DERMOCHROMES - I

PORTFOLIO

OF

DERMOCHROMES

BY

PROFESSOR JACOBI

Of Freiburg im Breisgau

English Adaptation of Text of the 1st and 2d Editions

BY

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Fourth Edition, Revised and Enlarged

WITH 246 COLORED AND 2 BLACK AND WHITE FIOURES ON 134 PLATES WITH EXPLANATORY TEXT

Volume I

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TO

GEHEIMRATH PROFESSOR ALBERT NEISSER

OF BRESLAU

Preface to the English Edition.

The process employed in the production of the illustrations in the following work is that known as Citochromy, and is the invention of Dr. Albert of Munich. The reproduction of colours by this process is believed to be more perfect than by any other hitherto in use, and is obtained almost entirely by mechanical means apart from manual work.

The great majority of the illustrations are taken from models in the Breslau Clinic, executed by Herr Kröner, and are reproduced by kind permission of Professor Neisser, to whom the inception of the work is mainly due, and to whom it is dedicated by his former pupil and assistant, Professor Jacobi.

Thanks are also due to Professors Lesser and C. Lassar of Berlin, Dr. Bayet of Brussels, and Dr. Henning of Vienna, for permission to make use of models in their possession.

Acknowledgment must also be made of the services rendered by the gentlemen who executed the various models utilized—viz., Herr Kröner of Breslau, Herr Kolbow and Herr Kasten of Berlin, Mons. Baretta and Mons. Tramond of Paris. A few of the models have also been made by Professor Jacobi himself after the method devised by Mr. Cathcart of Edinburgh.

The object of the Atlas is not to illustrate the rarer

forms of skin disease, but to furnish to medical men, teachers and students a handy and comprehensive series of illustrations of the skin affections most frequently met with in practice, in their various phases and at a reasonable price within the reach of all.

As no attempt has been made to supplement the necessary systematic treatises on diseases of the skin, the text has been condensed to the greatest possible degree, without, however, omitting any of the essential facts.

J. J. P.

LONDON.

Editor's Preface to the Second Edition.

THE early and gratifying demand for a second edition of this work testifies to its utility.

Two new plates, with text, have been added, viz.: Plate XVIa, Fig. 28a (*Scrofuloderma*), and Fig. 29a (*Tuberculide*); also Plate LXXVIII., Fig. 141a (*Syphilis circinata*) and Fig. 142a (*Paronychia syphilitica*). Both plates are taken from models in the collection of Professor Neisser, to whom the renewed thanks of the Editor are gratefully acknowledged.

The following figures have been substituted for those which appeared in the first edition, viz.: Plate LIX., Fig. 109; Plate LXXI., Fig. 129; and Plate LXXXII., Fig. 149.

It is hoped that these additions and alterations will enhance the value of the atlas, the price of which remains unchanged.

J. J. PRINGLE.

Preface to the Supplement.

The publication of a Supplement to Professor Jacobi's work has been prompted principally by the urgent request of numerous professional friends to fill in certain lacunæ in the existing work, so as to render it a practically complete pictorial Atlas of Diseases of the Skin.

To these friends Professor Jacobi desires to express his indebtedness. The Supplement contains seventy-six new dermochromes, many of which depict syphilitic manifestations, the importance of which is universally admitted. But several non-syphilitic diseases not hitherto illustrated are also included, some of which—*e.g.*, Darier's disease, Myiasis linearis—are regarded in most text-books as extreme rarities. This opinion Professor Jacobi does not share, and the translator endorses the author's view.

Numerous types or phases of common skin affections not delineated in the work have also been added, and cannot fail to conduce to its increased practical utility both to the student and practitioner.

Especial thanks must again be expressed to Professor Neisser of Breslau, who has placed his entire wealth of material at the author's disposal. A deep debt of gratitude is also due to Professor von Bergmann, Professor Lassar, Dr. Max Joseph, Dr. Buschke, Dr. Heubner, and Professor Greef, of Berlin; to Professor Schlossmann and Dr. Werther of Dresden; to

Dr. Henning and Professor Finger of Vienna; to Professor Pospelow of Moscow; and to Professors Fournier and Jullien of Paris, all of whom have permitted models in their possession to be utilized. Due recognition must also be acknowledged to the kindly and energetic assistance of Professor Jacobi's former assistant, Dr. von Linck, and to Messrs. Baretta, Jumelin, Kolbow, Kröner, Kasten, Fiweisky, and Johnsen, who are responsible for the models from which the dermochromes have been executed under the direct and special supervision of Dr. Albert of Munich, with whom rests the credit of first devising and carrying out the method of delineation employed throughout the work with such brilliant success and gratifying results.

J. J. Pringle.

London, 1906.

Preface to the Third Edition.

In this edition a number of illustrations are entirely new, others have been more perfected. In the place of some of the pictures contained in the previous editions which were not quite satisfactory, better illustrations have been substituted. The plates of the supplement have been properly classified with the other subjects, and the whole atlas now contains 132 plates with 245 illustrations. The text has been revised and such matter as refers to new illustrations has been added.

I wish to express my feelings of gratitude to all those who gave me such splendid aid in the preparation of the previous editions and of the supplement, and who extended their kind offices to me whilst preparing this third edition.

I wish particularly to thank my I. Assistant, Dr. Lever, for his active co-operation; also Dr. Henning and Mr. Kolbow, who made most of the models; also Dr. E. Albert of Munich, who made the clichés; likewise Messrs. Greiner & Pfeiffer, in Stuttgart, and Messrs. Christoph Reisser's Sons, in Vienna, who did the presswork with so much care. Particular thanks are due to my publishers, who have brought great sacrifices in order to produce this new issue in the same superior and elegant style as the previous editions.

E. Jacobi.

Freiburg i. Br.

Preface to Fourth Edition.

In this edition several figures of superior quality have been substituted. It also contains four new figures of an interesting character. Two of these belong to the article on Sporotrichosis by Dr. de Beurmann, of Paris, with his kind permission.

E. Jacobi.

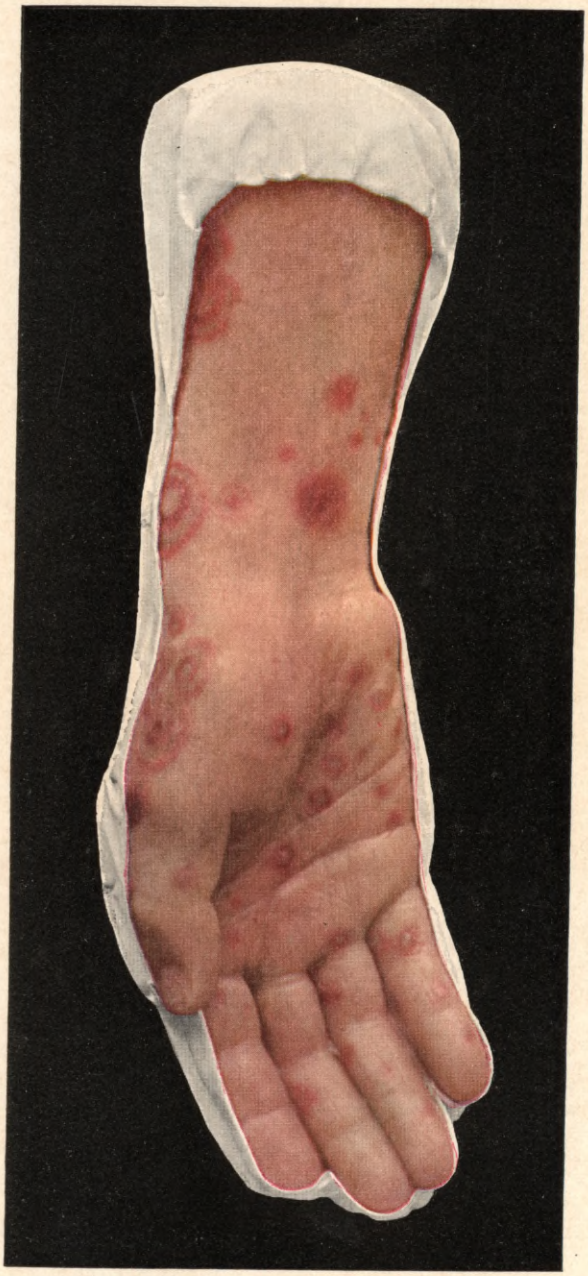
Freiburg i./Br.

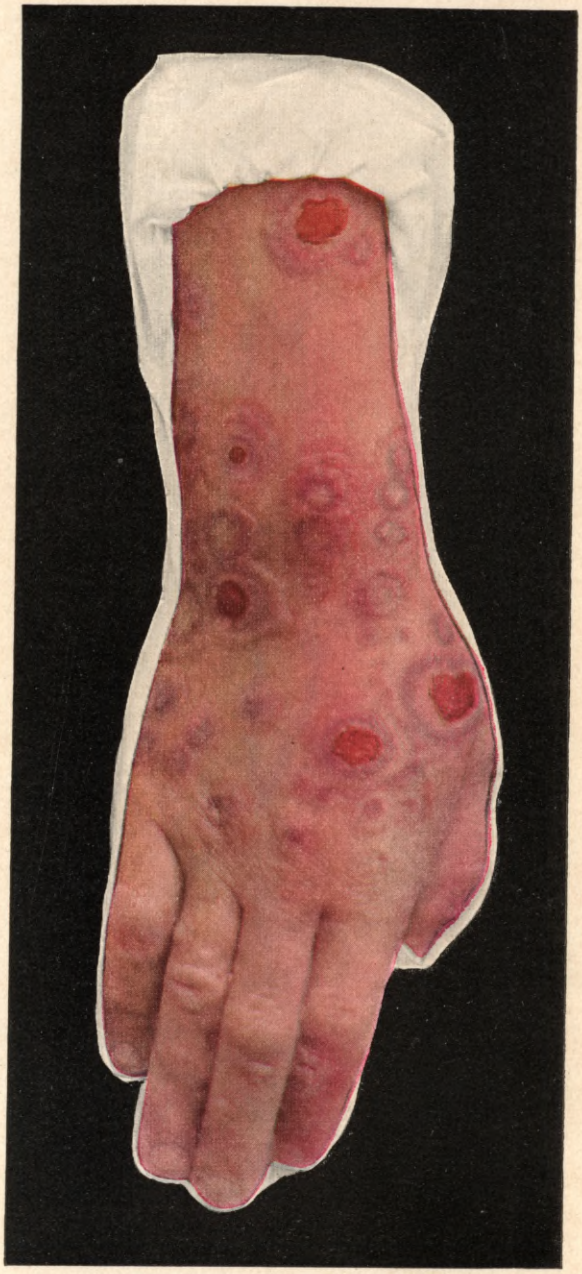
Erythema Exsudativum Multiforme.

PLATES I., II., FIGS. 1, 2, 3, 4.

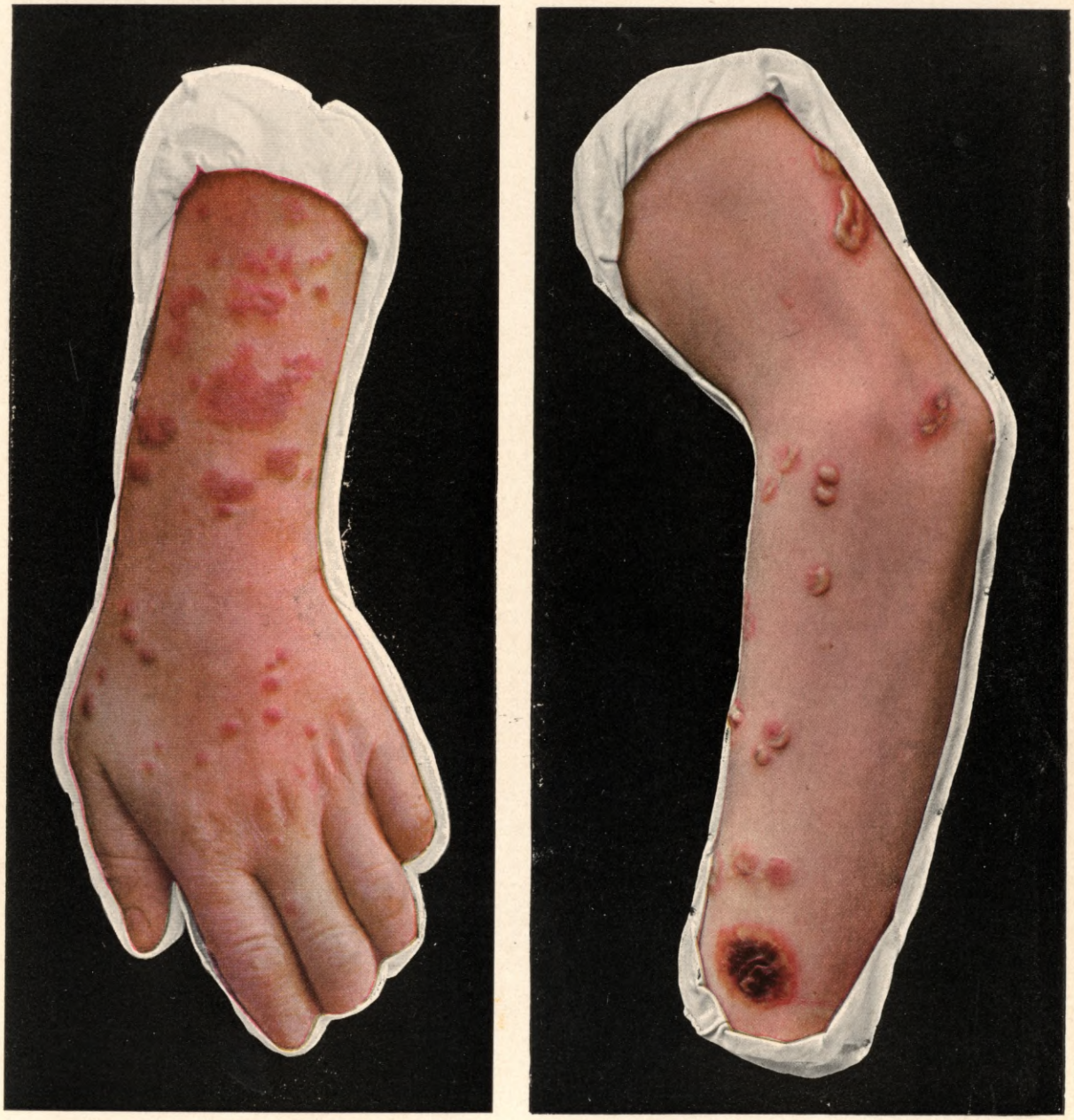
Erythema multiforme is a skin disease which occurs as part of a general infective malady—especially in spring and autumn—in which macules, papules, vesicles or bullæ develop in a few days on typical seats of predilection, especially on the backs of the hands and feet, and extensor surfaces of the forearms and legs; it often also appears on the face and other parts of the body, but only in exceptionally severe cases on the palms and soles. Thus, macular and papular erythema (Fig. 3) occur, becoming annular or gyrate (Figs. 1, 2)—when involution of the patches takes place in their centre—or vesicular (Fig. 4). The cause is unknown.

The colour is bright red in the most infiltrated marginal parts, but livid in the centre, which is frequently sunken, especially in cases of old standing and on the lower extremities. The disease is polymorphous, as different degrees of exudation may be present at the same time. If ring-shaped papules or circles of vesicles in concentric circles are present the affection is called *Erythema iris* or *Herpes iris* (a bad name). As the disease progresses the papules soften and pale without scaling, vesicles dry up, and, if no relapses occur—as they are apt to do—the whole





No. 1. 2. Erythema multiforme.



No. 3. 4. Erythema multiforme.

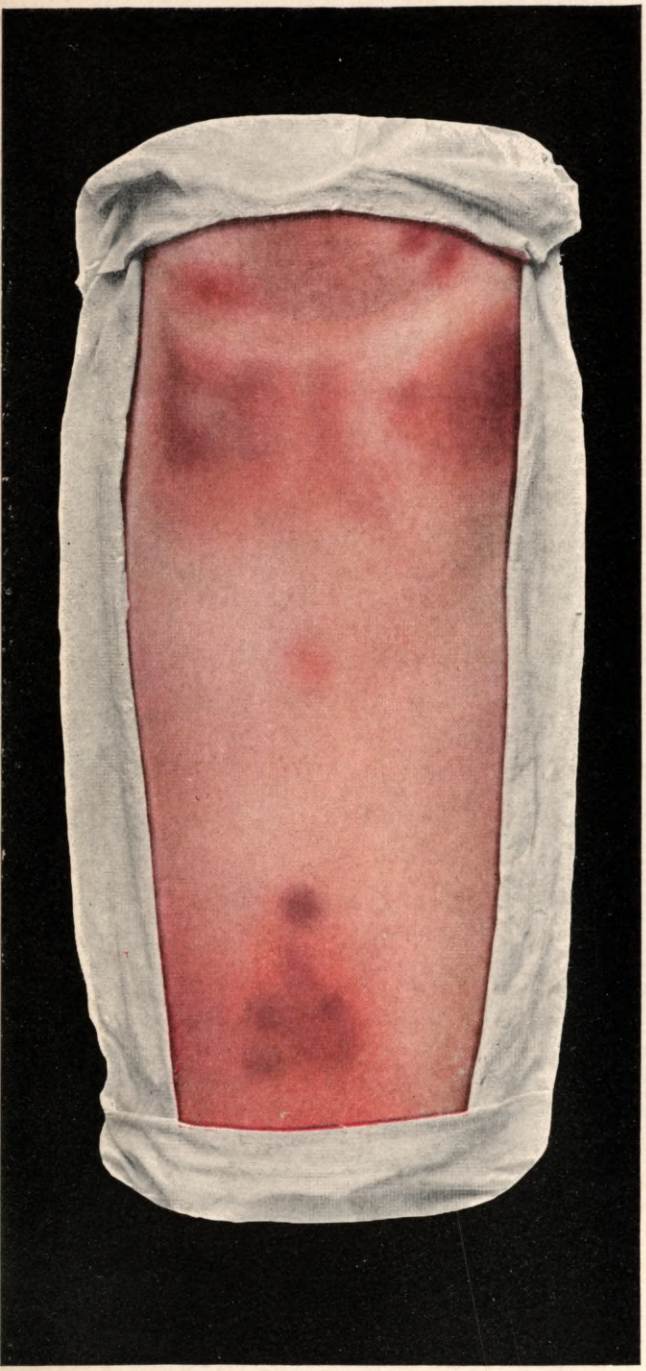
process runs its course in a few weeks. Some participation of the joints is not infrequently observed; implication of internal organs cannot as a rule be laid to the charge of the erythema. On the other hand, toxic erythemata occur in internal disorders, which ought not to be identified with true erythema multiforme.

Diagnosis can be easily established in typical cases from the acute onset, the general phenomena, the absence of subjective symptoms—apart from slight burning sensations—and the recovery without desquamation. The somewhat similar syphilide is different in colour, and usually occurs in different localizations; eczemas weep and itch; the occasionally similar urticarial eruptions are much more ephemeral. Ringworm, which may also occur in concentric forms, is scaly, and never presents the same typical distribution.

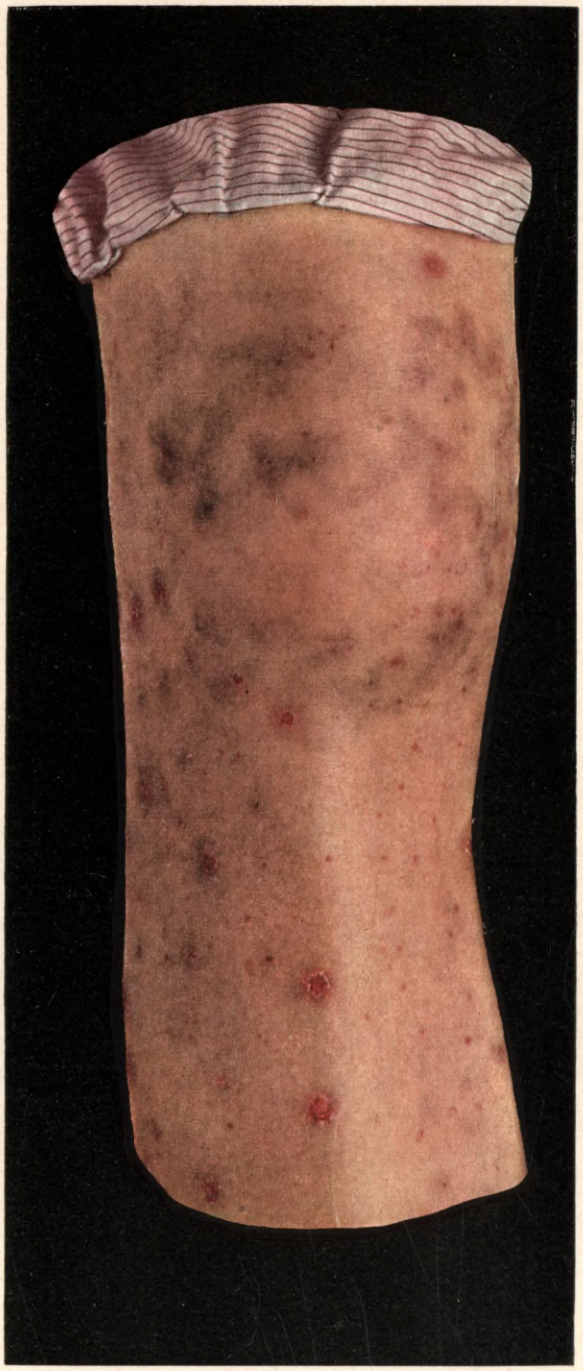
Prognosis is thoroughly favourable.

Treatment.—As the disease is a general one and joint affections are often present, salicylate of soda in doses of 30 to 60 grains daily, or similar preparations, are generally prescribed. When there is much burning, compresses of a 1 per cent. solution of acetate of aluminium may be locally applied; if blebs form, the alcohol spray may be recommended.

Figs. 1, 2. Models in Neisser's Clinic in Breslau (Kröner).
Fig. 3. Model in Neisser's Clinic in Breslau (Kröner).
Fig. 4. Model in Neisser's Clinic in Breslau (Kröner). A repeatedly recurrent vesicular eruption in a tailoress, twenty-five years of age, with high fever and joint symptoms.



No. 5. Erythema nodosum.



No. 6. Purpura haemorrhagica.

Erythema Nodosum.

Plate III., Fig. 5.

Occasionally associated with Erythema multiforme, but generally alone, there appear nodules as large as a hazel-nut or walnut, with special frequency on the fronts of the legs, but sometimes also on other parts, accompanied by pains and swelling of the joints, which give the impression of a bruise (*E. contusiforme*), and disappear in two or three weeks. The affection is most probably of infective character. The colour, which is at first bright red, goes gradually through the whole grade of tints which occur in blood pigment undergoing absorption. Complications with diseases of internal organs, especially endocarditis, sometimes occur, as well as hæmorrhage into mucous membranes.

The **Diagnosis** may be made without difficulty from the localization and colour of the lesions. Bruises seldom appear in such large numbers and in the same position, while they are generally accompanied by epithelial erosions. Multiple gummata develop insidiously, are different in colour, and tend to necrose.

The Erythema induratum of Bazin, which affects the same localization is an eminently chronic disease.

The **Prognosis** is favourable in uncomplicated cases, but it must be guarded in presence of endocarditis.

The **Treatment** consists of rest in bed and the administration of salicylic preparations.

Fig. 5. Model in Lesser's Clinic in Berlin (Kolbow). Woman, thirty-six years old, without joint symptoms, treated as an out-patient.

No. 8. Herpes progenitalis.

No. 7. Purpura haemorrhagica.

Purpura Hæmorrhagica.

PLATE III., FIG. 6; PLATE IV., FIG. 7.

Under the name of Purpura are described certain diseases, probably of infective nature, in which hæmorrhages into the skin of varying intensity are observed. Petechiæ, ecchymoses and vibices are all superficial hæmorrhages, characterized by their bright red or dusky colour, not disappearing under pressure with the finger or a glass. The lower extremities of young persons are the most frequent seats of small or large hæmorrhages, which develop—generally with rheumatic symptoms and rise of temperature—commonly about the knees, and especially in spring and autumn (*Purpura vel Peliosis rheumatica*). The number of hæmorrhages is often enormously increased by repeated relapses until, after several weeks, the disease ceases and the effused blood is gradually absorbed, undergoing the well-known changes of colour.

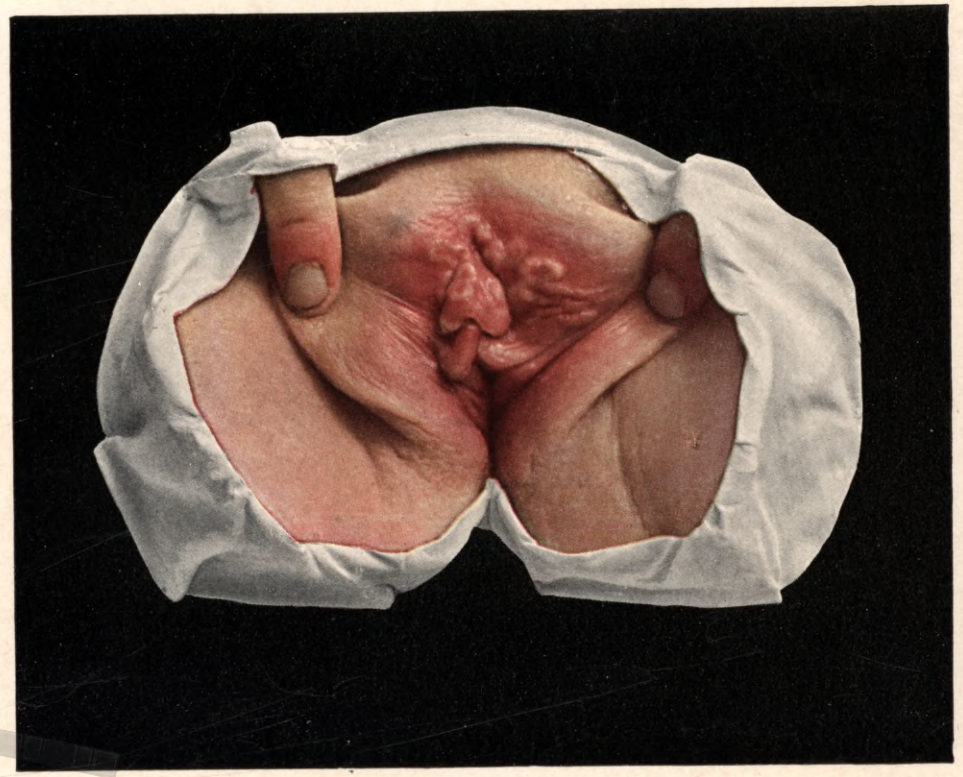
Some forms of purpura, such as Werlhof's disease and scurvy, in which the internal organs and mucous membranes are chiefly involved, differ from this clinical picture, and are serious diseases, whereas simple purpura rheumatica is a perfectly harmless affection. The epidermis over single hæmorrhages may be raised in form of bullæ. (See Fig. 7.)

The **Diagnosis** can be easily established from the symptoms described.

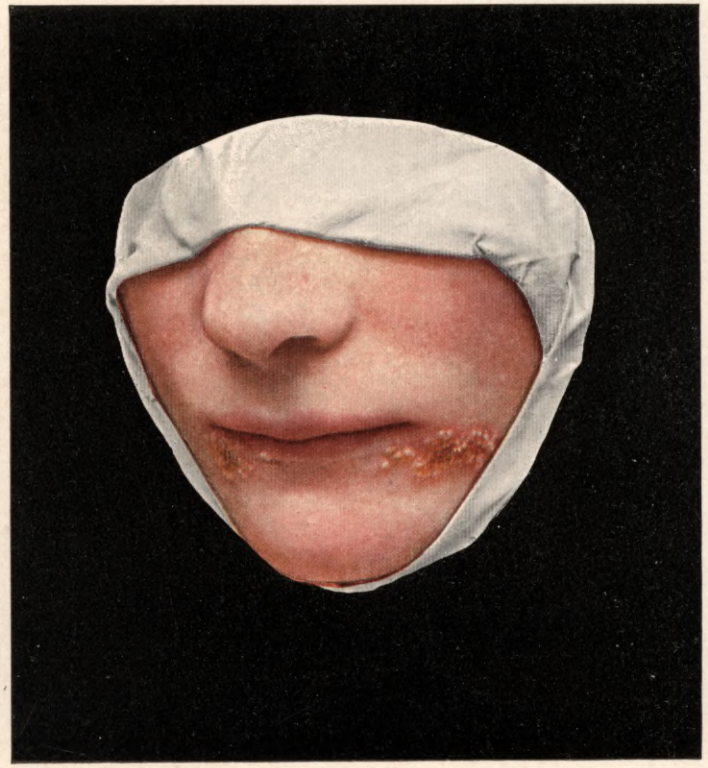
The **Prognosis** of simple purpura rheumatica is favourable.

The **Treatment** consists of rest in bed with elevation of the extremities, and the administration of hæmostatic remedies, such as ergotin, tincture of iron, etc.; salicylate of soda in doses of 30 to 60 grains daily may be given on the ground of the probable infectious nature of the disease.

Fig. 6. Model in the Vienna Clinic (Henning). The subject of the illustration was suffering from jaundice. A number of bullæ with slightly hæmorrhagic margins are present in addition to the usual purpuric spots.
Fig. 7. Model in Neisser's Clinic in Breslau (Kröner).



No. 9. Herpes progenitalis.



No. 10. Herpes labialis.

Herpes Simplex.

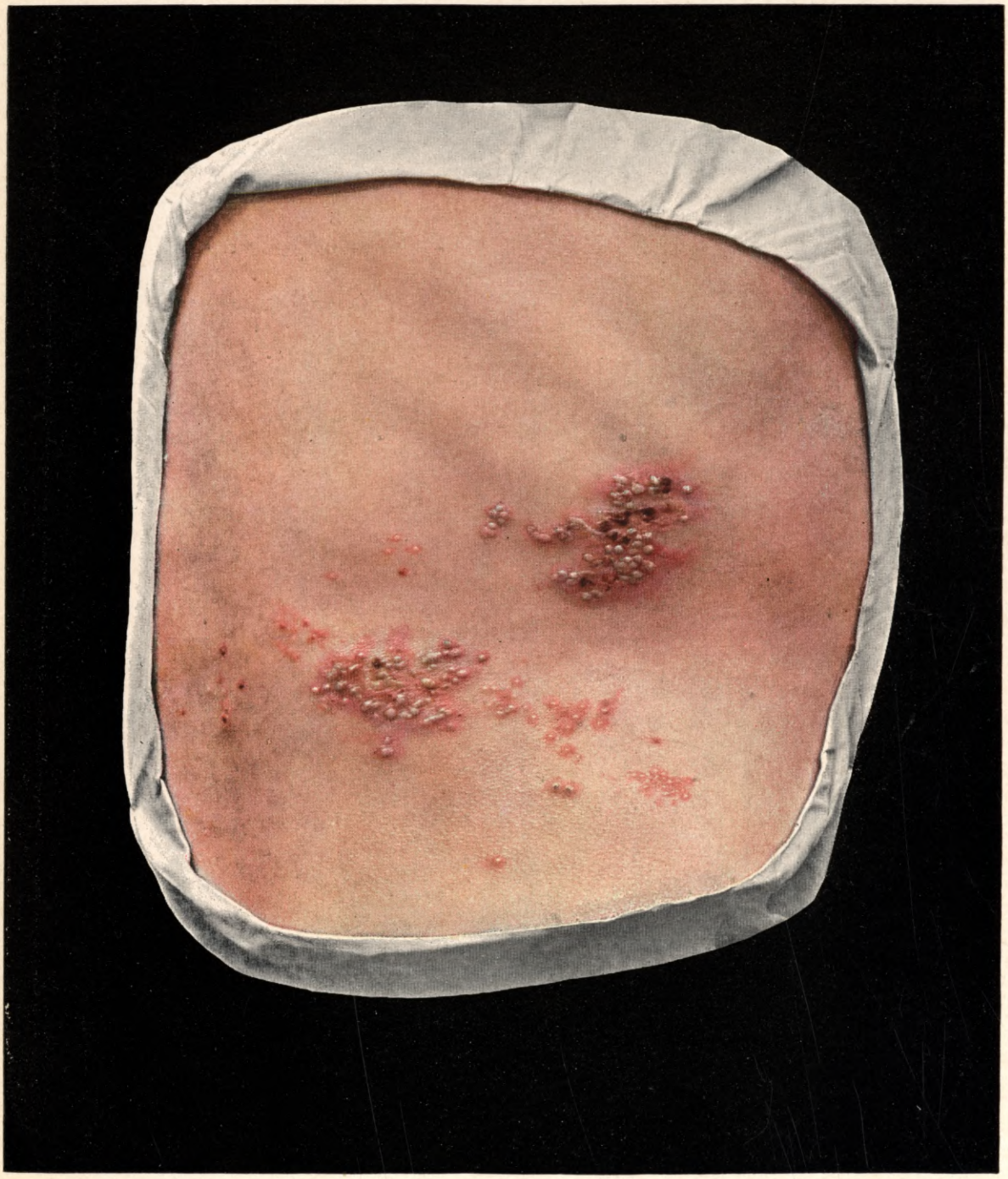
PLATE IV., FIG. 8; PLATE V., FIGS. 9 AND 10.

Herpes simplex is the commonest of the herpetic group of skin diseases, *i.e.* of benign affections which begin acutely and are characterized by the appearance of grouped vesicles on normal or slightly inflamed skin, and which exhibit no further developments but only undergo regressive changes. They are most frequently localized on the genitals (Figs. 8 and 9) or face (Fig. 10). Sometimes with sharp febrile symptoms and sometimes without them, one or several groups of small vesicles—with watery contents—appear upon the lips or their mucous surface, on the immediately surrounding skin or about the nose. These, after a short existence, dry up and heal without leaving scars. The eruption may also appear on the genitals, in men on the prepuce or glans, in women on the vulva and clitoris. Secondary infection or mechanical irritation may result in deeper lesions, so that some delay may occur in the healing process. It is specially to be noted that relapses are extremely common and that the seats of previously existent hard chancres show a marked predilection for herpetic outbreaks, both on the genitals and elsewhere. In some instances direct communication from person to person appears to be not improbable. As a rule there are no subjective symptoms except a little burning.

The **Diagnosis** can always be easily made on the face. On the genitals the differentiation of a herpes which has been badly treated, or become the seat of pus infection, from a soft chancre or primary syphilitic sore, may be difficult at first, but the course of the disease soon settles the point.

The first point in **Treatment** is to ward off secondary infection and to bring about the earliest possible, undisturbed desiccation of the vesicles; this can be done by means of powders, ointments or pastes but the best application is 90-95 per cent. alcohol with the addition of some carbolic acid (1 per cent.), resorcin, thymol ($\frac{1}{4}$ per cent.) or salicylic acid.

Fig. 8. Model in Saint Louis Hospital in Paris, No. 1923 (Baretta). Fournier's case.
Figs. 9, 10. Models in Neisser's Clinic in Breslau (Kröner).



No. 11. Herpes zoster.

Herpes Zoster. Shingles.

Plate VI., Fig. 11; Plate VII., Fig. 12.

Herpes zoster (*Shingles, Zona, Ignis sacer*) occurs as an acute infective disease, the cause of which is unknown; it is characterized by an outbreak of vesicles arranged in groups on an inflamed base and following the distribution of nerves or nerve plexuses (Fig. 11). The disease is almost always unilateral and the eruption is generally accompanied by neuralgic phenomena and swelling of the corresponding lymphatic glands. The vesicles of any one group are always in the same phase of development, but separate groups may appear either simultaneously or consecutively. The number of groups, as well as the number and size of the elementary vesicles, vary within very wide limits. Sometimes only a few papular groups are present or there may be blebs as big as cherries. Subsequently the blebs dry up leaving no scar. But in a certain number of cases the base of the vesicles is hæmorrhagic or gangrenous (Fig. 12), and in them very characteristic, grouped scars are left, sometimes with pigmented margins.

Zoster occurs most frequently in spring and autumn like other infective diseases, and as in them one attack, as a rule, confers immunity against others throughout life. The seat of disease may be in the distribution of the trigeminal nerve, or of various spinal nerves or

plexuses. In cases where death has taken place owing to intercurrent disease, lesions of the corresponding spinal ganglia have generally been demonstrated; but zoster of toxic origin also occurs *e.g.* after poisoning by arsenic or carbonic oxide, and it may result from disease of the nerve trunks.

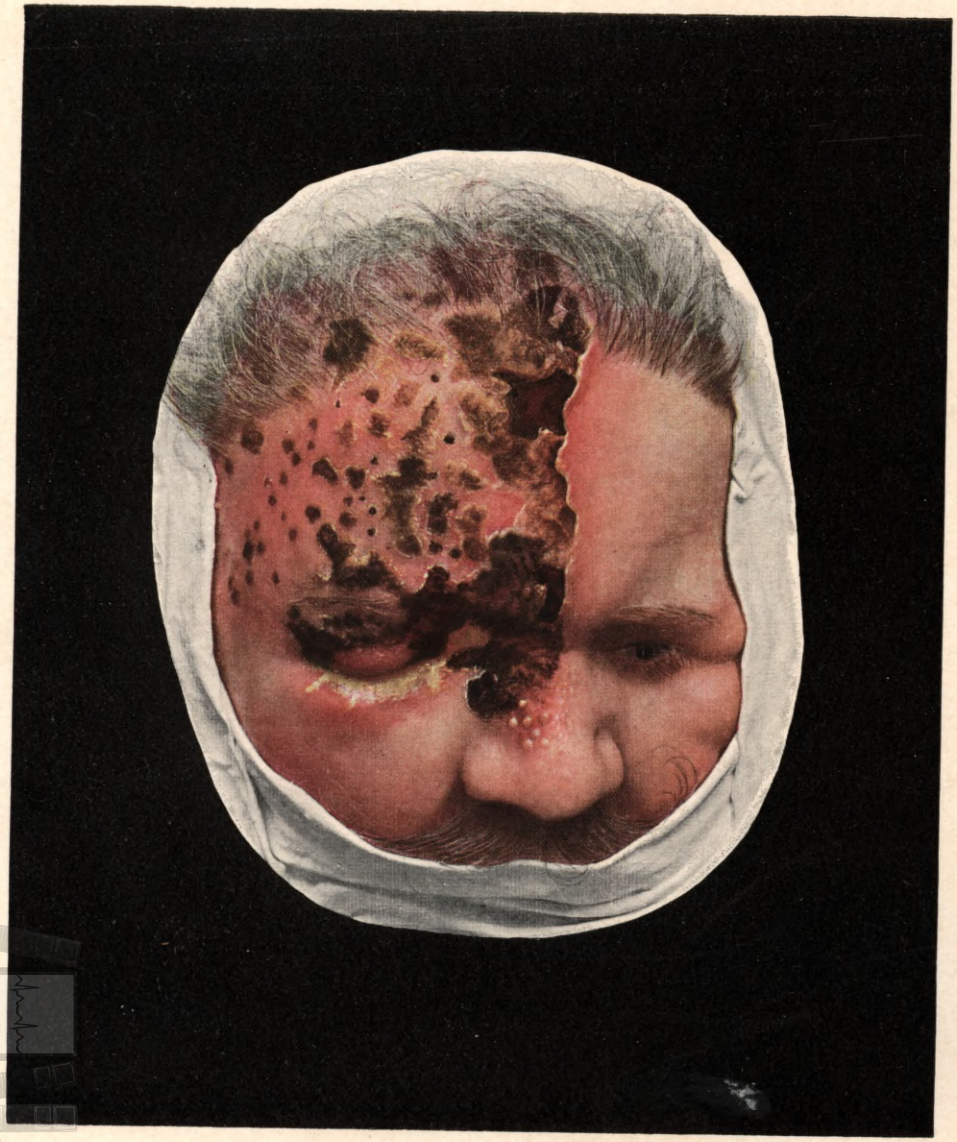
Central disease of the brain and spinal cord may also cause zoster. The primary lesion is, therefore, always to be sought for in the nervous system. Transgression of the middle line (which sometimes occurs) and extension to the distribution of neighbouring nerves are easily explained by the existence of nerve-anastomoses.

The **Diagnosis** of zoster is easily established from its unilaterality, its typical vesicles and the concomitant neuralgia.

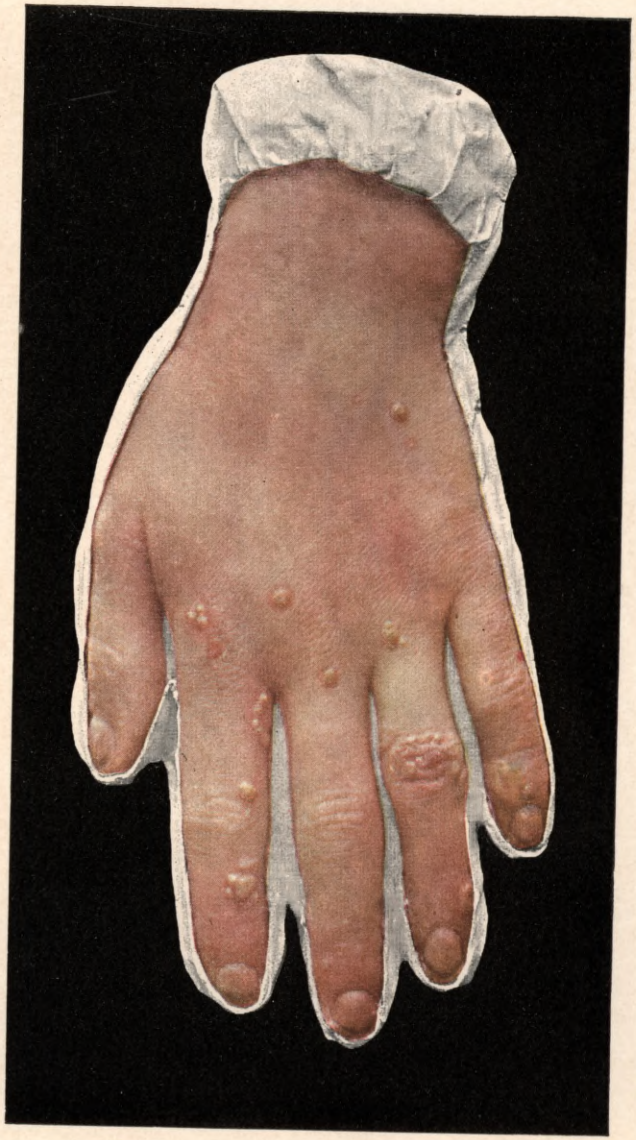
The **Prognosis** is generally favourable but must be guarded with reference to the accompanying neuralgia.

The **Treatment,** in view of the infective nature of the disease, must first consist of the administration of salicylic preparations. The pain may be combated by quinine, phenacetin, antipyrin and similar remedies. The best form of local treatment consists in alcohol compresses, under which healing most rapidly occurs. If there is extensive gangrene, hot compresses of a solution of silicate of aluminium or weak nitrate of silver may be used.

Fig. 11. Model in Neisser's Clinic in Breslau (Kröner).
Fig. 12. Model in Lesser's Clinic in Berlin (Kolbow).



No. 12. Herpes zoster gangraenosus.



No. 13. Dysidrosis.

Dysidrosis.

Cheiropompholyx.

Plate VII., Fig. 13.

In persons who sweat freely there often occur in summer small, clear vesicles which lie deep in the epidermis, especially on the sides of the fingers and toes, on the palms and soles, more rarely on the backs of the hands and feet. They are mostly localized round the excretory sweat-ducts and are accompanied by few or no inflammatory phenomena (Fig. 13). Larger blebs sometimes, but seldom form, the contents of which become cloudy. The vesicles gradually dry up and recovery ensues, accompanied by marked scaling. The disease gives rise to considerable itching. A transition to the establishment of eczema is sometimes observed.

The **Diagnosis** is at first easily made on the grounds of localization of dysidrosis and the absence of inflammatory symptoms.

Treatment attains only moderately favourable results. The hyperidrosis and itching must be chiefly combated; for these purposes painting with alcoholic solutions of tar, resorcin or liquor carbonis detergens is useful, but relapses occur with great regularity.

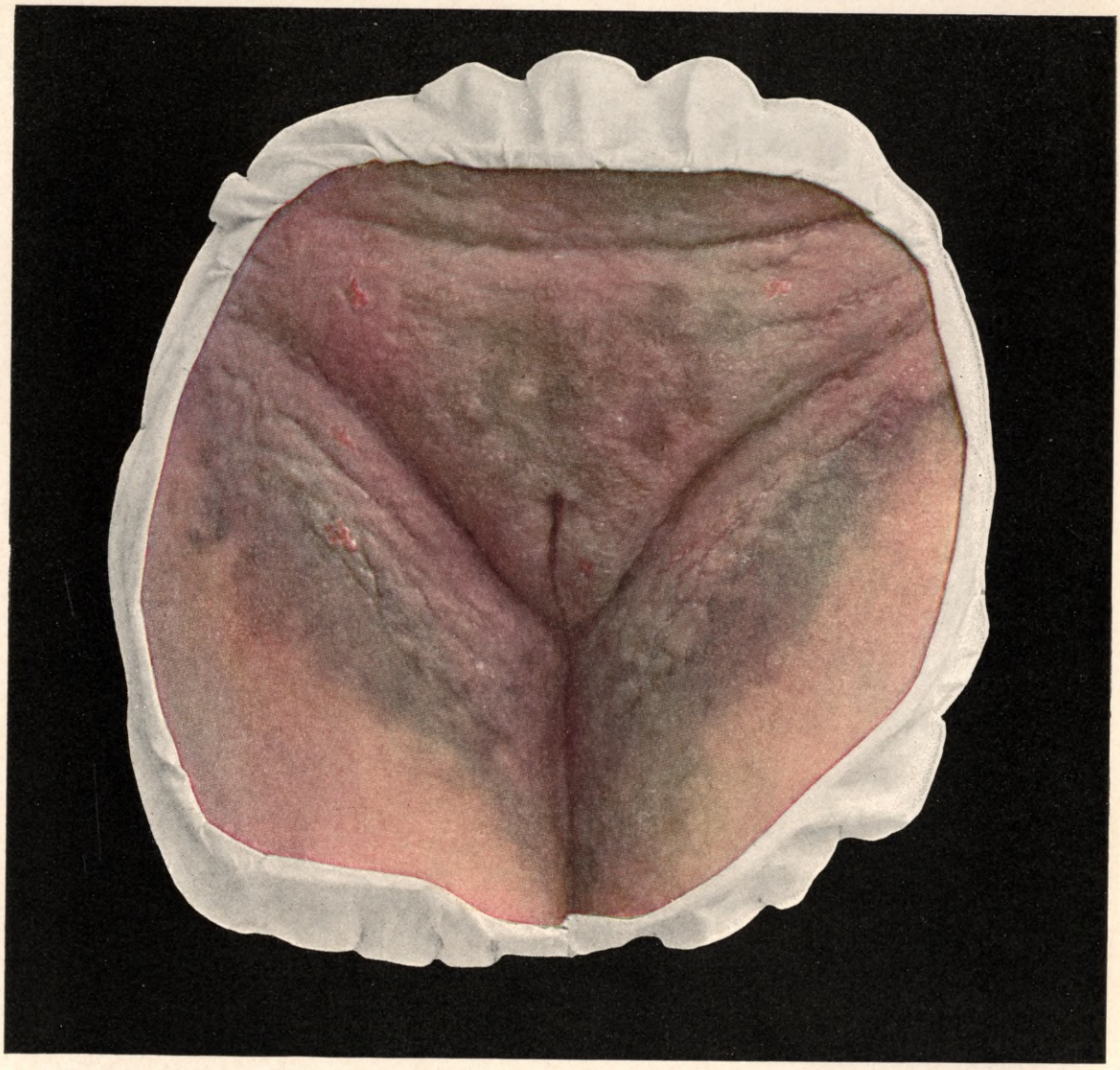
Fig. 13. Model in Neisser's Clinic in Breslau (Kröner).

Pemphigus.

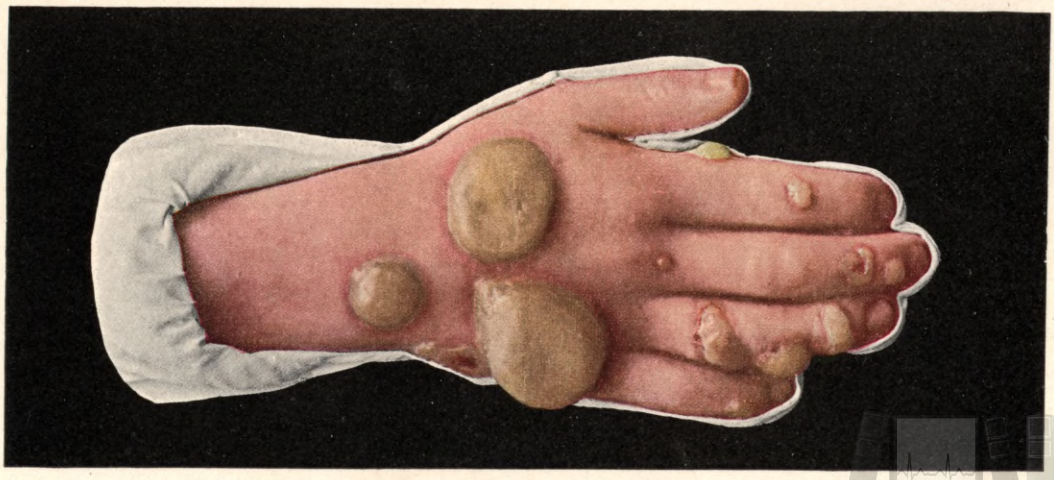
PLATES VIII. AND IX., FIGS. 14, 15, AND 16.

The name Pemphigus connotes a severe skin-affection of unknown cause, in which a bullous eruption of very chronic nature appears, accompanied usually by febrile phenomena. We do not consider infantile pemphigus (*Pemphigus neonatorum*) or Duhring's disease (*Dermatitis herpetiformis*) as being real forms of pemphigus. Usually two forms of chronic pemphigus vulgaris are recognized,—the one benign, the other malignant—but they cannot be definitely differentiated from one another, inasmuch as the latter may develop from the former. In both forms blebs of various size and indiscriminate distribution and which are filled with clear fluid, occur in crops, arising chiefly from healthy skin, either with or without rise of temperature; sometimes an erythema precedes the eruption. More rarely the contents of the blebs are hæmorrhagic.

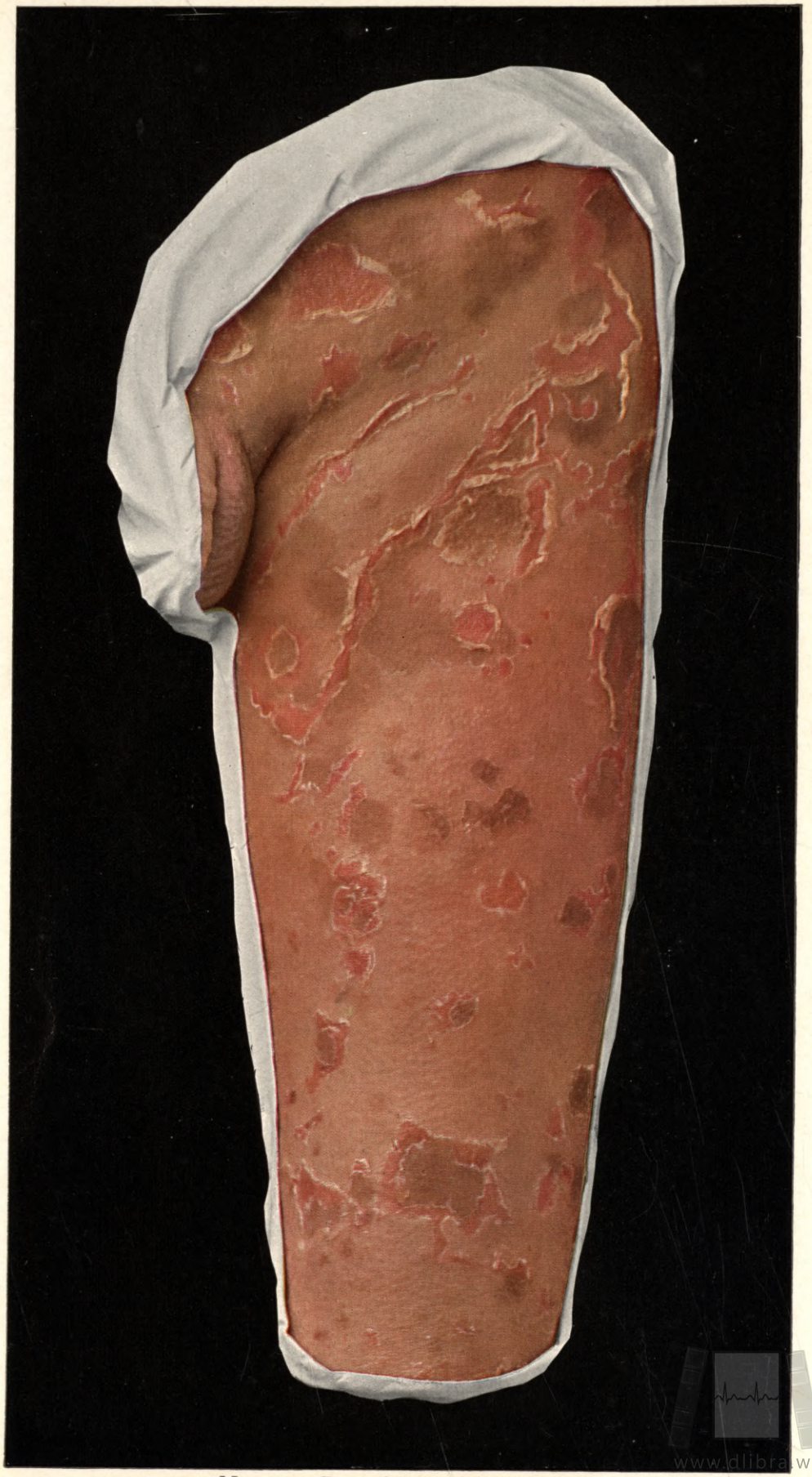
The course of pemphigus is usually extremely chronic and after the disappearance of one eruption intervals of months or years may occur before another attack ensues. The mucous membranes may also be attacked apart from the skin, in which case the bullæ do not attain their full development but the raised epidermis adheres in the form of a whitish, circumscribed membrane; however, the mucous membrane is



No. 14. Pemphigus vegetans.



No. 15. Pemphigus vulgaris.



No. 16. Pemphigus foliaceus.

usually involved only in severe or fatal cases in which the skin is also implicated.

In the group of pemphigus diseases *Pemphigus foliaceus* and *Pemphigus vegetans* occupy a special place. Other forms such as *P. circinatus,* with ringed grouping of the vesicles, *P. gyratus* and *P. pruriginosus* with severe itching must also be classified with Pemphigus vulgaris.

P. foliaceus and P. vegetans almost always end fatally; in the former (Fig. 16) the blebs are extremely flabby and flat, their contents being cloudy. Often the process does not go so far as bleb formation but the epidermis peels off in thin lamellæ over extensive areas. No normal reproduction of the epidermis takes place, so that after removal of the scales a weeping rete Malpighii is exposed or, if some apparent skinning over take place, the slightest mechanical injury suffices to expose the deep layers of the skin. The disease is accompanied by violent itching and profound interference with general nutrition and, after a prolonged period, death ensues.

Pemphigus vegetans as a rule first manifests itself by blebs, on the seat of which condylomatous outgrowths form, especially on surfaces of skin in apposition, on the genitals and surrounding parts (Fig. 14), in the axillæ and below the mammæ; in these places no normal keratinisation occurs but a dirty, horribly fœtid discharge accumulates. The disease always terminates fatally, its course being usually interrupted by many protracted intervals of passivity.

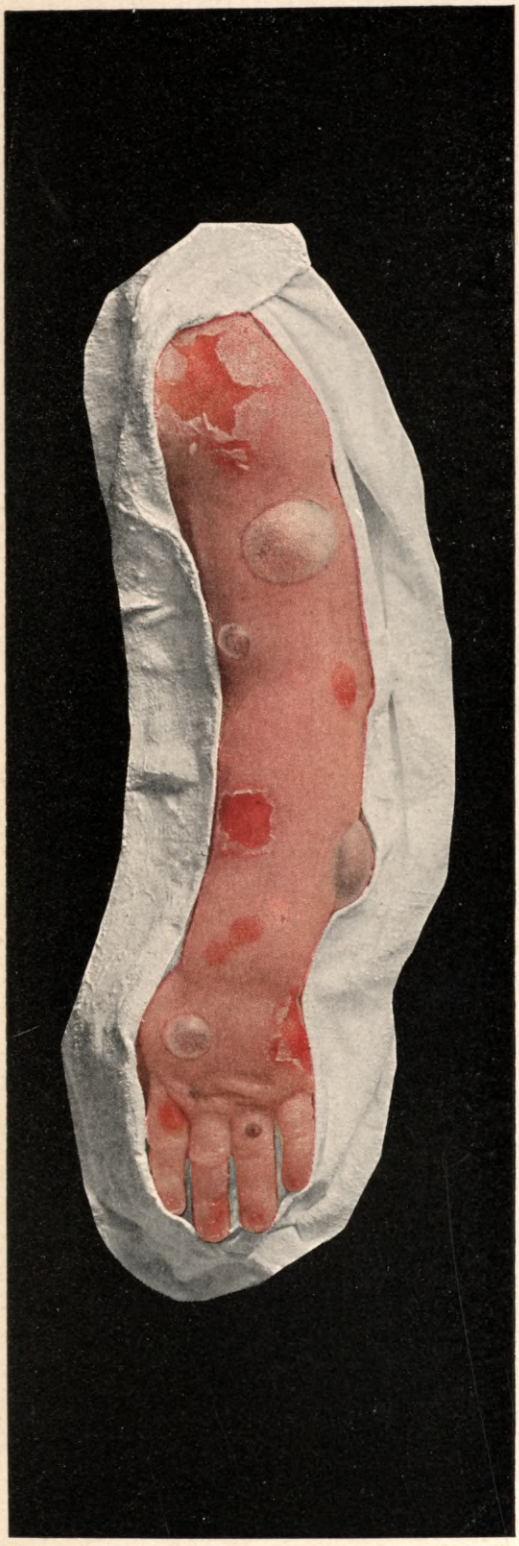
The **Diagnosis** of P. vulgaris is easy in typical cases if bullous eruptions only appear. If erythematous prodromal rashes occur, it must be diagnosed from erythema multiforme by the differences in localization and course. In its early stages P. vegetans

may easily be mistaken for syphilis, but the absence of other signs of syphilis the course of the disease and the utter inefficacy of antisyphilitic treatment will decide the matter. The diagnosis of P. foliaceus causes difficulty in many cases, especially as regards pityriasis rubra; the weeping, moist base of the lesions and the occurrence of flabby blebs will, however, decide the diagnosis, as they do not occur in pityriasis rubra.

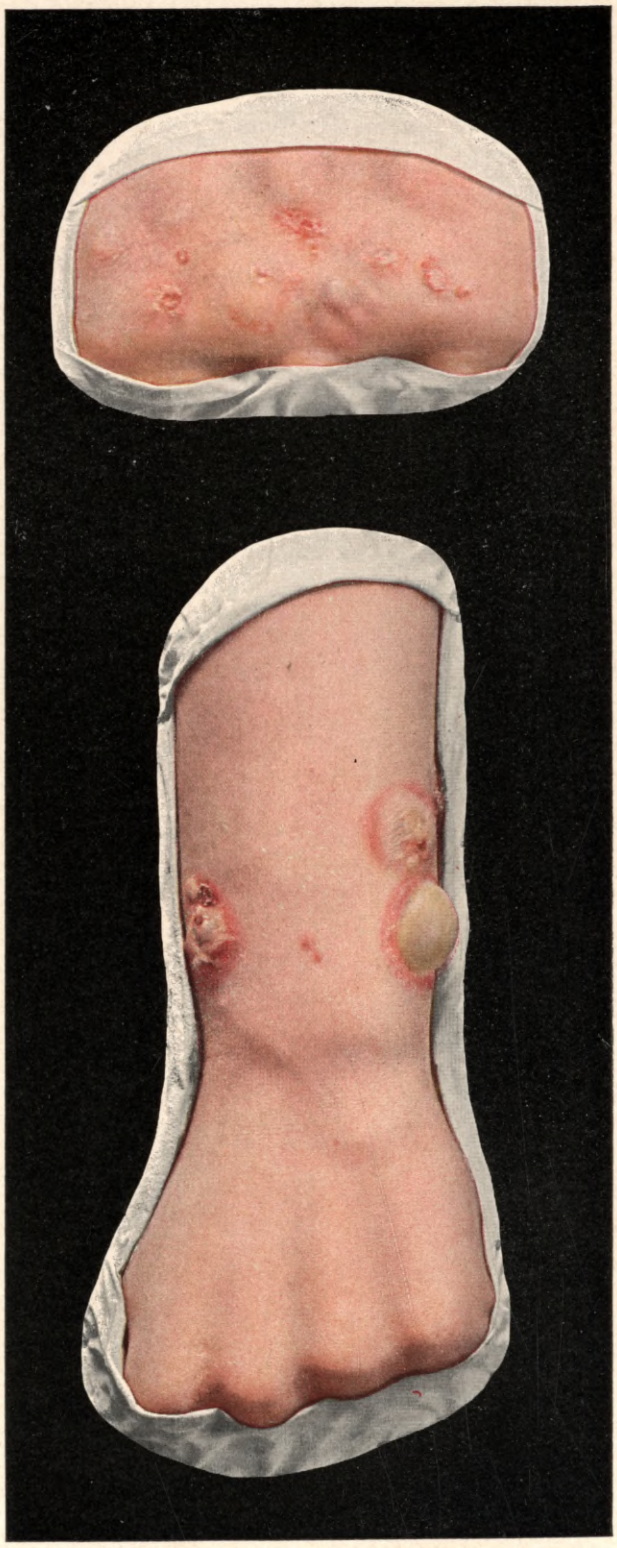
The **Prognosis** in pemphigus must be very guarded, as the differentiation between the mild and severe forms is at first extremely difficult to establish. In every case of definite pemphigus it must be considered dubious.

No efficient **Treatment** of pemphigus yet exists. We can only diminish the often terrible sufferings, the itching, and the frightful pain which results from the separation of the adherent clothes or bandages from the ulcerated skin by ointments, powders or baths; in extensive cases permanent baths are the best. Internally arsenic, strychnine and antipyrin are recommended, but their value is more than dubious.

Fig. 14. Model in Neisser's Clinic in Breslau (Kröner).
Fig. 15. Model in Lassar's Clinic in Berlin (Kasten).
Fig. 16. Model in Neisser's Clinic in Breslau (Kröner).



No. 17. Pemphigus neonatorum.



No. 18. Dermatitis herpetiformis (Duhring).

Pemphigus Neonatorum.

Plate X., Fig. 17.

Pemphigus neonatorum is an infective disease which almost always occurs in epidemics; it attacks especially new-born, but occasionally older, children. Vesicles and blebs, usually flat on the top, appear with or without fever on skin which may be normal or reddened, and the rete Malpighii soon becomes exposed (Fig. 17). As the disease progresses relapses may occur; but, on the other hand, it may rapidly recover after a single outbreak. Complications may take place, due to secondary infections.

The **Etiology** is not accurately determined; the distribution of the eruption is in no sense characteristic.

The **Differential Diagnosis** from syphilitic pemphigus of the newly born may be established by the localization in the latter of the blebs on the palms and soles, as well as by concomitant evidences of syphilis.

The **Prognosis** is usually favourable, but epidemics of unusual severity sometimes occur.

The **Treatment** consists chiefly of protecting the blebs by powders, and in the prevention of secondary infection by suitable dressings, or by baths to which antiseptics have been added.

Fig. 17. Model in Lesser's Clinic in Berlin (Kolbow).

Dermatitis Herpetiformis.

(Duhring.)

Plate X., Fig. 18.

The disease called Dermatitis herpetiformis, so distinctly described and differentiated by Duhring, is characterized mainly by the multiformity of its manifestations. Along with urticarial wheals, erythema and papules occur, but especially blebs of various size, accompanied by nervous symptoms and extremely violent itching. The process may be arrested in any stage of its evolution, or blebs may appear without preliminary lesions. The multiformity of the morbid picture is increased by itching, rubbing and secondary infections. As a rule, frequent relapses follow one another, and the disease extends over an extremely prolonged period; but, despite the fact that the patients become greatly exhausted by the severe subjective symptoms and the frequent relapses, the prognosis—in contrast with that of pemphigus—may be regarded as generally favourable.

The **Etiology** is unknown; but a neurosis is accepted, in many quarters, as its cause.

The **Diagnosis** can, as a rule, be established only after long observation, on the grounds of the poly-

morphism, the intense itching, the repeated relapses, and the benign course of the disease.

Treatment can only be symptomatic; nervous phenomena must be combated by nerve-tonics, and the sufferings of the patient alleviated by baths and the application of antipruritic remedies. Lotions containing alcohol, sulphur baths and tarry preparations often act favourably; as may the internal administration of arsenic and strychnine.

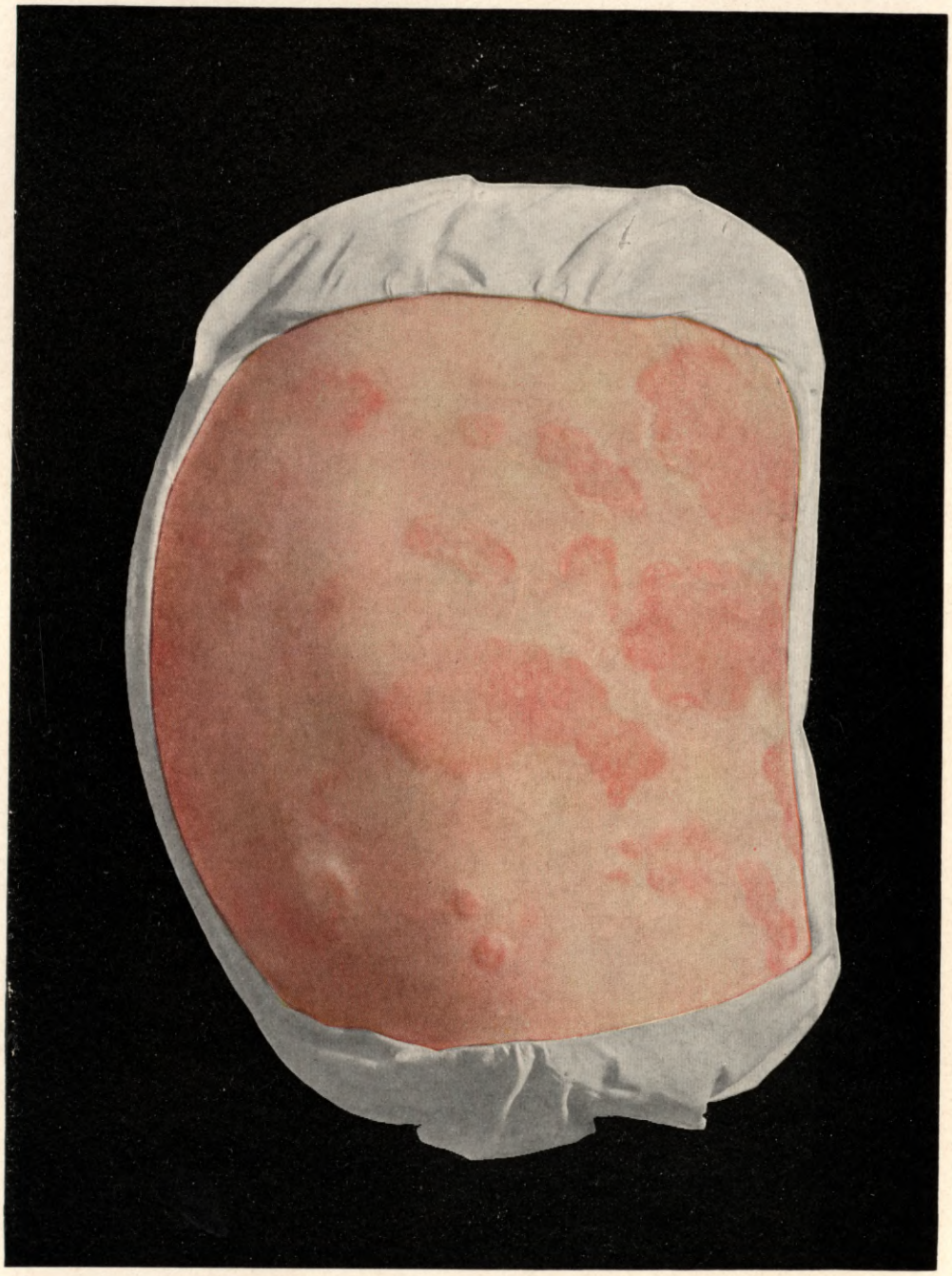
Fig. 18. Model in Saint Louis Hospital in Paris (Baretta) No. 1352. Tenneson's case.

Urticaria.

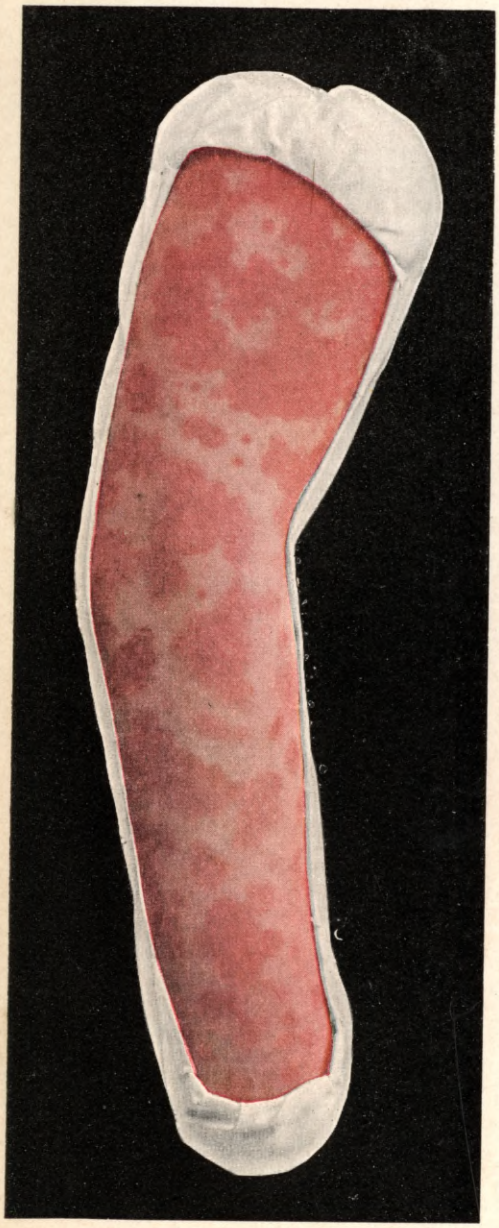
PLATES XI., XII., XIII., FIGS. 19, 20, 21, 22.

Urticaria is characterized by the appearance of wheals—*i.e.*, of very itchy, flat papules—either white, bright red (Fig. 19), or more rarely, dark red (Fig. 20) or livid in colour, which are of varying size, and appear either isolated, or in groups, or confluent. The wheals may disappear as quickly as they appear without, as a rule, leaving any pigmentation; serpiginous figures may be formed by the confluence of contiguous efflorescences. The extent of the skin affected varies extraordinarily; not infrequently the greater part of the body surface is affected either at one time, or by the occnrrence of successive outbreaks of the disease. In many persons there is a marked tendency—either congenital or acquired, as the result of previously existing skin diseases—for the development of wheals on any part of the skin submitted to irritation; every scratch mark becomes the seat of an urticarial linear tract (*U. factitia*).

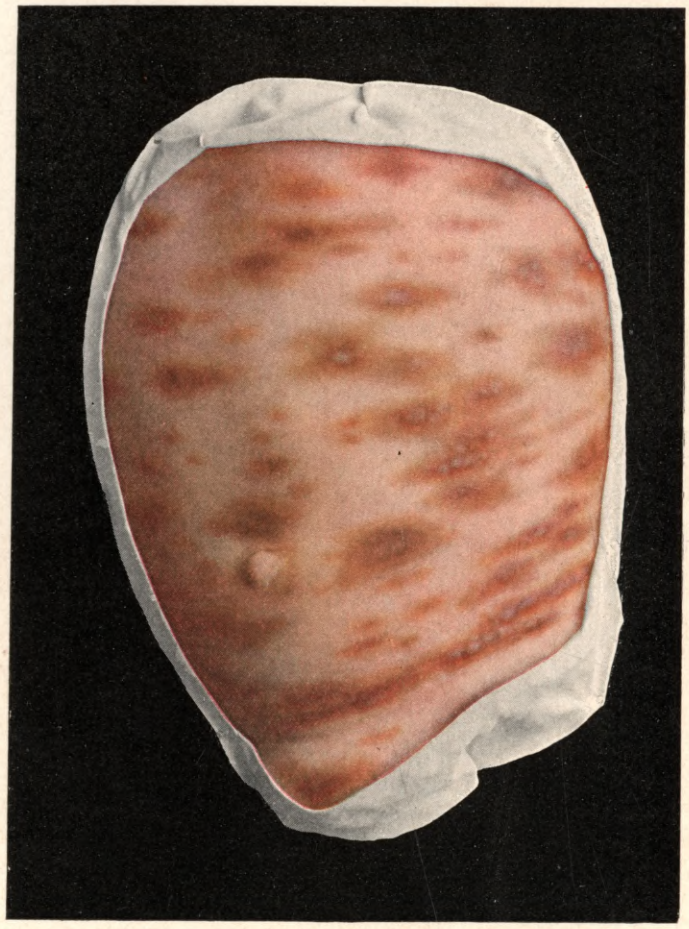
In children small wheal-like papules, intermixed with true wheals, often occur in frequently repeated outbreaks; these papules may exhibit a vesicle or blood-crust on their surface (*Lichen urticatus, Strophulus,* Fig. 22), constituting an affection which deserves



No. 19. Urticaria.



No. 20. Urticaria rubra.



No. 21. Urticaria pigmentosa.

special consideration, as it represents in many instances the forerunner of a severe, generally incurable, disease of the skin—viz., Prurigo.

The *acute circumscribed œdemas*—the so-called *giant Urticaria*—also belong to the urticarias, in which not only the skin, but also deeper tissues are affected; they appear and disappear suddenly; the disease is rare, and generally hereditary.

The very rare disease *Urticaria pigmentosa,* which occurs in children, must also be mentioned. The extremely persistent wheals leave deep pigmentary lesions, which exhibit the phenomena of factitious urticaria, and, as a rule, persist throughout life. (Fig. 21.)

Urticaria may be evoked by external irritants in contact with the skin (insect bites, nettles, etc.), but the eruption does not remain confined to the part directly affected; it may also proceed from the gastro-intestinal tract, being caused by certain foods in different individuals (fish, crab, fruit, especially strawberries), or by drugs. As a rule it is accompanied by digestive disturbances, such as vomiting and diarrhœa (*U. ab ingestis*).

Internal disorders, especially such as determine changes in the quality of the blood (leukæmia, diabetes), are not infrequently accompanied by urticaria. Disorders of the generative organs in women may also cause urticaria, as may the introduction of urethral bougies in men. Pregnant women frequently suffer from factitious urticaria throughout their pregnancy, which usually disappers after delivery.

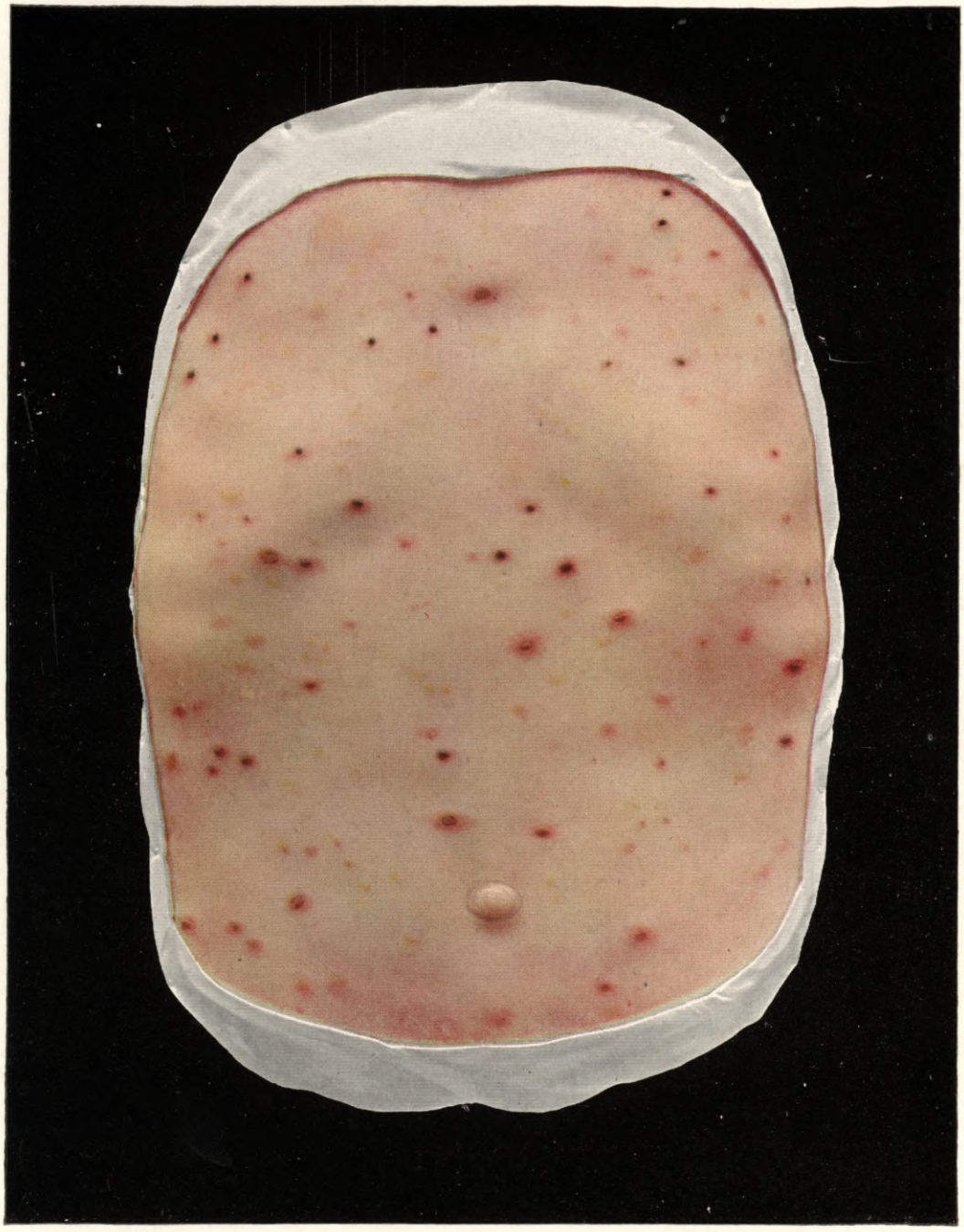
In addition to these forms, there are numerous cases of chronic urticaria in which no cause can be discovered, and which are specially rebellious to treatment.

The **Diagnosis** of urticaria depends upon the typical, evanescent wheals, and on the occurrence of itching. Some drug eruptions can scarcely be differentiated from urticaria.

The **Prognosis** must be guarded in chronic urticaria of childhood (? Prurigo), but generally speaking, is favourable, exception being made for chronic nettlerash in which the general condition may be very unfavourably influenced by itching and insomnia.

Treatment can only be successful in cases where the cause can be traced and therefore removed, particular attention being paid to disorders of digestion and general diseases. The cure of any affection of the female generative organs will often bring about recovery in cases of long-standing urticaria. If no cause can be discovered, treatment with atropine, arsenic, pilocarpine, ergotin, and finally with chloride of calcium, may be tried. In such cases the principal task is the relief of the sometimes excruciating itching. Opiates must only be used with the greatest caution as hypnotics; antipyrin sometimes stops attacks of irritation.

With regard to external treatment, it must be remembered that patients react in widely different fashion to heat and cold; the former is sometimes efficacious in the form of warm baths or douches, but cold water applications are often followed by better results. Lotions of pure alcohol, menthol, liquor carbonis detergens or tar may be tried, as well as tumenol, ichthyol or carbolic acid. Recently bromocoll, either in the form of salve or lotion, has been used successfully as an antipruritic. All mechanical



No. 22. Urticaria chronica infantum (Strophulus).

irritation of the skin, by rubbing or wearing coarse nnderclothing, must be avoided.

Fig. 19. Model in Neisser's Clinic in Breslau (Kröner). A man, thirty years of age, suffering from chronic urticaria since the age of one year.
Fig. 20. Model in same Clinic.
Fig. 21. Model in same Clinic (Kröner). Boy, two years old, suffering also from tetany. The affection distributed over the entire body; skin reflexes exaggerated; factitious urticaria over the entire skin.
Fig. 22. Model in Neisser's Clinic in Breslau (Kröner).

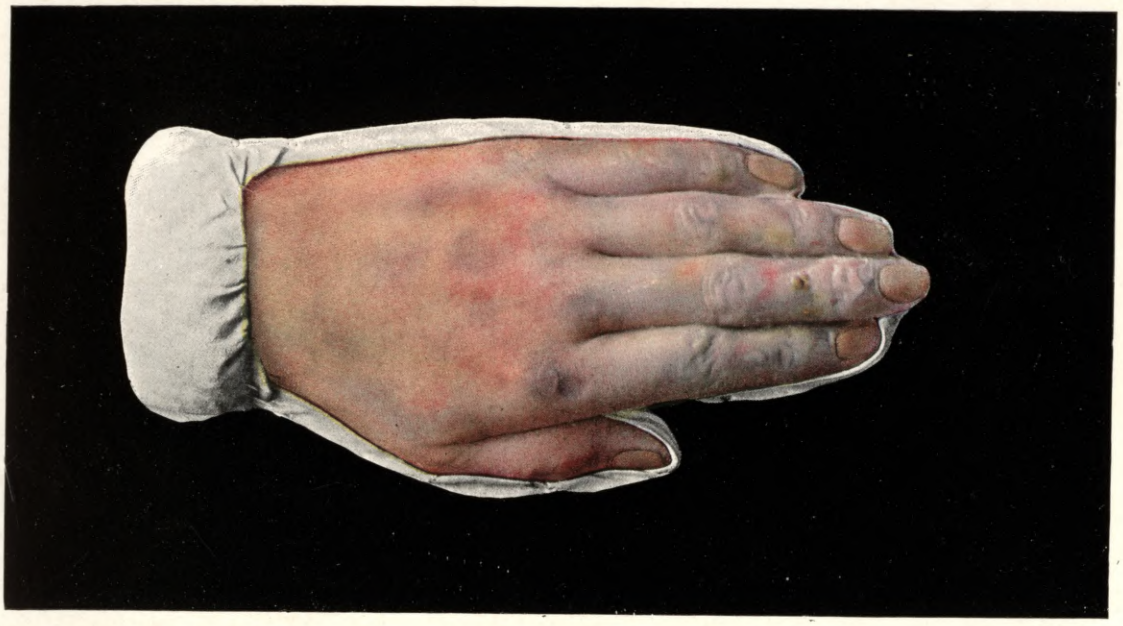
Perniones. Chilblains.

Plate XIV., Fig. 23.

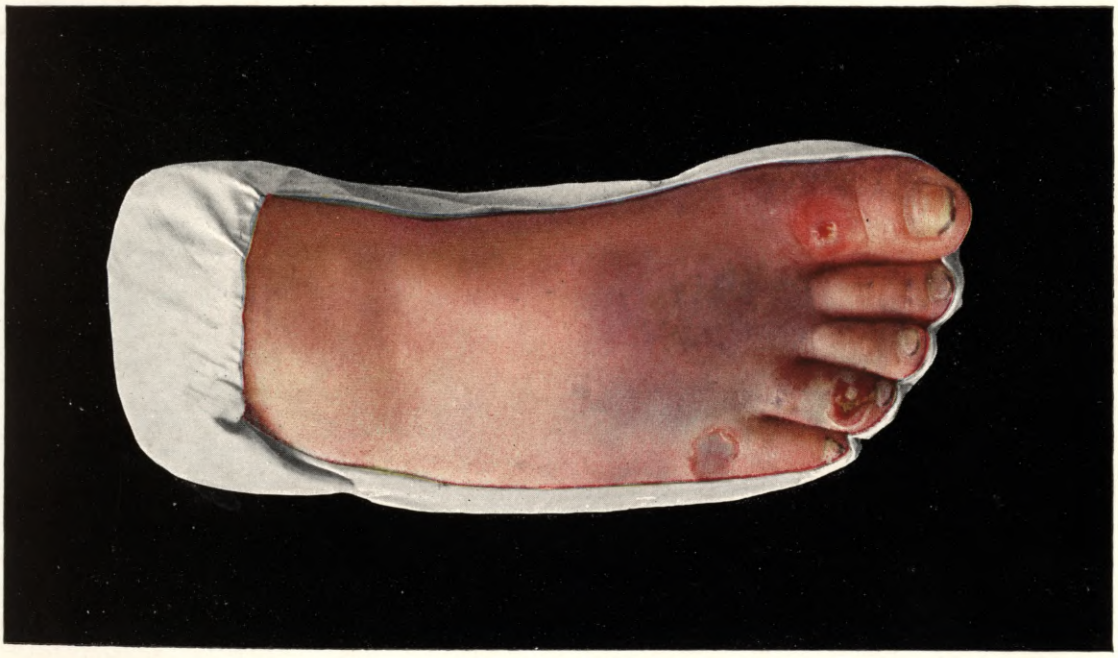
With the advent of winter, especially in anæmic young persons, and often as the effect of only slight degrees of cold, livid red nodules or swellings of doughy consistence occur on the hands and feet (Fig. 23), less frequently on the face and ears, which cause extreme itching, especially when the patient is warm. Slight mechanical irritants produce bullous elevations of the epidermis over these lesions, with blood-stained, serous contents, from which ulcers very easily form, which are atonic and heal with difficulty. In the majority of cases hereditary predisposition can be traced. Spontaneous recovery ensues with the advent of warm weather, but recurrences are almost always to be expected.

The **Diagnosis** of chilblains is easily made, based upon their seat and their occurrence with the onset of cold weather; the frequency of recurrences is to be borne in mind with regard to **Prognosis.**

Treatment must, in the first instance, be directed towards combating the anæmia, which is almost always present, and efforts must be made to harden the skin. After the development of chilblains, ulcers may be



No. 24. Raynaud's Disease.



No. 23. Perniones.

induced to heal by wet dressings with weak (1 per cent.) solutions of nitrate of silver, or with balsam of Peru ointment. Disturbances of circulation may be treated by massage, hot baths, and subsequent washing with alcohol, painting with tincture of iodine, collodion or traumaticin, by alcohol sprays, or by vigorous inunction of a 10 per cent. chloride of lime ointment.

Fig. 23. Model in Neisser's Clinic in Breslau (Kröner).

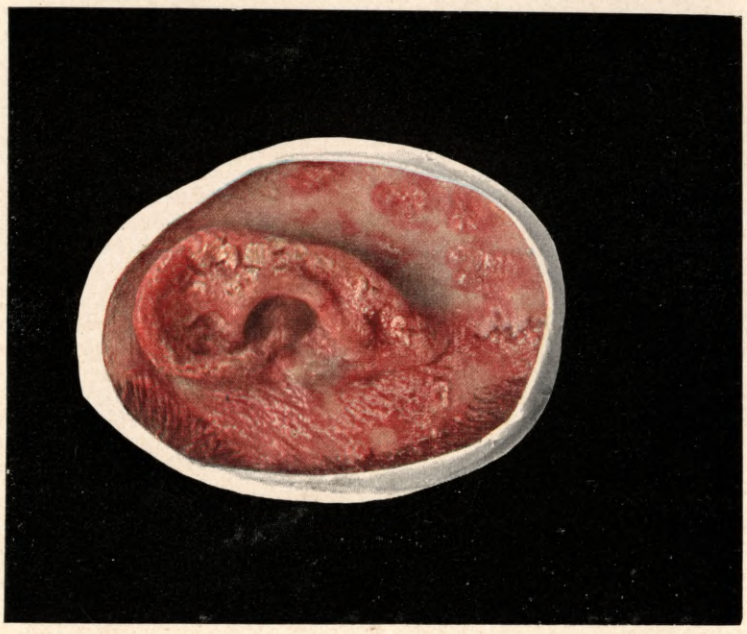
Raynaud's Disease.

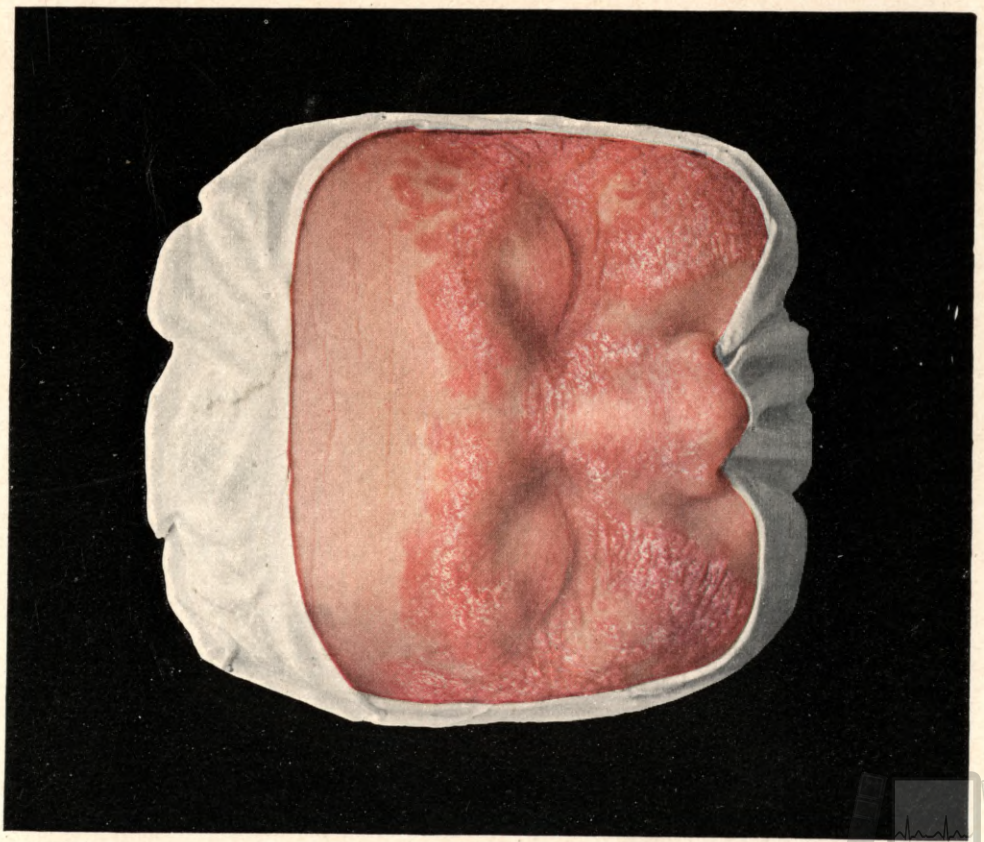
PLATE XIV., FIG. 24.

In **Raynaud's disease,** which is a malady due to disturbed innervation of central origin of the skin bloodvessels, local asphyxia with coldness and numbness occur along with very pale, or often cyanotic, discoloration of the skin (Fig. 24). For years the process may be limited to these associated symptoms, but necrosis may also occur, beginning at the tips of the fingers and toes (*symmetrical Gangrene*).

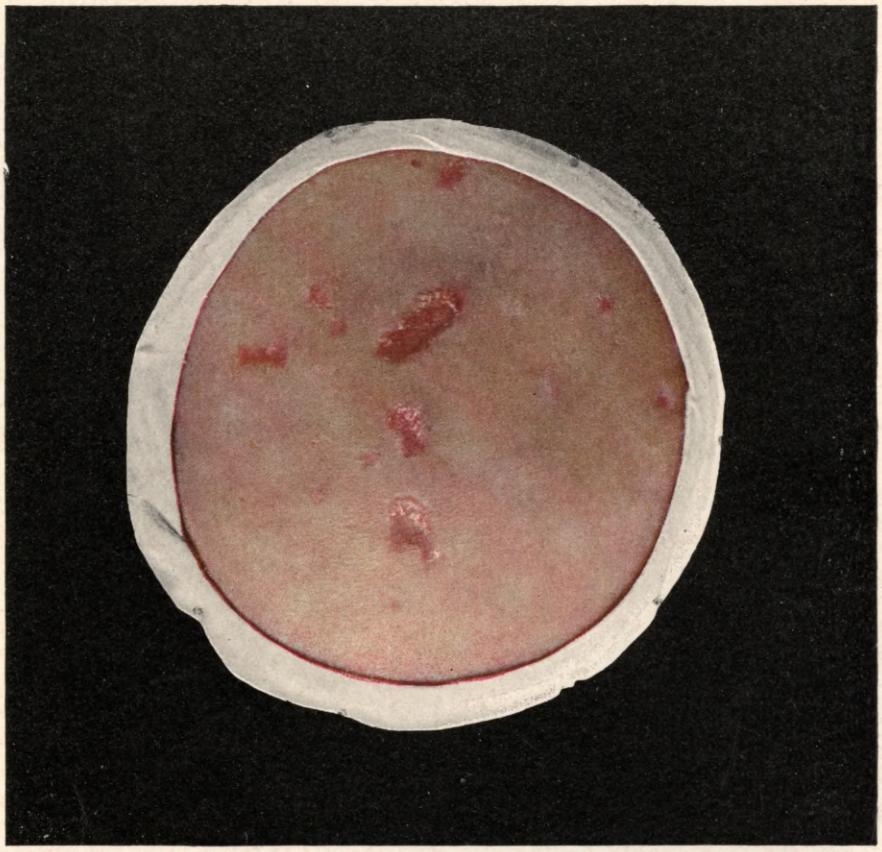
Treatment consists in attempting to improve the condition of the circulation by baths, massage, etc., but the results hitherto obtained are not encouraging.

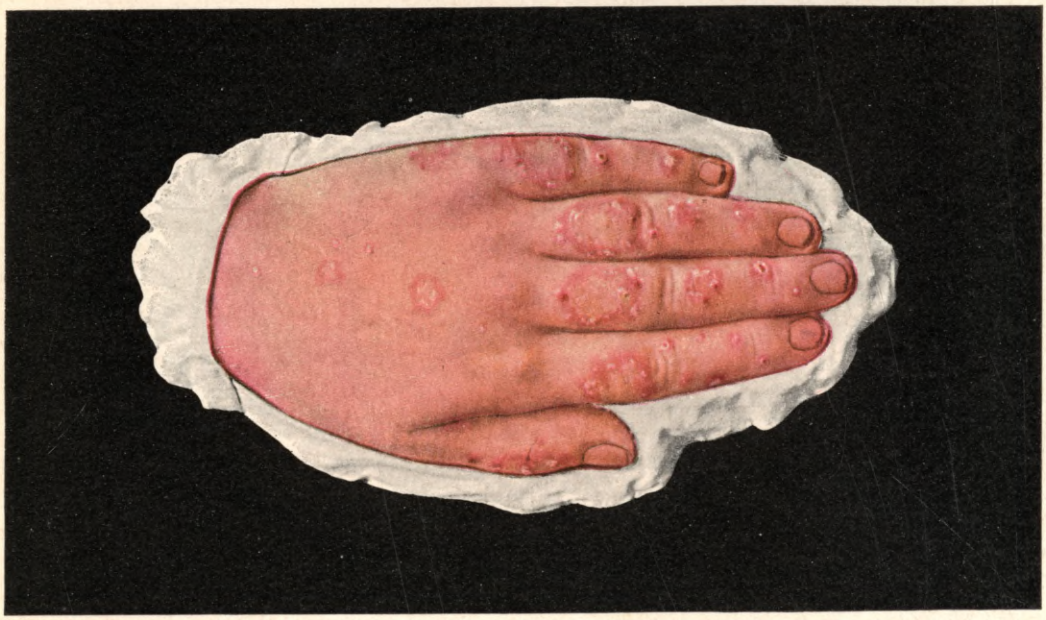
Fig. 24. Model in Neisser's Clinic in Breslau (Kröner). Confer Transactions of the Dermatological Congress held in Breslau in 1901.





No. 25, 26. Lupus erythematosus.





No. 27. 28. Lupus erythematosus.

Lupus Erythematosus.

PLATES XV., XVI. AND XVII., FIGS. 25, 26, 27, 28, 29.

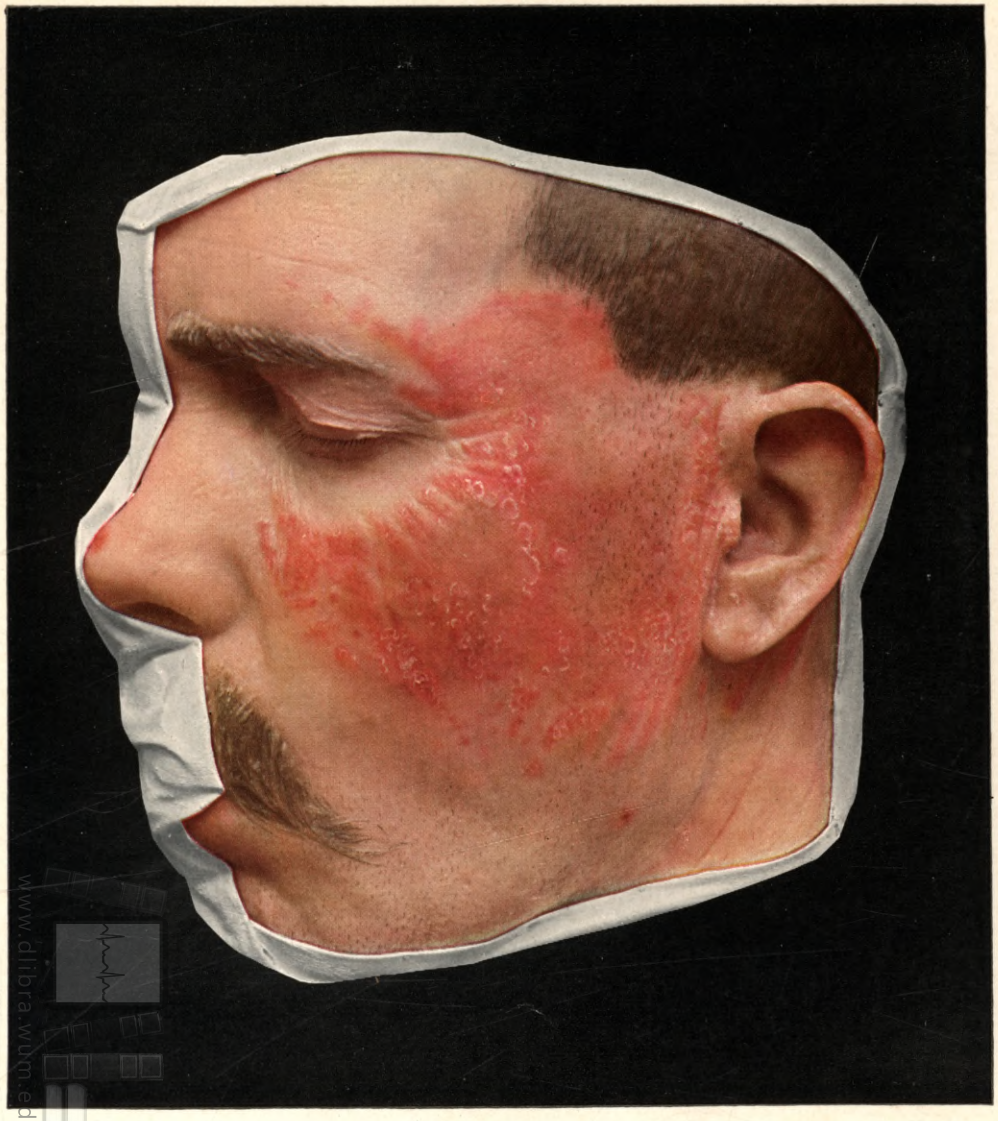
In **Lupus erythematosus** the skin changes usually begin on the face (Fig. 25), on the ears (Fig. 26), or on the scalp (Fig. 28), more rarely on the extremities (Fig. 27); they originate as indeterminate red papules, which develop by peripheral extension to form patches with margins of bright red colour, covered by firmly adherent scales. These become greenish if of long duration and, if separated, show finger-like processes on their under-surface corresponding to dilated follicular ducts. At the margin comedo-like plugs are also often present which, however, are drier and not so fatty as true comedones. The process extends peripherically with extraordinary slowness, while cicatricial atrophic spots, often traversed by telangiectases, develop in the centre without the occurrence of ulceration. A bats-wing configuration frequently results from the favourite localization on the nose and cheeks. On the scalp the cicatricial atrophy gives rise to permanent alopecia. It seldom occurs on the mucous membrane (lips).

The redness can be entirely dispelled by pressure; but on pressure with a lens the well-known nodules of Lupus vulgaris, from which this disease must be carefully distinguished, never appear. Sometimes chilblain-

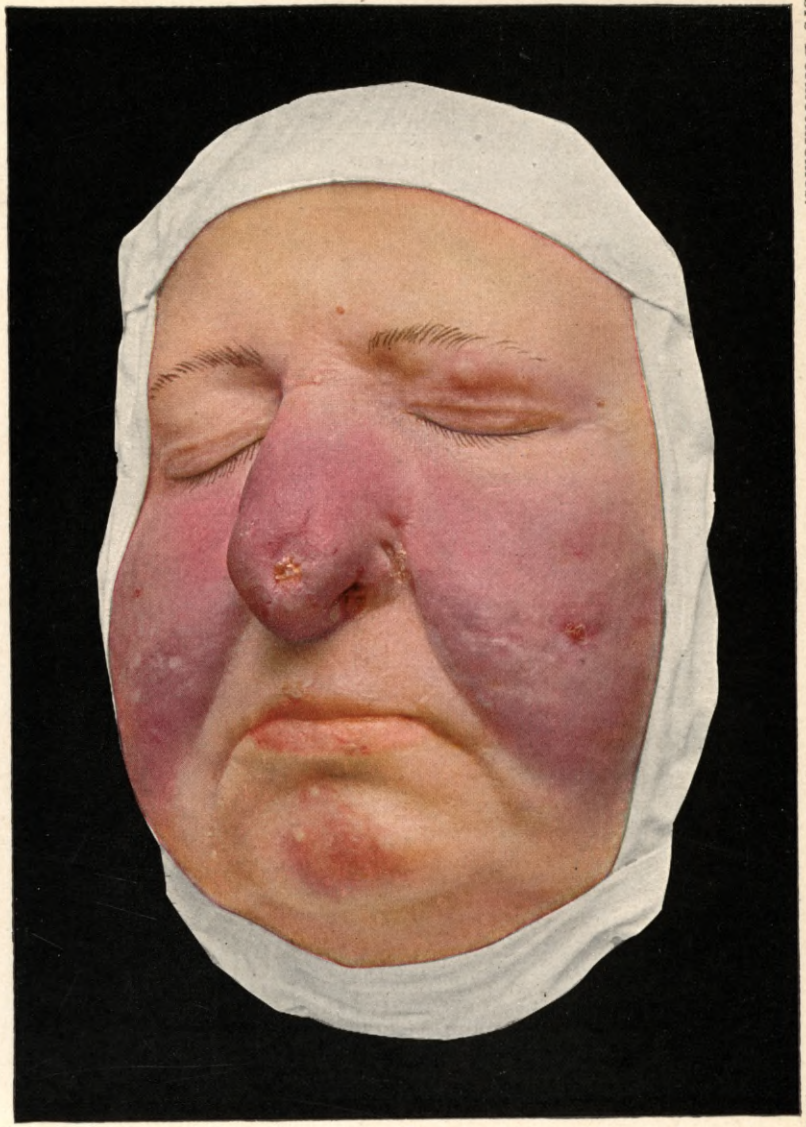
like lesions develop on the fingers, which may form rhagades and fissures, and cause considerable pain; apart from this, the disease causes little or no subjective symptoms. Besides this form, which is called *Lupus erythematosus discoides,* there also occurs an acute form (*Lupus erythematosus disseminatus*), in which numerous efflorescences occur on the face and body, accompanied by violent general symptoms and fever, which involute after a short existence and never extend peripherically, as in the patchy form, but heal with the formation of scars. This last variety may either develop from discoid Lupus erythematosus, or may arise spontaneously, and is always a serious disorder. The causes of Lupus erythematosus are unknown, but in recent years an attempt has been made to connect the disease with tuberculosis by attributing its existence to the presence of toxins in parts of the body where tubercle bacilli do not exist; no proof of this theory has yet been adduced. (Fig. 29.)

The **Diagnosis** of Lupus erythematosus may be based on its seat, the discoid shape of the lesions, the characteristic scaling, the dilatation of follicles, and the central atrophic scarring. The differential diagnosis from syphilis and Lupus vulgaris must first be established. The former is distinguished by the copious amount of infiltration and the coppery or burgundy-like colour of its elements, while other manifestations of syphilis are seldom absent. As regards Lupus vulgaris, the absence of nodules and ulcers is especially to be borne in mind. Psoriasis and mycotic diseases may be at once eliminated by the absence in them of atrophic scars.

The **Prognosis** must be guarded, as treatment is not always efficacious in the discoid forms; the dis-



No. 29. Lupus erythematosus disseminatus.



No. 30 Lupus pernio.

seminated form is a serious ailment, as has been already remarked.

Treatment.—As Lupus erythematosus usually recovers without deep destruction of tissue, although in no definite period of time, treatment must be adopted which prevents any implication of the deeper parts. External remedies which produce congestion and serous effusion often expedite the spontaneous tendency to recovery. Vigorous washing with soap, superficial application of the thermo-cautery, painting with tincture of iodine, and the inunction of sulphur or resorcin pastes, are often efficacious; but after each application a period of rest, with the employment of some indifferent salve or plaster till all reaction ceases, must be enjoined. Covering the part with mercurial plaster is often followed by good results. A long-continued course of quinine, with the simultaneous application of tincture of iodine frequently produces excellent effects, even in obstinate cases. In the vascular form good results may be obtained with plasters of Empl. salicyl.-saponat. 10%. High frequency currents are also recommended. In the follicular form X-rays are indicated.

Figs. 25, 26, 28. Models in Neisser's Clinic in Breslau (Kröner).

Fig. 27. Model in Saint Louis Hospital in Paris, No. 1437 (Baretta). Vidal's case. Symmetrical Lupus erythematosus of the hands, the face being similarly affected.

Fig. 29. Model in Freiburg Dermatological Clinic (Johnsen). The superficial invasion of the skin of the cheeks permits the recognition of the existence of numerous small circular lesions, especially in the marginal portions of the disease. Under internal treatment with quinine and painting with iodine the affection was soon reduced to minimal proportions.

Lupus Pernio.

Chilblain Lupus.

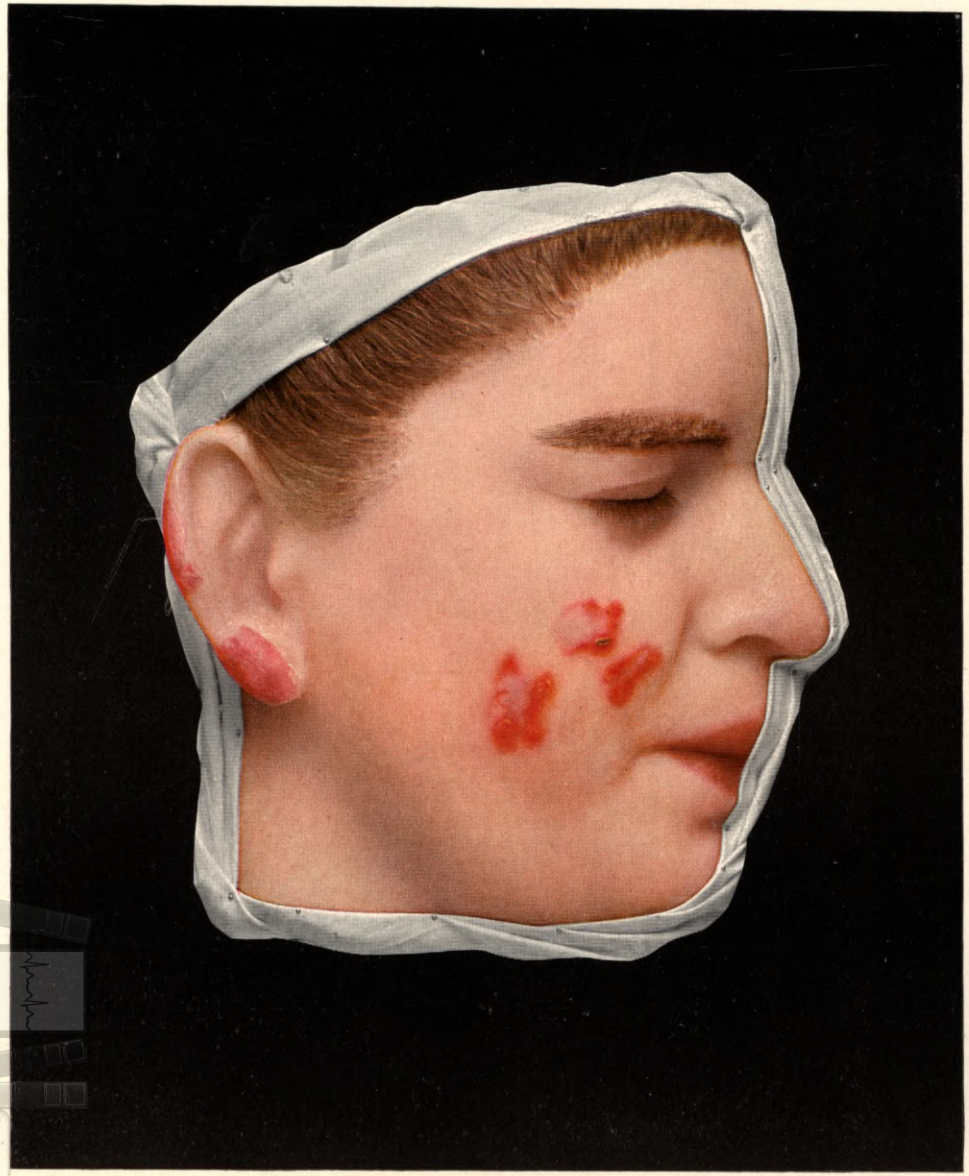
Plate XVII., Fig. 30.

Lupus pernio is a rare disease, the relationships of which to Lupus vulgaris and Lupus erythematosus are not yet clearly defined. It is characterized by the development of large cyanotic, ill-defined infiltrations and swellings, more especially on the uncovered skin of the face, ears, and hands. Small excoriations and ulcers may form in some spots, which heal up very slowly after scabbing, leaving scars. The malady, which generally occurs in anæmic persons, may recover spontaneously even after lasting for years.

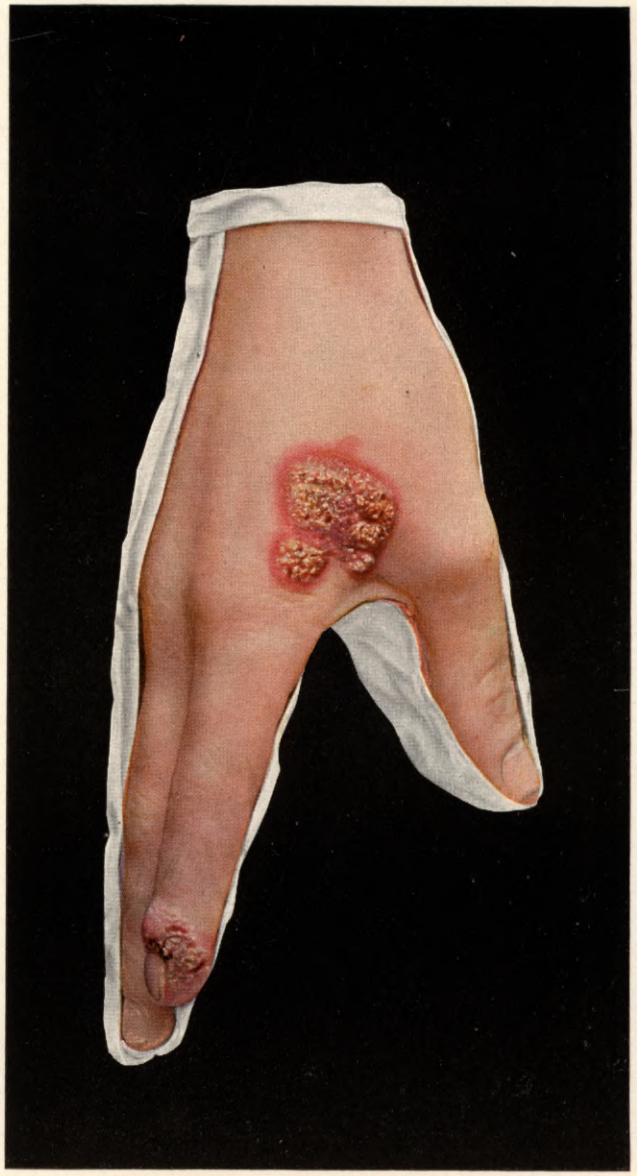
The **Differential Diagnosis** must be especially established from chilblains. These latter, however, are smaller in size, and disappear with the advent of warm weather.

Treatment.—No certain method of curing Lupus pernio is known. It is advisable to combat anæmia with iron and arsenic. For the ulcerative forms moist dressings may be used; but if the epidermis is intact, warm baths, massage, and mild plasters are suitable.

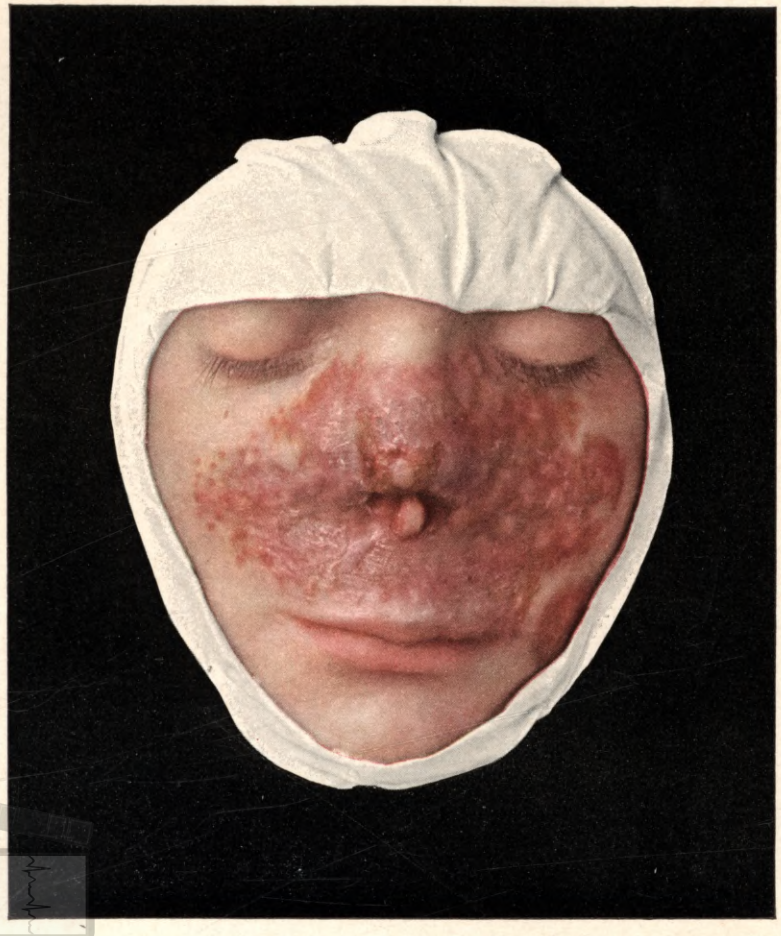
Fig. 30. Model in Saint Louis Hospital in Paris, No. 1694 (Baretta). Tenneson's case.



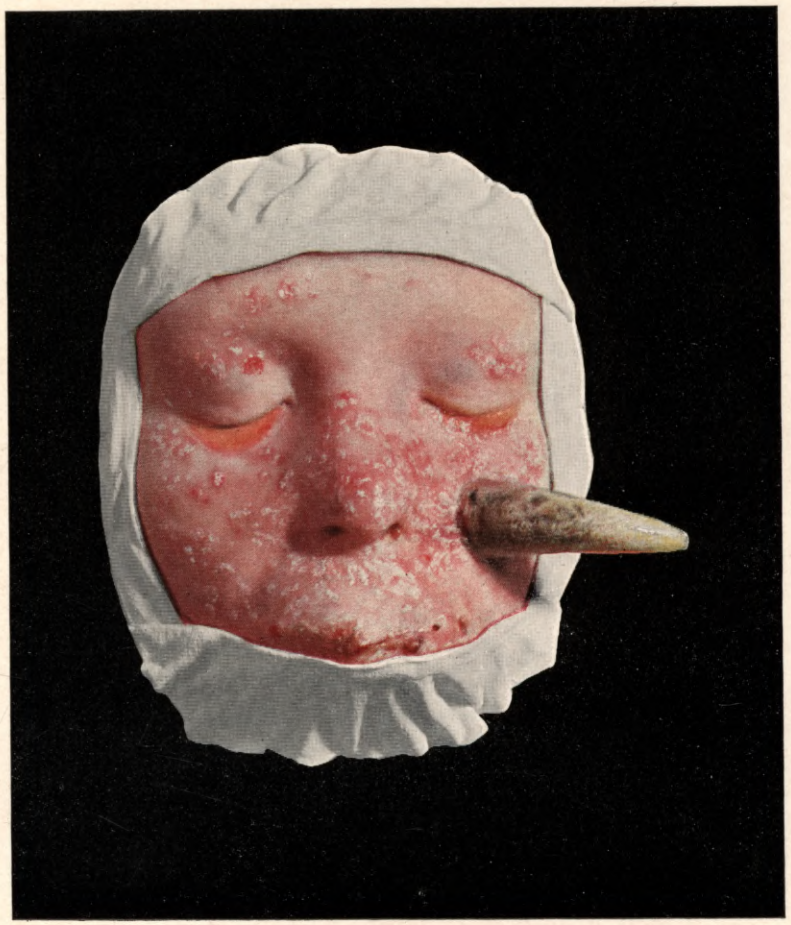
No. 31. Lupus vulgaris maculosus.



No. 32. Lupus vulgaris verrucosus.



No. 33. Lupus vulgaris.



No. 34. Lupus vulgaris; Cornu cutaneum.

Lupus Vulgaris.

PLATES XVIII-XXIV., FIGS. 31-42.

Lupus vulgaris is the most important disease of the skin produced by the migration of the tubercle bacillus into it—important both on account of its relative frequency, and of the severity of the changes and destruction of tissue produced by it; in most, if not in all cases it is caused by inoculation from the outside. The primary lesion of lupus—the lupus nodule—first appears as a brownish or brownish-red spot, which becomes pale yellow on pressure with a glass or lens, and which lies completely in the true skin; it is somewhat translucent, shiny and waxy, covered with intact epidermis, and several generally appear together in groups. Its consistence is softer than that of normal skin; a probe firmly applied to the part generally penetrates to a depth of 1 to 2 milimetres (*L. vulgaris maculosus,* Figs. 31, 33).

A slightly raised prominence results from the confluence of neighbouring nodules and their further growth in an outward direction (*L. tumidus*). The lupus nodules may now either disappear by fatty degeneration and absorption with some exfoliation, or may develop into ulcers bounded by smooth, soft margins, which are generally sharply demarcated, but are sometimes undermined. These ulcers present a more or less vigorously granulating surface, which

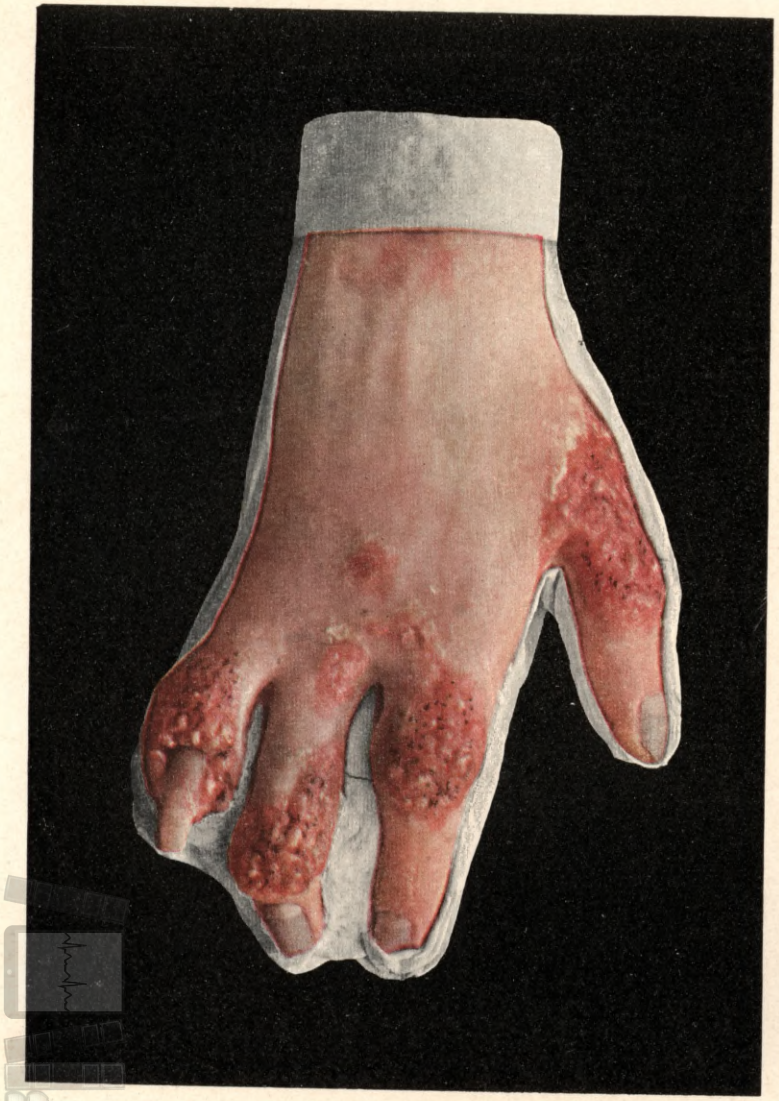
bleeds easily, and is seldom covered with slough (*L. ulcerans,* Fig. 39). Hypertrophy is sometimes simulated by burgeoning of the granulations (*L. hypertrophicus,* Fig. 35). If the granulations become covered by horny masses, as occurs chiefly on the fingers and toes, a warty appearance is produced (*L. verrucosus,* Fig. 32). The disease described by Riehl and Paltauf as *Tuberculosis verrucosa cutis* represents a form of Lupus verrucosus. Lupus serpiginosus (Fig. 39) is the result of healing in the centre and extension of the lupus nodules or ulcers at the periphery.

On the mucous membranes lupus shows itself as white, shiny nodules with a thickened epidermal covering, which soon disappears, so as to form lupus ulcers similar to those on the skin or areas covered with spreading granulations (Fig. 42).

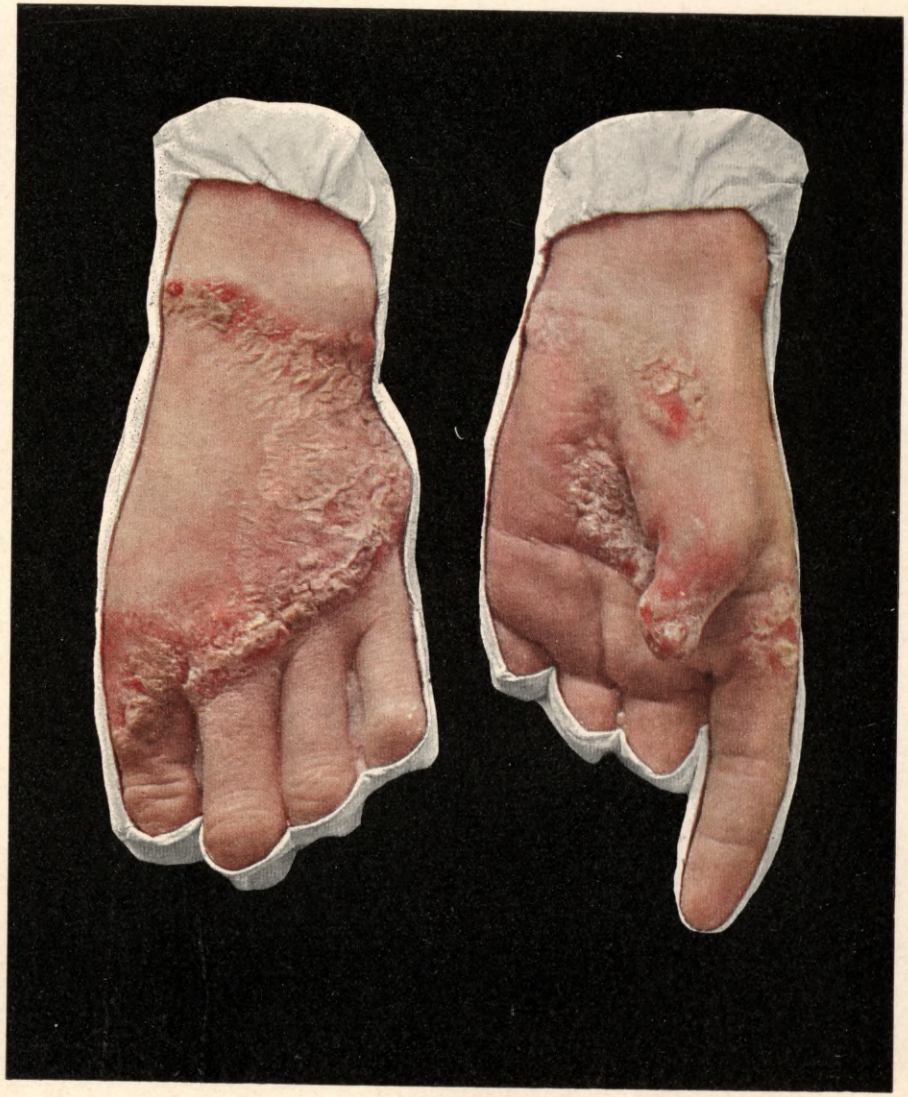
From the anatomical point of view lupus is always situated in the skin and subcutaneous tissues; it never directly attacks fascia, muscles or cartilage; these tissues can only be involved secondarily.

Lupus vulgaris most frequently occurs on the face, especially about the nose, where it causes an eroded appearance owing to absorption and shrinkage (Figs. 33 and 34); it is specially characteristic of this condition that the nasal bones remain intact. The starting-point of the disease may be either the mucous membrane or the skin, and hideous mutilation may be produced (Fig. 38, destruction of the eyes, contraction of the mouth).

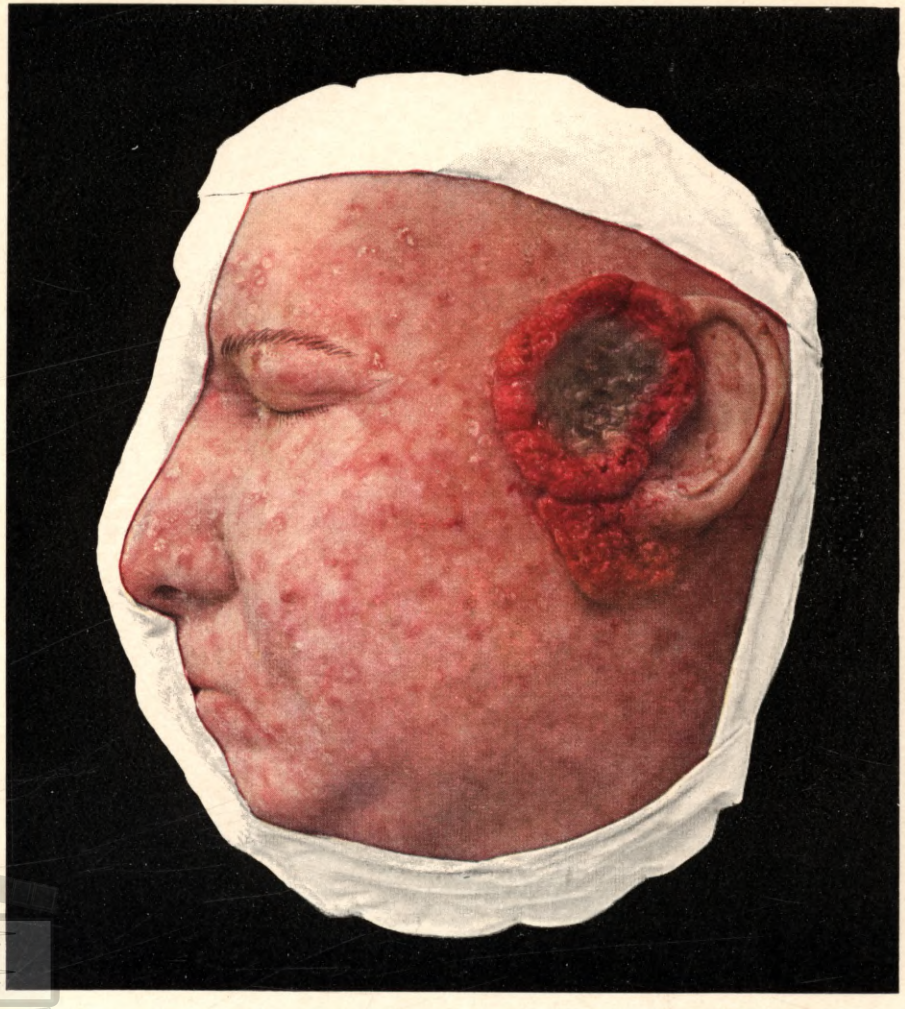
Not infrequently (Fig. 36) lupus is localized on the extremities, where it may cause the destruction of portions of the fingers and toes, or even of entire fingers and toes by obliteration of the nutrient blood-vessels of those parts (*L. mutilans,* Fig. 41). The phalangeal bones may persist, and their dislocation inside scar tissue may be observed by X-rays.



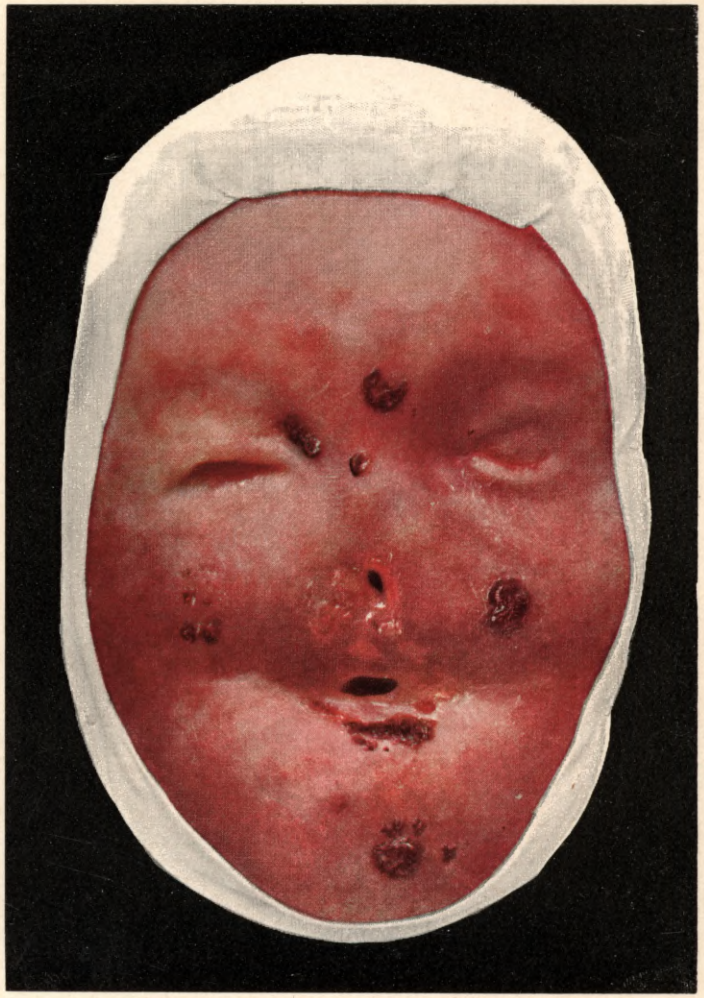
No. 35. Lupus vulgaris hypertrophicus.



No. 36. Lupus vulgaris.



No. 37. Lupus vulgaris et Epithelioma.



No. 38. Lupus vulgaris.

The course of Lupus vulgaris is extremely chronic; the disease usually begins in early childhood, more rarely at more advanced periods of life. It spreads slowly, or gives rise to fresh deposits round about. The general health is often little or not at all impaired, although persons suffering from advanced lupus are more liable to general tubercular infection than healthy individuals. In the course of lupus tubercular infection of lymphatic vessels may occur, as the result of which "cold abscesses" may form at various points, which may break externally, and from this results so-called scrophuloderma without lupus (*Gommes scrofuleux,* Fig. 32). The involvement of the afferent lymph channels as the result of erysipelas—which is not an uncommon complication—leads to the formation of elephantiasic growths on the genitals and extremities (Fig. 40), the lupus origin of which can only with difficulty be established after the healing of the lupus. A very malignant form of epithelioma develops in some cases on the top of lupus of many years' duration (Fig. 37); more rarely a benign new growth of epithelial origin may develop (*Cornu cutaneum,* Fig. 34).

Sometimes lupus exists secondarily to tubercular diseases of other tissues, more especially to old-standing affections of bones or glandular fistulæ, in which case the lupus nodules are generally present in cicatrices in the immediate neighbourhood of these lesions.

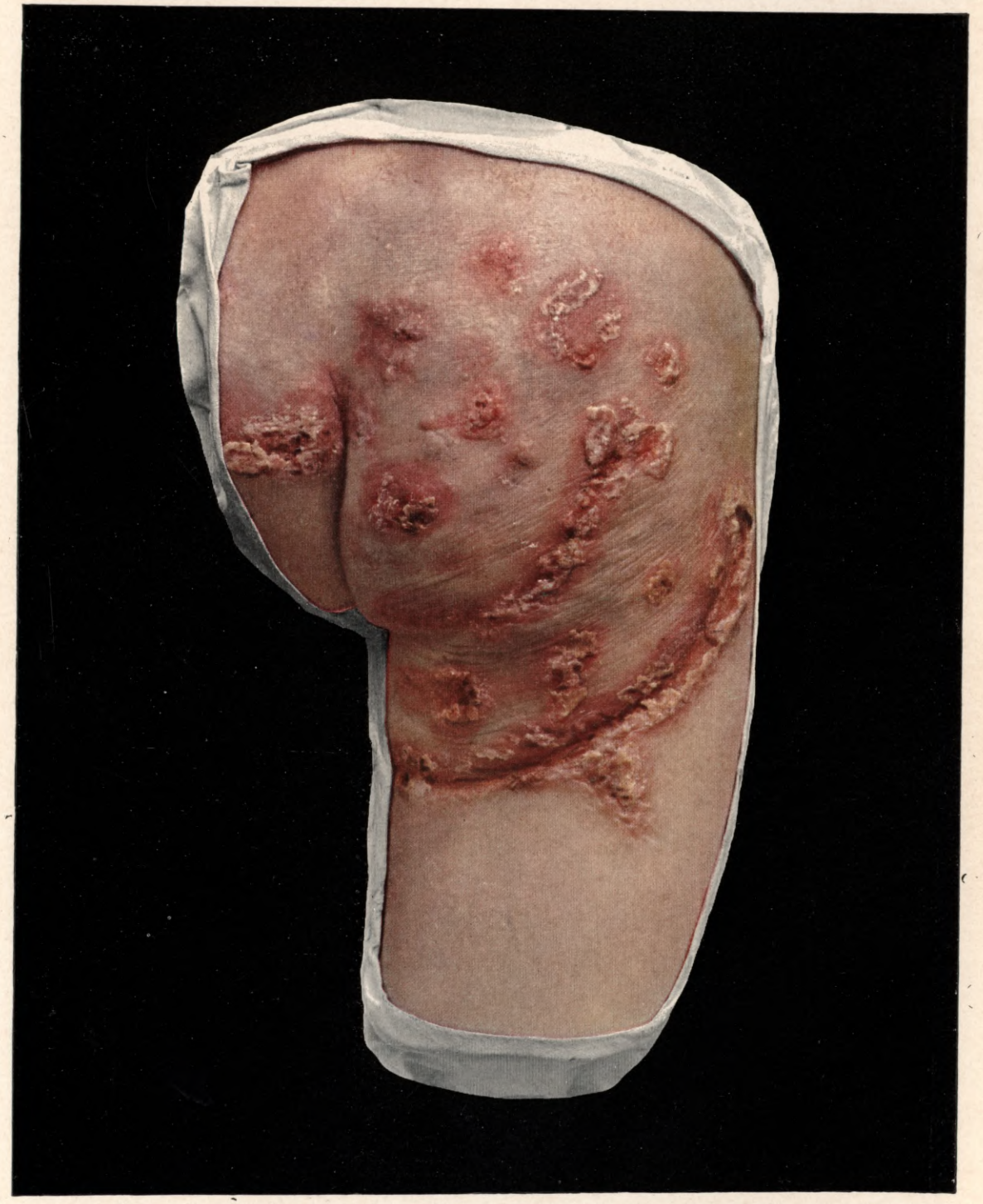
The **Diagnosis** of Lupus vulgaris is not difficult if typical nodules are present, especially when the part is examined by pressing a glass or lens on it, the nodules being thereby rendered manifest by the expression of the hyperæmia which conceals them. The result of exploration with a probe confirms the diagnosis. As nodules cannot be demonstrated in all phases of the disease, its extremely chronic course is worthy

of special notice. Syphilis produces much more extensive and deeper lesions in a much shorter time. Other points of importance are—the onset of the malady generally in youth, the absence of pain and lastly, the reaction to Koch's original tuberculin, which is an absolutely certain criterion.

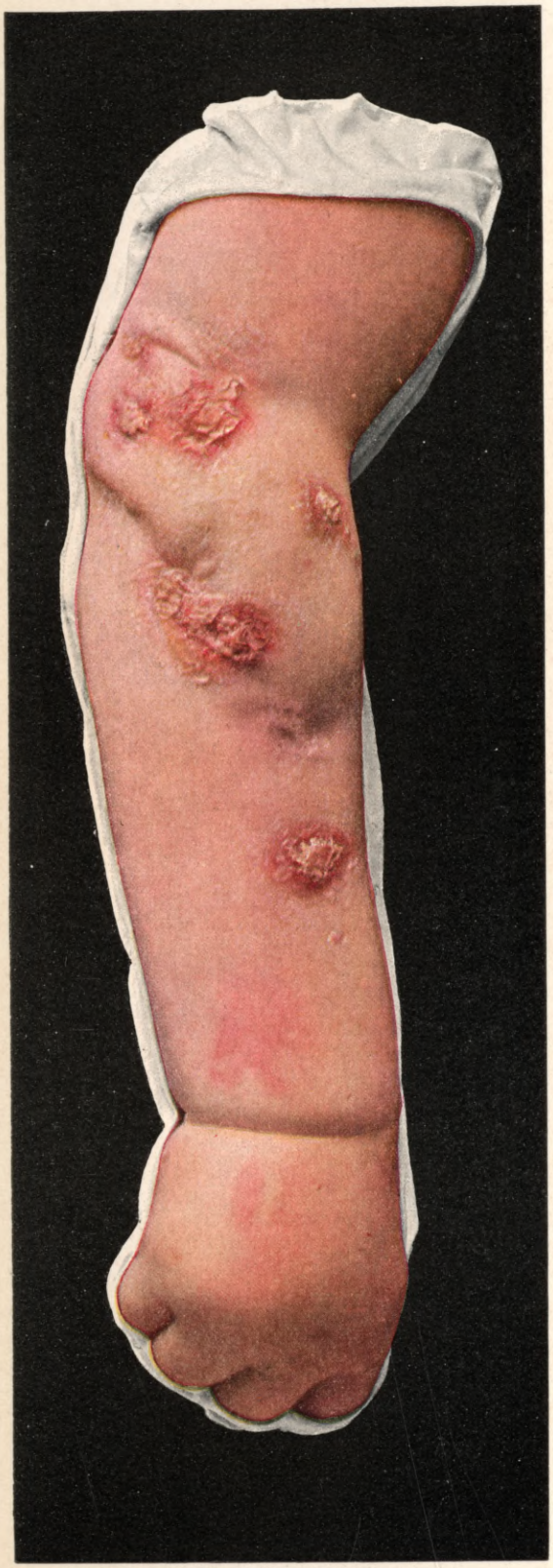
The differential **Diagnosis** must be established from Lupus erythematosus (absence of implication of bone and of lupus ulceration), from Acne rosacea (lumpy swellings, but no lupus nodules), from Ringworm (microscopical demonstration of fungus, no ulcers), but especially from Syphilis, as already mentioned. This latter point is not always easy, but the inefficacy of antisyphilitic treatment, the special tendency for syphilis to attack bones, and the typical reaction of lupus to tuberculin, generally decide the question.

The **Prognosis** as regards life is favourable, apart from the occurrence of general tubercular infection, but as regards cure it is absolutely unfavourable in extensive cases. Permanently successful results have hitherto been attained only in recent, limited cases suitable for excision. We have, however, in late years obtained, by the use of Finsen's light, permanent cures even in severe cases of lupus which have hitherto been considered of the most dire nature, owing to the hideous disfigurement so often produced by them.

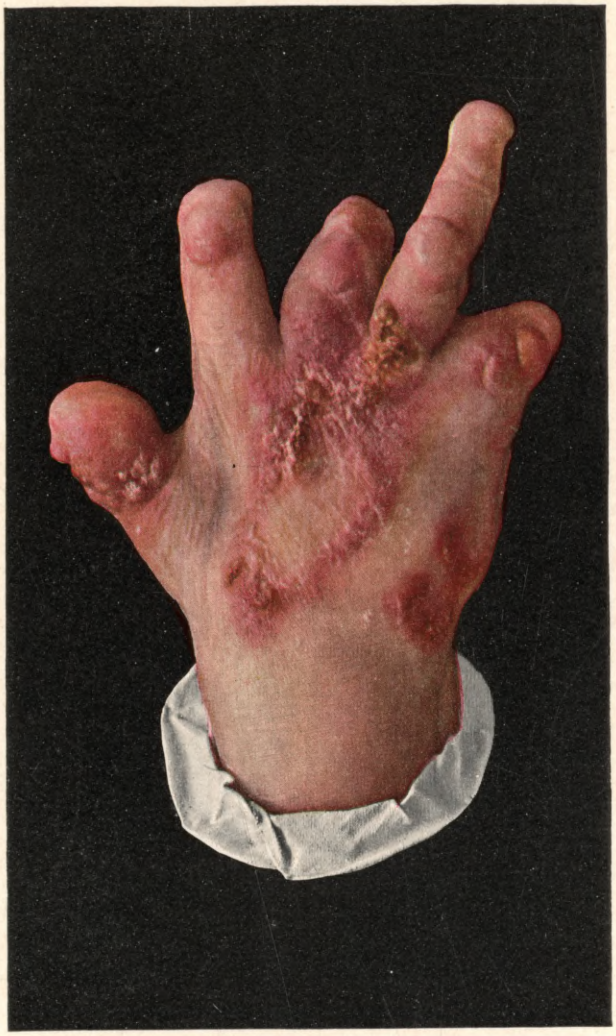
The results of **Treatment** depend in the first instance on early diagnosis. If the lupus infiltration is so circumscribed that it can be removed *in toto* without excessive loss of substance, radical extirpation is to be recommended just as if one were dealing with a malig-



No. 39. Lupus vulgaris serpiginosus.



No. 40. Lupus vulgaris; Elephantiasis consecutiva.



No. 41. Lupus vulgaris; Mutilatio.

nant tumour; the loss of substance must be remedied by suture or by grafting. In more extensive lupus, or when the subcutaneous tissue and lymphatic vessels are extensively involved, this procedure gives less certain and less beautiful results. By scraping, scarification, galvano-caustic, or galvano-cautery, or by hot-air treatment (which, however, often causes cheloid scars), either alone or combined with caustics, apparently good results may for a time be obtained, but recurrences almost invariably take place. The best caustic is arsenic in the form of arsenical paste, but it cannot well be employed over large surfaces on account of pain and intoxication; the same remark applies to pyrogallol in ointments from 2 to 10 per cent. in strength. Both remedies have a selective action—*i.e.,* they spare the sound and destroy the diseased tissue, but neither protects from relapses. Solid nitrate of silver, especially with the addition of nitrate of potassium to harden the nitrate stick, is of service for boring into nodules covered with epithelium, or may, in strong solutions, be used for ulcers, but its effects are generally too superficial. Chloride of zinc and caustic potash are deeply penetrative and energetic remedies, but they destroy also sound tissue. Lupus ulcers may heal well under 1 per thousand corrosive sublimate, or 2 per cent. permanganate of potash dressings, but the results are not permanent.

Lupus of mucous membranes can be advantageously destroyed by cauterization with lactic acid, or by thermo- or galvano- cautery. The injection of tuberculin, or of tuberculin and resorcin, cannot effect the cure of lupus.

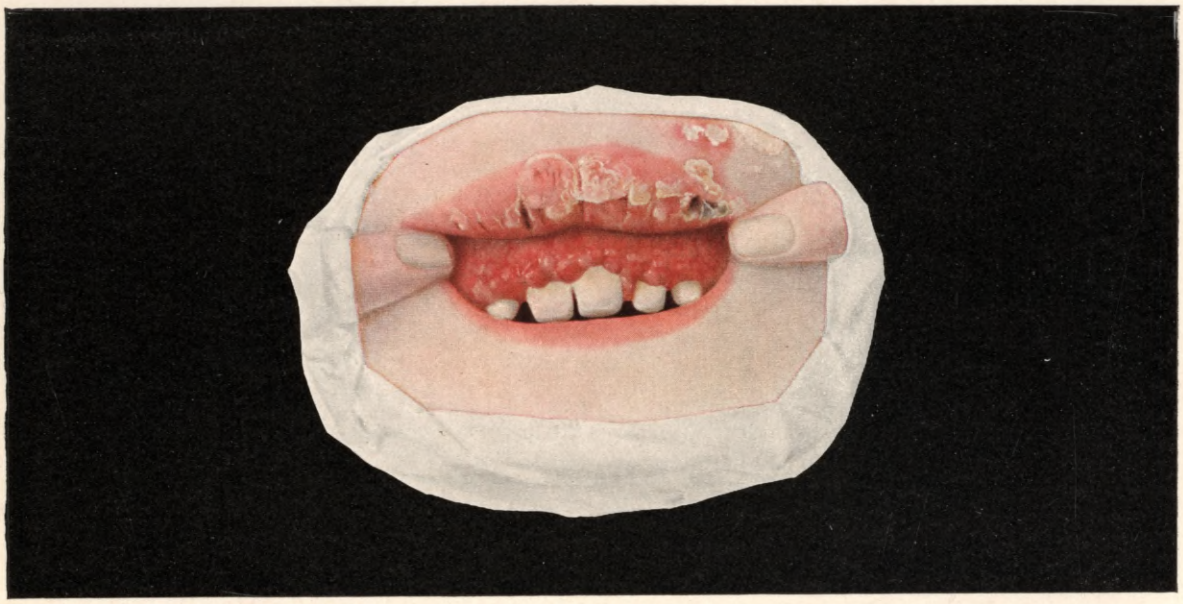
All the foregoing methods produce definite cure only in a small number of cases and after very prolonged use. Better results appear sometimes to be attained by treatment with Röntgen rays until scab-

bing is produced; but this method has not hitherto been generally adopted, on account of its very prolonged duration and the sclerodermic changes in the skin which sometimes result from it.

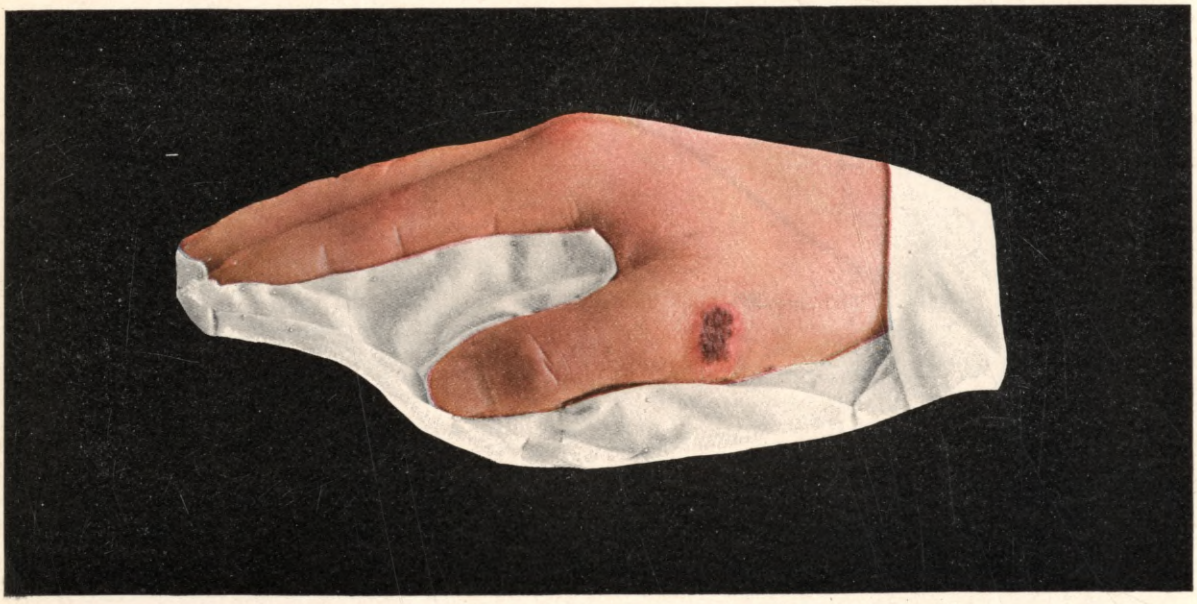
Undoubtedly the best results in extensive cases of lupus, both from the cosmetic and actually curative points of view, have been obtained by Finsen's treatment with concentrated sunlight, or by strong electric light from which the heat rays are eliminated. To judge by the results obtained by Finsen himself, the greater number of cases, even of protracted duration, which formerly would have been considered incurable may, by this means, be brought to a really perfect cure, and with the best imaginable cosmetic results, so that the possibility of completely eradicating lupus is not to be completely rejected. Unfortunately, the general adoption of the Finsen treatment has hitherto been rendered very difficult by the high price of the installation, the expense of the treatment, and by its long duration. None of the cheaper apparatus designed to replace Finsen's original apparatus (Lortet and Genoux, Bang, the Dermo lamp, Foveau and Trouvet) have, despite the great expectations founded upon them, succeeded in surely effecting the cure of lupus; so that up to the present the erection of public institutes provided with Finsen's original apparatus must be considered and advocated as the most potent weapon against this terrible malady.

General recuperative treatment must be adopted in lupus as in tubercular affections of internal organs.

Figs. 31, 32, 35, 42. Models in Freiburg Dermatological Clinic (Johnsen).
Figs. 33 and 39. Models in Neisser's Clinic in Breslau (Kröner).
Fig. 34. Model in Saint Louis Hospital in Paris, No. 1059 (Baretta). Guibout's case.



No. 42. Lupus vulgaris mucosae oris.



No. 43. Verruca necrogenica.

Fig. 38. Model in Neisser's Clinic in Breslau (Kröner).
Figs. 36, 40, 41. Models in Neisser's Clinic in Breslau (Kröner).
Fig. 37. Model in Saint Louis Hospital in Paris (Baretta). Besnier's case. Male, aged fifty-one; disease of twenty-two years' standing, only slightly treated, and especially never with thermo-cautery.

Verruca Necrogenica.

Post-mortem Wart.

Plate XXIV., Fig. 43.

Not infrequently there are present on the hands of anatomists, pathologists and post-mortem room servants peculiar brown or grayish-black hard growths, with reddened and somewhat inflamed surrounding tissue. The affection, which results from the inoculation of tubercle bacilli, is generally quite benign and superficial; only seldom can its transformation into lupus or extension into deeper tissues (lymphatics, tendons) be observed. Spontaneous cure frequently occurs.

The **Differential Diagnosis** has usually only to be established from common warts, in which there is no surrounding inflammatory zone; their surface is also generally more uniform than that of post-mortem warts.

The **Prognosis** is almost always favourable.

Treatment must be chiefly surgical. In very extensive cases the question of destruction by Light treatment may be worthy of consideration.

Fig. 43. Model by Professor Jacobi in the Freiburg Clinic.

Scrophuloderma.

Plate XXV., Fig. 44.

The subcutaneous lymphatics—and especially the lymphatic glands—are sometimes infected as the result of tuberculous disease of the skin, bones or joints; and, in consequence, painless semi-globular nodules form, either isolated or arranged in lines, which differ in size and vary from a pale reddish to a livid colour. These become attached to the skin from beneath, then gradually soften and break down, discharging a thin, purulent fluid. The walls of the resulting abscesses collapse and flat ulcers form, which secrete a slight amount of discharge and are soon covered with scabs. Their walls are deeply eroded; or narrow fistulæ result, in the neighbourhood of which the skin is extensively undermined. Sometimes spontaneous healing occurs, with the formation of irregular, radiating scars; but in other cases treatment alone effects a cure of this extremely obstinate disorder.

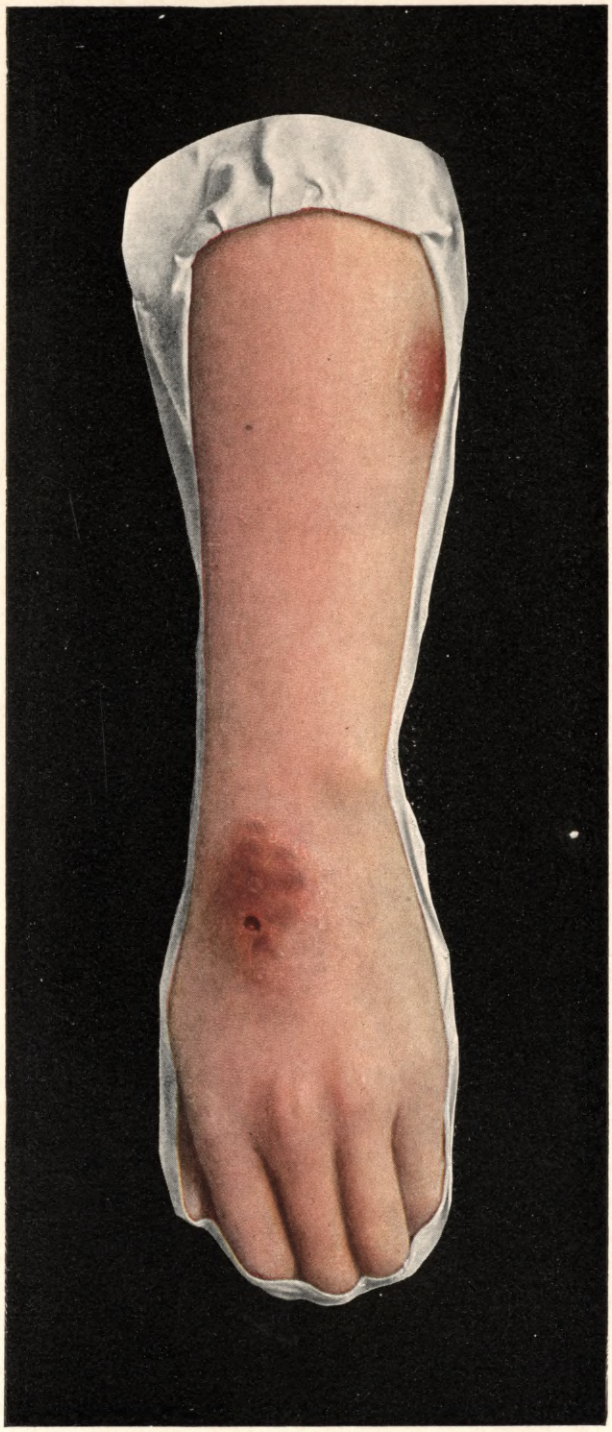
The **Diagnosis** is usually obvious owing to the co-existence of other scrophulo-tuberculous lesions, but sometimes it may present points of difficulty in differentiation from syphilitic gummata. The hardness of the infiltration and moderate degree of softening, as well as the formation of typical, crateriform, sharply-defined ulcers is to be specially noted. Finally, the

beneficial results—or inefficacy—of anti-syphilitic treatment settle any doubts.

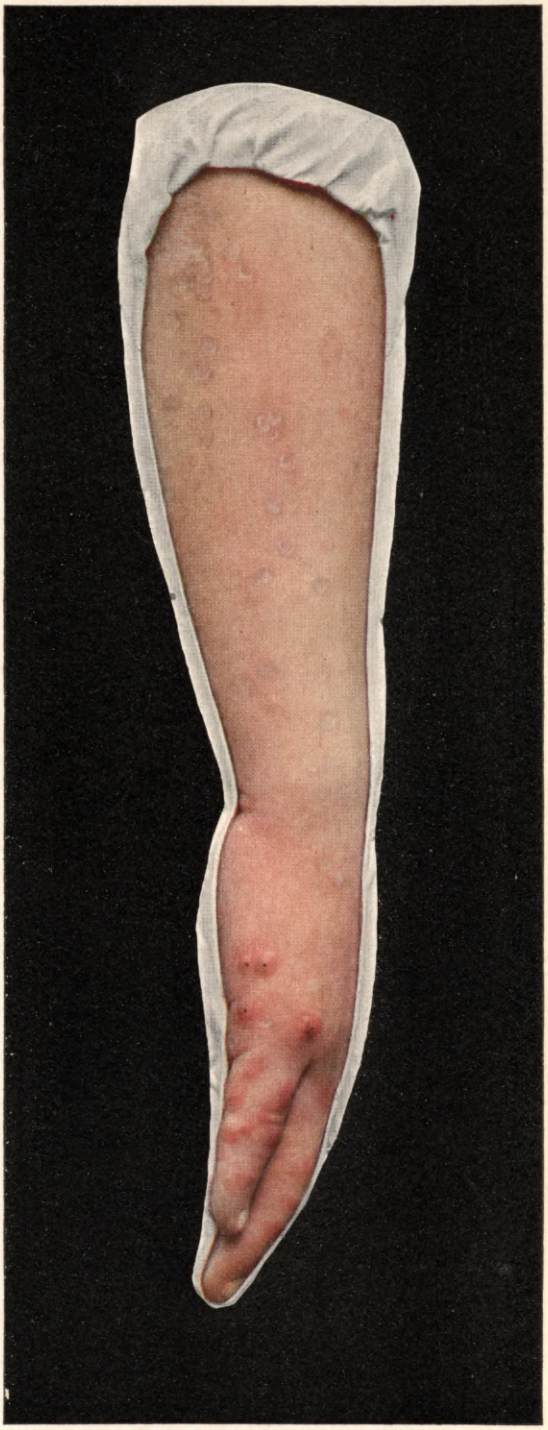
The **Prognosis** must be guarded.

Treatment.—The nodules are best treated by surgical extirpation extending well into sound tissue. If extensive softening has taken place, thorough scraping and subsequent dressing with iodoform may be recommended.

Fig. 44. Model in Neisser's Clinic in Breslau (Kröner).



No. 44. Scrophuloderma.



No. 45. Tuberculide.

Tuberculide.

PLATE XXV., FIG. 45.

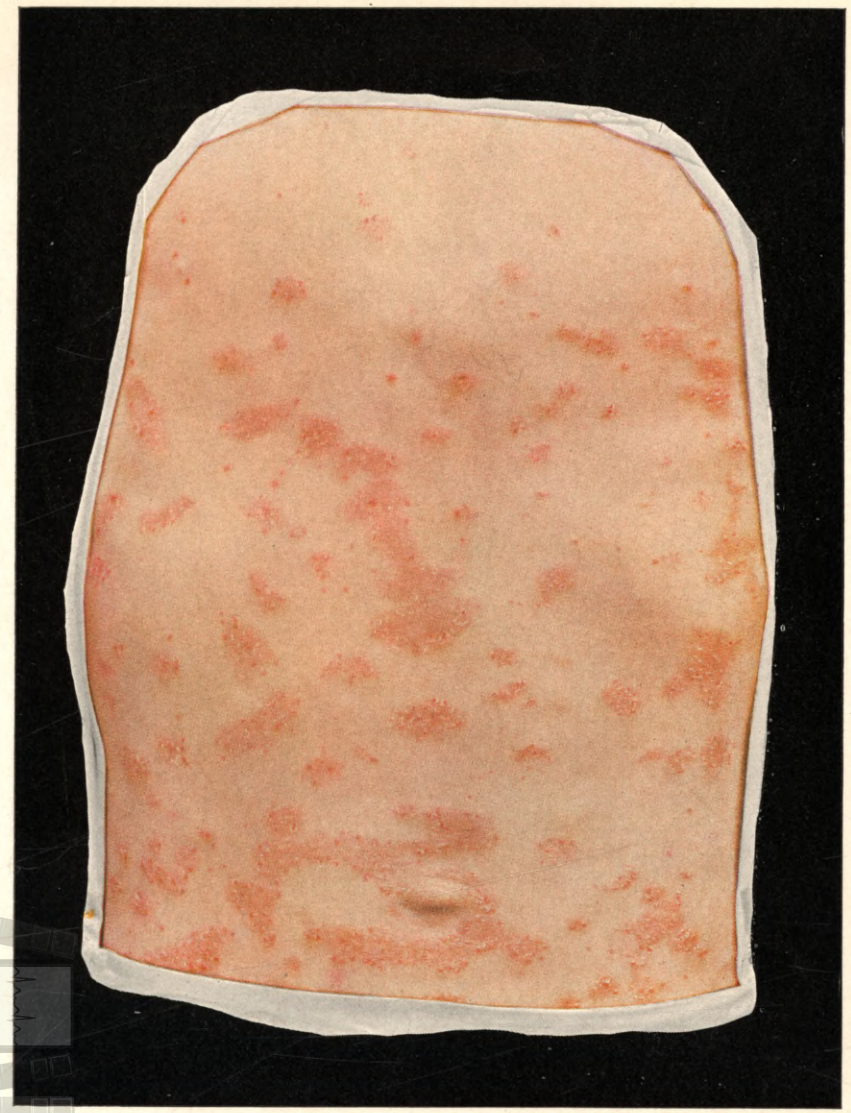
The justification of the term Tuberculide as applied to the majority of diseases of the skin supposed to result from the toxins of tuberculosis, or to many so-called "tuberculous exanthemata," appears to be extremely dubious. Some skin affections, however (*e.g.*, Erythema induratum of Bazin and Lichen scrophulosorum), are veritable tuberculoses; while the condition named the "acneiform" or "necrotic" Tuberculide (*Folliclis*) has a hardly contestable claim to the name of Tuberculide. In this protean disease sharply defined nodules develop in the subcutaneous tissue, and over these macules, papules or vesicles form. Either absorption or superficial necrotic changes ensue, resulting in loss of substance and the gradual formation of sharply defined white scars, the surrounding tissue being at first deeply pigmented. The seats of predilection are the backs of the hands, the flexor and ulnar sides of the forearms, and the ears. The eruption may, however, appear on other parts of the body and generally does so in the form of crops of lesions appearing in groups. The course of the disease is very tedious. Other chronic tuberculous lesions generally co-exist.

The **Diagnosis** in characteristic cases is based

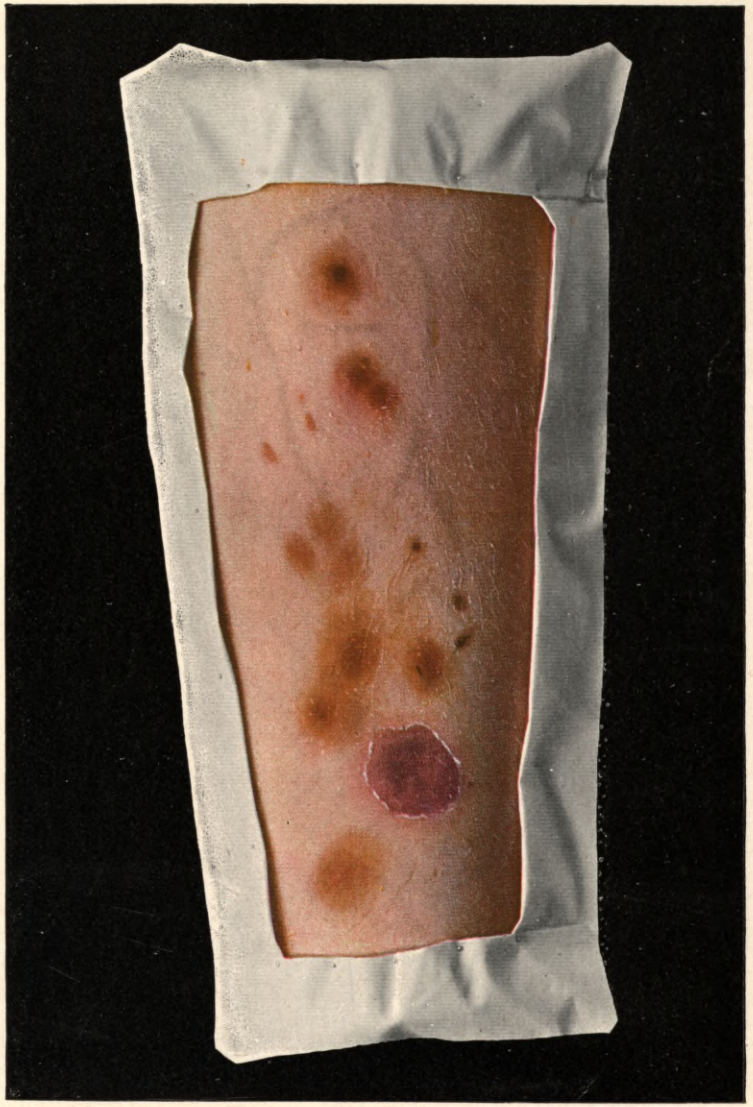
on the typical localization and evolution of the lesions. In others, it can only be established by a process of exclusion and in consideration of co-existent tuberculous manifestations.

Treatment must in the first place be directed to the tuberculous element in the condition. No specific method of local treatment is yet known.

Fig. 45. Model in Neisser's Clinic in Breslau (Kröner).



No. 46. Lichen scrophulosorum.



No. 47. Erythema induratum scrophulosorum (Bazin)

Lichen Scrophulosorum.

Tuberculosis Milio-papulosa Aggregata.

Plate XXVI., Fig. 46.

On the trunk, and less frequently on the limbs of persons suffering from tuberculosis of the skin, bones or glands, there develop (usually unnoticed by the patient) numerous yellow or yellowish-red, acuminate, small papules, sometimes in groups, at other times scattered indiscriminately. These papules, after lasting for some time, develop a small scale on their surface, and if present in larger numbers, coalesce to form scaly, rough, yellowish-brown patches (Fig. 46). The eruption, which generally occurs in young persons, causes no subjective symptoms; only seldom does the transformation of the papules into pustules or acneiform pimples occur. The disease is undoubtedly of tuberculous nature, as shown by reaction to tuberculin, the anatomical structure of the miliary tubercles, and the discovery of bacilli in them; but it is caused by bacilli of slight virulence. The intensity of the eruption varies according to the condition of the underlying tubercular disease.

The **Diagnosis** can be determined with ease on the existence of the typical papules and the co-exist-

ence of a tubercular basis, or ultimately on the occurrence of reaction to (the original) tuberculin.

The **Differential Diagnosis** need only be established from the small papular syphilide, which can be eliminated by the failure of antisyphilitic treatment.

The **Prognosis** is favourable.

Treatment must first be directed towards combating the original tuberculosis, and may be assisted by inunctions of cod-liver oil, or preferably, by weak chrysarobin ointment, which soon brings about a cure, without leaving any traces.

Fig. 46. Model in Freiburg Clinic (Johnsen).

Erythema Induratum Scrophulosorum.

(Bazin).

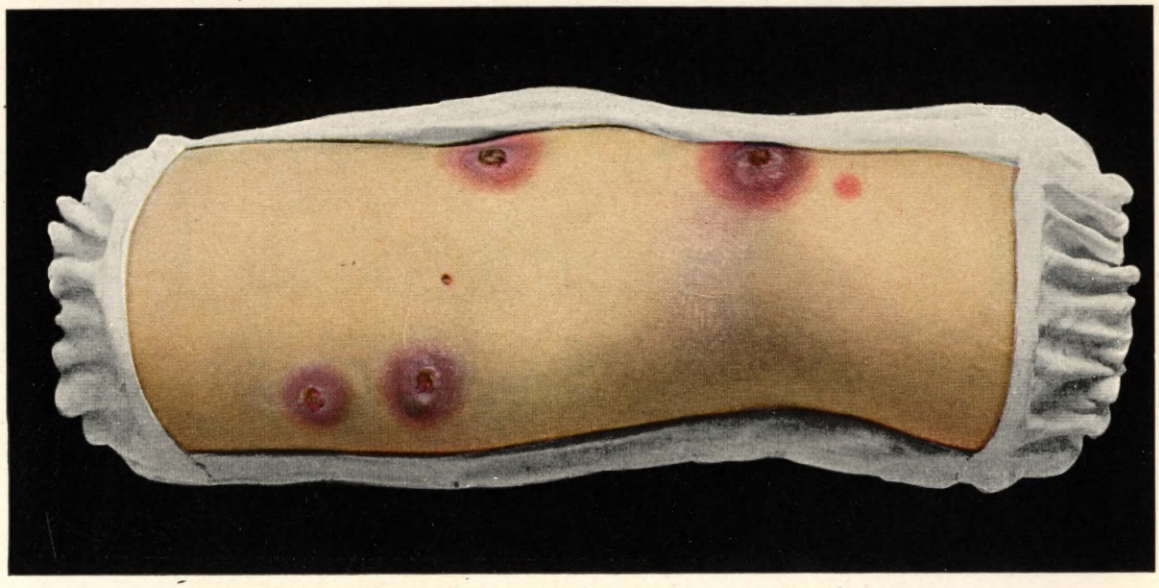
PLATE XXVI., FIG. 47.

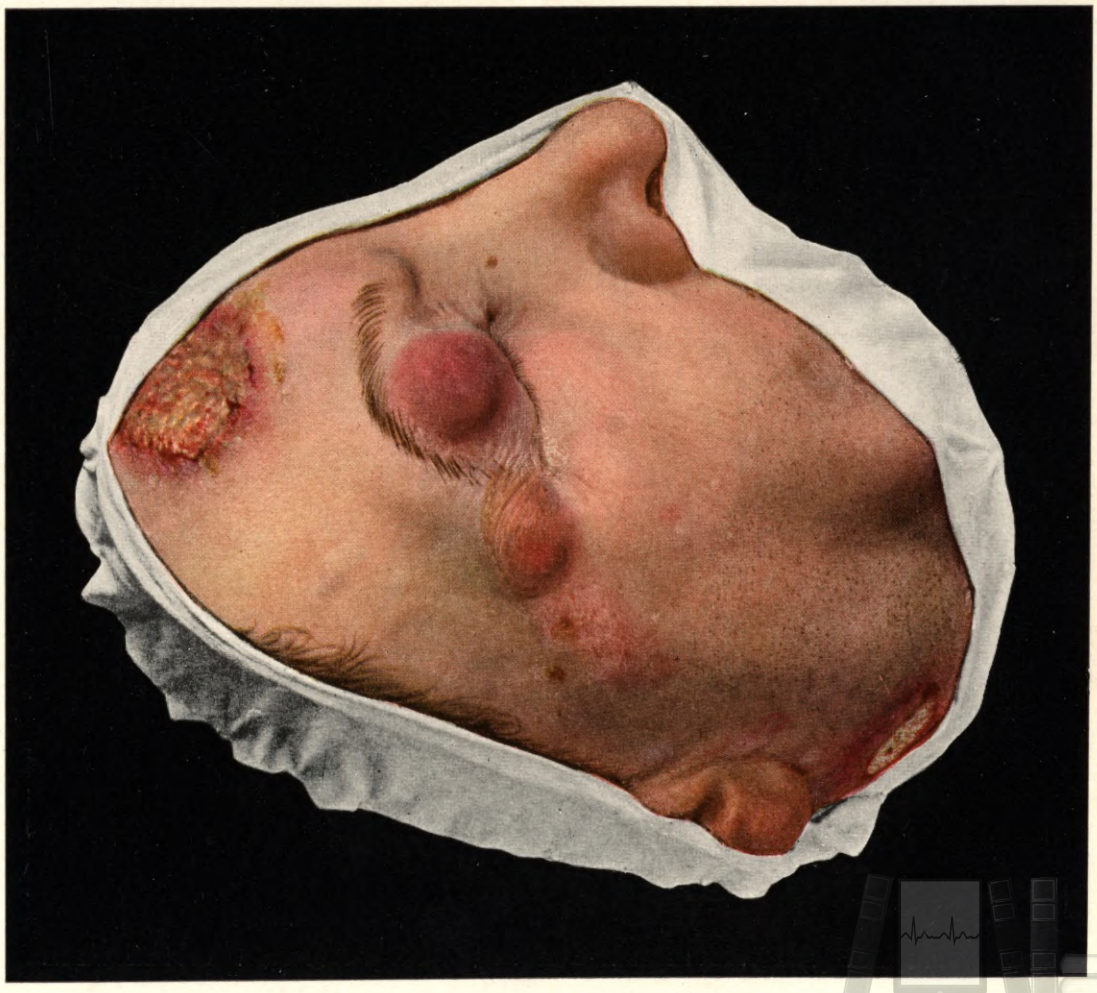
In young scrofulo-tubercular subjects, more frequently in the female than in the male sex, there are sometimes present on the legs hard, red or bluish-red, densely infiltrated nodules, which develop unnoticed, as they cause neither pain nor itching; these sometimes break and discharge their strikingly yellow-coloured contents. Either after or without rupture the nodules, which are of extremely long and persistent duration, are slowly absorbed, leaving behind deep pigmentation, while at the same time new lesions may develop. They are situated in the true skin and subcutaneous tissue; their margins are well defined; infiltrated areas as large as the palm of the hand may result from their extension and confluence. There is an undoubted connection between this disease (which is of greater frequency than is generally recognised) and tuberculosis, but the existence of tubercle bacilli in it has not yet been demonstrated. Deeper invasions of tissue do not occur.

Treatment must first be directed to the tuber-

cular origin of the disease. Local treatment is generally unnecessary and futile.

Fig. 47. Model in Freiburg Clinic (Vogelbacher).





No. 49a, 49b. Sporotrichosis (de Beurmann).

Sporotrichosis of Beurmann.

PLATE XXVII*a*; FIGS. 49*a* and 49*b*.

(*From Ikonographia Dermatologica—Rebman Company, New York*)

Beurmann and his associates have made special studies to enable them to more fully establish and define the changes caused in the skin by colonies of a certain filary fungus, called **sporotrichus.**

They have found two distinct types of *sporotrichosis.* In the first form, *sporotrichosis gummosa disseminata tuberculoides* (Fig. 49*a*), multiple, deep, subcutaneous nodules develop by a slow, painless process, which gradually affect the skin by nodulation. They soften in the centre and discharge, through a narrow fistula, on pressure, pus which at first is tenacious, but afterward turns into a serous fluid tinged with streaks of blood. The central depressed orifice is encircled by a tough infiltration of a bluish-red tinge. There is no tendency to heal spontaneously, whilst a similarity to *scrophulous gummata* exists; glandular swelling is absent, likewise other tuberculoid manifestations.

In the second but rarer type (Fig. 49*b*), a painful ulcer quickly makes its appearance without, however, any appreciable rise in the temperature. The centre of this ulcer shows a marked tendency to scar formation. The irregular but sharply defined edges are dotted with shaggy, papillomatous growths. From this primary ulcer lympathatic cords extend with nu-

merous gummatous nodes which are partially movable and partially adherent to the derma. These finally penetrate the skin and turn into verrucous plaques somewhat resembling the primary lesion. Freshly developed foci look more like acne nodules or strongly simulate the plaques of Eczema seborrhoicum.

There are other, but rather rare types of Sporotrichosis, such as the *lymphangitic gummous, classic form* described by Schenk-Hectoen, and also that mentioned by Dor with multiple larger abscesses.

Both types of Beurmann's Sporotrichosis show a well-marked similarity to certain forms of tuberculosis, especially to Scrophuloderma as well as to the gummous syphilis. The manner of softening, i.e., the foundation of narrow central fistulæ surrounded by a broad, indurated zone, as well as the absence of other tuberculoid manifestations, are the noticeable features of the Sporotrichosis gummosa disseminata. In the second form much quicker and more far-reaching changes may be observed than is the case in tuberculosis and syphilis.

The **Diagnosis** can only be established with certainty through cultural methods. Nearly all culture media (the most reliable for this purpose is Sabouraud's) produce from implantations of cellular tissue, pus, secretions or scales, under medium or body-temperature within 5-10 days, small white or brownish cultures surrounded by a fiat radiation which later on assumes a brown to black colour. Under the microscope this appears as long, about 2 μ wide, straight or slightly curved, and at times ramified threads. Adhering to these are numerous egg-shaped spores of various magnitudes. In the pus itself, as also in the secretions and in the cellular tissue, it is difficult to discover these spores with the microscope. Sporotri-

chosis produces similar changes in animal inoculation with cultures, whilst with the pus or cellular tissue itself no results are obtained.

Prognosis is favourable.

Proper **Treatment,** consisting of internal and external applications with Iodine preparations, will effect a sure, though at times slow, cure. The alkali compounds of Iodine meet the requirements for internal medication. For external use wet bandages with Iodine or Iodide of potassium and kindred lotions are indicated.

Figs. 49*a*, 49*b*. Models in the St. Louis Hospital in Paris (Baretta). No. 2531 and 2557. Dr. de Beurmann's cases.

Tuberculosis Linguæ.

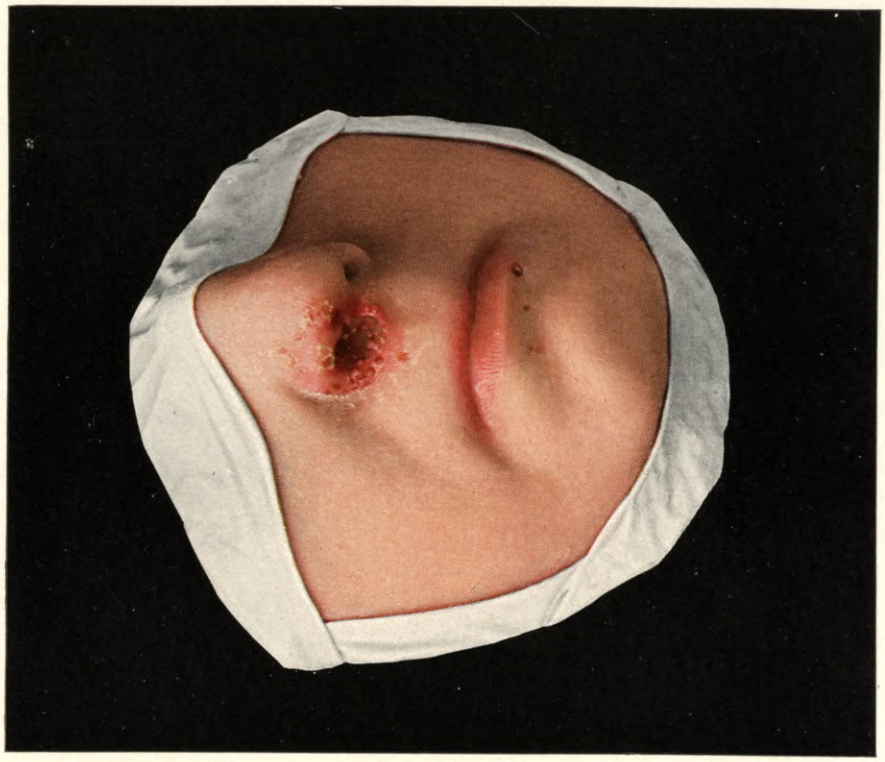
Tuberculosis Nasi.

Tuberculosis of Tongue and Nose.

PLATE XXVII., FIGS. 48 AND 49.

In persons who suffer from tuberculosis of internal organs, true tuberculosis of the skin and mucous membrane, especially at their points of junction, is observed much less frequently than ordinary lupus. But—generally as the result of direct infection by bacilli in the discharge—ulcers may form which are round or irregular in shape, painful, and extend rapidly; their base is granular, bleeds easily, and is partly covered with sticky discharge, while miliary tubercular nodules may not infrequently be identified at their margins (Fig. 49). On mucous membrane the margins are, as a rule, undermined (Fig. 48). Numerous bacilli are—in contradistinction to lupus—to be found in the ulcers, which have also a much slighter tendency to heal, extend with far greater rapidity, but seldom attain larger dimensions than in lupus, as the patients die sooner.

The **Diagnosis** can generally be established without difficulty on the grounds of their localization, characteristic appearance, painfulness, and the general



No. 49. Tuberculosis nasi.

No. 48. Tuberculosis linguae.

tubercular symptoms. It may be confirmed by the discovery of bacilli. The differentiation from syphilis may be established by the behaviour of the lesions under antisyphilitic treatment.

The **Prognosis** is unfavourable.

Treatment must have for its object the diminution of pain by dusting with orthoform, anæsthesin, and similar remedies, as the general condition of the patient usually forbids the use of energetic measures. Should such, however, be permissible, attempts may be made to effect a cure with caustics, "light treatment," or surgical measures.

Fig. 48. Model in Saint Louis Hospital in Paris, No. 1768 (Baretta). Tenneson's case.
Fig. 49. Model in Saint Louis Hospital in Paris, No. 2236 (Baretta). Hallopeau's case.

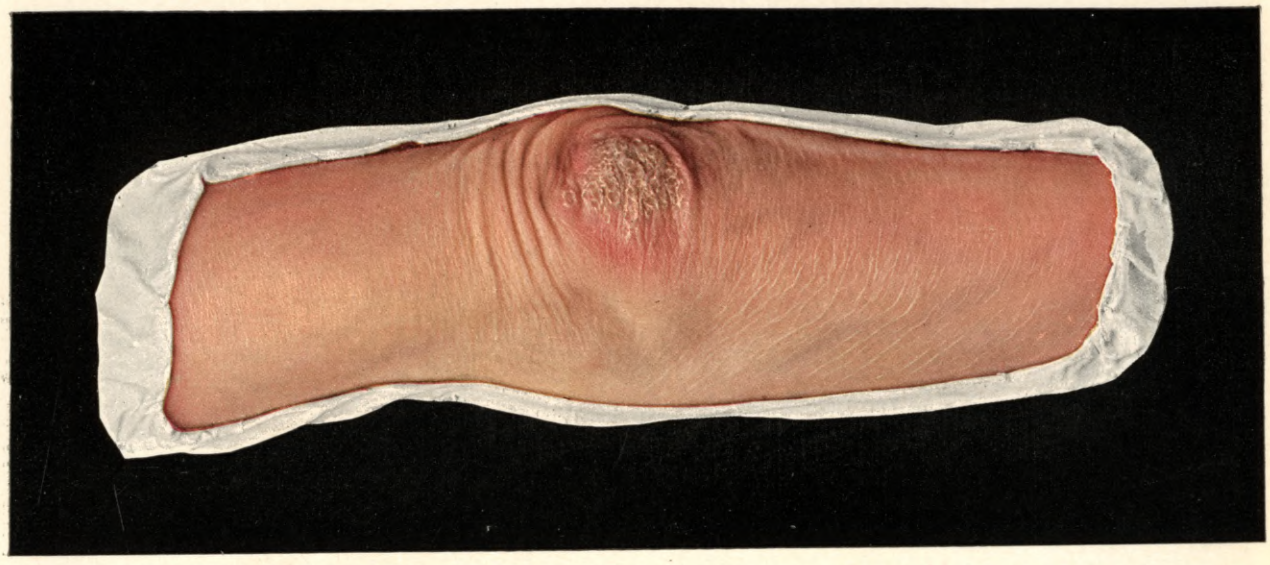
Lepra. Leprosy.

Elephantiasis Græcorum.

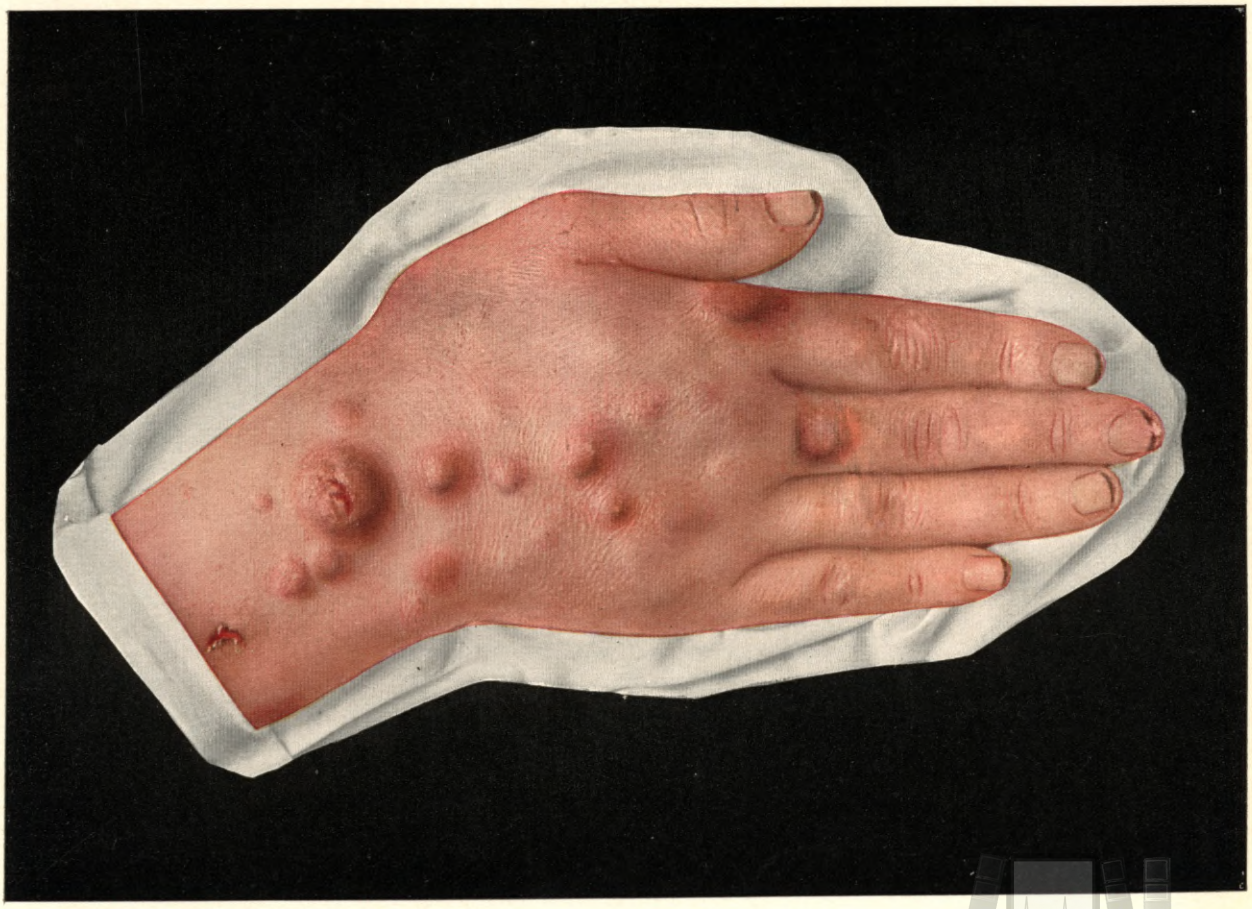
PLATES XXVIII-XXX., FIGS. 50-55.

Leprosy is a general infective disease, known even in very ancient times as a contagious malady, which was very widely distributed till the Middle Ages. At the time of the Crusades, however, it was forced into the background by the advance and extension of syphilis, and now its occurrence is extraordinarily diminished, so that it exists with frequency in the tropics only, and is scattered sporadically over Europe (Norway, Russia, Greece, with a small area near Memel). We draw a distinction between *tubercular leprosy* and *nerve leprosy,* according to the localization of the causative agents of the disease—viz., the lepra bacilli discovered by Hansen and Neisser—whether in the skin or in the nervous system. Not infrequently "mixed forms" also occur.

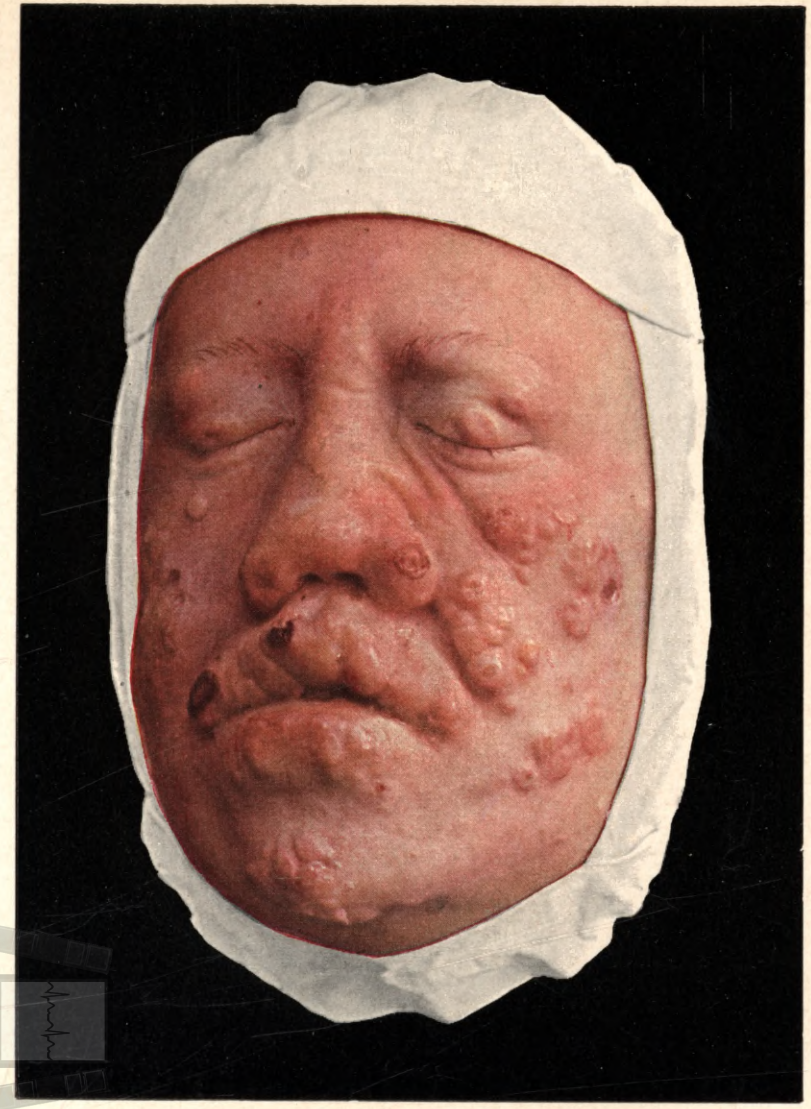
In tubercular leprosy, along with the symptoms of a general infective process—fever and prodromal exanthemata—nodules and infiltrated areas of varying size gradually form, over which the skin is usually brown and shiny (Fig. 50), or sometimes may present an eczematous or psoriasiform appearance. The commonest localization (Fig. 51)—viz., on the face—produces the early falling of the eyebrows and thickening of the facial folds, which go to make up the so-called

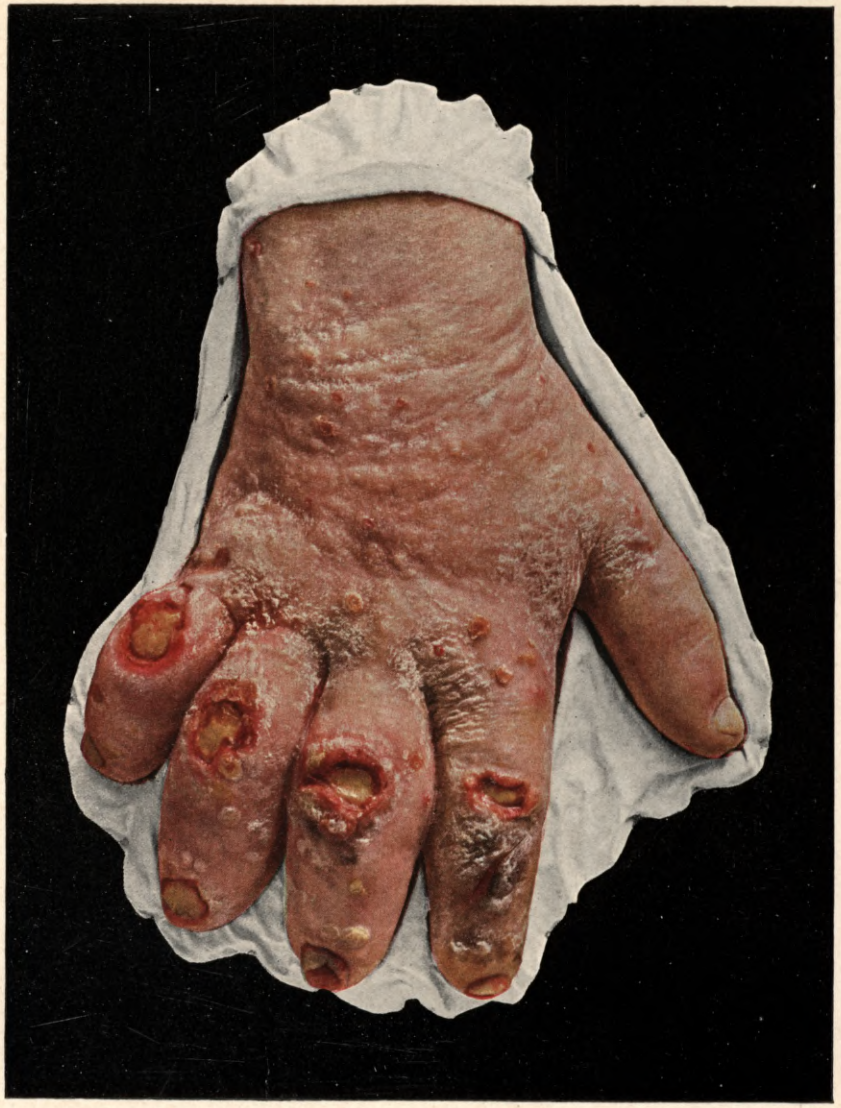


No. 51. Lepra psoriasiformis.



No. 50. Lepra tuberosa.





No. 52. 53. Lepra tuberosa.

facies leontina (Fig. 52). The nodules may be absorbed after long existence, or may form indolent ulcers, healing with great difficulty (Fig. 53), common on the mucous membranes, which are frequently involved. It seems that the mucous membranes are often the starting-point of the skin disease; at least, it is stated in many quarters that the primary lesion exists most frequently in the nostril.

If the disease is of long duration, the peripheral nerves generally are involved, and, finally, the internal organs also. After illness extending over years, death occurs, but previously blindness often results from destruction of the cornea or of the entire eyeball.

In nerve leprosy the morbid changes are referable to primary disease of the peripheral nerves. Hyperæsthesia, anæsthesia, and paræsthesiæ may generally be observed in the earlier stages. The nerve strands which lie close beneath the skin appear thickened like cords. At the same time there are changes in pigment distribution, sometimes corresponding to the irregularly distributed anæsthetic areas, sometimes independently, while atrophies and paralyses of muscles occur, especially in the face and hands—the so-called "clawed hand" (Fig. 55).

Frequently ulcers form as the result of trophic disturbances or of injuries and burns, which are not perceived owing to anæsthesia (*e.g.*, "perforating ulcers," Fig. 54), and more extensive destruction of the skin may give rise to mutilation and amputations of fingers and toes.

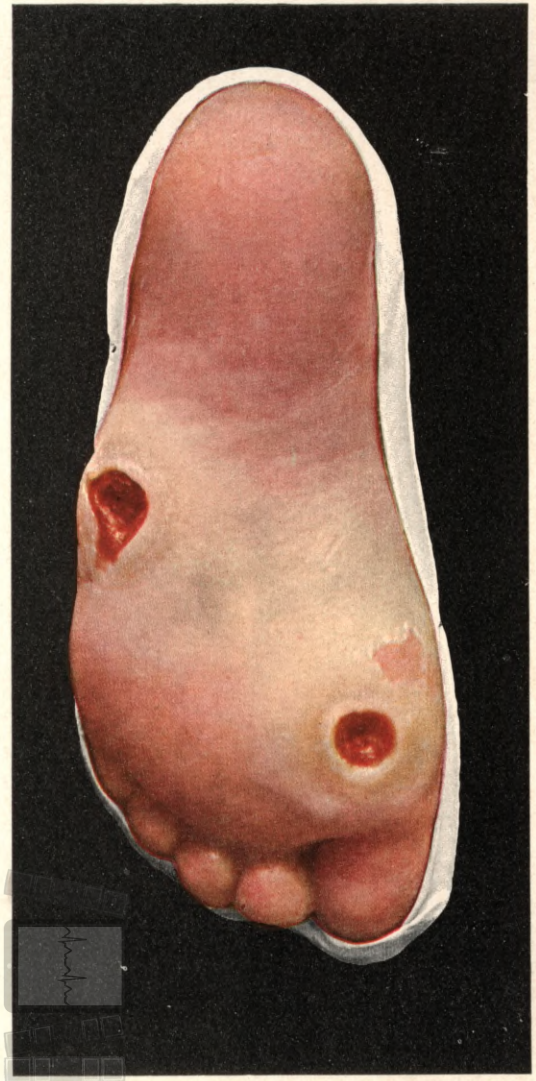
Although the course of tubercular leprosy is very chronic, and, on the average, lasts from eight to ten years before death ensues, that of pure nerve leprosy and of the mixed forms is even much slower. In such cases a duration of twenty to forty years is not very exceptional.

In fully developed tubercular leprosy the **Diagnosis** is not difficult, and may be confirmed by microscopical demonstration of the bacilli; the history of residence in the tropics or in a leprous district is to be taken into consideration. On the other hand, the diagnosis of nerve leprosy is not easy, especially from certain diseases of the spinal cord; the swelling of the peripheral nerves is of diagnostic importance. In the mixed forms all these points must be considered.

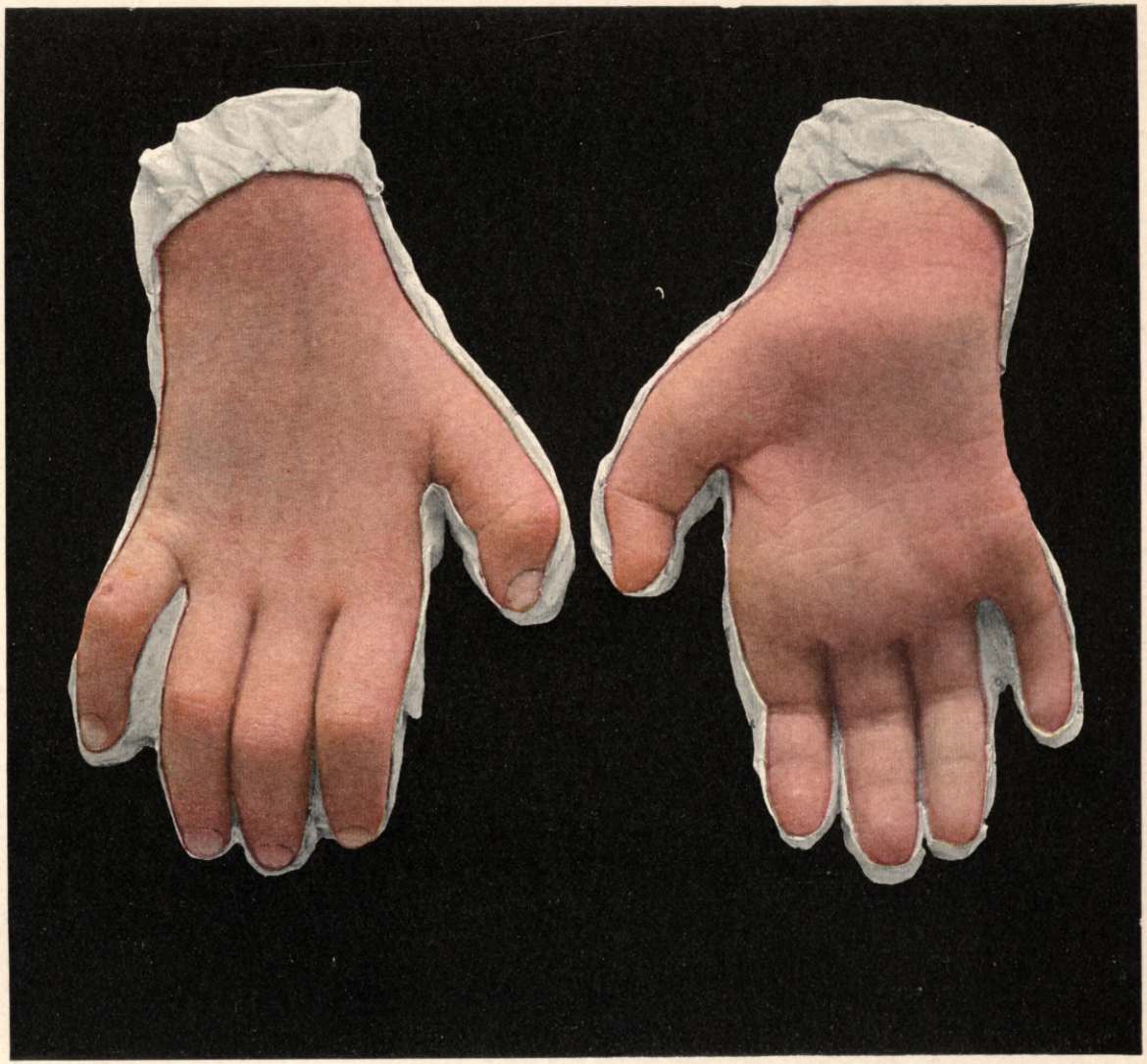
The **Prognosis** is absolutely unfavourable.

Treatment has hitherto yielded no uniformly favourable results. Salicylate of soda, Chaulmoogra oil, with baths and regular hygienic measures applied to the skin, must be tried. The most important measure is prophylaxis by the segregation of lepers, which has enormously reduced the frequency of the disease in Norway, and has been introduced into Germany in a modified degree.

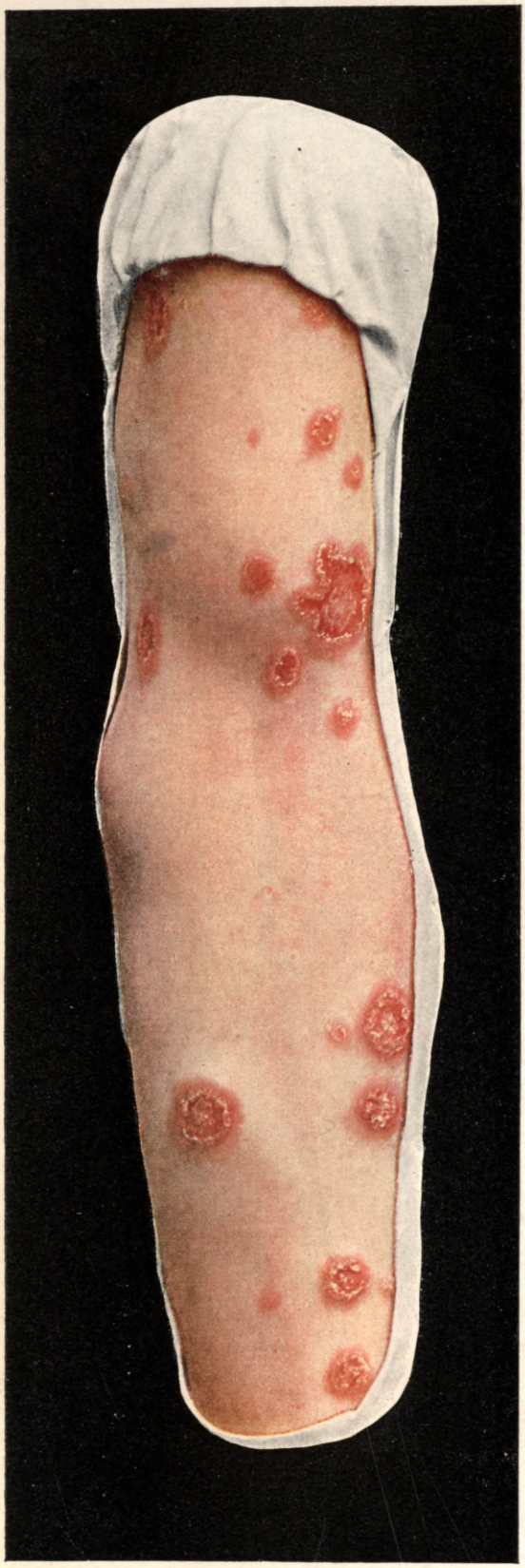
Fig. 50. Model in Lassar's Clinic, Berlin (Kasten).
Fig. 51. Model in Neisser's Clinic, Breslau (Kröner).
Fig. 52. Model in the Saint Louis Hospital, Paris, No. 1000 (Baretta). Leper from the Isle of Bourbon.
Fig. 53. Model in the Saint Louis Hospital, Paris, No. 1217 (Baretta). Vidal. Leper from Calcutta.
Figs. 54, 55. Models in Neisser's Clinic in Breslau (Kröner). The daughter of a fisherman from the neighbourhood of Memel, aged seventeen, with disturbances of sensibility; wasting, especially of the arms and legs, noticed for a year and a half; pigmentary and blanched areas on the trunk; atrophy of the hands, especially of the thenar, hypothenar, and interosseous muscles.

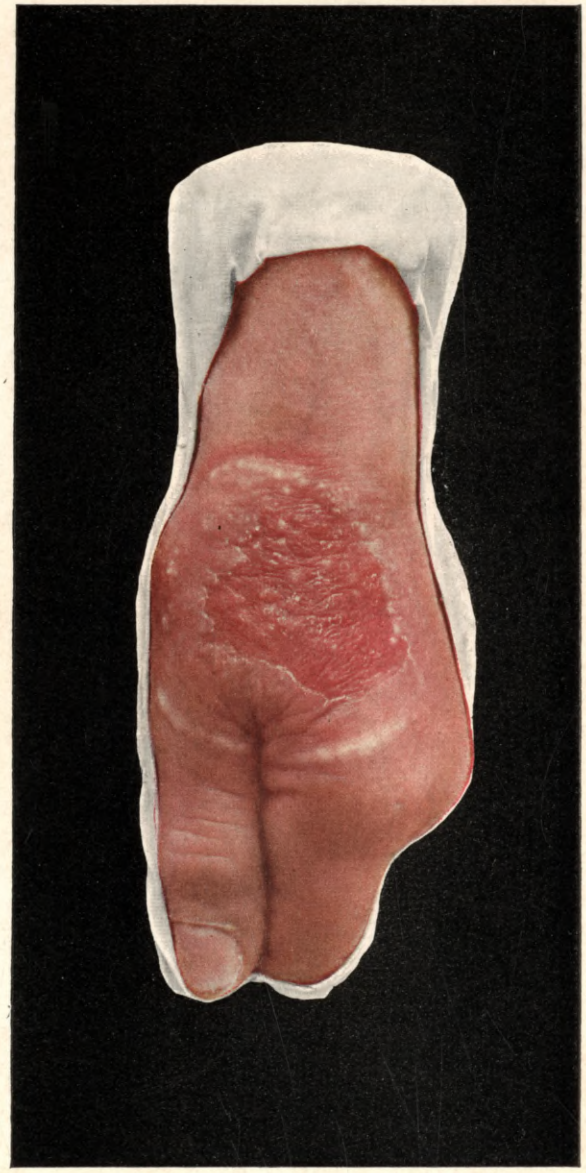


No. 54. Lepra; Malum perforans pedis.



No. 55. Lepra anaesthetica.





(Ringworm.)

No. 56. Trichophytia annularis.

No. 57. Trichophytia profunda.

Trichophytia. Ringworm.

PLATES XXXI.-XXXIV., FIGS. 56-63.

Under the name of Trichophytia (*Anglicè,* "ringworm") are included a number of diseases due to the presence in the horny structures of the skin (epidermis, hair, nails), or sometimes in the deeper layers, of Hyphomycetes. The unity of species of these hyphomycetic fungi was formerly unanimously accepted, but cannot now be maintained. There is at least one fungus, the cause of Gruby's disease (*Mikrosporia, "small-spored ringworm"*), which is definitely characterized clinically, and must be carefully differentiated from other trichophyta according to Sabouraud's researches. In Germany this disease may be said not to exist, but in England and France it forms the great majority of all cases of ringworm. The affected individuals are almost exclusively children under fifteen years of age. The seat of the disease is generally the scalp, where more or less numerous, round or oval patches are present, over which the hair is broken and stumpy, the scalp itself being covered with white or grayish, firmly adherent scales, here and there pierced by hairs (Fig. 58). Inflammatory phenomena are very slight, and may apparently be absent. This very obstinate complaint usually recovers spontaneously when the patient attains the age of fifteen years.

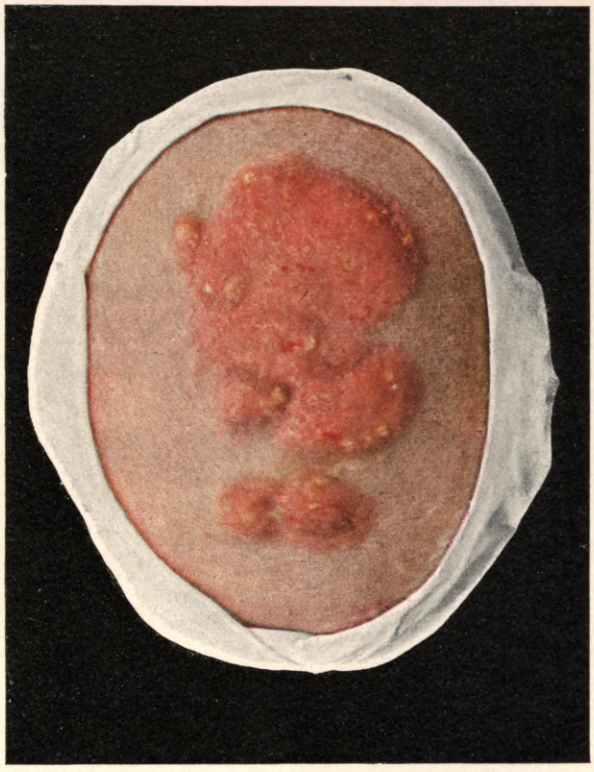
The principal seat of Trichophytia, properly so

called, is the outer layer of the skin. Here there occur circular areas, accompanied by considerable inflammatory phenomena, and generally with marked itching, which display either a ring of vesicles at the margin—giving rise to the unfortunate name of Herpes sometimes applied to them—or desquamating, scaly patches, which spread centrifugally (*Trichophytia annularis*, Fig. 56). While the process retrogrades in the centre, it extends at the periphery and forms serpiginous figures by the confluence of neighbouring circles. While the disease progresses recrudescences may occur in the centre of the patches, so that beautiful concentric rings may be formed (*Trichophytia iris*, Fig. 56). Most frequently the face, neck and hands are attacked, but the disease may be situated upon any other portion of the body. On the scalp and in the beard the appearances are identical, but bald, tonsure-like spots result from fracture of the hairs close to their roots. Owing to irritative, eczematous changes, the disease described as *Eczema marginatum* may result.

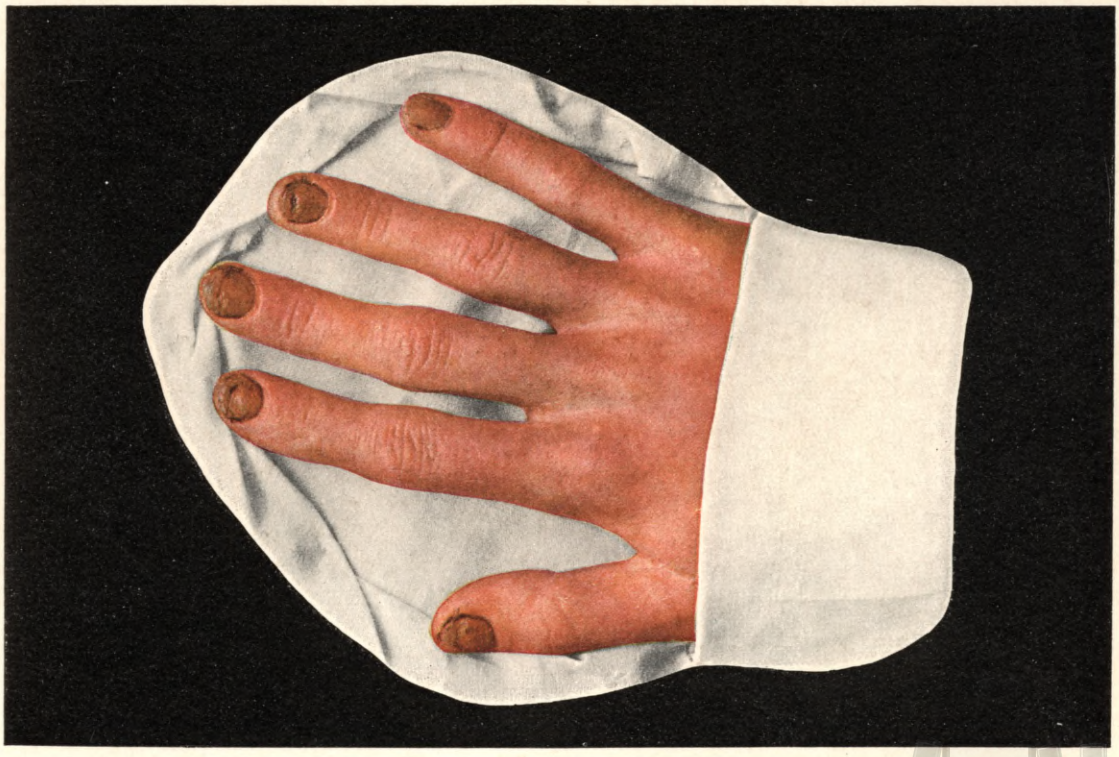
While these phenomena are due to the presence of the fungus in the upper epidermic layers, its migration into the hair-follicles of the scalp or beard causes much more severe changes. In the conditions denominated *Trichophytia profunda* (Fig. 57), *Sycosis parasitaria* (Fig. 62), and *Kerion Celsi* (Fig. 59), which almost exclusively affect hairy parts, hard, firm, irregular lumps and nodules form, or even dense infiltrations and abscesses (Fig. 61), penetrated by dilated hair-follicles, and may exhibit a peculiar scar-like appearance; these sometimes attain considerable dimensions. Finally, the hairs disappear by destruction of the follicles, and the affection heals very slowly, generally with the formation of scars.

We have to consider as a last form of Trichophytia of the skin a disease produced by an acute invasion of

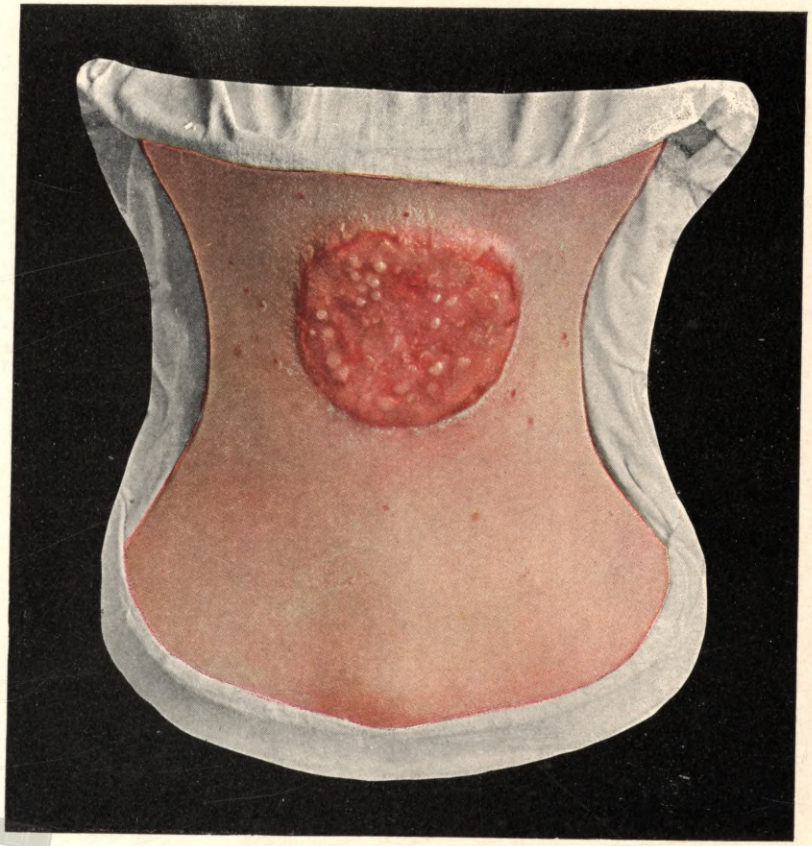
No. 58. Trichophytia capillitii (Ringworm.) (Mikrosporia).

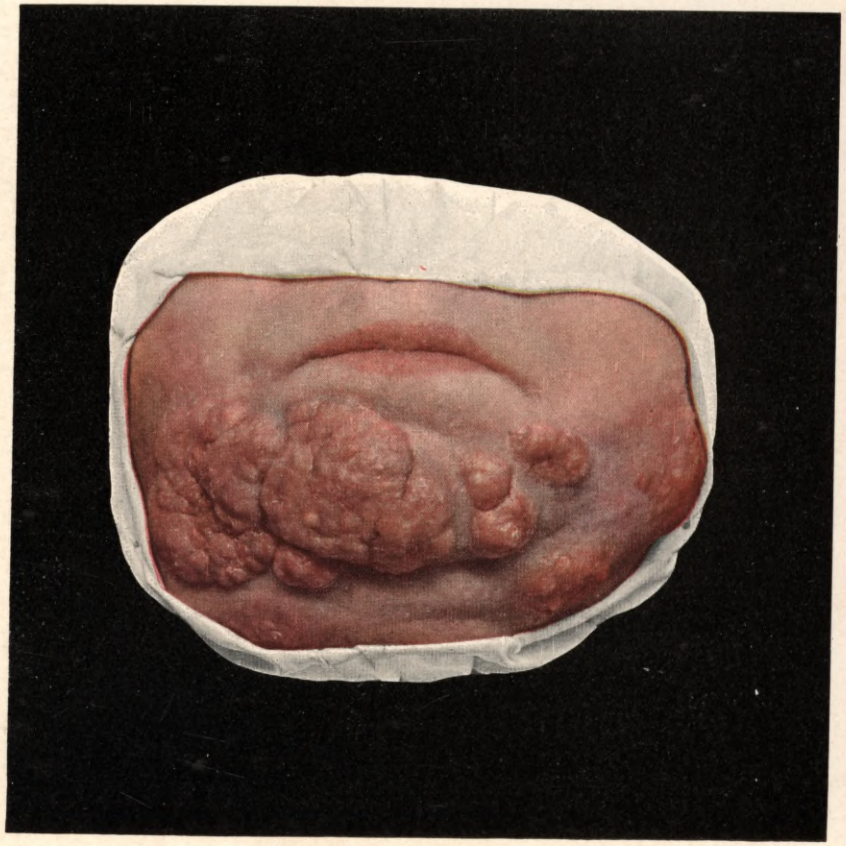


No. 59. Trichophytia profunda capillitii Kerion Celsi).



No. 60. Trichophytia unguium (Ringworm).





(Ringworm.)

No. 61. Trichophytia profunda nuchae.

No. 62. Trichophytia profunda barbae (Sycosis parasitaria).

fungus over large tracts of skin. This form may either begin as a solitary trichophytic disc (*Médaillon primaire, Herald patch*), which may exist for a long time, or may develop without it. From numerous pale-red little papules round, or more generally oval, discs form, some as large as a shilling, which coalesce very freely, and exhibit centrifugal desquamation at the margin. The process is extremely superficial, and spontaneous recovery usually occurs in the course of some weeks. This disease is termed *Herpes tonsurans maculosus,* and is identical with the *Pityriasis rosea of* Gibert. Its favourite seats are the neighbourhood of the neck, the chest, and back; less frequently the abdomen and limbs are affected (Fig. 63).*

Invasion of the nails may show itself under different aspects. The substance of the nails is rendered opaque, becomes brittle and of brownish colour, and their shape is altered, with formation of furrows, ridges, etc. At the margins they easily shell off (Fig. 60).

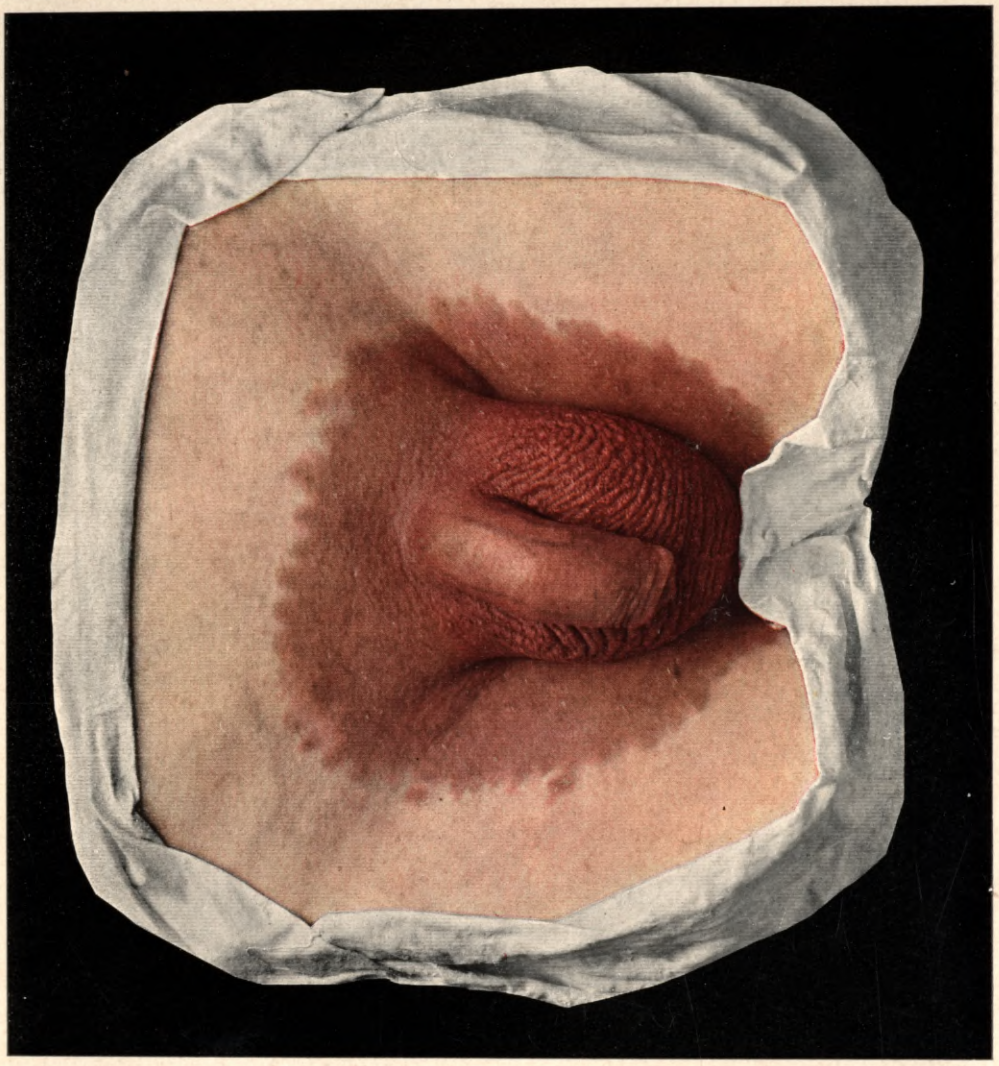
The **Diagnosis** of the various forms of ringworm offers no difficulty when the fungus can be microscopically demonstrated, either by staining or after mere soaking in liquor potassæ. The mycelia appear under the microscope as bright, segmented and dichotomous figures, with double contours. Culture experiments may also be employed for confirming the diagnosis. As, however, the existence of the fungus cannot always be demonstrated in all stages, other points

* Professor Jacobi follows the custom prevalent in Germany and Austria of considering pityriasis rosea a form of ringworm. He informs me that he has succeeded in staining a fungus by Boeck's method in one case; the fact is, as far as I am aware, an isolated one. Numerous observers in France and Great Britain—among whom I may include myself—have failed to find any trace of trichophyton or other fungus, and are agreed in thinking that this curious disease is in no way connected with ringworm. The differential diagnosis of the two diseases is, indeed, of the highest practical importance.—J. J. Pringle.

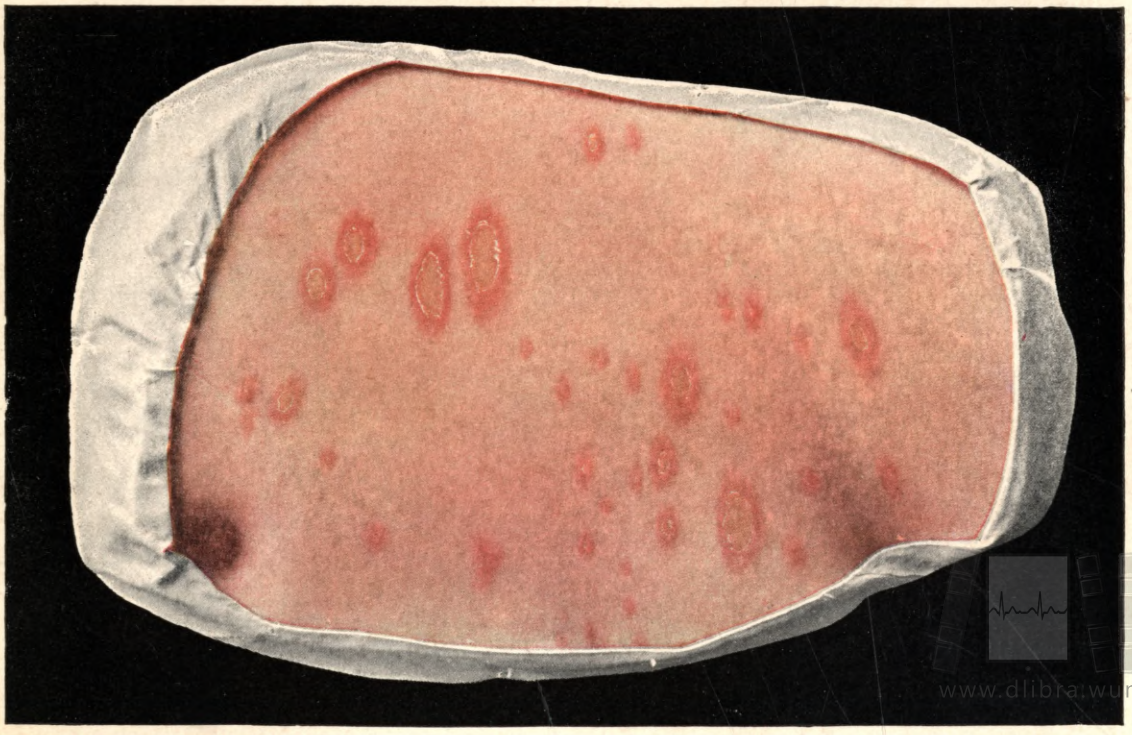
worthy of observation are: the localization, the circular form, the superficial situation, and the centrifugal desquamation at the margin of the patches. The tonsure-like spots over which the hairs are broken off, and the dusky appearance of the diseased hairs, especially after treatment with chloroform, may be considered as diagnostic in the scalp and beard.

As regards **Differential Diagnosis,** psoriasis must first be considered. In psoriasis the scales are larger, more brilliant, and, as a rule, punctiform hæmorrhages occur after their removal with the nail, while psoriasis generally itches less than ringworm. Certain forms of eczema may exhibit similar outlines, but they are seldom so definite; the discharge from an eczema may also facilitate the diagnosis. Syphilides show deeper infiltration, and are of darker colour. Lupus erythematosus may be distinguished by the invasion of the sebaceous follicles, as well as by the cicatricial atrophy in the centre. Parasitic sycosis of the beard is to be differentiated from the non-parasitic form chiefiy by the greater amount of infiltration and its deeper localization. In its earliest stages favus may sometimes present very similar appearances to ringworm, but after a certain time scutula always form. On the scalp the two maladies are often very difficult to distinguish, especially if favus has been previously treated, but the point is not one of very great practical importance. It is important to bear in mind that in favus the fungus usually is present in considerably greater abundance than in ringworm.

The **Prognosis** is generally favourable, but the disease in the beard and on the scalp is particularly obstinate.



No. 64. Erythrasma.



No. 63. Pityriasis rosea.

Treatment.—Cure can easily be obtained, when the disease affects merely the epidermis of glabrous parts, by means of bactericidal substances, or such as produce vigorous separation of the epidermis. Thus, tincture of iodine, the inunction of sulphur soap, or of Kaposi's naphthol ointment, attain this object without difficulty in the vesicular and squamous varieties, and the latter is efficacious in pityriasis rosea, which also yields easily to treatment with pastes or powders. The principal anti-mycotic remedies in use are chrysarobin, pyrogallol, or a 1 per cent. solution of corrosive sublimate in tincture of benzoin. Tar, either pure or in the form of Wilkinson's ointment, acts very usefully. The treatment of the deep-lying ringworms is much more difficult; in them poultices may be recommended, followed by compresses of a 1 per cent. solution of acetate of aluminium or resorcin. In later stages chrysarobin, Brooke's paste, or corrosive sublimate, may prove of good service. Epilation must always be practised, and must be a preliminary to the treatment of ringworm of the scalp; afterward inunction of chrysarobin, painting with tars, solutions of corrosive sublimate or tincture of iodine, ointments of sulphur or croton oil, may all be tried. Lastly, "Light treatment" may effect a cure, although often only after a very long time.

Fig. 56. Model in Neisser's Clinic in Breslau (Kröner).
Figs. 57, 59, 62. Models in Neisser's Clinic in Breslau (Kröner).
Fig. 58. Model by Professor Jacobi in the Freiburg Clinic.
Fig. 60. Model in Lassar's Clinic in Berlin (Kasten).
Fig. 61. Model in Saint Louis Hospital in Paris, No. 1051 (Baretta). Vidal's case.
Fig. 63. Model in Neisser's Clinic in Breslau (Kröner).

Erythrasma.

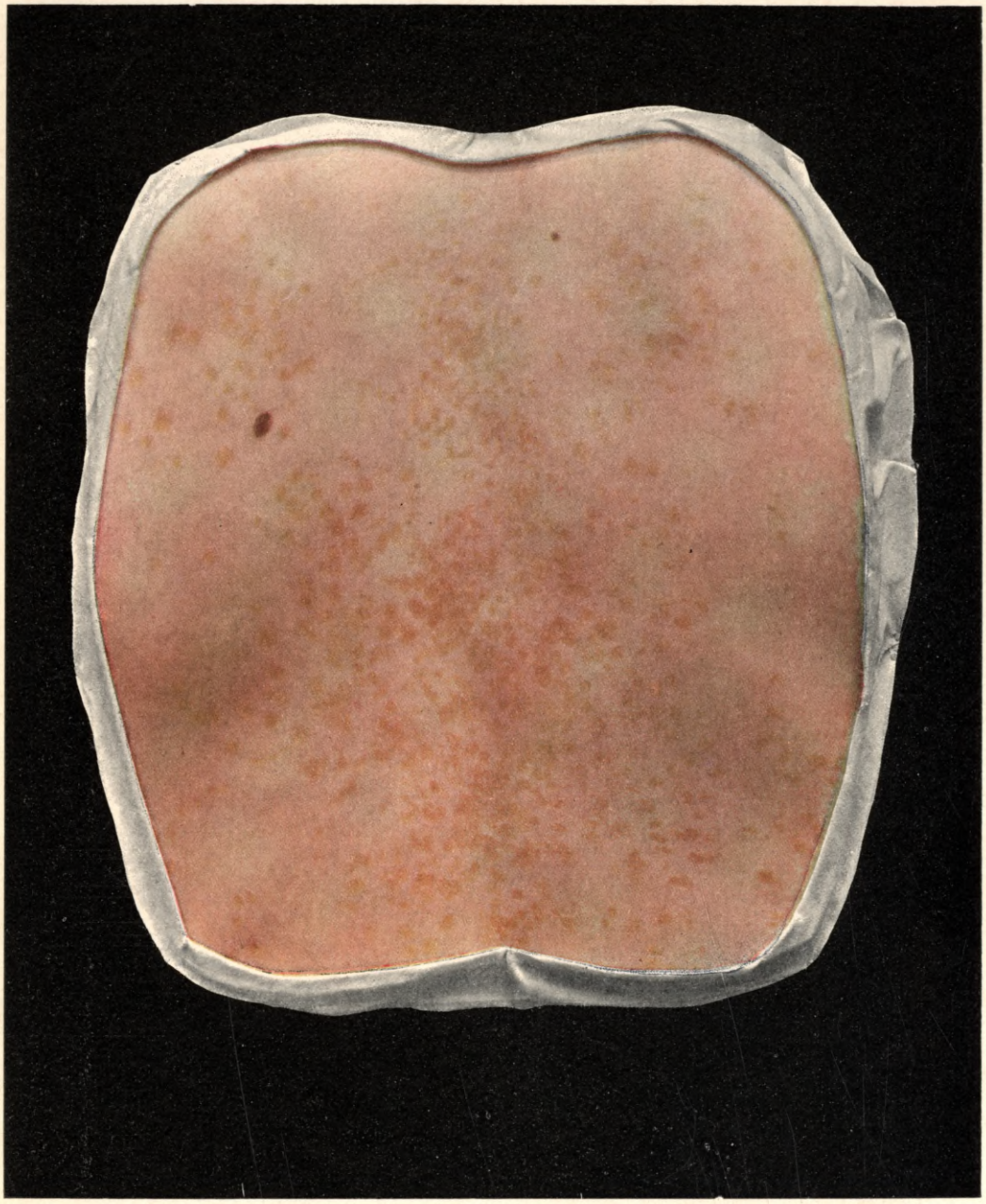
Plate XXXIV., Fig 64.

Erythrasma shows itself as accurately marginated patches of brown or brownish-red colour, with convex outlines and finely desquamative surface, the peripheral portions of which are slightly reddened. They occur principally on the inner sides of the thighs close to the genitals, on the scrotum, labia majora and perinæum, and on the adjacent portion of the abdomen; they may also attack the armpits and thence spread to the chest and trunk. It is caused by a mycelium, the *Microsporon minutissimum,* and it is always very superficially situated in the epidermis. The disease is obstinate, although absolutely harmless.

The **Diagnosis** is easily made on the grounds of its localization, colour and fine desquamation.

The **Treatment** is similar to that of the superficial forms of ringworm.

Fig. 64. Model in Riehl's Clinic in Vienna (Henning).



No. 65. Pityriasis versicolor.

Pityriasis Versicolor.

PLATE XXXV., FIG. 65.

Pityriasis versicolor occurs more especially in persons who sweat freely, and therefore very frequently in the phthisical. It shows itself as small yellow or brownish spots, which sometimes are arranged in confluent patches, and are caused by the invasion of the epidermis by the *Microsporon furfur*. The individual spots are very superficial, only slightly elevated, and rarely somewhat reddened at the edge. The branny desquamation is most marked when the spots are lightly rubbed; there is never coarse scaling. If the part is scratched, the entire diseased corneal layer is removed in the form of a thin pellicle, and the nearly normal subjacent skin is exposed. The disease chiefly affects the trunk, whence it sometimes spreads over the limbs and neck; the face, palms and soles are, however, always free.

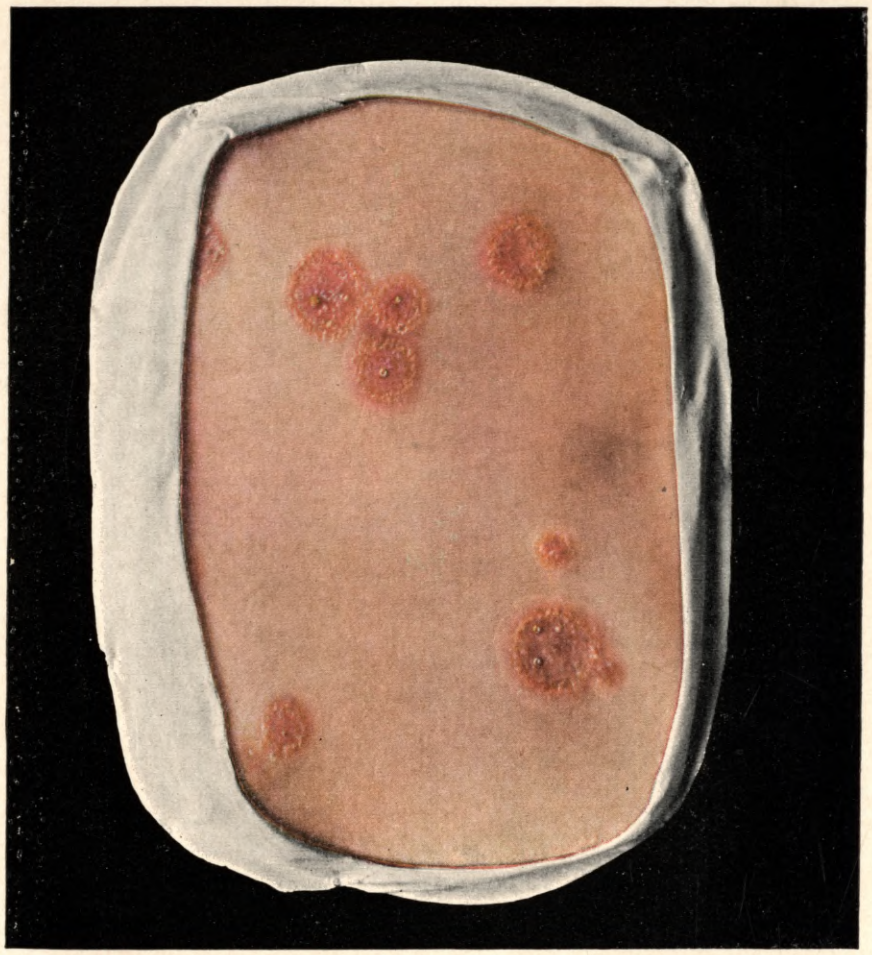
Subjective symptoms are, as a rule, completely absent, so that the malady is often unnoticed.

The **Diagnosis** can be made with facility from the yellow colour and localization of the disease, and by the possibility of removing the spots by scratching. It can be confirmed by the detection under the microscope of the network of mycelium and numerous clumps of brightly refractive spores.

The **Prognosis** is favourable.

Treatment easily produces temporary favourable results, but a permanent cure is obtained only with difficulty. All antimycotic remedies may be used with benefit, as may inunctions of sulphur soap, painting with alkaline spirit of soap, sometimes with the addition of 1 per cent. of naphthol; or baths followed by lotions of corrosive sublimate, naphthol, etc., may be used. The best results we have obtained have been with the treatment recommended by Besnier, consisting of the alternate inunction of salves containing 1 to 3 per cent. of resorcin and salicylic acid, and 5 to 15 per cent. of sulphur.

Fig. 65. Model in Neisser's Clinic in Breslau (Kröner).



No. 67. Favus scutularis et herpeticus.

No. 66. Favus scutularis.

Favus.

PLATE XXXVI., FIGS. 66 AND 67.

Favus is most commonly present on the scalp in children, and is characterized by the formation of so-called "favus cups" (or *scutula*); these are saucer-like, yellow or sulphur coloured, hollowed discs, which are composed of thickly welded masses of *Achorion Schönleinei*—the causative fungus of the disease—mixed with detritus and epithelium, covered with a thin coat of the horny layer, and perforated in the centre by a hair (Fig. 66). After the scutulum is removed, a shallow depression is perceptible, which, as the result of the exposure of the rete Malpighii, is moist and glistening. After some time has elapsed the favus cups coalesce to form whitish, mortar-like masses (*Favus confertus*), which in some cases involve the greater part of the scalp, and only show the mode of formation of the composite patches by some scattered cups at their margin. Over the affected areas the hairs are lustreless, as if powdered, and the disease exhales a musty, mouse-like odour. Its course on the scalp is extremely chronic, and in the majority of cases, terminates in cicatricial atrophy, as the result of pressure by the favus cups, with permanent alopecia of the affected parts.

The affection occurs more frequently on the scalp than on the body, where circles first appear, either

covered with scales, or showing vesicles at their margin, and these exactly resemble the lesions produced by trichophytia; only after protracted duration do they exhibit one or more scutula in the centre (Fig. 67). On the skin of the body the disease is not at all obstinate, and recovers without leaving any marks.

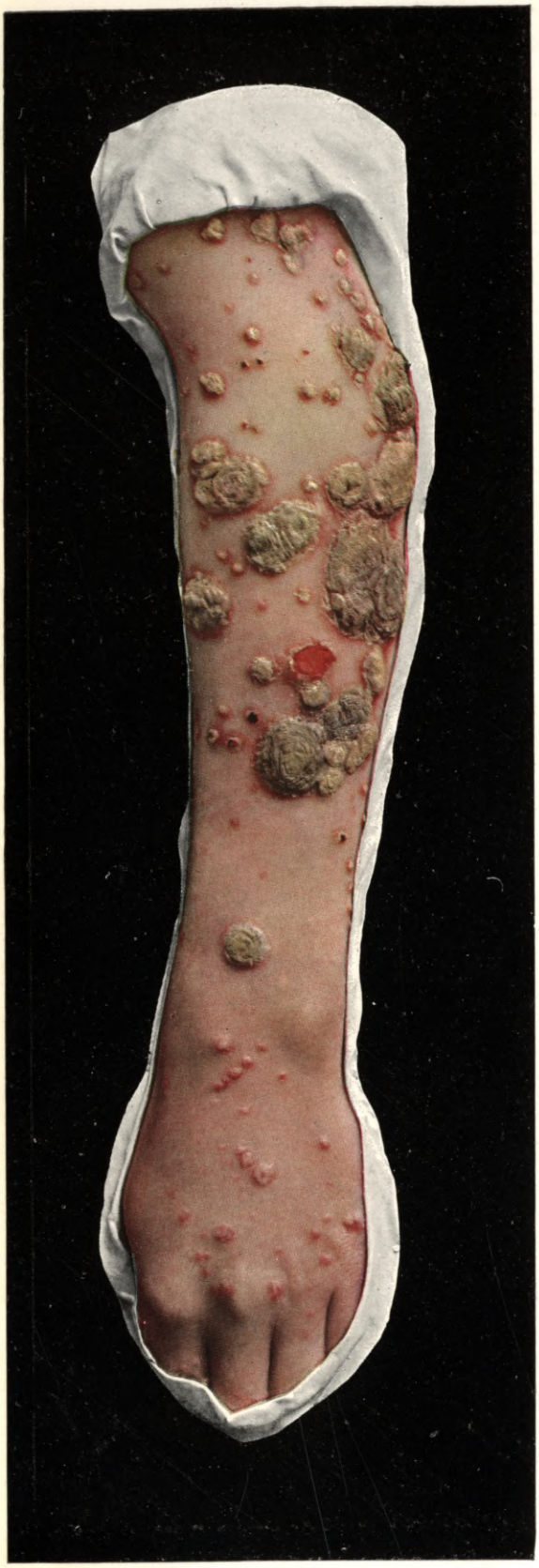
In rare cases the favus fungus may penetrate deeply, and evoke a condition analogous to kerion. The nails may also suffer in the same way as in ringworm; occasionally cup-like lesions are found embedded in the nail substance.

Recent investigations have proved, contrary to the views of Quincke, Unna and others, that favus is in all probability caused by one form of fungus only, which may assume different developmental forms on different media. Animals (*e.g.*, cats and mice), which are susceptible to invasion by favus, are often the starting-point of the disease in man.

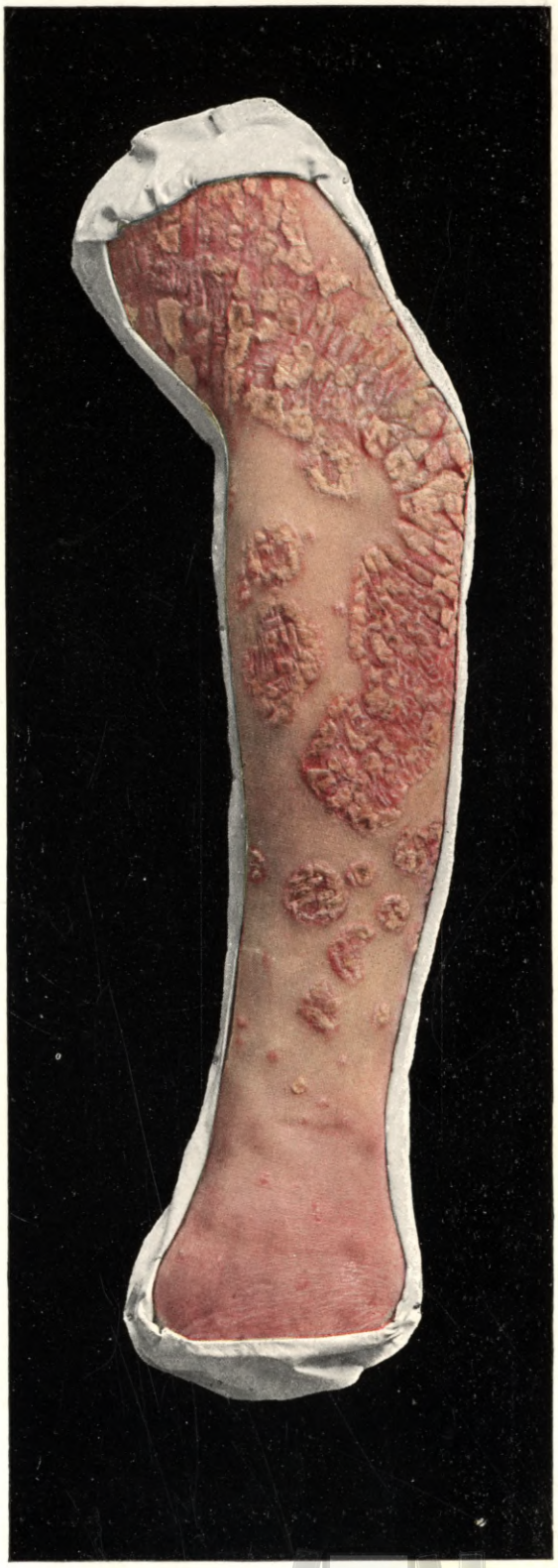
The **Diagnosis** is generally easy in presence of the favus cups, which become of an intense yellow hue when moistened with alcohol, or after microscopical demonstration of the fungus. The powdery appearance of the hairs and the musty odour are also points of importance. Even after favus has terminated, the cicatricial atrophy of the scalp may establish a retrospective diagnosis.

The **Prognosis** is favourable on the body, but on the scalp it must be very guarded, as permanent alopecia is usually the ultimate result of the disease.

Treatment has for its first object the removal of the scutula, which may be effected by an oil-cap; then energetic epilation must be instituted, and in very extensive cases this may be done by the application



No. 68. Psoriasis vulgaris guttata et ostracea.



No. 69. Psoriasis vulgaris.

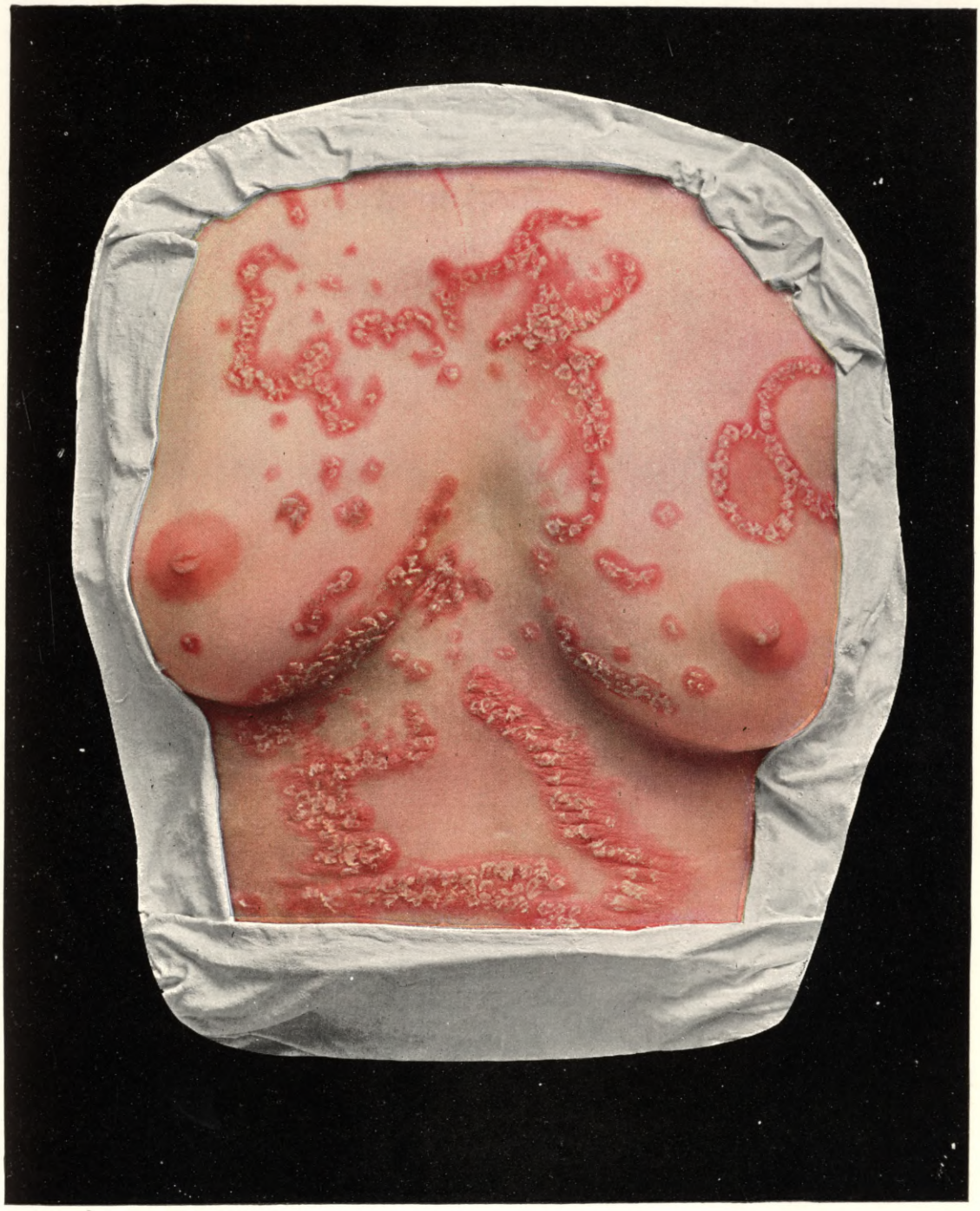
of the calotte under an anæsthetic. Afterward regular washing with soap and the subsequent use of chrysarobin, tincture of iodine, sublimate spirit or ointment, or naphthol may be recommended. Tar, ichthyol, and tumenol are used with good success. Treatment by X-rays appears to yield excellent results, but must be employed with the greatest caution on account of the risk of X-ray burns.

Fig. 66. Model in Saint Louis Hospital, Paris, No. 548 (Baretta). Besnier.
Fig. 67. Model in Neisser's Clinic in Breslau (Kröner).

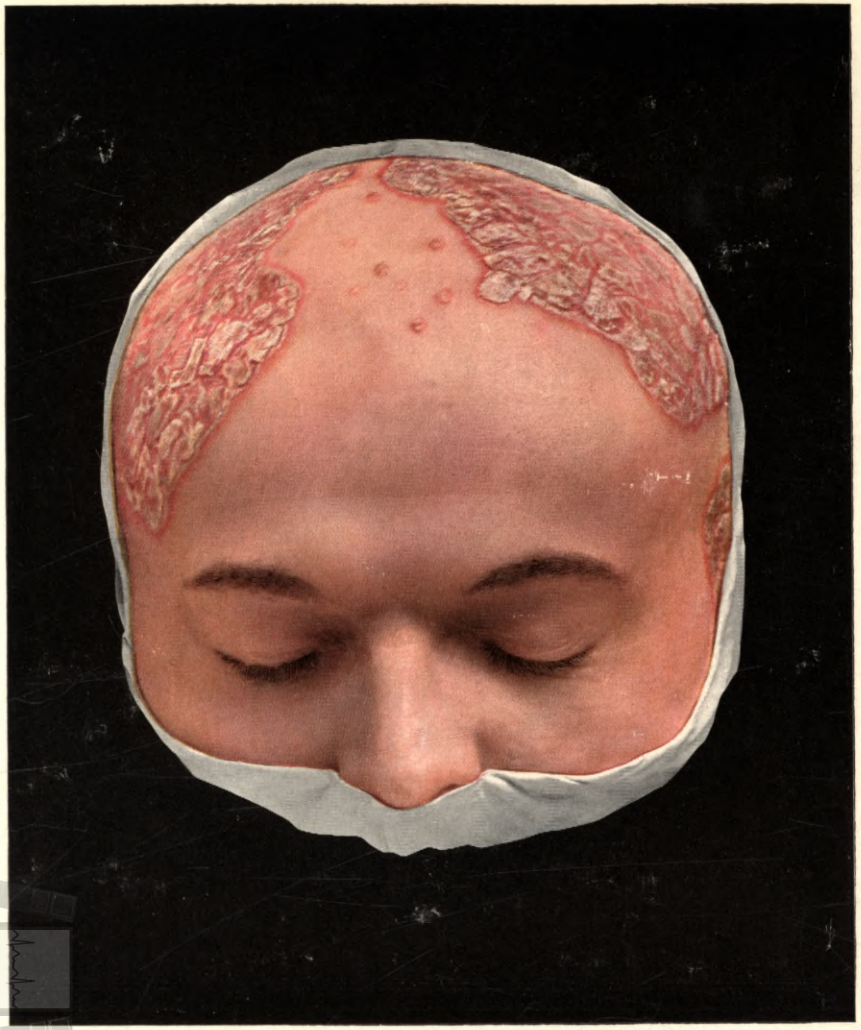
Psoriasis Vulgaris.

PLATES XXXVII.-XLI., FIGS. 68-76.

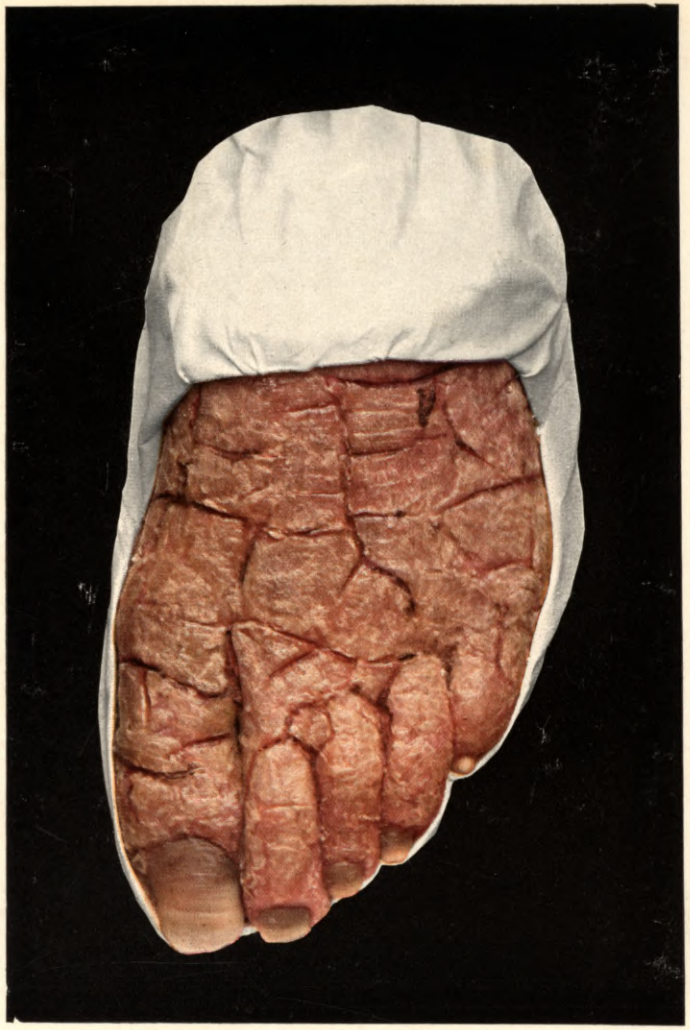
By Psoriasis we understand a chronic, nearly always incurable, disease of the skin, the cause of which is unknown—but is very probably of fungous origin—and in which relapsing outbreaks of eruption alternate with intervals of more or less freedom. The primary lesions are typical and consist of small points, the size of a pin's head, which soon become covered with firmly adherent scales. As they develop and spread, all the different forms of *Psoriasis guttata* (Fig. 68), *nummularis,* etc., arise; when healing occurs in the centre, *Psoriasis annularis* results, and when neighbouring circular patches run together the condition is called *Psoriasis gyrata vel figurata* (Fig. 70). The localization, chiefly on the extensor sides of the extremities and on the scalp (Fig. 71), is characteristic of psoriasis, as is the production of small, punctiform, bleeding points in the exposed, moist, red and shiny rete Malpighii, after the scales are rubbed off. Lastly, the absence of any dense infiltration is typical, in contradistinction to other similar diseases, especially scaly syphilides. Deviations from the general rule as to distribution occur, however, not infrequently and there is no part of the skin which may not occasionally be the seat of the eruption (Fig. 75). Even on the palms and soles psoriasis may exist, not only in universal attacks, but also in localized cases, so that it



No. 70. Psoriasis gyrata et serpiginosa.



No. 71. Psoriasis vulgaris capitis.



No. 72. Psoriasis vulgaris unguium.

is highly desirable to discontinue the use of the name *Psoriasis palmaris et plantaris* as designating papulo-squamous syphilides of the palms and soles (Fig. 76). Mucous membranes are hardly ever involved in *psoriasis*. The so-called *Psoriasis mucosæ oris* has no relationship to true psoriasis, and is better named *Leucoplakia*.

Very marked changes may be observed in the extremely chronic course of psoriasis without any treatment, a circumstance which greatly prejudices our judgment as to the value of all therapeutic measures. Frequently eczematous complications occur. Considerable differences may be observed not only in the shape and size, but also in other attributes of the psoriatic lesions; thus the characters and thickness of the scales vary greatly, and thick mortar-like or oyster-shell-like masses may be present side by side with comparatively thin scales; while all shades of colour may coexist, from a pure glistening mother-of-pearl white to a dark, grayish-yellow or gray tint (Figs. 68, 69, 74). In the same way the intensity and width of the red band which bounds the scales vary; sometimes it is of a yellow rather than a red colour, while on dependent parts a more livid tint may predominate.

The seats of predilection are, as already stated, the backs of the elbows, fronts of the knees and the scalp, but in other cases the disease is much more widely distributed and may involve the greater part of the integument. In acute cases scarcely any region may remain unaffected (Fig. 75), and in these circumstances severe general symptoms may develop, whereas in localized cases the general health is unaltered. It is a generally recognised fact that psoriatics are frequently robust, well-nourished individuals. In the chronic forms trifling itching is, as a rule, the only

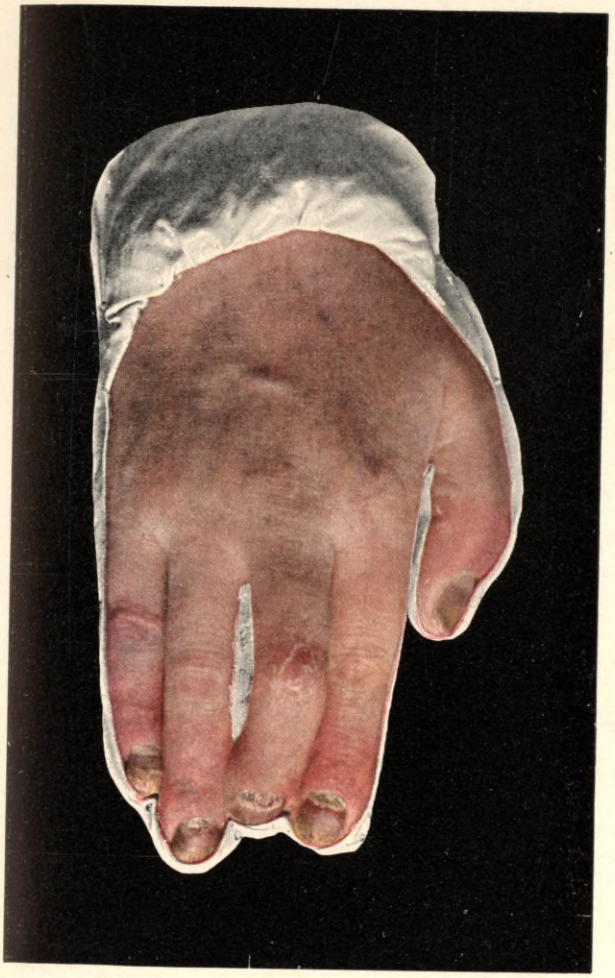
subjective symptom present, but in acute and extensive outbreaks a troublesome feeling of thirst is often complained of.

When psoriasis is localized on the hands and feet there occur, besides other changes in the nails, marked thickening of the nail substance, with opacity and separation from the nail-bed, which begins at the peripheral end (Figs. 72, 73). In severe cases the nails may even be completely shed.

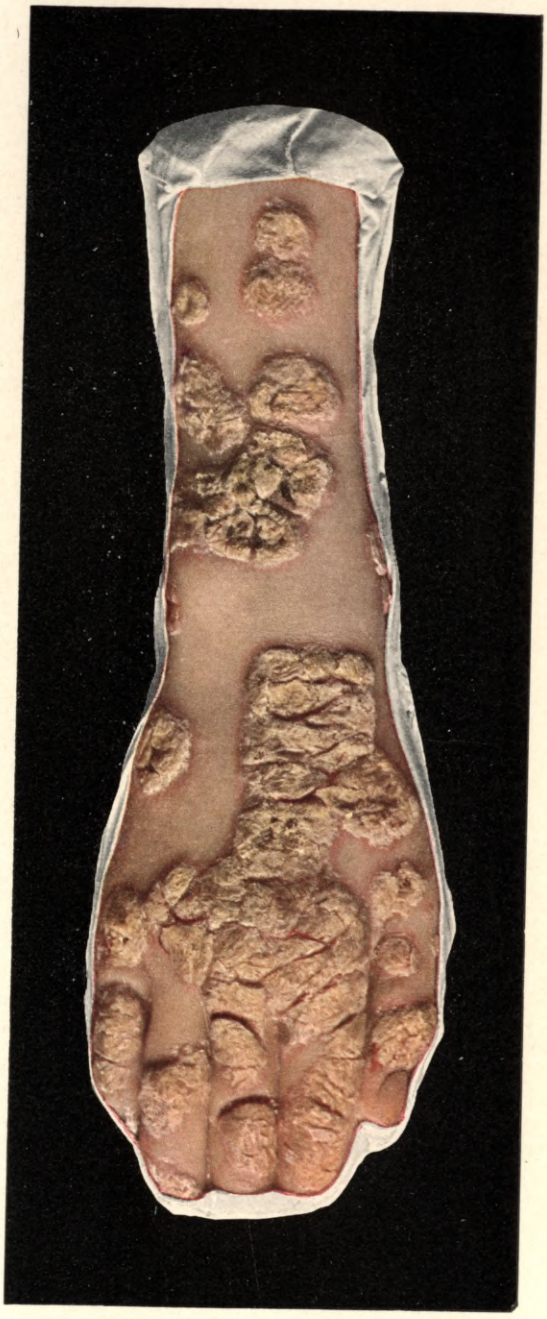
The **Prognosis** is so far favourable that only in exceptional cases is there any deterioration in the general health, and individual eruptions can be cured. A definite, final cure of psoriasis is, however, impossible.

Differential Diagnosis.—Syphilis, eczema seborrhoicum, lupus erythematosus, true eczema and ringworm must first be considered.

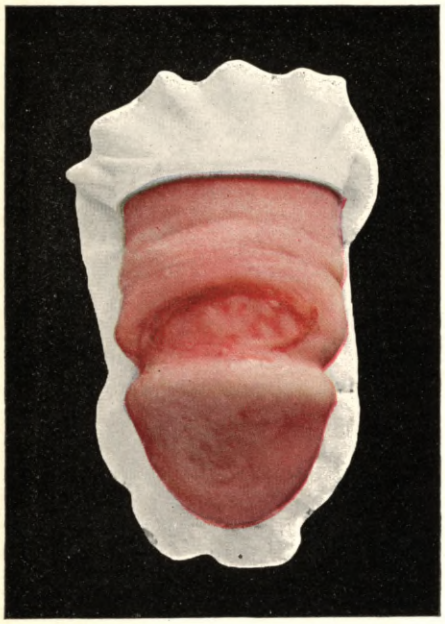
Ringworm may be eliminated by the absence of fungus and its acuter evolution. In contradistinction to lupus erythematosus, psoriasis never leaves scars, and does not invade sebaceous follicles. Eczema seborrhoicum corporis (*Lichen circumscriptus* of Villan) generally displays smaller and more fatty scales with brighter yellowish-red coloration, and its typical distribution is on the chest and back. The differentiation from simple eczema is more difficult, chiefly because combinations of the two maladies occur. As a rule the localization and the fact that true psoriasis never weeps, as well as the determination of the elementary lesions of either disease, suffice to establish a diagnosis. Syphilis attacks most frequently flexor surfaces, and its papulo-squamous lesions—which only need to be considered here—are accompanied by dense infiltration. In syphilis, too, itching is absent, but in dubious cases the effects of treatment will be decisive.

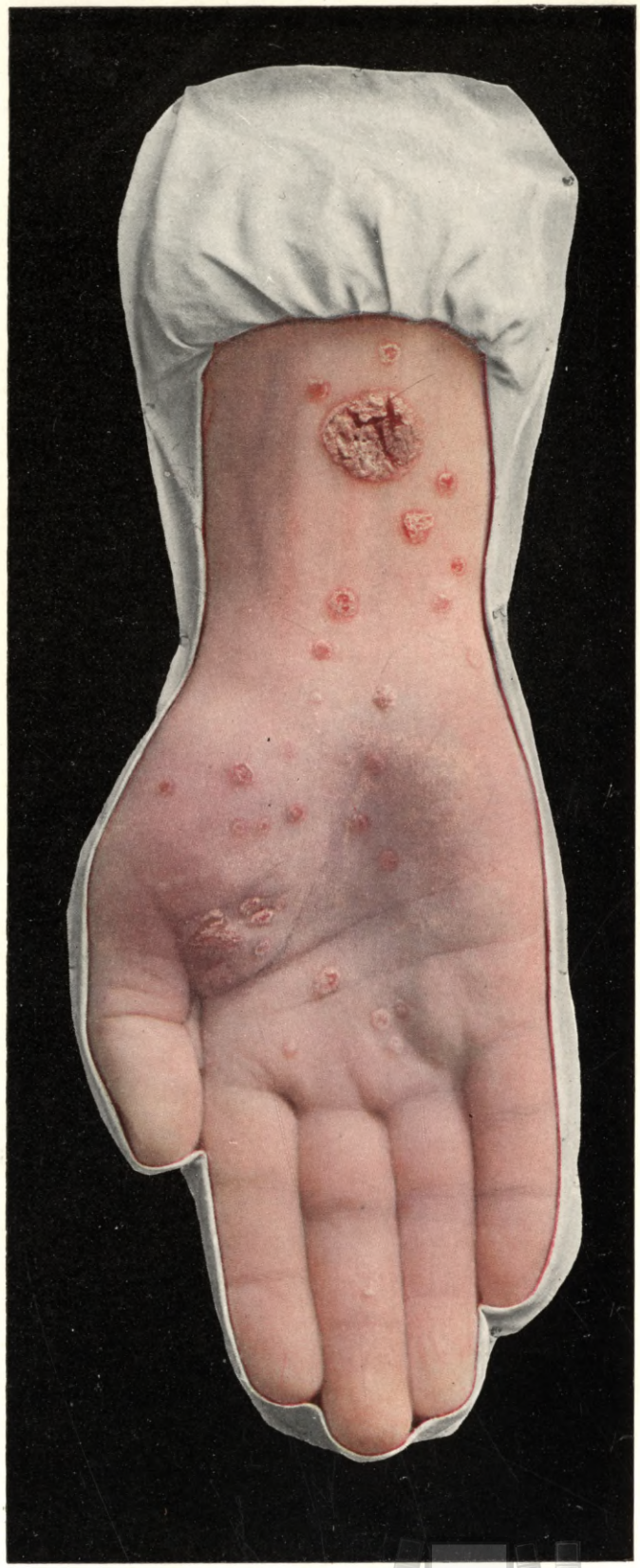


No. 73. Psoriasis vulgaris unguium.



No. 74. Psoriasis vulgaris rupioides.





No. 75, 76. Psoriasis vulgaris.

Treatment may be either by internal or external means. The most important internal remedy is arsenic, which, if properly employed, almost always brings about the recovery of psoriasis spots, but with deep pigmentation. It may be used in the form of "Asiatic pills," or of subcutaneous or intramuscular injections of the liquor sodii arseniatis. Iodine is not so certain a remedy, but is efficacious in a number of cases, provided it is prescribed in the form of iodide of potassium and in full doses. Other drugs (thyroid gland, etc.) have been proved to be uncertain in action or quite futile.

The first object of external treatment is the removal, after maceration, of the scaly masses. Baths, soaping and washing, salicylic ointment and super-fatty soaps, alcohol sprays or compresses, with frequent ablutions, soon produce the desired effect. Reducing and slightly irritating remedies must be applied after the removal of the scales. Chrysarobin stands in the first rank, and may be used in the form of weak ointments (2 to 5 per cent.) once or twice daily until slight irritation of the skin is caused. The effect of chrysarobin seems to depend on the variable quality of the drug. Only those preparations which produce, after protracted application, a dermatitis, will be found of importance in the treatment of psoriasis. As the drug varies greatly in quality and consequent effect, it is well to use only preparations which, after prolonged use, cause some degree of dermatitis. Chrysarobin ought not to be used for the face and scalp, on account of the ugly discoloration of the skin and hair it produces, as well as of its irritating effect on the conjunctiva. If chrysarobin irritation sets in, or even threatens to do so, the remedy must be at once discontinued and treatment by indifferent soothing ointments, pastes or tars substituted. Chrysarobin stains the normal skin a dark-

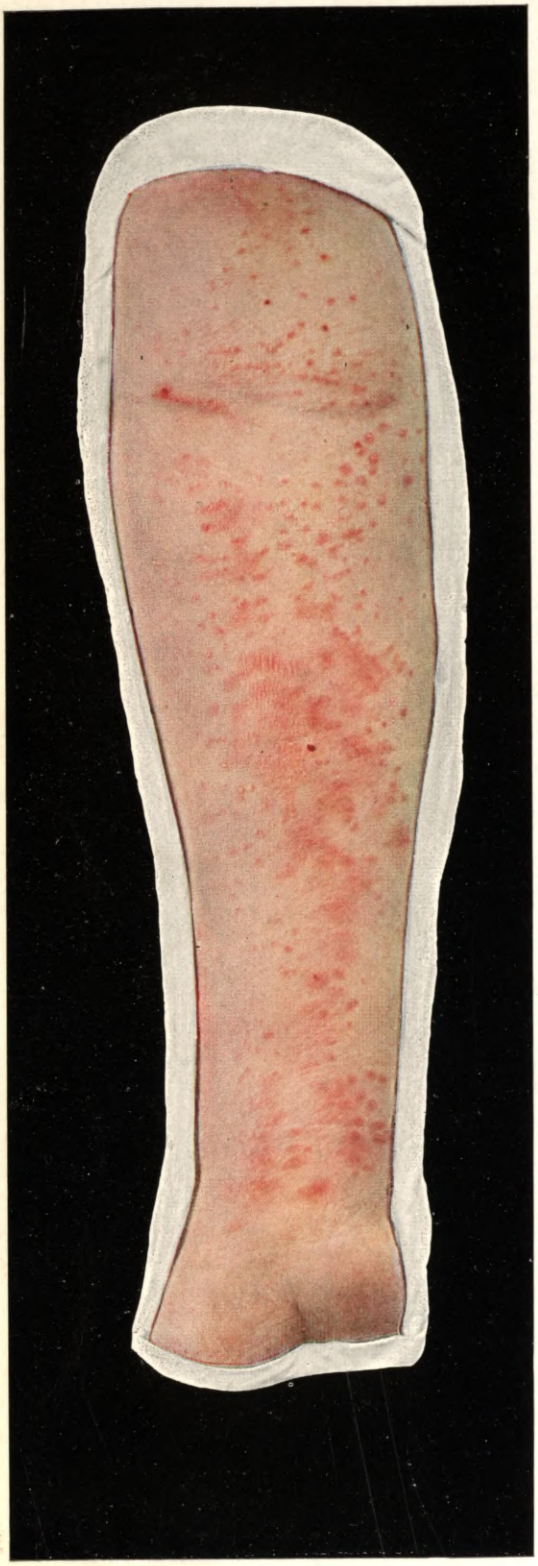
bluish or brownish-red colour, in the midst of which the diseased parts appear pale, and chrysarobin staining only disappears when recovery is complete. The drug may be applied to localized spots dissolved in chloroform (10 per cent.), traumaticin being afterward painted over them.

Pyrogallol produces similar, but not such satisfactory, results; it may be employed in the form of a 5 per cent. ointment, but ought never to be used over more than one-fifth of the surface of the body at a time, on account of the risk of poisoning.

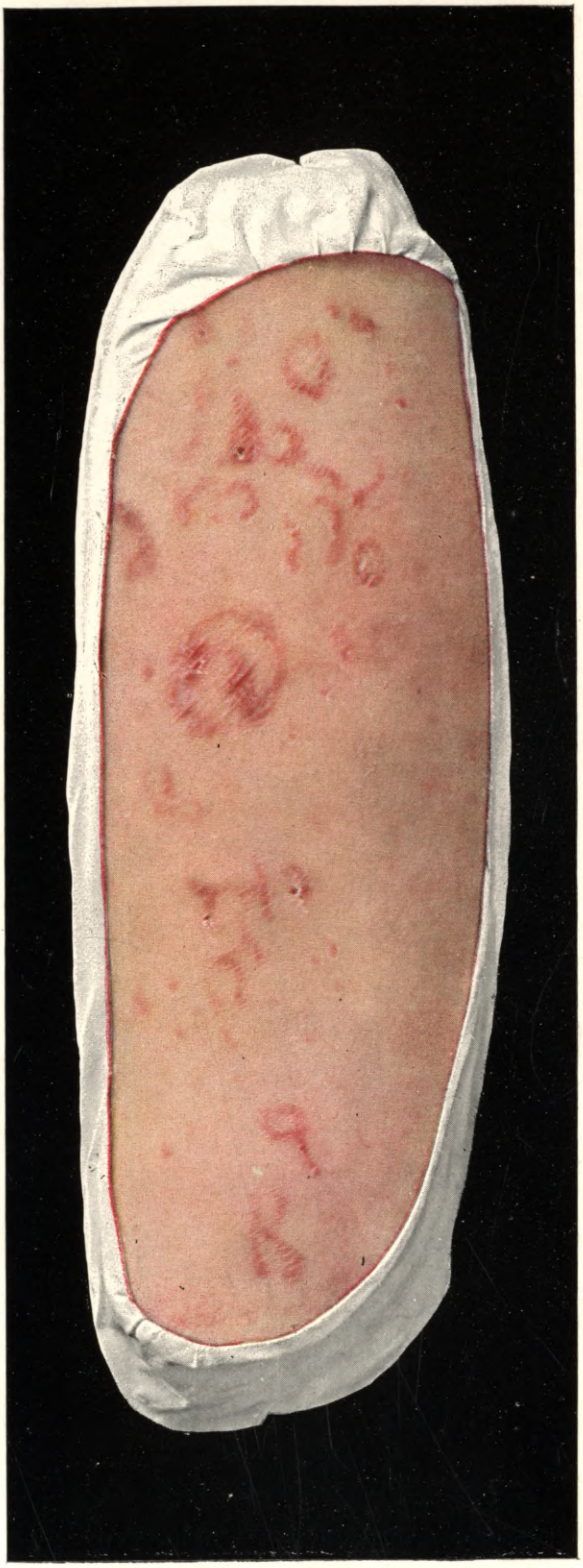
Tar is employed, principally in the form of tar baths, tar oil or tincture of tar, and is specially recommended for psoriasis of the scalp. Similar but milder in its action is the liquor carbonis detergens, which is applicable to uncovered parts, owing to its slight smell and colourlessness. A 10 per cent. white precipitate ointment, to which 10 to 20 per cent. of liquor carbonis may be added, is in common use for the treatment of the face. Specially obstinate psoriasis spots often disappear under eugallol—a pyrogallol derivative—which is applied mixed with 2 parts of acetone, and covered with zinc paste or dusting-powder.

It can, however, only be used for single small patches. Regular hot baths with sulphur, ordinary warm-water bathing or hot-air baths, help other treatment; sea-baths are often deleterious. If eczema is present, it must first be cured before the treatment of the psoriasis is undertaken. Radium, uviol and X-rays are also recommended.

Figs. 68, 71. Models in Neisser's Clinic in Breslau (Kröner).
Figs. 69, 72, 73, 74. Models in Neisser's Clinic, Breslau (Kröner).
Fig. 70. Model in Lesser's Clinic in Berlin (Kolbow).
Fig. 75. Model in Saint Louis Hospital, Paris, No. 1670 (Baretta). Du Castel.
Fig. 76. Model in Neisser's Clinic in Breslau (Kröner). A man, thirty-five years of age, who, in the course of a rather extensive eruption, had manifestations on the palms and soles.



No. 77. Lichen planus.



No. 78. Lichen planus atrophicus.

Lichen Planus.

PLATES XLII.-XLIV., FIGS. 77-81.

Under the term Lichen are included those diseases, the primary lesion of which is represented by a small papule which undergoes no further development. Properly speaking, therefore, only two affections come into consideration—viz., *Lichen ruber planus,* and *Lichen acuminatus.* The latter is a very rare disease, first observed by Hebra, in which numerous, red, pointed papules occur, tipped by horny caps, which may run together to form rough, grater-like patches. As the disease spreads the nails are involved, the hair falls, and the earliest described cases proved fatal, with all the characteristics of a severe general malady. It is uncertain whether this type of disease still exists, or whether its serious results are now warded off by the arsenical treatment introduced by Hebra.

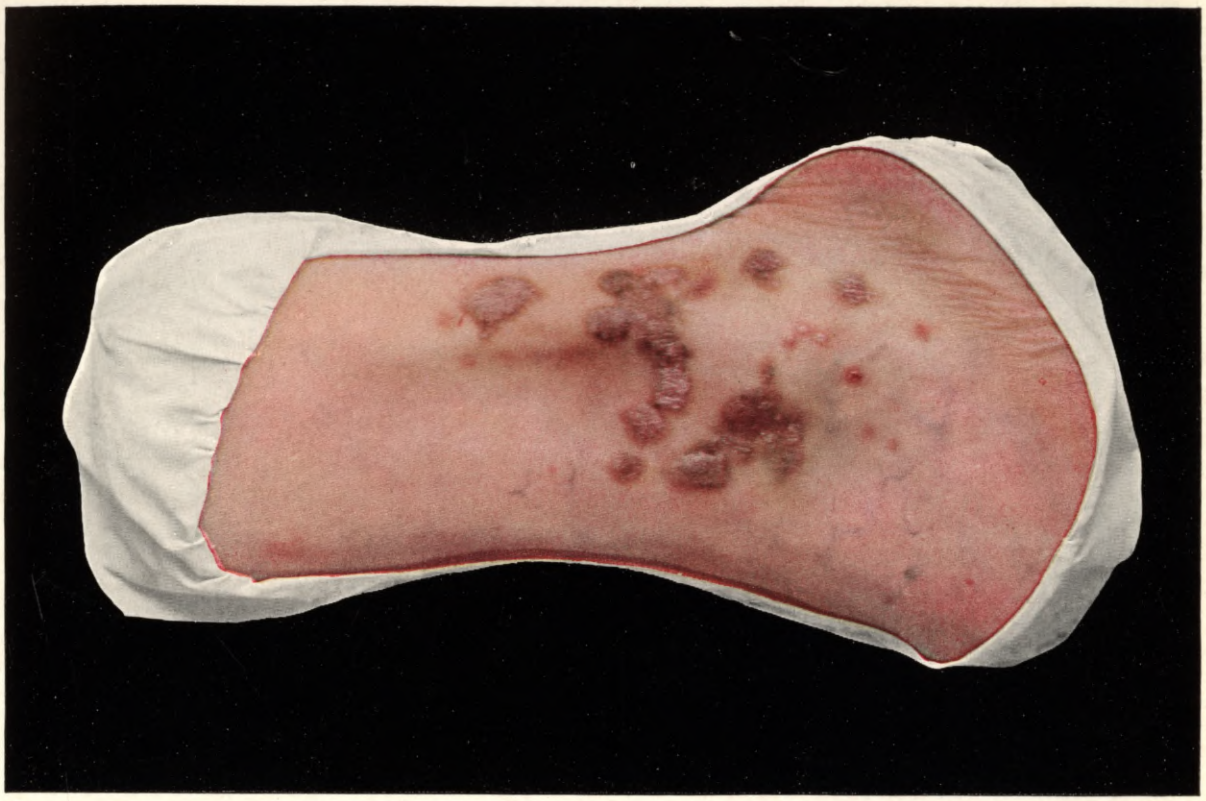
The great majority of lichen cases now observed are examples of Lichen planus, the elementary lesions of which consist of minute papules, sometimes as large as a hempseed, but occasionally larger; they are waxy-looking and shiny, and of bright-red colour; they are generally smooth on the surface, accurately delimitated and polygonal, while sometimes they are crested with a firmly adherent scale. When numerous papules run together the skin presents peculiar, raised patches. Involution is accompanied by deep pigmentation, and

often begins in the centre, while the process spreads at the margin, so that the skin assumes the appearance of shagreened leather. Intense itching is the most prominent subjective symptom; it gives rise to scratching and thus to narrow linear bands, which appear to be made up of lichen papules in close apposition. Lichen papules also may exist, arranged in the most diverse manners, sometimes being in rings, or in net-like patterns, or in circles (*Lichen annularis,* Fig. 79). After long duration a peculiar warty appearance may be assumed, especially upon the legs (*Lichen verrucosus,* Fig. 80). The disease, which is a very chronic one, generally occurs in successive outbreaks, and disappears very slowly, sometimes leaving atrophy of the parts occupied by papules (*Lichen atrophicus,* Fig. 78). The affection is frequently localized on the flexor surfaces of the extremities (Fig. 77), but any part of the body may be attacked, even the mucous membranes (Fig. 81), on which the lesions appear as whitish, silvery, glistening patches with thickened epithelium. Their occurrence on the penis is noteworthy, either alone or in conjunction with a generalized eruption. Very rarely lichen papules become vesicular.

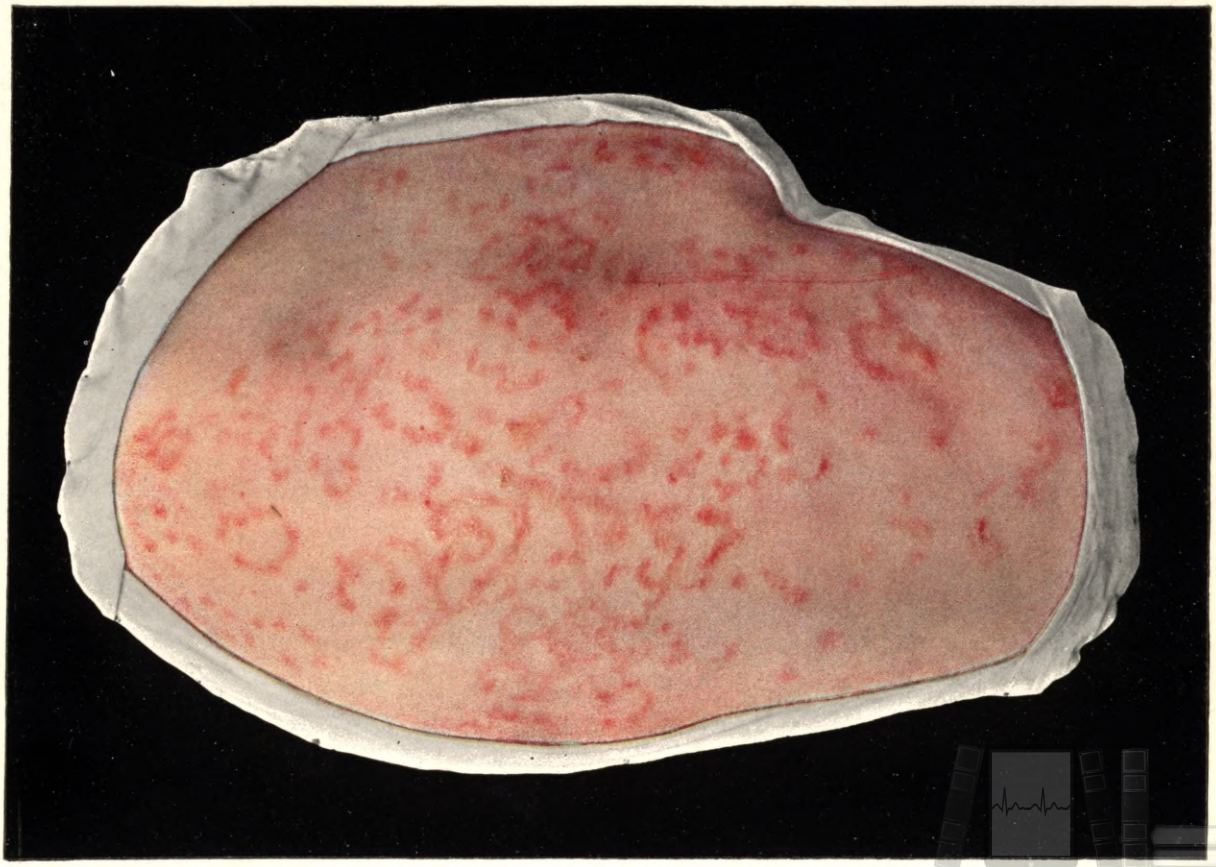
The **Etiology** of lichen is not yet definitely established, but many exciting causes of vegetable nature (fungi) have been assumed to exist.

The **Diagnosis** can be made without any difficulty if typical lichen papules are present.

The **Differential Diagnosis** must first be made from the small papular syphilide—sometimes unfortunately called *Lichen syphiliticus*—which may, however, be distinguished by the coppery colour char-

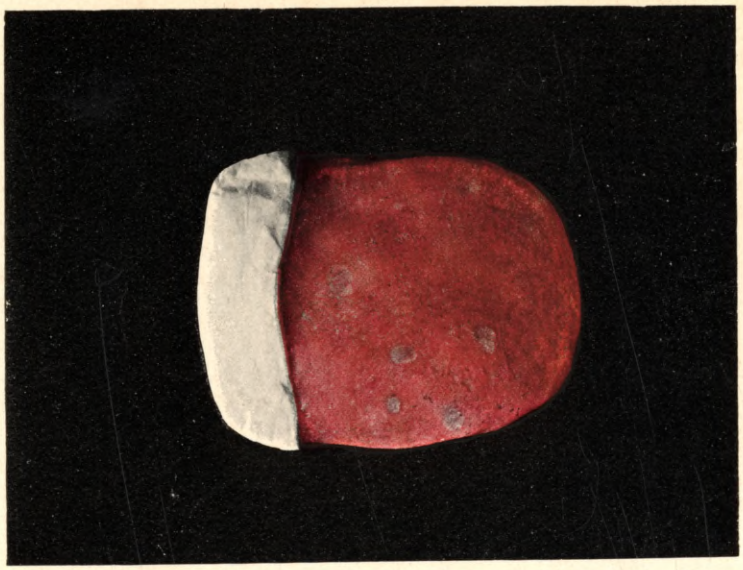


No. 80. Lichen planus verrucosus.



No. 79. Lichen planus annularis.

No. 82. Leukoplakia linguae.



No. 81. Lichen planus linguae.

acteristic of syphilitic eruptions, by the absence of itching, and by the presence of concomitant manifestations of syphilis. When large tracts of skin are involved by lichen, difficulties may arise as to diagnosis from psoriasis; but in the latter disease there are no typical lichen papules and none of the scratch-mark phenomena described, whereas the typical, large, mother-of-pearl lamellar scales are present. The diagnosis may be difficult when the soles and palms are involved, as lichen causes large callosities in these situations. The primary lesions must, therefore, be looked for and the existence of itching considered in establishing a diagnosis between lichen on the one hand and ichthyosis or psoriasis on the other.

The **Prognosis** is, on the whole, favourable, but relapses and recrudescences are not infrequent during treatment. Fatal cases of Lichen acuminatus of Hebra are no longer observed.

Treatment.—Most important is the internal administration of arsenic, either in the form of "Asiatic pills," or by subcutaneous or intramuscular injection of the liquor sodii arseniatis; but recovery only sets in after comparatively large doses have been administered. The first object of external treatment is to allay itching by the use of tarry applications. Chrysarobin, pyrogallol, mercurial plaster, or Unna's sublimate and carbolic acid plaster-mull, act well in combination with warm baths. In stubborn cases light treatment (X-rays and ultraviolet rays) has proved beneficial.

Figs. 77, 79. Models in St. Louis Hospital in Paris, Nos. 1398, 1554 (Baretta). Hallopeau.
Figs. 78, 80. Models in Neisser's Clinic in Breslau (Kröner).
Fig. 81. Model in Lassar's Clinic in Berlin (Kasten).

Leucoplakia.

PLATE XLIV., FIG. 82.

On the tongue, especially at the margins, on the buccal mucous membrane in contact with the teeth, at the angles of the mouth, and on the mucous lining of the lips, roundish, often confluent patches are frequently present, especially in persons who smoke and drink to excess, over which the epithelium is thickened and opaque. They pursue an extremely chronic course, they are slightly, if at all, raised and exhibit little or no inflammation at the edge. In many cases there is a history of antecedent syphilis, but the affection can certainly not be regarded as specific, inasmuch as it also occurs in non-syphilitic subjects, and is absolutely uninfluenced by anti-syphilitic treatment. Epithelioma may develop on leucoplakial patches as the result of long-continued irritation. There is usually very little pain.

The **Diagnosis** is easy in typical cases, as the long duration, the localization and the absence of inflammatory phenomena permit of easy distinction from syphilitic plaques. Lichen planus of the mucous membrane of the mouth is always accompanied by lichen elsewhere. The "geographical tongue" is congenital, and soon alters in character.

The **Prognosis** is, on the whole, favourable, except in the rare cases in which carcinoma develops on a leucoplakial basis.

Treatment can only be followed by good results in the early stages. Apart from local treatment by chromic and lactic acids, papayotin or salicylic alcohol, lotions of decoction of bilberry are recommended. Obviously, smoking and indulgence in alcohol must be interdicted.

Fig. 82. Model in Saint Louis Hospital in Paris, No. 1573 (Baretta). Fournier.