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SKIN AND VENEREAL DISEASES

BY

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SKIN AND VENEREAL DISEASES

CHAPTER I.

CONSTITUTIONAL RELATIONS OF SKIN DISEASES.

Pellagra has assumed great prominence in American dermatologic and psychiatric literature. As was pointed out last year,¹ erythema with the acute confusional psychoses of toxemia and exhaustion is not clearly demarcated from pellagra nor is scorbutus in terminal demented and secondary confusional lunatics. Pellagra cutaneous lesions, according to B. Wolff,² are divisible into three more or less marked periods or stages, a stage of erythema or dermatitis, of desquamation and pigmentation and a stage of atrophy. Of these stages the first is the most distinct, the last the most characteristic. The erythema exists alone, pigmentation, desquamation and atrophy coexisting to a greater or less extent.

The stage of erythema may occur at any period in the course of the disease, either early or late. As a rule it makes its appearance in the spring, but may occur at any other time. It manifests itself as a mild erythema or a severe dermatitis with the production of blebs, followed by crusted lesions which heal, forming bluish discolorations. In the mild form there is a bright or dark red eruption affecting chiefly the exposed parts of the body, the hands, wrists, face and lips, though more extensive areas of the body may be primarily involved or be invaded by secondary extension. The erythema may or may not disappear on pressure, depending upon the relative degree of congestion of the skin. In some instances the erythema is rather irregularly distributed, occurring, for instance,

(1) PRACTICAL MEDICINE SERIES, IX, 1908, p. 31.

(2) Amer. Jour. of Derm., August, 1909.

on the forehead, between the brows, on the lips, but not affecting the cheeks or neck. In others there is a continuous sheet of redness, involving the localities of predilection. In the severe form of dermatitis the resemblance to an acute erythematous eczema is fairly close. Small bullæ and vesicles may appear at the height of the eruption, and drying, produce thick scales or thin crusts and leave the skin rough, ragged and discolored. The subjective symptoms of this stage may consist in moderate itching and burning or a sense of chilliness if the eruption is extensive. These symptoms are not nearly so well marked as in eczema of a corresponding degree of intensity. The erythematous stage does not bear a very close relation to the character of the general symptoms as the latter may be severe and the former mild or *vice versa*. The personal equation seems to be concerned in the number of attacks of the eruption and their relative severity. A good proportion of the patients gave the history of having had but one outbreak of erythema, and that at an advanced stage of the disease, while others had been subject to vernal appearances of it for a very long time. Though capricious in its appearance, the rash is prone to be associated with lesions of the buccal, vaginal and probably also the gastrointestinal mucosa. With the implication of the alimentary tract, the general symptoms become aggravated and the health declines rapidly. The same cause being generally active, the skin lesions are apt to manifest themselves simultaneously with the implication of other systems, digestive and cerebrospinal. When the erythema involves the mouth cavity, the mucosa becomes bright red, glazed and tender; the lips are scarlet, as though painted, and dry and glistening. The vagina is similarly affected, though there is not so much dryness as in the mouth; rather a tendency toward a leucorrhœal discharge. The duration of the erythema is variable, lasting from 10 days to 6 weeks before giving place to the desquamative event.

The stage of desquamation follows upon the precursory erythema and varies directly in intensity with it. The scales are large and thick, especially upon the fingers and lips, or fine and branny. The skin beneath is red and shining, dull pink or bluish in hue, gradually assuming

a more normal aspect, but never quite taking on the natural tone of the sound skin.

The pigmentation resembles that following sunburn, but at times is much darker. The buccal and vaginal cavities are frequently denuded of epithelium and become dry, glazed and sensitive. Occasionally patches like mucous patches occur in the mouth and vagina, and petechia-like plaques are seen at the commissures of the lips. The palms of the hands share in the desquamation, but the nails appear unaffected even after repeated eruption.

The subjective symptoms are not marked. A number of patients complained greatly of burning of the soles of the feet, though they were apparently not involved. Painful fissures may appear at the interdigital web, and lips, particularly the lower, may become dry, stiff, chapped and painful. The pigmentation occupies the seat of the antecedent erythema and desquamation, and as a rule is much more distinctly marked about the dorsum of the hand and wrist than elsewhere. It is sharply defined and resembles the discoloration following a slight carbolic acid burn. The pigmentation about the face is not marked, but in some instances the skin is dusky and shows a fine scalliness, giving it a crêpe-like appearance. The desquamation is uniform, not patchy. The duration of this stage is very irregular. It may last a few weeks or many months.

The atrophic stage is, perhaps, the most distinctive feature of the cutaneous involvement of pellagra. It coexists with pigmentation, and as a rule is limited to the hands. The skin becomes exceedingly dry, withered, shrunken and shriveled like that of one long dead. The palms are thickened, even tylotic, the lines being much deepened. The hand is held in a semi-flexed position and has the appearance of having been frozen. Sweat secretion is absent and sensitiveness is much below the normal. This condition was always noted in patients during the terminal stage of the disease. It does not necessarily proceed from the repeated attacks of the eruption, for it was observed among several who had had but one attack of the erythema. It is indicative of a high grade of infection and of an exhausted resistance. The etiologic factor is here, as usual, not taken into account. The fact that all these lesions

may be mimicked in the insane and neurasthenic by other states, renders determination of the mouldy maize causation a necessity. Ergot, as Siemanns¹ has shown in an investigation of ergotism epidemics, will produce similar states to pellagra, but the dermic phenomena will be in the background while epileptiform mental and convulsion states are predominant. Metabolic disorders like scurvy, resultant on neurasthenia and insanity, predispose to changes in skin and nerve associations.

Diagnosis of erythema pellagrosum is best made from the associated symptoms. Taken alone in the earlier stage it is indistinguishable from the commoner forms of erythema, dermatitis and erythematous eczema. With the advent of the pigmentary and atrophic stage, there should be no difficulty in recognizing the disease. The concomitant symptoms consist in various neurasthenic disorders, loss of flesh, of appetite, depression and diarrhea. Given a patient with a history of periodical outbreaks of a rash affecting the exposed surfaces and accompanied by depression, diarrhea, weakness and loss of flesh, the diagnosis of pellagra is pretty safe.

Agricultural Aspects of Pellagra in the United States. According to C. L. Alsberg,² pellagra is caused by the consumption of spoiled Indian corn by poorly nourished and badly housed individuals. The tendency of the farmer is to harvest his corn before it is fully ripe, and this promotes the tendency to disease in the grain. Moreover, a most important factor is the present faulty method of transportation in bulk. The grain of corn is a live thing. It breathes, consumes oxygen, and gives off CO₂ and heat. The latter increases sufficiently to create ideal conditions of temperature and moisture for the growth of fungi. Corn shipped to the Northeast will have the tendency to ferment checked by the colder climate; if sent South the reverse effect follows. The avoidance of moisture in bulk transit is the thing desired. It is to the interest of the farmer to sell corn with as great a moisture content as possible, for such corn is heavy and will average more bushels to the acre than after proper drying and curing.

(1) Arch. of Psych., B. XII.

(2) N. Y. Med. Jour., July 10, 1909.

When it is loaded into cars it straightway heats up, ferments and spoils, often before it reaches its destination. The dealer who receives such corn naturally often succumbs to the temptation of mixing it with enough good corn so that meal made from the mixture will not be offensive to the taste or smell. The amount of spoiled corn used in this way is very great. The only means to combat this evil is to induce purchasers of corn to pay for it according to its moisture content. The remedy is to cause the corn to be thoroughly dried before transportation.

Eugene D. Bondurant¹ states that pellagra is a toxemia due to eating fermented or damaged corn meal, resulting in gastrointestinal symptoms, with mental changes in the nature of insanity, which cause the patient to be placed in an insane hospital. The disease is more frequent than has been thought in this country, and especially among negroes. The clinical picture of the disease is definite and characteristic, and having been once seen is easily recognized. The skin is affected with an erythematous eruption on face, hands and joints. There is salivation, gastric and intestinal irritation and diarrhea. The nervous symptoms are those of toxic irritation of the cortex and spinal cells.

Leprosy. *Leprophobia.* Considering the exploitation of leprosy for purposes of advertisement by pseudoexperts in leprology it is hardly surprising that the *Medical Record*² should doubt that there is a science of public health. When health officers in several states became hysterical when a leper escaped from his place of unjust confinement a few years ago; when the officials of another state make prisoners of a retired army officer and his wife because one of them was alleged to have leprosy; and now when a man, whom competent authorities have declared not to be a leper, is imprisoned in the capital of the country because he inquired of his physician if possibly he had leprosy, we wonder whether there is a science of public health. This last mentioned case, in which public interest has been aroused by the recent examination of the victim by a well known dermatologist of New York City, seems to call for

(1) Medical Record, Aug. 21, 1909.

(2) Medical Record, July 19, 1909.

some comment, for it presents a peculiarly flagrant instance of official cruelty inspired by unreasoning fear.

The case is as follows: A man, aged 36 years, born in North Carolina, living there most of his life, served 9 years in the army, about 2 years in the Philippines and a short time in Cuba; in neither of these countries did he see a case of leprosy nor ever hear it mentioned. In June, 1908, he went to work in a pulp mill where he came in contact with a certain liquid made from "black ash," which is very poisonous and irritating. The hands became inflamed, then the face and later the feet. There were a dozen or so in the mill who were more or less similarly affected. On August 18 he went to Washington, D. C., to get relief from the distressing inflammation of the skin. According to his statements the hands and forearms were greatly swollen and also the face, so that the eyes were almost closed; the feet and lower legs were also acutely inflamed. As the physician to whom he had applied was examining him, the patient innocently and foolishly remarked, "I wonder if I have leprosy." The hint was taken and the case referred to the health authorities. The inspector is said never to have seen a case of leprosy, but accepted the patient's interrogative diagnosis, after a hasty examination, and called in another physician who had seen some leprosy many years ago; the latter regarded the case as "strongly suspicious." He excised a portion of the inflamed skin from the forehead and reported the finding of bacilli, "corresponding morphologically with those of leprosy." On this evidence the man was quarantined and has been kept a prisoner since August 21, 1908. So far as can be learned, no further attempt was made to establish the diagnosis, and until the arrival of L. D. Bulkley, of New York, May 9, 1909, no one well acquainted with diseases of the skin had ever examined the patient, although there are numbers of men in Washington perfectly competent to determine the nature of the trouble. At the first visit of Bulkley, the patient was stripped and the case was studied for an hour and a half. On May 30 another similar study of the case was made for three-quarters of an hour. At both of these examinations pieces of skin were punched out and were placed at once in abso-

lute alcohol, most carefully stained, and examined by many pathologists, among them William H. Welch of Baltimore and William H. Park of New York. Absolutely no sign of leprosy was discovered, certainly no leprosy bacilli. A third visit was made June 6. There were then absolutely no signs of leprosy on the face; the nose was aquiline, the lips and ears normal and there were no lesions within the nose or mouth.

Analyzing this case, the *Medical Record* denies the slightest ground for even guessing that the man had leprosy. He went to Washington with an acute inflammatory dermatitis, caused by a vegetable poison and of only 5 or 6 weeks duration. Leprosy would have taken as many years to have involved an equal area so severely. During his imprisonment all this has slowly disappeared, the cause being removed. The whole case seems to be one of official overzealousness, but the excess of zeal is in danger of becoming something worse by the action of the health officer in placing every possible obstacle in the way of the man's freedom. The officials of the New York Health Department have said in writing that he would be admitted here, as, "for some years past the Board of Health of this city has considered that leprosy in this climate is not of so infectious or contagious a nature as to require segregation." The New York Skin and Cancer Hospital has written that the patient "will be admitted to the wards of this hospital whenever he may come," adding "We have had many cases of true leprosy in the hospital, often for considerable periods of time, dating back 20 years, and have never seen reason to fear the disease"; yet the Washington officials not only did not discharge him from custody but doubled the guard around his place of confinement. Even assuming that Bulkley is mistaken, and that the man is really a leper, which, in view of the gradual disappearance of the dermatitis, is scarcely possible, there is absolutely no excuse for depriving him of his liberty.

Leprosy Bacillus and Vaccine. In a paper read before the Philippine Islands Medical Society, M. T. Clegg¹ reports cultivating leprosy bacilli from cultures taken from the spleen of lepers on necropsy. He has succeeded in cul-

(1) *Medical Record*, Aug. 7, 1909.

tivating the bacilli from cultures taken from the ear of live cases, and the technic has been verified so frequently that there can be little doubt that leprosy bacilli are actually grown. A vaccine has been made from these cultures which, when injected into leprosy persons, produces a most pronounced reaction in the leprosy lesions.

Lepra Tuberosa Mimicking Sarcomatosis is reported by J. Kingsbury¹ in a 26-year-old native of Courlander, Russia. Leprosy is endemic there. Six years previous to coming under treatment he had pleurisy. Health was otherwise good. There was no evidence of syphilis. In May, 1906, he noticed that at night his legs would often be swollen. There was no pain, but he had occasional chills. The swelling of the legs increased and persisted for nearly 3 months. About this time lumps began to appear above the shins. At first they were small and few in number, not more than half a dozen. These gradually increased in size, however. Soon new ones appeared on the calves and thighs. Later the arms and forearms became affected, and about 9 months ago a single nodule appeared on the forehead. There had been diminished sensation in the arms and legs for nearly one year. In June, 1908, the man had an acute leprosy exacerbation. There was moderate fever, the lymphatic glands became enlarged, and the left leg was red and swollen. He was admitted to Bellevue Hospital and remained in the erysipelas pavilion for over 2 months. He came under Kingsbury's care shortly after his discharge from Bellevue. He then weighed 125 pounds and was about 5 feet 7 inches in height. He had light hair and the skin on unexposed and unaffected parts was very fair. He was not very well developed, although wiry and fairly strong. There was general though moderate adenopathy.

Physical examination showed the heart and lungs to be in normal condition, and no enlargement of the spleen was made out. No reaction was obtained from the conjunctival tuberculin test. This was employed because marked reactions have been frequently reported in nontuberculous leprosy after injection of tuberculin. Urine and nasal secretions examined for leprosy bacilli gave negative results.

(1) N. Y. Med. Jour., Oct. 16, 1908.

The cutaneous lesions varied in size from papules the size of a pin head to flattened tumors $\frac{3}{4}$ inch in diameter. These were soft and reddish brown in color. There were nearly 40 nodules that were about the size of a split pea on each of the upper extremities. The larger number of these lesions was found on the extensor surfaces. There were about 60 similar nodules on each thigh and probably half of this number on each leg. Several papules on the soles resembled those seen in syphilis. There was a tubercle on the forehead about $\frac{3}{8}$ inch in diameter. It was soft and velvety, but showed slight telangiectasia on the surface. This was the only lesion on the face. On the arms and thighs were numerous minute yellow papules. These for the most part were closely aggregated and many had coalesced. Quite a number of these papules had invaded an old vaccination cicatrix on the left arm. The trunk was free of lesions. There were superficial scars on the right elbow and left thigh, the result of recent trauma. On the legs there were numerous dark pigmented areas that showed the site of previous nodules. Right leg showed slight swelling, and the skin was shiny and bluish red in color. The left leg is now apparently of normal size.

The ulnar nerves were but slightly thickened and there was no contracture of any of the fingers. Peroneal nerves were a little enlarged, but the great auriculars seemed normal. There were but a few areas of complete anesthesia, although sensation was diminished in the forearms and legs. Several areas on the back showed hyperesthesia.

There was no seborrhea of the scalp, but the hair was dry and thin. Probably half of it had been lost. The beard was scanty and the eyebrows, particularly at the outer third, were exceedingly thin. There was hardly any suggestion, however, of the characteristic facies of the disease. Microsections of a nodule excised from the forearm showed large masses of lymphoid and epithelioid cells with many large giant cells. With stained bacteria, the giant cells and many epithelioid cells were seen to be crowded with leprosy bacilli.

The Nose in Leprosy. W. R. Brinckerhoff and W. L. Moore¹ state that within recent years it has been main-

(1) N. Y. Med. Jour., Sept. 4, 1909.

tained that the nasal septum is frequently the site of the earliest lesions of leprosy and that in the secretions of the nose the bacillus of the disease is most likely to be found at an early period. When it is not practicable to make a complete physical examination of all individuals of a class suspected of leprosy, the examination of the nasal septum and the bacteriologic examination of the nasal secretions will prove of value by permitting the recognition of the most dangerous type of the disease, and is therefore worth while even if it does not reveal all cases of the disease in those who came under observation.

Leprosy in the United States. According to B. A. Penrose,¹ the Leprosy Commission of the Marine-Hospital Service obtained official information of 278 cases of leprosy in the United States, 73% of which were at large, and only 72 provided for by the states or cities in which they were located. One hundred and forty-five were born in the United States, 120 in foreign countries, and 13 were of unknown origin. They claim that many were infected in the United States. Twenty-two of the cases came from Norway, 11 from Iceland, 8 from Sweden, 12 from Germany, 12 from the Bahamas, 6 from Cuba, 4 from other West Indian islands, 3 from Mexico, 6 from Ireland, 3 from England, 3 from France, 3 from Italy and one from Spain.

Considered from the standpoint of the states in which they were found, Louisiana furnished 155; California, 24; Minnesota, 20; Florida, 24; North Dakota, 16; New York, 7; Illinois, Missouri and Mississippi, 5 each; and other states a lesser number or none at all.

Tuberculosis. K. von Ruck² reports that a patient admitted to his sanatorium had an irregular *tubercular ulceration upon the left labium* which had existed several months prior to admission. The patient refused to have it curetted. The ulcer reacted locally under tuberculous treatment and healed.

Skin Hyperalgesia and Pulmonary Tuberculosis. According to W. C. White and K. H. Van Norman,³ hyperal-

(1) Marine-Hospital Reports, 1908.

(2) Wingate Sanatorium Reports, 1909.

(3) Arch. of Int. Med., July, 1909.

gesia to pain, heat and cold sensations is present over active pulmonary tuberculosis, corresponding closely to the pulmonary distribution of the disease. It depends upon the involvement of the lung and not of the pleura. With arrest of activity, it disappears.

Variola. I. R. Baueroff¹ analyzes the initial stage of 444 cases of variola. The length of initial fever in 74 cases was 4 days; in 231 cases 3 days; in 111 cases 2 days; in 21 cases one day. In 7 cases initial fever did not occur. Of 916 cases the initial symptom was backache in 234; headache in 255; general pains in 107; nausea and vomiting in 175; chills in 122; vertigo in 76; sore throat in 14; cough in 19; menstruation in 10; faintness in 6. While the onset was seemingly abrupt as a rule, in many cases malaise existed for days.

Chill was often the first indication of a disturbance of temperature. Immediately following the chill a rapid rise of temperature took place, and as a rule remained nearly at its original maximum height for about 3 days with very little daily remissions. The drop to normal was sudden as a rule except in the severe cases. This drop was definitely related to the appearance of the eruption so as a general rule the complete appearance of the eruption was accompanied by a complete absence of fever. Pain might be said to be the most constant symptom aside from fever. The pain was more often referred to the head and back, but was frequently general and indefinite. The backache was usually definitely located in the small of the back. Sometimes it was dull but more often acute and steady. It sometimes radiated to the loins and down the thighs. In the more severe cases it often continued after the complete appearance of the eruption and lasted for 6 or 7 days. Sometimes backache was the sole symptom. Headache, which was more frequent than backache, varied from an indefinite feeling of malaise to a severe, agonizing and sharp pain. It was usually more severe than would accompany a similar temperature in other diseases, and was more often localized in the posterior and cervical regions. Often there was severe pain in the upper chest and

(1) Southern Calif. Pract., April, 1909.

between the shoulder blades, and sometimes deep hypogastric pains were present.

The infection acted as a profound intoxication to the nervous system. Even the light cases complained sometimes that they disliked to go to sleep because of the bad dreams that they had. Delirium was sometimes present, and at times lasted through the initial fever. Children sometimes had convulsions and vertigo was often marked, and at times was mistaken for alcoholic intoxication. Syncope in strong and ruddy persons also existed, and in several persons the power of speech was impaired. As a rule marked insomnia existed, but at times somnolence was present and patients were dull and stupid when awake. Cough and sore throat appear as an accompaniment rarely. Epistaxis, at times severe, was occasionally present. The tongue was usually covered with a thick yellow coat and the appetite lost. Nausea and vomiting occurred in many cases. Constipation was the rule. In women, menstruation often took place out of time.

Physical examination during the initial period showed nothing abnormal as a rule. Sometimes, however, splenic enlargement existed, and rarely initial rashes appeared on the parts of the body which were subsequently free from the specific eruption. More often the face was suffused and red until the eruption appeared.

Quinin Erythema. W. Gripper¹ reports the case of a woman known to be very susceptible to quinin who took two-dram doses of a preparation containing one-quarter of a grain to a dram. During the day the rash appeared and spread over the entire body. She was advised to continue with the preparation in the hope that she might become accustomed to it. During the next two days the condition remained the same. The condition was worse at night. She had no headache and practically no eruption on the face. The drug was then stopped. On the fourth day the hands, legs and ankles were greatly swollen, the palms red and shining, while the fingers and toes were stiff, feeling numb and distinctly cold to the touch. Bran baths, etc., gave no relief. By the seventh day desquama-

(1) British Medical Jour., July 3, 1909.

tion began on the hands and arms, extending to the trunk and legs, the epidermis separating in large strips and flakes with almost casts from the toes. During the fourth week, this was completed and the appearance was like that of scarlet fever. Sodium salicylate had similar effects on the patient. There was hence a special idiosyncrasy.

Dermic Disorders in Hodgkin's Disease are discussed by J. D. Bloom.¹ The skin in a few instances becomes the seat of nodular deposits more frequently on the front of the chest and infrequently in the neck and face. These growths take origin in the true skin and show progress by the condition of exudation, of which mention has been made. The subcutaneous tissue contains these growths in great part, and they occasionally become pedunculated. These multiple growths and tissue changes are painless, save the splenic ones, which at times occasion radiating pains in the back over the splenic area.

Hypertrichosis is divided by J. D. Bloom² into the congenital and acquired. The congenital occurs more often in unusual situations. The palms and soles of the feet, the backs of the last phalanges of the toes and fingers, the inner surface of the prepuce and labia majora, glans penis and both upper and lower eye-lids remain free. Hair rarely grows on these parts. The texture of the hair varies in this perversion in the different anatomic parts. The growth is continually toward the coarser and becomes of darker hue until fully developed. It is most coarse in the beard locations. Its direction of growth is usually downward, and in both posterior and anterior portions of the body away from the line of the middle. In this form the teeth are defective.

It may be an excessive growth in locations where it is normally found, or development of hair in regions commonly spoken of as hairless. These parts may be furnished with lanugo under ordinary conditions or with early pubertal hair or be of abnormal development. By heredity alone it cannot be explained, nor by theories of nervous effect, maternal impressions, atavism, fecundation of the female by a hairy animal, etc. An acquired form

(1) Amer. Jour. of Derm., August, 1909.

(2) Amer. Jour. of Derm., February, 1909.

favored by local conditions that determine a congestion to the part must also be recognized.

Hair may exist over the sternum and shoulders in excess. Women have had hair trailing on the ground. This has been met with in women with beards. In the case of an 18-year-old girl the condition, which had existed since puberty, simulated a pair of drawers extending from the waist line to a margin just above both knees in both posterior and anterior aspect. The patient, reserved and modest, had for a time marveled at her condition. The quest for relief was made as an ulterior effort to rid herself of what she had considered a curse.

Hereditary Hemorrhagic Telangiectasit. according to F. M. Hanes,¹ manifests itself in localized dilatations of capillaries and venules, forming distinct groups or telangiectases which occur especially upon the skin of the face and nasal and buccal mucous membranes, giving rise to profuse hemorrhage either spontaneously or as the result of trauma.

Three factors seem of etiologic import; namely, heredity, repeated traumatism, and abuse of alcohol. Of these three factors the hereditary tendency to the disease is by far the most striking and constant. There is no instance of a patient suffering with this affection and having children all of whom were free from the disease. Males and females are affected alike and both are equally capable of transmitting it to their offspring.

Repeated traumatism plays a part in the telangiectases. The ears, the cheeks, the mucocutaneous junction of the lips, the nasal and buccal mucous membranes, the finger tips—these are the sites of predilection and these are obviously the points most subject to frequent slight traumatisms.

In most cases neither positive nor negative evidence of alcoholic abuse exists. Osler's first 3 cases are exceptions. The first 2 were sailors, much given to those alcoholic habits so common in sailors; the third patient came from Kentucky. One patient has many more telangiectases than any other member of his family. He earns a fair wage

(1) Amer. Jour. of Derm., June, 1909.

and "drinks when he has the money." His uncle also had a profusion of facial telangiectases which he, with commendable candor, called "whiskey bumps." The vasodilator action of alcohol upon the peripheral capillaries may be mentioned with relevance in this connection. Upon inspection of the red spots characteristic of the disease it becomes obvious that they are true vascular formations and not blood extravasations. They blanch on pressure and regain their color when the pressure is removed. Those occurring upon the face are very prone to show the typical spider-nevus formation.

Hemorrhage is the one constant symptom of the disease and the source of all other symptoms. It takes in the great majority of cases the form of epistaxis, but this symptom may be entirely wanting. The hemorrhages always originate in telangiectases. Next to the nasal telangiectases those on the lips and buccal mucous membrane most frequently cause bleeding. The hemorrhages are astoundingly profuse; patients describe the blood as spurting from the injured spot. The nose may bleed freely several times each day, and while lay descriptions of hemorrhage are to be taken *cum grano salis*, personal observation upon several occasions has convinced Hanes of the severity of the epistaxis. Secondary anemia follows as a natural sequence of the frequent and profuse hemorrhages, and the concomitant symptoms of palpitation, breathlessness and swelling of the ankles become painfully evident. The hemorrhages produce anemia, the anemia conduces to hemorrhage, and thus a vicious cycle is inaugurated, each symptom playing the double rôle of cause and effect.

Multiple telangiectases constitute the sole characteristic sign of the affection. Their occurrence is most constant upon the nasal and buccal mucous membranes and the mucocutaneous junction of the lips. They have been observed upon the skin of the face, hands and feet, upon the scalp, the conjunctivæ, and once postmortem in the gastric mucous membrane. They begin as dilations of the capillaries, having a bright red color. As they increase in size the venules participate in the ectasia, giving the cutaneous telangiectases a violaceous or purple color. The telangiectases of the mucous membranes are always brilliant red,

The small telangiectases do not project beyond the surrounding structures, but as they increase in size they tend to become more elevated. They never attain to a great size; a split pea seems to represent approximately their maximum development. They are true developmental faults, beginning in early childhood, frequently causing increasing annoyance during adolescence and becoming serious menaces to health toward the evening of life.

The therapeutic indications are clear. Destruction of the culpable telangiectases should be the first consideration. A bead of chromic acid fused upon a probe is an excellent cauterizer and its action can be checked at any time by the application of an alkali. Repeated cauterizations may be necessary, especially within the nose, for here the bleeding frequently takes place from very small telangiectases which are easily overlooked. The patient should be instructed to report for treatment, if possible, each time the nose bleeds, for it is only by the repeated destruction of small telangiectases that one can check the epistaxis and at the same time avoid widespread cicatrization of the mucous membranes. It is futile to treat the secondary anemia so long as the hemorrhages continue. Remove the cause and the effect is readily amenable to treatment.

Pathomimic Scars is a title¹ applied to artificial dermatoses, especially those provoked by the neurotic. Apert and Brac have recently reported the case of a girl of 14 who presented on the left thigh and leg scars voluntarily made by the application of commercial potash (concentrated lye). On the left thigh there were recent scars from the opening of abscesses also voluntarily produced. On the front of the right thigh there was a large, old scar also due to an application of lye. On the lower limbs, the left arm and left mastoid region there existed large scars, either round, linear or keloidal, having the same characteristics as the preceding ones, but it could not be ascertained whether they were artificially produced. This young girl presented no symptoms of hereditary syphilis. Intra-dermo reaction, in her, was clearly positive. She was subject to numerous attacks of hysteria and had diur-

(1) Amer. Jour. of Derm., June, 1909.



PLATE I.

HERPETIC ERUPTION ALONG COURSE OF ULNAR NERVE.

Two photographs taken five days after appearance of eruption; patient, married negress, aged 23; complained of severe pain along course of ulnar nerve twenty-four hours preceding the outbreak. (From the Dermatologic Clinic, Post-Graduate Medical School, Chicago.)

nal and nocturnal incontinence of urine. Her parents were alcoholics and her brother an epileptic.

Dermatitis Herpetiformis with Grave Eye Lesions. Balzer and Sevestre¹ have had a patient who had the painful polymorphous dermatitis of Dühring. The history of the patient furnishes two peculiar facts that are worthy of note. It began subsequent to a mercurial application which had produced a stomatitis. The dermatitis appeared a few days later. In addition to this the patient presented ocular symptoms of such a nature that eye-sight was almost completely lost. There were bullæ on the free borders of the lids, but none on the conjunctiva. At the time of the report he presented a symblepharon that was internal and external as well as bilateral and an opacity of the cornea which interfered considerably with vision. It would appear that attention has not yet been called to these ocular complications of the disease.

Nail Growth. A. M. Bloch² has investigated nail growth. With a sharp file he makes two furrows in the shape of an X, then with wax he takes an impression of the finger and of the nail. This he uses as a mold into which he pours plaster of Paris and thus obtains a model of the finger and of the nail as well as of the furrow that was artificially made. A month later, a new impression is taken and then by means of a pair of dividers the distance is taken from the groove to a well marked furrow on the skin which is as plain on one model as on the other. In this manner the growth of the nail may be determined.

This method may be applied to the nails of the toes as well as to those of the fingers. The author calls attention to the fact derived from a number of old observations, confirmed by recent ones, that the growth of the nails is a function of the individual's age. It varies from single to triple, being less than 0.1 mm. below 5 years, increasing to 0.14 mm from 5 to 30 years and falling to 0.04 mm. per day toward 66, 80 years and more. When the growth of the nail of the big toe is studied, in comparison with the nails of the hand, there is noted a lessening of rapidity, a function of the age which does not follow a

(1) Amer. Jour. of Derm., June, 1909.

(2) Amer. Jour. of Derm., May, 1909.

constant proportion. In the young, the growth of the toe-nail varies between one-half and one-third of the growth of the finger-nails, whilst in the aged the difference is not quite so great. At about 80 or more there is an average of 0.05 mm. daily for the hand and of 0.04 mm. for the foot. The trophic activity of the lower limb is better preserved than that of the upper, which is explained by the fact that healthy aged individuals use their legs and hardly employ their arms. An examination of the muscles will testify to this fact. Muscular atrophy is more marked in the thoracic limbs than in the abdominal. Nail growth does not vary with the seasons.

Dermatoses and Acidosis. According to H. R. Harrower,¹ many dermatoses are associated with acidosis. Acne, herpes, eczema, pruritus and many other conditions seem, from results obtained in their treatment, to be often due to this condition. This is at least true in some cases, for when the offending cause is removed and the poisonous substances present are properly neutralized and eliminated from the body, the offending skin lesions disappear without further attention in the majority of cases. The excessive acidity which is so common is due to certain acid substances manufactured during the process of the depraved metabolic conditions practically always associated with intestinal putrefaction.

The most common dermatosis—acne vulgaris—is almost invariably associated with a greater or less degree of auto-intoxication, as probably the most frequent exciting cause is a disturbance of digestion with an accompanying constipation. In these cases an examination of the normal products of metabolism eliminated in the urine very often makes plain the way for successful treatment.

Conditions previously assumed to be due to some basal neurotic difficulty, as, for example, herpes, will be found in the majority of cases to evidence in a marked degree the findings associated with autointoxication, particularly to show an excessive degree of acidity. One case of herpes zoster of very long standing showed the following urinary findings: Amount 1,250 c.c., specific gravity 1.014, total

(1) Amer. Jour. of Derm., May, 1909,

solids 40.75 grams, acidity 78 degrees, acid units 97,500, urea 1.1%, indican much, with traces of indol-acetic acid. Thorough elimination by the use of calomel in broken doses, a saline each morning, with intestinal antiseptics and neutralization of the acidemic condition, resulted in a remarkable amelioration of the condition. The continuation of the local remedy which had been previously prescribed for this patient, together with this modification of the systemic acidity, caused a serious condition of long standing to disappear within a month. When the urinary findings show an excessive degree of acidity and this is brought down to normal by the judicious use of alkaline remedies, guided always by the acid index, success will be attained.

Hematuria after Purpuric Eruptions is discussed by R. del Vecchio,¹ who cites the case of a 12-year-old girl with influenza complicated with follicular tonsillitis. This was followed by a purpuric eruption on the lower extremities. In addition hematuria occurred in crises; with each one was renal albuminuria accompanied by a fresh eruption and gastroenteralgia. Hematuria became less frequent. The general state of the patient was always a good one. Repeated examinations revealed albumin always proportional to the amount of blood, a normal elimination of urea and the presence of epithelial, granular and hyaline casts. There existed an absence of neoplastic elements and tubercle bacilli. The specific gravity varied from 1.011 to 1.020, the daily amount from 1,300 to 1,500 c.c. Vacchio accounts for the condition by a disseminated vasomotor stasis of toxic-infective origin due to a process analogous to that which occurs in disseminated cutaneous stasis and in the purpuric eruption.

Diagnostic Skin Reaction in Acute Infections. In determining these L. K. Hirshberg² employs the following procedure: The hairless portion of the arm or forearm is cleaned with ether. No alcohol, soap, water, or other disinfectant is used. Five or more scarifications are made (the number is dependent on the varieties of vaccines

(1) Riforma Medica, January, 1909.
(2) N. Y. Med. Jour., Sept. 18, 1909.

used) with a small metal screw-driver like lancet. The blade is 0.3 centimeter broad and half moon shaped. This makes an ideal scarifier when given the rotary motions of a screw driver. It is so tempered that the half moon blade may be repeatedly sterilized in an alcohol flame without injury. The scarifications are made in two parallel columns an inch apart. Each time between vaccinations the scarifier is sterilized in the alcohol flame, thus preventing contaminations or mixed vaccines. The ends of the tubes containing the various vaccines are wiped with sterile gauze to clear away the spicules of glass. The usual amount of the various vaccines taken has been 2,000,000 gonococci; 40,000,000 of the *Staphylococcus aureus*; 4,000,000 streptococci; 8,000,000 colon bacilli and 4,000,000 typhoid bacilli. In each case the amount corresponds to 0.1 c.c. of the stock vaccines of manufacturing laboratories. The skin is scarified with sterile water, a salt solution of physiologic strength, or 50% glycerin and 1% phenol in isotonic salt solution. This is used as a control. Usually five other vaccinations are made. The types of organisms used depend upon the suspected infection. A fairly good reaction shows a slightly reddened area in the neighborhood of 5 mm. in diameter with slightly tense, firm and hard center. A moderately good reaction shows the hyperemic area about 10 mm., persistent and distinctly infiltrated. A very good reaction shows a distinctly edematous site about 25 mm. or more and marked infiltration and hyperemia.

CHAPTER II.

SPECIAL DERMATOSES.

Dermatobia Noxialis Dermatitis. J. D. Manget¹ reports the case of a patient infected by *Dermatobia noxiadis* by being bitten by flies while bathing in Mexico. The symptoms were general malaise, slight fever and small lesions on the back and shoulders, which caused sharp lancinating pains at times. Six weeks after exposure there were no malarial parasites found in his blood. In the five lesions on the shoulder and arm were found motile larvæ, with branched hooklets on the head, which caused the intense pain. Recovery soon followed the removal of these.

Morphea-like Epithelioma. M. B. Hartzell² reports 3 cases of morphea-like epithelioma. The first patient was temporarily cured by x-ray treatment, as was the patient in the second case, which was of interest on account of the early age at which the disease appeared, the patient being only 24. The third case was of more special interest because it was microscopically diagnosed, this not having been permitted in the other two. In all three the disease began as a smooth slightly elevated plaque, of a yellowish-white or yellowish-pink tint, over which numerous small blood vessels ran, gradually increasing in size and after some time developing ulceration with usually sharp margin. The progress was slow without marked subjective symptoms. Stellwagon, who has the only text-book reference to the subject, curtly alludes to the possibility of epithelioma resembling morphea. Crocker refers to rodent ulcer, unique in his experience, which Hartzell thinks must have been this sort of epithelioma.

Dermatitis Pediculoides Ventricosus. For 8 years cases have occurred in and about Philadelphia¹ of a new skin

(1) Medical Record, June 26, 1909.

(2) Jour. Am. Med. Assoc., July 24, 1909.