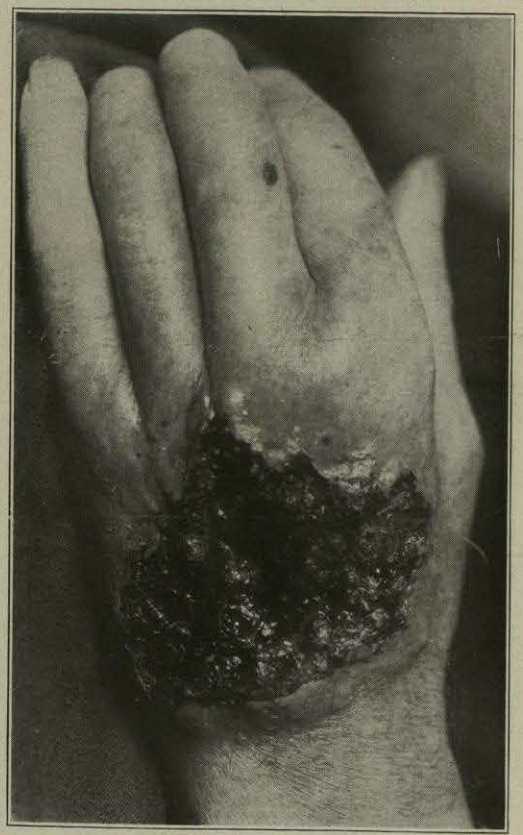
PLATE II.



Prickle-cell epithelioma, resembling blastomycosis, and following an injury on the hand of a man 78 years old.—*Dr. Oliver S. Ormsby's patient.*

and from the blood in two cases the same organism was also obtained.

The details of the work are to appear in the near future in the Journal of Infectious Diseases.

Classification of the Chronic Resistant Macular and Maculopapular Scaly Erythrodermias. The possible relationship of the various conditions comprising that ill-defined group of dermatoses for which Fox and MacLeod have suggested the very apt designation of "chronic resistant scaly erythrodermias," is a matter of more than academic interest.

Brocq would classify the various clinical entities under the general heading of "para-psoriasis" with three subdivisions: para-psoriasis guttata, para-psoriasis lichenoides and *érythrodermie pityriasique en plaques disséminées;* and would include in the group not only Unna's para-keratosis variegata, but also Jadassohn's psoriasiform and lichenoid exanthem and nodular psoriasiform dermatitis, Neisser's lichenoid eruption, Fritz Juliusberg's psoriasiform and lichenoid exanthem and pityriasis lichenoides chronica, Boeck's dermatitis variegata, Crocker's lichen variegatus, Colcott Fox and MacLeod's resistant maculopapular scaly erythrodermias and the dermatosi squamosi anormale of Casoli.

Civatte believes that many of the disorders of this class bear a definite relation to tuberculosis and the tuberculids. It is interesting to note, however, that the sections from one of Civatte's cases were histologically identical with those from Darier's case of *"sarcoïde cutanée,"* consequently, as Menahem Hodara intimates, it is probably safer to consider each case in all its aspects, and not place too much stress on any single clinical or histopathologic phase.

In describing the symptom-complex for which Pernet suggested the name *"xantho-érythrodermia perstans,"* Crocker was at first in doubt as to whether it should be considered as a hitherto unknown affection, or included under *"érythrodermie pityriasique en plaques disséminées"*—one of the cases in the series being clinically indistinguishable from this variety of Brocq's disease; but, finally, in view of the large size of the affected

areas, their smoothness and yellowish color, their more or less regular distribution, the presence of a distinct degree of infiltration in a large proportion of the patches, and the favorable manner in which the lesions responded to treatment, he concluded that the condition did not belong to the para-psoriasis group. In Crocker's opinion, *dermatitis psoriasiformis nodularis, para-keratosis variegata* and *érythrodermie pityriasique en plaques disséminées,* all were but different manifestations of a single disease, which he preferred to call "lichen variegatus," a clinical term designating a conspicuous feature of many of the typical cases that had been described. The appellation "para-keratosis," first rather vaguely employed by Auspitz in 1881, and later clearly defined by Unna as indicating "a parenchymatous edema of the transitional epithelium," Crocker would not accept. At present, however, the consensus of opinion, judging from the literature, would indicate that Unna's definition and adoption of the term have met with general approval.

R. Sutton,[8] in a discussion of the classification, concludes that there are certain cutaneous disorders which combine in greater or lesser degree the clinical characteristics of seborrhoic dermatitis, psoriasis and lichen planus. For the sake of brevity, it would be well to class all of these conditions under the general heading of the chronic resistant macular and maculo-papular scaly erythrodermias. From a scientific point of view, however, it is probably best to separate the various conditions into groups, placing in each group only those disorders which bear a close clinical and histopathologic resemblance to each other.

At the bottom of the list may be placed Crocker's xantho-erythrodermia perstans, and at the top, the parakeratosis variegata of Unna, Santi and Pollitzer, with Brocq's para-psoriasis group, and psoriasis lichenodes, in which is included Neisser's lichenoid eruption, Jadassohn's psoriasiform and lichenoid exanthem and nodular psoriasiform dermatitis, and Juliusberg's pityriasis lichenodes chronica.

While this arrangement may be open to criticism, in

(8) Jour. Miss. State Med. Ass'n., December, 1913.

view of the fact that our knowledge of several, in fact of all the conditions is more or less incomplete, it is only by the adoption of a comprehensive classification that the science of dermatology will be advanced. The charge is often made that we already recognize too many affections of the skin. If the diseases exist, it is our duty to familiarize ourselves with their symptomatology, and not dodge a professional responsibility by converting well-defined clinical entities into ragged and embarrassing scrap-heaps.

Localized Syringoma, With Other Developmental Anomalies. Since Max Winkler[5] published his last paper, in 1907, there has been a growing tendency to discard the theory of the endothelial origin of syringoma, for the reason that all the evidence seems to indicate that the tumors are of epithelial genesis. Dohi, Riehl, Sutton and Dennic, Sequeira, and Joseph and Siebert all favor this view. More recently, Ricker and Schwalb, in their monograph, "die Geschwülste der Hautdrüsen," state that the syringoma is a "characteristic type of fibro-epithelial tumor of the sweat-gland duct."

The case reported by Winkler was a young laboring man of 22 years. The family and personal history was without interest. The lesions, which had been present for one year, were localized about the scrotum and penis, especially on the under side.

The patient had been reported as unfit for military service. His voice had not changed, and there was no sign of a beard. The auxillary and pubic hair was very scanty. The external genitals were small and undeveloped.

The lesions were very numerous, and varied in size from that of a pinhead to a cherry stone. The larger ones were a genuine yellow in color, whereas the smaller were yellowish-white. There was a mild folliculitis of the scrotum.

Clinically, the lesions suggested atheroma, but when studied in serial sections by Jadassohn and the author they were found to be a combined atheroma and syrin-

(5) Arch. Derm. Syph., June, 1914.

goma. Winkler offers the case as further evidence that syringoma is a developmental defect of the sweat-gland apparatus.

Drug Eruptions. These are encountered chiefly in epileptics, as they are the principal consumers of the bromin compounds. Though almost any drug may cause an eruption, yet, for obvious reasons, those caused by the iodids and bromids have merited the greatest attention by the profession. The mode of development of these eruptions has been quite conjectural, but certain observations have brought us nearer to concrete facts, although not to perfect understanding. There are several theories extant concerning the nature and manner of drug eruptions. It is somewhat disappointing that the most natural explanation, the excretion of the "materia peccans" by way of the blood through the glandular system of the skin, is doubted.

It is impossible to narrow down all the manifestations of drug exanthems into a system. Neither from the point of view of the drug, nor from that of the different responses on the skin, is such a generalizing possible. Recourse must be had to various theories, namely: an especially vulnerable skin, differences in the anatomic structures or their distribution (vessels, nerves), a peculiar receptivity of the system, deviation from the normal of the position of the skin-glands, secretory and excretory alterations of their functions, and many other incidents, partly speculative, partly scientifically demonstrable. Predisposition and idiosyncrasy for a certain drug, food, or external irritant are yet valid as causes, but unfortunately not the exclusive explanations in this contradictory domain.

According to Weiss,[9] the evidence that drug eruptions are of angio-neurotic character, caused by functional disturbances of vasomotor nerves, is the fact that they simulate, almost to the point of confusion, other well-known exanthems like erythema nodosum, erythema multiforme, urticaria, scarlatiniform eruptions, thought to be of angio-neurotic origin; that fever and general systemic disturbances are mostly absent, or when present

(9) Trans. Sec. Derm. A. M. A., 1914, p. 248.

appear only in a mild degree. This forms a distinctive point in the diagnosis of a drug eruption. The differentiation from the infectious angio-neuroses—acute exanthems—will not be a difficult task if we take into account their onset, development, and the highly violent systemic disturbances accompanying them.

Drug eruptions may simulate almost any known skin affection. A skin eruption starting suddenly without any prodromal symptoms is almost sure to be a medicinal eruption. The violence of development, the preponderance of the local over the systemic disturbances is characteristic. The brevity of the acute stage and the quickness of defervescence constitute a notable asset in diagnosis. The usual four stages of the acute contagious exanthems, namely: the prodromal stage, the eruptive, the fully developed and retrogressive and the desquamative stage, are wanting. The temperature never rises to the point shown by the acute exanthems, and the affection of the mucous membrane is never so severe.

Differential Skin Reaction in Variola and Varicella. Tièche[1] applies a test technic, similar to that of Pirquet's tuberculin skin reaction, as a means for rapid differentiation of smallpox from varicella and other eruptive diseases. His eighteen months of experience have confirmed, he says, the harmlessness and reliability of the simple measure. Kling's experience with protective vaccination against varicella, when an epidemic broke out in an institution with 200 children, also confirmed incidentally the value of the test, as he mentions casually that no local reaction was observed until the eighth day at the point inoculated with the varicella lymph. Vaccine lymph, on the other hand, always induces a prompt local reaction and generally in four hours at longest. Tièche experimented on himself until he had demonstrated that no local reaction was evident for several days, if at all, after he had vaccinated himself in the arm with the secretion or rubbed-up contents of a varicella pimple. On the other hand, the secretion or scrap of contents from a smallpox pustule promptly induced a typical early reaction in the skin at the point

(1) Cor. Bl. f. schweiz. Aerzte, Vol. 44.

of inoculation. In his first communication on the subject he reported constantly negative results in eighteen varicella cases and constantly positive in nine variola cases. He here brings his report down to date with seven new cases suspected to be smallpox. The reaction was positive in five, and the course of the cases confirmed the assumption of variola, while the negative reaction in the other cases likewise was proved correct by the further course. The test inoculations were made on three healthy adults, himself, his wife, and his sister-in-law.

To render the secretions harmless, he heated the lymph to 60° or 70° C. for five minutes before applying it to the three minute scratches on the arm, or treated it with carbon-dioxid snow or with ether, or with all three. If a harmless substance, like a tuberculin, could be prepared to use, this would be better, but too much time would be lost. He obtained a positive early reaction with the variola lymph after keeping it for eleven months in one case. A few cases are described in which everything seemed to indicate smallpox but this negative local reaction, and on this he based his diagnosis and allowed the patient to stay at his hotel, thus saving all concerned great annoyance and trouble, and the course of the case confirmed that it was not smallpox, but either varicella or an atypical erythema multiforme. Public health officials might test themselves with varicella secretions to learn whether they are especially sensitive to it. If not, they can feel confident that they will be able to differentiate variola in its earliest stages by the above technique. He gives an illustration of the typical positive and negative findings.

The Duty of the Government in Leprosy Care and Control. The modern interest in leprosy was excited in the decade between 1880 and 1890, governed largely by the announcement of the discovery of the leprosy bacillus by Hansen, in 1879, and by the death of Father Damien in the later eighties.

Impetus was given the study of leprosy, I. Dyer[2] says, by the immense work undertaken and completed by the

(2) Trans. Sec. Derm., A. M. A., 1914, p. 39.

British government in India and embodied in the report of a special commission, promulgated in 1890.

Many other governments grew active and the Berlin conference of 1897 was the direct outcome. Representatives of all important lêprosy centers were there, as well as delegates from countries casually interested. The findings of that conference were important. Not only was leprosy declared contagious, but it was also considered so important in the economic relations of governments as to occasion especial recommendation of isolation "in all countries where social and legal conditions permit."

As special action covering this phase of the control of leprosy, resolutions were adopted, without a dissenting vote, covering isolation, to-wit:

1. All cases of leprosy should be reported, and this should be made compulsory.
2. Each leper should be isolated.
3. Every government must recognize the necessity and the method of effecting isolation, under its own social conditions.
4. That it be recommended to every government that isolation is necessary to prevent the spread of leprosy, and that the health authorities be authorized to act under the regulation of civil and national assemblies.

The response to the deliberations of the Berlin meeting was widespread, and renewed effort was made by most civilized countries to investigate leprosy and to provide for its control. Among the few countries which ignored the findings was the United States.

Twice in the last fifteen years the United States Public Health Service has been authorized to make a leprosy survey in this country.

The first report of 1902 submitted 278 cases as the result of the commission's work. Of these cases, 155 were from Louisiana alone. The remainder came irregularly from other states, where no general system prevailed for the care of leprosy or of its notice.

The second report, in 1912, showed practically the same results.

The mere compilation of state records and of current periodicals showed that neither of these official reports was of any statistical value.

Since 1894, the Louisiana Leper Home alone has cared for nearly as many lepers as the Public Health Service statistics showed for the whole United States. The leper home has had a gradually increasing population, now numbering nearly 100 inmates. Texas has a number of cases, known to be as many as twenty-five or thirty, and estimated at twice that number. Florida has a number of cases also. There are cases in Mississippi and Alabama, and in all these states the great majority have originated in the state in which the disease has been recognized. California has had about thirty cases under control for many years. New York City has many cases—more reported in the journals than in all other sections put together; in New York the number is usually estimated at more than 100. Massachusetts has enough cases to have demanded an isolation hospital for them. Other states have noted cases, as Oregon, Minnesota, Michigan, Pennsylvania, Iowa, Wisconsin, Missouri, Ohio, and Indiana.

The disease is widespread and without much hindrance or control. The easy entrance of these cases from foreign countries is evident in the clinics in New York City, as reported at the various dermatologic societies. In the winter of 1911-1912, at a meeting of the Academy of Medicine, seventeen cases were shown; among them not more than two or three were native-born, the rest coming from Central America, the West Indies or Continental Europe. At a clinic on the day of that meeting, several cases of extreme types were shown; all the patients were foreign-born.

The indifference of many states is in strong contrast with the hysteric activity of others. In New York the leper goes about freely, visiting the clinics, and often remaining as an inmate in a general hospital. Some lepers are confined on Blackwell's Island, but too few to be significant of any public health effort. The states of West Virginia and Maryland a few years ago struggled with one another to see which could be more

medieval in the handling of a Syrian leper. The case of the soldier Early is still an acute problem in the case of leprosy. It will be remembered that his final allotment to government care quieted popular clamor. Texas has passed laws which could not be enforced because of popular prejudices.

In Louisiana the law is adequate, compelling the report and confinement of lepers; but they abscond to another state as soon as they learn what their disease is.

The knowledge of the existence of the Louisiana Leper Home has made it the asylum for lepers from other states and even other countries, in spite of the fact that the law is specific in restricting provisions to Louisiana residents. There are many ways of subterfuge. The growing tax on Louisiana will be an obvious object-lesson to other states as soon as the provision for leprosy control is demanded by the incidence of the disease. Meanwhile no state has as yet solved the problem of leprosy control, and the disease grows annually in its spread and in its numbers.

The federal government until now has been apathetic to this question. It might be properly urged that leprosy, like tuberculosis, syphilis, pellagra, or smallpox, is a question of state administration under local health authorities. But the government has taken direct interest in some of these things, even at home. The stronger opposing argument, however, is the attitude of the government abroad.

Leprosy is a matter of such direct concern to the United States in the Sandwich Islands, Porto Rico, the Philippines, and even on the Island of Guam, that in each of these territorial divisions there are large provisions for leprosy. The Philippines are provided with several asylums; the Sandwich Islands conduct a model leper colony for less than 500 inmates, and appropriations are constant for the care of this asylum. More than this, only a few years ago as much as $250,000 was appropriated for the study of leprosy at Molokai.

Good work in the study of leprosy has been accomplished by Brinkerhoff at Molokai, and Heiser and

Clegg at Manila, but with the very limited opportunities afforded in this country more has been done in treatment and care than in the colonies. The influence of climate has been observed in Minnesota; the treatment now most used in this country originated at the Louisiana home. The study of leprosy transmission to monkeys, fish, and cold-blooded animals was elaborated by the laboratories of Tulane. The cultivation of the accepted bacillus of leprosy was furthered in this country, and at least one of the modern vaccines was originated in this country.

How much more could be done with governmental control and governmental opportunity, coördinating the many men available in the United States for such work.

This is a problem of national interest and importance and it only needs concentrated effort to solve it, which means permitting proper methods.

As yet, no great effort has been made to control leprosy in the United States. The foci of the disease are already recognized at all the four points of the compass—Minnesota, New York, California, Louisiana, and Texas The sporadic cases in the states in the middle territory show the signals of new areas of infection. Each seaport at present is a ready medium of new cases as quarantine of leprosy is administered, and once admitted the regulations of local and state boards of health are not adequate in provisions or enforcement to check the ingress by a proper notification to federal officials charged with the quarantine enforcement. Those who have been persistently militant in the demand for national control of leprosy are repeatedly subjected to the charge of hysteria in their ideas of the dangers of leprosy. Such attacks are engaged in by men to whom leprosy is an exotic disease, rarely observed, and to whom no economic, sociologic, or domestic phase can appeal. The disruption of a family through the occurrence of leprosy in the breadwinner; the horror of public condemnation of the unfortunate attacked by the disease; the notice of fresh outbreak in the same family, all are forceful arguments to one who knows the habits of the disease and the

possibilities of the outcome. While leprosy is slowly contagious and probably mildly contagious, its usual horrors argue the danger of neglect. With probably 500 known cases to-day, how many will there be in two years, if there is no control?

In 1900 a bill for a national leper law was introduced at the Fifty-sixth Congress by Mr. Raynor of Maryland. Its provisions generally contemplated a response to the Berlin Lepra Conference. A commissioner on leprosy was projected, to coöperate with state boards of health. A reservation in Yellowstone Park or other suitable place was suggested, with an appropriation of $50,000 for the erection of suitable buildings. The bill carried provisions for the apprehension, observation, and control of the individual leper, in and out of the national asylum, which should be open to all lepers in the United States. Provision for regulation of entrance or transportation of lepers from foreign countries and territories, was also made. It was intended that the asylum should be in charge of the U. S. Public Health Service. This bill died in committee.

In April, 1913, at the first session of the Sixty-third Congress, Mr. Lafferty introduced House Bill 1751, providing for a national leprosarium. The text follows:

"Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled: That the Secretary of the Treasury be, and he is hereby, authorized and directed to establish a national leprosarium in the United States or any of its insular possessions, the location thereof to be decided upon after proper investigation by the Surgeon-General of the United States Public Health Service, subject to the approval of the Secretary of the Treasury. The Secretary of the Treasury shall have power to acquire, by condemnation or otherwise, a suitable site for the leprosarium, and shall erect thereon all necessary buildings and thoroughly equip the same for the proper care and treatment of lepers confined therein, and for the investigation and study of the disease of leprosy.

"Sec. 2. That the Surgeon-General of the United States Public Health Service shall appoint all medical officers, assistants, surgeons, pharmacists, and other necessary employees, and shall promulgate and adopt, subject to the approval of the Secretary of the Treasury, all necessary rules and regulations to carry this act into effect.

Sec. 3. That, under authority of this act, any state or territory

of the United States is authorized to transport all persons afflicted with leprosy found therein to the leprosarium, and the Surgeon-General is directed to receive the same, such transportation charges to be paid by the United States.

"Sec. 4. That there is hereby appropriated, out of any money in the treasury not otherwise appropriated, the sum of ..... for carrying this act into effect."

This bill has been before Congress over a year. A recent reading of the bill was noted in the press, but unless more interest is excited it will likely go the way of the first attempt.

Recommendations. The Lafferty bill should become law and the provisions for leprosy isolation should be adequately undertaken at once.

The institution of a leper colony should carry with it all of the necessary details for the proper care of the patients as well as for the study of the disease.

The cases should be grouped according to their type and stage. Terminal cases should be separated from recently developed cases. An infirmary should care for those with complicating diseases. Single rooms are better than wards, and these should be arranged with ample ventilation—as nearly open air as possible. Frame buildings are more desirable than other structures, as they may be easily destroyed or renewed should this be desired. The walls, ceilings and floors should be of such material as to permit frequent fumigation. Men and women and children should be separated in any colony, provision aiming at final cure.

All hospital plans should look out for the provision for bathing facilities, hot water especially.

No matter what experimental treatment may finally attain, accepted methods should be systematically followed.

The first and most important thing is to have a national asylum established. Then its opportunities should be broadly offered to all students of the disease.

The hospital facilities should be of such a character as to attract the leper who wishes treatment and care. The general public should know early that the national leper home is not for compulsory detention, but for the care and possible cure of the disease.

Melanotic Pigment of the Epidermis. Kreibich[6] finds that the conversion of lipoids into melanin is a function of the epithelial cells known as melanoblasts. These are recognized by the loss of protoplasmic fibers; by the round, oval or dendritic forms and by the lipoid content of the protoplasm. They are found chiefly in the basal-cell layer, and are considered by Kreibich not as mesodermic pigment cells, but as epithelial cells which have become changed in their form and function by some influence. It is probable that any epithelial cell may undergo such a transformation. These are the cells of the Paget carcinoma, the nevus, and the melanocarcinoma. In the development of the pigment there are two components, the lipoid and the melanin, which vary in amount and duration of the formative stages, depending on the physiological object of the pigment. The lipoid is double-refracting and sudanophilous. The pigment occurs either in granules or as a crystaloid. The pigment of the hair and retina arise from a lipoid body.

Granuloma Annulare. Although the credit of having first described this affection is usually and properly ascribed to Colcott Fox, who, in 1895, reported a case under the name "ringed eruption," the first case to be found in dermatologic literature is probably the one reported by Radcliffe Crocker a year previously as a case of erythematous lupus resembling lichen planus. Crocker soon recognized his error after seeing other cases, and proposed the name *granuloma annulare,* by which it is generally known at present among English and American dermatologists.

Although the affection is usually described as rare, Graham Little, is an exhaustive paper published in 1908, had collected reports of not less than forty-nine cases, including six of his own, observed by various authors in a period of less than fifteen years; and since the publication of this paper a considerable number of additions to this list have been made by European and American observers. In view of the number of cases now on record, all of them reported within a period of twenty years, it can no longer be properly described as

(6) Arch. Derm. Syph., March, 1914.

a rare malady. In all probability, too, the reported cases by no means represent the frequency of its occurrence, since, owing to the usual complete absence of annoying symptoms and the frequent insignificance of the lesions, many cases doubtless never came under the notice of a physician.

Hartzell[3] has reported five cases. There were four girls and one boy; their ages ranged from 3 to 24 years. All were typical cases except the boy, who presented flat, irregularly shaped, oval, pinkish plaques on the back of the neck, the dorsum of the hand, and the lateral side of the leg. A clinical diagnosis of erythema elevatum diutinum was made. All the patients were in good health, with no history of tuberculosis. Two yielded readily to Roentgen-rays, one to pyrogallol, and the others ceased their visits before treatment was commenced.

Microscopic examination of several of the discrete nodules and a portion of the annular patch removed from the hand of the first patient showed that the pathologic alterations were confined exclusively to the corium. Beginning in the subpapillary portion and extending down to the hypoderm was a moderately dense, fairly well-circumscribed, cellular exudate, composed chiefly of lymphocytes and spindle-cells of the connective-tissue type, with a few polymorphonuclears and some large epithelioid cells. The exudate was densest about the vessels and the coil-glands and their ducts, the cells being especially numerous in the latter situation. Neither giant- nor plasma-cells were seen in any of the many sections examined. The most striking feature, however, was an area of necrosis occupying the central part of the exudate, from which all traces of cell-elements had disappeared, and about which were numerous oval and spindle-cells arranged in radiating lines. This necrotic area was present in every section of every lesion examined, the area involved being apparently in proportion to the age of the lesion, since in lesions a few weeks old it was quite small. The elastic and collagenous tissues were apparently but little affected except in the areas of necrosis, where the former had entirely disappeared and the fibers of the latter had lost their sharpness of outline, were granular in places, and stained poorly.

(3) Trans. Sec. on Derm., A. M. A., 1914, p. 27.

Sections were also made and examined of the plaque on the back of the hand of the patient in whom a clinical diagnosis of erythema elevatum diutinum had been made. The most cursory examination of these sections showed that the histologic features of the lesion were practically the same as those observed in the ringed lesions of the first case; there were the same perivascular and periglandular cellular exudate composed of round cells and spindle-cells, and the same central area of necrosis, although this was much less in extent than in the sections made from the first case, owing doubtless to the much shorter duration of the lesion, which was only a few weeks old. There was one notable difference, however, and that was the presence of many small mast-cells, a variety of cell not seen at all in the first case.

A case reported by Rasch and Gregersen, in 1909, was regarded by them as a new type of sarcoid tumor; and Galewsky likewise described the case, which he reported in the third fasciculus of the *Ikonographia Dermatologica*, with an excellent colored portrait, as benign sarcoid tumor of the skin. Later observers, however, are practically in accord in rejecting this view of the character of the affection; indeed, its histopathology leaves but little doubt that it is in no way related to the malady described by Boeck as sarcoid.

Graham Little is strongly of the opinion that it is in some way closely related to tuberculosis, but the evidence which he presents in support of this opinion is far from conclusive. In only four of the forty-nine cases, reports of which were collected by the author—or in five out of fifty, if we include a case presented later at a meeting of the Dermatological Section of the Royal Medical Society—was there a history of tuberculosis in the patient's family, and in but a single instance did the patient himself present signs of tuberculosis.

The observations of Wende, Graham Little, and the author seem to indicate that the so-called erythema

elevatum diutinum of Crocker is simply a clinical variety of granuloma annulare; histologically, there is no essential difference between the two affections.

As to the essential nature of this curious malady, little or nothing definite is known. The objection which has been made to the name "granuloma annulare" that it is not a granuloma is apparently supported by its histopathology, which is much more that of a connective-tissue neoplasm than of a granuloma. Some observers, it is true, have found plasma- and giant-cells, usually in very small numbers, but this finding is decidedly the exception rather than the rule. Halle thinks it a chronic inflammation of the middle and deep portions of the corium, while Dalla Favera believes it dependent wholly and alone on the blood-vessels. None of these views, however, explain in the least the peculiarities of the neoplasm. As to its etiology, even a reasonable conjecture can not be given.

Lupus Syphiliticus. This term was first applied to a syphilitic lesion which strongly resembled lupus vulgaris. The skin of the nose in more or less degree is reddened, swollen and superficially ulcerated. It may, as in lupus vulgaris, attack the upper lip. The ala nasi, the site of predilection of lupus vulgaris, is likewise involved, and may lead, in healing, to a defect.

This disease appears, as the literature and the following case reported by Heinemann[4] would indicate, to be rarely recognized. In the *Münchener Medizinische Wochenschrift*, in 1910, two cases, in a mother and daughter, were reported. The patients were treated for years without result. Before a correct diagnosis had been made, the mother lost her vision. Such cases show the importance of a recognition of the etiologic factor.

Heinemann's patient was a woman of 42. The condition had existed for seven years, and had been treated by a great many medical men, with all the usual antilupus remedies, but with no improvement. The whole nose was involved, in places it was swollen and reddened, and in others covered with white scars. There were ulcerations on both alae nasi, and on the bridge,

(4) Berlin klin. Wochenschr., September 7, 1914.

resembling those of lupus vulgaris. They were flat and had a granular appearance. One, about 1 cm. in diameter, was sharply outlined, and with somewhat of a punched-out appearance. The inside of the nose was crusted, and far back was a perforation of the septum. Removal of the crusts caused but slight bleeding.

The resistance of the lesions to long-continued antilupus treatment made the diagnosis plain. In six weeks, with antisyphilitic treatment, Heinemann accomplished what a number of others had failed to do in six years, namely, complete healing of the lesions.

A New Variety of Congenital Dystrophic Pemphigus. In spite of much recent work, the question of the congenital dystrophic dermatoses still remains obscure. Three interesting cases, reported by Nicolas, Moutot and Charlet[5] have some characteristics of a congenital pemphigus with a cicatricial tendency. Three children of the same parents, aged 18 months, 4 years, and 15 years, were affected. The lesions were essentially characterized at the beginning by a vesicular or bullous lesion, which eventually gave a chronic, trophic, ulcero-vegetating lesion. The lesions were constantly associated with onychial dystrophy, and a laryngeal stenosis, which was due to a true cicatrization of the mucous lesions, similar to that of the skin.

The congenital and familial characteristics, the bullae at the onset of the eruption, and the constancy of the onychial dystrophy, allow of a classification with the dystrophic form of congenital pemphigus. But the ulcerative evolution and the persistence of the lesions make the disease a separate entity, thus creating a new clinical variety of congenital pemphigus.

Pemphigoid of the New-Born. H. N. Cole and H. O. Ruh[7] reported an epidemic of nine cases of "infantile pemphigoid" (pemphigus neonatorum). From the unbroken vesicles they isolated *Staphylococcus aureus* in all the cases. There was a fatal termination of one case, apparently due to a staphylococcic septicemia.

The epidemic was started from a typical case of

(5) Ann. de Derm. et de Syph., Vol. 4, p. 385.
(7) Trans. Sec. on Derm., A. M. A., 1914, p. 299.

pemphigoid of the new-born, which later changed into a clinical picture of dermatitis exfoliativa neonatorum (Ritter); and as the etiological factor is the same, the authors believe that no distinction should be made between them. Impetigo contagiosa *seu* vulgaris *seu* bullosa (streptogenes), however, should be sharply differentiated from infantile pemphigoid because of its different bacteriologic origin.

They believe that the disease should be reportable, for the reasons that it is readily transmitted, and has a high mortality (from 25 to 50 per cent.).

Their results with the use of autogenous vaccines were good.

Skin Lesions in the American Negro. From his personal observation of 2,000 cases in the Johns Hopkins Hospital and the Freedmen's Hospital in Washington, D. C., Hazen[6] concludes that mulattoes suffer more severely from skin diseases than do full-blooded negroes. The following diseases are more prevalent among negroes than among whites: dermatitis papillaris capillitii, keloids, dry seborrhea, syphilis, tinea tonsurans, urticaria, and vitiligo.

The following diseases are less prevalent among negroes: alopecia areata, cancer, dermatitis actinica, acute eczema, erythema multiforme, furuncles and boils, angiomata and nevi, pediculosis capitis, psoriasis, rosacea, sycosis vulgaris, tinea cruris, and xanthelasma.

Anemic Erysipelas. Although Czyhlarz[7] searched the literature carefully he was unable to find any mention of a case similar to the three he reports.

A girl 16 years old was seen with a swollen face and a high fever. The swelling suggested that of nephritic edema, but the swelling was limited to the nose, the eyelids and the cheeks, and the urine was free of albumin. The following day the swelling had increased in area. The subjective symptoms were merely a feeling of tension. The temperature reached 40° C., and the white count 25,000. On the third day the other cheek became involved in a similar manner. On the fourth day the

(6) Jour. Cut. Dis., October, 1914.
(7) Berlin klin. Wochenschr., June 8, 1914.

temperature fell to normal and remained there. Marked scaling followed, which ceased at the end of a week. Ten days later, the patient had a chill, and the fever mounted to 39° C. There was a return of the swelling on the nose, lasting two days, after which the temperature again fell and scaling of the areas recurred. Two other somewhat similar cases are described.

Changing Views on Pellagra. When the unusual frequency of pellagra in various sections of this country awakened general interest in the disease, says I. Dyer,[8] an almost universal opinion prevailed that maize was the cause of the disease. The investigation was directed at the element in corn products which might be held responsible. In the South many persons who had eaten corn in all forms became abstinent so far as this food was concerned.

The prevalence of the disease outside of larger cities and mostly among those living in country districts caused some revision of the earlier views, still, however, entertained among those who studied pellagra at first hand in the asylums for the insane. Perhaps the historical picture of pellagra had much to do with professional opinion. Barring a few of the French observers, the almost unanimous opinion of those who had worked among pellagrins for over two hundred years had been in favor of diseased or immature grain as the casual factor.

The experience with the disease in the United States has thrown several new lights on the question. It is established that the removal of pellagrins to greater altitudes and a cooler climate will ameliorate their condition and often cure them. The study of the epidemiology of the disease around Spartanburg, North Carolina, has pointed conclusively to environmental influences, which provoke a larger incidence among those who are constantly in the house (as the women and children); more than this, the cases are grouped in districts, and the disease has seemed to travel along certain topographical lines. Season has much to do with the frequency of pellagra, as it develops more in summer than in winter;

(8) Jour. Cut. Dis., 1914, p. 111.