long been totally destroyed by irido-choroiditis, and as there were unmistakable symptoms of sympathetic irritation of the fellow-eye, we did not hesitate to advise enucleation.

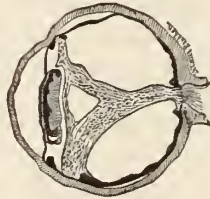
The eyeball was enucleated by Dr. C. R. Agnew, at the Manhattan Eye and Ear Hospital, on the 13th of the following October, and the patient returned to her home in the interior of the State a week or two later, wearing an artificial eye.

I did not see her again until January 18, 1884, when happening to be in the city she called upon me. She had developed into a robust and rather fine-looking young woman. She still wore her artificial eye with comfort, and her vision was $= \frac{20}{12}$. All the symptoms of sympathetic irritation had quickly and permanently disappeared after the removal of the blind eye.

The enucleated eyeball was examined by Dr. T. Mitchell Prudden, Pathologist to the Manhattan Eye and Ear Hospital, who made the following report.

PATHOLOGICAL LABORATORY,
COLLEGE OF PHYSICIANS AND SURGEONS, }
NEW YORK, Dec. 6, 1880.

DEAR DOCTOR :—On making a meridional section through the eye of H. J. B., it presents the general appearance indicated in the sketch.



The degenerated lens is in place and closely adherent, over a considerable part of its anterior peripheral zone, to the iris. The vitreous has entirely disappeared, and the greatly altered retina is drawn completely away from the choroid, forming, with a membrane which extends across from just behind the ciliary processes, an irregular wedge-shaped mass, extending from the lens, ciliary body, and *pars ciliaris retinae*, back to the optic-nerve entrance, leaving a large cavity between it and the choroid containing nothing but the preservative fluid and a little granular detritus.

The choroid, slightly separated from the sclera in places, is seen with

the naked eye to be irregularly thickened at several points, especially near the ciliary body and around the optic-nerve entrance. The space seen in the sketch just behind the lens is, I think, formed by shrinkage in the preservative fluids.

Microscopically, the changes observed are as follows. Cornea and sclera little changed, except that near the sclero-corneal junction the sclera shows considerable dilatation of blood-vessels. The iris presents no abnormalities in the anterior portion, but posteriorly the pigmented layer is very irregularly swollen and attached, especially towards the periphery, to the anterior lens capsule, by a small amount of new connective tissue.

The ciliary body shows some flattening and slight infiltration with pus. From the posterior portion of the ciliary body and from the *pars ciliaris retinae* a new connective-tissue membrane stretches across the eye, forming with the detached retina the wedge-shaped mass above described, within which a small pyramidal space represents the nearly obliterated cavity of the vitreous. The tissue forming this wedge-shaped mass presents, especially in its posterior portions, the bizarre cell forms and utterly irregular arrangement of tissue elements so frequent in chronic retinitis with detachment. The retinal arteries persist, with greatly thickened walls, but no nerve elements could be detected.

The choroid is everywhere thickened, especially in the walls of its vessels, and the inner layers show extensive ossification.

The optic nerve is atrophied.

The lens, attached as above indicated to the iris, presents, so far as could be seen, an intact capsule. Just behind the anterior capsule is a thin zone of fibrillar detritus, and posterior to this an irregular layer of larger and smaller lime globules. The remainder of the lens shows in a few places remnants of fibres, but for the most part consists of an amorphous or granular, crumbling mass in which are numerous oval cavities and irregular fissures, partially filled with fluid, or loose granular material. At one side the lens substance has entirely broken down, leaving an irregular cavity; while around this and in the anterior zone, dense calcification has occurred. Nothing was seen which anatomically would mark the changes as of specific nature. Accordingly, the anatomical diagnosis would be—Iritis, plastic cyclitis, chronic retinitis with detachment, chronic choroiditis with ossification, cataract with extensive degeneration and calcification; atrophy of the optic nerve.

TWO CASES OF RECURRENT ALOPECIA AREATA.

BY

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St. Louis, Mo.

C. F. S., a young man twenty-three years of age, first consulted me about four summers ago for a typical alopecia arcata situated in the right occipital region of the scalp. There was a large patch, size of a child's palm, and a smaller one of the dimensions of a silver dollar. When I saw him, the disease had already been in existence for several months. There was no appreciable cause for his affection, and he was notably a man of superb physique. After some little while the hair returned in the bald spots, first quite light, but gradually assuming the usual color—a reddish-brown.

The following spring he again presented himself with the same disease. The hairs had fallen suddenly, leaving two bald areas. He again recovered. Last spring—1883—the same thing occurred once more, and followed the usual favorable course.

On the 14th April of this year, Mr. S. again called my attention to a bald spot on the right side of the occiput, near the ear, about the size of silver dollar. The place was quite destitute of hair. There was no other lesion. I dismissed him May 30, with a good growth of thick light hair in the involved region.

Every attack has come on in the spring of the year, generally the latter part of March or towards the first of April. In every instance the same region, the occipital, has been implicated, and usually two patches have appeared; but this year only one.

In looking about for some plausible explanation for these recurrent attacks, I found that my patient had gone into training very actively every spring for boat-racing, and I thought probably that this unusual strain, coinciding so exactly with the alopecia, was the fons et origo of his difficulty. This view of the case I suggested to him, and he accordingly gave up training after the second attack. But notwithstanding, the disease made its appearance for two successive years afterwards.

On May 9, of this year, a man of some thirty-five years of age showed me several extensive patches of alopecia areata on his scalp, which had appeared this spring. On putting himself under my care, he stated that, so far as the bald places now present were concerned, he was not particularly solicitous, since he was sure that the hair would grow out again before a great while; but that he desired a treatment that would effectually prevent returns of his difficulty. Inquiry developed the fact that

every spring for the past *ten* years he had suffered loss of hair in distinct circumscribed patches. The patient assured me that the hair would return without any special treatment. He did not think that the disease occurred in the same site year after year, but that the bald areas would appear indifferently over the scalp.

In the first case, which was under my personal observation in every attack from the beginning, while the alopecia occupied exclusively the back of the hairy scalp, I am positive that in the greater number of instances, entirely different portions of this region were attacked each time.

I believe that these cases present points of interest, both etiological and clinical, which justify their publication.

2303 OLIVE STREET.

ATROPHIA PILORUM PROPRIA.

BY

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ATROPHY of the hair exists under two forms, namely, *Fragilitas crinium*, and *Trichorrhæxis nodosa*. In both forms the hair-shaft is easily friable and splits or breaks of itself, or by the slightest traction. In certain diseases, as *trichophytosis*, *favus*, *seborrhœa*, and such as are attended with a general lowering of nutrition, *phthisis*, *scrofula*, and various *cachexiæ*, the hair becomes dry and splits or breaks off. This form of fragility of the hair may be considered as symptomatic *fragilitas crinium*, but does not properly belong to the essential atrophies of the hair.

FRAGILITAS CRINIUM.

This disease has been called *scissura pilorum*, and has for its distinguishing feature splitting of the hair. The cleft is usually at the free extremity, and at times runs some distance up the shaft. These split hairs are either scattered here and there through the otherwise normal hair, or all the hairs of the part are split. The disease occurs most often upon the scalp, the beard being the place next most frequently affected. Splitting of the ends of the hair is a common occurrence in the long hair of women. The shaft may be split into two or more *fibrillæ*, and these spread out from each other simply, or curve up upon themselves. The cleft may also occur in the middle of the shaft, or at its exit from the follicle, and in the latter case the shaft will be split throughout its entire

length, the segments either separating or holding together. Duhring¹ has reported a case occurring in the beard in which the hair began to split within the bulb, and which was attended by an irritation of the follicles so great as to cause follicular papules and pustules. In this case "the hairs were very bristly, sometimes they were of good length, sometimes short, sometimes thicker than normal, sometimes abnormally slender, sometimes straight, sometimes crooked, sometimes came out easily when pulled upon or fell out of themselves, and sometimes they were quite fast in the follicle and broke off, leaving the root behind when epilation was attempted." Besides the splitting, the hair may show no other abnormality, but it is generally more dry and brittle than normal, and may be irregular and uneven in its contour. The bulb of the hair may be normal or atrophied.

Etiology and Pathology. The cause of the idiopathic fragilitas crinium is yet undetermined. Kaposi has said that the splitting of the ends of the long hair in women was due to the distance of the distal extremity of the hair from its source of nourishment, the hair-root or bulb. But this explanation does not apply to those cases in which the splitting affects the short hair of the beard. Gamberini regards neglect of the hair and allowing it to grow to excess as being favoring motives of fragility of the hair. The disease is without doubt due to some interference with the nutrition of the hair, probably a yet undetermined trophoneurosis.

In Duhring's case the microscopical examination showed marked atrophy of the hair bulbs, and fissure of the hair-shaft beginning within the bulb, separation of the segments taking place at the bulb or at variable distances beyond it. The cortical substance presented a dry and brittle look in the narrowed portions and a spongy luxuriant appearance in the thickened portions of the hair. The medulla was nowhere normal, but was present here and there in broken tracts.

Treatment. When occurring only at the free end of long hairs, they should be cut above the cleft. In all cases the scalp should be kept in good condition, as directed under alopecia prematura. If the disease occur in the beard, shaving would at least remove the deformity, and possibly cure the disease.

TRICHORRHESIS NODOSA.

Synonyms. Trichoclasia; Trichoptylöse; Tinea nodosa; Piedra.

Under this heading is grouped a number of abnormalities or diseased conditions of the hair which have one common feature, that is, that the hair shaft suffers a lesion of continuity, and is deformed by the presence of nodular swellings. Properly speaking, trichorrhesis nodosa is a non-

¹ Amer. Journ. Med. Sc., 1878, July, fol. 88.

parasitic disease of the hair occurring chiefly in the beard; piedra is a fungoid growth met with, as far as reported, only in Columbia; while tinea nodosa is a parasitic disease which may be found in any country. We will consider each separately and begin with the typical disease.

Trichorrhæxis nodosa. Wilks and Beigel were the first to describe this peculiar affection, but of late it has received considerable attention from various observers. The disease generally affects exclusively the hair of the beard and moustache, and here it reaches its highest development. Very infrequently it is found in the hairs of the pubic region, and still more rarely in the head-hair. It consists of one or more whitish or grayish shiny transparent nodular swellings occurring along the shaft of the hair. In people with red hair the color may be black. The number of nodes that may be present is from one to five; and their size will vary with the diameter of the hair. The nodes, according to S. Kohn,¹ occur usually in the upper third of the hair. These nodes give to the hair an appearance not unlike that produced by the presence of the nits of pediculi. The hair is exceedingly brittle and fractures upon slight traction, or spontaneously, the fracture taking place through a node, and the hair-fibres separating like the hairs of a brush. When many hairs in the beard are thus broken, their frayed out ends make the beard look as if it were burnt. Sometimes the hair-fibres splinter about the node, but the two ends do not separate, and this gives an appearance like as if two small brushes were pushed together. Sometimes the hair presents an irregular contour, and looks as if frayed along its entire length. While the fracture is usually transverse, if there should be an excessive amount of medulla present in the node, it may be longitudinal. The hairs themselves are usually firmly fixed in the follicles.

W. G. Smith² reports a case in which the ends of the broken hairs were pointed, the fracture taking place through the internodular portion, and many of the hairs were bent at a right angle. This case occurred in the hairs of the head.

The microscopical examination of the affected hairs shows that in the early stage of development of the disease there is simply a spindle-formed thickening in the continuity of the shaft of the hair, and a swelling of the medulla, while the cuticle is still intact. Later the cuticle becomes cleft, and the cleavage extends on all sides of the node till the brush-like appearance is produced by spreading of the separate fibres. At the same time with the cleaving of the cuticle, the medulla undergoes degenerative changes, and either slowly disappears or else, according to Pye-Smith, oozes out as a finely granular material between the separated fibres. There is either no marked change in the appearance of the hair-root, or

¹ Vrtljsch. f. Derm. u. Syph., 1881, viii., 581.

² Brit. Med. Journ., 1880, i., 654.

it is slightly atrophied. Air globules are only very occasionally found in or about the nodes.

The cause of the disease is obscure. It is probably a tropho-neurosis interfering in some way with the proper nutrition of the hair. That it is not parasitic is the almost unanimous opinion of those who have studied the disease. It does not seem to depend upon any diathesis, nervous or otherwise. Anderson¹ has recently reported a case of hereditary trichorrhæxis nodosa, the disease in his patient being congenital or nearly so. He gives a "family tree" of this case in regard to the disease, by which it may be traced as far back as a great-grandmother. One member of the family had three sons and two daughters with what the patient called "weak hair," and it was peculiar that this "weak hair" occurred almost invariably in those of the family who dark complexions.

The cause of the splitting of the hair is ascribed by some investigators to a degeneration of medulla, a consequent rapid accumulation of cell at one point which eventually bursts open the hair sheath.² Pye-Smith³ regards it as due to a gradual drying of the cortical substance, a consequent loss of coherence of its constituent fibre-cells; the breaking-up into a granular material and swelling of cells of the medulla, till the rupture of the cortex is complete, there being nothing left to hold the hair together.

The treatment of the disease is very unsatisfactory. Continued shaving probably offers the best hopes of any plan. All sorts of applications have been made to the affected parts, generally of a stimulating character, particularly various forms of mercurials, but without curative effect. Gamberini, in his work on the hair, recommends either bathing the part with a lotion composed as follows:

℞ Potass. subcarb. 15.— ʒ ii j.
Alcohol. dil. 150.— ʒ v.

M.

or innunctions of tannic acid or oil of cade.

Schwimmer advises that an ointment of

℞ Zinci oxid. 0.5.—gr. vi j.
Sulphur loti. 1.0.—gr. xv.
Ung. simpl. 10.0.—ʒ iiss.

M.

be rubbed in morning and evening.

Piedra. The best description of this disease is given by Malcolm Morris in his paper reported in the "Transactions of the Pathological Society" of London, 1879, volume xxx., and page 441; also in the *Lan-*

¹ Lancet, 1883, ii., 140.

² Startin, Lancet, 1878, ii., 866.

³ Trans. Path. Soc. (Lond.), 1879, xxx., 439.

cet, 1879, x., 407. It is upon this paper we mainly rely in the following account of the disease, as from its very rarity we have not had an opportunity to study the disease.

This disease, or deformity of the hair, is said to occur only in one of the United States of Colombia, and was first described in 1874 by Dr. N. Osorio, of the University of Bogota. It consists in the occurrence along the shaft of the hair of from one to ten small, dark-colored nodes which are very hard and gritty, and rattle like stones when the hair is combed or shaken. The stony hardness of the nodes gave the disease its name, "Piedra," which is the Spanish for "stone." These nodes are always placed at irregular intervals along the hair-shaft, and are first met with at about half an inch from the point of exit from the hair, the roots being unaffected. The disease occurs most commonly in women, men being but rarely affected, and it is the head hair alone which exhibits these nodes. The disease is non-contagious, and is met with only in warm valleys.

Dr. Osorio thought that the nodes were produced by an agglomeration of epithelium in certain parts of the hair. Dr. Morris believes that it is due to the use of a peculiar mucilaginous linseed-like oil, which is used particularly by the native women to keep their hair smooth and shiny. Another theory is that it is due to the use of the water of certain stagnant rivers which is very mucilaginous. Heat seems essential for its production, as the employment of either of these fluids will not cause the disease in cold climates.

Microscopical examination of the affected hairs shows that the nodes consist of a honey-combed mass of pigmented spore-like bodies, the whole mass arising from one cell which send out spore-like columns radially in all directions. As soon as the cells have reached a certain size, they seem to alter their shape, become darker in color, and form a pseudo-epidermis. It is, therefore, a fungous growth. The nodes were found to be very hard to cut, and when considerable force was used they broke.

Piedra differs from trichorrhexis in the stony hardness of the nodes, in its occurring principally upon the head hair, in its probable etiology, and in the microscopical appearances it presents.

Tinea nodosa is the name selected by Cheadle and Morris¹ to designate a condition of the hair which differs from trichorrhexis nodosa in the presence of a parasitic growth resembling, though larger than, that of tinea tosurans; in the marked incrustation of the hair-shaft by this parasitic growth; and in the absence of multiform symmetrical nodosities. Paxton² has also reported a case of nodose condition of the hairs of the axillæ in which parasites were found on section through the nodes.

¹ Lancet, 1879, i., 190.

² Jour. of Cutaneous Med. (Lond.), 1869, iii., 133.

Besides these three forms of atrophy of the hair, there have been several abnormalities of growth reported from time to time, which deserve mention in this chapter. Thus Ferber¹ reports two cases in nervous individuals in whom under special nervous irritation or exhaustion, the hair which naturally was soft and curly, became over night flabby and harsh.

Bulkley² describes a case occurring on the hair of the pubis of a man affected with itching and sweating of the genitals, which resembled in its appearance trichorrhexis nodosa. The hair looked as if invested with the nits of pediculi, but the microscope showed that the appearance was due to the presence of a double knot on each hair, composed of several turns.

The writer of this article has recently met with a case of undoubted trichorrhexis nodosa of the beard in which, besides the nodes, there was the knotting of the hair described by Bulkley. The patient was not quite in his right mind, and kept constantly pulling at the hair of his beard. The knotting of the hair was ascribed to this habit.

THE ELIMINATION OF MERCURY DURING AND AFTER ITS CUTANEOUS EMPLOYMENT.

(SECOND ARTICLE.)

BY

DR. SCHUSTER, Aix-la-Chapelle.

IN No. 12 of the preceding volume of this JOURNAL appeared an article by me on the elimination of mercury, with remarks on the methods employed in the examination of the urine and fæces, yielding these results:

1. Mercury introduced in the organism through the skin or in any other way is eliminated continuously.
2. This elimination in the ordinary mercurial treatment is completed after the lapse of six months.
3. There is no persistence in the organism of the introduced mercury.

There was one remarkable circumstance, namely, that in about fifty per cent of the cases mercury was not found in the urine where it would have been particularly expected; for instance, where it was dis-

¹ Virchow's Archives, 1866, xxxvi., 598.

² Archv. Dermat., N. Y., 1881, vii., 403.

covered in the fæces. This led to the conclusion that mercury is not regularly excreted by the urine. From a physiological standpoint we should expect that when mercury is excreted through the intestines, it should likewise be eliminated by the kidneys. This point seemed to require thorough examination. It was possible, at all events, inasmuch as in examining the fæces the organic masses were decomposed by means of aqua regia before instituting the amalgamating process (Fürbringer's), while the slightly acidulated urine was immediately tested by the same method, that where small quantities of mercury were present in the urine its organic substance might prevent the amalgamating of the mercury, and its demonstration thus be rendered impossible. In order to determine this point, I arranged with my chemist, Dr. Schridde, the following procedure, and asked him to put it into operation:

a. To one litre of water a small quantity of mercury, 0.2 milligramme, should be added and determined according to Fürbringer's method. The result was positive in every case.

b. For the examinations of urine now to be instituted, one litre of ordinary urine shall be taken each time, and 0.2 milligramme of mercury added to it.

1. This mixture is to be tested for mercury after Fürbringer's method. The result was negative in every case.

2. The mixture is to be examined according to the same method as the fæces, that is to say, the urine is evaporated, the residue treated with aqua regia, and after the nitric acid is removed, the aqueous solution is tested according to Fürbringer.

This procedure gave a negative result in every case.

The explanation is probably the following:

On treating the fæces with aqua regia, a very large insoluble, and a small soluble part result. On treating the urine with aqua regia, the reverse takes place, that is to say, while in the case of the fæces by far the greater part is on the filter and but little in solution; in the case of the urine, the ammonium chloride formed from the urea, together with the inorganic salts, or everything, enters into solution. Thus there is produced a lye of salts, in the presence of which the failure of Fürbringer's method, *i. e.*, the amalgamation by means of lametta, is readily explained.

3. An attempt was therefore made, before resorting to the amalgamating process, to combine the mercury present in the urine with sulphur by passing sulphuretted hydrogen through it, and then to dissolve it with aqua regia; Dr. Schridde proceeding as follows:

The urine having been acidulated with hydrochloric acid, sulphuretted hydrogen is introduced, and the fluid set at rest for twenty-four hours. A slight sediment forms, consisting of uric acid, pigment, and

mucns. The sediment is then filtered, the whole filter with its contents decomposed with aqua regia; it is desirable to use the aqua regia that has served for rinsing the large vessel in which the urine has been treated with sulphuretted hydrogen, so as to obtain any mercury in solution which may possibly have remained in the bottle. The filter is heated on the water-bath with the aqua regia in a porcelain sancer until the nitric acid has disappeared (to dryness). The residue is then dissolved in about 100 grammes of water, and the amalgamation instituted in a slightly acid fluid in the usual manner according to Fürbringer. In this way the mercury was always *clearly* demonstrated.

Such triple examinations of urine (as per 1, 2, and 3) were made eight times of each, and every time the result above stated was obtained.

According to the third method, another trial was made with one litre of urine to which one-tenth milligramme of mercury had been added, that is, in a proportion of 1 : 10,000,000! The mercury was again clearly demonstrated.

These experiments show that the Ludwig-Fürbringer method is not sufficient for the examination of the *urine* for mercury; and hence it is very probable that where mercury was found in the *feces* and not in the urine, a better method would certainly have shown it. This assumption was confirmed by the following investigation: In one of my patients treated by inunction, mercury could not be found in the urine by the Fürbringer method. But by the new method of Schridde the mercury was clearly demonstrated.

Further confirmatory investigations could not be made up to the present time. But those undertaken thus far render it more than probable that the elimination of mercury is equally regular by the *feces* and by the urine.

But we can conclude from this with so much greater certainty that the elimination of mercury must be completed within some determinable time. For ordinary courses of inunction I could place this period at six months.

Therefore it is surely not accidental that frequently, in from four to six months after mercurial treatment, the banished syphilitic symptoms reappear or show themselves more decidedly, both in the early and in the late manifestations of syphilis. After the elimination of mercury has continued for four months, there is too little mercury left in the system to retard the renewed increase of the syphilis in such relapsing cases. It is advisable, therefore, in view of the eliminative period of the incorporated mercury, to repeat the mercurial treatment of syphilis in from four to eight months after the course which has suppressed the syphilitic manifestations, according to the earlier or later expectation of fresh symptoms.

Correspondence.

DERMATOLOGY AND SYPHILOGRAPHY IN GREAT BRITAIN.

(From our Special Correspondent.)

"TWO cases of PURPURA HÆMORRHAGICA in which micro-organisms were found" were communicated to the Pathological Society on February 19 by Mr. Watson Cheyne. The first case was one under Dr. Russell, already reported on in this JOURNAL (Vol. II., p. 49). In the second, which was under the care of Dr. Pye-Smith, a portion of lung containing two hemorrhages was examined, and it was found that between them a considerable number of the vessels contained colonies of micro-organisms which, in some places, completely blocked the capillaries and some of the larger vessels; the organisms were streptococci, forming very long chains coiled together so as to form dense masses. They did not occur free, nor in the vessels of other parts of the lung, nor in the heart, but in the tonsils some of the vessels were plugged with cocci; there was no evidence of inflammation about the colonies. He observed that, in these two cases of idiopathic purpura hæmorrhagica, micro-organisms had been found, and in both cases the hemorrhages were evidently due to the plugging of the vessels by them, but the micro-organisms in the two cases were not the same, and they differed in their mode of growth from other organisms of the same classes in that they formed colonies in the blood in the vessels; in this respect, the only organism hitherto described which resembled them was the typhoid bacillus. Bacillus anthracis might plug the vessels, but this was not its usual form of growth; streptococci also grew commonly in the tissues. The significance of the organisms could only be made clear by a large number of observations and by cultivations. We might either have to do with an infective disease, of which the essence was the entry of certain specific organisms into the blood and their growth there; or the primary affection might be something quite distinct from the organisms, but resulting in such a change in the fluids of the body that, of the innumerable organisms present in the mouth and intestines, some became able to penetrate into and live in the blood. Similar observations should be made in scurvy. Dr. Pye-Smith observed that, in his case, which was a typical instance of purpura hæmorrhagica, the blood had not been examined for micro-organisms. The great facility with which the slightest violence, even such as could be caused by a house-fly, could give rise to extravasations in these cases, seemed to show that the walls of the vessels were altered. Dr. Stephen Mackenzie referred to the fact that purpura occurred under very varied conditions; in iodid purpura, for instance, it seemed impossible to suppose that, in the very short time which elapsed between the administration of the drug and the occurrence of the purpura, there could be time for an organism to develop.

Dr. W. Russell, writing on the same subject (*Brit. Med. Journ.*, March 15, p. 507), suggests the desirability of observations on the blood in an early stage of the disease. He admits the absurdity of considering that all capillary hemorrhages are due to plugging of vessels by organisms; but although purpura may be only a symptom, it is a question whether there is not a disease which is properly named purpura simplex. Nothing is certainly known as to its path-

ology, but every now and again such a disease is met with in practice unassociated with any other condition. It is often, if not always, febrile and recovers under treatment, but may develop into the hemorrhagic form. Turpentine, the empiric remedy which leads to recovery, is not only a hæmostatic, but a parasiticide.

“A case of a Remarkable ERUPTION following the Administration of IODIDE OF POTASSIUM” is recorded by Dr. James Lindsay (*Brit. Med. Journ.*, March 29, p. 602). A woman, aged fifty-eight, suffered from paralysis of one arm. Iodide of potassium was ordered in $3\frac{3}{4}$ -grain doses; after taking two doses ($7\frac{1}{2}$ grains), the patient felt very sick, had a severe headache and intense itching, beginning between the shoulders and spreading rapidly over the trunk, upper extremities, and face; following the itching came an eruption of bullæ, each of which was surrounded by two bright-red concentric rings, the outer about as big as a crown piece (a little larger than a dollar), the inner somewhat smaller. Except two spots on the left thigh, the lower extremities escaped, but elsewhere the body was quite covered; on the face, the spots were close round the eyes and mouth, and even in the nostrils. She suffered severely from sore throat, but had scarcely any nasal catarrh; the headache and prostration were intense. Notwithstanding these phenomena, the medicine was continued in diminished doses (not stated), and at the end of a week the eruption began to disappear. A curious fact was that the catamenia, which had been absent twelve years, reappeared and continued during the greater part of the week for which she was taking the iodide. Dr. Lindsay recommends that, in the severer forms of iodide eruption, such as the present one (hydroa), the drug should be greatly diminished, or even suspended, and refers to Hutchinson's cases, in which death followed persistence in the drug. The latter is of opinion that those patients who show extreme susceptibility to iodide, will be found to derive the same benefit from very minute doses as others do from the usual three, five, or ten-grain doses, and has repeatedly cured tertiary ulcerations by doses of gr. $\frac{1}{3}$ to $\frac{1}{2}$ of iodide in patients for whom it had been believed to be a poison, even in the smallest quantity.

In a paper on “Cases of FACIAL ERYSIPELAS with low Temperature” read before the Medical Society of London on March 24 (*Brit. Med. Journ.*, March 29, p. 599), the present writer drew attention to the great variation in the temperature of erysipelas, and communicated five cases in which this was very low throughout, practically under 100° F. One of these cases was preceded by a rigor, two of them were first attacks, and in two an extension of the inflammation of the skin took place, while the temperature was below normal. He pointed out that, while some might consider these cases abortive attacks of the true disease, others might hold that they should rather be viewed as examples of spurious erysipelas or erythema, and thought it of importance to decide the question, as true erysipelas had been proved to be contagious. He mentioned that, while inoculation experiments with erysipelatos virus often gave rise to a highly febrile form, it frequently happened that the result was spreading redness and swelling, resembling erysipelas exactly, but without fever. These had been considered not to be genuine cases, but he thought the selection of high fever as the pathognomonic sign of the true disease was altogether arbitrary, and even if accepted, impossible to apply with accuracy, for the cases with the highest fever and those with the lowest, or even with none, are connected by transitional forms which establish an insensible gradation between the two extremes, and he could not see where the line should be drawn, on one side of which we were to

place all the genuine cases, and on the other all the spurious ones. He thought the character of rapid spreading at the margin was the most characteristic symptom of the true affection, but admitted that cases would arise in which the diagnosis must be doubtful. He could not agree with Tillmanns that this was a matter of no importance, as we could never be quite sure that a mild case was not contagious, and thought it desirable that precautions should always be taken by practitioners, especially those engaged in midwifery and vaccination.

This paper is shortly commented on by Dr. Goodridge (*Brit. Med. Journ.*, April 26, p. 810), who expresses his belief that there are primarily two forms, infective and non-infective, and further, that the presence of marked fever and constitutional disturbance proclaims, and the more emphatically the greater their intensity, that a case belongs to the infective form, while the absence of fever and constitutional disturbance denotes that a case is non-infective or "spurious." For the reasons given above, the present writer cannot share these views; moreover, a case which is highly febrile at one period may be the reverse at another stage, long before convalescence. Has it then ceased to be contagious? Dr. Goodridge, however, admits that doubtful cases will arise, and thinks that after all, if we err at all, we should be careful to err on the safe side.

The subject of "IMPETIGO CONTAGIOSA" was discussed by Dr. Colcott Fox in a paper read before the Medical Society of London on March 17. He pointed out that, although independently described by Tilbury Fox in 1863, the affection was known to Willan, Bateman, Thompson, and Startin. He described the eruption, and gave examples of epidemics in streets, schools, and barracks. He thought many of the slighter cases were entirely local inflammations, excited by contact of pus from some such source as a vaccine pustule, a festering excoriation, otorrhœa, and dermatitis from lice, and then extended by auto-inoculation. He then considered the question whether every case should be looked upon as belonging to this category, or whether any group of cases was to be regarded as an infectious disease, like varicella, or an inoculated affection like vaccinia, and concluded that probably all cases were merely local affections, the severe and acute ones being caused by special virulence of the pus, or by micro-organisms. Dr. Radcliffe Crocker believed that the cases were always of external origin. He had found chains of micrococci in the vesicular stage, which became more numerous in the pustular stage.

Dr. Ogilvie Will, in a "Note on the Use of SALICYLIC PLASTER" (*Brit. Med. Journ.*, March 29, p. 602), gives an instance of the value of this remedy, which has been already noticed in this JOURNAL (Vol. II., p. 147). The patient was a man with a peculiar affection of the dorsum of the left foot, the anterior half of which was brown, rough, and warty-looking, "not unlike hippopotamus hide;" the warty growth was firmly fixed, and bleeding followed an attempt to detach it. Unna's salicylic plaster was, therefore, applied, being cut into strips, with which the affected part was accurately strapped. The plaster was left untouched for three weeks, and on its removal the foot was found cured, the warty layer coming off on the plaster, leaving a fine, soft, healthy epidermis.

A note "On the Use of the SULPHIDE OF CALCIUM in the TREATMENT OF SCABIES," by Dr. Dolan (*Brit. Med. Journ.*, February 9, p. 260) strongly recommends this well-known remedy. The patient is first put into a warm bath, and afterwards painted with a brush dipped in the solution, which is allowed to dry on in bed between blankets; the skin becomes of a bright-yellow color from deposit of sulphur, and one application usually suffices in a simple case, but in old cases longer treatment is necessary. The remedy is largely used in the army and

poor-law medical service, and is quite as effective as sulphur ointment, while it is cheaper and less tedious. Any irritation may be at once removed by alkaline baths.

Mr. J. F. Le Page, in a paper "on NEUROPATHIC PLICA" (*Brit. Med. Journ.*, Jan. 26, p. 160), describes a unique specimen presented by him to the museum of the Royal College of Surgeons. The case was that of a girl, aged seventeen, who, after suffering from 'general numbness' for a week, had severe frontal headache for a day, with fornication of the whole scalp; to obtain relief she washed the head the same evening with warm water. "After partially drying the hair, which measured three feet and one inch in length, with a towel, she commenced combing it out on the left side in the presence of her parents, who are intelligent and reliable people, and, whilst so engaged she felt a tearing sensation on the right side of her head, as though the hair were being pulled out, and on placing her hand to her head, found that it was being drawn up. In one or two minutes nearly the whole of this long hair on the right side was drawn into a hard lump." This could not be disentangled, and extended to nearly the median line behind, and to within an inch of the forehead; the hair on the left side being quite smooth, very slightly wavy, and not in the least tangled. Under the superficial portion of the affected side, the hair was looped and festooned in a 'beautiful' manner. The microscope showed that all the hairs which were contracted and intertwined were flat, whilst those which were festooned were round. The patient had not menstruated for six months, and many of her symptoms were doubtless those of hysteria; deception is rejected by Mr. Le Page, who is inclined to think the remarkable tangling was brought about "by the presence in the hair of that form of force which we name nerve-force." (!)

A valuable and suggestive paper "on LUPUS, with special reference to certain rare forms" was read to the Medical Society of London, on February 11, by Mr. Jonathan Hutchinson. He said it was customary to recognize two forms of lupus only, *l. vulgaris* and *l. erythematosus*, and some authorities thought that even these two should not be brought together closely; he, on the contrary, thought that not only they, but some other processes ought also to be classed with lupus. Lupus might be defined as a slow, creeping, and inflammatory form of new growth, which affects only the skin and mucous membranes; the histological changes found were all products, and not causes, so that it was necessary to define lupus by its clinical features. In *lupus vulgaris* multiplicity was the exception, but the process had so much infective vigor that it was constantly spreading at the border, and had little tendency to spontaneous cure. *Lupus erythematosus* differed very distinctly from *l. vulgaris* when typical cases were compared, but aberrant cases filled the gap; *e. g.*, *l. vulgaris* might be multiple and further, it varied much according to the part affected; on the hands and feet the cellular tissue was more involved, and the resulting scar led to considerable deformity. To the form described by Tilbury Fox as disseminated follicular lupus, he thought the name of 'acne-lupus' was suitable, as acne was mixed with lupus, and the acne pustules were liable to become lupoid. 'Eczema lupus' was the name he applied to a condition where the infiltrated skin wept like eczema, but where the disease was very intractable and left scars; it was quite uninfluenced by ordinary treatment. He next referred to a peculiar lupoid affection of the hands which led to extreme deformity, owing in part to arrest of growth, and in part to interstitial absorption of bones; this was due to a diseased process which affected the cellular tissue and skin, and had a red, thin, scar-like appearance; he called the condition 'lupus mutilans.' To a superficial form in which patches spread very

slowly by a papular margin, he had applied the name 'lupus marginatus;' it was distinguished from l. erythematosus by the absence of symmetry, and of erythema. He had seen three cases of lymph-warts with a certain amount of cell-growth, spreading very slowly, and remaining for years with very little change: little vascular tufts were formed, and there was no symmetry; this he designated 'lupus lymphaticus.' Lastly he thought there was good ground for regarding Kaposi's disease (*Xeroderma pigmentosum*) as a family form of lupus; by which he meant that it occurred in several members of the same family. He believed it was a modified form of l. erythematosus.

This extremely rare and peculiar disease formed the subject of a communication to the Royal Medical and Chirurgical Society, on March 25, by Dr. Radcliffe Crocker, on "Three cases of *Xeroderma pigmentosum* (Kaposi) or *Atrophoderma*." He mentioned that the disease was first described by Kaposi, in 1870, who gave a more extended account last year. The present cases were the first and only ones known in England, and consisted of two sisters, aged respectively twelve and ten years, and their brother, aged nine, out of a family of four. Besides the above cases, there were thirty-one others known, all closely resembling each other. The disease usually commenced in the first or second year of life without apparent cause, affecting the face and the exposed parts of the neck and extremities; it spread slowly, reaching as low as the third rib in front, and up to the middle third of the upper arm. In the first stage red blotches or spots appeared, which faded, but left lentiginous pigment spots: or the freckles might come first, and increase in size, number, and depth of color. The skin then became very dry, and white atrophic spots appeared between the freckles, which coalesced into larger areas; the skin in part peeled off in thin lamellæ, and afterwards became contracted and parchment-like. Some years later superficial ulcerations covered by crusts appeared, and warty projections grew from some of the pigment-spots. Then, at about the fourth to sixth year, the warty growths and sores became the starting-point of fungating epitheliomata. The patients became marasmic, and died exhausted, usually before puberty. Of the whole thirty-four cases, the number of males and females affected were equal, but the disease usually limited itself to members of one sex only in the families affected, seven boys having been attacked in one case, and in another, five girls. Treatment was futile. Dr. Crocker did not agree with Mr. Hutchinson in thinking that the disease was in any way related to lupus erythematosus; he thought that it was apparently a primary atrophy of the skin, and could hardly be mistaken for any other affection. Mr. Marrant Baker thought the name *Xeroderma* singularly inappropriate. Dr. Colcott Fox was not able to distinguish any difference between the tumors in this disease and rodent ulcer by the microscope. Dr. Crocker said the tumors in his case were papillomata.

Under the title a "case of SYPHILIS in which the fingers of one hand became cold and livid; suspected arteritis" (*Med. Times and Gazette*, March 15, p. 347), Mr. Jonathan Hutchinson relates the following curious case. A gentleman, aged thirty, when first seen, had a serpiginous ulcerating syphilide on the thighs and trunk; the primary sore had occurred four years previously; he had also signs of early phthisis. In two months the eruption was quite cured by mercury and iodide of potassium, and he was looking well, but he then for the first time had constant aching pain in the middle finger of the left hand; nothing could be seen, but during the next two months the pain in the finger got worse, and after a while the other fingers were also involved. When seen again a little later, the fingers were blue and mottled, as if they had been exposed to great cold, this con-

dition being most marked at their ends, and diminishing gradually towards the knuckles. The middle finger, which was first affected, was now almost well, and the thumb had never suffered much; the fingers were very cold to the touch, and by the thermometer there were ten degrees difference between the corresponding parts near the ends of the little, middle, and ring fingers of the two hands; on the ring finger at its pulp, there was a sore with livid edges, which was very tender; the nails were quite livid, and the fingers stiff and difficult to flex, but not swollen; the whole arm was flabby, and considerably thinner than its fellow. The pulses were nearly equal, and there was no evidence of occlusion of veins; the ulnar nerve was not enlarged, and there was no aneurism in the neck or chest; pain was almost constant, and severe at nights, and there was no anæsthesia. He was treated by specifics and recovered. Six months after the pain had ceased, the temperature of the fingers of the two hands was the same; the affected fingers were much thinner than those of the other hand; the nails, owing to the shrinking of the fingers, were more curved, and there was no clubbing of the finger-ends. Some years later, there had been no return of pain in the fingers, and no further sign of syphilis. The attack lasted altogether six months, and approached gangrene; it was slowly aggressive, affecting one finger for months before the others were involved. The affection differed from Raynaud's disease in the extreme pain, and the freedom of certain fingers. Mr. Hutchinson thinks it may probably have been due to an arteritis beginning in the small vessels and travelling to the larger trunks, and is doubtful how far syphilis be the cause, as the patient had been for some months under efficient treatment. As the fingers affected were not those supplied exclusively by any one of the nerve trunks of the forearm, and there was no loss of sensation or motion, he excludes a nervous origin.

CAVAFY.

LONDON.

Selections.

TREATMENT OF SEVERE FORMS OF LUPUS.

IN the treatment of lupus, none of the milder remedies hitherto proposed, each of which has in turn enjoyed its share of popularity, has been able to supersede the "rough and ready" methods of operative surgery. On the contrary, linear scarification, multiple puncturing, and the use of the curette have been the measures almost exclusively resorted to ever since their advocacy by Volkmann, for the cure of this formidable and obdurate complaint. The reasons for this preference are not far to seek. Besides being more expeditious, the last-named procedures are apparently recommended by their superior results, and also by the fact that they actually produce less pain than the caustic applications formerly in vogue—whence many old lupus patients, after running the gauntlet of a ten years' treatment, with all its successive changes and improvements, are decidedly in favor of them. It is true that the operative measures may themselves be of a more or less energetic kind, according to the form and extent of the disease and the constitutional peculiarities of the patient; and that it is therefore quite unnecessary to attack each and every case of lupus with the same

unsparing severity, as has been the recent practice of certain French and English surgeons. Alibert, C. Fox, and Malcolm Morris recommend deep scarification, with extensive destruction of the diseased tissues, to be effected in the fewest sittings possible. Besnier prefers the thermo- and galvano-cautery, in their various modifications, with which he employs an imposing array of knives and needles. These processes being very painful and requiring to be frequently repeated, some of the above authorities recommend local anaesthesia, sometimes aided by subcutaneous injections of morphine and atropine solutions.

For my own part, having, in the course of several years' practice, thoroughly tested all the known methods on some hundreds of lupus-patients, I have found none which, *when employed singly*, can be pronounced suited to every case. I have often obtained better results from simple than from energetic measures; nay, more, I have frequently witnessed, in consequence of the latter, an extension of the disease into neighboring parts previously exempt; so that I am compelled to regard severe local procedures as capable, in certain cases, of doing much more harm than good. Many other dermatologists can testify to a similar experience; in short, it is always impossible to foresee precisely when and where the treatment of lupus is certain to be permanently successful. This much, however, is established—that favorable hygienic surroundings, a strong constitution, and a healthy condition of the organs not involved in the disease, furnish no absolute security for its radical removal. That many lupus patients exhibit not a sign of tuberculous or strumous tendencies, and yet are difficult of cure, is no less true than that such as are poorly nourished, scrofulous, or cachectic, are still less promising subjects for the exercise of our skill. The best chances for success are generally met with in those cases where the lupus patches are of small dimensions. Here favorable results are not unfrequently obtained, whatever method may have been resorted to; yet even here, the return of the complaint, after a longer or shorter interval, should cause us no surprise. It may be imagined, therefore, how perplexing and almost hopeless our situation must oftentimes appear, when the disease occupies large surfaces, and goes on extending itself for years, and when we must endeavor not only to effect a restoration of deeply altered or destroyed cutaneous tissues, but to check the further advance of the devouring evil, especially in those mismanaged or neglected cases so frequently met with in our hospitals. The remedies applicable to the more circumscribed forms of lupus have their value also in these almost desperate cases, but here it is necessary to proceed step by step, and with frequent changes of agencies and methods. Among the remedies we must reckon pyrogallic acid, an acquisition of decided importance within a limited sphere. It is useful in many ways, and sometimes effects quite a speedy destruction of the infiltrated cells in particular localities. Applied in the form of a ten to fifteen per cent ointment, three or four times daily, it transforms the morbid growth into a pulpy, dirty-gray substance. The removal of this renders difficult the further employment of the acid, on account of the great sensitiveness of the denuded corium, and the obstacles offered by the purulent layers which are speedily deposited. The cicatrix, when formed, looks smooth and handsome, but is seldom free from tubercles, which in many cases present the same appearance as at first. A second and third application to the same diseased surface were always followed by a like result. In short, I was forced to the conclusion that *the total destruction of the lupus-infiltration is very rarely possible by the sole agency of pyrogallic acid*. If, however, we could succeed in checking, or in wholly preventing this reproduction of tubercles from the destroyed stroma, the problem of how to cure lupus without resorting

to surgery would be solved at once. With this object in view, I made trial of numerous remedies without success, until I hit upon the employment of empl. mercuriale, the effects of which, *in conjunction with pyrogallic acid*, have been surprising in some instances, gratifying in most others, and unsatisfactory in only a few. The plan I have adopted is this: When the suppuration produced by the pyrogallic acid is at its height, instead of promoting a healing action by means of simple cerates or antiseptic ointments, I employ the mercurial plaster either immediately after the removal of the acid, or on the day following, and thus almost always succeed in satisfying the requirement which the latter agent leaves unfulfilled. The gray plaster, when used alone, is well known to be of no value in the treatment of lupus, since it is incompetent to cause absorption of the infiltration. That is, it has no such specific influence over the lupus deposit as it exerts in the case of syphilis—which fact may help us to a correct conclusion as to the difference between the two maladies.

The number of patients affected with the *most malignant forms of lupus*, who were subjected to the above treatment, and who remained under careful observation until its close, amounted to twenty. The following was the course pursued with all of them: For several days after admission the diseased surfaces were kept completely covered with vaselin smeared on cloths, in order to facilitate the removal of all secondary morbid products, such as scabs, etc. A ten-per-cent pyrogallic ointment was then applied over the same area, and renewed two or three times in the twenty-four hours. This dressing was employed from four to six days, or, in cases where the cutaneous tissues were insensitive, for six or seven days. On its removal vaselin was again applied for one day, after which the entire suppurating surface was covered with mercurial plaster. Healing began in from ten days to a fortnight in most localities, but isolated nodes and tubercles could still be detected in the cicatrized integument. Pyrogallic acid was now once more applied for three or four days, causing renewed suppuration of the partially healed infiltrations, while those more firmly skinned over remained unaffected. When treatment was repeated, so much pain in many cases was experienced on the second day that mercurial plaster had to be at once substituted for the ointment; but if this was not the case, the latter was left on for two days longer. The gray plaster was allowed to remain—being changed once daily, if the suppuration was trifling, twice or thrice if it was more profuse—until cicatrization was complete, which sometimes required four weeks. When the complaint was peculiarly indolent and obstinate, the same process was gone over for a third time, but treatment never extended further than this.

An accurate and unprejudiced comparison of the results obtained in this way, with those which have followed other methods, has proved decidedly favorable to the former. A speedier and much better resolution of the most advanced and wide-spreading morbid growths was found to occur under the combined pyrogallic and mercurial treatment, than could have been brought about by the united agencies of scarification and the thermo-cautery.

To make our estimate more precise, and to obviate any misconception which might cause the means I have recommended to be regarded in the light of a *lupus-panacea*, I present the following summary of the objects which they may reasonably be expected to accomplish:

1. The severest and most extensive forms of lupus—those hitherto most difficult and frequently impossible of management—may often be essentially ameliorated by these simple and comparatively painless procedures.
2. The application of mercurial plaster, immediately after several days' use of

pyrogallic acid, is able to bring about complete absorption of the tubercles and infiltrated cells at some points, while at others it is remarkably effective in arresting the morbid growth and forming complete and smooth cicatrices, results which are not attained by the use of either remedy alone. The combined treatment may be employed two or three times in succession without any inconvenient consequences.

3. The more circumscribed forms of lupus are *less* amenable to this method than the diffuse, serpiginous, and ulcerated varieties—perhaps for the reason that in the latter the corium affords a less congenial breeding place for the morbid cells. Yet sometimes, in these same cases, better results are obtained through a previous deep scarification of the affected parts, although scarification alone will prove entirely ineffectual.

4. The duration of treatment is shorter than under the other methods, not exceeding three or four months in the worst cases.

5. *Relapses* are to be looked for here no less than after other processes, but are least to be apprehended when the treatment has been thoroughly carried out, *i. e.*, has terminated in uniform and complete cicatrization.

6. This method is indicated in the most extended forms of lupus, whether occurring on the face, the body, or the extremities, and is especially suitable in neglected cases which have received no previous treatment.

7. The affected surfaces, after healing, retain their redness for a considerable period. The discoloration gradually fades, however, and its disappearance can sometimes be hastened by using an ointment of bismuth or zinc.—ERNST SCHWIMMER. *Wien. Med. Wochenschrift*, Nos. 20, 21, 22. 1884.

CONGENITAL LIPOMA.

IN dealing with this subject, the author excludes all reference to general obesity, that is, hypertrophy of the adipose tissue under the whole of the surface and in the interior of the body. He considers only local changes, and, therefore, the cases of infants and children weighing from fifty to one hundred pounds, or more, in very early years, form no part of this paper.

Local hypertrophy of the adipose tissue will sometimes increase the size of a limb enormously. Thus the hand of a boy of sixteen years has been known to weigh eight pounds. The extremities are also increased, both in length and circumference, and in these cases the development of the bones is liable to correspond with that of the adipose tissue.

With this exuberant growth other anomalies are apt to be combined. Thus Fisher observed a supernumerary nail, though without a phalanx of its own. The swelling is mostly of irregular shape, and is not unfrequently found at a great distance from the heart. In many cases, impeded circulation may bring on or aggravate the morbid process.

Congenital hypertrophy, with the development of a great deal of fat, is mainly found in the fingers, the volar side of which is liable to carry a large quantity. The presence or absence of fat in them or elsewhere depends on the time in which the congenital hypertrophy started. In the first half of intra-uterine life no fat is formed. Thus local hypertrophies dating from that time are complicated with gelatinous or myxomatous enlargement of the inner layers of the skin. Such, however, as originate in the second half of foetal life will be found complicated with an abnormal concomitant development of fat.

The skin of the occiput and back, the abdomen, the upper extremities, besides

the calves of the legs and the dorsal and plantar surfaces of the feet, are also the seats of such deposits. On the head, lipomata are found but very rarely. It must be taken as a rule that lipoma will form under circumstances and in localities where fat is normally deposited in disproportional quantities. It is to be taken as the (pathological) excess of normal (physiological) growth. Thus, in the adult, lipoma will mostly be found on the chest, shoulders, abdomen, and congenitally it will be where physiological growth of fat is rapid. Fat having been developed, its increase is generally slow; as a rule, slower in an adult with an acquired than in the infant with a congenital tumor. It would also appear that, contrary to adult lipoma, the congenital variety is apt to be diffuse and not capsulated.

The author's own cases are as follows:

1. Mary C—, aged three years, admitted May 23, 1879, to Mount Sinai Hospital.

Family history good. The swelling on both sides of the vertebral column in the *lumbar region* was noticed immediately after birth. It increased in size slowly up to six months ago, when it began to grow rapidly. It was not painful: she was playful, and her appetite and general appearance were good, although she was delicate. She had two brothers and two sisters in good health.

When admitted there was a swelling in the lumbar region, extending five inches or more to the right and to the left of the lumbar vertebral column. It was soft, elastic, and lobulated, and from three to four inches in its vertical diameter. It was not painful on pressure, and the skin over it was not changed with the exception that a few blood-vessels were enlarged. There was a smaller swelling on the (left) gluteal region and another on the level of the scapula, the latter being the smaller of the two, and having a diameter of two or three inches. There was no doubt that all of these tumors were lipomata. On the third of June, a semicircular incision about ten inches in length was made over the main tumor, with its concavity downwards. No capsule was found. Large masses of fat between the skin and the vertebral column were removed, still it was not possible to dissect deep enough to remove all the fat present. The condition of the patient after the operation was fair. On the ninth, however, she began to have dysenteric stools. At the same time, the wound looked badly and began to slough. The child was fed well, took quinine regularly, and was stimulated freely with alcohol and camphor, but she grew paler, emaciated considerably, and the wound continued to slough. There was a great deal of discharge, which always had an offensive odor.

There was never any fever, but emaciation continued, anæmia increased, and the patient died on the 2d of July.

II. A boy of three years had in and below his *left groin* a nodular swelling of irregular shape, apparently originating in the femoral ring. It measured from three to four inches in the axis of the femur, and from two to two and a half inches transversely. The blood-vessels of the surface, which was quite normal, were but slightly enlarged. Pressure gave no pain and resulted in no reduction of size. The tumor had been observed through more than two years, and had grown larger, but never changed its location. Removal was proposed, but at that time refused.

III. A lipoma, probably congenital, I observed on the *back* of a man of fifty-five. It was located over the ninth and tenth dorsal vertebræ, of the size of a walnut, not changed in color, not painful, indolent on pressure, not reducible in size. The blood-vessels in the neighborhood were but slightly enlarged. It ap-

peared nodulated, soft, but offered a certain resistance. I advised an operation only in case the tumor should ever commence to grow. It never did, however, and twenty years afterwards, when he died, it was exactly in the same condition and of the same size.

IV. A female child, a patient of Dr. Moeller, was born on January 26, 1882, and died April 4, 1883. This case was one of gigantic growth of the left foot, localized lipoma of the *right thigh*, diffuse lipoma of most of the surface of the *abdomen and chest*, and teleangiectasia of the right side of the thorax, mostly anteriorly.

In the last few months of life, large subcutaneous abscesses developed and discharged considerably. The autopsy corroborated the diagnosis, and revealed, besides, hydrocephalus and perinephritic abscess on the left side.

V. A case of lipoma of the *lumbar region, complicated with spina bifida*, came under the author's observation many years ago. According to Dr. Dawson's description (*Am. Journ. Obstet.*, Feb., 1871), "A tumor the size of a large orange was seen over the lower lumbar region. Its appearance was somewhat flattened and very slightly pediculated, and its color was uniform with the surrounding skin. To the feel the tumor was uniformly tense and unyielding, though not hard, and by grasping it with the fingers considerable mobility was obtainable. Continued and very firm pressure failed to diminish its calibre, and produced no marked impression on the appearance or behavior of the child."

Under the supposition that the case was one of uncomplicated lipoma, its removal was undertaken. It was found to be diffuse, one and three-quarter inches in thickness, not capsulated, and covering a small sac of spina bifida, containing not more than half an ounce of fluid, of the size of a small thimble, just admitting the little finger to the depth of three-fourths of an inch.

The paucity of collected cases, extending over nearly a century, proves the rare occurrence of congenital lipoma. Every additional case must be considered welcome.

What was emphasized in the introductory remarks appears to be confirmed by the cases on record. Few of them were capsulated, most of them diffuse. Some of the patients had both diffuse and localized and capsulated lipomata. Many were uncomplicated; some were complicated with teleangiectasia, either superficial or deep-seated, or with dermoid degeneration, or fibroma, or the formation of bone or cartilage, or calcification. The most interesting and dangerous complication was that with spina bifida, the author's case.

The shape of congenital lipoma is frequently irregular, not spheroid as it is in the adult. This difference is the result of its uncapsulated, diffuse nature. Processes and protuberances are not infrequent, and apt to interfere with complete extirpation.

Its locality varies. Cases have been found all over the body. There is but a single case of lipoma of the head, but a goodly array of those on the back, and particularly the lumbar and gluteal regions. Many are found on the extremities, the hands, and still more, the feet yield the largest number. Few of these, however, are uncomplicated, very few of them but are found on the palmar or plantar side, where the acquired lipoma of advanced age is not found.—A. JACOBI, *Arch. of Pediatrics*, Feb., 1884.

MODERN AND ANCIENT LEPROSY IN SYRIA.

THE intrinsic and historic interest connected with leprosy is such as to make it a fascinating field for research. The recent case at Salem, Mass., is fresh in

the minds of our readers, in which the disease was imported from the Sandwich Islands. Descriptions of the leprous community on one of those islands have been frequently given us by travellers. Recently an interesting account has been published by Professor Lortet, dean of the Faculty of Medicine at Lyons, of the disease as observed by him in Syria. These papers may be found in the first few numbers of *Lyon Médical* for the current year. The picture presented is a most revolting one, but inasmuch as it shows the disease as it occurs among a people crowded together and entirely devoid of even that palliative treatment which medical knowledge is able to afford, it may perhaps be taken as a fair representation of that type of the disease which in the Middle Ages followed back the returning Crusaders, and spread terror over so much of Europe.

It seems that in Syria leprosy is closely limited to the southern parts bordering on the Egyptian confine, Neapolis on the north, and Joppa, Jerusalem, and Hebron on the south, representing its topographical range. The nomadic Arabs on the shores of the Dead Sea are exempt. The total number of lepers in Syria is given as about one hundred. They are confined to certain cities, where they beg alms during the day and retire at night to their quarters and contribute their gains to a common fund. Until recently they had their "quarter" in Jerusalem, where they occupied a collection of huts made of reeds and mud, so low that it was necessary to crawl into them, and filled with all sorts of filth. Now they are removed outside the wall to a big one-story structure built on a spot partly cut out of the rock above the valley of the Kedron, where hygienically they are about as badly off as before. The several compartments all have their entrances looking against the face of the rock. These rooms are each thirteen feet by twenty-two, and serve each for shelter to a group of lepers, or a family if they are married. The only furniture in these rooms consists of two boxes, one for containing the poor food on which they subsist, the other the rotten rags with which they cover their putrefying sores. The floor is of bare earth with perhaps a few bits of old clothing that they have begged to sleep on. There is no fireplace, but two or three stones are put together when there is wood to burn, and the smoke, with the exception of what is deposited on the walls and roof, escapes through the door and window.

Of the aspects of the disease in its worst forms we have not space to speak in detail, nor would the description be especially novel to our readers. The reddish-purple tubercles on the face, shoulders, and extremities, particularly the posterior surface of the forearm, the inside of the thigh, and the front of the leg; the large yellowish spots which in milder cases replace the tubercles and have a similar distribution; the breaking-down into ulcers of these first formations; the extensive areas of superficial anæsthesia; the contraction of the flexor muscles so that the hands cannot be opened, and the toes are drawn down upon the plantar surface of the foot; the ulceration and sloughing of the phalanges one by one, till the metatarsal and metacarpal bones are exposed, protruding from a bleeding, horribly fetid wound; finally, the gangrene attacking the face, the cornea, the ears, and the scalp, and eating its way into the bones of the nose and cranium—these are among the salient features of the portrait drawn by M. Lortet as well as by other observers of the worst forms of the neglected leprosy of to-day. For the more complete details we refer the reader to the article cited.

The community on the banks of the Kedron is, we learn, governed by a sheik, himself a leper, for whom his subjects show the utmost submission and respect. Lepers can marry only among themselves. Women, being less frequently the victims of the disease than men, are at a premium in the matrimonial market,

and command a substantial pecuniary price. The desire for marriage among the men seems to be chiefly based on the hope of securing a nurse against a time when they can no longer do anything for themselves. Either from the frequency of an implication of the organs of generation or from the constitutional depression these marriages are almost always sterile. The disease is eminently hereditary. Out of twenty-six cases which are described in detail by the writer, no less than twenty-one were of leprous parentage. While a child of a leprous father may in rare cases escape the malady, there is no authentic instance, according to this author, of a leprous mother failing to transmit the disease, which appears in the child at from eight to ten years, never earlier.

Little is known regarding the cause of leprosy, but M. Lortet points out the interesting fact that all the lepers in Syria are fellahs, that is, mussulman or Christian farmers, whose diet is notably poor, consisting of innutritious vegetables like lentils, with never any meat. The Israelites, and in general the inhabitants of the towns, however insalubrious the surroundings of the latter, are exempt from leprosy. Ichthyophagy, as a cause of the disease, is rejected by M. Lortet, his Syrian fellahs having for the most part no fish to eat. The largely maritime distribution of leprosy, with other facts which have given credit to the theory that ascribes it to a fish diet, are reconcilable with M. Lortet's observations if we suppose leprosy to be in part at least a vice of nutrition, and caused alike whether bad fish or any other innutritious food is made the only diet to the exclusion of adequate alimentation.

M. Lortet believes leprosy to be contagious through the channel of the cutaneous lesions, the lungs, and the digestive tract. He also confirms the view of its parasitic nature, held by many recent observers. He found in sections from non-ulcerated leprous tubercles that the derm was infiltrated with large, irregular cells, multipolar, and filled with long, very slender bacteria, which possessed a very active movement.

The description of leprosy as it exists to-day in the Holy Land suggests, very naturally, the inquiry how far it is identical with the disease called by that name in the Bible. In the thirteenth chapter of Leviticus are to be found the Mosaic rules for diagnosis of leprosy. From these it seems probable that the law-giver included under that title a number of contagious diseases, among them favus and tinea barbæ (verses 29, 30). While some authorities have denied that the leprosy of Moses included at all the *elephantiasis Græcorum*, others have recognized this as one of the types which he described. In the *Popular Science Monthly* for April Dr. George H. Fox discusses this question. He shows that the expression "white as snow," so frequently applied to the appearance of the disease, does not seem applicable to modern leprosy of either the macular or of the tuberculous type. The direction for the patient to be examined by the priest after seven days for evidence of change in his condition, seems to contemplate some disease less chronic in its development than leprosy. It may well be supposed that the practical purpose of Moses' instruction being preventive treatment, the law-giver may have included all contagious skin diseases with which he was acquainted under one term, without specifying or even knowing their diagnostic differentiation.—EDITORIAL, *Bost. Med. and Surg. Journ.*, April 10, 1884.

NON-ERYTHEMATOUS NODES IN RHEUMATIC SUBJECTS.

ACCORDING to M. Jaccoud, the earliest mention of these morbid manifestations was made by Froriep, in his essay on Rheumatic Indurations, which appeared in 1883. They were first clearly and distinctly treated of, however, by Jaccoud him-

self. An examination of the various publications relating to the subject has led me to conclude that, for the present at least, the phenomena in question may be divided into two classes, viz., *ephemeral cutaneous nodes* and *rheumatismal subcutaneous nodes*.

1. The first of these has been well described by M. Féréol in two communications, one to the French Association for the Advancement of Science, at its meeting in 1879, the other in 1883, to the Société Médical des Hôpitaux. It is also referred to in a paper by Davaine (*Contribution à l'Histoire du Rhumatisme; (Edème rhumatismal; Nodosités éphémères rhumatismales du tissu cellulaire sous-cutané*, Paris, 1879). In this class the protuberances are usually seated on the forehead. They are frequently not very prominent, present no discoloration, are entirely painless, even on pressure, and are unaccompanied by itching, pricking, or heat. Their size varies from that of a hazel-nut to that of a small pea. They are never very numerous; sometimes there is only one of them, oftener two or three; seldom more. They are generally movable, together with the skin, over the deeper-lying parts, though sometimes they seem adherent to the periosteum. According to M. Féréol, they often arise during the hours of sleep, without occasioning the slightest pain or even uneasiness. In most of the instances observed by myself, however, they have made their appearance towards evening. They are literally ephemeral, for, after lasting a few hours, or a day at farthest, they disappear, to be speedily reproduced under the influence of causes thus far entirely unknown.

2. The second variety is of much more common occurrence. It is characterized by small subcutaneous tumors, more or less prominent, bearing at first sight a strong resemblance to syphilitic gummata or to exostoses. Over these the integument glides freely—being slightly adherent only in very rare cases, which constitute a transition between this class and the preceding—and is not at all discolored, though rather paler than elsewhere, owing to its distention. Upon palpation, the elevations impart a peculiar feeling of hardness and elasticity, and lateral pressure shows them to be movable over the subjacent tissues. This last feature is especially perceptible when the nodes are situated in the neighborhood of the joints, or on the aponeuroses, the tendons, or the peri-articular ligaments; but when occurring on the pericranium their mobility is too slight to be detected without careful examination. They are, indeed, not easily discoverable in the latter situation; on laying the hand flat upon the head, they may be felt under the scalp, like small, hard, scattered lumps, resembling, as already mentioned, certain exostoses. In some cases they are devoid of sensation, but more frequently are painful on pressure. In a typical case observed by Dr. Troisier and myself, this sensitiveness became so extreme that the patient could not bear to rest his head upon his pillows.

The size of the nodes varies greatly, from that of a small pea to that of an almond, their shape is seldom oval, more frequently round, and is clearly defined. Their eruption is unaccompanied by any special symptoms; their growth is sometimes rapid, sometimes slow; they are of longer duration than their congeners of the first class; they remain stationary for some days, or it may be for weeks, after which they gradually dwindle and finally disappear, without leaving a trace of their existence. As a rule, they put forth several successive crops. Their entire duration is generally from a few days to three or four weeks; though they have been known to last more than two months. They are usually met with in the neighborhood of the joints, *i. e.*, on the elbow, knee, wrist, instep, hand, etc., and the fibrous tissues investing the superficial bones—those of the knee,

ankles, fore-arm, shoulder-blade, crest of the ilium, hand, and above all, the head, more particularly the frontal and occipital bones. They are usually isolated, in rare instances becoming confluent. Their number is much greater than that of the first class, varying from one to sixty.

If it be asked whether the two varieties of nodes which I have briefly delineated, should be kept completely apart in our nosological catalogues and descriptions, I answer in the negative. I believe them to be morbid products identical in their nature, differing from each other in certain external peculiarities which I have endeavored to elucidate, but on the whole belonging to the same pathological class. Hence, I should be disposed to place them both in one group, under the common appellation "rheumatismal or rather arthritic non-erythematous nodes," cutaneous or sub-cutaneous, as the case may be. I call them *non-erythematous*, because I believe that they should be carefully distinguished from erythema nodosum, which differs from them in its mode of development, its objective symptoms, and the well-marked boundary lines of its eruption, and whose tubercles, moreover, present an external discoloration which is decidedly pathognomonic.—L. BROCOQ, *Journal de Médecine de Paris*, No. 10, March, 1884.

CUTANEOUS MANIFESTATIONS OF CHOREA.

MUCH interest has always attached to the study of complex physiological phenomena, and of the organic and etiological relations through which their apparently dissimilar elements are traceable to a common origin. Such are those numerous instances which daily fall under our observation of various skin-affections accompanying rheumatism, neuralgia, and the entire series of trophic lesions connected with diseases of the nervous system. Of this sort are the two following cases of cutaneous symptoms co-existing with chorea, recently brought under our notice by Dr. Ollivier.

A child of thirteen years was admitted May 22, 1883, to the St. Louis Hospital with a fracture of the thigh. When union had taken place, the child was sent to Vincennes, where, after the lapse of three weeks, it became the subject of chorea, which kept growing worse, and was accompanied by pains in both knee-joints. Shortly afterwards, an eruption broke out, the traces of which were still visible when M. Ollivier first saw the patient, whose condition at that time was as follows: Child well built and of vigorous appearance, though pale; always makes faces when spoken to, and answers by signs, as if ill-humored. When trying to speak, its utterance is difficult, the tongue protrudes, and the lips and commissures twitch about in every direction. Eyes not affected. Voluntary movements irregular and hesitating; arms and legs always in motion. The gait in walking is natural. The choreic symptoms cease entirely during sleep. Sensibility normal. Action of the heart irregular, tumultuous and intermittent-palpitation coinciding with the choreic movements; very distinct presystolic and systolic murmur at the apex. Pulse small, irregular, and intermittent.

The cutaneous eruption made its appearance on the hands, extending next to the neck, body, and lower limbs, but leaving the face intact. It consisted of macules, papules, and nodosities. The trunk presented erythematous patches, some of which were circinate; on the nape of the neck and neck were numerous pimples of a deep-red color, which only partly disappeared on pressure. On the anterior surface of the legs were several nodes the size of a small hazel-nut, while the forearms and arms were covered with erythematous spots which were

beginning to turn slate-colored. This polymorphous erythema was accompanied by a slight itching.

The eruption had been out about a fortnight, and its appearance was followed in a few days by a cessation of the articular pains. The chorea gradually became less troublesome, and ceased entirely towards the end of three months.

Treatment consisted simply in the administration of bromide of potassium in gradually increasing doses (from one to seven grammes per day), and the application of several fly-blisters to the precordial region.

The other case was a girl of the same age as the preceding, who was brought to the Children's Hospital, January 15, 1884. At the beginning of March, 1883, after running a considerable distance in the cold, she noticed upon both her hands whitish elevations encircled by a reddened zone which itched a great deal and compelled scratching. At the same time she had pains in both metacarpophalangeal articulations, with slight redness about the joints, but no swelling.

The eruption disappeared in two or three days, but the pains in the joints lasted some time longer. During this interval choreic movements began in both hands, extending gradually to all the limbs and to the face, which was chiefly affected on the right side. Fowler's solution was prescribed, together with wine of colchicum, wine of cinchona, and syrup of iodide of iron. The chorea and accompanying pains persisted during six or seven months, after which her health was completely re-established.

In the month of August a relapse took place. Pains were now felt in the tibio-tarsal joints, with swelling around the ankles; then successively in the carpo-phalangeal joints, wrists, and elbows, and were accompanied by chorea of the upper limbs, facial muscles, and head. Painting the joints with tincture of iodine, and the administration of bromide of potassium, with sulphur-baths, caused the disappearance, one after another, of all these symptoms.

We see that in one of these cases the choreic, eruptive, and rheumatic symptoms appeared simultaneously; in the other they were manifested in succession. It is difficult not to entertain the idea that these three series of phenomena were more or less intimately connected.—*Gaz. des Hôpitaux*, No. 63, May 31, 1884.

BOUTON DE GAFSA.

THIS is an exotic cutaneous disease belonging to the same nosological category with the eruptions known as "clous de Biskra, laghouat des Zibans, Boutons du Nil, d'Alep, de l'Inde," etc. On account, however, of its comparatively harmless character and short duration, it will here be considered as simply a mild form of the latter affections.

Bouton de Gafsa recently made its appearance as an epidemic in the military camp at Sathonay, whither it had been imported from the south of Tunis by a battalion of returned soldiers. We thus, as army surgeons, enjoyed an opportunity—the only one hitherto afforded in France—of observing its progress and development in over forty almost simultaneous cases.

The course of the malady comprises the four stages of induration, ulceration, desquamation, and cicatrization. It commences with the appearance of a small, red, hard, and indolent tubercle, which never assumes the character of a vesicle or of a pustule, and lasts from one to two weeks. A process of exfoliation then begins at the apex of the tubercle, whence the epidermis is detached in large, white, dry, and very thin scales, and gradually extends, not only over its entire surface, but also downwards, as far as the deeper layers of the derma, where

thicker scales are formed with a slight serous exudation. This period is usually very short, but in some cases may last two or three weeks. It is succeeded by an ulceration of the derma, producing large dry crusts of a deep-brown color. The tubercle now flattens down into the semblance of a turtle-shell, having an average breadth of three or four centimetres. As the ulceration proceeds, this crust loosens and falls off, leaving a perpendicularly excavated sore, with jagged edges and a livid base, which discharges pus or blood. This process may involve the subcutaneous cellular tissue, but never extends further. The duration of this stage is about five or six months. When healing commences, the discharge becomes less abundant; then the crusts fall off, leaving a granulated surface, like a simple sore, with slight tendency to cicatrization. At the end of five or six weeks the scar is fully formed. It is of a brown or purple color, with whitish streaks, and sometimes remains visible for over a year.

A spontaneous arrest of the disease is liable to take place at any one of the above-described stages, giving rise to peculiar symptoms, from which several varieties of more or less importance have been formed, such as the "abortive," the "desquamative," the "crusty," etc.

In the majority of our cases, only one or two tubercles were produced, and their number never exceeded twelve.

The parts chiefly liable to be attacked are those which are usually, or most frequently uncovered, as the hand, wrist, neck, and face.

As to treatment, only one out of the many methods which we essayed proved of positive efficacy. This was the actual cautery, lightly and repeatedly applied, at a red heat, to the base of the ulcer after the crusts had been removed by means of poultices or of local bathing.

The etiology of this disease, like that of its kindred affection, *bouton de l'Inde*, is still involved in obscurity. Its contagious character was evinced in the case of a soldier at Sothanay, in whom the complaint was developed without his ever having quitted France.

With the view of testing its transmissibility by inoculation, we instituted a series of experiments in the medical laboratory at Lyons, whose results are briefly presented in the following conclusions:

1. *Bouton de gafsa*, which prevails endemically in the south of Tunis, is probably contagious and is certainly inoculable in human beings. In the *cobaye*, its inoculation produces a variety of morbid symptoms; in the rabbit, and especially in the horse, the process gives rise to an ulcer, bearing some resemblance to the original disease.

2. This inoculation may be successful either with the lymph, the crusts, or the successive culture fluids.

3. The eruption is not caused by a dermatophytic vegetation, as was asserted by Vandyke Carter in the case of the *bouton de l'Inde*, and by Weber in that of the *clou de Biskra*, but rather by a bacterium (*micrococcus*), which can be isolated by cultivation, according to the method of Pasteur.—ED. BOINET and CH. DÉPÉRET, *Lyon Méd.*, April 20, 1884.

ERYSIPELATOUS ERUPTION ON THE FACE, CAUSED BY ARNICA.

PATIENT a baker, aged forty-two; skin white and delicate; no previous cutaneous disease; since 1870, has had two attacks of rheumatism in the small articulations.

December 4, 1883, in consequence of falling against a door-post, he sustained a slight contused wound, which bled a few drops, on the outer portion of the left superciliary ridge. He first made use of cold-water compresses, then, in order to keep down the swelling, he procured at a drug-store some tincture of arnica, which he applied several times in the course of the evening. Next day, the affected region being a good deal swollen, he went again to the druggist, who gave him a compound of bran-water and arnica tincture, probably in equal proportions.

I first saw him on December 6. The face, clean shaven with the exception of a moustache, was enormously swollen; the skin of the forehead and of the cheek on the injured side was bright red and covered with phlyctenæ, from some of which issued an abundance of clear, lemon-colored fluid; the left eye could not be opened, and the aperture of the lids was almost hidden by the tumefaction. The rest of the face was similarly affected, but in a less degree; the redness faded away at the neck, where some small vesicles gave the skin a roughened appearance; the hairy scalp was untouched. Temperature in the axilla, 37.4° C. Pulse 70. Next day the œdema had fully extended over the right side of the face, and both eyes were completely closed. Submaxillary glands swollen on both sides. Loss of appetite. Urine scanty and high-colored.

Dec. 8. The swelling and the phlyctenæ had mostly passed over to the submaxillary region and the neck; the left eye could be opened a little. Some restlessness, but no fever. Slight dysphagia, without inflammation of the pharynx.

Dec. 9. General improvement; both eyes open; œdema, however, still continues.

Dec. 12. The vesicles are succeeded by yellowish scales; œdema has disappeared; patient comfortable.

Dec. 22. Skin still red; desquamation not quite completed; general condition excellent.

Treatment consisted in washing off the tincture of arnica, and applying a liniment of oil and lime-water, as in cases of burns. This gave more relief than the bran-water poultices. A saline purgative was previously administered, the tongue being somewhat foul.

The above-described affection bore a strong resemblance to facial erysipelas, in the œdema and erythema of the skin, in the abundant phlyctenæ, and in the swelling of the adjacent glands. It differed chiefly in being accompanied by complete anorexia, and in its exact localization at the contaminated points.

Other prominent features in the case where the dysphagia, caused by tension of the swollen cervical tissues, the pharynx being unaffected, and the scanty urine, of a mahogany color, like that of an icteric patient.—CARTIER, *Lyon Médical*, April 13, 1884.

PATHOLOGY OF HERPES ZOSTER.

A DETAILED account of the autopsy in a case of herpes zoster forms the text of the author's subsequent remarks on theories which have been advanced respecting the etiology and mode of development of that disease—especially by Friedrich and Eulenburg. His own views are summarized as follows :

I believe that through irritation of certain nerves, or, more probably, through failure in their functional activity, a partial tissue-necrosis takes place in the corresponding region of the skin. This necrosis may be quite superficial and so

limited in extent as to be only microscopically discernible, or it may affect a larger surface and penetrate more deeply. In this way, a *reactive inflammation* is always set up—leading, in the first of the above-mentioned cases, to the formation of vesicles, without any other obvious phenomena, and in the second, as a consequence of visible gangrene, to the production of an eschar to separative inflammation, and sloughing, and finally to cicatrization. On comparing the clinical, and more especially the anatomical facts that are ascertained respecting zoster, it appears most probable that the nerves in question take their rise from the spinal ganglia, particularly the ganglion of Gasser, and that, following by preference the course of the sensory nerves, they send their final ramifications into the integument. Consequently the function of these nerves must be modified, not only remotely by disease of the ganglia in which they originate, but also by any injuries which they may sustain in their course from the ganglia to the skin. This affords the simplest explanation of the fact that zoster makes its appearance most frequently in the tract of ganglionic disorder, but that it can also be evoked by affections—inflammations, wounds, etc.—of the peripheral nerves. And lastly, as has been noticed in some rare cases of diseases of the brain and spinal cord, the extension of a morbid process to the ganglia themselves from a still more centrally situated portion of the nervous system, may be the cause of the eruption.

A long series of observations might be cited to prove the occurrence of zoster after lesions of the peripheral nerves; and I would especially refer to a case minutely described by Eulenburg in which, coincidently with an inflammation of the n. ulnaris, an eruption of this character appeared upon the ulnar portion of the n. cutaneus brachii. I will here relate a peculiar instance of this sort, because, in the first place, the cause of the symptoms was so clearly evident, and secondly, it presents an example of *successive appearances* of the eruption, corresponding to the gradual advance of the morbid process along the affected nerves.

Frank S—, student, aged twenty-three, on July 9, 1883, had the nerve of the last back tooth but one in his left lower jaw “killed.” July 11, a vesicular eruption appeared on his chin and under lip, accompanied by some pain and a moderate feeling of tension in the skin of those parts. When first examined, July 13, several groups of vesicles were found on the left side of the chin and under lip, which, at some points, slightly overpassed the median line, and corresponded precisely to the tract of the n. mentalis. On July 6, this first crop had dried up, but three groups of fresh vesicles having a reddened base had arisen on the side of the left cheek, and a single vesicle in the left auricle. There was also a moderate, rather painful, swelling of a lymphatic gland just in front of the left ear. Sensibility was normal.

It seems to me that no question can be entertained as to the nature of the morbid process in this case. By mechanical or chemical irritation, an inflammation was produced in certain twigs of the n. alveolaris inf. which, in two days, extended upward to the nerve itself, thence to fibres of the n. mentalis (which is a direct continuation of the n. alveolaris), and called forth an eruption upon the tract of the latter. The inflammation then advanced in a centripetal direction, until, in four days more, it finally affected fibres belonging to the n. auriculo-temporalis, and excited an eruption in their territory as well.—EDM. LESSER, *Virchow's Arch. f. Pathol. Anat. u. Phys. u. f. Klin. Med.*, Vol. xciii., 1883.

Review.

ETUDE SUR LES CLASSIFICATIONS DES MALADIES DE LA PEAU. ETIOLOGIE ET PATHOGÉNIE DE QUELQUES DERMATOSES. DIAGNOSTIC, PROGNOSTIC, TRAITEMENT. Par le DR. ARMAND RIZAT. Paris: Octave Doin, Editeur. 1884.

TRULY it may be said that of the making of classifications of skin diseases there is no end. The history of dermatological literature records so many efforts in this direction that it would be difficult to enumerate them. Almost every author of a work on diseases of the skin has prefaced it with the author's own classification. Dermatologists in this country, with one exception, have taken the system of Hebra as a model and guide, and while they have made many modifications in unessential particulars, the general scheme has remained unchanged. Certainly, nothing has been produced which would justify the distinction of being termed "a new and improved system of classification of skin diseases."

This continual effort to improve upon existing systems would imply obvious imperfections in the older methods, yet it must be confessed that none of the substitutes thus far proposed fulfil the conditions of an ideally perfect classification. The failure to present a satisfactory system of grouping diseases of the skin must be sought for in the indeterminate character of the most suitable basis upon which such a classification should be constructed. The natural system of Lorry, the lesional system of Plenck and Willan, the anatomico-pathological system of Hebra, with their subsequent modifications and enlargements, are each admirable, when regarded from the point of view from which each was undertaken; but when submitted to the tests of scientific accuracy, simplicity, convenience, and practical adaptation to the wants of the dermatological student, they are each deficient in one or more important particulars. The assertion of Hillairet would seem to be justified, viz., "that a classification is a thing at present impossible to make in a satisfactory manner."

In the little work before us, Dr. Rizat has confined himself to a study of the recent classifications which have been put forth by Bulkley, Kaposi, Hillairet, and Schwimmer, assuming that they represent the American, German, French, and Hungarian schools respectively. Taking these four classifications as a basis of comparison, he calls attention to their differences, as well as the main features of similarity and identity which unite them. His discussion of their relative value, their imperfections and points of superiority, is characterized by intelligence and tempered with calm philosophic judgment. He favors the classification of Schwimmer which recognizes the predominant influence of the neurotic element in the pathogenesis of most dermatoses, and is quite sanguine that this will be the classification of the future.

In support of this view, he brings forward many arguments drawn from analogy, from the clinic and from anatomico-pathological investigations, to prove the neuritic origin of many dermatoses in which this factor has been altogether ignored or assigned a subordinate importance, such, for example, as psoriasis, pemphigus, lichen, eczema, etc.

The book concludes with some general considerations respecting the etiology, pathogeny, diagnosis, and treatment of certain skin diseases.



Plate - The course of the Veins

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Original Communications.

A CASE OF SARCOMA CUTIS; WITH A SUPPLEMENTARY ACCOUNT
OF A CASE PREVIOUSLY REPORTED.¹

BY

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SUCH is the comparative rarity of this affection of the skin that I shall take the liberty of occupying a few minutes of your time in its clinical study.

CASE I.—L., æt. fifty-six, resides in the interior of this State. His social condition and surroundings are of the best. It is said that his mother died of uterine cancer, otherwise there is no history of diathesis in the family, and with the exception of once having suffered from an obstinate conjunctivitis, and at one time having used wine a little too freely, it is noted that the patient's general health has been good.

Patient states that about two years ago a smooth, reddish, somewhat transparent nodule, size of a bean, appeared in the lobule of the left ear. It itched a little, but never scaled, wept, or ulcerated. After six months it was extirpated. It has never returned. Six months after the appearance of this first lesion, several others manifested themselves, situated on the right side of the neck just below the ear, also bean-sized, and still

¹Based upon a paper read before the Missouri Medical Association, May 20, 1884.

others on the back of the left hand. The first evidence of the disease on the hand showed itself on the second finger as a diffuse patch of infiltration. Shortly after this a similar patch appeared on the corresponding finger of the right hand. After these last, the evolution of new growths was gradual.

When Mr. L. was first seen by me, in consultation with his family physician, Dr. Pryor, of Palmyra, on January 30, of this year, the following notes were taken:

The patient is about six feet in height, although he stoops considerably, and is quite thin.

The general color of the integument is peculiar—a sort of yellowish-brown.

The only subjective sensations complained of were slight darting pains in the hands.

The ears are the seat of a diffuse violaceous infiltration. Under the left eye is a small pea-sized, purplish, almost black tumor. Over the right malar region is a dirty, brownish discoloration of the skin, not much, if at all, prominent, but when pinched up, betraying a marked infiltration of the whole thickness of the cutis. At the junction of the scrotum with the thighs and the perineum are several new growths as large as a silver quarter-dollar. On the scrotum itself are nine variously sized tumors. The trunk is free from lesions. The hands offer the most marked involvement. The lesions here consist of slightly elevated tumors, and of broad, flat infiltrations, which latter are but slightly raised above the general level. The backs of the hands are more abundantly involved than the palms, and the left hand than the right. The accompanying plate will show more exactly than any written description the exact seat and other features on the hands.

The infiltration is so massive on the fingers that they are pressed apart, and the patient is totally unable to close the hand. The fingers have a gristly, cartilaginous feel. In other situations the neoplasm is comparatively firm, but not especially brawny. The fingers have assumed a spindle-shape, as is well shown in the plate. When the growths first appear, they are of a dull reddish color, but after awhile they take on a violaceous hue, and assume a quite peculiar glistening appearance. Some few of the nodules are decidedly blackish—notably one under the right eye and one over the tibia. Some weeks after the patient's return home, he wrote me that the hands had become quite painful, the pain being both spontaneous and the result of pressure. He described it as a "dead, burning, aching pain," with occasional paroxysms of a lancinating character. The tumors and plaques of other regions cause him no inconvenience. I saw the patient again on the 28th April, 1884. His general health did not seem so good as on the

first visit—he appeared weaker, and there had been an increase in the local affection. There was much œdema of the legs. Some few new tumors—hazelnut size—had come out on the legs, and a nodule that had been excised for microscopical examination had recurred. The hands were much more involved. Several small tumors had newly appeared on the left hand. Three new nodules had been evolved on the back of the right hand, together with a flat, reddish infiltration on the forefinger and two masses of infiltration on the outer border of the palm. The forefinger of the left hand is much enlarged from a decided increase in the amount of infiltration. This hand cannot be flexed at all, and the right is rapidly getting into the same state.

The circular spots in the palm of the left hand are now of a lighter color, and undoubtedly depressed in the centre. At the patient's first visit he was ordered hypodermic injections of Fowler's solution. This prescription was carried out by his family physician, and up to his second visit he had taken about twenty-five injections in all, consisting of three drops administered every third day. This treatment was advised in view of Kœbner's recent success (*Berl. Klin. Woch.*, No. 2, 1883), in a case of spindle-celled sarcoma of the skin occurring in a girl of eight and a half years, who was cured by this method. I am entirely unable to say whether the treatment has been of any benefit.¹ A microscopical examination of an excised piece of new-growth showed it to be a fibro-sarcoma, thus substantiating the previously expressed clinical diagnosis. For these examinations I wish to thank my friends, Dr. Heitzmann, of New York, and Dr. F. A. Glasgow, of St. Louis.

In the issue of this JOURNAL for January, 1883, I reported very minutely a case of sarcoma of the skin, illustrating, according to the microscopical examination, the alveolar variety of the affection. The paper was accompanied by an excellent chromo-lithograph, with which, as a matter of clinical interest, I would advise the reader to compare the present picture.

At a recent meeting of the St. Louis Medico-Chirurgical Society, I had the opportunity of exhibiting both of these patients.

The following notes, taken some three months ago, will show the further progress of the disease in the case of alveolar sarcoma reported in January, 1883:

I found that S.'s general condition had not materially changed in the last year and a half—a little yellower and thinner, perhaps, but this might have been due to other causes. However, the number and extent of the sarcomatous growths had increased. The plaques on the forehead,

¹ He discontinued it shortly afterward, as the injections caused much pain and inconvenience, but the amount administered made no appreciable impression on the disease.

which are seen to be partially separated in the portrait, are now completely merged, although the former orange-colored borders are still to be traced as lines of division, and the vessels are yet visible in the same situations. A growth over the right brow, whose centre, it will be remembered, was described as having become almost normal from an involution of the morbid process, has developed a new deposit, and it is now similar in appearance to the other lesions. The pigmentation in the various tumors is no deeper than at the first report.

A number of new growths have come into existence, mainly on the backs of the hands and feet. None on the trunk.

It will undoubtedly be observed by any one who will take the trouble to carefully compare these two cases of sarcoma cutis, that they do not offer any striking clinical likeness to each other, either in their history, course, or lesional features; yet it is noteworthy that the new and small nodules in both are almost exactly alike in color, shape, elevation, and other general features. It is only at a later stage that the clinical dissimilarity occurs.

Another point worth noting is, that in the case of alveolar sarcoma the disease has been in existence for ten or more years, and although the prognosis, from the standpoint of the microscopist, is and has been of the gravest sort, the patient is yet alive and in the enjoyment of good health; while in the case of fibro-sarcoma of the skin just recorded, dating back only two years, and suffering from lesions of a presumed less malignant type, we find that the tumors have rapidly developed in the skin, and I have no doubt in the internal organs, and the patient is now in a grave and precarious state. Whether the clinical features of sarcomata having certain histological characters are at all constant, that is to say, whether an alveolar sarcoma of the skin or a fibro-sarcoma of the same tissue will always present analogous pictures to those just reported, I cannot determine; in fact the whole subject still needs much patient investigation.

ACTIVITY IN AN OLD VACCINE CRUST.

A REMARKABLE instance of the preservation of the activity of a vaccine crust is related in a recent issue of the *North Carolina Medical Journal*. It seems that during the term of office of the Hon. Willis Alston, grandfather of Dr. Alston (as a congressman from North Carolina from 1803 to 1825), Dr. James Smith, of Baltimore, was Director of the Vaccine Institution for the State of Maryland. He sent to Mr. Alston a package of vaccine, and it remained unopened until it fell into the hands of his grandson, Dr. Alston, in May, 1869. It was a crust imbedded in wax, and inclosed in a wooden box. Dr. Alston vaccinated his servant with a part of the crust, "and in due time," he writes, "it took effect, leaving a well-defined scar."—*N. Y. Med. Journ.*, July 19, 1884.

A CASE OF UNILATERAL CHROMIDROSIS (?).

BY

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THE occurrence of so-called chromidrosis over limited areas of the cutaneous surface is among the rarer affections of the skin, not a single instance having been reported in the "Combined Returns of Five Years" published by our association in the last volume of the Transactions; not one case, that is, in 58,617 cases of disease of the skin observed by members of this society. Even the comparatively few instances which have been reported in various parts of the world under this title have not all been true cases of chromidrosis or colored sweat, but apparent discoloration of the skin due to the growth of bacteria upon the hairs of parts thus affected. In the majority of these cases there is no evidence that the sweat itself is colored, or in any way abnormal in character, or even excessive in amount. They are apparently cases of parasitism of the hairs, chiefly in localities kept constantly moist by abundant perspiration, as the axillary and genital regions, although the presence of the sweat may be an essential condition of its existence. Such are, no doubt, the reported instances of the "red sweat" of the axillæ, the color of the parts and of the garments stained by contact with them being of an orange or brilliant red tint. The parasitic nature of this form of the affection has been well established by the investigations of numerous competent observers.

Bacteria have also been found in yellow sweat² and in blue sweat, but the same forms have also been observed in colorless perspiration. Indeed, in well-marked forms of persistent red sweat, where the red bacteria have been redeveloped by cultivation upon other soil, these growths are sometimes colorless in parts, so that it may be that some occasional individual peculiarity in the character of the perspiration is essential to the development of this pigment in a plant possibly of common occurrence in a colorless form in the axillæ. Babesi¹ states that these bacteria resemble both the ordinary colorless growths of the hairs and sweat, and also the red *bacterium prodigiosum*. The coloring-matter is situated in the substance between the cells, and is changed to a light-yellow by ammonia, but to a red again by the addition of an acid.

The cases more properly called chromidrosis are not due to the

¹ Read at the eighth annual meeting of the American Dermatological Association.

² Eberth, *Centralblatt für Med. Wiss.*, 1873, No. 20.

³ *Centralblatt für Med. Wiss.* 1882, p. 146.

presence of bacteria, but to some coloring principle of the economy discharged through the cutaneous secretions in a soluble form, and deposited upon the surface of the skin in an amorphous or granular state. Foot¹ collected thirty-eight cases, which he considered to be authentic, in which the color in twenty-one was black, blackish, or brownish; fifteen in which it was blue, bluish-black, bluish-brown, or violet; and two in which it was yellowish-brown or ochreous. In the cases which have been reported since then, the color has been mostly blue or some variation on it, as blue-black or blue-red. This form occurs chiefly upon the face, especially upon the eyelids, and all but one of Foot's series occupied this location. In this exceptional case the backs of the hands were affected. Similar discolorations of the sternum and genital regions have also been observed. Chemical analysis of the matter deposited upon the skin in several of these cases revealed the presence of indican, a well-known pigment of the human economy, in some of its forms, indigo-blue or indigo-red; nor is it surprising that the sweat glands should supplement occasionally the action of the kidneys in the excretion of this substance, as in the case of other principles of the urine. Cyanogen compounds and phosphate of iron have also been discovered in such cases of blue sweat.

Much doubt has been entertained at times concerning the genuineness of this class of cases, and instances of attempts to deceive on the part of patients by the artificial production of such appearances upon the face are on record. An example of such simulation, although unintentional, occurred under my own observation, some twenty years ago. I was asked to see a case of blue sweat which had excited the interest of many members of our profession in Boston, and which, it was claimed, was genuine, because exhibited upon the person of an honest old woman far beyond the hysterical age at which it usually appears in her sex. The patient presented upon the lower eyelids a distinct blue stain extending downwards upon the cheeks. It was seen also at times upon the upper eyelids. Its position varied slightly from day to day, and occasionally it was wholly absent. The color was always very faint in the morning and increased in intensity until evening. The patient stated that the parts affected itched slightly. The case had been reported as chromidrosis, and had an analysis been made of the pigment, which gave a decided blue stain to a white handkerchief wiped over it, this diagnosis would have been undoubtedly confirmed by the discovery of some of the coloring principles of indigo. I found the face at my visit of a decidedly bluish tinge about the eyes, darkest upon the lower eyelid, which faded out, with no well-defined border, half-way down the cheeks. The skin thus discolored appeared otherwise entirely normal, and the patient stated that it did not perspire more freely than other parts of the face. This condi-

¹ Dublin Quarterly, Aug., 1869.

tion had existed for several weeks. I noticed that the attending physician had, strange to say, overlooked that the woman's occupation was knitting of stockings, and that the yarn employed was blue. On examination her finger ends were found to be deeply stained by the indigo pigment, and a little observation showed that she had the habit of frequently rubbing the skin below her eyes with her fingers, probably on account of some habitual pruritus of the parts, and that the face became more and more deeply stained through the day by their constant application to the face. When gray or white yarn was substituted, the blue stain about the eyes ceased to appear. Thus simply was solved the etiology of an apparently genuine case of blue chromidrosis.

References to the excretion of yellow sweat are among the least common in literature, and the case which I now report is, so far as I can ascertain, unparalleled. The patient was referred to me by my friend, Dr. Garland, in April last. He was a German, twenty years old, in apparently perfect health. He was a light blond, and of fresh color. He had been in this country three years, working in a sugar factory. Since last October, a period of six months, he had noticed that the left side of his shirt was constantly stained of a yellow color, and that the ordinary processes of laundry washing did not wholly remove the color from the underclothing, so that it became more and more deeply stained. He, as all workmen in this employment, was accustomed to sweat profusely during his working hours over the whole surface, but not more freely since October, nor more upon the left side, according to his observation, than previously to that date. He was somewhat alarmed at his condition, but felt well in all respects, and there were no abnormal sensations upon the affected side of the body, nor in the skin itself covering it.

By the direction of Dr. Garland, he had put on an entirely new white shirt a week before his visit to me, which he had worn constantly since. It was stained of a bright saffron color upon the left side from the shoulder down to the end of the flap. The color was most intense upon the back and side, not extending beyond the median line posteriorly and scarcely reaching beyond the line of the nipple in front. The sleeve was slightly discolored near the shoulder. The stained portions had a somewhat translucent, greasy look. The skin itself of the corresponding regions presented no abnormal appearances, and was of a natural color. According to the patient's report, it never became more yellow than other parts of the surface. The care of the integument had been in accordance with the usual customs of working men, infrequent bathing, that is; but no amount of extra washing with soap since the appearance of the trouble had seemed to control it, even temporarily.

The patient was kept under observation for two weeks without treatment, and the clothing continued to be stained as before. He was then

directed to apply an ointment of salicylic and boracic acids to the parts affected, and the trouble disappeared in the course of ten days. He was seen once again two weeks subsequently, and again August 19th, and he still remains free from it.

The shirt, which was so deeply stained after a week's contact with the skin, was carefully examined by Dr. Ernst for the presence of bacteria, but no such growths were found. It was then given to Professor E. S. Wood for chemical analysis, who reported that the yellow coloring matter was insoluble in water, but was readily extracted from the garment by ether. An examination of this ethereal solution showed that the color was not due to the presence of lutein, the coloring principle of serum and yolk of egg, as it did not give the absorption-bands of that substance with the spectroscope, although it resembled it in absorbing the blue and violet rays when in a concentrated solution. On gradually diluting the latter, the spectrum slowly reappears without any absorption-bands being produced, whereas, by diluting a strong solution of lutein the two absorption-bands in the blue are plainly discernible. Neither did the yellow coloring matter give the characteristic absorption-bands of any of the known animal pigments, as indican, bilirubin (hæmatoidin), or coloring principles of the urine. On evaporating the ethereal solution, there remained a homogenous oily fluid freely soluble in ether and alcohol, from which the coloring matter could not be extracted.

Does the result of the chemical analysis in this case determine whether it was one of chromidrosis or not? This is a question not easily settled in the ordinary forms of the affection even, and the origin of the colored secretions has been referred both to the sebaceous and sweat glands by dermatologists. The oily nature of the product here would give greater probability to the inference that it was derived from the sebaceous glands, but recent investigations show that fat is also excreted by the sweat glands in considerable quantity, and some observers, as Unna, maintain that the secretion of oil for the skin is their principal function, and that the sebum is designed for the use of the hair alone. This latter view may have been applicable to the primeval hairy man, as for the scalp of his descendants to-day, but, as the result of possible evolution, the preservation of the sebaceous glands and the degeneration of the pilous tissues over the general surface have so reversed the mutual relations of these structures that no such restriction in the economy of the former to the lanugo growth alone seems tenable. The fatty nature of the product, therefore, cannot be offered as conclusive evidence of its source of excretion. On the other hand, the more complex composition of the sweat, its more intimate connection with the blood, and the well-known supplementary relationship between the sweat glands and the kidneys, as a general channel of excretion, point to the latter as the more

probable origin of a strange pigment. But whichever of these systems of glands be the source of excretion, how comes this substance in them? Is it a constant element in their secretions in minute amount, manufactured in this instance in extraordinary quantity, thus explaining the not very uncommon yellowish staining in slight degree of the underclothing of some persons; or was it exceptionally formed in this case within these gland structures, or excreted by them by chance from the blood? Whichever hypothesis seems the more likely, it affords no satisfactory explanation of the unilateral character of the discharge, although this localization suggests a secretion rather than an excretion on the part of the glands. Nor is it easier to understand how the treatment should have so abruptly and effectually brought this strange phenomenon to an end. We must leave the solution of these problems to the farther investigations of the chemist and physiologist.

CASE OF "PITYRIASIS RUBRA."

BY

GEO. B. AYRES,

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EDWARD SIMON, age 28 years, native of Hanover, Germany, presented himself at Clinic, Feb. 14th, 1884, and gave the following history:

"My disease first appeared upon head and forehead in September, 1882, while I was in Cincinnati, Ohio, and continued to trouble me until January, 1883, when it disappeared while taking medicine procured at that place. I do not know what the medicine contained. Soon after, in March, had scales upon legs and arms to limited extent; in April and May it became worse, appearing on breast and abdomen, gradually covering whole surface of body except soles of feet, back, and palms of hands.

"During this time was travelling with a museum of anatomy, and as I moved from place to place received treatment from different physicians, was treated in Des Moines, Iowa, St. Paul and Minneapolis, Minnesota, and other places. Nothing I did improved my condition, but instead was worse. I have never had itching or pain, and my health has been perfect all the time, except I get cold easily and have some stiffness in knee-joints. My disease has been called psoriasis by some, by others eczema. I was treated at one time by an external application of soft soap; this caused much pain and removed the scales, but they returned

again next day. Sometimes the scales are large, and a few have come off the size of palm of hand; they have always been dry and like paper."

I did nothing for the man the day he came, but placed him in hospital, and the next morning, Feb. 15, had him photographed. On getting out of bed this morning, there was scraped from the sheet a double handful of scales, quite enough to fill a pint measure, and he informed me that this was the case every morning. On removing the shirt for photograph, the scales fell in large quantity and, as the photographer remarked, "it looked like a snow storm." Feb. 16 prescribed the following:

℞ Sulphate Quinia..... ʒ ss.
 Mur. Tinct. Iron. fl. ʒ ss.
 Glycerin..... fl. ʒ iiii.

M. Sig. Teaspoonful three times a day in water, through glass tube; also, seidlitz powder every other morning before breakfast, inunction of plain cosmoline over entire body morning and evening, with warm, soft-water bath twice a week.

The improvement was marked. The scales never returned after the second day. The skin at this time presented a reddish shining appearance. Treatment was continued unchanged for ten days, when, as an experiment, instead of the iron mixture, put him on gts. iij. Fowler's solution three times a day, he grew worse until I discontinued the Fowler after five days, and returned to former treatment.

The reddish color of skin gradually faded, and in five weeks was smooth, soft, and white, face good color and scalp free from all traces of disease. He was in ward three weeks more, and then discharged as cured, eight weeks from date of entrance.

Was cautioned about probable relapse, and advised to continue the iron and quinine, but failed to do so. Was under observation for two months after, and no relapse up to time I lost trace of him.

Correspondence.

DERMATOLOGY AND SYPHILOGRAPHY IN FRANCE.

(From our Special Correspondent.)

CUTANEOUS MANIFESTATIONS OF CHOREA—ERYTHEMA NODOSUM CAUSED BY THE ADMINISTRATION OF IODIDE OF POTASSIUM—TOXICODERMA AMONG FEATHER-DRESSERS—CHLOROFORM PURPURA—SUPPURATING PERIFOLLICULITIS, CONGLOMERATED EN PLACARDS—MICROBE OF THE BOUTON DE BISKRA—OF THE BOUTON DE GAFSA AND EPIDEMIC OF THE BOUTON DE GAFSA—ECZEMA OF THE

NIPPLE WITH CONSECUTIVE CANCER—LICHEN PLANUS AND LICHEN PLANUS CORNÉE HYPERTROPHICUS—LUPUS AND ITS RELATIONS WITH TUBERCULOSIS—GENERALIZED AND CIRCUMSCRIBED FIBROMA MOLLUSCUM—TREATMENT OF TINEA TONSURANS—TREATMENT OF SYPHILIS BY THALLIUM.

DR. OLLIVIER, formerly physician to the St. Louis Hospital, has recently contributed to the *Revue Mensuelle des Maladies de l'Enfance* a very interesting article in which he reports two cases of cutaneous eruption occurring in choreic patients. The first was a child of thirteen years, who had been affected with chorea one and a half months, when he was attacked with an eruption which first appeared upon the hands, then invading in succession the neck, trunk, and lower limbs. It consisted, first, of macules or erythematous patches, some of which upon the trunk were circinate. Second, of papules of a deep red color, especially upon the neck. Third, of nodules the size of a small nut upon the legs, while the forearms and arms were studded with erythematous spots, commencing to take on a slaty tint. It was then a true polymorphous erythema of Hebra, accompanied by a slight sensation of pruritus and burning and some articular pains. Fifteen days later, all these cutaneous manifestations disappeared, but a cardiac affection, which seemed to have developed about the same time as the chorea, still persisted.

In the second case, a girl thirteen years old, there had appeared, when she was eleven years of age, crops of urticaria upon both hands, coincident with the development of the first symptoms of chorea and accompanied with articular pains.

From these two cases Dr. Ollivier thinks that chorea may be preceded or accompanied with cutaneous manifestations, simple erythema, papular or nodose erythema, urticaria, and probably, also, purpura. Now, if we admit, on the one hand, the opinion of Bazin, who connected certain varieties of eruptions with rheumatism, classing them among the arthritides, and on the other, the opinion held by many modern authors that chorea and the accompanying cardiac affection are of a rheumatic nature, we can thus establish a connecting link between these cutaneous manifestations and true chorea.

Dr. Valanur has observed, in the service of Prof. Germain Sée at the *Hôtel Dieu*, an exceedingly rare case of iodic eruption. The patient was a woman, forty-nine years of age, affected with mitral contraction, who had been given for four days two and a half grammes of iodide of potassium, when she was attacked with acute pains in the buttocks, thighs, calf of the leg, and in the dorsal region; there then appeared upon the painful points small indurated nodules, of the size of a nut, of a deep-red color, slightly salient, readily appreciable by palpation. During three days they developed in size, one or two attaining the volume of an egg; the iodide was discontinued and the nodosities then rapidly disappeared, without presenting the ecchymotic discolorations characteristic of erythema nodosum. Some days later, the iodide of potassium was again administered, and the same cutaneous accidents were again reproduced. This experience was repeated three times more, always giving the same results. It is absolutely incontestable that the appearance of these nodosities must be attributed solely to the iodide of potassium. This case and other similar ones which have been published by Ricord, Fisher, Pellizani, etc., possess a considerable practical importance, which it is necessary to bear in mind when prescribing the iodide for syphilitic accidents.

Drs. Lermoyez et de Molènes have studied, in the April number of the *Annales*

de Dermatologie et de Syphiligraphie, an artificial eruption of which they have observed several cases among the workers in feathers, and to which they have given the name of *Toxicoderma*. This eruption has been determined by the feathers of a old gold shade of German production, less expensive than the analogous feathers of French production, which are innocuous. The coloring matter of these German feathers, analyzed in the Laboratory of M. Girard, was a mixture of different aniline oranges, incompletely separated from irritant empyreumatic products. Ten or twelve days after commencing to dress these feathers, the workers experience a slight itching in the interdigital spaces, coinciding with the appearance of a crop of small, fine, transparent vesicles occupying the lateral surfaces of the first phalanges. The eruption then increases by successive crops, the painful sensations become extreme, the vesicles augment in volume, and form, by their confluence at certain points, small irregular bullæ, surrounded by an inflammatory base which extends to the fingers and involves the rest of the hand, accompanied by a marked tumefaction, immobilizing the fingers, and entirely preventing any kind of work. Finally, the bullæ open into each other, producing veritable phlyctenulæ similar to the phlyctenulæ of burns or vesicatories, and occupying the entire surface of the fingers, the dorsal and palmar surface.

The general health is but slightly affected. One patient presented the same eruption upon the feet which were not sufficiently protected against the noxious powder diffused from the feathers.

Under the influence of emollients, the phlyctenulæ were cured and disappeared, leaving beneath them a rosy epidermis of new formation, which cracked, fissured, and desquamated several times, simulating a dry eczema; there occurred at this stage numerous fissures in the articular folds. In some cases, a return of the affection, in light form, was observed. This affection may be confounded with the itch, dysidrosis, or eczema, but the development of the vesico-bullæ and its etiological suggestion will always enable one to make a correct diagnosis.

As to treatment, it is necessary, first of all, to remove the patients from the action of the irritating agent, then to calm the inflammation by means of emollient applications. It would be well for the government to be aroused by these facts and carefully examine the cheap products, almost always nocuous, which come from the other side of the Rhine.

Since I am now speaking of artificial eruptions, I may call attention to certain cases of purpura following the administration of chloroform, reported by Dr. Morel-Lavallée in the *Annales de Dermatologie et de Syphiligraphie*. This observer has seen in three patients, at the moment he began to administer chloroform, a discrete eruption of purpuric spots, of an average diameter of three or four millimetres, occurring in a single crop and within the space of one or two minutes.

The process was of such intensity that in certain points the spots were immediately transformed into sanguineous bullæ.

These eruptive phenomena were situated upon the middle portion of the body, and especially upon the anterior surface of the chest. Dr. Morel-Lavallée does not believe that in these cases the chloroform acted after penetrating the economy, as is the case with mercury, copaiba, belladonna, iodide of potassium, etc., which thus act in producing the medicamentous purpuric eruptions at present so well known. He thinks that the cases which he relates should be classed with the purpuras produced by violent emotions, nervous purpuras, properly speaking. The chloroform acted in overwhelming the general nervous system, either by virtue of its general anæsthetic or by a simple reflex action due

to the brusque seizure undergone by the patient at the beginning of the inhalation.

We may search, moreover, by a vigorous analysis of each of the cases reported by the author whether an idiosyncrasy for purpuric eruptions manifested by these patients may not be explained by predisposing conditions having relation to a peculiar condition of the vessels, the blood, or the nervous system. These several questions are of the most important character, to be convinced of which it is only necessary to read the interesting memoir of Prof. Leloir upon this subject, published in the January number of the *Annales de Dermatologie et de Syphiligraphie*.

I will not at present enter into more ample details in regard to this question, the more especially since purpura has been much studied in England and America, and I have already spoken, in a previous letter, of most of the investigations recently published in France upon this subject; but I would call the attention of your readers to another memoir of a most interesting character by Prof. Leloir upon a new variety of suppurative perifolliculitis conglomerated *en placards*.

This affection is characterized by a projection of the skin, rounded or slightly oval, raised two to five millimetres above the normal level of the integument, varying in dimension from a ten-cent piece to that of a silver dollar, or larger. This protuberance is most often covered with pus and small crusts; when it is cleaned, the surface is smooth or slightly irregular, riddled with a large number of small orifices of pin-head size, the most of them obstructed by a small yellowish plug of concrete pus. One may perceive scattered here and there numerous yellowish points, the size of a grain of millet, which will become in their turn open when the epidermic layer which covers them shall have been perforated. If the lesion be compressed, there is forced out of these several orifices either pus or a serous fluid or a large number of minutely elongated rolls resembling fine vermicelli. A silver probe introduced into one of these conduits will penetrate several millimetres, but there is no detachment of the derma. In a more advanced stage of the lesion, or in certain forms which the author designates as anthracoid or phlegmonous, there may be produced small intra-dermic purulent burrows. The hairs are healthy; it is always quite difficult to observe them, since the lesion described by Prof. Leloir develops in regions in which there are only downy hairs, which soon fall, as a result of the process of perifollicular suppuration. The local reaction is slight, the itching almost nil, adenitis or secondary lymphangitis are never observed, it never produces general reaction. The author has observed this affection four times on the dorsal surface of the hands, once upon the dorsal surface of the foot, once disseminated over various regions of the body. Most often there exists but one patch on the same patient.

This dermatosis develops with rapidity, requiring about eight days to arrive at a period of maturity. It remains at its acme of development from eight to fifteen days; then, if properly treated, it gradually disappears in about twelve days, without leaving very appreciable cicatrices. Sometimes there persists for a long time a livid, violaceous, or biskre tint of the skin. In some rare cases the surface of the lesion finally assumed a papillomatous appearance, simulating at first glance an inflamed papilloma. Prof. Leloir has designated this as the *papillomatous variety*. The presence of such a lesion at once suggests a parasitic sycosis, but the author has never discovered in the cases observed by him any trace of a parasite—the hairs were always perfectly healthy. As to non-parasitic sycosis, or the kerion of the old dermatologists, these affections have never been observed or described in regions deprived of long and abundant hairs. On the other hand,

we cannot, as Prof. Leloir remarks, identify this lesion either with the bouton de Biskra, anthrax, in which we always find cores, or with the cutaneous inflammatory papilloma of Roser and Veil.

From an anatomical point of view, the histological sections have proven that this affection is nothing else than a perifolliculitis, conglomerating at first the hair follicles containing downy hairs, then the pilo-sebaceous follicles, a perifolliculitis capable of becoming profound and phlegmonous.

Prof. Leloir, in searching an explanation of the pathogeny of this affection, has remarked that there exist on the level of the median region of the derma giant cells, and that in all the diseased parts, especially in the neighborhood of the vessels, the pilo-sebaceous follicles, and the sudoriparous glands, there are microbes in abundance, micrococci distinct, sometimes isolated or disseminated in the form of points, simple or double, rounded, quite voluminous, and sometimes irregular. These microbes have been found by the author in the blood of these patients and in the blood of another patient affected with simple inflammatory sycosis of the beard. This microbe does not, on the contrary, appear to exist in the blood of patients attacked with a parasitic sycosis. These facts, if they are confirmed by further researches, will have, as one may see, a great importance, and they will throw an entirely new light upon certain cutaneous affections of obscure pathogeny, and which may be only an external manifestation of a vitiation of the blood by microbes. We think that these questions, so difficult to study, demand still long and patient experimentation. We find it difficult to admit here the existence of an infectious malady when the most simple treatment, such as emollient applications or a simple head dressing, is sufficient to effect a rapid cure.

It was with the assistance of Dr. Duclaux that Prof. Leloir made his investigations of the microbe of perifolliculitis, and must here call attention to the work which the same Dr. Duclaux has done in conjunction with Prof. Fournier in investigating the microbe of the bouton de Biskra. Since this question possesses only a mediocre interest for our confrères in America, I shall content myself with saying that the communication of the results which these two authorities think they have obtained has been received with some reservation by Drs. Legouest, Colin, et Larrey, and that Dr. Legouest, in particular, has claimed the priority of the discovery of the microbe of the bouton de Biskra for the army physicians, Drs. Boinet and Deperet. These two authors published in the *Lyon Medical*, April, 1884, an exceedingly interesting report of an epidemic of the bouton de Gafsa¹ brought from South Tunis by the men of the 38th regiment, and observed by them at the camp at Lathonay, near Lyon. They had an opportunity of studying sixty-eight cases, and believed that they had discovered the microbe with which they made positive inoculations. In my opinion, the most curious fact to which they have called attention was the contamination by these patients of a healthy man who had never quitted France, and had never been in regions where the bouton de Gafsa, Biskra, Nil, Alep, Delhi, etc., is endemic. This case, it seems to me, proves indubitably that the affection is actually contagious and inoculable, and not, as has been so long supposed, simply endemic, depending upon climate, the use of the waters, etc. It constitutes then a strong

¹ Gafsa is an oasis of South Tunis, situated to the east of Biskra, but in the same region as this last city. It is evident that the boutons de Biskra and Gafsa constitute one and the same malady. In sojourning in the camps of El Guettar and El Oiocha, near Gafsa, the men of the 38th contracted the disease.

argument in favor of the virulent or microbial nature of this singular dermatosis.

The work of English and American dermatologists upon Paget's disease of the nipple begins at last to be known in France. Prof. Verneuil has spoken in one of his clinics of a patient aged fifty-four years, subject for twenty years to numerous eczematous eruptions diversely localized, but tending particularly to converge upon the breasts, more especially the right. Recently this breast has augmented in size; the nipple gradually retracted and disappeared; in its place was observed a superficial, circular eruption, without the least discharge. The entire breast was then occupied by a hard, voluminous neoplasm, having for its point of departure the nipple; the axillary ganglia were engorged. Histological examination showed that it was a true carcinoma of the breast. In this case there had been an antecedent eczema, and as the patient had been eczematous for twenty years, the nature of the primitive cutaneous lesion was not to be doubted. Prof. Verneuil took occasion, in connection with this case, to recall the opinion of Bazin upon the diverse phases of arthritism and herpetism, and to insist upon the fact, formerly so well recognized in France, that arthritism may have eczema as a primary manifestation, and as a terminal accident, cancer.

Dr. Fernand Lavergne has published the most complete monograph which we have upon lichen planus. He has given us a truly magistral study of this disease and has cited numerous unedited cases. He recognizes three principal forms of lichen planus; the first is chronic lichen planus. This variety is much the most common and well-known, and which Erasmus Wilson has described with master hand. The second is acute lichen planus: it differs especially from the first in its course, it makes its appearance as flattened shiny papules with the characteristic facettes, but the papules, far from being slow and so to speak torpid in their evolution, originate and develop with the most extraordinary rapidity: they take on a deep red coloration and form in a few weeks, sometimes in a few days, by confluence, immense red patches at the level of which the skin is appreciably thickened, sometimes slightly painful, and the seat of a very abundant desquamation. Dr. Lavergne recalls in this connection a case of Buchanan Baxter, which I have already referred to in my work upon "Generalized Exfoliative Dermatitis," and in which an eruption of lichen planus was observed to take on an acute course, become generalized, and present the aspect of a generalized exfoliative dermatitis. Ordinarily an acute lichen planus terminates after a variable lapse of time by resolution and a cure more or less complete. The patches leave a pigmentation of the skin which persists for a certain time. The third form of lichen planus admitted by Dr. Lavergne is that to which Drs. Vidal, Fournier, Besnier, and Heguy have given the name of *lichen planus cornée*. It is an essentially chronic variety, almost always localized on the anterior surface of the leg and characterized by patches of variable dimensions, from a quarter of dollar to the size of the palm of the hand; irregular in form, variable in color, sometimes reddish, sometimes bluish, brownish or even black, and upon the surface are perceived numerous follicular orifices large as the point or the head of a pin, sometimes obliterated by minute epidermic cones in the forms of cups. The patches are covered with fine, closely adherent, grayish scales, sufficiently thick to form here and there a sort of rugous mass. The derma is very much hypertrophied at their niveau, so that the patches of horny lichen form veritable tumors several millimetres in height with quite distinct borders, and around which are found at certain points isolated papules of lichen planus, permitting at a glance a correct diagnosis. This variety usually causes intolerable itching, it is excessively slow

in evolution and persists for years. Under the influence of treatment, the centre of the patches becomes red, around which is observed a whitish areola, then a brownish areola. The skin remains always much thickened and as if glued to the deeper parts. Dr. Lemoine has reported a very interesting and complete case of this variety of lichen planus, to which he has given the name of *lichen planus hypertrophicus*. In this case racleage of the patches gave excellent curative results. Dr. Lavergne has endeavored in his work to investigate the relations of the lichen ruber acuminatus of Hebra with lichen planus as he comprehends it. I shall not enter into a profound examination of this discussion because it would lead me too far, but I will remark that there are incontestable cases of acute lichen planus, and that I have observed cases in which small acuminate papules were disseminated here and there over the body. It is possible that certain cases classed by Hebra and Kaposi as acuminate lichen ruber were identical with the preceding. There are other cases described in France under the name of pityriasis rubra pilans which these authors have entered into this same category, as if they themselves had first recognized them. It is also probable that they have likewise thus classified cases of general exfoliative dermatitis. It seems to me that the type lichen ruber acuminatus corresponds to no well-defined morbid entity, and that it is only an assemblage of cases but little related to each other. It would be better to eliminate this term from the nosological category. As regards the treatment of lichen planus, Dr. Lavergne recommends, with other dermatologists, the arseniate of soda in massive doses, and for a long time continued; he recalls, moreover, that in the opinion of some of the physicians of the St. Louis Hospital, M. Vidal in particular, it is indispensable to institute, in addition, local treatment with glycerole of starch twenty parts, and tartaric acid one part. For lichen planus cornée one should at first make applications of soap plaster, tincture of iodine, or pyrogallic acid, or even practise racleage.

I said to your readers in my last letter that the quarrel still continues in France between the partisans of the tuberculous nature of lupus and those who hold to the contrary opinion. Dr. Emil Renouard has just published a voluminous and conscientious work of two-hundred and forty-three pages octavo, in which will be found strongly arrayed all the arguments which it is possible to invoke in favor of the tuberculous nature of lupus. I cannot analyze it here, but I would recommend those who wish to study this question to procure this work. The exposition of the subject, its history, the description of the several varieties of lupus are there treated with the most minute care. But Dr. Renouard has written a polemical work, and in the discussion of the diverse theories of the nature of lupus he limits himself to the accumulation of arguments in favor of its tuberculous nature. I should have been pleased to find in his admirable work documents or reasonings sufficient to destroy the several objections to this theory which Dr. Robt. B. Morrison has so ably formulated in an article in the *American Journal of Medical Sciences*, April, 1884. The principal new facts which the Thèse of Dr. Renouard calls attention to have already been reviewed in my previous letters.

I call the attention of American dermatologists to the little known Thèse of Dr. Broudet upon Fibroma molluscum, because it contains an idea, false it may be, but which it is desirable to verify. The author is disposed to accentuate the division which exists in classical treatises upon fibroma molluscum; between circumscribed fibroma molluscum and generalized fibroma molluscum. Already Recklinghausen has, from a purely histological standpoint, completely separated these two varieties and has made of one, generalized f. m., a neuro-fibroma—that is to say, a neoplasm which develops itself around the nerve ramifications of

the skin, and of the other, a lymphangio-fibroma—that is to say, a neoplasm developing along the lymphatic vessels.

Dr. Broudet has remarked that generalized fibroma molluscum is always congenital, that is, a veritable mollusciform nævus; now it is well known that in the opinion of many authors, and I agree with them, these nævi should be referred to congenital trophic troubles. Generalized fibroma molluscum being a nævus, comports itself like all nævi—that is to say, in the immense majority of cases it undergoes with age a development proportionate to the development of the several constituent elements of the skin.

Circumscribed fibroma molluscum, on the contrary, is a veritable non-congenital cutaneous tumor, capable of acquiring a considerable volume, but developing itself by preference upon a congenital deformity, as upon a nævus, so that, according to Dr. Broudet, we should not regard the cases of generalized fibroma molluscum, in which one may observe one or two voluminous tumors on any part whatever of the body, as being cases of simple generalized fibroma molluscum, but as being cases of mollusciform nævi, upon which circumscribed fibroma molluscum have accidentally developed.

I ought to mention, in terminating this too long letter, an excellent general review upon the treatment of tinea tonsurans which Dr. Thomas has just published and the interesting experiments of Messrs. Pozzi and Courtade upon the treatment of syphilis by thallium.

Those who wish to know through what revolutions the medication of the trichophyte of the hairy scalp has passed should procure the conscientious work of Dr. Thomas. They will there find collected the different methods, each thought infallible at its debut, which have been employed and rejected in turn, from the calotte of Roger de Parme and Ambroise Paré to our modern processes more perfect, but equally inefficacious. The author then brings forward new statistics of tinea tonsurans treated by pyroligneous acid, and he concludes that, while this agent seems in certain instances to have determined a cure, such action is far from being constant. It may produce dermatitis with consecutive alopecia. Dr. Thomas does not hesitate to conclude that epilation with parasiticide frictions should at present be preferred to any other treatment.

Dr. Rabuteau first enunciated the idea of experimenting with thallium in the treatment of syphilis, because of the chemical and toxic analogies which this agent presents with mercury, gold, and platinum. Messrs. Pozzi and Courtade have administered iodide of thallium to eight syphilitics who had never been subjected to mercurial treatment and whose accidents were of recent date. They gave them each day a pill of one centigramme. Some amelioration was observed in the case of vulvar syphilides. The medicament caused lesions of the gums and some pains in the epigastric regions. It seems to be inferior to mercury in the treatment of secondary syphilis. I think it would be altogether premature to attempt to draw precise conclusions from these few experiments. It will be necessary to wait until they become more numerous before one can assign to thallium its proper place in therapeutics.

DR. L. BROCCQ.

PARIS, Aug., 1884.

TREATMENT OF PSORIASIS.

Editors Jour. of Cutaneous and Venereal Diseases.

DEAR SIRS:—I desire very much to report to you the success I have had in the treatment of psoriasis.

CASE I.—Male, truckman, aged about thirty-eight. Had psoriasis for nine

years. In perfect health otherwise ; temperate, hard-working. Had taken much medicine. Spent two years in mountains, by advice of physicians ; no relief. No syphilitic history. Prescribed Fowler's solution and potassium iodide, in increasing doses, until limit was reached. This dose he continued four four months, from August to October. I then lost sight of him until April following. He then returned to me, saying he must have some relief. He was then in the tenth year of the disease. I had read somewhere (*Therapeutic Gazette*) of the use of Burdock seed in psoriasis. I prescribed it for him. He took about fifteen drops three times a day of an office-made tincture. He improved steadily after about two weeks. The scales came off entire in some places. In two months he was entirely free from them. He was then satisfied that he was cured, and ceased taking medicine. In about two months, he returned and showed me that the disease had begun to return ; but it soon disappeared under the same treatment. A month or so afterward, he left the city and I did not see him again.

CASE II. was a carpenter, German, well-fed and cared for. On examination, he proved to be the worst case of psoriasis I had ever seen. Over his breast, back, and arms it was confluent ; scarcely the smallest portion of healthy skin was discernible. No scales appeared upon his hands, neck, or face. It had first appeared when he was a child, and had existed ever since. He is now about thirty-five. No syphilitic history. It seemed in this case that every variety of treatment had been tried. In Austria (his home until twelve years ago) he had lived within a few miles of Vienna, and he had often been taken there to consult the noted specialists, and had followed their directions, with no apparent result. Upon his arms, back, and breast are many scars caused by various caustic applications which were recommended to him. He had never been able to find a successful treatment.

This case coming soon after case I., I put him upon the burdock seeds, and the result has been marvellous. First the redness disappeared, then the elevated patches loosened and could be lifted or rubbed off, much as can the scaly eruptions of the scalp in syphilis. At the present time, after the lapse of several months, his skin is perfectly smooth, fair, and healthy ; smooth excepting the scars of the caustic. He is still taking the medicine, though not so frequently.

I have also under treatment two other and less severe cases which are both improving steadily. I will not detail the particulars, for they are in all essentials similar to those above, and the results the same.

Now, whether these results are permanent or not, they settle one point in my mind, viz. : whether it is possible to reach the affected parts by constitutional treatment. I have often heard it stated remedies *per os* were of no value in psoriasis. I think the experience above stated disapproves this. And if the result is not a permanent *cure*, at least it accomplishes as much as the chrysarobin, and without leaving the almost indelible stain which the latter agent causes. I believe it is generally confessed that the cure by chrysarobin is only temporary. And I believe with case II. that "it pays to be rid of the trouble, even if one is obliged to take medicine continuously to accomplish it."

Yours very respectfully,

A. B. POORE.

Selections.

THE SEQUELÆ OF ERYSIPELAS.

THE collection of morbid phenomena known as erysipelas covers at the present day a far more extensive territory than was formerly assigned to it. The great majority of medical authorities now regard it no longer as an inflammatory process localized on the skin, but as a disease originating in contagion, and affecting—either at once, or after its complete development—the entire organism. Just as we long ago ceased to consider ileo-typhus as an enteritis, diphtheria as a pharyngitis, and articular rheumatism as a disorder of the joints, so in erysipelas we recognize, in addition to its cutaneous symptoms, various other organic complaints equally demanding our attention.

Now, it is a peculiarity of the infectious diseases in general that, besides these complications, their period of convalescence is liable to be disturbed by a number of sequelæ, seemingly unconnected with the parent malady. Although any one of these sequelæ may be absent in individual cases, or during an epidemic, still none of the infectious diseases are entirely exempt from them, and to this rule erysipelas forms no exception. I will now proceed to give a brief description of the ailments consecutive to the latter, founded upon published reports as well as my own observations—arranging them under the heads of the bodily functions which they respectively involve.

From this point of view, our first attention is claimed by the *general integument*. That erysipelas should be succeeded by many cutaneous maladies is not at all surprising. Indeed, the external inflammation is developed upon so extensive a scale that a complete restoration of the skin to its normal condition appears almost impossible after the enormous changes to which it is subjected at the height of this process. The vast infiltration of the cutis, by which the latter is often increased to threefold its natural thickness, and the surrounding parts swollen into deformity; the compression of the subjacent tissues, especially of the vessels, and the irritation caused by frequent relapses—all these, despite the brief duration of the whole complaint, must necessarily give rise to numerous morbid alterations in the structure concerned. Most of these alterations are brought about by the immediate agency of *suppuration*. It is difficult, in considering this process, to draw a precise line of demarcation between suppuration following erysipelas and a primary purulent inflammation of the skin, as is shown even in the nomenclature of the former disease; the terms erysipelas, suppurative erysipelas, phlegmonous erysipelas, pseudo-erysipelas, being employed interchangeably without the slightest discrimination. It is easy, however, to distinguish erysipelas, in its earlier stages at least, from other phlegmonous disorders always accompanied by suppuration, since these are to be regarded as consisting from their outset in an inflammation of the subcutaneous connective tissue, to which the inflammation of the cutis is only secondary, while erysipelas is principally seated in the latter structure. It is a much more difficult matter to define the limits separating an erysipelas from a subsequently developed suppuration. Should the latter be looked upon as normally resulting from the former? A consideration of the more delicate anatomical processes involved enables us to return

a ready answer in the affirmative. Among the most important sequelæ of this kind are the purulent collections, in which secondary inflammation of the subcutaneous connective tissue finds its points of exit. In many uncomplicated cases of erysipelas, suppuration takes place as soon as the disease becomes more severe and penetrates more deeply than usual. Such processes are quite frequent, although by no means uniform in their occurrence. Certain parts of the body are peculiarly liable to suffer from them. This is owing to the connection which exists between the cutis and its underlying tissues; erysipelatous abscesses are most liable to form wherever the integument is tensely stretched over fascia and bones, so as to exert a pressure on the circulation. Such localities are found especially on the lower extremities, *e.g.*, about the ankle, on the outer thigh, and on the trochanter on the back, and on the hairy scalp, which last is often fairly riddled by purulent openings. Here we see how much the condition of the skin at any particular point has to do with this symptom; on the face (especially the cheeks), where the specific eruption is most frequent, erysipelatous abscesses are very rarely met with.

From twelve to fifteen per cent of all cases of erysipelas are followed by suppurations. This estimate, however, is subject to modification in view of the fact that particular epidemics have been especially marked by their occurrence. Their production is also favored by external influences: thus they are observed to be more frequent during certain states of the atmosphere. In the winter, for instance, more cases of erysipelas pass into suppuration than at any other season.

The prognosis of these sequelæ is less unfavorable than might at first glance be supposed. This is chiefly owing to a tendency on the part of the suppurative process to remain circumscribed, unless a pathway is opened for it into surrounding tissues by a too early incision. It is better, therefore, except when perforation threatens, to avoid this operation as long as possible, especially since absorption and resolution of the abscesses is more likely to occur in these cases than in most others of the kind. Even large purulent collections are said to disappear entirely, without entailing any bad consequences. Erysipelatous abscesses are attended with danger when, as not unfrequently happens, they are formed in very large numbers, whereby the patients' strength is often seriously reduced. Their contents also possess infectious properties, which render them capable of working serious injury by transmission. Sometimes the inflammation passes over from the fascia into the surrounding connective tissue, and abscesses similar to those above mentioned are formed among the muscles. Bad results are to be feared only when this takes place in the vicinity of serous membranes, in which case the latter may be affected by continued inflammation. In this way, erysipelas may give rise to peritonitis or to pleurisy.

Another species of suppuration, less frequent than the foregoing, is met with in localities entirely unaffected by the erysipelatous inflammation. It originates in the patients' cachectic condition, which either existed previously to the disease or was caused by long-continued recumbency, and consists of numerous small abscesses in the subcutaneous connective tissue, especially of the parts in contact with the couch; or sometimes larger purulent collections are formed beneath the skin or among the muscles, which take the shape of cold abscesses unaccompanied by pain or inflammation. These latter are of the worst angury, since they usually lead to a fatal state of general debility.

Besides these inflammatory processes tending to the destruction of the skin, there is still another which, instead of injuring that organ, results in its increased

development by means of *hypertrophy*. An erysipelas of average duration and severity may spontaneously disappear so rapidly and completely that a section of the affected integument, made a few days afterwards, will exhibit not the slightest trace of morbid alteration. Now, it is observed, on the other hand, that certain individuals, after recovering from a first attack, are liable to renewed visitations of the disease. Some persons suffer in this way at almost regular intervals or as a result of trifling cutaneous lesions, especially those ulcers and abrasions on the face which in scrofulous subjects so readily give rise to a condition of chronic irritation. When under these circumstances the infective principle of erysipelas and its resulting inflammation have repeatedly pervaded the tissues, they leave behind them a permanent thickening of the skin, in which usually all its layers are equally involved. Moreover, this process may pass beyond the fascia, so that even the intramuscular connective tissue and the periosteum experience a similar alteration. In general, only circumscribed areas of the integument are thus affected, since the progressive condensation of the tissues soon puts a stop to the serous transudation. It was formerly the custom to connect with previous attacks of erysipelas a disease resembling the above variety, viz., elephantiasis arabum. In this we have cutaneous hypertrophy, which appears after repeated inflammatory attacks bearing a likeness to erysipelas, and is due to an excessive growth of connective tissue. But not only is the inflammation much milder than in erysipelas, but the affection of the lymphatic system, which is so marked a feature in elephantiasis, is entirely absent from the former.

Before leaving this branch of our subject, brief mention should be made of a sympathetic capillary disorder. Erysipelas of the scalp is very frequently followed, during convalescence, by a *falling off of the hair*. As to the causes of this occurrence authorities are not agreed, but in all cases the crop is speedily and plentifully renewed.

If now we turn our attention from the external surface, the principal seat of the erysipelatous processes, to the remaining parts of the organism, we shall find that these latter present a very different aspect. The morbid changes we are considering are the result of inflammation called forth in a purely mechanical manner, whereas the others can only be explained by the action of a specific virus on the constitution at large. First, as to the *central nervous apparatus*, its share in the production of erysipelatous disorders is so exceedingly limited (despite the once prevalent opinion) that the sequelæ thus evoked are hardly worth mentioning. That cerebral affections, however, may follow in the train of erysipelas has been clearly established by clinical observations. Mental disturbances may occur during convalescence from violent attack of erysipelas of the head. In these rare cases, as in similar conditions attendant on typhus and variola, we have a state of acute melancholia, alternating with short-lasting paroxysms of maniacal excitement. It is of brief duration, recovery taking place in about six weeks. Only two cases are on record of other severe seizures proceeding from the nervous centres. An instance of general paralysis, soon recovered from, and another of a chronic nature, complete our list of ailments traceable to this source. On the other hand, the *peripheral nerves* are known to participate much more frequently in the production of erysipelatous sequelæ. This is explained by assuming an extension of the cutaneous inflammation along the nerve-tracks, and the consequent creation of new centres of morbid activity. The character of these processes is shown most clearly by a description of certain consecutive diseases to which the *eye* is subject. These may affect almost every part of the organ, both external and internal, and lead to either transient or permanent structural altera-

tions, the latter constituting without doubt the most deplorable results of the erysipelatous infection. The eyelids are more frequently and severely affected by morbid influences, and especially in the way of suppuration and gangrene, than any other portion of the integument, and their recovery also takes place very slowly. Occasionally, indeed, the last remaining vestige of an erysipelas consists in a persistent, pale, painless, doughy swelling of the lids, sometimes so great that the latter cannot be opened, and strips have to be excised from them in order to afford relief. Far worse are the results when an erysipelatous gangrene of the lids has extended to the *bulbus oculi*, giving rise to great swelling of the conjunctiva, softening and cloudiness of the cornea, ulcers with tendency to perforation; in short, to all the symptoms of a severe keratitis. The disease may also spread to the adipose and connective tissues of the orbit, entailing no less fearful consequences. Only in slight cases of the kind does the process terminate in resolution; the most favorable issue usually to be looked for is a suppuration of the tissues, which leaves the *bulbus oculi* intact and ends in perforation outwardly. In one case, panophthalmitis was developed, followed by death from pyæmia. In other instances, complete blindness ensues, caused by atrophy of the optic nerve. All of these unfortunate events are simply due to an advance of the infiltration. But there is a still larger number of these consecutive eye-affections which can be accounted for only on the ground of neuritic processes. These generally attack the optic nerve. Atrophy of this nerve varies to a remarkable degree in its clinical manifestations, according as both sides or only one are affected. But three cases of double-sided atrophy consequent on erysipelas have so far been noted, none of which resulted in complete blindness. Two of them were accompanied by pain in the head, and in one there was paralysis of the right arm. Ophthalmoscopic examination revealed nothing to distinguish them from ordinary examples of the kind. Cases accompanied by a one-sided pupillary atrophy are far more typically developed. The impairment of vision begins as soon as the cutaneous inflammation has reached its height, and speedily becomes complete and permanent. The aggregate number of eye-affections connected with erysipelas that are based upon an optic neuritis is by no means small. Even the least sensitive portions of the eye, where alterations most rarely occur, does not always escape the contagious influence. A case is reported in which a soldier, aged thirty-two, suffered from disturbance of vision following erysipelas. The ophthalmoscope revealed as its cause a cloudiness of the vitreous. Affections of the other peripheral nerves are much less frequently encountered, and are unimportant in their consequences.

The *gastro-intestinal tract* plays only an inconsiderable part in connection with erysipelatous sequelæ. All the symptoms belonging to this organ—heavily-loaded tongue, copious vomiting, and diarrhœa—which accompany almost every attack of the disease, and are especially characteristic of the so-called “abortive erysipelas,” subside with the fever, without leading to permanent alterations. Quite recently, however, in a number of post-mortem examinations of erysipelatous patients, phenomena have been observed which require to be mentioned in this connection, not only on account of their intrinsic character, but as throwing light on some obscure points in etiology. They consisted of intestinal ulcers, freshly formed, and situated chiefly in the neighborhood of the pylorus, the usual locality of gastric ulcers, with which their rounded shape likewise tended to identify them. In the most severe of these cases, the erysipelatous symptoms had ceased upon the appearance of profuse and fatal hemorrhage from the bowels; in two others, death occurred suddenly on the eleventh day of apparent convalescence.

In still another instance, where recovery ultimately ensued, the facial eruption had run its regular course without disturbance, and desquamation had already begun, when profuse intestinal hemorrhage set in, with great tenderness of the abdomen. The flow returned three times before it was checked by a resort to the most approved remedy in such cases—*liquor ferri sesquichlor.* Here also it was undoubtedly caused by recently formed ulcers. These singular occurrences can best be explained by a reference to what takes place in the case of very severe burns, when large tracts of highly organized vascular tissue are destroyed. The current of the circulation is diverted from its usual course in this direction, with the necessary result of such an increased afflux to other parts, especially the bowels and kidneys, as leads to profuse bleeding. Precisely the same causes may operate in erysipelas. The enormous infiltration of the cutis, pressing hard on the subjacent vessels, obstructs their channels, and this gives rise to a violent, though short-lasting intestinal congestion, which terminates in ulceration and hemorrhage.

With regard to the influence of the *circulatory system* at large in developing the sequelæ under review, if we first take cognizance of the central organ of that system, the heart, we shall find that no other infectious malady, with the exception of polyarthritis, is equally concerned with erysipelas in the production of cardiac affections. None of these, however, can be classed as a consecutive disease, since their appearance coincides with that of the primary inflammation, or even precedes it, and they are deserving of the same consideration as the latter. We shall here, therefore, only allude to disturbances in the arterial system which arise from embolism, caused by endocarditis with ulceration, and are characterized by the usual symptoms. The veins are affected in a similar manner, not as was at one time supposed, by the phlebitis and phlebitic abscesses to which the erysipelatous suppurations were attributed, but by the formation of coagula, due to the agency of engorgements of gangrenous processes, and detached fragments of which obstruct the vascular channels at particular points. Affections of the lymphatics are often observed as sequelæ of erysipelas, but they are of little consequence, and very quickly subside. Glandular suppuration, which takes place so frequently during the inflammatory processes, is here an exceptional occurrence.

Of consecutive parotitis, only three cases are on record. Disorders of the *kidneys* are by no means rare. They consist of an acute parenchymatous swelling and infiltration of these organs, with very scanty urine, containing albumen and abundant epithelial débris. They are distinguished from similar affections accompanying other infectious diseases, first, by their much greater frequency, and secondly, by the presence of so much blood in the urine that its sediment is composed almost wholly of red corpuscles in conjunction with blood-casts. The albuminuria disappears very soon after the erysipelas has subsided, and nephritis much less frequently remains as an independent affection than in scarlatinal cases. Some authorities maintain that a chronic form of this disease may succeed to erysipelas, and even result in death.

We shall conclude our subject with a reference to sequelæ affecting the *articulations*. They are of an acute inflammatory character, and appear under a great variety of forms. They invade the superficially situated joints, causing intense pain, and filling their synovial sacs with fluid in the space of a few hours. Suppuration ensues very rapidly. The prognosis is highly unfavorable, as softening of the capsule, granulation of the synovia, and dissolution of the cartilage generally take place, followed by complete destruction of the joint. A fatal issue can be averted only by resorting to amputation or resection, and even these are

unsuccessful in about one-half the cases.—PAUL HARTUNG, *Inaug. Dissert.*, Berlin, 1883.

CUTANEOUS TEMPERATURE.

STUDENTS of the human temperature in health and disease have always bestowed their chief attention upon the interior of the body, to the comparative neglect of its outer integument. And in this they are quite right, since an accurate general estimate of temperature, such as can be formed under normal conditions respecting the interior of the system, is out of the question with regard to the skin, exposed as it is to all the vicissitudes of the surrounding medium. Hence the present method, by which the skin is made use of as merely a guide in determining the internal temperature, is in fact the only correct one. By perceiving that the surface of the body is unnaturally hot or cold, we are prompted to ascertain the temperature of its cavities: in this way only can the temperature of the skin be of service in our clinical investigations. To apply a single thermometer to the skin is a practically useless proceeding, and the published statements of its medium temperature must be regarded as wholly unreliable, so widely do they differ among themselves. It can only be said upon this point that the average temperature of the skin is somewhere between 30° and 40° C., but that in particularly cold air, or after profuse perspiration, its temperature in health may fall considerably below the former point. A skin temperature of 40° C., or upwards, is always indicative of disease.

A very inadequate conception appears to be generally entertained of the enormous fluctuations in temperature to which the skin is constantly subject. I happened recently to have under my care a hospital-patient who, being deaf and dumb, and not fond of reading, was accustomed to lie perfectly quiet during much of the day, so that the thermometer could be left undisturbed upon his chest for an hour and a half at a time. When this was the case, I almost always found that a change of temperature, amounting sometimes to a whole degree, or even more, was indicated at least as often as every ten or fifteen minutes. From these observations it is a necessary inference that all attempts to determine the precise temperature of the human skin must result in failure, both when made upon large numbers at once, on account of the diverse thermal conditions which exist among them, and in the case of individuals, by reason of the continual fluctuations above referred to.

The temperature of the skin can be successfully investigated in only one way—by taking it at two points of the surface simultaneously, and noting the difference. This method enables us to say that the skin at one point is warmer or colder, as the case may be, than at the other, but not to ascertain its absolute average temperature. Comparative experiments of this kind are followed by three results; either the thermometers always indicate the same temperatures at both localities—of the chest, for instance:—or they mark a constant difference; or lastly different variations are shown at different times, one of the thermometers rising or falling more quickly than the other. In the first two of these cases the variations are chiefly caused by changes in the surrounding medium (external causes); in the third, by alterations in the bodily heat production and the circulation of the blood (internal causes). The observations thus made by Peter Fräntzel and Paul Philipp have resulted in nothing of value so far as diagnosis is concerned, and therefore I shall only cite the conclusions arrived at by Wegscheider as to the relations of the cutaneous temperature in general: (*a*) The temperature of the interior of the body does not necessarily correspond to that of the exterior

at any point whatever of the latter. (b) No two localities at the surface, even if precisely symmetrical, exhibit the same variations. (c) Fluctuations in temperature become greater during fevers.

The ordinary thermometers with bulbs are of little use in the observation of external temperature. In the first place, it is very difficult to fasten them securely on the chest, and secondly, as they are usually applied, only the under surface of the bulb is in contact with the skin. Hence, they are a long time in getting heated. An instrument better adapted to the purpose has lately been recommended by Professor Kronecker. In this the mercury is not contained in a bulb, but in an exceedingly delicate glass spiral, closely coiled in a horizontal plane at right angles with the marking tube, and having a diameter of about $2\frac{3}{4}$ cm. The mercurial surface is in this way applied almost directly to the skin. It heats up rapidly and is exceedingly sensitive. The mode of employing this apparatus is as follows: A wide piece of flannel is spread over the anterior surface of the chest, and the latter is encircled by an elastic band, furnished with buckles. Both flannel and elastic are pierced with holes over corresponding points on either side of the chest; through these holes the upright portion of the thermometers is inserted, the elastic binder is buckled snugly over the horizontal spirals, and the preparations are now complete. The mercury in the spirals is protected from the air by the flannel, which also lessens the tension of the elastic on the chest. The latter appliance, moreover, exerts an equable pressure on the two spirals, which are thus held in place with uniform firmness. Care must be taken that there are no folds in the flannel compress, since at such places more warmth will be produced. As the flannel and the elastic together generate a great deal of heat, which makes the patient restless, and thus may lead to a breakage of the tube, it is better after adjusting them to wait eight or ten minutes before introducing the thermometers, which will then afford the required indications in from five to eight minutes. This method will prove successful in most instances. But in a case of pleurisy, the fastening of the elastic binder will sometimes cause so much pain as to be quite unendurable, and I have therefore been led to devise another mode of keeping the thermometers in position. I had two iron rings made, about $1\frac{1}{4}$ cm. in height and of the same circumference as the glass spirals already described. After setting up the thermometers on their respective halves of the chest, they were covered with pieces of flannel of the same size over which the rings were slipped, and these latter, resting like paperweights upon the horizontal spirals, kept the instrument steady until the examination was finished, provided the patient did not move.

Fifty of these comparative observations were made on healthy persons by Philipp, who noticed in seven cases a difference in temperature between the two halves of the chest, amounting twice to 0.1° , twice to 0.2° , and once to 0.5° . In five instances the left side was the warmer; in two, the right side; in one of these two the difference amounted to $+0.5^{\circ}\text{C}$. It may be that this species of thermometry constitutes a more sensitive medium of research than other methods of physical exploration, and although the differences thus brought to light may not be sufficient to settle the diagnosis of a disease, or to indicate the stage at which it has arrived, yet they may sometimes be marked enough to aid us in protecting the thoracic organs from the threatened onset of disease. At the commencement of chest-complaints, inflammatory symptoms are predominant; hence arise disturbances of the circulation which may be manifested in an increased vascular fulness of the cutaneous, and especially of the subcutaneous, connective tissues.

On summing up the results of my observations, and comparing them with the published reports, I find that in those pulmonary diseases which generally attack both lungs, no constant differences were discoverable between the external temperature of the two sides; while in exudative pleurisy, usually a one-sided complaint, the temperature of the affected side was raised in the majority of cases. As to pneumonia, which is also for the most part confined to a single lung, I had no opportunities for investigation.—A. WITOWSKI, *Inaug. Dissert.*, Berlin, 1883.

LONGITUDINAL TUMEFACTION OF THE UNGUAL SURFACE OF THE DERMA, WITH RESULTING ATROPHY OF THE NAILS.

THE affection upon which I have bestowed this somewhat clumsy appellation is of rare occurrence and has never, to my knowledge, been previously described. Every busy practitioner, however, who has paid any attention to the more important diseases of the nails, must have noticed it at least once. It was first observed by myself in a gentleman who sought advice for other ailments. Within the following six months, I encountered it three times under the same circumstances, and eighteen months later still, an assistant of the photographer whom I employed to take a picture of the first-mentioned patient's hands, showed me that his own were similarly affected. No doubt, during the latter interval, other examples would have been detected, had I been sufficiently watchful.

Collectively considered, these cases differed from each other in numerous though unimportant particulars. In three of them, both fingers and toes were affected. The features *common to them all* consisted, first, in the formation on the unguual surface of the derma of longitudinal ridges and swellings, standing out much more prominently than the ordinary "ribs" of the nail, and secondly, in the *gradual atrophy* of the latter and its *final separation into two lateral parts*. In the first, fourth, and fifth cases, these were the only phenomena presented, the nails being otherwise unaltered in structure and not much discolored. In the second and third cases, however, the nails became extremely thin and abnormally convex in their general outline, so as to resemble those of phthisical patients, and were decidedly cyanotic in hue. In the former series, also, the transverse furrows on the nails were wanting, which were present in the remaining cases. Finally, in some instances the disease of the unguual surface of the derma was combined with considerable local cyanosis arising from chilblains. Nothing can be more incorrect, however, than to regard the disorder of the nails as merely a result of the latter condition. Our ideas on the subject of chilblains in general certainly stand in need of a careful revision. To confound this complaint, as our best text-books on dermatology now do, with the acute congelations, is, at the present advanced stage of the science, both a subterfuge and an anachronism.

It requires no unusual discernment to perceive that in very few cases of "chilblains" do the latter constitute the only sign of disturbed vascular innervation, and that, furthermore, the direct effects of cold perform but a subordinate part in the production of this *exceedingly chronic ailment*. According to my observation, diseases of the nails which originate in congelation are characterized by various primary affections of the nail itself (especially its matrix), as well as by alterations of the unguual surface of the derma. Longitudinal ridges and divisions of the nail are indeed observed, but here they are less conspicuous features than transverse swellings and changes of form in the entire finger-ends. Still further removed are the lesions I have described from phthisical incurvation of

the nails. There is only one influence which takes part in the causation of *all* these abnormalities, and that is the influence of venous engorgement.

Now it is not at all surprising that venous engorgement should lead to alterations in the shape of the finger-ends and especially of the nails, since Hoyer has demonstrated that there is a direct communication between the veins and arteries in the terminal phalanges of the fingers and toes, precisely underneath the unguis surface of the derma. In this situation, consequently, the congestive process goes straight on from the venous into the arterial system without being weakened by the intervention of a capillary network, and chronic conditions of engorgement may easily give rise to circulatory disturbances sufficient to produce the disfigurements in question. The various forms under which this species of "onychitis from engorgement" may manifest itself are now clearly made out, and will undoubtedly in due time be referred to their respective anatomical sources. One of them may, even now, be thus accounted for. When the venous engorgement operates only on the deeper-lying vascular portions of the skin, as, for instance, by dilatation of the vessels, the unguis surface of the derma, and thence the nail itself, will change their contour, so as to correspond with that which is assumed by the entire finger-end (phthisical nails) while structurally they will remain unaltered. On the other hand, when merely the superficial vascular districts of the skin—including the papillary body, together with the longitudinal ridges on the surface of the derma, and the matrix unguis—are affected, the nail will not become curved as a whole, but will exhibit longitudinal swellings and furrows, followed by its partial secondary destruction, or will undergo *primary* degeneration and atrophy, as in certain cases of so-called chilblains. On these grounds there is a possibility that the particular nail-disease we are considering may be really only a circumscribed affection of the papillary body at the unguis surface of the derma, depending on a state of venous engorgement, and combined, in some instances, with a lesion of the deeper-lying vascular districts. The nail itself, in such cases, remains entirely unaltered, except that, in consequence of its natural thinness, it adapts its shape to that of the morbid elevations on the underlying surface. The malady cannot be classed among the epidermidoses or parakeratoses, since the epithelial alterations which it causes, especially those exhibited by the nails, are entirely of a secondary character.

My conclusions regarding it may be concisely summed up in the following definition:

It starts from circumscribed centres on the unguis surface of the derma. Especially the mesial portion of the same, where it assumes the form of longitudinal swellings, over which the substance of the nail is at first elevated in corresponding ridges, remaining otherwise intact, but becomes gradually atrophied, so as to leave the swellings uncovered; it runs a chronic course, dependent upon a condition of venous engorgement, is capable of spontaneous improvement and recovery, although but slightly amenable to treatment, and is occasionally combined with similar symptoms of venous engorgement of the entire finger-end.—P. G. UNNA.

INJECTIONS OF CORROSIVE SUBLIMATE SOLUTIONS INTO THE INGUINAL GLANDS AND INTO THE SPLEEN IN SYPHILIS.

SUBCUTANEOUS injections of iodine, ergot, and the like have been made as frequently for the purpose of reducing hypertrophied glandular organs, as those of corrosive sublimate with the view of curing constitutional syphilis. Ergot has

been employed in this way, not only to diminish the enlargement of the spleen, but also to improve in general leucæmic conditions.

Peiper and Mosler both agree as to the essential conditions for the successful and innocuous injections into the parenchyma of the spleen. The organ must be of dense, solid consistence, and almost touch the abdominal wall; it should at least lie as near to it as possible. Then the patient must have no tendency to a hemorrhagic diathesis, and not be in a state of leucæmic cachexia. Of the utmost necessity is the preparation of the system and of the organ for these injections. The patient has previously to be subjected to a prolonged internal treatment with remedies by the action of which upon the contractile elements of the spleen the quantity of blood in the organ is diminished. Lastly, for several hours preceding and following the operation, the external application of ice-bags to the spleen is necessary.

Lewin, as is well-known, was the first to suggest and practise hypodermic injections of corrosive sublimate in constitutional syphilis. He recommended the regions of the glutæi muscles as the most suitable locality. Many cases have since been reported, in which this treatment proved rapid, reliable, and effective, though the local irritation has often given rise to complaints. I have also made use of the same method, but must confess that the internal administration of mild mercurial preparations in gradually increasing doses, until salivation is fully developed, or the inunction cure, carried to the same issue, and each of these treatments followed by iodide of potassium, has met with far greater success in my hands than Lewin's method.

An accident gave me the opportunity of trying a new treatment, May 12, 1882, five young men came together into my office. They had each contracted the primary sore from one and the same woman. All were free from organic disease and otherwise perfectly healthy. I will name them A, B, C, D, E.

Perceiving that here was an opportunity for comparison of different procedures, I treated them as follows:—In A, B, C, and D, I cauterized the sore with nitric acid, then applied for a few days lead-water, and afterwards kept the wound dressed with iodoform. In E, I removed the indurated part with scissors, and then used iodoform. In none did I employ any internal treatment, save in A, to whom I gave calomel, guarded by opium, in gradually increasing doses, and B, whom I put under what I shall call, for the sake of convenience, the preventive treatment, which I shall describe later. C had a bubo five weeks after the initial sore, D on the sixteenth day, and E on the twenty-seventh day; while in A and B a very small bubo developed itself, in B at the end of the fourth, and in A in the middle of the fifth week. I now employed the preventive treatment in D, making the injections directly into the swollen inguinal gland.

Varying in time from five weeks up to seventeen weeks, all the cases showed evidences of constitutional affection save D's, in whom, up to this time, no secondary or any other symptom of lues has as yet been observed. In A and B the symptoms were very moderate—the former suffering from a very mild form of psoriasis palmaris, and the latter from angina syphilitica, not in the least severe. C and E had roseola, which, in E, was followed by a syphilitic eczema eruption all over the body, and almost synchronously by violent angina coupled with ulceration of the right velum. I put A, B, and E through an inunction cure, followed by iodide of potassium. They have since had no symptom of lues. In C's case I made use of the preventive treatment, injecting the remedy into the parenchyma of the spleen. The treatment was commenced the third day after the appearance

of the roseola, the latter having lasted but two days. Thus far, no further constitutional disturbance has been evinced in C's case.

Regarding the preventive treatment, this consists in the injection of a solution of corrosive sublimate, first into the enlarged inguinal gland, when this succeeds an indurated primary sore, and at a later stage into the parenchyma of the spleen, to be continued, in both cases, until the first warning symptom foreshadow the approaching mercurial stomatitis. Should the spleen be but moderately enlarged, and should a great amount of adipose tissue intervene between the abdominal covering and the spleen, such injections, if not impossible, become impracticable. For, even granted that we have a needle long enough to reach the organ, how are we to be positive that the needle really enters the spleen? Still, there is one consolation: a solution of only one-sixteenth of a grain of the bichloride of mercury, if it contains no other obnoxious ingredient, will scarcely cause any danger should it even enter the peritoneal cavity or find its entrance into the bowel—that is, provided proper antiseptic precautions have been observed, and these, it should be remarked, are especially necessary in the case of the spleen.

From the data above presented I conclude—and I may add that my experience in general leads me to the same result—that a thorough anti-syphilitic treatment, instituted during the progress of the primary, indurated sore, while not preventing the constitutional affection, probably not even postponing it, has a subduing influence on the whole future course of the lues: the symptoms are decidedly milder and more amenable to treatment.

That the preventive treatment, if applied to the bubo, and ere other constitutional symptoms have appeared, seems to eradicate the disease, and that, if the same treatment be made use of, either at the time of roseola or at any time preceding the constitutional symptoms, and is applied to the spleen, it seems to extinguish the poison of syphilis and to prevent further constitutional affection.

Lastly, from an experience extending over a period of more than twenty years, and owing to accidental circumstances specially considerable in luetic maladies, I am convinced that syphilis can be eradicated.—HUGO ENGEL, *Phila. Med. Times*, June 14, 1884.

A CASE OF ANTHRAX OR CHARBON, WITH EXTERNAL TOMS (MALIGNANT PUSTULE); EXCISION; RECOVERY.

J. L., aged forty-two, waterside laborer, was admitted into St. Bartholomew's Hospital on Monday, April 7, suffering from charbon, or woolsorters' disease, with external symptoms, or so-called "malignant pustule." On March 26, twelve days before he was admitted to the hospital, the patient, in the course of his work, had been handling two heavy bales of hides from China. The next day, March 27, he noticed a small, hard swelling below and behind the right ear, near the site of an old parotid abscess. This swelling increased rapidly, and in a few days he experienced considerable pain in mastication and difficulty in swallowing. On Friday, April 4, the swelling was poulticed, and in a few hours a cluster of "vesicles" appeared on it. On Saturday, April 5, he vomited, and again on the 6th. At this time, indeed, he was feeling very ill; he could not eat because of the pain in masticating and swallowing, and the discomfort was so great as to prevent his sleeping.

On admission, there was on the right side of the neck, two inches below and

two inches behind the lobule of the ear, a large, flat pustule, about the size of a florin, with a very dark centre, apparently formed by a superficial slough, its circumference being formed by a bleb with an irregular circular outline, looking as if several blebs or vesicles had become confluent. Immediately above and behind this sore was a separate bleb about the size of a large split pea. Below the ear was a mass of inflamed lymphatic glands. All the surrounding tissues were œdematous and brawny, so that the fossa below the ear was filled up and the parts projected. The skin surrounding the pustule was very œdematous and erythematous. The erythema extended from the posterior border of the sternomastoid muscle behind to the anterior border of the masseter muscle in front; above, it reached the level of the temporo-maxillary articulation; below, it extended as far down as the third rib on the right side. The patient felt very sick; his temperature was 101.4°; he experienced much difficulty in swallowing, and was in great pain. The spleen could not be felt.

In the afternoon of the day of admission, it was decided to excise the pustule at once. Chloroform was given, and I made a free incision round the pustule, at a distance of a quarter of an inch from its margin, and removed it to a depth of half an inch. The tissues at the base were found so infiltrated and adherent, that it was necessary for removing it cleanly to dissect off some fibres of the sterno-mastoid muscle. An incision was also made into the mass of inflamed glands. Pure carbolic acid was applied to both wounds, and they were covered with sanitas oil (1 in 30) dressings. There was considerable oozing of blood during the operation, and Paquelin's benzine cautery was afterward used to check it. Six hours after the operation, the temperature had fallen to 99°; the pulse was 100, and regular. The patient seemed quite comfortable.

On April 8, the morning after the operation, there was much less œdema and erythema of the neck and chest. The wounds looked clean, and the patient felt much more comfortable, suffering no pain. He was ordered an exclusively animal diet, this being usually recommended in cases of charbon, on account of the fact that the disease is not communicable to the carnivora.

During the day the swelling of the glands and the extensive œdema and erythema decreased markedly. There was no longer any difficulty in swallowing, and the patient's appetite was good. The temperature was normal. He had vomited twice in the night, and slept but little.

Next day he felt fairly well, and from this time there was a steady improvement. The temperature never rose above the normal. The glands below the ear decreased in size, and the wounds rapidly healed. The meat-diet was continued until April 16, and nothing occurred to check further progress towards complete recovery.

A microscopic examination of the excised pustule was made, but no bacilli were found in it.

On a governmental investigation, it was found that the same consignment of hides to which belonged the two bales handled by J. L., had been the means of infecting three other men with "charbon."

In the case of J. L., the period of incubation is very conclusively shown, as beyond having to unload some hides on February 22, he had had no contact with anything capable of infecting him until March 26.

From the results of careful microscopical examinations during the progress of the case, it may be regarded as certain that, in this patient, the blood had become generally infected, and the complete and rapid recovery is the more satisfactory.

The diagnosis of charbon was not difficult. The characters of the local disease,

which led one instantly to suspect, as a cause, some animal poison, and to cross-examine the patient from this point of view, were quite different from any other; and the voluntary statement of the patient that he had been engaged in carrying hides left but little doubt of the nature of the disease.

Cases of "charbon" appear to be much more frequently admitted to Guy's Hospital than to any other metropolitan hospital, from its neighborhood to the large leather manufacturers of Bermondsey; and it appears, from the table of cases given by Mr. Davies-Colley (vol. lxxv. of the *Medico-Chirurgical Journal*), that the success of the treatment by excision has been most marked. It may be fairly said that in this particular case the greatest benefit was apparently derived from the procedure. The temperature fell, the erythema ceased spreading, and began to fade; and the patient described himself as feeling altogether a different man within twenty-four hours after the excision of the pustule.

Sulphite of soda, in ten-grain doses, three times a day, was the internal remedy ordered. I was induced to select it by the marked success which has attended the treatment of this disease (splenic fever) in cattle, by this drug in the hands of Mr. J. B. Gresswell, of Louth.—W. MORRANT BAKER, *Brit. Med. Journal*, June 14, 1884.

IODOFORM IN ERYSIPELAS.

A SOLUTION of iodoform in collodion, of the strength of 1 oz. of iodoform to 10 oz. of collodion, applied by painting it over the affected surfaces and a little beyond has certainly proved, in my experience, the most successful of the many remedies employed externally for erysipelas. In all the four cases in which I have thus far tested it, the disease appeared to be at once stopped, "jugulated," if I may use the word; the burning pain was promptly relieved; in no case was extension observed after the first application; in no case did vesication occur; it seemed as though the cutaneous inflammation subsided immediately under the influence of the drug. These results, together with the remarkable freedom from irritation during the period of desquamation following the subsidence of the disease, are all strong reasons in favor of its extended use.

Tincture of iron was administered internally in three of the cases, but in the fourth no internal treatment was tried, except a smart purge of sulphate of magnesium; yet by the next day the erysipelas had subsided. Simple collodion, it is known, while giving relief to certain well-marked symptoms, *does not stay the progress of the disease*. The odor of iodoform is objectionable, to some extent; but this disadvantage may be overcome. The temporary disfigurement caused by its application, particularly in facial erysipelas, will not, I think, be urged against it when its advantages are thoroughly appreciated.—C. CLARK BURMAN, *Practitioner*, May, 1884.

Received.

L'Urina in Rapporto colle Dermopatie del Prof. PIETRO GAMBERINI (Reprint).
De la présence des Bacilles de la Tuberculose dans les Gommès Syphilitiques, par le Prof. C. PELLIZZARI (Reprint).

Éléments diagnostiques de la Syphilis héréditaire tardive, par le Prof. ALFRED FOURNIER (Reprint).

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Syphilis Héréditaire Tardive (Accidents cérébraux) par le Prof. A. FOURNIER (Reprint).

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Item.

AMERICAN DERMATOLOGICAL ASSOCIATION.—Eighth Annual Meeting, held at Highland Falls, August 27, 28, and 29, 1884. Papers: Address by the President, Dr. R. W. Taylor. 1. Case of General Idiopathic Atrophy of the Skin, by Dr. W. A. Hardaway. 2. A Clinical Contribution to the Study of Lupus Erythematosus of the Hand, by Dr. J. Nevins Hyde. 3. Suggestions Respecting the Treatment of Acne and Acne Rosacea in the Male Subject, by Dr. S. Sherwell. 4. A Case of Unilateral Chromidrosis (?), by Dr. J. C. White. 5. A Case of Late Cutaneous Syphilis (Acne-form Syphiloderm of the Nose), Illustrating the Occasional Necessity of Large Doses of Potassium Iodide, by Dr. Henry W. Stelwagon. 6. Dermatitis Herpetiformis: Its Relation to Impetigo Herpetiformis, by Dr. L. A. Duhring. 7. Case of Xanthoma Multiplex, by Dr. W. A. Hardaway. 8. A Case of Vitiligo Involving the Whole Surface, by Dr. H. W. Stelwagon. 9. Cases of Arsenical Dermatitis, by Dr. J. C. White. 10. On Miliaria and Sudamina, Dr. A. R. Robinson. 11. On a Peculiar Scaling Affection of the Glans and Prepuce, by Dr. R. W. Taylor. The officers for the ensuing year are: *President*, Dr. W. A. Hardaway; *Vice-presidents*, Dr. J. E. Graham and A. Van Harlingen; *Secretary*, Dr. W. T. Alexander; *Treasurer*, Dr. G. H. Rohé.

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A CLINICAL STUDY OF LUPUS ERYTHEMATOSUS AS IT AFFECTS
THE HANDS.¹

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DURING the last decade, the contributions to a knowledge of the symptomatology and pathology of the disease known as lupus erythematosus have been both numerous and valuable. The excuse to be urged, were one needed, for a description in detail of the clinical features of a disorder thus well recognized, lies in the fact that the following pages are devoted to a study of its evolution in a somewhat unusual situation, viz., upon the hands. These organs are justly assigned a subordinate rank in the order of frequency with which the several parts of the human body are involved in the disease; but at present there appears to be a want of agreement as to the precise position in that order to which the hands should be referred.

In the description of the four following cases, they are recorded, as far as was found possible, in the order of their severity.

CASE I.—Miss E. B., aged nineteen years and unmarried, applied in March, 1881, for relief of her cutaneous disease. She was a well nourished and fully developed girl, though her darkly tinted checks bore no traces of the fresh color often seen at her years. Her eyes and hair were of a brown hue. She gave no history of serious illness, and stated

¹ Read at the Eighth Annual Meeting of the American Dermatological Association, August, 1884.

that her functions were all properly performed. She was accompanied by her brother who presented the external evidences of sound health. They were in comfortable circumstances and in the middle ranks of society.

She had suffered from her disease for five years, and had been treated by her family physician, a practitioner of repute. Under treatment, however, it had steadily advanced. It had always been strictly limited to the dorsum of the left hand. It had begun by the development of a small red spot on the radial side, and had thence extended toward the point of the thumb. There was no history of pustulation or discharge, the disorder having been from the first unattended by secretory symptoms and unproductive of subjective sensations. She wished to be rid of it chiefly on account of the resulting deformity.

When examined, the disease was found to be limited to a single, circumscribed patch. This patch extended in an irregular oval, from near the middle of the dorsum of the first left metacarpal bone, quite to the dorsal aspect of the articulation of the distal phalanx of the thumb with its neighbor, involving also, to a slight extent, the web between the thumb and the index. Its outlines were perfectly defined. The proximal half of the oval was exclusively made up of delicate cicatricial tissue. This was soft, smooth, shining, non-attached, readily gathered between the fingers, and of a dead-white color. It was throughout uniformly dotted in darker-tinted punctations. Proceeding from the metacarpus downward, this scar-tissue was found to be succeeded by the adjacent segment of the oval, which was infiltrated, of reddish-gray hue, and covered with yellowish-white, firmly attached scales. Its advancing border presented a circular wall of elevation, about two millimetres in height. Over the affected phalanx of the thumb, a singular effect was produced by the natural furrows of the skin, in consequence of which the disease in this locality was made to suggest to the eye the external configuration of ichthyosis simplex. This was due to a packing together of the adherent scales, and to the motions of the thumb by which the skin was extended in the lines of these furrows. The palmar surface of the hand and fingers was not involved.

This patient, in the ensuing April, was persuaded to appear at the clinic for skin diseases, in Rush Medical College, Chicago, where, in connection with two patients affected with lupus erythematosus of the face, she was presented to a number of practitioners then in attendance.

Of the four patients, whose cases are described in this paper, this one alone has enjoyed a complete involution of her disease, the other three being still under observation and treatment. It should be added, however, that hers was decidedly the least severe of the four cases collated.

When thus completely relieved, in the succeeding year, of the last

traces of an active disease, the entire patch of skin which had been involved was the seat of a smooth, thin, shining, non-attached, extensible, and homogeneous sear, regularly dotted over its entire surface with minute punctations, and perfectly defined. The thumb-nail had been throughout completely spared.

As this patient has not been under my observation since her case was dismissed, it is not possible to report as to the recurrence of the disease in the hand or elsewhere. At no time while she was under observation was there any trace of the same disease in any other portion of the body save the hand.

CASE II.—Mrs. J. F. S., of Iowa, presented herself with a letter of introduction from her physician on the 3d of July, 1884, in fact after a production of this paper had been prepared. She was thirty-eight years of age; of pallid complexion; and accompanied by her husband, a man apparently in sound health, to whom she had been married for seventeen years. She had never miscarried nor lost a child; her only daughter, twelve years of age and presenting evidences of fair vigor, was present at the consultation. The patient stated that all her functions, including those of the digestive and genito-urinary tracts, were properly performed. She weighed one hundred and thirty-four pounds; her father had died of brain fever at fifty-six; her mother, of some chest affection at sixty-four. One brother was living in poor health; four were dead of infantile disorders. The only diseases of which she gave a history were, lung fever in the thirty-seventh year; and a miasmatic affection contracted when she was ten years old.

Her general appearance was that of a woman in poor health, her color being decidedly suggestive of chloro-anæmia.

When closely questioned upon this point, her husband declared that even before her marriage, and always since that date, she had exhibited the same peculiar tint of the skin.

Her cutaneous disease, strictly limited to the right hand, had existed for exactly fifteen years, dating from the year after her marriage. She stated that it had begun as a small swelling on the back of the hand, which gradually formed a sealy ring. This slowly spread till its present dimensions were attained. The subjective sensations were quite limited to a sense of burning, moderate in degree, when the affected part was exposed to the sources of the heat. She sought relief on account of the resulting disfigurement, and the inconvenience experienced in attending to her domestic duties. She was right-handed. The only diagnosis she had ever heard expressed was that of a physician who termed her affection, "a serofulous ringworm."

When examined, the right hand was found to be involved in a distinctly circumscribed patch, extending from the dorsal aspect of the first

carpo-metacarpal joint exactly to the ulnar side of the thumb-nail, the nail being perfectly respected. The outline of this patch was in large salient curves, and as distinctly defined as if drawn with a pencil. Laterally, it extended on one side only to the palmar border of the thumb; on the other, it reached to the dorsal aspect of the joint between the proximal and adjacent phalanges of the index finger. The ulnar border of the thumb and the radial face of the index finger to the middle joint only, were invaded; but between the two, and here only, the palm was involved, the disease-process having swept over the free border of the web and reached beyond, to the extent of about one centimetre.

The entire plane of this patch was free from infiltration, hyperæmia, redness, or other signs of active disease. It was solely occupied by a thin, depressed, wasted, cicatriform tissue, shining in parts more than in others. Instead of exhibiting the peculiar punctate appearance noted in the case last reported, it was irregularly covered with larger, rape-scud to split-pea-sized, circular and ovoid pits, between which stretched the thinned and glistening, atrophic skin.

The active evolution of this disease was displayed only in the relatively narrow border of the patch. This was a wellnigh linear circumvallation, raised to an average height of nearly three millimetres, with a still narrower, dense, dry, dirty-yellowish ridge at the summit, composed of scales. On either side of this, a narrow dull-red halo exactly followed its marking, projected in advance to about the height of the wall, and slightly narrower within. So firm and unyielding was this infiltrated border, that on one of its salient circles, a shallow fissure had formed at its foot, evidently wrought by the retreat of the healthy skin from the inelastic infiltration to which it had been united. This shallow, linear furrow resembled some of the superficial forms of intertrigo, seen, for example, beneath the pendulous mamma affected with that disorder.

The scaly summit of the ridge described above, strongly suggested in appearance a crust, but in fact there has been no moisture nor at any time a history of discharge. The peculiar packing together of the scales at the point of greatest infiltration had been in part influenced by the motions of the hand, and in part by the external friction to which the affected organ was particularly exposed.

At a short distance from the eye, a distance sufficient to obscure the atrophic condition of the skin bounded by this wall, the entire disk would have suggested a patch of aggravated tinea circinata, or some of the serpiginous syphilodermata in the inherited forms of that affection.

This same patient had a small patch of similar disease upon the vermilion border of the left side of the lower lip, involving also the cutaneous surface. It was not fixed at the angle of the lips, but midway between the centre and the angle. It was crescentic in shape, its long

axis parallel with the line of the oral fissure, its convex border regarding the chin, and was nearly three fourths of a centimetre in its longest diameter. It was dull ham-colored, moderately infiltrated, and not the source of subjective sensations. It was chiefly annoying by reason of its interference with the motion of the lip. At the convex border, a few adherent scales could be seen. It had existed for only one year, making its appearance, therefore, fully fourteen years after the involvement of the hand.

Two smaller, rape-seed-sized lesions, of still more recent date, were visible on the chin below. They were dull-red in hue, scale-capped, and not the seat of subjective sensations. Unaided by the light thrown upon their significance by the older lesions described above, it can scarcely be doubted that the diagnosis of the case would have been exceedingly obscure.

Throughout the entire course of her disease, this patient had never noticed the occurrence of weeping, moisture, or discharge of any sort from the affected surface. The sole sensation which it had at any time awakened was a burning feeling when the part was exposed to rays of heat. Her conviction was that some species of worm had been boring through the skin during the years in which she had been annoyed.

CASE III.—Mrs. L. E. H., twenty-nine years of age, of bilio-nervous temperament, a resident of Chicago, and in comfortable circumstances, presented herself for advice, April 11th, 1884. She stated that she had been for eight years married, and had never been pregnant. She was a decided brunette in the color of skin and hair. After the removal of a quantity of toilet-powder from her face, distinct striations of melano-derma were visible over the brow and temples, of the character often recognized in sterile women. She declared that her husband was a man of unusually good health, weighing over two hundred pounds. Her menstrual functions were regularly performed; and she gave no history of disorder of the alimentary or genito-urinary tract. She was tall and had a decidedly slender figure, being only sparsely nourished, with a suggestion of hollowness in each cheek. Some three years before, she had been under the care of a gynæcologist of repute, in the vain hope of becoming a mother. The only tangible evidences of disease were those of the skin.

This cutaneous disorder had begun in the fourteenth year of her life, and had therefore lasted for fifteen years. Though sometimes a trifle better or worse, it had continuously endured and extended during the period named. It had throughout been strictly limited to the left hand. She employed pre-eminently the right. It had begun by the development of a roundish, pea-sized spot on the palm, and by a slow process of multiplication and coalescence, a patch had gradually formed.

There was no history of pustulation, discharge, or crusting. She had consulted a number of physicians, who had given the usual variety of diagnosis. From none of these had she secured relief. By one, it had been pronounced syphilitic.

When examined, this left hand was found to be involved as follows: The entire palm, with the exception of a riband of sound skin, next the proximal border of the carpus, was the seat of a single, discoid, infiltrated patch of disease. Its outline was in general circular, and defined very perfectly. In color it was a dull pinkish-red, modified somewhat by the superimposition of coarse yellowish and firmly adherent scales. Its border was somewhat elevated above the level of the sound skin, but not to the extent of the patches described in the preceding pages. There were two centrally situated, cicatricial spaces, having an indefinite outline, and not marked, as in the cases previously described, with puncta or larger-sized depressions. These were smoother, flattish, and decidedly less depressed. Beyond these, the patch was uniformly firm, infiltrated, and covered with coarse, adherent yellowish scales, so firmly attached indeed that the curette was necessary for their complete removal.

The distal border of this patch extended beyond the palm, well into the first and second interdigital spaces, and over the sides of the thumb and index fingers; to a less extent over the radial border of the index. On the dorsal face of the second metacarpal bone, were two bean-sized, circumscribed, slightly elevated, flattish disks, scale-covered, and beneath the scales of a dull reddish hue. A number of other and rather smaller isolated spots could be recognized in the third interdigital space, cropping out in still smaller adjacent lesions so as to encroach slightly upon the dorsal aspect of the middle finger.

There was no history of itching, nor at any time of the production of subjective sensations. Like the other patients whose cases have been narrated, she sought relief on account of the disfigurement of the hand. It was noticeable that, though the palm was extensively invaded, there was no tendency to the production of inextensibility of the digits, so commonly noted in long-standing chronic eczema of the palm, nor of a tendency to retain the fingers in the semi-flexed position.

As compared, too, with the other cases, apart from the marked tendency of the disease to a palmar limitation, the vivid color of the main patch of the disease, the persistence of the scaliness centrally, and the absence of pitting in the atrophic and wasted centres of the palm, were features of special interest.

The treatment of this patient's hand was temporarily interrupted by a febrile attack, induced by unusual fatigue and exposure to weather-changes. Convalescence from this intercurrent disorder was protracted, and once established, she visited the sea-shore by advice, in the hope of

fully establishing her health. At the date of her departure there was only very slight improvement of the cutaneous disease.

CASE IV.—E. B., a merchant of Iowa, largely confined to his desk by his business engagements, thirty-eight years of age, and fifteen years married, applied for advice in January of 1883, bringing a letter from his physician. He admitted that before his marriage he had contracted a gonorrhœa, for which he had been treated and from which he had recovered in a few weeks, without the occurrence of complications. He could give a history of no other disease in the past. He was of medium height, but weighed only one hundred and forty-two pounds, a circumstance possibly to be explained by his inordinate use of tobacco. He used this both by smoking and chewing, and wellnigh continuously. There was no history of adenopathy, involvement of mucous surfaces, of alopecia, or of cutaneous maladies, save that described below.

His skin-disease had existed for twelve years, and had always been strictly limited to the right hand, a member which he used predominantly. It had begun as a small, scaly patch on the web between the thumb and index finger, and had thence gradually spread till the present condition was produced. It had never been the source of subjective sensations, except at the rare times when fissures formed. He desired relief chiefly on account of the disfigurement. He gave the common history of widely varying diagnoses and methods of treatment, adding that he had been declared to be syphilitic.

When examined, the hand was found to be the seat of a firm and infiltrated patch extending from the dorsum of the first and second metacarpal bones and of the corresponding digits, involving the web between the two fingers, and reaching over the free border of the interdigital fold to the extent of nearly one centimetre into the palm. The nails of the involved fingers were perfectly free from all traces of the disease. The outline of this patch was very distinctly defined. Its edges were prominently raised; its color was a dark bluish-red. Throughout, it was covered with relatively large, firmly adherent, dirty-white and grayish scales. In the web between the involved fingers was a distinctly cicatricial patch, of irregular contour, and nearly of the size of a silver quarter of a dollar. It was irregularly dotted centrally, and not attached. Over the dorsum of the proximal and distal joints of the involved fingers were superficial fissures, lying transversely to the long axes of the digits, which showed a slightly reddened floor in each furrow. These he reported as at times somewhat painful. In this case there were no outlying disks of similar disease.

As contrasted with the other cases described above, it is noticeable that in this alone fissures had occurred, though these were neither deep, crusted, nor the apparent sources of discharge. As this patient was the

only one of the four whose cases are collated who was, as a male, actively engaged in the pursuits of business, it is possible that the hand was, as a consequence, subjected, more than those of the women similarly affected, to the action of friction and external irritation of various kinds.

If any apology were needed for the detailed description of the cases cited, it should be found in the apparent rarity with which, it would seem, similar facts have been placed on record.

In Hebra's treatise on diseases of the skin,¹ the chapter on lupus erythematosus is from the pen of Kaposi. In these pages, the hands are not named as possible sites of the discoid form of the disease; and with reference to the disseminated and aggregated form, it is stated that the disorder may "ultimately" develop over "even the fingers and toes" in the cases subject to a gradual development; and in those exhibiting acute exacerbations, the flexor and extensor faces of the fingers, and the palms and backs of the hands are said to be involved. "Even in a case of unusually diffused lupus erythematosus," the author proceeds to say, "either only discrete patches occur, or these are met with in a recent form, on the fingers and toes for example, while on the face the older condition of the same form, the discoid variety occurs." Again, in the complication termed by the writer, "erysipelas perstans faciei," after describing the accompanying tumefaction and incrustation of the visage, it is added that "isolated and aggregated spots of lupus erythematosus are met with at a distance. . . even on the fingers and toes."

Elsewhere, however, Professor Kaposi describes the discoid form of lupus erythematosus as of occurrence on the anterior faces of the fingers; the disseminated and aggregated form, on both the anterior and posterior faces. In a series of very interesting cases exhibiting the acute type of erythematous lupus, reported by him at another date,² there are four in which the hands were involved. In all four, however, the disease had first appeared either upon the face or upon some other part of the body than the hands.

Kohn (Kaposi) discusses the subject of lupus erythematosus also in an exhaustive paper published in 1869,³ in which he gives some space to the appearance of the disease upon the hands and the fingers.

Neumann⁴ states that in this disorder the palm is very seldom involved, and refers to a case under his observation which he describes as exceedingly rare, where the face and both palms were affected with lupus erythematosus.

¹ New Sydenham Soc. Trans., London, 1875, vol. iv.

² Arch. f. Derm. u. Syph., 1872, Prag, p. 36.

³ Arch. f. Derm. u. Syph., 1869, p. 18.

⁴ Beitrag z. Kent. d. Lup. Erythem., Wien, Med. Wochenschr., 1869, No. 68.

Hans v. Hebra¹ merely refers to the possibilities of involvement of the hands.

Behrend² contents himself with a reference to the experience of Neumann and of Sir Erasmus Wilson.

Veiel, at the International Medical Congress in London, 1882, reported fifty cases of lupus erythematosus, occurring between the twentieth and fortieth years of life, but it does not appear that among these the hands were in any case affected.

Geber reports a single case where the disease appeared first upon some other part of the body than the face, in a woman twenty-one years of age.

Profeta³ names the fingers of the hands as the third in the order of frequency of involvement of the several regions of the body, after indeed only the face and the scalp.

A few cases have been reported among Americans, none, so far as I have been able to discover in a survey of dermatological literature, where the hands were first involved. Bulkley⁴ describes a case where both palms were involved in patches from one-half of an inch to an inch in diameter, in a woman twenty-five years of age. Weisse⁵ has also seen a case representing the diffuse form; and Geddings⁶ has had experience of a similar case. He indeed would seem to have noted the involvement of the hands in more than one instance, since he makes a statement which is not to be found in the writings of other observers, viz., that when the hands are involved, it is almost always along the ulnar margins, with slight encroachment upon the palms. He also describes well the peculiar hardness and dryness of the crust which forms in this situation.

French writers seem to have paid but little attention to this special subject. Cazenave alone⁷ describes a case of lupus erythematosus in a male patient, aged thirty-eight years, in whom the disease had lasted for ten years. The fingers and backs of the hands were affected in its progress from other regions of the body.

It is a fact, not without some interest in this connection, that English observers have not only described a larger number of manual cases than those of other nationality, but also that several of them choose to institute a comparison between these special lesions of the disorder and those termed by them "chilblains." How far the English climate may be responsible for this circumstance it might be difficult to decide.

¹ Die Krankh. Veränderung. d. Haut., Braunschweig, 1884.

² Lehrbuch d. Hautkr., Berlin, 1883, p. 422.

³ Tratt. Elem. d. Malatt. Cutan. che osserv. in Italia; Palermo, 1881.

⁴ Jour. of Cutan. and Vener. Dis., v. ii., No. 3, 1879.

⁵ Arch. of Derm., v. i., p. 6.

⁶ Amer. Jour. of the Med. Sciences, 1870.

⁷ Annales d. Malad. d. la Peau et de la Syph., 1850-51, p. 297.

Sir Erasmus Wilson¹ writes as follows: "Associated with lupus erythematosus of the face, we not unfrequently meet with similar spots on the fingers; in the latter situation they have the appearance of chilblains, and are commonly mistaken for them. But their persistence through the summer as well as the winter, the white dry cuticle which covers their surface, the central depression, and frequently the atrophy of the portion of the attacked skin, indicate their real nature. The erythematous spots or blotches are usually of a circular figure, of a purplish color, and slightly raised above the level of the surrounding skin. They vary in size from two or three lines to an inch in diameter; and gradually become depressed in their centre; the cuticle in the centre assumes a whitish opaque appearance, gradually dries up into a thick yellowish and horny layer, and desquamates from time to time. A common situation of these blotches is the joints; and they are commonly associated with coldness of the fingers and hands, which gives a color to the suspicion of their being chilblains. Like the similar affection of the skin of the face, the special character of the disease is atrophy; and in a young girl now under our treatment, the atrophy has extended to the whole of one finger, which is conical toward the end from loss of substance and contraction of the skin, and bloodless from the tight clasp of the skin upon the phalanges."

Aside from the fact that this paragraph presents an accurate picture of the disorder to which it refers, it possesses an interest in consequence of the fact that it represents, so far as I have been able to determine, the fullest description of lupus erythematosus of the hand which has been thus far contributed to dermatological literature.

In an exceedingly full contribution to the general subject of lupus erythematosus, published in the *Journal of Cutaneous Medicine*,² which this lamented author then edited, are collected no fewer than fifty-six cases illustrating the features of the disease, in twelve of which the fingers and toes were involved.

Mr. Jonathan Hutchinson, of London,³ seems, however, to have had an experience of almost equal extent. He collates forty cases of the disease, some of them observed by himself, a few represented by the Sydenham Society's plates, and, of these, four patients displayed manual lesions. One of them is particularly interesting in this connection, as in this case the disease began not upon the face, but upon the forearms. The arms were the exposed limbs of a seven-years-old child, in whom the disease was not displayed upon the face till several years had elapsed. In a communication made to the *Medical Times and Gazette*, January 4,

¹ Diseases of the Skin, Phil., 1868, p. 375.

² January, 1869.

³ Lect. on Clin. Surg., Part ii., London, 1879, p. 275.

1879, p. 1, the same observer declares that "next to the ears in frequency come the backs of the two hands, and it is very rare indeed to see one hand alone or one ear alone affected."

The late Dr. Tilbury Fox¹ presented a picture of what he termed lupus erythematosodes of the hand, occurring in a patient under his observation. It is somewhat difficult to decide from the text accompanying the plate whether the hands are those of the patient whose face is also figured in connection; but the portrait is an interesting and suggestive one. The fault with these plates in general is the failure to make use of a sufficient number of stones to properly represent the various shades of color exhibited by the diseases of the skin selected for illustration; but in this case the portraiture is sufficiently complete. In it are represented faithfully the clinical appearances of the hand of the patient whose case is the first described by me in the present paper, the resemblance between them having been noted by the physicians to whom this plate was shown at the time of their examination of the hands of the young woman. The text accompanying the plate runs as follows: "I represent in this figure an unusual phase of erythematos lupus, and purposely so, for a reason that will appear directly. The basis of the disease, as seen in the isolated patch at the back of the hand and in the part over the knuckles of the first finger, is a new growth of tissue or infiltration, the edges of the patches of disease being well-marked and somewhat raised, and the central portion slightly scaly and yet thinned. Such patches, and they are identical with that on the tip of the nose in Figure 1, are common in connection with, and typical of, erythematos lupus, as it attacks the scalp, the ears, and the hand in particular, as stated in the description of Fig. 1 in this plate. But in some cases the disease may not be so well defined; there are merely red, slightly thickened patches about the hands that look like chilblains, only that they are more indolent, and are not excited by cold, whilst some little atrophy occurs usually. But in this representation there is an exaggerated condition of things, or rather a superaddition of crusting, together with hypertrophy of the papillary layer of the skin, constituting a warty outgrowth from the centre of the lupus spots."

Stowers² reports that he has observed the disease three times on the backs of the hand. Jamieson³ has seen the disease co-exist on the left cheek and the back of the hand, occurring first in the former situation. In this case he notes a result in stiffness and diminished flexion power described by other authors. Thin,⁴ after examination of the tissue re-

¹ Atlas of Skin Diseases, Phil., 1876, p. 74.

² Trans. Brit. Med. Assoc., Arch. of Derm., vol. v., p. 414.

³ Edin. Med. Jour., 1878, p. 1,006.

⁴ London Lancet, January 16, 1875.

moved from the inner face of the second toe, where there are no sebaceous glands, recognized vascular dilatation about the sweat follicles and papillæ. It is interesting to note in this connection that the more modern conclusion respecting the origin of lupus erythematosus at points outside, not merely the peripheral tissues embracing the sebaceous glands, but also outside the sweat glands, was really anticipated by Neumann in commenting upon his case of lupus erythematosus of the two palms.

A case reported by Milton¹ is interesting as another of the few instances where the disease seems to have begun on the hand. The case is that of a woman, twenty-four years of age, whose little finger had been involved six years before, and singularly enough had been, in consequence, amputated. One year afterward, the nose became involved. The disease spread upon the hand, after the amputation of the fingers, forming a patch reaching from the distal side of the ulna to the first phalanx of the third finger.

It will be proper to conclude this summary of what has been published in connection with the subject of lupus erythematosus of the hand by referring to the fact that in the six cases illustrated by drawings, models, and charts to be found in the Hunterian Collection, of London, which were made the subject of Sir Erasmus Wilson's lectures, the hand is not represented as affected with the disease.

In the appended Table, the cases to which reference has been made in the preceding pages have been associated for purposes of comparison. Many of the spaces allotted to data which should be added in order to make the Table complete, are left blank in consequence of the fact that the reports have been in these particulars lacking. The following, however, are the inferences which a study of the collated cases seems to justify:—

In eleven patients the age at which the disease first appeared in any part of the body is noted. The average was somewhat over twenty years, the youngest being seven; the oldest, forty-two. It is, however, to be seen that, in twelve cases where the dates are given, an average of seven years intervened between this onset of the malady, and the time when the patient came under the observation of the reporter.

Of twenty cases of lupus erythematosus with manual involvement, the face was first affected in twelve patients; the hands, in four; the fingers, in three; and the forearm (exposed), in one. It will be remembered that the large number of patients in whom the face was first involved are those fully reported by Kaposi, all of an acute character, with generalization of the disease, and during the course of that generalization, involvement of both hands. No German author seems to have

¹ Arch. of Derm., vol. ii., p. 131.

Table of Cases of Lupus Erythematosus with Affection of the Hand.

NO.	AGE WHEN AFFECTED	AGE WHEN OBSERVED	DURATION OF DISEASE.	PART FIRST AFFECTED.	PARTS AFFECTED OTHER THAN HANDS.	HAND.	FINGERS.	PART OF HAND OR FINGERS INVOLVED.	SEX	REMARKS.	OBSERVERS.
1	.....	.....	.....	Fingers...	.....	.....	Fingers...	.....	..	.....	Wilson, E.
2	.....	.....	.....	"	.....	.....	"	.....	.....	.....	"
3	.....	.....	.....	Nose.....	.....	.....	"	.....	.....	.....	"
4	.....	.....	.....	"	.....	.....	"	.....	.....	.....	"
5	.....	.....	.....	do. & cheek.	.....	.....	"	.....	.....	.....	"
6	.....	.....	.....	.....	.....	.....	"	.....	.....	.....	"
7	.....	.....	.....	Ears & ch'k.	.....	.....	"	.....	.....	.....	"
8	.....	.....	.....	Lids & neck.	.....	.....	"	.....	.....	.....	"
9	.....	.....	.....	cheek, ears and scalp.	.....	.....	"	.....	.....	.....	"
10	.....	.....	.....	.....	.....	.....	"	.....	.....	.....	"
11	.....	.....	.....	Ears & nose.	.....	.....	"	.....	.....	.....	"
12	.....	.....	.....	.....	.....	.....	"	.....	.....	.....	"
13	.....	.....	.....	Face.....	.....	.....	"	Dorsum.....	.....	Diminished power of flexion	Jamieson.
14	18	24	6	Fingers...	Nose.....	Left.....	3d & 5th.	Dorsum.....	F.	One fing. amputated.	Milton.
15	.....	.....	.....	"	.....	Hand...	.....	Dorsum.....	.....	.....	Stowers.
16	.....	.....	.....	"	.....	"	.....	"	.....	.....	"
17	.....	.....	.....	"	.....	"	.....	"	.....	.....	"
18	.....	.....	2	Face.....	Face.....	Both.....	Fingers...	Palm.....	F.	Rhagades.....	Kohn (Kaposi).
19	20	33	3	"	"	"	"	Sides.....	F.	.....	Kaposi.
20	.....	36	.....	"	"	"	"	Extremities...	F.	.....	"
21	.....	24	.....	"	"	"	"	Sides.....	F.	.....	"
22	.....	29	.....	"	"	"	"	Dorsum.....	F.	.....	"
23	.....	32	.....	"	"	"	"	Palms & dors.	F.	.....	Neumann.
24	17	20	3	"	"	"	"	Dorsum.....	F.	.....	Cazenave.
25	28	38	10	"	"	"	"	Dorsum.....	M.	.....	Bulkeley.
26	21	25	4	Face.....	"	"	"	Palms.....	F.	.....	Fox, J.
27	.....	.....	.....	Forearms.	Face.....	Hand.....	Fingers...	Dorsum.....	M.	Fingers "pulpless."	Hutchinson.
28	7	14	7	Face.....	"	Both...	"	.....	M.	.....	"
29	.....	12	.....	"	"	"	"	.....	M.	.....	"
30	42	44	18 mos.	"	"	"	"	.....	F.	.....	"
31	.....	46	.....	"	"	Both.....	"	.....	M.	.....	"
32	14	19	5	Hand.....	Lip & chin..	Left.....	"	Dorsum.....	F.	.....	Hyde.
33	23	28	15	"	"	Right...	"	"	F.	.....	"
34	14	29	15	"	"	Left.....	"	Palm.....	F.	.....	"
35	26	38	12	"	.....	Right...	"	Dorsum.....	M.	Rhagades.....	"

set on record a history of lupus erythematosus limited to one hand, as in England and America.

In twenty-nine cases where parts other than the hand were involved either before or after the appearance of manual lesions, the face is named thirteen times ; the nose, four times ; the nose and cheek, twice ; and once each, the ears and cheek ; the lids and neck ; the cheek, ear, and scalp ; the nose and ears ; and the lips and chin. In five cases, the hands only were affected.

As to the hands more particularly, in twenty-one cases ; both hands were affected twelve times ; the left alone, three times ; the right alone, twice ; and in four, the special organ of one side is not indicated. It is reasonably certain that, however correct the English authors may be in describing lupus erythematosus, as influenced by climatic changes and as occurring for the most part, indeed in the vast majority of all cases, only upon the parts exposed to the weather, certainly friction and pressure effects are here without influence. Lupus erythematosus of the left hand in right-handed patients is fully as severe as lupus of the predominantly employed hand in other patients. This is a conspicuous departure from a rule of common procedure in such a constitutional disorder as syphilis, for example, palmar syphilodermata being incontestably more abundantly exhibited upon the predominantly used hand.

The fingers are shown to have been affected in twenty-eight cases of those tabulated.

Of seventeen cases, where these particulars are noted, the palms were three times affected ; the dorsal surfaces, ten times ; the sides, twice ; and the extremities only once.

Of eighteen patients whose sex is mentioned, thirteen were females ; and five males ; figures which strongly corroborate the assertion made by Kaposi before the International Congress in London, in 1882, that two-thirds of all cases occur in women.

Lastly, as respects the local complications of the disease, as well as the general condition of the patients, there is little to record. In two cases there were fissures that formed in the hands. In one of Hutchinson's patients, the pulps of the fingers atrophied ; and in some of the patients, the power to flex and extend the fingers was to a marked degree diminished, as in severe palmar eczema. The prognosis of the disease when the hands are involved would seem to be favorable in point of gravity ; unfavorable as respects the duration of the local ailment, which, everything said and done, would be properly classed among the disorders chiefly annoying by reason of the resulting disfigurement. One patient lost a finger by amputation, for what reason does not appear.

It is noteworthy, however, that most of the patients affected, lack the essential features of robust health. They do not resemble the class of

florid-faced, well-nourished, and vigorous-looking men and women whom we not rarely find displaying an eczema, a psoriasis, or even an epithelioma. They are, even when not recognized as the subjects of a definable disorder beyond the lupus erythematosus, pallid, thin, or with a peculiar tint of the cheek, which can be scarcely described as cachectic, though departing from the highest standard of healthy color of the human skin, which may be in general regarded as a fair index of a thoroughly wholesome body.

SUGGESTIONS RESPECTING TREATMENT OF ACNE AND ACNE
ROSACEA IN THE MALE SUBJECT.¹

BY

S. SHERWELL, M.D., Brooklyn, N. Y.

WHILE all authorities writing on the subject of acne vulgaris and rosaceous acne (without exception, as I think) refer to uterine or other sexual pathological conditions as having a causative action in these troubles, it is curious to note how little as a rule they have to say regarding therapeutic measures directed towards those states of functional or organic disturbance.

German, French, and English authors, particularly the first named, ignore almost totally any reference to constitutional or local treatment of the organs in question.

Among American authors, two may be named as having given more than the usual prominence to this matter: Drs. Piffard and Hyde, and those in the order as named. In both books of the former, the phenomena, developmental and accidental, are dwelt on at some length, and with, as I believe, correct judgment; in his latest work, "Materia Medica and Therapeutics of the Skin," a very just estimate is given as to the etiology of acne vulgaris and rosacea.

Dr. Hyde, while in his work not dwelling so much on these points, mentions, with comment somewhat approbatory, the advised use of ergot or its extractive principle in this connection; and gives Hardaway and Heitzman the credit of the more modern suggestion, which I think an error, as I am sure that all members of the N. Y. Derm. Soc. will agree with me in believing that Le Grand Denslow deserves priority; he having read a paper on the subject before the society mentioned in the winter of 1880-81, afterwards published in the *New York Med. Journal*, February, 1881.

¹Read at the eighth Annual Meeting of the American Dermatological Association, August, 1884.

At the time of the discussion of that paper, I expressed my views of the benefits of the remedy as certain in many female cases, and declared the fact that I had long been using that with other oxytocics, and other specific uterine agents in these diseases.

I was not, however, convinced, or only partly so, by his theory claiming the therapeutic results as coming from its tonic action on the arrectores pili and other non-striped muscular tissue around or near the sebaceous glands, etc.

However, I did not intend, on commencing this article, to discuss gynecology, and were I to go over the whole field of the supposed etiology of acne and rosacea, I should only succeed in being tiresome, so will confine myself to registering what I do and do not believe.

First, I do not believe in the causes often alleged by certain authors, that powders, paints, cosmetics, etc., have anything to do with the production of acne vulgaris, certainly never of rosacea. That they may produce a certain mechanical or other irritation of the skin is doubtless often true, as is also the fact that they may cause the comedo or punctate acne to be more distinctly apparent.

Nor do I subscribe myself a believer in diathesis (as strumous) in these conditions, though there is some possibility that such may add to the vulnerability of the individual, in light of the fact that such persons are more liable to congestions of a passive nature of internal organs, or parts of the same, and are slower in recuperation therefrom.

I do, however, believe, as Piffard puts it more "in extenso," that these morbid states of the skin, acne and rosacea, either alone or combined, do depend in almost every instance upon conditions reflected from the sexual or digestive apparatus, and in the relative order as given; and that even the red face and nose of the coachman, of whom Hebra speaks, are only intensified, not created by the external irritation of biting winds, etc.

My theory of the etiology of the more pronounced forms of acne, as the tubercular variety, and rosacea, is that nine out of ten cases are caused by congestion of the mucous membranes of some of the viscera spoken of, probably passive in character; why they should be reflected upon the face I do not know and can form no opinion, any more than I can in urticaria, which arises, in my belief, from a more active and ephemeral but similar condition of the gastro-intestinal mucous membrane in the same relative number of cases. I think it probable, however, that the mucous irritation and consequent congestion is situate higher up in the alimentary canal in urticaria. In these cases, too, it might be difficult to explain why the efflorescences are almost always situate on the trunk and limbs.

It will be seen in the foregoing how far I am removed from the Mar-

syran-like dogma of the Viennese school, and not alone in respect to these diseases, but in regard to others, as, for instance, eczemas of the infant or child; in those cases I pay quite as much attention to the primæ viæ as to the skin, considering the trouble as springing very often, if not generally, from gastro-intestinal irritations. In short, I believe in the complete analogy between the skin and mucous membranes, and think their reflected action is much more common and important than many authors would have us believe.

This may all seem like a very swollen prologue to a very small theme when I tell you that all the recommendation I have to offer in persistent cases of acne and rosacea in the male subject is the use of the cold urethral sound, and that too with some degree of diligence. I do not, of course, mean by this that proper topical measures to the parts affected are not to be used in comity therewith; or that tonic, cathartic, dietetic, and hygienic measures and principles to meet common-sense indications should be omitted.

I have had two cases under my treatment of late which have seemed to me to point very decidedly to the benefits of this treatment; both young men of about twenty-five, neither of whom have ever suffered from sexual disease; both of whom, being honest, manly fellows, have confessed to the usual irregularities so common, if not universal, of adolescence, but long ago abandoned.

One of those cases was my despair, he had been intermittently under my care for nearly two years, and was one of the worst cases of rosacea with the acne annex I ever met with. A slight degree of improvement could be made under each course of treatment, but we would get mutually tired, and then he would go away only to reappear in a few weeks or months, having sometimes been under other care in the mean time. He was much distressed by his appearance, being in business for himself and having in the course of that to do mostly with ladies; it was therefore a great source of embarrassment to him, and of probable comment on the part of his clientele. His digestion, general health, mental condition, etc., were all perfectly normal when he appeared again about three months since, and showed his face, and retold his story.

I put him on same treatment as before, directed to his general health, same local application, but with only slightly beneficial effect; until one day it occurred to me to pass a sound, which I did, finding a sensitive urethra throughout, but markedly so at about the junction of the membranous portion with the prostatic; the site, it will be noted, of that homologue of the uterus.

I continued to pass those sounds every third day for the time, gradually increasing the interval, until now he comes to me only once a week,

to have that local congestion, which I believe to have been present throughout, toned down.

His face is now a marvel of improvement, and so far as I am able to judge as a reasoning being, I believe it to be due chiefly to that measure. He is almost well and getting careless now.

The other case (less aggravated) was treated in the same manner, with the same result, and it would only be waste of time to summarize it here.

I believe in both these cases there was a persistent congested state of that portion of the urethral tract, particularly where are situated the seminal ducts, the utriculus.

We all know in the sequences of gonorrhœal troubles how valuable an agent is the cold steel sound for subduing evident conditions of passive engorgement of the urethral canal.

I think the sound had a like action here in subduing this more chronic condition, and hence the beneficial action.

Society Transactions.

NEW YORK DERMATOLOGICAL SOCIETY.

147TH REGULAR MEETING.

DR. A. R. ROBINSON, *President, in the Chair.*

DR. SHERWELL presented a case of

CHRONIC ULCER ON THE UPPER LIP

of a patient seventy-three years of age, which had lasted five years. This case was presented to the Society in February of this year for diagnosis (see *JOUR. CUTAN. AND VEN. DIS.*, for April, 1884). Since then the ulcer has been carefully protected from irritation, and dressed with an ungt. of ten grains of calomel to the ounce of simple ointment. The ulcer still occupies the middle line of upper lip, principally on the vermilion border, and while it has but slowly increased in size, its edges are more raised and indurated, and its base has a more excavated appearance. It was covered, when shown, with a thick crust.

DR. PIFFARD thought the case was one of epithelioma; or if it were not, it would soon become so.

DR. BRONSON said that when he saw the case before he thought it was not one of epithelioma, although liable to become so, in the same manner that an eczema of the nipple is liable, under proper conditions, to become cancerous. There was then no marked induration. But now this element was present, and he believed the ulcer to be malignant.

DR. MORROW held the ulcer to be undoubtedly an epithelioma. Despite the rarity of the development of epithelioma upon the upper lip, there was no reason why it should not develop there as well as elsewhere.

DR. SHERWELL had all along held the disease to be epitheliomatous, but as so many of the Society had cast doubt upon his diagnosis at the previous presentation of the case, he had kept it without active treatment to see what would come of it. He was very glad that now his diagnosis was generally accepted, and would proceed to more active measures of treatment.

DR. BULKLEY presented a

CASE OF DEVELOPMENT OF SYPHILIS UPON PSORIASIS.

The patient was a man twenty-four years old, who had had psoriasis for eighteen years in the ordinary form, almost disappearing at times and recurring with the season. Four years ago he said he had a chancre, and since that time he had noticed a difference in the character of the eruption. Previous to having a chancre he never had had any eruption on palms or soles, but since then eruptions in these places have given him considerable annoyance.

At present he has characteristic psoriatic patches on his back and some portions of his limbs. On the backs of the arms about the elbows the eruption is of a mixed character, of a deeper red than is usually the case in psoriasis, and the skin is more thickened. On the palms are scaly tubercles of syphilis, and on the soles are a number of tubercles scaly and ulcerated in places, besides numerous papules.

DR. PIFFARD said that the essential feature of the case was that the man had had psoriasis for fourteen years without lesions of the soles, but since he had contracted syphilis four years ago, he had lesions there. These lesions were clear and sharp cut. Whether they could be duplicated without syphilis, he could not say. The case was important, but we needed careful study of a few more like this, before we could decide whether syphilis predisposes to lesions of the soles.

DR. SHERWELL was not prepared to say that psoriasis of the palms was *always* evidence of syphilis, but still believes it to be the case. He can recall three cases of psoriasis, in which palmar lesions occurred first after acquiring syphilis. The lesion of the hand in these cases is, to all intents and purposes, a true psoriasis, though modified by syphilis.

DR. BRONSON always took great interest in these combined cases of syphilis and psoriasis. They were sometimes very puzzling. Hebra held that psoriasis was sometimes modified by syphilis. Pre-existing lesions on the skin were rarely affected with syphilis, and he did not think that the psoriatic affection of this man's elbows was at all affected or modified by his syphilis. The lesions upon the soles were syphilis and nothing else.

DR. BULKLEY had seen a number of cases in which the two diseases were combined, the psoriatic patches undergoing infiltration, becoming more crusted, thicker, more elevated, dusker, more sharply defined. He remembered a psoriasis case of four years' standing in which the patient noticed that a few months after contracting syphilis his psoriasis grew much darker in color. He did not agree with Dr. Bronson as to syphilis sparing other diseased conditions of the skin. He had seen a tubercular syphilide develop in a patch of eczema of the legs.

The Society then took up the special business of the evening namely:

THE DISCUSSION OF DR. BRONSON'S PAPER ON THE OBJECTS OF DERMATOLOGICAL CLASSIFICATION.

DR. SHERWELL thought that the medical profession, and especially dermatologists, were greatly indebted to Dr. Bronson for his most exhaustive and comprehensive review of Auspitz's classification, and for his comments on the same which were excellent. Dr. Bronson's own classification he regarded as comprehensive, full, and very scientific. He feared, that the very fulness of it, and its scientific form would render it unfit to be used as a basis for teaching. He regarded his second and third classes (angio-epidermidoses and cryptoses) as being specially admirable. They had given him much food for reflection. He had been in the habit of regarding the exanthems as largely due to an elimination of the poison through the skin—a view which he was glad to see that Dr. Bronson

supported. He thought that if the paper had been confined simply to the consideration of Auspitz' classification, even then it would have been a good thing for dermatology and an honor to American dermatologists.

DR. MORROW had been very favorably impressed by reading the paper. Dr. Bronson's comments and criticisms on Auspitz's system were both sound and just. The modifications he had proposed were in the main judicious. It was a question, if the classification, while striving to attain scientific accuracy, might not be too comprehensive. The grouping of the diseases was admirable in many respects.

DR. ROBINSON said that the paper contained so much that the few readings he had been able to make of it were not sufficient to give him a grasp of the subject. He appreciated it nevertheless very highly, and believed that any one who read and studied it, would get a better knowledge of the skin than he had before. It was, however, too intricate for clinical purposes—an objection which would apply also to Auspitz' classification. Indeed it required considerable knowledge of the skin to appreciate it. He regarded it as being superior to Hebra's from a scientific standpoint. Unfortunately at present we know too little of skin diseases, or even of inflammation itself, to build up any durable or complete system of classification. Dr. Bronson deserved the greatest credit for the work he had done, and the way in which he had done it. His classification was an improvement upon Auspitz, but still for practical use it would not take the place of older systems.

DR. BULKLEY considered the classification to be a step in the right direction. But it was very intricate and needed much study to understand it. The idea was right and it was an improvement upon Auspitz. He thought that the matter was worthy of being kept before the Society and should be considered again.

DR. PIFFARD stated that Dr. Bronson's classification was by all odds the most thorough one yet devised. Nevertheless he did not think it would be of practical use in teaching, but it would prove a convenience to working dermatologists. One great feature of it was the etiological feature, and he (Piffard) was the first dermatologist to advocate this in America. It was good to have this classification on record, like the natural system in botany, which no one pretended to learn. Plenck's classification he regarded as the most convenient for teaching, and as an aid to diagnosis, though there were not a few mistakes in it. Hebra endeavored to base his classification upon the supposed pathology, and often his pathology was wrong. It is impossible to base a system upon pure pathology. He thought that Dr. Bronson's classification was an improvement upon Auspitz' which was an advance on previous ones.

DR. MORROW said that he looked for animal parasitic affections in the classification, but did not find such a class. He would like to have Dr. Bronson show the etiological element which he spoke of as prominent in Auspitz' classification.

DR. BRONSON then said that Auspitz' classification was clearly etiological with the exception of the seventh and eighth classes. In all the others, the diseases were classed according to the etiological conditions to which they were due. The system was not etiological in the sense relating to the specific general diseases, but in regard to those general pathological conditions on which the various cutaneous manifestations depend. In the first class the diseases were idiopathic, in the second class they were dependent upon general neurotic conditions, in the third class on local nervous disease, etc. He (Dr. Bronson) had followed out the same general plan, with the exception that he had regard to the immediate causes as they existed in the skin itself, the exciting rather than the predisposing causes. The result had been an anatomical classification in which diseases were divided according as they affected specially certain tissues, such as the blood-vessels, the epidermis, corium, or follicles, etc. The diseases affecting the epidermis and derma differed according as they were essentially dependent upon vascular disturbance of constituted purely anomalies of growth. Thus the angio-epidermidoses and angio-desmoses had been separated from the desmoses and epidermidoses. A separate division was made of the follicular diseases for the reason that the anomalies of secretion which they involved constituted a peculiar factor and gave rise to a special train of symptoms. Another division was made of the "idioneuroses" of the skin, which included only functional diseases of the cutaneous nerves unattended by trophic changes; and finally a class identical with the "dermatomycoses" of Auspitz. In reply to the objection of Dr. Morrow in regard to the

absence of a special class of animal parasitic diseases, he would say that there was no separate division made of animal parasites for the reason that they did not themselves constitute the disease. The effects they produced upon the skin were various, sometimes causing erythema, sometimes urticaria, sometimes erosion, sometimes eczema. The particular disease to which in any instance they gave rise would be classed under its proper head. In vegetable parasitic diseases, on the contrary, the presence of the parasite in the skin constituted the disease.

Dr. Bronson then proceeded to an explanation of the several subdivisions of his classes. Under "telangioses" a division had been made according as there was or was not trophic change. In the first family was included "simple angiomas," that is, the simple functional anomalies, anæmias and hyperæmias. It was to be observed that under hyperæmias a distinction was made between *rubor* as the diffuse form of hyperæmia of the skin, and "roseola hyperæmica" in which the hyperæmia occurs in the form of macules. In the passive form a similar division is made between "cyanosis" as the general and "livor" as the local affection. Under the second family had been included all effusions from blood-vessels of non-inflammatory character. These had been denominated "ecchyses," and included hemorrhages, œdemas, and adventitious effusions. Heretofore hemorrhages and œdemas had been classed separately, but they should be placed together as effusions from blood-vessels, inasmuch as the processes were very closely allied. An innovation had been made in including in this family icterus and argyria. They were due to effusion from the blood-vessels, and had no relation to pigmentary diseases, which pertain to anomalies of the epidermis, under which head they are commonly classed. The second division of the first class included the *inflammatory angiomas* which comprised erythematous and roseolous affections. The erythematous diseases included certain idiopathic forms, among which appear such of the "stigmatoses" of Auspitz as are characterized by erythema. The speaker would call attention to the fact that the term erythema as employed by him was limited to inflammatory forms of disease, while the term "rubor" corresponded to the "erythema hyperæmicum" of Hebra. Under the deuteropathic division the "simple" form included such essential erythematous affections as the "erythema multiforme" of Hebra, urticaria, erythema nodosum, etc.; while the "symptomatic" forms comprised those that occur as symptoms of certain specific general diseases such as pellagra, acrodynia, and lepra; these forms of erythema not being regarded as essential manifestations, but purely as incidental effects. Plenck's term "gutta rosacea" had been adopted in preference to the expression "acne rosacea" of Willan, for the obvious reason that the latter term imperfectly characterized the affection. Willan's term had been reserved for the pustular variety of the disease, while "erythema rosaceum" was used to designate the erythematous form. He objected to the term "rosacea" adopted by the American Dermatological Association inasmuch as it was substituting in an adjective for a substantive. He had made an innovation in including *lupus erythematosus* under the "angiomas," believing that the affection of the blood-vessels constituted the essential factor in the disease, and that this disease should be entirely disassociated from lupus vulgaris. Under "roseolous angiomas" were included the roseolæ of variola, vaccina, cholera, typhus, and syphilis, together with the exanthem of measles. Attention was called to the fact that the exanthems of the various acute infectious diseases, instead of being all classed together as in most classifications, had been divided according to the character of the reaction upon the skin.

Under the second class, two orders had been described according as the disease especially involved the stratum corneum or mucosum. Under the first order, "angiotic parakeratoses," or diseases attended with perverted growth of the cuticle associated with marked implication of the blood-vessels, were psoriasis and lichen rubra. The second family, angiotic keratolyses, or diseases characterized by exfoliation of the cuticle associated with marked vascular implication, comprised pityriasis rubra, and dermatitis exfoliativa infantum. The second order, "acanthoses angioticæ," embraced diseases primarily seated in the prickle-cell layer, and dependent on vascular disturbance. Pemphigous diseases had been brought into relation with certain idiopathic forms of inflammation, which were regarded as analogous, comprising bullous inflammations due to heat, cold, or acrid irritants and the like. It was impossible, according to the principle adopted in this classification, to include all burns in one class. A divi-

sion had to be made according to the structure involved. The eczematous dermatoses, constituting a family under this order, had been arranged on the general anatomical scheme adopted throughout, according as they implicated especially one or another of the cutaneous strata. Thus the erythematous form was related to the angioses; e. papulatum folliculare et sudorale were related to the follicular diseases; e. squamosum was characterized by keratolysis or parakeratosis; e. rubrum by acantholysis; e. hypertrophicum epidermidis, by hyperacanthosis, etc. Finally a division was made of eczematous affections due to animal parasites. Under the family of "exanthematous" epidermidoses were included scarlatina, miliaria (crystallina), the exantheims of variola, varicella, and vaccina, in all of which affections implication of the epidermis is essential. The third class, "Cryptoses," were the follicular diseases of the skin. For the name of this class he had adopted a new expression, which was the only new term for which the classification was responsible. The subdivisions of this class corresponded in the main with Auspitz' divisions. Under the fourth class (angio-desmoses) were included three families, viz.: 1. chronic diseases due to lymphatic or venous engorgement; 2. acute or phlegmonous diseases, comprising erysipelatous and furunculous dermatoses, erysipelas being divided according to the tissues especially involved, and 3. necrotic dermatoses, including gangrenous and ulcerative affections.

The remaining classes did not differ essentially from Auspitz' classification. Certain changes had been made under keratoses, in accordance with investigations of Unna; while for the seventh class, the term "Desmoses" had been substituted for Auspitz' term of "*Chorioblastoses*."

Correspondence.

DERMATOLOGY AND SYPHILOGRAPHY IN GREAT BRITAIN.

(From our Special Correspondent.)

ERYTHEMA NODOSUM—RARE FORM OF SKIN DISEASE—RHEUMATIC PURPURA—PURPURA OCCURRING IN THE COURSE OF TYPHOID FEVER—ANTHRAX OR CHARBON—BROMIDE OF POTASSIUM ERUPTION—UNUSUAL SYMPTOMS AFTER HYDRARGYRUM AMMONIATUM—PITYRIASIS RUBRA—PEMPHIGUS—ACNE IN FIBRE-DRESSERS—COMEDONES IN CHILDREN—MYXEDEMA—ACNE KELOID—SCLERODERMA—HISTOLOGY OF RODENT ULCER—IODOFORM IN ERYSIPELAS.

THE value of lectures to students may be said to vary directly as the skill and experience of the lecturer; they do not usually contain much that is novel or striking, but are rather to be looked upon as critical reviews of that which is already known. When this task is undertaken by men of originality combined with wide knowledge, the result is always worth attention, even when the information given is, from the necessities of the case, somewhat fragmentary. Mr. Jonathan Hutchinson holds quite the first rank as a lecturer on the many departments of medicine with which he is familiar, and has fortunately found time to revise and issue lectures on "Natural Groups of Skin-Diseases" (*Medical Press and Circular*, Feb. 13, p. 131), on "Gangrene" (*Ibid.*, Feb. 27, p. 176, and March 5, p. 201), on "Syphilitic Lupus" (*Ibid.*, March 26, p. 269), on "Diseases of the Nervous System of Syphilitic Origin" (*Ibid.*, April 23, p. 371, and April 30, p. 394), and on "The Cryptogam Group" (*Med. Times and Gazette*, March 29, p. 413). All these are most interesting, and will well repay perusal.

A "Lecture introductory to the Study of Infantile Syphilis," by Dr. R. J. Lee (*Lancet*, June 21, p. 1,109, and June 28, p. 1,156), may be recommended as a careful study of the subject of which it treats.

"The local distribution and etiology of ERYTHEMA NODOSUM" are considered by Dr. Handford (*Med. Times and Gazette*, May 3, p. 592). He first describes a case in a girl aged nearly eighteen, who presented the usual lesions on the shins, a few half way up the thigh, one or two over the ulna on each arm, a few over the triceps, and one on the lobule of the left ear. The patient had never had rheumatism, but was very subject to chilblains, and always had cold hands and feet. Dr. Handford points out the strict limitation of the disease to the extensor surfaces, the greater frequency in females, and the great similarity to chilblains in almost everything but local distribution. He believes the exciting causes to be chiefly cold, imperfect local circulation, and slight injuries; the extensor localization he considers to be due to less perfect circulation there, owing to the fact that the skin over them is habitually stretched, and the vessels therefore compressed.

"A RARE FORM OF SKIN DISEASE" was the subject of a communication to the Academy of Medicine in Ireland by Dr. Wallace Beatty, on March 14 (*Dublin Journ. Med. Science*, June, p. 512). The patients were two brothers, aged fifteen and twelve respectively, and the disease appeared at the age of twelve in the elder, and at the age of eleven in the younger brother. The affection began by an itching spot without eruption, but after scratching, redness and sometimes "an appearance like lobes" (?) was seen; this subsided, and in a few hours a slight, raised, pin-head-sized pimple appeared; this soon flattened, enlarged, and became pigmented of a dull brown color, forming a circular spot three-eighths of an inch in diameter, and feeling either like normal skin, or like skin rather tougher than usual; it was unaltered by pressure. The centre afterwards became white, the pimpling remaining brown, and finally all brown color disappeared, leaving white spots of different sizes, the greater number smaller than the original brown spots; some of these white spots were on a level with the surface of the skin and firm to the touch, while others presented minute depressions, somewhat "thimble," or minute scar-like grooves radiating from the centre. All these varieties were present on the front and back of the chest chiefly, producing a mottled appearance, especially on the back; they were absent from the abdomen and genitals, and slightly present on the face and flexor sides of the limbs; no factitious wheals could be developed, and there was no evidence of syphilis. Dr. Beatty considered that the disease resembled urticaria pigmentosa, but differed from it (1) in commencing several years after birth; (2) the spots were at first chiefly papular and rapidly flattened; they did not occur as nodules; (3) the final formation of white spots was peculiar. Dr. Walter Smith had seen the cases, and was struck by the peculiar features of the disease; the trophic changes, and the production of scars without pustulation, vesication, or breach of surface; he thought it was not easy to name the disease anything but urticaria pigmentosa. The present writer would remark that the full description given by Dr. Beatty does not correspond either to the urticarial or to the nodular form of the latter disease; in the development of atrophic white spots the affection seems to him rather to approach morphœa.

In a paper on "A Case of RHEUMATIC PURPURA, with notes" (*St. Bartholomew's Hosp. Reports*, vol. XIX.), Dr. Wickham Legg gives the following as the conditions in which purpura occurs: (1) acute purpura seen in eruptive diseases. (2) Toxic purpura following drugs and poisons, including snake-bite. (3) Purpura

of disease; the varying conditions of icterus gravis, chronic jaundice, anæmia, Bright's disease, and cirrhosis of liver. (4) Purpura also sometimes occurs in ague, syphilis, and tuberculosis. (5) Purpura due to congestion, as in heart-disease. (6) Due to increase of colorless corpuscles, as in leucæmia, and in splenic enlargement from various causes. (7) It has been shown to be associated with multiple sarcomata. (8) Peliosis rheumatica. (9) Idiopathic purpura, unassociated with any of the above conditions. The case published by Dr. Legg was that of a boy, aged eighteen, with old heart-disease and rheumatism, who had been taking iodide of potassium in three-grain doses every four hours. He had hard tender raised purpuric patches of various size on the face, neck, chest, belly, arms, backs of hands, back, buttocks, and extensor sides of thighs and legs; subsequently large bullæ formed in various parts; he got sore gums, hæmoptysis, fresh purpura, and died. Although Dr. Legg does not consider the case to have been toxic (iodide), scorbutic, or embolic, the present writer must hesitate to admit his conclusion for rheumatic purpura.

Dr. T. Barlow has published a "Case of PURPURA OCCURRING IN THE COURSE OF TYPHOID FEVER" (*Lancet*, April 26, p. 745). The patient was a woman, aged twenty-six, in whom ecchymoses first appeared on the palate, followed by blood in the urine and small purpuric spots on the arms and chest, with larger patches on the thighs and legs; they appeared from the 18th to the 21st day; treatment with ergot was followed by fading of the spots in a few days, and the patient nearly recovered from her fever; she relapsed, however, and died a month after admission. Post-mortem examination showed blood extravasations in the upper part of the posterior mediastinum, in front of the œsophagus and around the root of each lung; also in the retroperitoneal tissue opposite the hepatic flexure of the colon; infarcts in the spleen and in one kidney, and a thin layer of blood under the dura mater; no large vessel was found ruptured, and the other appearances were those usual in typhoid fever. The proper typhoid eruption was present copiously, but did not become purpuric. Dr. Barlow remarks on the rarity of purpura in typhoid, and that it is not necessarily a sign of malignancy, as cases have recovered after its occurrence. This is borne out by two cases which occurred at St. Bartholomew's Hospital, under Drs. Church and Gee, in which ecchymoses appeared on the 21st and 14th days respectively; the first died, the second (and severest) recovered (*Med. Times and Gazette*, June 28, p. 866).

"A Case of ANTHRAX or CHARBON, with External Symptoms" has been published by Mr. Marrant Baker (*Brit. Med. Journal*, June 14, p. 1,134). A laborer, aged forty-two, after handling some hides from China, noticed on the following day a small, hard swelling below and behind the right ear, increasing rapidly, so that he soon had difficulty in swallowing; in eight days a cluster of vesicles appeared on the neck, and vomiting came on. When first seen (eleventh day), there was a large, flat "pustule" on the side of the neck the size of a florin, with a dark centre formed by a superficial slough, the circumference consisting of a bleb with an irregular circular outline, looking as if several blebs had become confluent; below the ear was a mass of inflamed lymphatic glands, and all the surrounding tissues were œdematous and brawny, covered by very erythematous skin; the redness extended from the posterior border of the sterno-mastoid to the anterior border of the masseter, and from the temporo-maxillary articulation to the third rib. The temperature was 101.4°; spleen not enlarged. The pustule, with a quarter of an inch of surrounding skin, was at once excised, and the glands incised, the wounds being dressed with "sanitas" oil (1 to 30) after the application of pure carbolic acid. The œdema and erythema subsided and disappeared

in two days, but the glands remained swollen a little longer; bacilli were found in the blood and in the urine, but none could be discovered in the excised pustule. The patient was treated with sulphite of sodium, which has been found successful in animals, and he was restricted to a purely animal diet, as the carnivora are never attacked by anthrax. He made a good recovery.

A drawing of a case of "BROMIDE OF POTASSIUM ERUPTION" was exhibited at the Pathological Society on May 20 by Mr. Warren Fay. It occurred in a child eleven months old to whom the drug had been given in doses of gr. ivss. for eleven days. Spots appeared on the ninth day, and were stated to have been at first vesicular, but soon formed large elevated discs with a surrounding zone of partially desiccated vesicles limited to the buttocks and lower extremities. The drug was stopped on the tenth day, and the eruption disappeared in six weeks after the last dose. Dr. Stephen Mackenzie has made a microscopical examination, and found infiltration of all parts of the skin, pus cells being especially aggregated in the vicinity of the sebaceous glands and hair-follicles; the color was due to hyperæmia of the papillary body and its persistence under pressure to numerous extravasations.

The following "UNUSUAL SYMPTOMS FOLLOWING THE USE OF UNGUENTUM HYDRARGYRI AMMONIATI" were observed by Mr. W. E. Green (*Brit. Med. Journ.*, May 3, p. 853). A lady had redness and swelling of the left temple, forehead, ear, and scalp, with a feeling of fulness only, there being neither pain, burning, nor itching; the left eye was partially closed by œdema of the lids; the tongue was furred, but there was no fever. She said that the scalp had been scurfy, and that she had applied "dandruff cream" the day before, the symptoms commencing very soon after. It appeared that some years previously an ointment containing mercury had produced exactly similar symptoms, so she was specially susceptible. The œdema increased for two days, but afterwards rapidly disappeared. The preparation used contained forty grains of white precipitate to the ounce of ointment.

Dr. Kingsbury communicated a case of "PITYRIASIS RUBRA" to the Manchester Medical Society on March 19 (*Brit. Med. Journ.*, April 26, p. 218). A man, aged twenty-five, who had been ill for three months, appeared to be rapidly sinking when first seen; he lay completely prostrate, unable even to raise himself in bed without help, and suffered great pain on any movement. The whole skin, from the scalp to the soles, was intensely red, but here and there on the forearms and calves were patches which looked simply erythematous; elsewhere there were loose scales of varying thickness, with an uneven, wavy appearance, varying in size from coarse bran to a crown-piece. A large house-bucket was filled in a week by epidermis swept from his bed; the nails were thickened, dark, and uneven, and there was a trace of moisture on the inside of the thighs. There was no itching, the temperature was normal, the pulse very feeble, and the urine albuminous; he had lost his appetite completely, and the skin exhaled an offensive odor. Arsenic and many other drugs had been tried, and various local applications; after persisting for two months in tar ointment and an iron and quinine mixture, he recovered, and was able to resume work. The man was a grocer's assistant, and the disease seems to have begun in "grocer's itch" eczema. "A Case of Pityriasis Rubra," by Dr. Cole (*Practitioner*, Jan., 1884, p. 36) may be referred to, in which there was "much itching," and recovery took place in two months under treatment by phosphorus. The disease seems to have been universal, but the description is so short that much doubt may be entertained as to its nature.

"Two Cases of PEMPHIGUS," by Dr. I. F. Payne (*St. Thomas' Hospital Re-*

ports, Vol. XII.), are of some interest. The first case was that of a boy, aged three and one-half years when first seen, who had suffered from the disease practically without intermission since he was a fortnight old. The bullæ were situated on the knees and elbows in the psoriasis positions, and also on the hands and feet; the nails were broken, thickened, and irregular, and some absent or rudimentary, having partly grown again after being destroyed by the disease. Blebs were noticed to form on any part of the skin after slight injuries by blows or tumbles; there was no evidence of syphilis, and mercury made the disease worse. Syrup of phosphate of iron and steel wine with cod-liver oil were followed by improvement; a year later arsenic was given, with improvement of short duration only, and a year after this phosphorus, with fairly good results. The patient subsequently came under the care of the present writer, and continued under his observation to the age of ten. He can confirm Dr. Payne's description in all particulars, and noticed further that hemorrhage into the bullæ took place very often; the eruption still occupied the same positions, and no improvement took place under various treatment, including arsenic in full doses. The remarkable features in the case are the frequency of traumatic bullæ, the long duration, the affection of the nails, and the failure of treatment. Dr. Payne's second case occurred in an old man, and recovery took place after six months' arsenical treatment. In connection with the first patient, Dr. Legg's "Cases of Congenital Pemphigus Persistent from Birth" (St. Bartholomew's Hospital Reports, Vol. XIX.) may be noticed. They were a boy, aged nine, and his sister, aged eighteen months, out of a total of five children. There was no evidence of syphilis; the boy had it from birth, a little on the trunk, but chiefly on the extensor surfaces of the forearms and elbows, the backs of the hands, knees, and front of legs; the nails were ribbed and brittle, and that of the right thumb was wanting. While under observation bullæ formed in the above positions, and also on the ankles and dorsum of toes; they were sometimes bloody. The girl has blebs on the hands, feet, knees, and elbows, and wherever she knocks herself; the left thumb-nail was loose; treatment was useless. The present writer had an opportunity of seeing Dr. Legg's first case, which was almost an exact counterpart of Dr. Payne's.

In a paper on "ACNE IN FIBRE-DRESSERS" (*Lancet*, May 31, p. 978), Mr. Atkin points out that acneiform dermatitis from irritants is rare, occurring chiefly in workers of tar, paraffin, benzole, etc. He found it in dressers of fibre for brush-making, on the forearms, front of thighs and shins, and especially on the knees, the face being unaffected. It was discovered to be due to paraffin oil used in preparing the fibres, which frequently fell on and soaked through the trousers, and in which the men worked with their sleeves rolled up.

Dr. Radcliffe Crocker, writing on "COMEDONES IN CHILDREN" (*Lancet*, April 19, p. 704), gives three cases, at the ages of fourteen months, three and one-half years, and twelve months respectively, and had seen others. They occur chiefly in boys between three and twelve years old, on the scalp, forehead, cheeks, and occasionally the shoulders and temples. He thinks they may be due to warmth and moisture from wearing caps, and has seen them form under poultices; but in some instances several members of the same family are affected, and it is possible that there may be an element of contagion. The comedones differ from those of adults in being mainly due to local causes, in their greater tendency to group, in their occurrence on the scalp, and their ready amenability to treatment, weak sulphur or soft soap applications being sufficient to cure them. Mr. Julius Cæsar (*Lancet*, June 28, p. 1,188) reports twenty cases exactly similar to Dr. Crocker's, in boys and girls aged from two to eleven years. He does not consider them con-

tagious, as only one or two cases were found by him in schools attended by large numbers of children.

The literature of MYXŒDEMA grows apace, but all the cases published present a close similarity to each other. That reported by Dr. Kirk (*Glasgow Med. Journal*, January, p. 1) is of interest, as it had continued for twelve years, during the last two of which a great improvement took place quite independently of treatment, and in the midst of the poorest surroundings. Dr. Suckling's case (*Birmingham Med. Review*, April, p. 156) was of ten years' duration, and had been treated by nitro-glycerin and pilocarpine without benefit. Dr. White's case (*Lancet*, May 31, p. 974) was associated with insanity, and the thyroid was not atrophied, "as far as one can judge." Dr. Jacob's case (*Ibid.*, p. 976) presented nothing unusual. In a paper on "The Pathology of Myxœdema as illustrated in a typical case," read before the Royal Medical and Chirurgical Society on April 8, Dr. John Harley expressed the opinion that myxœdema could not be regarded as a specific disease, but was merely a variety of what he called "chronic cold debility" dependent on depression of the vital functions, and frequently associated with fibroid degeneration of the lungs, consequent on which a degeneration of the thoracic sympathetic took place.

Under the name of "ACNE KELOID" Mr. Roger Williams exhibited at the Pathological Society on April 1 a photograph of a stout, healthy-looking woman, aged fifty-three, with a keloid six by two inches, extending transversely across the back of the neck, at the junction of the skin and hairy scalp. It was smooth, shining, and reddish, and on its surface were follicular depressions from which projected tufts of hairs, which gave a characteristic aspect. On pressure, it was tender and firm, and a material of caseous appearance exuded from the follicles. The affection began without known cause as a small pimple five years before. Microscopic examination of an excised portion showed a new growth of fibrous tissue in the deep part of the corium, with numerous large vascular channels filled with leucocytes, but no small-celled infiltration of the surrounding fibrous tissue; the epidermis and papillary body were normal, except for the complete absence of cutaneous glands, which were only represented by the few hypertrophied hair and sebaceous follicles. He thought it was merely a variety of keloid, and that it differed essentially from the dermatitis papillomatosa capillitii of Kaposi.

A "Case of SCLERODERMA affecting the left lower extremity," by Mr. Sympson (*Brit. Med. Journal*, June 7, p. 1,089), occurred in a child, aged five, and seems to have followed an injury to the knee three years before. The limb was one and one-half inches shorter than the right. Dr. T. Barlow showed drawings of a boy, aged seven, affected with "Congenital Xanthelasma" to the Pathological Society on May 20. There were very characteristic patches in the neighborhood of the eyelids, and the vaccination scars had become tinted. There were no obvious signs of hepatic disease, but marked symptoms of renal calculus. Only a few cases had been recorded in children, and in those there were no patches on the eyelids as in the present instance.

In a communication to the Manchester Med. Society on "the HISTOLOGY OF RODENT ULCER" (*Brit. Med. Journal*, April 19), Mr. Paul came to the conclusion that the disease could not be ordinary epithelioma, and that if a sufficient number of cases were examined, all the various epithelial structures would be found affected. He therefore thought it probable that the disease originated not in any particular gland, but in the skin as a whole. Dr. Dreschfeld showed sections in some of which the development was traceable from the hair-follicles; in others

from the sebaceous glands; and in some there was marked endarteritis obliterans, with endo- and peri-lymphangitis. He thought this might possibly explain the slow growth of the ulcer and the very early ulceration from the endarteritis, while the blocking and compression of the lymphatics might prevent the invasion of the neighboring lymph glands, and thus explain their non-implication.

In therapeutics, Mr. Clark Burman recommends "IODOFORM IN ERYSIPELAS" (*Practitioner*, May, p. 365) in the proportion of one to ten in collodion. Dr. Sawyer's "Remarks on the therapeutic uses of some improved oleates" (*Birmingham Med. Review*, February, p. 49) are strongly in favor of the preparations introduced by Dr. Shoemaker, of Philadelphia. Mr. J. W. Taylor, writing "On the treatment of Lupus" (*Ibid.*, May, p. 193) insists on the scrofulous nature of lupus, and claims for patients more attention to hygienic details, especially warmth, dryness, and good food. The best internal medicines are cod-liver oil and Parrish's food, and the best local agent is the curette. Dr. J. G. Marshall recommends "The use of Salicylic Acid in the treatment of Lupus" (*Brit. Med. Journal*, June 28, p. 1,253). He reports a case in which it was employed in the strength of ζ i., and afterwards ζ iss. to vaseline ξ i. The ulcers soon began to heal, no fresh tubercles appeared, the scars became soft, and the skin almost sound. The patient was also taking Donovan's solution and dialyzed iron, which, however, had been used without benefit before the ointment. CAVAFY.

LONDON.

Selections.

DIAGNOSTIC AND PROGNOSTIC SIGNIFICANCE OF VITILIGO.

THE question implied in the above title is one which frequently confronts us, but is far from being easily answered. The following case, recently treated in the Cochin Hospital, Paris (service of M. Dujardin-Beaumetz), possesses considerable interest from its bearing upon this subject. It is that of a man, aged thirty-seven, a shoemaker by trade, who, when admitted, was laboring under extreme general debility, arising from anemia, with loss of sleep and appetite, and conjoined with an eruption compounded of furuncles, pemphigus-bullæ, and spots of vitiligo. Of these cutaneous manifestations, the vitiligo was the oldest, having existed four years. It was caused, according to the patient's account, by taking cold after a bath, and was first noticed under the form of whitish elevations upon the skin. These disappeared at the end of a month, leaving circular blotches, smooth, greasy, and colorless at their centres, but with marginal zones tinted somewhat like chamois-leather. These latter were in striking contrast, on the one hand, with the natural hue of the surrounding skin, and, on the other, with the white and waxy central portions. The pigmented places were distributed symmetrically, *i. e.*, on homologous bodily regions, or on corresponding parts of a single region. The upper extremities exhibited them on the arms, the fore-arms, and chiefly on the hands, so that in this situation they became more strongly marked in proportion to their distance from the shoulder. The reverse took place on the lower extremities, since here the spots were most conspicuous at the upper part of the thighs, and became fewer and fainter in hue as they approached the knees. On the body they followed a very different course. Chest, back, and

loins presented no traces of them ; they were found only on the abdomen beneath the epigastrium. One irregularly marked zone of discoloration surrounded the umbilicus, while a line of the same extended along either side of the penis, and even on the glans a brownish pattern could be traced, having its borders variegated with spots of white.

Later on appeared the furunculous eruption. This came out abruptly in the shape of small, scattered elevations, of which some few arrived at suppuration, but the greater number assumed the character of what are denominated "blind boils" by the English dermatologists. They were seated at the bend of the right groin, and on the thighs and loins, *i. e.*, on the parts unaffected by vitiligo.

Next occurred the pemphigus, contemporaneously with the patient's admission to the hospital. Only two of the characteristic bullæ were produced ; one on the back of the hand, the other on the right hypochondrium. The disease was of the ordinary acute type.

But these cutaneous symptoms were followed by events which also exerted an influence on the general morbid state. About a month before his admission, the patient had fallen from the first floor of a building upon his feet and back. Apparently, he was not seriously injured, and went on with his work until, two hours later, he was seized with sharp pains in the loins, which extended into the thighs and obliged him to keep his bed for several days. In spite of energetic treatment, these pains persisted, the muscular weakness also continued, and the attending physician detected, at his first examination, a tenderness on pressure in the left hypochondrium, and a marked diminution of the tendon reflex. There were, however, no signs of any chest affection, and the urine was normal in quantity and quality.

This patient's history shows that his vitiligo was not of that variety sometimes met with *in the course of recovery from severe diseases*, such as pneumonia ; it did not spring from a *syphilitic or tuberculous diathesis*, nor was it of *traumatic or neuralgic* origin. *Emotional causes* must also be excluded, since these result in loss of color, rather than its excess. *Vitiligo of the insane* is here equally out of the question, and so is *cerebral vitiligo*, which co-exists always with tumors of the brain—also *facial vitiligo*, caused by obstructed circulation, as from carotid aneurism. Should we adopt the vague title of *idiopathic vitiligo*, it would only serve as a cover for our ignorance. There is yet another form—*rheumatic vitiligo*—which sometimes occurs in alternation with asthma, megrim, and other arthritic manifestations, and still oftener from taking cold. This latter accident appears to have preceded the pigmentary changes in the present instance ; but are we, therefore, justified in attributing them to rheumatism ? It would be rash to do so, in the absence of any other evidence.

The author's positive conclusions, drawn from a careful study and comparison of the four leading factors in the above case—*viz.*, the discoloration, the derangements of digestion, the pains in the back and thighs, and the rapidly progressive asthenia—are concisely stated as follows :

In this patient, as probably in many others, the vitiligo was the earliest among a set of concurrent phenomena similar to, though not identical with, those which mark the existence of Addison's disease of the supra-renal capsules (bronzed skin). In both maladies, the pigmentary deposits immediately caused by an alteration of the chromogenic function, are primarily the results of a nervous affection which, in the absence of discoverable anatomical lesions, must be regarded as a tropho-neurosis. Hence the occurrence of vitiligo as a manifestation of certain morbid conditions, constitutional or acquired ; hence its im-

portance in some cases, as the precursor of an approaching cachexia; and hence, finally, the diagnostic value of this cutaneous disorder as a first indication of diminished nutritive activity, with associated impairment of the nervous system.—CH. ELOY, *L'Union Méd.*, No. 53, April 12, 1884.

CUTANEOUS HORNS.

HORNS on the human skin had only been looked upon as curiosities until Lebert, in 1864, published his work on *keratosis*, in which he brought together one hundred and nine cases, mostly compiled from different literary sources. In 1868, Hessberg published twenty-five supplementary cases ("Beiträge zur Kenntniss der Hauthörner von Menschen und Thieren"). In 1872, Dr. Bergh published two new cases, and referred to some which had been overlooked by his predecessors (*Hospitals-Tidende*, Vol. XV., Nos. 49-50), and likewise to one described by Pancoast, of Philadelphia (*Archiv für Dermatologie und Syphilis*, III., 1, 1871, p. 126).

Now the same author adds three new cases to the list.

I. N. N., æt. 38, merchant, of strong build, with very light-colored hair, has never had any skin disease, and no venereal affections besides some attacks of urethritis. Yet his skin had never been quite clean, as he was liable to acne and small furuncles. Without known cause, a small horn had formed on the inner part of the left infraspinal region several years before he came under observation. When it grew larger, it caused sometimes some pain during movements, and was repeatedly torn off, with slight bleeding, but reappeared in the course of a few months. At its base it was surrounded by a low fold of skin, and it was somewhat movable. It was removed by means of two curved incisions, after which there was formed a resistant cicatrix, and the horn was not reproduced. It was almost straight, or at least only slightly curved, 1.4 centimetres high, with a diameter of 5 millimetres at base. The upper end was obtuse, the base irregularly convex. The surface was slightly and irregularly striped. Its color was dark grayish-brown, its consistency rather hard. A more minute examination showed a similar structure as the next.

II. The second horn was sent to him by another physician. It had developed in the course of a few months on the nose of a spinster, æt. 74, on the place where her spectacles rested. It began as a circumscribed red and tender spot, on which formed a small tumor, which was not sensitive, and on which there was developed a small horn. It was extirpated, but was reproduced in the course of six months. It was again removed more carefully, and did not reappear. The first horn was 8.75 millimetres high, and measured 3.5 by 3.25 in diameter at the base. It was grayish-brown, slightly curved, almost cylindrical, striped lengthwise. The base was a little extended, and of oval shape. It was rather hard. The cut surface showed an irregular disposition of brownish-gray and yellowish-white parts. The latter color predominated in the whole axial part. A thin cortical substance could be indistinctly separated from the much thicker and somewhat softer medullary portion. The reproduced horn corresponded in all essentials with the one that had been removed. The structure of these horns was the same as that found in previous cases by the author. They were composed of thin perpendicular columns with longitudinal stripes. These columns were more or less intimately connected, and seemed to extend almost uninterruptedly from one end of the horn to other. In them and between them were seen here and there longitudinal or transverse blood-colored spots or larger masses. The columns correspond to and are produced by the papillæ of the subjacent skin,

and near the base they are often dichotomous. They are composed of concentrically arranged flat horn cells standing on the edge, in which there almost always appears a distinct nucleus by the treatment with ammonia or acetic acid, especially on the lower part of the horn.

III. The third horn came from a poor woman, seventy-two years old, with light hair and blue eyes, and very filthy habits. It had existed for at least six years, but had repeatedly fallen off, and been reproduced in the course of six months. It was located on the middle of the bridge of the nose, and surrounded by a low wall of skin. In consequence of a blow on the forehead, there formed an epithelioma which extended down to the horn, and loosened it from its connections. It was of a dirty brown color, with yellowish point, coniform, a little compressed, and, upon the whole, remarkably like that of the common rhinoceros. It was 10.5 millimetres high, and measured 15 by 10.5 millimetres at the base. Its base was almost even with numerous superficial recesses and thorns. The point was turned somewhat downward in the direction of the upper lip. The surface was slightly fluted lengthwise. The consistency was less hard than in the preceding cases. The cut surface was striped in the direction of the height with white and yellowish stripes. Like the preceding horns, this one was composed of longitudinal columns, but they were separated by regularly curved transverse layers, which produced the yellowish stripes on the cut surface. Both the columns and the intervening layers were formed of cells like those described above. They contained many fissures, but there were only few and small extravasations of blood. Here and there were seen groups of round, oval, or irregular bodies, varying from 0.0055 to 0.009 millimetres in diameter, in which one or two nuclei could be made visible by means of acetic acid. The author explains the structure of this horn by supposing that the papillæ were deficient in some places of the matrix, and that the epidermis on these interpapillary spaces formed the cement substance between the columns.

According to Lebert, such horns give in twelve per cent of cases rise to consecutive epithelioma. Occasionally, the epithelioma is the primitive affection on which the horns later develop themselves. On account of this affinity to cancer, it is best to extirpate the horns as soon as possible, and to remove the whole skin which forms their foundation.—BERGH, *Hospitals-Tidende*, 1884, Vol. II., No. 32.

CHANCRE OF THE TONSIL.

THIS form of chancre, although not common, is not so rare as was once supposed. It deserves attention on account of its causes and diagnostic relations, and also of the fact that there is little doubt that some cases of the *syphuis d'emblée*, or *larvée*, of the French, really originated in tonsillar infection, since nothing is more assured than that acquired syphilis always begins in a chancre.

Three instances have fallen under my own observation in which the disease was undoubtedly caused by depraved and unnatural sexual contact, which of late has increased to an alarming extent in America. Many similar cases have been reported by European authorities.

The clinical history of these chancres is as follows: The first appearances noted are redness and swelling, without perceptible induration. In the course of a few days these symptoms are accentuated, the redness is greater, the hypertrophy is more marked, and there is also superficial erosion of the organ. Then this exulceration may increase, and is usually accompanied by the appearance of a grayish-white coating, which may be very thin or thicker, and may be of granu-

lar appearance and irregularly distributed over the ulcer. The induration is usually well marked, sometimes even cartilaginous. It, of course, differs in accordance with the density of the tonsil. If the latter has been the seat of chronic hypertrophy, it will be hard and firm; if it was previously healthy, it may be only slightly indurated. The prominence of the organ in disease will in a measure also depend on its size and condition previous to infection.

The diagnosis rests between mucous patches and syphilitic ulcerated sclerosed tonsils, in both of which the lesions will not be so sharply confined to one side, nor accompanied by such well marked adenopathy. Again, the history of the case will often establish the late origin of the lesions. The subjective symptoms are more or less difficulty in swallowing, perhaps pain and uneasiness on the affected side, swelling of the corresponding glands, parotid and submaxillary, and of the lymphatic ganglia. This swelling, besides being at first unilateral, is always out of proportion to that observed to accompany secondary and tertiary lesions.

The points of diagnosis may be thus enumerated:

1. The details of the mode of infection, either from syphilitic sores, primary or secondary, chiefly about the mouth or face, and mostly by kissing; from infection by some article, such as a nursing-bottle, cigar, pipe, cup, or the like; or from indulgence in bestial practices.

2. The slow, unilateral development of the chancre, with corresponding glandular enlargement, so well marked.

3. The limitation of the lesion to the affected side.

4. The difficulty in deglutition, and even pain, which is referred to one side.

5. The history of the evolution of the syphilis, the absence of chancre from other parts, especially the genitals, and the much less indurated condition of the ganglia seated elsewhere. Those that are seated at a distance may not be affected until near the date of the evolution of secondary manifestations.—R. W. TAYLOR, *N. Y. Med. Journ.*, May 24, 1884.

Received.

Eritema Orticato Atrofizzante—Atrofia parziale idiopatica della Pelle, del Professor CELSO PELLIZZARI (Reprint).

Item.

A PROMINENT European dermatologist, located in a large German city, will give thorough theoretical and practical instruction in dermatology to an American physician for one year without fee. For particulars, address the Editors of this JOURNAL.

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AMERICAN DERMATOLOGICAL ASSOCIATION.

EIGHTH ANNUAL MEETING.

Official Report of the Proceedings by the Secretary.

THE eighth annual meeting of the American Dermatological Association was held at Highland Falls, near West Point, New York, on the 27th, 28th, and 29th of August, 1884. There were present Drs. J. C. White and E. Wigglesworth, of Boston; G. H. Fox, H. G. Piffard, A. R. Robinson, R. W. Taylor, and W. T. Alexander, of New York; S. Sherwell, of Brooklyn; J. N. Hyde, of Chicago; L. A. Duhring, of Philadelphia; and W. A. Hardaway, of St. Louis.

First Day—Morning Session.

The Association met at 10 A.M., and after a business meeting with closed doors, the scientific proceedings were inaugurated with a few introductory remarks by the President, DR. R. W. TAYLOR, who welcomed the members to the meeting and congratulated them on the high position which the Association occupied in the dermatological world. He then called upon DR. HARDAWAY, who read the first paper, which was entitled

A CASE OF XANTHOMA MULTIPLEX OF THE SKIN,

exhibiting the plane, tubercular, and tuberous varieties of the disease.

The patient was a man 44 years old who had suffered from the disease twelve years. The skin on the right half of his body was bronzed, on the left yellow. He complained of intense pruritus, the liver was enlarged and nodular, and a trace of sugar was discovered in the urine. He also suffered from pulmonary emphysema and occasional attacks of asthma. After minutely describing the lesions on the different parts of

face, trunk, and extremities, the author of the paper called especial attention to the following points in the case: to the fact that the bronzing of the skin preceded the development of the xanthomatous lesions by a number of years; that the eruption was symmetrical, with the exception of the lesions on one side of the chest; that the mucous membranes, certain internal organs, and some of the long bones were evidently involved in the disease; that the characteristic lesions were also present in tendons and in the subcutaneous areolar tissue; that the case seemed to furnish evidence that the nervous system exerted an influence in causing the disease, as was shown by the zosteriform arrangement of the lesions on the side of the trunk; and finally, that some of the growths had undergone spontaneous involution.

In conclusion he stated that from a careful study of this and other cases and of the literature of the subject, he ventured to suggest that xanthoma was a diathetic affection, and that its connection with hepatic derangement was entirely secondary, or, in other words, that jaundice occurring during the course of the disease was a consequence of a deposition of xanthomatous tubercles in the liver. He believed, however, that this organ was peculiarly prone to become the seat of these growths. It seemed to him also probable that in persons having what for want of a better term he would call "the xanthomatous diathesis" certain conditions of irritation or of unusual motion might provoke a deposit in situ, *e. g.*, on the eyelids, over joints, etc. It also seemed possible that the zosteriform lesions on the side of the body might have resulted from an abortive attack of herpes zoster.

The reading of the paper was accompanied by the exhibition of a drawing illustrating the lesions on the chest.

DR. SHERWELL, in discussing the paper, alluded to the old view that the liver was usually primarily affected in the disease under consideration, and stated that he had never been able to confirm this in any one of a large number of cases which had come under his observation. He thought that in the case reported the affection of the liver and the consequent icterus were wholly secondary. In all his own cases the patients had been otherwise in good health. One in particular, which showed more than five hundred lesions, discrete and confluent, was that of a man in robust health, with an admirable hereditary history, and with no evidence of hepatic derangement.

DR. WHITE said that he believed that jaundice was very seldom found associated with xanthoma. He had observed the connection in only one instance of the many that he had seen of the latter disease, and he had devoted special attention to the question during the past twenty years. This remark he would apply to xanthoma of all grades of severity. He had seen only one case of xanthoma multiplex. With regard to the discoloration of the skin, he had, in this disease, often noticed a diffused deposit of permanent pigment in both upper and lower eyelids, which rendered the contrast between the color of the xanthomatous patches

and the surrounding skin very striking. Although he had seen several cases of xanthoma in one family, he had never been able to trace a connection between the malady and a diathesis.

DR. DUHRING said that a point of unusual interest in the case was the presence of intense itching, beginning not with the jaundice, but with the disease of the skin. He had for some time been much interested in attempting to trace a possible relationship between the tumors formed in xanthoma and growths usually regarded as of a different nature, met with in the affection called urticaria pigmentosa. He believed that two varieties of disease had been described under this title, viz., cases of true urticaria and cases partaking more of the nature of xanthoma, with intense itching and pigmentation, and the formation of distinct papules and tubercles. Such cases he regarded as of an identical nature with those that Tilbury Fox had described and figured in his "Atlas of Skin Diseases," under the name "Xanthelasmaoidea." Intense itching was said to be a feature of that disease also. He himself had no doubt but that an affection existed having a relationship to xanthoma multiplex, but differing from it in that the lesions undergo involution and run a definite course. He alluded to the fact that certain English observers, Dr. Morris in particular, had claimed to have noticed the spontaneous disappearance of the lesions of xanthoma multiplex.

DR. TAYLOR said that he also had been unable to establish a connection between xanthoma and a diathesis, having seen the disease in the strong as well as in the dyspeptic, the gouty, and the jaundiced. He had seen only one case of general xanthoma in the person of a woman, in whom the whole body, as well as the face, was involved. With regard to the involution of the lesions, he believed that, if it ever did occur, it would take place on the body, for he thought that all present would agree with him that it never did on the face. He mentioned one case in which the lesions disappeared, leaving the skin in an atrophied condition.

DR. HARDAWAY said that he had only the statement of the patient to prove that involution of some of the lesions had occurred, but had not observed it himself. He had been much interested by the osseous lesions which his patient presented, and which to him were involved in great obscurity. In the literature of the subject, he had found only one allusion to such lesions, viz., one by Colcott Fox, who had spoken of peculiar changes in the bones in one case of the disease, "due to the rheumatic or gouty state."

Evening Session.

DR. HYDE read a paper entitled

A CLINICAL STUDY OF LUPUS ERYTHEMATOSUS OF THE HAND.¹

DR. WHITE said that he had seen three or four cases of lupus erythematosus in which the hands alone were affected. He had also seen cases of the disseminated variety of the disease, in which the hands were free, although the lesions were widely scattered. In none of these cases had he been able to recognize any general disturbances, which would indicate a depraved condition of the system. He believed that cases in

¹ See JOURNAL OF CUTANEOUS AND VENEREAL DISEASES, Nov., 1884.

which the hands were involved were not relatively rare, but thought that the disease was often mistaken for other affections.

DR. SHERWELL remarked that he had never seen the disease on the palms. He had encountered it, however, on the backs of the hands.

DR. TAYLOR had seen two cases of that variety of the disease described in the paper, one in a man, the other in a woman. The patients were well nourished, and seemed to be free from any diathetic taint.

DR. HYDE stated that his object in writing the paper was to point out the ease with which the affection could be recognized, and to enrich the scanty literature of the subject.

The second paper of the session was then read by DR. SHERWELL. It was called

A SUGGESTION RESPECTING THE TREATMENT OF ACNE AND ACNE ROSACEA IN THE MALE SUBJECT.¹

DR. ROBINSON said that he supposed that all would agree that acne was usually produced by reflex action from some disturbance of the economy, especially of the digestive or genital system, and these conditions should receive special attention, otherwise permanent cure of the acne would not be assured. In strumous cases, cod-liver oil rendered valuable service, and was usually sufficient to effect a cure. If urethral irritation were present, the use of the sound might do good if the urethral condition had anything to do with the production of the acne, consequently he thought the suggestion a philosophical one.

DR. FOX called attention to the fact that patients, after putting themselves under the care of a physician, often made radical changes in their hygienic regimen without the knowledge of the physician. This he thought might in some cases be the true cause of improvement in a disease which the medical adviser might attribute to some particular plan of treatment. The suggestion concerning the use of the sound had impressed him favorably, for he believed that acne might be produced by genital disturbances. He knew that other skin diseases might be thus caused, and had seen eczema of the scrotum and anus relieved by the passage of sounds into the urethra.

DR. SHERWELL was positive that there had been no alteration in the regimen of the two cases he had reported. In both of them he had found intense irritability at the part of the urethra spoken of, and this had speedily disappeared under the treatment.

DR. WHITE then read a paper on

A CASE OF UNILATERAL CHROMIDROSIS (?).²

DR. DUHRING thought that the description read, gave an accurate idea of the process, and judging from it he would pronounce it a case of undoubted chromidrosis. He now saw more of these cases than he did ten years ago, and had quite recently seen one of red chromidrosis in the person of a young woman who presented a number of spots as large as the palm of the hand on different portions of the body.

¹ See JOURNAL OF CUTANEOUS AND VENEREAL DISEASES, Nov., 1884.

² See JOURNAL OF CUTANEOUS AND VENEREAL DISEASES, Oct., 1884.

DR. FOX had never seen a case of undoubted chromidrosis, as he believed that reported to have been. The only instance of the affection (as he at first regarded it) which he had ever thought of reporting, was that of a medical student who presented a red discoloration of the chin and neck, which could not be made to disappear by washing. The patient noticed that the discoloration usually wore off during the day, and that when he shaved his chin the lather was always stained red. While still under observation, he one day announced that he had discovered the cause of the affection to be the contact of the red edge of a new bed-spread, which he had been in the habit of drawing up under his chin at night.

DR. HARDAWAY had had an almost identical case, in which a physician had made a diagnosis of lupus erythematosus, and had burned the patch with red-hot needles before its real nature was discovered.

DR. HYDE had seen two cases of the same nature, one of which was almost identical with that of Dr. Fox.

DR. WHITE then read a second paper on

CASES OF ARSENICAL DERMATITIS.¹

It contained brief notes of cases of supposed arsenical dermatitis, in connection with the report of a train of uncommon cutaneous manifestations in a mother and her new-born infant after confinement within a chamber, the walls of which were covered with arsenical pigments. The object of the paper was to raise the question, how far was the apparent case of "pityriasis maculata et circinata" in the mother dependent upon the presence of arsenical compounds in the atmosphere of the lying-in chamber, an affection concerning the etiological relations of which nothing is known. In the infant the symptoms were of an eczematous type, with unusual manifestations of intertrigo.

DR. HYDE remarked that the number of cases of artificial dermatoses was increasing rapidly, and alluded to the importance of considering the question of a possible artificial cause in all uncertain cases.

DR. SHERWELL said that the paper recalled to his mind two obscure cases of bullous eruption now under his care which he had called "pemphigoid." The bullæ were large and very tense, and had appeared very suddenly on the bodies of the patients who were otherwise in good health. He had inquired, but had so far failed to find any evidences of poisoning or traumatism from stings or bites, etc.

DR. WHITE asked whether the patients had recently landed in this country, and on receiving an affirmative answer, said that the disease was probably produced by the bites of mosquitoes. He had observed bullous eruptions on persons who had never before been exposed to the attacks of these insects, the lesions being sometimes as large as a pigeon's egg. He called attention to an article by himself on the subject, published in the *Boston Medical and Surgical Journal* for Nov. 9, 1871. He recalled to mind certain cases of this form of disease which appeared during the winter, when, of course, mosquitoes were not abundant. On visiting the home of the patients, he had found it to be a damp cave-like

¹ See *Boston Medical and Surgical Journal*, Nov. 6, 1884.

place, containing numerous large and active mosquitoes. The fact that the bullæ in Dr. Sherwell's cases were also present on the thighs and body could, he thought, be explained by supposing that the patients had thrown off the bed-clothes during sleep, thus exposing the parts.

Second Day—Morning Session.

The first paper was read by DR. DUHRING, and was entitled

DERMATITIS HERPETIFORMIS, AND ITS RELATIONS TO IMPETIGO HERPETIFORMIS OF HEBRA.

After describing the disease and its several varieties, the author endeavored to show that the affection described by Hebra was merely one manifestation of an extensive multiform and protean process. The history of impetigo herpetiformis was referred to and a resumé of all the reported cases given; the conclusion being arrived at that the so-called impetigo herpetiformis of Hebra should be viewed as the pustular variety of dermatitis herpetiformis.

DR. FOX expressed the very great satisfaction and profit which he had derived from listening to the paper. He thought great credit was due Dr. Duhring for taking so comprehensive a view of many varying forms of disease which had hitherto been described under so many different names, as pemphigus pruriginosus, herpes chronicus, herpes gestationis, etc. He thought that all these affections undoubtedly belonged to the disease described by Dr. Duhring. He then briefly described a case which he had recently been treating under the name of chronic erythema multiforme pigmentosum. The patient was a widow, thirty years old. Her second child was born when she was nineteen years old, and since that time she had never been strong. About one year ago she had a thick, red rash all over her body, which was called prickly heat. It was attended by swelling of the arms and legs. The eruption was in the form of welts and ridges, but showed no vesicles. Two months later, blebs appeared all over the body and extremities. Before the old ones had dried up successive crops of new ones would appear. The eruption persisted in this form for a period of two months. Great improvement finally took place under the use of arsenic. The skin, which before the attack was unusually white, was deeply pigmented after it, except where the blebs had formed and disappeared, leaving white cicatrices. There had also been a few pustules on the back. Six months ago she was unable to walk, and recently the red eruption again developed on the arms and legs. It soon assumed the form of rings, but did not extend to the trunk, its color gradually growing darker. When the patient was first seen, the skin was uniformly dark, with groups of white cicatrices here and there, most marked on the back of the neck, in the groins, and on the thighs. Upon the trunk and extremities there was an erythematous eruption of a dusky hue, consisting in many places of confluent, pale-centred, circular patches. There were also a few excoriated papules. The palms of the hands were involved. The lesions were slightly elevated, but did not present a conspicuous appearance, owing to the discoloration of the skin. A peculiar feature of the disease was that there was

an outbreak of bullæ at each menstrual period. Great improvement had taken place under treatment, but entire recovery was, he thought, improbable. He believed that this was an instance of the affection which Dr. Duhring had described, but thought that the name dermatitis multiformis would define the disease better than the term used in the paper.

DR. PIFFARD said that the disease which Dr. Duhring had so ably described was rare, and that its manifestations were not sharply defined. Many cases of disease hitherto reported under various names could be grouped under the comprehensive view which was taken in the paper. He did not believe, however, that the affection was in any way allied to herpes, at least in its most typical form, viz., zoster. Even morphologically it could not be classed with that affection, its lesions being too protean, only one of its five varieties being of a vesicular nature. He had seen cases of the disease, and one quite recently, in the person of a female physician, not pregnant. She had at first lesions of urticaria on the elbows, and afterwards tubercles, vesicles, pustules, and bullæ on the face. The bullæ were not tense, but were rather such as were found in pemphigus foliaceus. In six weeks the face was almost free from the lesions, nothing but slight staining of the skin remaining. Recently small, deep-seated aggregated pustules had appeared, and several milia had formed around the eyes. The patient stated that she had had a similar attack ten years before. At that time also she was not pregnant. No itching nor burning was complained of, but she suffered from intense pain in the affected parts, which required the use of morphia for its relief. He was at first inclined to believe that the affection was of a neurotic origin, but when the pustules appeared he thought it might have resulted from some septic metastatic process. This seemed improbable, however, in view of the general good health of the patient. The etiology of the affection was, to his mind, still involved in great obscurity.

DR. WHITE was convinced that the more these cases were studied the greater would be the difficulty in classifying them absolutely. He was, on the whole, inclined to believe that the term "multiform dermatitis" would apply to them better than any of the others which had been proposed. He was not yet ready to admit that Dr. Duhring had proven the existence of an absolute connection between his own cases and the disease which Hebra had described under the name "impetigo herpetiformis." He himself had never seen a case of Hebra's fatal impetigo of pregnant women, and would prefer to regard the question of the identity of that affection with the comparatively common one described by Dr. Duhring as still undecided. He saw no more reason for admitting that the latter was of a neurotic origin than he did in the case of almost any other inflammatory skin disease. In the cases of the affection which had come under his own observation, pigmentation was rare. He thought that the disease was much more likely to be called eczematous than herpetic in character by the general practitioner.

DR. HARDAWAY expressed the opinion that a certain class of cases in which the lesions assumed the vesicular form, as a rule could be properly designated as "herpetiform." He thanked Dr. Duhring for grouping such affections, and thought that the name proposed was a perfectly satisfactory one. He was convinced that there was a neurotic basis to many of these cases, but would not regard their manifestations as a distinct disease, any more than he would a drug eruption.

DR. SHERWELL expressed his belief that Hebra's cases at least were of septic origin, and that they were identical in nature with a certain class of diseases often met with in military hospitals infected with nosocomial gangrene. He himself had seen many such cases in the ambulance at Sédan and elsewhere. He ventured to suggest the name "dermatitis necrogenica" for such eruptions, as he believed that in Hebra's cases, which occurred in pregnant or puerperal women, there might have been a septic absorption from an occluded tube (in salpingitis), from the peritoneal cavity, a uterine clot or a retained placenta. The pruritus which was so common in these cases he would attribute to irritation set up by the embolic deposits in the skin. He had very recently been consulted in a case (although he did not see the patient) in which, according to the description given him by a very intelligent practitioner, the lesions were of the character mentioned, at least in part, erythematous blushes being also present. He told the attendant that he might expect to find a pus cavity somewhere and was afterwards informed that the woman had been recently confined and had had a very severe attack of pelvic cellulitis, with an abscess which had opened into the vagina.

DR. ROBINSON spoke of three cases which he regarded as belonging to the class of affections described in the paper, and showed a colored drawing illustrating the lesions of one of the patients, a boy ten years old. The subjective symptoms of the case were very similar to those detailed by Dr. Dühring. The eruption was multifiform and in some places looked very much like ringworm, except that there was but slight furfureous desquamation. In other parts it at first resembled varicella, being composed of pea-sized vesicles seated upon a reddened base. In still other places there was found a central impetiginous-like crust, with a ring of pustules around it. Discrete bullæ were occasionally observed, but there was a marked tendency to grouping of the lesions. On the thighs were many patches of inflamed tissue which somewhat resembled at first glance keloidal tissue: elevated, red, non-discharging lesions. The eruption in short resembled ringworm in some places, herpes in others, and pempligus in still others. He believed the symptoms showed a well-marked neurotic element in the case, and consequently ordered nine drops of Fowler's solution three times a day, and soon noticed marked improvement in the disease, and in about twenty days complete disappearance. He felt that thanks were due Dr. Dühring for classifying such cases as had been described to-day, of which all dermatologists had seen instances, and which they were at a loss to properly designate. He agreed with Dr. White in his unwillingness to admit without further investigation the identity of such forms of disease with Hebra's impetigo herpetiformis. He mentioned incidentally that he had never seen the scarring described by Dr. Fox as a feature of the disease.

DR. DUHRING said that his paper was partly a synopsis of one read at the late meeting of the American Medical Association, which, he regretted to say, was not yet in print. His knowledge of the disease it treated of was derived from careful study of sixteen or seventeen cases observed during the past thirteen or fourteen years. Some of them had been under his care ten or twelve years, the disease still existing. He did not regard the objections which had been raised against the name he had proposed as valid, since a large proportion of the cases were from

the first of a distinctly herpetiform character. He was willing to acknowledge that most of his cases were of a different type from those of Hebra, but some of them closely resembled the latter, except that they did not terminate fatally. A few of them were so acute that they presented cutaneous disturbances of an intense grade. He felt confident that the difference between the two sets of cases was simply one of degree. Although some of his cases had a neurotic origin, he thought that, in others, the disease was the result of septicæmia. Hebra's cases were undoubtedly of this nature. The causes of the affection were varied, and it might be both neurotic and septic in origin. He expected to soon report a case in which it was caused by nervous shock, having appeared on the next day after the shock was received. In his experience, pigmentation was the rule in the affection, several of his patients having been much pigmented. It was unquestionably a distinct affection, as much so as any skin disease. The term "dermatitis necrogenica" he thought decidedly objectionable, for in many of the cases there was no possible suspicion of a septic origin.

The evening session of the second day was mainly devoted to the consideration of the report of the special committee, Dr. White, chairman, which was appointed at the preceding annual meeting to revise the official nomenclature of the Association.

Third Day—Morning Session.

In the absence of DR. STELWAGON, the Secretary read two papers written by him, one entitled

A CASE OF LATE CUTANEOUS SYPHILIS

(acne-form syphiloderm of the nose), illustrating the occasional necessity of large doses of potassium iodide, the other described

A CASE OF VITILIGO INVOLVING THE WHOLE SURFACE.

DR. HARDAWAY then read a paper on

A CASE OF GENERAL IDIOPATHIC ATROPHY OF THE SKIN.

The patient was a blind man, aged twenty-three years, of healthy parentage. He stated that he had a sister who was also blind, and suffered from the same skin disease. His cutaneous malady dated from infancy, and the affection of the eyes from the age of seven years. With the exception of headaches, his health was good. His intellect was clear, but he was poorly nourished. His face presented a rosaceous appearance, the skin being thickened and reddened. There were scars around the mouth. The integument of the neck was pigmented in spots and reddened on the sides, where enlarged vessels were visible. The front of the trunk presented a shining, checkered aspect, due to the alternation of many pigmented spots with atrophic macules. The entire skin was in fact atrophic and tense. There were a number of cicatrices over the

chest and abdomen, and the umbilicus was stretched until on a level with the surrounding skin. The appearance of the back was similar to that of the front of the body. No telangiectases were at any time visible. The skin around the elbows was deeply pigmented and slightly scaly. The skin and muscles of the hands were atrophied, and the sides of the fingers were adherent half way up to their tips. The condition of the lower limbs resembled that of the upper. The feet were normal. The hairs over the entire body were short and scanty. The perspiratory function was poorly performed, but the cutaneous sensibility was not much altered. There were no marked objective symptoms. Examination of the eyes showed xerosis of the conjunctivæ, corneal opacities, and adhesion of the lids to the globes.

DR. DUHRING said that study of the recorded cases of this disease had taught him that, aside from atrophy, there were no special features which distinguished the process, neither telangiectasis nor pigmentation being essential elements of it. In the xeroderma of Hebra and the angioma pigmentosum et atrophicum of Taylor, the features presented often varied greatly, cases being met with of all grades of severity, from those showing no tendency to degeneration to others developing sarcoma or carcinoma.

DR. TAYLOR expressed the opinion that the condition of the skin in the case reported was not like that met with in the disease known as angioma pigmentosum et atrophicum, this patient presenting simply an ill-nourished senile-like integument, with no evidence of vascular disturbance. The process had not been sufficiently active to lead to neoplastic formations. When these were present, they were usually seated at the points of junction between skin and mucous membranes, or upon surfaces constantly exposed to irritation or to friction from active movements.

DR. WHITE was unable to agree with Dr. Duhring as to the affinity between the different varieties of atrophic processes in the skin. In one class of cases there was loss of pigment and deposition of epithelium without change in the corium, in another hypertrophy of the corium was a marked feature, and in a third class, new growths, such as sarcoma and carcinoma, were present. He did not think that the case reported by Dr. Hardaway could be placed in this last class. In the majority of the cases that he had seen, atrophy was a mere phenomenon and not an essential feature of the disease.

DR. ROBINSON then read a paper on

MILIARIA AND SUDAMINA.

He first quoted the opinions of various authors on the essential nature of these eruptions, usually described under a variety of names, such as miliaria alba et rubra, eczema solare, lichen tropicus, prickly heat, sudamina, etc., and showed that they conflicted greatly. The object of the paper was to clearly define the real nature of the affection, and the conclusions reached were based upon careful microscopical study

of the lesions. A number of drawings illustrating the pathology of the affections were exhibited. The author of the paper found that the papules and vesicles in miliaria alba and rubra (prickly heat) were due to an exudation into the rete mucosum around the orifices of the sweat-ducts, composed of serum, corpuscles, and some sweat (but never of the latter fluid alone). The changes in the rete were similar to those met with in eczema, and the exudation came from the vessels of the papillæ. A catarrhal condition of the sweat glands was also often noticed. He concluded that miliaria alba et rubra was not an inflammatory affection of the sweat-glands, but one of the skin, especially around the duct orifices. Sections through sudamina (the "dew-drop eruption") had revealed the facts that the vesicles were always formed in the corneous layer, and that they were in direct communication with sweat ducts. The rete around the vesicles was normal, and their contents were always sweat. The glands and ducts seemed normal. The disease was, therefore, not an exudative affection, as maintained by Hebra, but consisted in an increase in the production of sweat (the result of hyperæmia) together with some obstruction to its escape, caused ordinarily by detached or stretched epithelial cells. He therefore concluded that miliaria alba et rubra was a form of eczema, or catarrhal inflammation of the skin, due to heat, irritating clothing, acrid sweat, etc., and was situated in a sweat-duct orifice area, as that was the part most hyperæmic or deranged in circulation in prickly heat, and that sudamina was not an exudative affection, but was solely due to a disturbance of the sweat-glands and corneous cells, the result of a hyperidrosis, etc. He thought that the term miliaria should be dropped, and that the name sudamina should be applied to the lesions of the dew-drop eruption.

DR. HARDAWAY objected to the use of the term eczematous to designate the affection, which was, in his opinion, a true dermatitis, whereas eczema was a distinct disease.

DR. HYDE was inclined to fully accept the views advocated in the paper. He thought that miliaria and lichen tropicus were due simply to accidents occurring in the course of eczema.

DR. WHITE thought that any attempt to lessen the prevailing confusion in dermatological nomenclature should be warmly welcomed, and that the view advanced in the paper was the only philosophical one. He himself recognized no such disease as miliaria alba et rubra as a distinct affection, but regarded it simply as a form of eczema. The question was, after all, one of definition only. He supposed that some would say that every affection resembling eczema not caused by a diathesis (purely imaginary in his opinion) should be called a dermatitis. He thought such a distinction a purely arbitrary one. He cited the case of an infant which on an intensely hot day was warmly wrapped up and placed upon a bed where it slept six hours. During this time it sweated freely, and when taken up its body was found to be covered with a punctiform redness, an erythema, due, doubtless, to the profuse perspiration. If this

eruption had subsided it would have been called a punctiform erythema, or miliaria rubra. But instead of disappearing it developed into a typical general eczema, which any one would have at once recognized as such.

DR. DÜHRING pronounced the paper a valuable contribution to dermatology. But little histological work had hitherto been done on the subject, and most of the opinions held concerning it were based on clinical rather than anatomical studies. Hence the majority of writers had regarded miliaria as an inflammatory affection of the sweat-glands. It was a disease characterized by genuine inflammatory phenomena, such as papules, vesicles, and vesico-pustules, whose formation began around the sweat-glands and their ducts. It seemed to him very plausible that the products of this inflammation should appear at some slight distance from the glands and not at their orifices. He had always held that the disease was primarily caused by some disturbance of the sweat apparatus, which resulted in vesiculation, papulation, or more diffuse hyperæmia of the surface of the skin. The question whether it should be called miliaria or eczema was, in his opinion, a very important one. He believed that erythematous, papular, or pustular eczema was clinically entirely distinct from miliaria. He was strengthened in this view by a consideration of the natural history of the diseases, the chronic, not self-limited course of the one differing widely from the brief career of the other, with its tendency to rapid recovery. It seemed to him that to call miliaria a papular eczema would lead to great confusion. Although he fully recognized the value of Dr. Robinson's work, he thought that he had to too great an extent ignored the natural history of the disease, and had attached too much importance to the purely histological aspect of the matter.

With regard to that portion of the paper which treated of sudamina, he thought its conclusions correct. The clear, deep-seated vesicles which it stated occurred only on the face, he had seen on other parts also, especially the hands and feet. In the matter of dysidrosis and pompholyx, he had always disagreed with Fox and Hutchinson, the disease which he himself recognized as dysidrosis being closely allied to the affection which Dr. Robinson had described and depicted as sudamina of the face. To designate it he would prefer the former to the latter term, as it really was a "difficult sweating" and not an inflammatory trouble. Ordinary sudamina which were so common on the chest did not seem to be exactly like the lesions depicted in the drawing shown by Dr. Robinson. This picture had also suggested to his mind another affection, an example of which was described by Jamieson, of Edinburgh, under the name "cutaneous cysts." He thought that this malady might possibly have some connection with the peculiar form of sudamina or dysidrosis of the face described by Dr. Robinson. Cutaneous cysts had no place in our nomenclature, and no anatomical investigation of the affection had been made, as far as he knew.

DR. ROBINSON, in closing the discussion, said that the formation of the papules and vesicles took place around the orifices of the sweat-ducts, where the congestion was greatest. If this congestion were prolonged, a quasi-inflammatory process would be set up, resulting in a periglandular extravasation into the rete. Hyperidrosis alone could never produce miliaria, the action of some external irritant in addition being necessary.

He reiterated his opinion that the affection should be called an eczema, and that the term "miliaria" should be abandoned, just as "lichen simplex" had been. The sago-grain-like eruption observed on the faces of women in middle life was caused by retention of sweat in the sweat-duct situated in the corium, a true dysidrosis, and resulted from obstruction by detached epithelium; the facility of distention being aided by a loss of tone of the sweat-duct walls consequent upon the circulatory disturbance. This eruption was not an ordinary sudamina, but might be classified under that head, as the etiology was in some respects the same as in that affection. (A drawing showing this eruption was also exhibited.)

DR. TAYLOR then read a paper on

A PECULIAR RINGED AFFECTION OF THE GLANS AND PREPUCE.

It contained a description of three cases of the disease which had come under his observation during the past ten years. The patients were from forty to fifty years of age, and all free from syphilis. Well-marked neurotic disturbances preceded and attended the outbreak of the eruption in all the cases. In one there was a history of an attack of orchio-epididymitis and recurring balanoposthitis, and in another a chancre had been severely cauterized, producing persistent swelling and other inflammatory disturbances of the parts. In all the cases the disease showed itself in the form of rings, covered with thin, firmly adherent glistening scales, seated upon an apparently normal mucous membrane. The lesions underwent no appreciable change, and no new ones appeared. The mucous membrane alone was affected. The patients all complained of unpleasant sensations around the seat of the disease. The affection resisted local treatment, and would grow better and worse in a very capricious manner. The patients finally recovered under the long-continued use of large doses of arsenic. One of them has since remained six, and another five years free from the disease. Although he was unwilling to pronounce the affection a disease *sui generis*, he had, in studying the cases, carefully eliminated from the diagnosis psoriasis, tinea circinata, and syphilis.

DR. DUHRING said that judging from the description given of the gross appearances of the lesions, he felt that he was familiar with the disease. With regard to the subjective symptoms detailed, these were not present in his cases, which were also three in number. He had been much puzzled for a diagnosis when he first saw them, but had finally concluded to call them lupus erythematosus. He was of the opinion that Dr. Taylor's cases were probably instances of that affection. In his own cases the appearances presented, the course and manner of evolution of the lesions, the occasional outbreaks of hyperæmia, and the persistence of delicate, very superficial, cicatricial tissue here and there after the subsidence of the hyperæmia, all pointed to the disease mentioned. In his cases, the course of the affection was variable, the rings at times starting from pin-head-sized papules, and increasing to one-half an inch in diam-

cter, and after coalescing, clearing up in the centre and scaling off. At other times the lesions assumed the form of patches, not rings. They were seated upon the glans and spread over the mucous membrane, half upon the corona and half upon the prepuce. The cases were all free from neurotic manifestations, and all proved very obstinate. A cure was finally accomplished in two of them by destroying the lesions with caustic potash.

DR. WHITE had had one case of the affection under observation for several months. The glans alone was involved, over almost its entire surface. The disease had existed one year, and was no better when he last saw the patient. He had not made a positive diagnosis, but saw no improbability in the supposition that it might have been a case of lupus erythematosus.

DR. HARDAWAY described what he regarded as a case of the same nature as those of Dr. Taylor. The patient had been successfully treated for psoriasis, and a few months later again presented himself with a red, scaly, non-elevated patch on the side of the glans. No improvement had taken place after six months' treatment, even with increasing doses of arsenic. The course of the affection was entirely unlike that of psoriasis.

DR. WIGGLESWORTH mentioned the case of a man whom he had successfully treated for leukoplakia buccalis, and who afterwards returned with a kidney-shaped scaly patch, clearing up in the centre, on the glans penis. It was attended with disagreeable itching sensations. There were no evidences of syphilis in the case, and he had eliminated from the diagnosis everything but lupus erythematosus, which he finally pronounced it to be. The lesions ultimately disappeared under the local use of pure carbolic acid.

DR. TAYLOR said that in his cases the affection did not begin as a papule, but always as a clearly-defined ring, of the size of a ten-cent piece. They were not indurated, were but slightly elevated, and were thinly covered with dull-gray, adherent scales. No scarring had taken place, and there were no recurring attacks of hyperæmia. He was positive that they were not instances of lupus erythematosus.

The Association then adjourned, to meet again on the last Wednesday in August, 1885, at the Indian Harbor Hotel, Greenwich, Conn.

NEW YORK DERMATOLOGICAL SOCIETY.

148TH REGULAR MEETING.

DR. A. R. ROBINSON, *President, in the Chair.*

PRESENTATION OF CASES.

DR. KEYES presented

A CASE FOR DIAGNOSIS.

John H., fifty-six years old, a resident of North Carolina, and a patient of Dr. P. C. Jenkins, has an eruption covering the back of both hands, the entire face and hands. It commenced ten years ago as an itching, oozing, and excoriated sur-

face on the back of the right hand, similar to the spot now present on the left cheek; there were no vesicles, pustules, or solid elevations. The oozing surface soon scabbed. The scab remained on for three or four weeks, then shed off, leaving no scar, but a red, thinned, dried-up, shining, atrophied condition of the skin. In this way the disease spread by continuous, isolated outbreaks of excoriation.

A flat scab is now present on the right hand, a spot from which a scab has just fallen, and an excoriation still open on the left cheek, much older than the ordinary excoriations, for it has been open six months. There are also many dried scabby patches about the cheek, recalling *seborrhœa sicca*. The skin seems thinned and atrophied, but there are no true scars. The lower eyelid on both sides is drawn down and everted by the contraction which the skin has undergone. The left malar bone seems decidedly enlarged. The right cheek is occupied by a tumor, seemingly the size of the half of a small orange. Over this the skin is red, lightly œdematous, but not hot. This first appeared high up under the malar bone eight years ago, as a lump in the thickness of the soft parts of the cheek. It slowly enlarged for five years. Three years ago it was opened through the mucous membrane into the mouth and at the lower edge of the cheek over the inferior maxilla. There was discharged an abundance of bloody serum, no pus. The surface healed, and in eight days was opened again, discharging this time an offensive watery fluid, no pus. Since then the mucous membrane has healed, the outside opening remained discharging a thin watery serum as at present. Granulations surround this opening, and into it a probe enters, an inch and a half, passing under the masseter muscle. No bone can be touched. The teeth and gums are not involved. A softish tumor, as large as a marble, projects into the mouth from the mucous surface of the cheek in its upper and back part. The patient cannot open his mouth well, and his nutrition has failed in consequence. He feels strong. There is no history of cancer, lupus, or tubercle in the family.

In presenting this case, Dr. Keyes asked for an expression of opinion as to the nature of the process going on in the opening in the cheek, viz., whether it were cancer, tubercle, or a simple inflammation, and also, if the eruption on the face were in any way connected with the tumor on the cheek.

DR. FOX had never seen a lesion of the skin resembling the one present in this man; he was inclined to believe the eruption on the face to be a lupus erythematosus, but did not recall any instance in which the latter disease presented an inflammatory base. He believed that the two conditions presented were dependent on each other.

DR. MORROW did not believe that there was a necessary connection between the tumor on the cheek and the inflammatory process. He thought that the general condition present was lupus erythematosus, and that the development of the tumor was a coincidence.

DR. JACKSON said that he coincided with Dr. Morrow in his opinion.

DR. ROBINSON asked if the verrucous condition present on the hands had any connection with the disease on the other parts.

DR. MORROW said that he had often seen a verrucous condition of the hands in old persons, especially if they were in the habit of doing out-door work. In the case under consideration he did not think it a necessary part of the disease, and believed it was caused by the slight injuries to which the patient was liable from his occupation.

DR. KEYES thought that the excoriated condition described was the primary lesion, as the disease commenced in that way. He considered the process on the cheek and that going on in the interior of the cavity identical, and that the disease was not a simple inflammation, but a neoplasm.

DR. JACKSON then showed a case of

PSORIASIS.

Edward B.; Eng.; æt. thirty-five; laborer. His first attack of the disease was five years ago. From it he entirely recovered. The present attack began as an eruption of small pinkish scaly "pimples," which came out very thickly so as to form patches. The eruption is still spreading, new papules constantly appearing. The patient complains of the disease being very itchy. Patient's general condition is fair. He complains of some headache, and his tongue is slightly coated white.

The eruption is located specially upon the extensor surfaces of both arms; on chest, from below middle transverse line to umbilicus; upon back, most marked over the loins. In these locations the disease occurs in large patches, covered with dry, parchment-like, gray, rather adherent scales which peel off in large flakes, leaving the skin smooth, dry, and pinkish. Where the scales are wanting, the skin seems thickened, and is red. Here and there are deep cracks of various sizes, leading down to corium. On the backs of the hands are small similar patches. Over the rest of the body are scattered macules and papules from pin-head to three-cent piece size, scaly, and many excoriated ones. On the legs are a few small, scaly, thickened patches and papules. The palms of hands present the appearance of eczema fissum.

Dr. Jackson, in presenting this case, said he did so because it was a rather unique case of psoriasis resembling very much in appearance the condition seen in dermatitis exfoliativa.

DR. FOX exhibited a case of

SUPPOSED PARASITIC DISEASE OF THE NAILS.

Louis S.; forty-one years old; by occupation a cigarmaker, and a patient of Dr. Büchler's. The disease began three months ago on the outer side of the nail of the right index finger; there was redness, followed by moisture, and the root of the nail loosened. Shortly after, the end of the nail turned brown, and at the end of three weeks this discoloration had extended to the middle of the nail. The nail then fell off. The nails were attacked in the following order: middle finger of the left hand; right ring finger; right thumb; and finally the left index finger. Only the nail first mentioned presented any moisture. The patient has never had eczema or ringworm of any part of the body.

Present condition.—The left index finger presents a dry, scaly, and eczematous condition beneath and at the side of the nail, and extends half an inch down on the palmar surface of the finger. The under surface of the nail is dry and rugous; the nail itself is stained as if with iodine, extending back almost to the lunula. There is slight congestion of the skin back of the nail. The right thumb presents a similar but more aggravated condition. The brown mahogany staining stops abruptly across the middle of the nail, and it can be scraped off. There is a black discoloration of the side of the nail, apparently caused by blood effused beneath. The root of the nail is loosening. There is more scaling around the nail, and slight retro-ungual redness and swelling. The left middle finger presents the same appearance as the right thumb, the nail is twisted to the inside. The scaling extends down upon the palmar surface of the finger. The right ring finger is similarly affected, the nail being turned inward. The right forefinger nail has been lost. The new nail is yellowish, rough, uneven, and separates at the base. None of the fingers are painful. A little pus can be squeezed from the sulcus

between the nail and skin, on the posterior border. Portions of the nails have been examined microscopically by Dr. Büchler, and found to contain the trichophyton.

Dr. Fox would like to have a diagnosis of the case made, based on clinical appearances, and also asked for suggestions as to treatment.

Dr. KEYES thought that it did not belong to either form of syphilitic disease of the nails, viz., that in which the nail becomes speckled and thin and finally falls off; or the variety in which the nail becomes thickened. Perhaps it might be a new form of disease. He would suggest wrapping one of the nails in oleate of copper, another in oleate of mercury, and the third in solution of bichloride of mercury. He suggested this because of the supposed parasitic origin of the disease.

Dr. PIFFARD had seen a number of such cases as this one, but he questioned very much if they were all of parasitic origin. He had seen two within the past year.

Dr. BRONSON thought it might be possible to account for the lesion as being due to syphilis. To him the lesion looked very much like syphilitic onychogryphosis. In parasitic disease of the nail, there would be a greater loss of lustre and a decided accumulation of scaly débris, which we do not see here. The discoloration might be accounted for from the occupation of the patient.

Dr. SATTERLEE would like to know if any disease resembling this were seen in other workers in tobacco; there did not seem to him to be any other cause. He did not believe it to be constitutional.

Dr. SHERWELL said that he had seen many cases resembling this one, and cited an instance in a barkeeper who had syphilis, and whose nails were somewhat similarly affected; he got well under the use of the mixed treatment. He certainly considered this condition of the nails as one of the signs of syphilis and would treat this patient with that idea in view.

Dr. BRONSON said that it might be due to some local deposit in the matrix of the nail.

Dr. ROBINSON did not think a diagnosis between eczema and parasitic disease could be made with any certainty unless the spores could be found. He had never seen parasitic disease commence at the matrix; it generally commenced at the front, and left the back of the nail in good condition. It appeared to him more like an ordinary eczema.

Dr. FOX, in concluding the remarks, said that he thought it was safer to call it an eczema, although it had many of the characters of parasitic disease. He was loath to call it syphilitic. In regard to treatment, he did not think that the results were very brilliant. A good plan to follow was to immerse the nail in chrysarobin, having first separated the nail from the substance beneath; this produces a derivative action and tends to kill the parasite. He would also be inclined to make use of the treatment suggested by Dr. Keyes.

Dr. MORROW showed a

CASE OF IODIDE-OF-POTASSIUM ERUPTION.

This case was presented because of the rapidity of development and multiplicity of the eruption. A woman, thirty years old, has had syphilis for some time; the exact date of infection was not ascertained. She was first seen on October 1, 1884, and at that time there was necrosis of the nasal bones, and diffuse inflammation of the integument covering that organ. She was placed on the mixed treatment of bichloride of mercury and iodide of potassium, there being two and one-half grains of the latter to each dose. As she did not improve under this treatment, on October 23 she was given thirty drops, three times a day, of a solution containing half an ounce of iodide of potassium in two ounces of water, or seven and one-half grains of the iodide. At this time, the external integument was perfectly intact. The dose of iodide was increased by ten drops, or two and one half grains, each day. On Sunday, 26, she was taking fifty drops of the mixture

when there was a sudden outbreak of the lesions present, being accompanied by intense lachrymation, coryza, and œdema of the face and eyes.

Now the whole of the nose presents a fungoid, red appearance, being greatly enlarged. The forehead, face, neck, and forearms are also the seat of the eruption. On the left cheek is a furuncle, over the malar bone is a large dark bulla. On the forehead are many papules and pustules. The eruption on the back of the neck resembles very much molluscum contagiosum. On the forearms, there is a variety of eruptive elements—papules, tubercles, vesicles, pustules, and bullæ.

DR. KEYES said that this was a very rapid development of eruption from the use of iodide of potassium. He said that he had seen many cases, but they were generally developed more slowly. He related a case which presented the appearance of a variola, in which there were a number of pustules with umbilicated centres and ecthymatous bases. He mentioned two cases of peculiar idiosyncrasies in the use of the drug, both occurring in physicians; one who could not take the cork from a bottle containing a solution of iodide of potassium without having an eruption; the other, a well-known physician, who could not use tincture of iodine without producing an iodic eruption. On the other hand, he had given as high as two or three hundred grains of the iodide without causing any unpleasant effects.

DR. PIFFARD said he would like to call attention to the similarity in appearance between this case and the disease described as dermatitis herpeticiformis; he did not think they differed very much in their general aspect.

DR. FOX thought that the eruption was peculiarly characteristic of an iodide-of-potassium eruption, but he had never seen the lesion elevated at the base. In the instance referred to by Dr. Piffard, there was elevation of the base, but he did not agree with him in diagnosing it dermatitis herpeticiformis.

DR. SHERWELL cited a case of ulcer of the leg in which the iodide of potassium produced an acne. The eruption disappeared and the patient got well after discontinuing the use of the drug and keeping the affected parts clean.

DR. MORROW said that the points of interest in this case were the rapidity of development of the eruption and the variety of lesions present. In looking up authorities, he had found few recorded instances of polymorphous eruption following the internal administration of the iodide. One writer speaks of the idiosyncrasy of the patient determining the character of the eruption; if the lesion is purpuric, it will always, in subsequent outbreaks, assume a purpuric form; and if papular, a papular appearance subsequently. In view of this, the present case is unique and rare, presenting, as it does, an erythema, papules, tubercles, vesicles, pustules, and furuncles; these forms might be considered as different stages of the same eruption. Pellizzari was the only one who had published a series of such cases; cases are recorded in which the lesion appeared in four hours after the first administration of the drug, although it generally took five or six days for the eruption to develop.

DR. JACKSON afterwards presented a

CASE OF LUPUS ERYTHEMATOSUS.

Miss M., aged thirty-seven years, has had the disease upon the left side of her nose and cheek for the past eight years. It began in both places as a small red "pimple," as the patient describes it, the pimples soon developing into red blotches. The disease gets worse in spring and summer. She has never been entirely free of it since it began, though at times it has apparently been almost well. Otherwise she has never had any skin eruption. The patches have always been dry, and never scaly, until three weeks ago, when they began to spread and to crust. The patches are very annoying, on account of their itchiness. The patient's general condition is good, though she has a slight amount of dyspepsia; she eats and sleeps well, and her bowels are regular.

When the patient first presented herself at my office, July 31, 1884, the patch upon her nose was of irregular shape, with its longest diameter one and one-fourth inches. The patch on the cheek had a longest diameter of about three

inches. The borders of the patches had a markedly dark-red congested look and were decidedly raised. The centres of the patches were of a less congested red, apparently sunken, and covered with light scales. The disease was evidently in an active state and spreading. The follicles were not papulous nor prominent. Under diuretics and local treatment with Lassar's paste, with and without oil of cade, during the next four weeks, the patient made good improvement, so that on September 1 I note that her nose had only a very faint spot on it, her cheek had lost its congested look and the patch was smaller, and a little spot which had come on her left ear in the middle of the month had gone again.

On October 4, the patient came to me again, saying that up to September 30 her nose was well, and cheek much better; but at that time they both grew worse. She was given a mercurial ointment, under which she grew worse, so that on October 9 she was put on Lassar's paste, with salicylic acid. This caused some improvement, and on October 12 she was put on the green-soap treatment. Since then she has been growing better. On the 19th I cauterized the whole of the patch on the cheek with pure carbolic acid, continuing the green soap on the nose. On the 26th she was put on phosphorus, $\frac{1}{60}$ gr. t. i. d. As the patch on cheek had still a large crust, it was not cauterized. Removing this crust left a dry surface. Upon the under surface of the crusts the plugs of the sebaceous follicles are plainly visible.

Dr. Jackson said that he presented this case to show the effects of the local application of carbolic acid in the treatment of the disease.

DR. FOX recalled four cases which he had presented to the Society, in three of which carbolic acid locally applied had produced the best results. He had a girl under treatment with two patches of lupus erythematosus beneath the eyes, which had almost disappeared, leaving no cicatrix.

DR. MORROW asked if carbolic acid were the only remedy employed.

DR. FOX said that the pure carbolic acid was always beneficial, and that he relied on that chiefly, although he gave phosphorus internally. He did not always see improvement from the use of phosphorus, although there was marked benefit from its use in some instances.

DR. ROBINSON exhibited a

CASE OF HERPES ZOSTER, WITH A PECULIAR DISTRIBUTION.

The patient, a boy four years old, has had an eruption of herpes zoster for the past twelve days, having been preceded by neuralgic pains in the forearm and hand.

Now the right forearm, from the elbow to the wrist, and extending on the hand to the ends of the fingers, are covered with an eruption of herpes zoster; most of the vesicles have dried down.

The case was presented to show the peculiar distribution of the lesion, and Dr. Robinson asked if any of the members of the Society had met with a similar case. He thought the distribution was unique.

DR. BRONSON described a case, which he had seen with Dr. Gibney, where the eruption extended from the elbow downward; this was followed by paralysis.

DR. FOX had seen Dr. Gibney's case, and said that the eruption extended from the shoulder downward, but that the middle, ring, and little fingers only were affected, and that their ends were not involved.

DR. MORROW said that he had never seen an eruption of herpes zoster similarly located. Most of authorities said that it did not occur below the wrists or ankles. He had a case where the eruption extended below the knees along the course of the cutaneous branch of the anterior peroneal nerve, and over the instep to the great toe, being confined chiefly to the outer side of the leg. Pain in the second toe preceded the development of the vesicles, and he was inclined to believe that the lesion commenced on the plantar surface of the toe.

DR. SHERWELL had a marked case of the lesion which extended from the shoulder down to the wrist, following the course of the circumflex and cutaneous branches of the musculo-spiral and median nerves. He had, however, never seen it on the hands before.

DR. WEISSE would like to know the course of the pain. He said that it was of interest because of the involvement of the cutaneous distribution of the ulnar and median nerves. So far as frequency of occurrence, he did not believe that he had ever seen the median nerve involved so far down as in this case. He had seen the cutaneous branch of the ulnar nerve on the side of the little finger affected. He would like to ask if any one had seen a herpes zoster occurring along the course of a nerve without cutaneous branches, and whether the area of distribution of the lesion was not always confined to the area of the cutaneous nerves.

DR. BRONSON mentioned an instance, where an eruption, following a paralysis of the third branch of the trigeminal nerve, occurred; the lesion was seen on the side of the cheek, lips, tongue, and the parts supplied by the post-auricular branch, the throat not being affected. There was no traumatic cause to account for the appearance of the eruption, except lying on the face.

DR. ROBINSON showed the case simply on account of the rarity of distribution of the lesion. It had all the clinical appearances of a herpes zoster.

Correspondence.

HISTORY OF A CASE OF TUBERCULAR LEPROSY, OCCURRING IN RENVILLE CO., MINNESOTA.

To the Editors of the Journal of Cutaneous and Venereal Diseases:

A PROPOS of the subject of leprosy in this State, which has lately received some attention from our local medical journals, and in our State Medical Society, I beg to submit the following history of a case now under observation, photographs of which—front and back view—accompany this article.

The case came under my care some time in July last, when our County Commissioners ordered me, as County Physician, to visit a pauper, living some thirty miles from here, who was popularly reported to be a leper.

Upon my arrival at the place, I found a man whose history, given through an interpreter, is as follows: O. E., Norwegian; aged forty-six years; married, has three children; has always enjoyed the best of health until about four years ago, when, being on board an emigrant vessel, as a steerage passenger to America, he had vague symptoms of general malaise, but no definite local symptoms, either subjective or objective, except slight pains in the limbs, which were never severe, were intermittent, and finally disappeared almost entirely; his appetite at that time was poor, and he lost flesh.

Upon landing at New York he came directly to this county and established himself as a small farmer.

About this time he noticed that his skin began to assume a slightly bronzed or coppery hue; was thicker, more stiff, and inelastic than usual, and directly small elevations began to appear about the face and upon the back. These were numerous, the whole face being thickly studded with them; and they enlarged quite rapidly, reaching their maximum, as nearly as he can recollect, in about two years, at which time they had attained the size of small walnuts.



He now observed that his voice, from being clear and resonant, began to assume a thick, guttural, and wholly unnatural sound, the finer modulations could not be executed; his efforts to sing, which had formerly been attended with a fair degree of success, now resulted in nothing but a stridulous and discordant jumble; his voice was indeed "the voice of a raven with a hoarseness upon him;" this, in time, became aphonia, the breathing became thick and wheezing, so as to be heard plainly at a distance of several yards.

During all this time, and notwithstanding the progressive and inveterate character of his disease, his general health had not suffered much—indeed, our climate seemed to improve him in many ways: he had a fair appetite, his bowels were regular; he slept well, and weighed about one hundred and sixty-five pounds. He could still do an average day's work; his greatest trouble being a shortness of breath, which finally became so bad that the slightest exertion provoked the most painful dyspnœa, and, being thus deprived of his only means of support and having a wife and three children, he was compelled to call upon the county for aid.

In the mean time the elevations began to subside slightly, an ulcer appeared upon the roof of his mouth; his throat, tongue, and lips seemed swollen; his appetite became poor, and mastication and deglutition were difficult.

As before stated, he is forty-six years old, has three children—all born before the disease appeared, and all look strong and healthy, as does the wife. He never saw but one case of leprosy, the subject being his own aunt. Cases were reported to exist in his locality, but none nearer than eight or ten miles. The patient claims and insists upon a clean record as regards syphilitic taint, and I believe he speaks the truth.

So much for the history, as elicited entirely through an interpreter, after the exercise of much patience and not a little tact.

He presents at this time an appearance not at all attractive:—the whole facial expression is distinctly leonine, the forehead is gnarled, brown, and shining, the brows corrugated and so prominent as to almost overhang the eyes; the whole face presents a mass of irregular tubercles, giving it a peculiar nodular, fissured, and repulsive appearance. These tubercles vary in size from that of a split pea to that of a small walnut. They are soft, smooth, glossy, having a bronze color, and the skin between them has a thick and boggy feel; the alæ of the nose are thickened, giving that organ a broad, flattened appearance, very like the nose of a lion. This livid, shining, coppery hue characterizes the skin over the whole body, showing more decidedly over certain portions of the back and upon the face and limbs. The skin is much thickened, evidently from subcutaneous deposit, the extremities are larger and less bony and angular in their contour than normal. This is well shown in the hand and wrist, which I have thrown forward in the picture. The feet and lower limbs have the same appearance. The back presents a group of tubercles similar to those upon the face; they are also to be found scattered promiscuously over the chest and abdomen. The beard, which was once plentiful, is scanty and growing thin, having disappeared over a large portion of the face.

Exploring the mouth and fauces, I found upon the membrane covering the hard palate, just in front of the uvula, a round, shallow ulcer, six lines in diameter, and depending from the apex of the uvula there was a pendulous, pyriform mass, about one and one-half inches in length, having a contracted pedicle, and resembling a fibroid in its gross appearance. I hooked it forward with a tenaculum and cut it off with a blunt bistoury, much to the patient's relief.

There is complete aphonia; the utmost effort put forth by the patient cannot elicit a single vibration of the vocal cords. The breathing, though quite improved by the removal of the mass above mentioned, is still thick and labored, probably due to the presence of deposits in and beneath the membrane of the larynx, lessening its calibre. There is no sign of breaking down of any of the tubercles; if they have grown smaller it has been by absorption. Nor is there perceptible enlargement of nerve-trunks, nor marked anesthesia of any especial tracts; the sensibility over the whole surface is diminished.

A. G. STODDARD, M.D.

BEAVER FALLS, MINN.

Selections.

DERMATOLOGY AT THE INTERNATIONAL MEDICAL CONGRESS AND IN THE DANISH HOSPITALS.

IF the total number of members attending the Congress of 1884 was less than at that of 1881, the foreign element was both numerically and relatively greater, and the amount and quality of the work done will compare very favorably with the great meeting in London. There is a degree of quiet earnestness in the Danish character which may have conduced to this; and while labor and refreshment were most admirably blended, there was an entire absence of any feverish hurry. As I devoted my time exclusively to the section of Dermatology and Syphilis, I can speak only of what was done there. The class-room in the University, where it held its meetings, was always well-filled, and close attention was paid to the subjects for the nonce under discussion. Professor Haslund, the President, opened the proceedings on Monday morning, the 11th August, by a short address of welcome, delivered in French, and then the programme for the day was proceeded with. The etiology of lupus vulgaris took the first place in the list, and Professor Doutrelepoint, of Bonn, enunciated his views. He regards lupus as a form of tuberculosis of the skin, and cites in support of this the histological structure of the lupus tubercles, the proved presence of tubercle bacilli in these, and the results of the inoculation of portions of lupus tissue on animals. He believes also that the clinical course of lupus is in favor of this view. Dr. Leloir, of Paris, followed, and developed still further the same view. When Professor Kaposi in turn spoke, he rejected the opinion that lupus is a tuberculosis of the skin *in toto*. He had seen, he said, twelve hundred cases of lupus, and considered it a disease *sui generis*, and quite distinct from tuberculosis of the skin, a rare disease, of which, however, he had seen a few examples. He produced from his portfolio some drawings of true tuberculosis of the skin, the scrofuloderma of some authors. One of these showed the characteristic, painful, and well-defined ulcerations on the upper lip of a man; another, those on the lips and tongue. The features of scrofuloderma there depicted were most truthful and life-like, and were certainly quite different from those ulcers ordinarily seen in lupus. Professor Pick, of Prague, held that while tuberculosis of the skin was not necessarily lupus, yet lupus was a form of tuberculosis of the skin. While, therefore, an advance was made towards the solution of the question, no definite agreement was arrived at.

A paper by Dr. Goldscheiden (Neisse) "On the Specific Functions of the Nerves of the Skin," was illustrated by a number of diagrams, life-size and enlarged, of the points of sensation of heat and of cold in different parts of the body, such as the tips of the fingers, the palms and backs of the hands, and the arms and back. On comparing the magnified charts, it was seen that the points where heat and cold respectively are perceived, while in close relation, are not identical.

On Tuesday morning, Dr. Armauer Hansen and Dr. Neisser showed microscopic preparations illustrative of the bacillus lepræ in the museum devoted to the exhibition of instruments, drugs, and appliances generally useful in cutaneous or venereal diseases, before the meeting of the section.

Dr. Hansen showed the threads, chains, and spores, stained with methyl violet, the result of cultivation in blood-serum.

Dr. Neisser demonstrated the presence of the rods in the liver and spleen of lepers. Dr. Unna then described and exhibited some of his very useful and ingenious additions to the local treatment of skin diseases. In the first place, he showed his salve muslins—thin, pliant rolls of muslin or thin cotton spread on one or both sides, very smoothly and perfectly, with various salves. These salves are so compounded by Mr. P. Beiersdorff, No. 46 Wohlers Allee, Altona, that they do not run, and are thoroughly incorporated with the muslin. In this way pieces of suitable size, and containing ingredients adapted to the case, can be cut off and at once applied. They accommodate themselves to all the sinuosities and inequalities of the parts, and at the same time adhere closely. Those salve muslins, which are spread on both sides, containing a larger quantity of the materials, are efficient for a longer time than those merely treated with the unguent on one surface.

Unna showed on a person present the way in which the zinc salve muslin, one of the most ordinarily applicable forms, can be fitted to the fingers, to the spaces between the fingers, by making slits in the piece and then drawing it on; to the forehead, the cheek, and, wrapped round a tube of oiled paper, to the inside of the nose. Iodoform salve muslin can, in like manner, be applied to the glans penis. More adhesive, owing to a basis of gutta-percha or India rubber, the plaster muslins were next shown. These were beautifully flexible, and admit of close adhesion. The mercurial and the salicylic plaster muslins attracted most attention. The glycerogelatins were next exhibited, or, as Unna called them, the glycerinleim compositions. These are soft and hard, and when employed are melted by means of boiling water, in a vessel containing which the can with the gelatin is placed, and when these are melted a layer is painted on with a brush, and allowed to become hard. A formula for a generally useful one is:

℞ Zinci oxidi,	
Gelatini puri	ãã 10.0
Glycerini,	
Aquæ	ãã 40.0

This Unna recommends for eczema of the bends of the elbows. Pencils of iodoform were shown which, dipped in water, could be used to touch a sore more or less lightly; and others made like those recommended by Bulkley, by Mieli (Hamburg), of adhesive substances, which, heated in a flame and then pressed closely to the scalp and snatched rapidly away, could be used to replace epilating forceps. The museum contained many modifications of Volkman's spoons for lupus and epithelioma, and of scarifying knives and acne lancets; also

an ingenious instrument, the invention of Professor Berg, of Copenhagen, for facilitating the discovery of the *acarus scabiei*. This consisted of an achromatic Coddington lens, with a broad needle in its focus. This needle could be used to explore the furrows, which were rendered distinct by the magnifier. This is made by Nyrop, Kjöbmagergade, Copenhagen.

When the section met, a deep impression was made on the members present when Professor Haslund announced, in a few appropriate sentences, the death of Sir Erasmus Wilson, who had so ably presided in the same section at the London meeting in 1881, and who then seemed as energetic and vigorous as ever. The chair for the day was then taken by Professor Kaposi, of Vienna. Dr. A. Hansen, of Bergen, showed three leprous patients affected with the anæsthetic as well as the tubercular form. One of these was a still healthy-looking man, who had the tubercular form of leprosy on his cheeks and forehead, and the anæsthetic on the forearms. There were symmetrically-placed atrophic patches on the outer aspect of each forearm near the wrist, but so far movement was not materially interfered with. The second was a more advanced case. There were tubercular patches on the forehead, and these interspersed with atrophy on the nates, the brownish-red patches alternating with the white atrophic areas. All the affected parts occurred on the extensor, and not on the flexor aspect. The third was the most advanced case of all. There was complete wasting atrophy of the muscles of the forearm and of the leg near the ankle, and this was developed to such a degree that the man required assistance to undress, his hands being quite helpless. On the foot the last phalanx of the great toe had become necrosed, and a mere pad of flesh was folded over the second. On the back were pigmented spots, where there had been macules or tubercles. There was ectropion of the under eyelid, and keratitis, due to exposure and desiccation. Dr. Hansen regards the disease as a specific one, contagious, and not hereditary. The anæsthetic form, in which bacilli have not been found abundantly, he considers curable. The bacilli were found in nerves which had been extirpated from a patient in Honolulu affected with the anæsthetic form. Though cured, and no longer able to communicate leprosy, since they do not convey the leprous products, such persons are nearly valueless for active purposes. The tubercular cases die either as the direct result of the disease, or, more often, from secondary causes, and, as a rule, long before they are cured. With reference to the etiology, heredity and communicability exclude one another, since we are unacquainted with any contagious disease which is at the same time hereditary. Syphilis is not an example of this. It was shown by elaborate tables that isolation causes a rapid, or, at least, a very considerable diminution in the evolution of new cases of leprosy. The discovery of the *bacillus lepræ* has not yet solved the question of contagiousness, but goes to establish this, and the failure of experiments in animals is inconclusive. Dr. Zambaco, of Constantinople, maintained that the disease was hereditary, and not contagious. He described a primary stage of congestion omitted, he thought, by Dr. Hansen, and showed a large collection of recently executed drawings of leprous cases in all stages of the disease which he had brought from Turkey. These were chiefly tubercular. The afternoon was occupied with a discussion on a paper by Dr. Pick (Prague) on the excision of the hard chancre.

Wednesday was a day of pleasure intercalated between those of serious work. Five large steamers conveyed the members of the Congress, their wives, and many Danish ladies and gentlemen, to the number in all of more than two thousand, to Elsinore. The day was genial, and the coasts of Denmark and

Sweden showed to much advantage. The harbor at Elsinore is small, and some time was occupied in landing the passengers, as one vessel only could enter at a time. A large concourse of people had assembled to welcome the learned men. Throughout all the time, the extreme orderliness, patience, and good humor of crowds in Denmark was particularly observable. On entering the castle of Kronberg, a salute was fired from the guns mounted on the walls, and an excellent lunch was partaken of in various rooms of the castle set aside for this purpose. After this, the members dispersed themselves to the town and its neighborhood, including the pretty sea-bathing suburb of Marienlyst. On returning to Copenhagen by rail, a halt was made at Hilleröd to see the palace of Fred eriksberg, scarcely yet completely restored after a disastrous fire in 1859. It contains a number of pictures of the kings and queens which were saved, and the rooms are exceedingly handsome.

Work was resumed on Thursday, the hour before the section met being occupied by another demonstration in the museum, partly by Unna, partly by Grünfeld, of Vienna. The latter showed a new and simple form of endoscope, in connection with his paper on "Endoscopy," read at the day's meeting. He described in it the different appearances presented by the membranous and prostatic parts of the urethra. And he pointed out that when applications were made to the latter part, these more frequently were deposited on the sides rather than the *veru montanum* and openings of the vesicular ducts. By the endoscope, too, granulations and polypi could be seen in the mucous membrane. Dr. Liebreich (Berlin) took up the subject of the treatment of syphilis by means of mercurial injections. He employs the formamide of mercury. Formic acid is $\text{C}^{\text{H}}_{\text{O}000}$,

when two molecules of oxygen are replaced by ammonia we have $\text{CO}^{\text{H}}_{\text{NH}_2}$.

And when one molecule of hydrogen is replaced by one of mercury we have

$\text{CO}^{\text{H}}_{\text{NH, Hg}}$, the formamide of mercury. This, when injected deep into the

tissues, causes much less chemical reaction than the solution of perchloride of mercury, or, indeed, than any other solution heretofore used. The acetamide and the propionamide are also useful. In the discussion which ensued, Kaposi declared himself still favorable to the method of inunction. Dr. Behrend (Berlin) read a paper on a mode of diagnosis between hairs affected with the fungus of *tinea tonsusans* and that of *favus*. So long ago as 1873, Dr. Dyce Duckworth had shown that hairs from a case of *tinea tonsurans* which were affected by the fungus elements became yellowish-white when moistened with chloroform and allowed to dry. This observation, though quoted by Neumann in his "*Lehrbuch der Haut-Krankheiten*," seems to have been forgotten, and is not mentioned in any of the more recent manuals; it has escaped the notice of Dr. Alder Smith. Behrend, however, again unearthed it, and in his communication pointed out that dark hairs affected with the *trichophyton tonsurans* become white when touched with chloroform, while hairs from *favus* are unchanged. Specimens of healthy hairs, of hairs from ringworm, and of hairs from *favus* so manipulated were handed round neatly inclosed between two watch-glasses, when the difference was at once perceptible.

A paper on the time when gonorrhœa ceases to be contagious, by Dr. Bockhart, Wurzburg, led to an animated discussion on the relation of the gonococcus to gonorrhœa.

On Friday, Dr. Wulff, of Strasburg, expressed an opinion confirmatory of that

originally propounded by Professor Lang, of Innsbruck, and published in Volkmann's *Klinische Vorträge*, as to the parasitic nature of psoriasis. He showed micro-photographs of the spores and mycelial threads which he had found in the membrane described by Lang and Bulkley as underlying the mass of scales, and which he said were identical in appearance with those found and figured by Lang. He stated that a parasitic disease of the skin was not necessarily contagious, and cited tinea versicolor in illustration of this. Professor Pick said that it was more common to find spores in the scales of psoriasis than to fail in finding them, yet declared himself not as yet converted to the parasitic theory of the disease. Dr. Unna mentioned a clinical fact in support of the contagiousness of psoriasis, at least in some instances. A nursemaid with psoriasis on the elbows and knees was placed in charge of three children, having no hereditary history of psoriasis, yet all three in course of time manifested it. Professor Lang maintained his previous opinion, and added that the fact that many of the most efficient remedies for psoriasis were of the class of parasiticides—as tar, chrysophanic acid, naphthol, thymol, etc., favored this. Dr. Jamieson had not so far found the fungous elements described, though psoriasis was common in Scotland, and thought that the beneficial effects of alkaline baths, which could scarcely be regarded as in any sense parasiticide, in causing the disappearance of the patches of psoriasis told against the parasitic theory. Dr. Wulff, in summing up, made the suggestion that the spores might possibly proceed from within outwards, as well as be implanted from without on the surface. The whole subject is very interesting, and deserves, and will likely obtain a searching investigation.

Dr. Lipp, of Gratz, read a contribution to the study of variola and vaccinia, chiefly with reference to the occurrence of micrococci in the vesicles of these diseases. He had found micrococci in both, which, if not identical, resembled one another very closely. These micrococci arrange themselves in fours and multiples of fours. He had inoculated the result of the cultivation of the second generation, but so far unsuccessfully.

The concluding paper was read by Professor Haslund on the "Pathogenesis of Gonorrhœal Rheumatism." Respecting this two theories exist. One, that the so-called rheumatism is a result of the invasion into the articulations of the pathognomonic microbes of gonorrhœa; the other, that it is a purulent infection caused by the absorption of pus, produced by the urethral inflammation. The discoveries of MM. Petrone and Hammerer still remain the sole proofs of the first view. The gonococci have been sought for in vain in the fluid which distends the articulations by many. Dr. Haslund's observations incline him to the theory of purulent infection, without, however, being contradictory of the other opinion.

The President then closed the section with a short farewell address; and on a motion of thanks to him made by Dr. Doutrelepont, and seconded by Dr. Thin, the meetings terminated. The general feeling was that much valuable work had been done, and much information gained by all.

On Monday, the 18th, I visited the Kommune Hospital, which is situated in an open space in the north-western part of the city. It embraces three sides of a square, and was built about twenty years ago at an expense of about £112,000. It is arranged on the corridor system—the wards, which run across the building, opening endwise from the corridor. Two wards often communicate directly by an arched doorway. The hospital and wards, so far as I visited them, are clean, well ventilated, and not overcrowded. There are two hundred and fifty beds for skin diseases and syphilis or other venereal disorders, under the charge of Pro-

fessor Haslund and Dr. Pontoppidan. The latter took me round the male wards, the visit being made alternately by each to the male and female side. All those patients who were able came to the doctor, who seated himself at the end of the ward with his back to the window. Moist eczema was treated while still oozing with unguentum diachyli, and when the discharge had ceased with Lassar's paste. The treatment was almost entirely external, internal medicines of any kind are scarcely ever prescribed. Dr. Pontoppidan admitted that possibly this was carried too far, though he thought we, but especially American physicians, erred in the opposite direction. He said the result of treatment by local measures alone was quite satisfactory. He told me, in answer to a question, that eczema of the palms and soles, by no means uncommon in Britain, is scarcely known in Denmark.

Psoriasis, which seems of pretty frequent occurrence, is treated with alkaline baths, followed by inunction with vaseline, as recommended by Liveing, combined with the internal administration of arsenic. For circumscribed cases painting with chrysarobin traumaticine is employed. In scabies Kaposi's naphthol ointment is used, one to three inunctions being usually sufficient. No baths are given when this mode of treatment is followed. One entire family had come in to be treated for scabies. All except one were found to be affected, and he, a boy of eleven, had psoriasis presenting an unusual localization. The knees, elbows, head, and trunk were not implicated, but the patches of psoriasis were scattered symmetrically over both thighs, and there alone, though the disease had existed for some time.

For pediculi pubis, a solution of corrosive sublimate in vinegar is used, and found efficacious. Petroleum or kerosene oil in the treatment of pediculi capitis is either unknown, or, at least, has not come into use. True prurigo seems to occur much in the same way as in Austria. One child, aged eleven, was shown to me who had already been treated for it in hospital fourteen times. Gonorrhœa in the male is treated with weak injections of permanganate of potass till the purulent secretion becomes moderate, then with mild injections of sulphate of zinc. There seem to be far more cases of gonorrhœal rheumatism than with us; at least, many cases affected with it were seen occupying the beds. The fluid, too, sometimes becomes purulent, and then, as when the joint is very much distended, it is drawn off by the aspirator.

Chancres are treated with iodoform till nearly healed, and then are covered with emplastrum hydrargyri. Chloride of calcium in lotion is also a favorite application. For the constitutional treatment of syphilis the hypodermic method is exclusively employed, the needle being plunged deep into the nates, and the part rubbed briskly with the hand, when the needle has been withdrawn, to diffuse the fluid through the cellular tissue. The preparation already mentioned as that suggested by Professor Liebreich, of Berlin, is the one adopted. One per cent of the formamide of mercury is the strength employed, dissolved in distilled water, and of this one gramme (15 minims) is injected every second day. From twelve to eighteen injections are required in general. No pain is caused, nor are abscesses apt to form, while the disappearance of the cutaneous symptoms is rapid. Buboës are freely incised as soon as pus forms; then the interior is scraped with the sharp spoon, and the part dressed with iodoform, and covered with salicylic wool.

Quite a contrast to the modern Kommune Hospital is the Almindelig Hospital or Infirmary for Incurables, situated in the north-eastern part of the city, quite near the winter residence of the Royal Family, and considerably more than a

hundred years old. For part of it little is being done—that part into which registered prostitutes, found or suspected to be diseased when examined at the police office, are admitted and kept till cured. There are in all one thousand three hundred beds in this hospital. Dr. Grünfeld took me over the incurable portion, the beds being filled mostly with old people. One case of myxœdema was shown me, exhibiting the same features as are found in the disease with us. The man had had it for more than ten years. There were many examples of myelitis, of ataxy, and of chronic rheumatic arthritis. One woman affected with the latter had been upwards of forty years in the hospital. Only one part seemed inconveniently crowded—that division where aged persons, not suffering from any ailment in particular, are kept. Here the beds were certainly packed rather closely.

In the absence of Professor Bergh, Dr. Jespersen showed me the Lock Hospital. There are five hundred and twenty registered prostitutes in Copenhagen, and many suspected women. At present the registered alone are treated here, the others are taken into the Kommune Hospital. A new hospital for venereal diseases is being built near the Tivoli, where all will be admitted when it is opened next year. From sixty to seventy women are usually inmates of the Lock. Inspection seems to be carefully conducted, since the cases are not as a rule severe: gonorrhœa, soft sores, lacerations, and abrasions constitute the majority. Syphilis is rare; usually there are but six or seven cases in all, and of these some are recurrences. Gonorrhœa is treated with irrigation with boracic acid lotion through a speculum. Urethral gonorrhœa is carefully looked for, the urethra being everted by the examining finger. If there is any evidence of its existence, and this seemed by far the most frequent complaint, the urethra and bladder are injected with a one in five thousand of water solution of corrosive sublimate. This is repeated twice a day, seems absolutely painless, and cures in from ten to twelve days. Lacerations are treated with iodoform. Ulcerations, non-specific, of the cervix, with glycerin of tannin. For syphilis, subcutaneous injections of the formamide of mercury as in the Kommune Hospital, only the injections are made daily for twenty-one days, then every second day. Mucous patches are treated with chromic acid solution, latterly as strong as one in five. The gonococcus is often looked for in gonorrhœa, and is usually found. In examining the patients, except specula, no mechanical means were used to replace the fingers, though I was shown flat spatulæ at one time employed to separate the labia, now disused. Occasional cases of contagion from examination have occurred. The women were mostly young, but there were none very young, and there was one whose age was stated as forty-nine.—W. ALLAN JAMIESON, *Edinb. Med. Journ.*, Oct., 1884.

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