DERMOCHROMES - II

PORTFOLIO

OF

DERMOCHROMES

BY

PROFESSOR JAOOBI

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 II

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Exfoliatio Areata Linguæ.

Geographical Tongue.

Plate XLV., Fig. 83.

In this disease there appear upon the tip and marginal portions of the tongue—without apparent cause—grayish-white, sometimes yellowish, round spots, which extend rapidly in crescentic lines enclosing somewhat depressed, smooth areas of mucous membrane of a brighter and deeper red colour than the other parts of the tongue. The margins, which are made up of thickened epithelium, measure from ½ to 3 millimetres in breadth, and spread in crescentic segments; but they do not cross the middle line, and only exceptionally invade the lower aspect of the tongue. Decorative, festooned, and geographical figures result from the confluence of contiguous patches and the appearance of fresh rings in the centre. Gradually the central portions become paler and resume their normal characters; the whitish margins disappear, and the diseased parts heal without scarring, but the process of cure may be delayed for months or even years by the occurrence of repeated exacerbations.

Subjective symptoms are usually slight, and consist of a certain amount of oversensitiveness, but sometimes severe pain is observed.

The affection occurs most frequently in children, and

recovery generally takes place at the age of four or five years. In adults the duration of the disease is unlimited. Its cause is absolutely unknown, but in some cases hereditary predisposition has been definitely established.

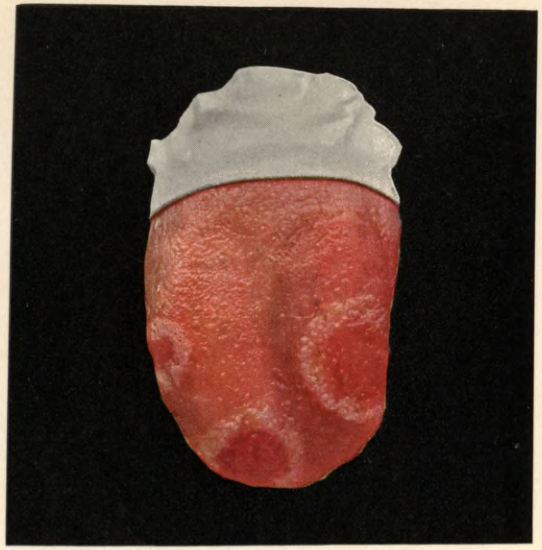
The **Diagnosis** is easily made by the observation of the typical, rapidly spreading rings surrounding intensely red areas of mucous membrane. Syphilitic mucous patches are not of so deep a red colour; their epithelium, as a rule, is not dullish white at the margin only; they are painful, often deeply eroded, and do not change their form so quickly; finally, they disappear under antisyphilitic treatment.

Leukoplakia of the tongue exhibits a permanent picture without recent inflammatory phenomena.

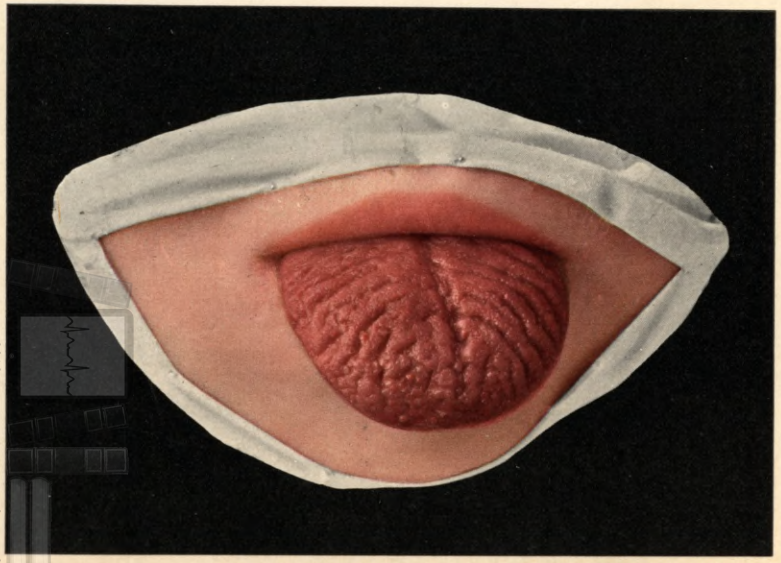
The **Prognosis** is so far favourable, as the condition does not produce severe symptoms; but the outlook is dubious as regards cure.

No effectual form of **Treatment** is known; only temporary benefit can be attributed to the remedies recommended, which include lotions of decoctions of camomile or bilberry, solutions of boric acid, common salt, chloride of potassium, as well as caustic applications of lactic acid, chromic acid, nitrate of silver, and other similar substances.

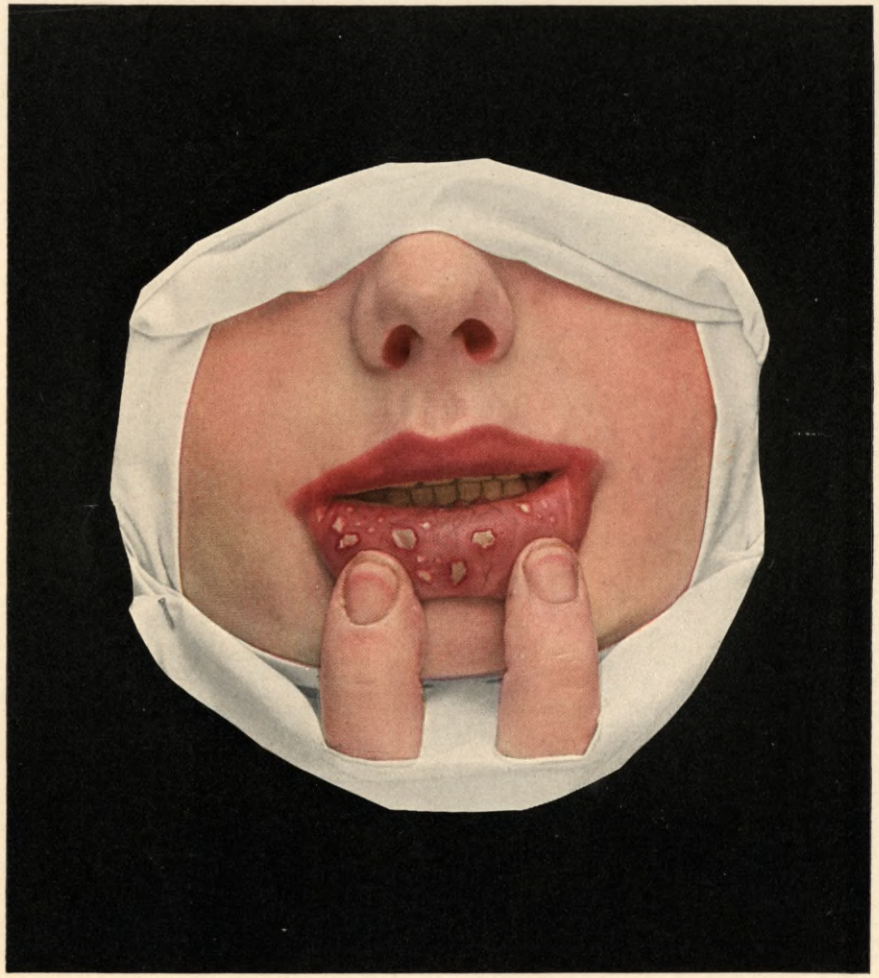
Fig. 83. Model in Saint Louis Hospital in Paris, No. 2235 (Baretta). Meureman and Raymond's case.



No. 83. Exfoliatio areata linguae (Geographical Tongue).



No. 84. Lingua scrotalis.



No. 85. Aphthae.

Lingua Scrotalis.

PLATE XLV., FIG. 84.

The "scrotal tongue" derives its name from its resemblance to the scrotum when contracted by cold. It is a congenital and usually hereditary affection in which the mucous covering is proportionally too extensive to correspond exactly to the body of the tongue, and appears to be arranged in numerous branching, longitudinal and transverse folds. Often these folds are arranged like the veins of a leaf (Fig. 84). Local irritation—*e.g.*, by the decomposition of the remains of food in the depths of the furrows—may cause some degree of local superficial inflammation, but otherwise the condition is of no consequence.

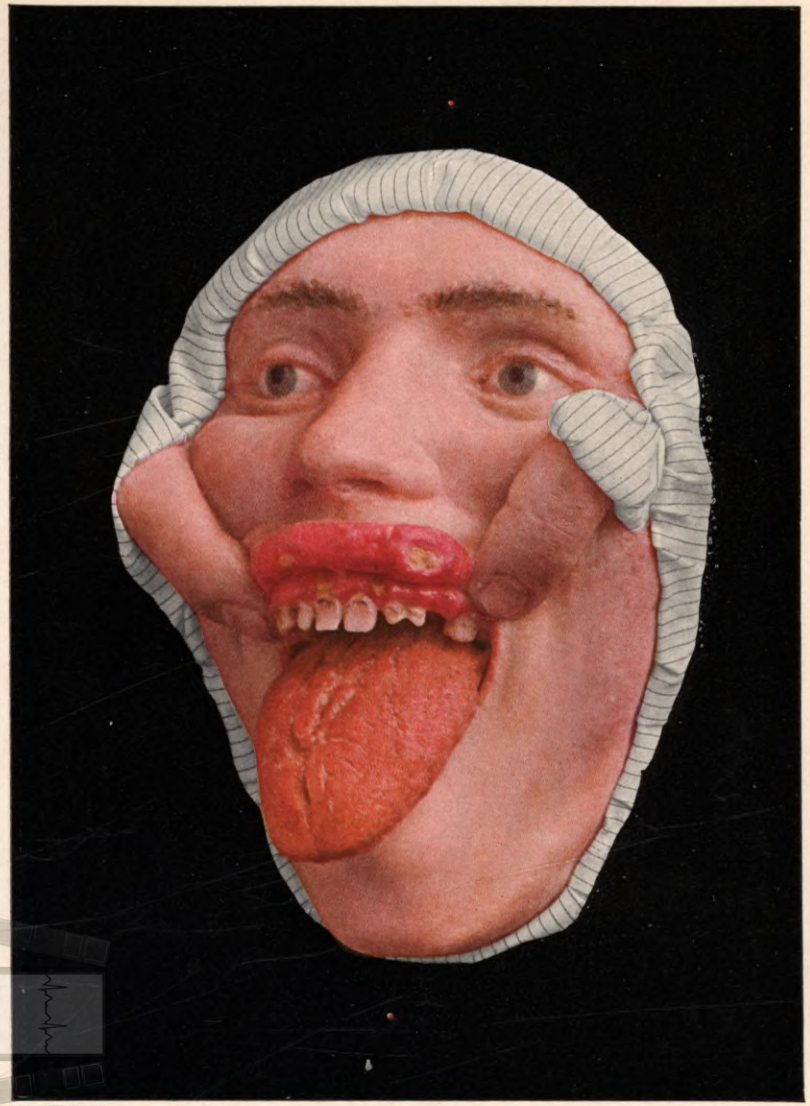
Fig. 84. Model in Freiburg Dermatological Clinic (Johnsen).

Aphthæ.

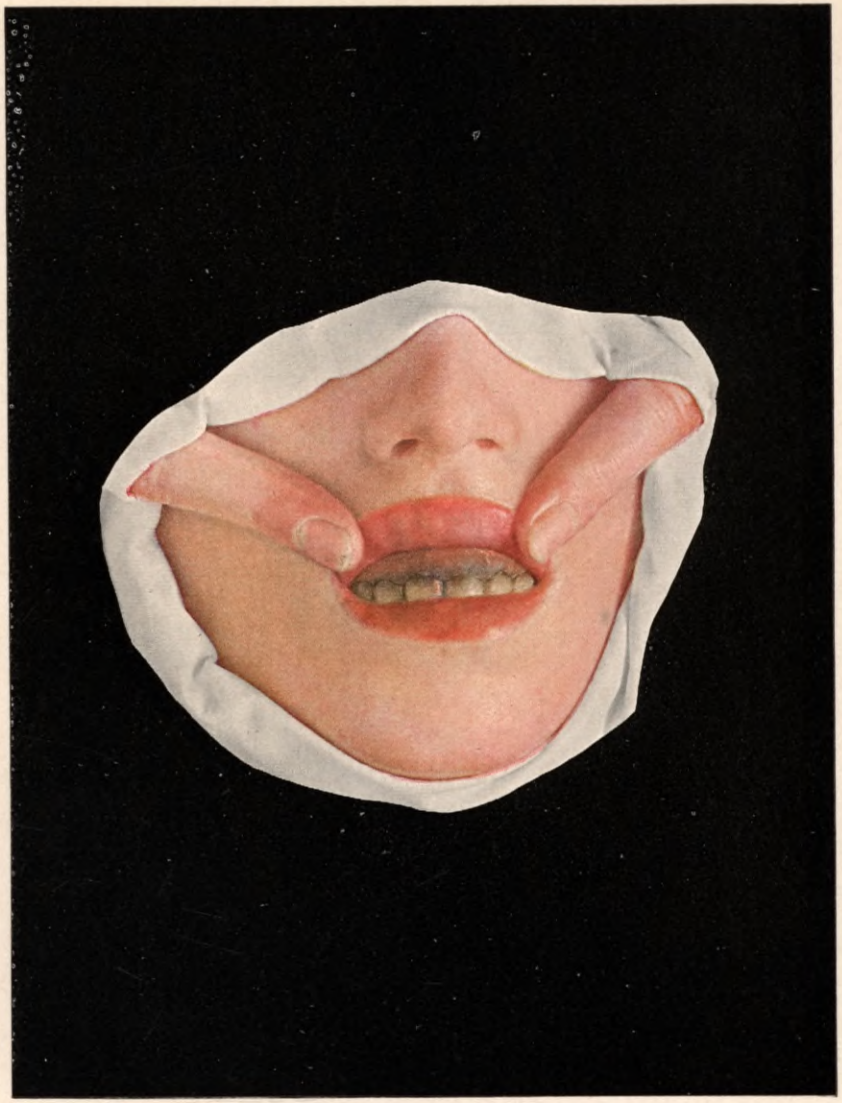
PLATE XLV., FIG. 85.

The name Aphthæ (*Stomatitis aphthosa*) is employed to connote roundish or oval patches of whitish colour with narrow, red margins which occur in the month either as a subacute or acute condition, in the latter instance being accompanied by the symptoms of a general infection. They attack more especially the lips, the tongue, and the gums, but also the hard and —more rarely—the soft palate. By their confluence they may assume irregular forms, and may attain much greater dimensions. They may give rise to considerable pain, especially as the result of eating; and they heal in two or three weeks, unless repeated exacerbations occur. Analogous eruptions sometimes attack the female genital organs. Symptoms of general stomatitis are usually present in the more severely febrile cases. The disease occurs most frequently in children during teething, but cases of obstinately recurrent aphthæ are of not infrequent occurrence in adults.

Aphthæ are very probably caused by various excitants of bacillary nature, and disturbances of digestion or decayed teeth are favourable concomitants for their operation.



No. 86. Stomatitis mercurialis.



No. 87. Dyschromia gingivae saturnina
(Blue line on gums from lead).

Treatment.—The most important factor here is *prophylaxis.* Removal of all defective teeth before mercurial treatment is entered upon, is necessary During mercurial treatment utmost hygienic care of the oral cavities must be observed, frequent rinsing of the mouth with weak antiseptic and astringent solutions, such as liq. alumin. acet., solution of hypochloride of lime, etc. The same applies to men who work with quicksilver.

In cases of ulcerating stomatitis, the ulcers must, under anæsthesia with cocaine, be touched with the stick, or with a strong solution of nitrate of silver, or hydrobromic acid, or a 10% solution of chromic acid. Painting with balsam of Peru or hydrogen peroxide is also beneficial. Mouth washes of weak solutions of corrosive sublimate, permanganate of potash, hypochloride of lime, hydrogen peroxide, tincture of myrrh, or tincture of ratanhia (tinctura krameriæ) should be used as often as possible. As the patient has to subsist for a considerable period on liquid foods, local anæsthetics, such as cocaine, anæsthesine, orthoform and similar means should be applied, so as to assist the process of nutrition. If the pain is very severe, narcotics should not be neglected. Hypnotic suggestion also deserves attention.

Fig. 86. Model in Finger's Clinic, Vienna (Dr. Henning).

Dyschromia Gingivæ Saturnina.

Lead Poisoning.

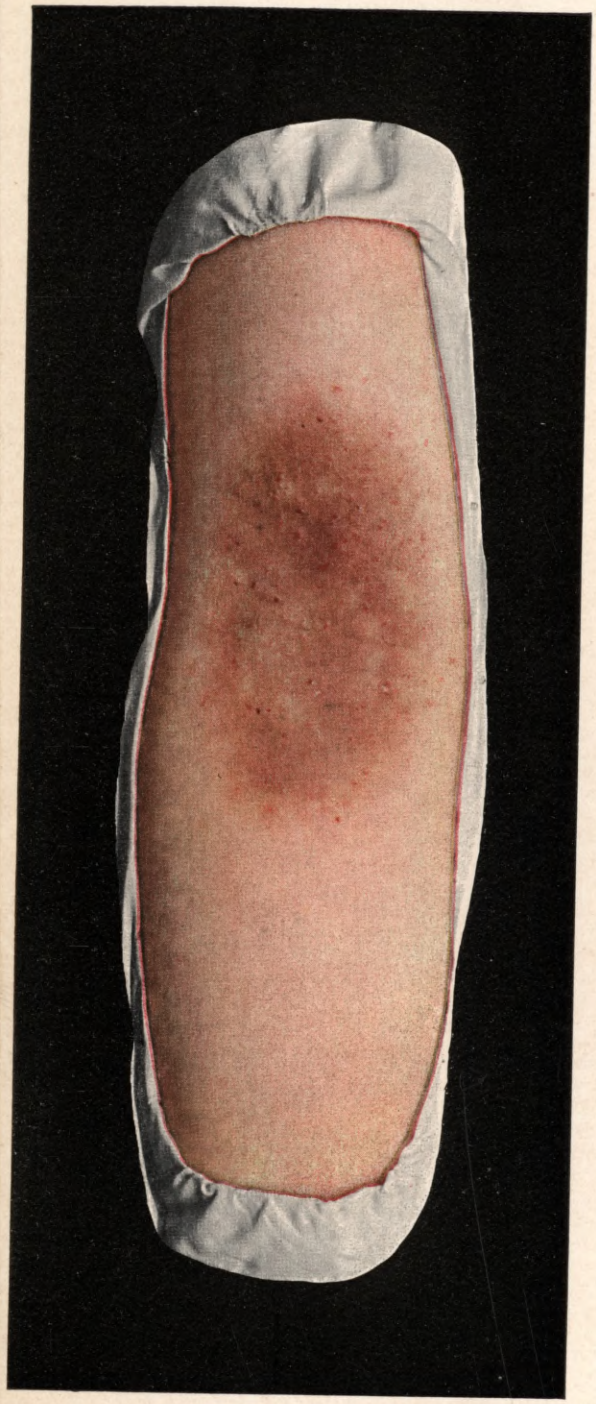
Plate XLVI., Fig. 87.

A characteristic symptom of lead poisoning is the blue line of the gums, readily recognised in compositors and house painters, but also found in others who work with lead products. It is a bluish-black discoloration of the gums, chiefly discernible on the edge nearest to and between the teeth. It consists of sulphur of lead deposited in the tissues. In serious cases it is accompanied by stomatitis with *fœtor ex ore* and a heavy coating of the swollen tongue.

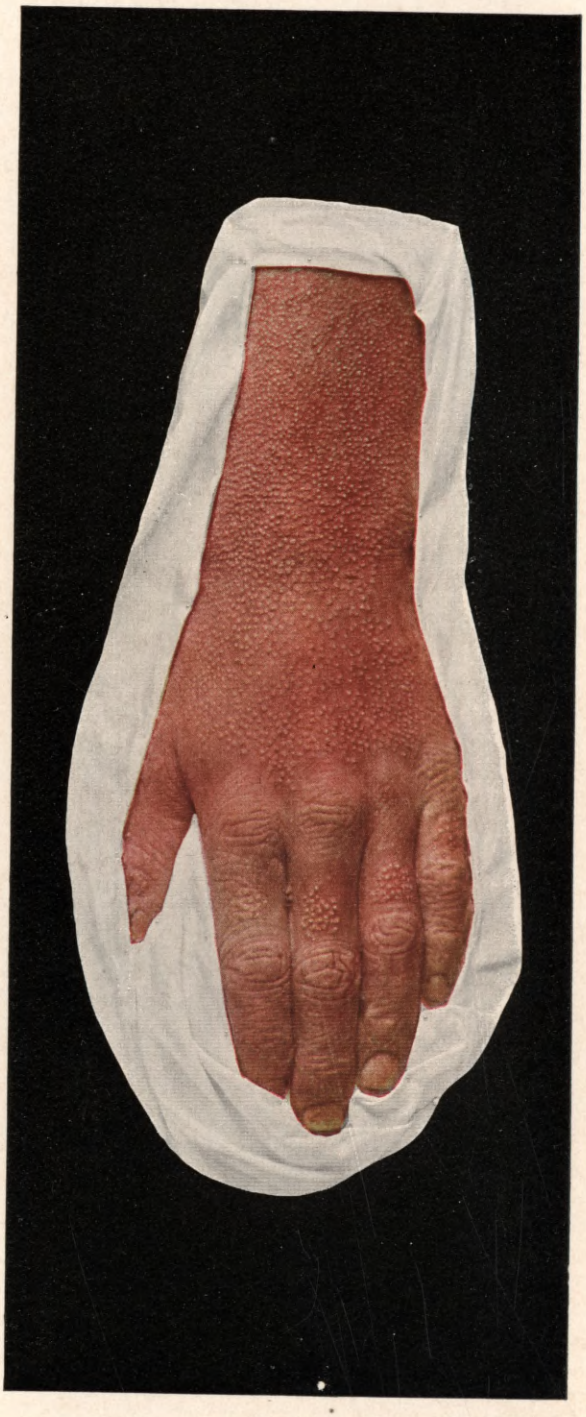
Diagnosis of this very marked and characteristic manifestation is easily made. The insertion of a strip of white paper under the edge of the gums will prevent the observer from mistaking it with the black deposit which shows through the gums in heavy smokers.

No special **Treatment** is to be mentioned. The chief factor is **Prophylaxis**; viz., to prevent as much as possible the entrance of the poison into the system by respiration or through the alimentary canal.

Fig. 87. Model in von Bergmann's Clinic, Berlin (Bolbow).



No. 88. Lichen simplex chronicus (Vidal).



No. 89. Pityriasis rubra pilaris.

Lichen Simplex Chronicus (Vidal.)

PLATE XLVII., FIG. 88.

The affection termed Lichen simplex chronicus of Vidal (*Neurodermitis* of Brocq, *Dermatitis lichenoides pruriens*) attacks the neck, the inner sides of the upper parts of the thighs, the flexures of the knees and elbows, the peri-anal region, and more rarely, the lateral aspects of the abdomen; it must be distinguished from true lichen. Violent itching occurs in situations where at first there are few or no demonstrable changes, so that the patients are compelled to scratch and thus produce a diseased condition which, at its maximum of intensity, shows a central, lichenified area of gray or grayish-brown tint, surrounded by a brighter zone, in which more or less numerous, small, slightly scaly and generally scratched, lichenoid papules are present. The disease is extremely chronic and is more frequent in women than in men.

The **Diagnosis** in fully developed cases is easily made from the localization, the chronic course and the absence of marked inflammatory phenomena.

Treatment of the most prominent symptom is best accomplished by the use of tarry or chrysarobin ointments. General treatment with arsenic is almost entirely useless.

Fig. 88. Model in Neisser's Clinic in Breslau (Kröner).

Pityriasis Rubra Pilaris.

Plate XLVII., Fig. 89.

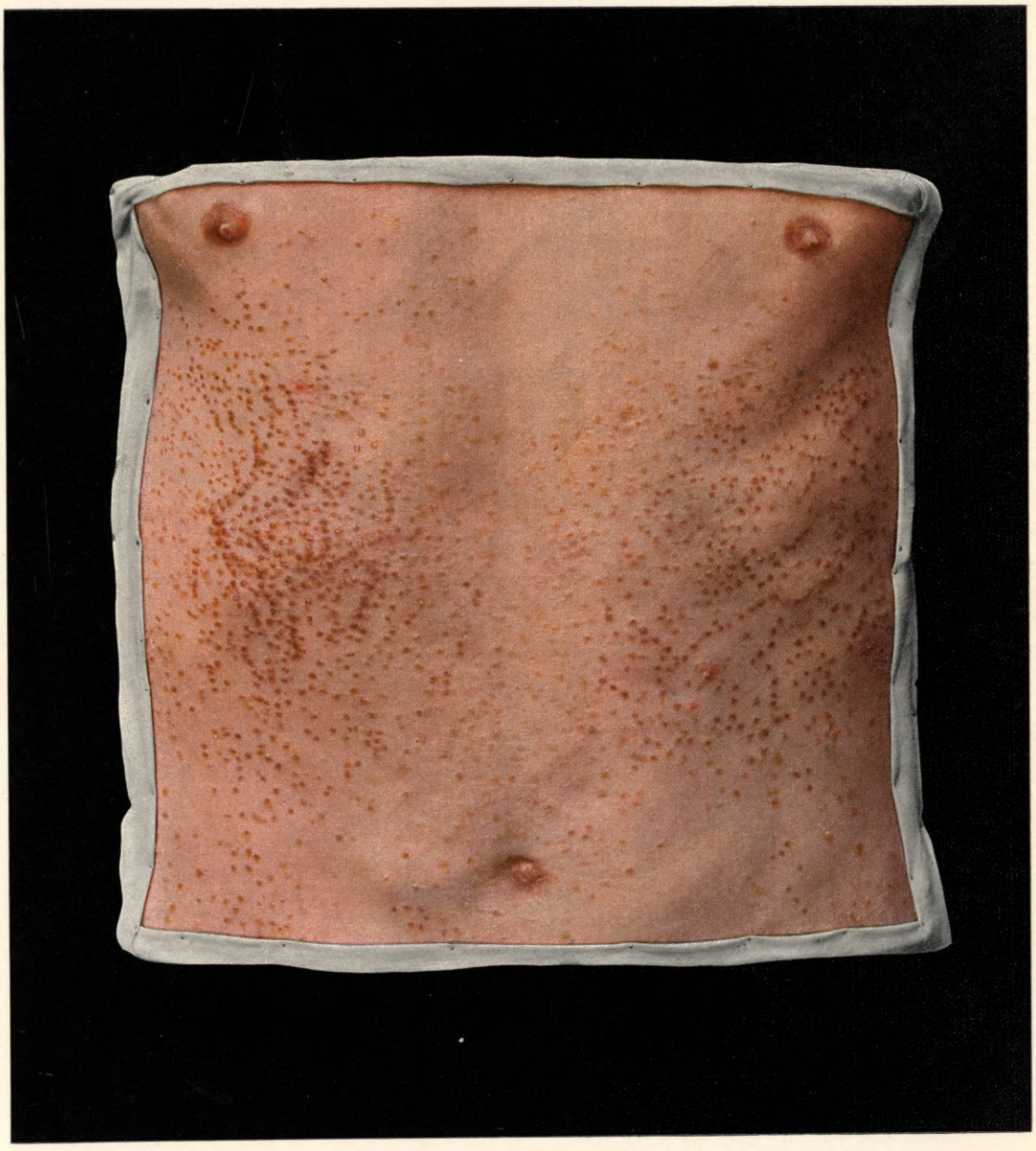
Pityriasis rubra pilaris is an extremely chronic but benign affection—in contradistinction to Lichen ruber acuminatus, with which it is often erroneously identified—in which small, circumscribed, horny papules which are often crateriform and penetrated by hairs, form round the follicles; they are of white or grayish tint, and occur most abundantly on the backs of the hands, arms and legs, and on the trunk. Often these little nodules coalesce and give to the skin the sensation of a nutmeg-grater. In places the follicular composition of the eruption is irrecognisable, so that a psoriasiform appearance is presented. The soles and palms exhibit thickening of their epidermis and deepening of their natural folds; in very extreme cases the nails are involved. The severity of the inflammation varies within very wide limits.

The **Diagnosis** of this somewhat rare disease may, in typical cases, be made without difficulty from the presence of the white, horny masses and their localization.

The **Prognosis** is favourable.

The **Treatment** consists in the employment of baths and tarry, chrysarobin or pyrogallic acid ointments.

Fig. 89. Model by Dr. Bayet of Brussels.



No. 90. Darier's Disease (Psorospermosis follicularis vegetans).

Darier's Disease.

Psorospermosis Follicularis Vegetans.

PLATE XLVIII, FIG. 90.

Darier's disease was named by the author who first described it as "*Psorospermosis follicularis vegetans,*" although it is not due to the presence of psorosperms, nor is it connected with follicles, nor is it—in all cases—accompanied by vegetations. It is characterized by the presence of small acuminate nodules, most thickly aggregated on the face, scalp, and flexures; but they often exist also on the thorax, where they are more scattered or grouped (Fig. 90). They are at first of the normal colour of the skin, but, as they develop, assume a grayish-brown or brownish-red tint. At their summit they are covered by a conical horny plug which can be scratched off, disclosing a peg-shaped process on their under surface. These lesions are thickly packed together on the backs of the hands, where they resemble recent warts; while on the palms the prominent features are the general hyperkeratosis and the marked dilatation of the sweat ducts. Even the nails show morbid changes, especially linear stripes. The morbid picture is often complicated by the presence of seborrhœic eczema. More rarely the condition culminates in papillomatous growths of special character in the flexures of the joints, in the groins, and behind the ears.

Etiology.—The majority of cases of this incurable disease develop about puberty; in a certain number hereditary predisposition can be established with certainty. Infectivity cannot be proven.

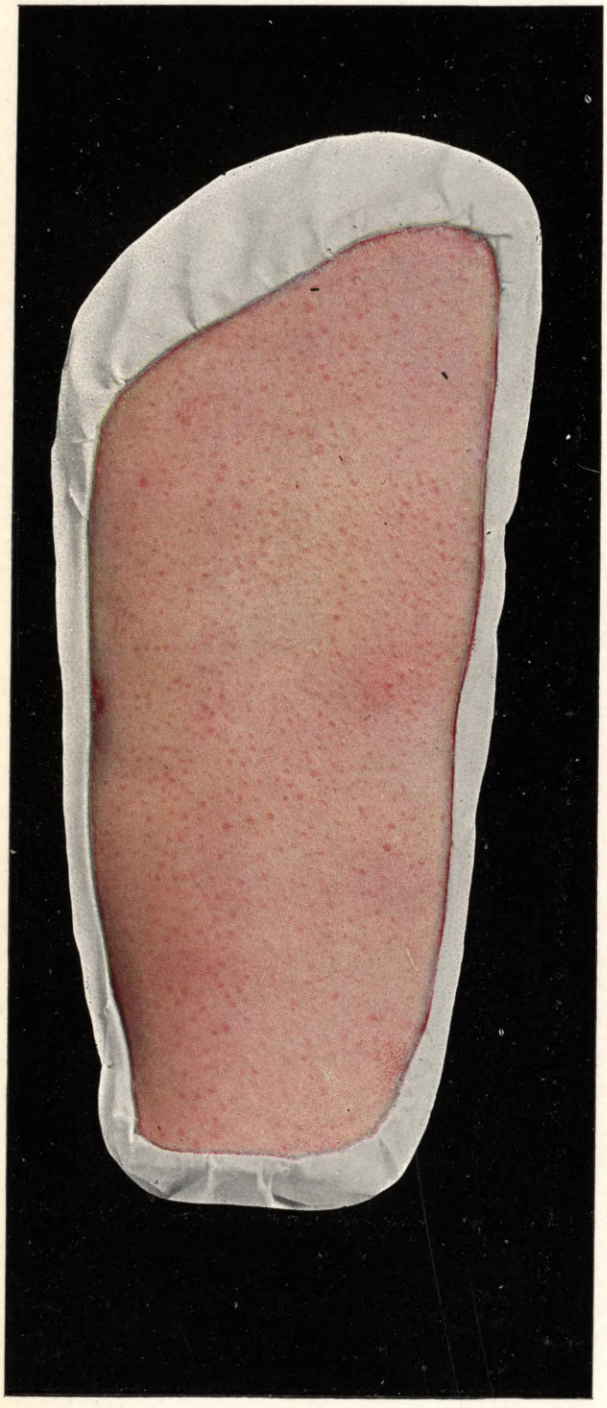
The **Histological characters** are very striking, and consist of changes in the epithelium, where special round glistening bodies are present in great numbers (the "corps ronds" of Darier), as well as smaller granular masses. The disease is clearly defined as a distinct entity by the presence of these bodies, and must be strenuously differentiated from other somewhat similar affections—*e.g.*, certain forms of Ichthyosis—to which it has no relationship whatever.

The **Diagnosis** is extremely difficult on clinical characters only, and can only be rendered certain by a biopsy.

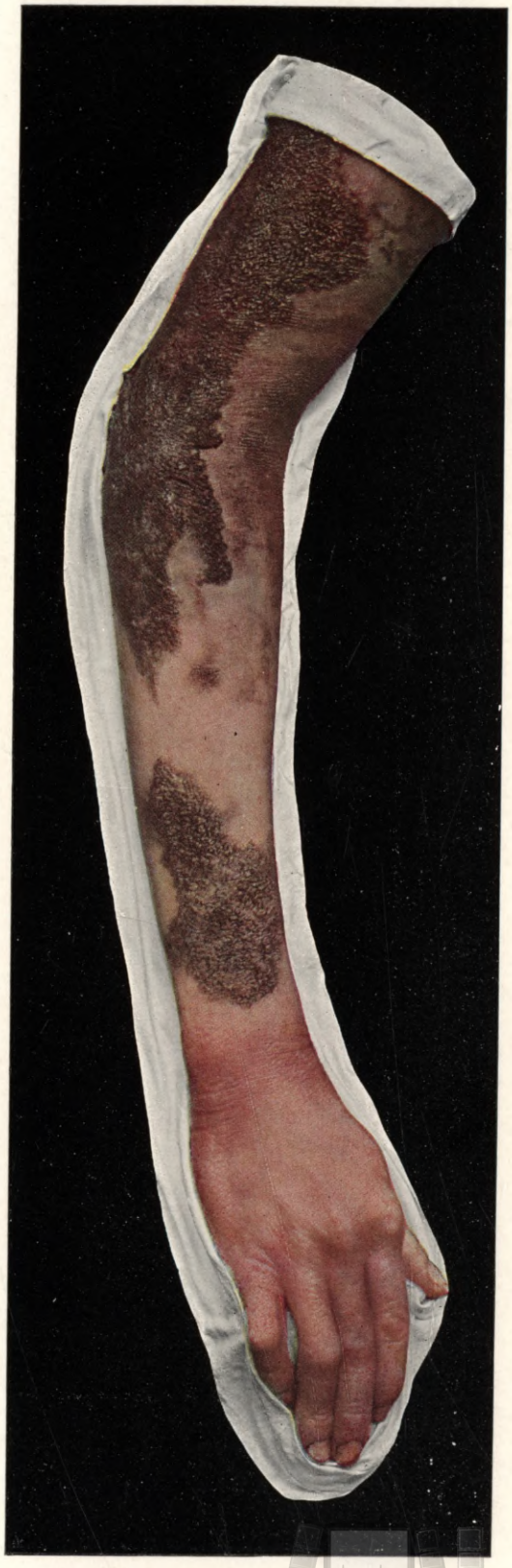
The **Prognosis** is unfavourable as regards recovery, but the general health is unaffected.

Treatment can, unfortunately, only be directed towards removing the seborrhœic eczema which may be present; vegetations may be destroyed by keeping the parts dry and touching with nitrate of silver or other caustics. The underlying, essential disease is rebellious to all treatment.

Fig. 90. Model in the Freiburg Dermatological Clinic (Johnsen).



No. 91. Lichen pilaris.



No. 92. Ichthyosis hystrix.

Lichen Pilaris.

Plate XLIX., Fig. 91.

The disease called Lichen pilaris occurs chiefly on the extensor surfaces of the forearms and legs in children up to the age of puberty; it is often considered to be the mildest form of ichthyosis. Over the regions mentioned the follicular orifices are closed by small horny plugs which, when removed by scratching, disclose a twisted lanugo hair. Sometimes hyperæmia and inflammatory manifestations appear round the follicles, while, after the little scales are shed, tiny scar-like pits may persist.

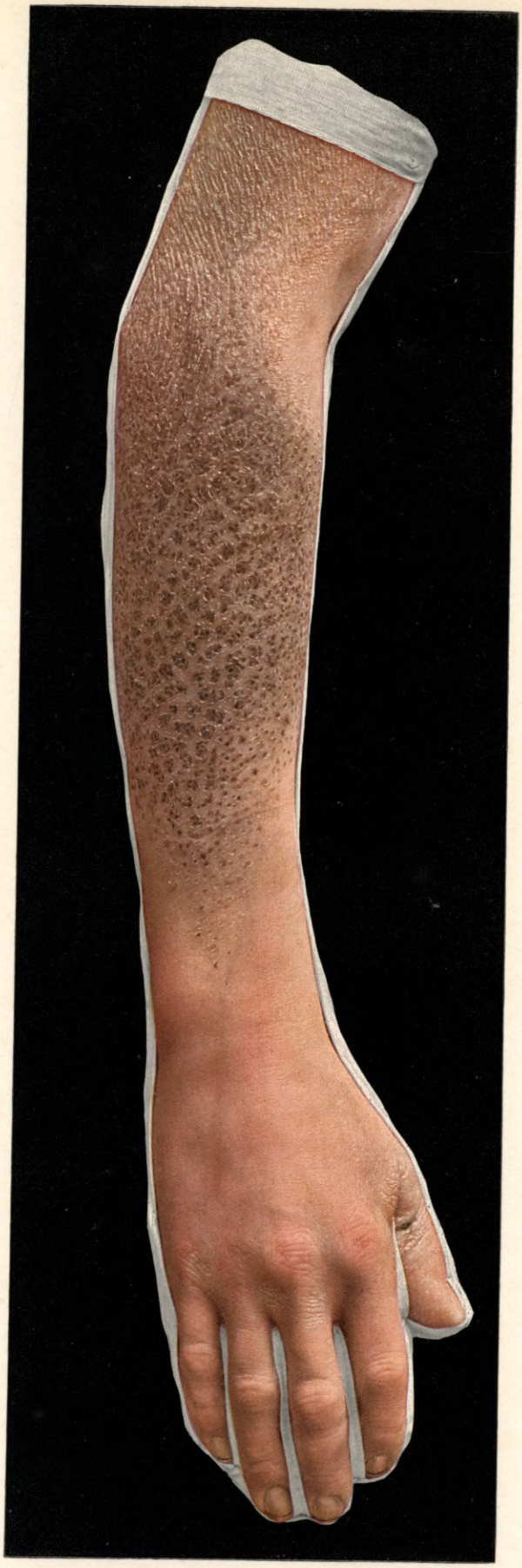
The **Treatment** of this perfectly harmless affection consists in the use of macerating salves or simple fats, washing with "marble soap," or frequent baths. As the result no real cure occurs, but if these remedies are persisted in, the symptoms, which cause annoyance merely from the cosmetic point of view, may be ultimately controlled.

Fig. 91. Model in Neisser's Clinic in Breslau (Kröner).

Ichthyosis.

PLATE XLIX., FIG. 92; PLATE L., FIG. 93.

By the name *Ichthyosis* is understood a hereditary change in the skin, manifesting itself in early childhood, in which the impaired functions of the sebaceous and sweat glands, and the excessive formation of epidermis, constitute the characteristic features. In the milder degrees (*Ichthyosis simplex*) the epidermis is somewhat thickened and forms firmly adherent, dry scales, which are detached at the edges, especially marked on the extensor surfaces of the extremities and trunk, less so on the face, and almost never present on the palms, soles and flexures. Higher grades of the affection are represented by *Ichthyosis serpentina* (Fig. 93), in which the thick, grayish-green scales assume the look of a serpent's skin; by *Ichthyosis nitida,* in which the scales are of glistening, mother-of-pearl appearance; and of *Ichthyosis hystrix,* in which warty growths are scattered either irregularly or symmetrically over extensive areas of the skin. Occasionally different grades of the affection occur simultaneously in the same person (Fig. 92). In true ichthyosis there are no inflammatory phenomena, but eczema may occur as a complication. Sometimes regular shedding of the horny masses or "moulting" may occur. The disease, which is incurable, usually gives rise to no subjective symptoms, but in its most marked forms may be extremely disfiguring.



No. 93. Ichthyosis simplex et serpentina.

The skin affection called *Ichthyosis congenita,* which is present at birth, and generally in prematurely born children, is characterized by the existence over the whole body of seborrhœic plates, like a coat of mail; it ought not to be considered a true ichthyosis.

The most important etiological factor is heredity, and it is worthy of remark that frequently individuals of one sex only in the family are affected, while instances of skipping over some generations occur.

Treatment may certainly cause the manifestations of ichthyosis to disappear for a time, but never effect a cure.

The use of baths after preliminary inunction with salicylic ointments or soaps, with sulphur soaps or spiritus saponis alkalinus, generally suffices to remove the superfluous horny masses, while in milder cases the simple anointing of the body may be efficacious.

Fig. 92. Model in Lesser's Clinic, Breslau (Kolbow).
Fig. 93. Model in Freiburg Clinic (Johnsen). The transitions from the slightest grade of Ichthyosis simplex to the fully developed Ichthyosis serpentina are beautifully rendered in this picture.

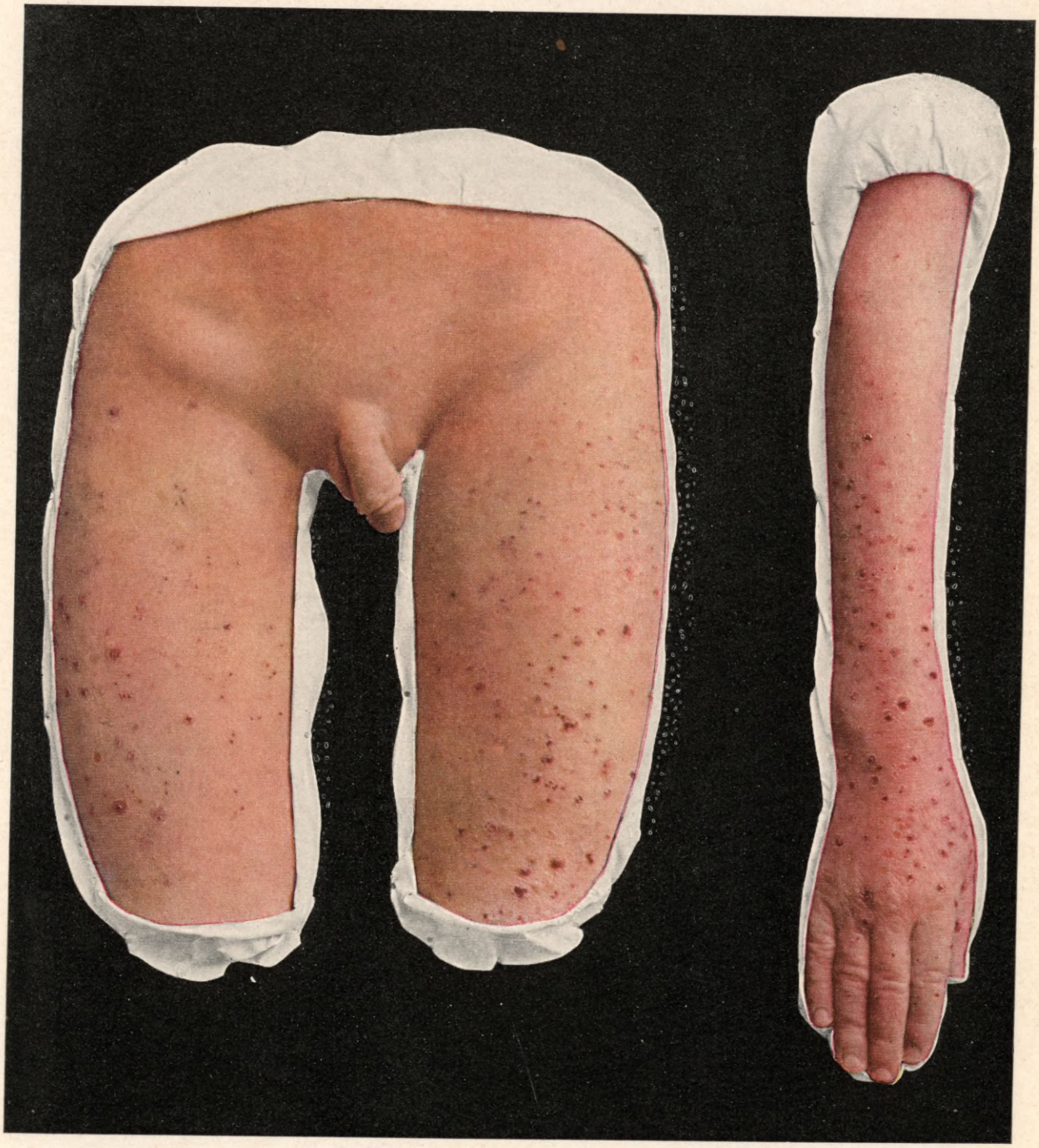
Prurigo.

PLATE LI., FIGS. 94, 95.

Hebra's Prurigo is a disease which begins in early childhood; its typical, elementary lesions are localized principally on the extensor surfaces of the extremities (Figs. 94, 95), while generally the flexor surfaces are free and, even in severe cases, the flexures of the knee and elbows remain so. The trunk is usually only moderately affected, the face as a rule remaining free. The typical prurigo lesions develop from those of chronic infantile urticaria; they consist of conical papules which itch violently, and are usually at first covered by normal skin, which is scratched soon after their eruption. As a result the skin becomes densely infiltrated and pigmented, its surface rough and nutmeg-grater-like; its glandular structures and hair atrophy. Firm, indolent swellings of the lymphatic glands in the groins and axillæ also result (*Prurigo buboes,* Fig. 94).

The disease may be ameliorated by suitable treatment, but is not really curable; afflicted children generally remain backward in growth and development.

The severest attacks generally occur in autumn and winter, and in patients of the poorer classes, who are the most frequently attacked. Eczemas and deep ulcers may be observed as complications resulting from the frightful pruritus, which occurs in paroxysms. The intensity of the malady varies within wide limits (*Prurigo mitis—Prurigo agria seu ferox*).



No. 94, 95. Prurigo.

The **Prognosis** may be considered as favourable in mild cases only; in severe cases the disease is merely capable of some alleviation.

The **Diagnosis** is based upon the presence of the typical prurigo-papules and their localization on extensor surfaces; on the dense infiltration of the skin over the seats of predilection; on the deep pigmentation and glandular swellings; and, finally, on the development of the disease from chronic infantile urticaria.

The **Differential Diagnosis** need only be made from eczema, which can be easily excluded by the differences in localization, the absence of the typical nodules and by the frequent occurrence of weeping in that disease.

Treatment must be begun as early as possible and must be continued for a very prolonged period. No internal medication is efficacious, but good feeding and the bringing of the patient into healthy surroundings and general conditions assist local treatment. This has for its main objects the relief of itching—as a great part of the skin-changes are referable to scratching—and the restitution of the functions of the cutaneous glands. For these purposes prolonged baths containing tar or sulphur are of service, while ointments with tars, naphthol or epicarin (2-5 per cent.) may be rubbed in with advantage. Finally, Turkish baths or pilocarpine subcutaneously may be employed.

Figs. 94, 95. Models in Neisser's Clinic in Breslau (Kröner).

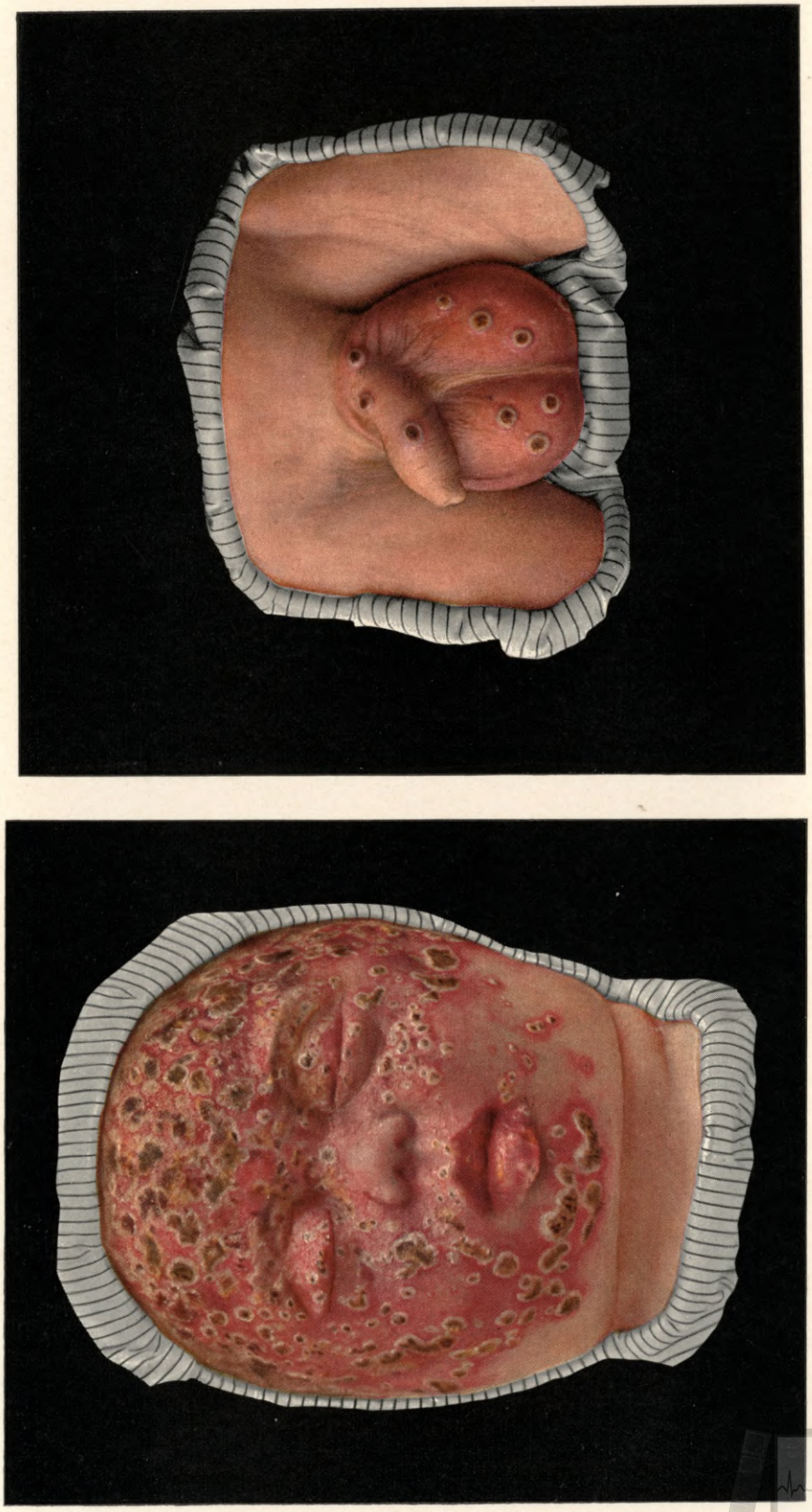
Vaccinia.

PLATE LII, FIGS. 96, 97.

In vaccinated children the virus of the primary pustules may be transferred by scratching either to the surrounding skin or to distant parts—especially (Fig. 96) the genital regions and face—where secondary vaccine pustules may develop. If some itchy skin disease is present—*e.g.*, eczema, scabies, or prurigo—the condition may result in an outbreak of vaccinal lesions over the whole body (Fig. 97), with severe general symptoms. This usually occurs as a relapse two or three weeks after the vaccination, and is often considered as a general infection with vaccine matter. The disease almost always runs a favourable course, but leaves behind it annoying scars, and may, if the cornea is attacked, give rise to damaging opacities or even to total loss of vision. It is also possible for vaccine virus to be transferred from recently vaccinated persons to children who have not been vaccinated, but who are the subjects of itching skin diseases.

The **Diagnosis** can be easily established by the presence of the typical lesions and the determination of a preceding vaccination, possibly of a relative or neighbour.

The **Prognosis** is favourable as a rule.



No. 96. 97. Vaccinia generalisata.

Prophylaxis is of great importance. Children suffering from itchy skin diseases ought not to be vaccinated until the skin disease is quite cured. All vaccination pustules must be covered with a protective antiseptic dressing.

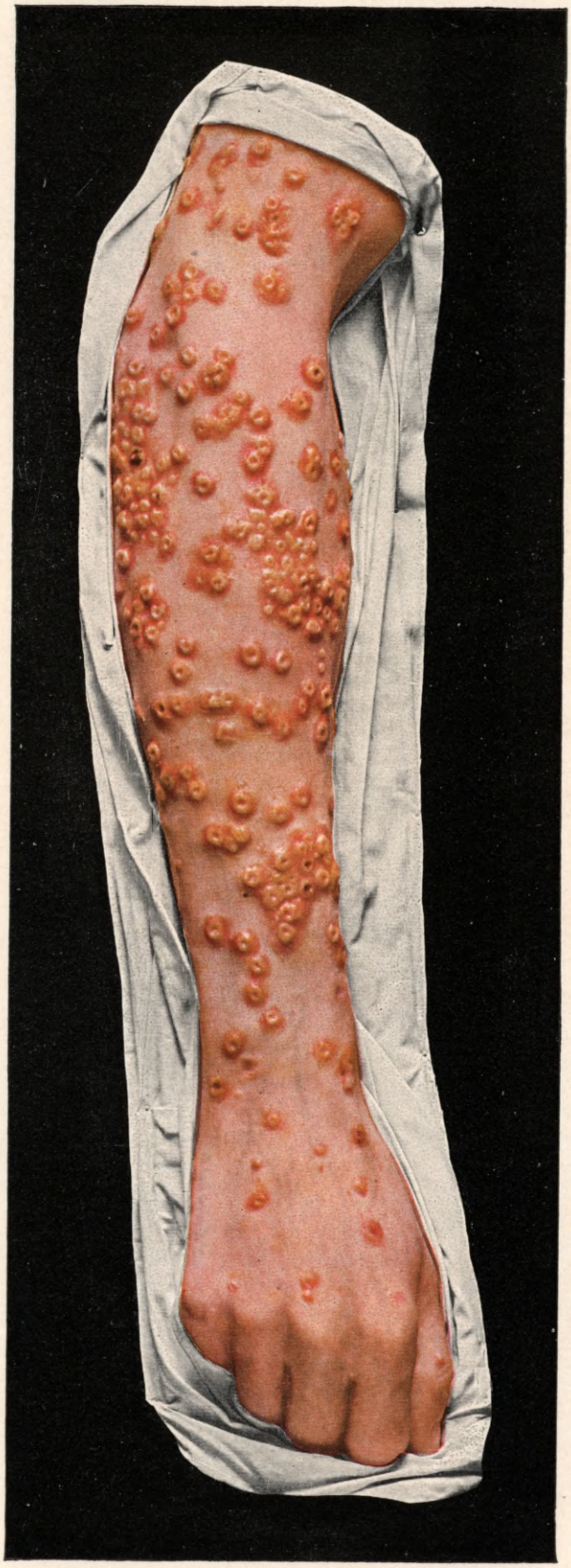
Treatment.—In every recent case of vaccinia an attempt should be made to employ Finsen's method of excluding all chemically active light rays. If the pustules are fully developed, wet compresses may be employed soaked in acetate of aluminium, or boric acid, or 1 per cent. resorcin solution. Painting with pure ichthyol or the use of ichthyol ointment may also be recommended.

Fig. 96. Model in the Imperial Vaccine Institute in Vienna (Dr. Henning).
Fig. 97. Model in Finger's Clinic in Vienna (Dr. Henning).

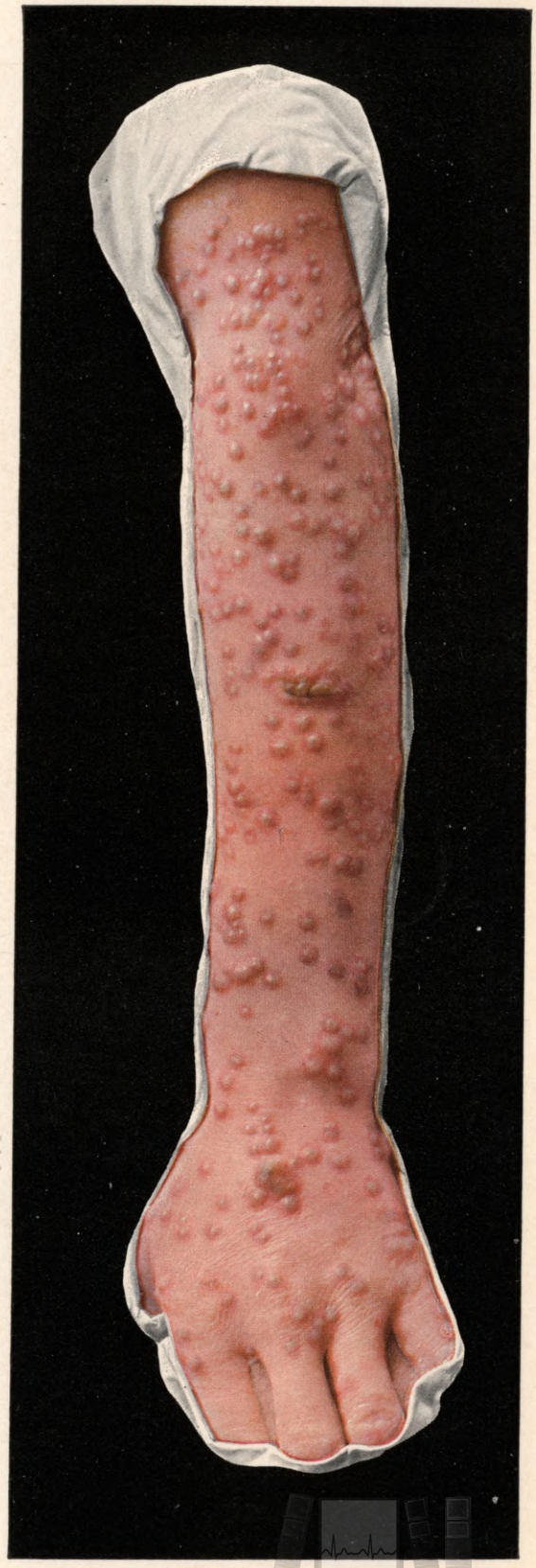
Variola. Small-pox.

Plate LIII., Fig. 98; Plate LIV., Fig. 101.

Small-pox is an extremely infectious disease, the contagium of which is still unknown; it is, however, very resistant and is capable of communicating the malady both directly and indirectly. After a period of incubation, ranging from ten days to a fortnight, severe general symptoms manifest themselves, especially high temperature, backache, delirium, vomiting and swelling of the spleen. Then a prodromal eruption appears, which is composed of erythematous or hæmorrhagic spots occurring chiefly on the abdomen and inner sides of the thighs; this diminishes in a few days at the same time as the fever and general symptoms decrease. Now the characteristic eruption appears, first on the scalp and face, then on the trunk, arms and legs, in the form of small, red nodules, which increase in number and size, and develop into vesicles with clear contents. As the temperature again rises the contents of the vesicles become cloudy, a little depression or umbilication forms in their centre and the pustules, which may either remain discrete (Fig. 101) or run together, surrounded by a red zone, represent the acme of the eruption's development or "maturation" (Fig. 98). The rash is specially abundant and confluent on the face and hands, but the mucous membranes—especially the conjunctiva—may also be involved. At this stage serious nervous disorders and internal complications occur, which gravely imperil the patient.



No. 98. Variola (Small-pox).



No. 99. Varicellae in adulto (Chicken-pox).

In favourable cases the involution of the eruption begins in from twelve to fourteen days, with some fall in temperature. The pustules dry up and form crusts, which separate in three or four weeks, leaving red scars, when the process may be considered as at an end, although the period of infectivity lasts some time longer. In less favourable cases the epidermic covering of the vesicles is shed, and extensive pustulating surfaces are exposed, while the general symptoms remain extremely severe. Confluent and hæmorrhagic small-pox must always be regarded as specially virulent forms, which generally end fatally. Milder forms with scanty eruption, or abortive cases in which the rash is arrested in the earlier stages of its development, run a shorter course, with less severe general symptoms.

Apart from the above-mentioned nervous disorders and internal complications others may arise, especially secondary infections, and these may cause death by general sepsis, or extensive scarring and the loss of one or both eyes.

The **Diagnosis,** which is often extremely difficult in the earlier stages—or, indeed, scarcely possible —becomes easy when the rash with its typical pustules is fully developed.

The **Differential Diagnosis** must be established from other infectious diseases, more especially from pustular syphilis, but the latter always shows other "specific" manifestations on close examination. In every case one must ascertain if the patient has been recently vaccinated and if he has been exposed to the danger of contagion. In chicken-pox the general condition is not so grave, the prodromal eruption and the umbilication of the vesicles are not present; and

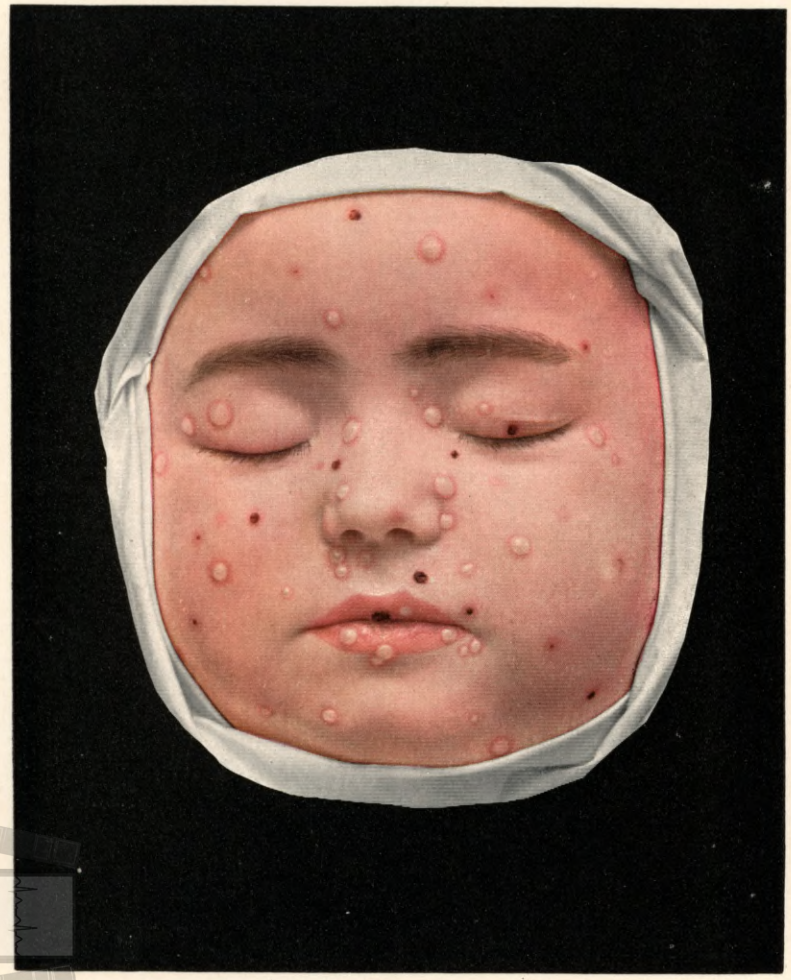
different stages of development of the eruption are almost always present at the same time.

The **Prognosis** of variola is always dubious, the percentage mortality differing markedly in different epidemics; the severity of infection, as well as the age of the patient, must be taken into account; the danger is greatest in children and old persons.

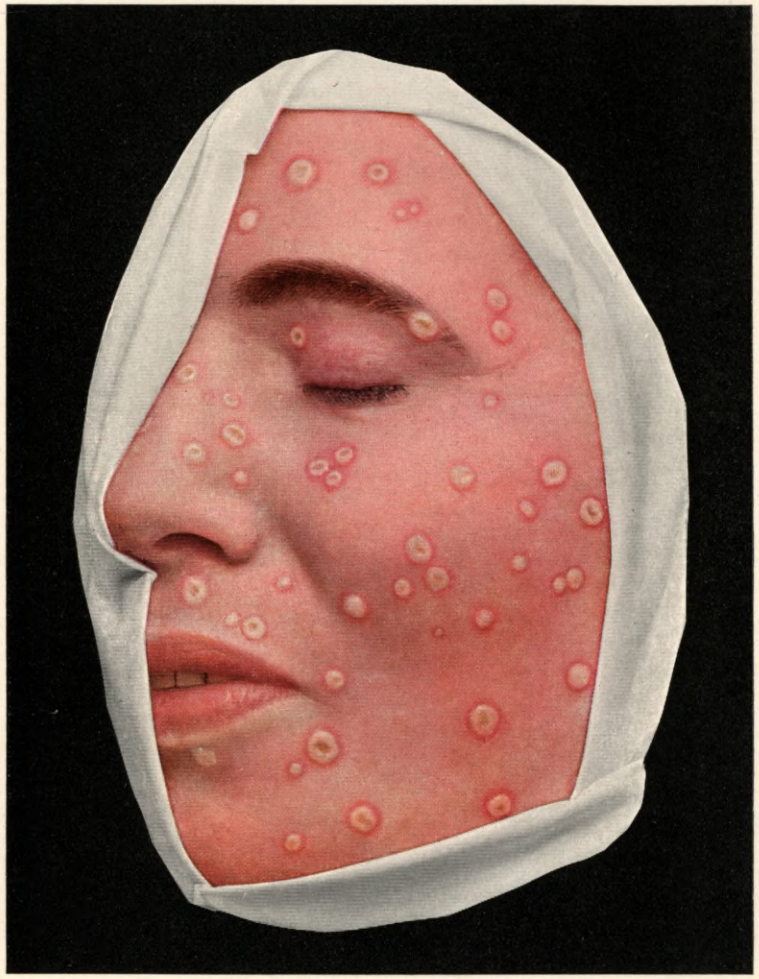
Prophylaxis against small-pox is of the very highest importance. Vaccination, properly carried out and sufficiently often repeated, is a nearly certain guarantee against contracting the disease and has almost entirely stamped it out in Germany, where it was formerly so prevalent.

Suitable **Treatment** consists chiefly of rest in bed with proper dietetic measures and afterward of baths. In the later stages the maintenance of integrity of the vesicles, the protection from scratching, the provision of free escape for secretion and the avoidance of secondary infections must be considered, and these are best carried out by means of antiseptic lotions (solutions of silicate of aluminium, boric acid, resorcin, ichthyol, etc.). Of late years an old method has been revived and placed on a scientific basis by Finsen, viz., exposure to red light with exclusion of the chemically active rays. It appears that if this method is rigidly carried out the suppuration of the lesions, and consequently secondary infections and scar-formation, can be avoided with considerable certainty. The attempted removal of resulting scars by "scaling" processes can only be successful in very exceptional cases.

Fig. 98. Model by M. Tramond, Paris (Jumelin).
Fig. 101. Model by Kolbow, Berlin.



No. 100. Varicellae (Chicken-pox).



No. 101. Variola discreta (Small-pox).

Varicella. Chicken-pox.

Plate LIII., Fig. 99; Plate LIV., Fig. 100; Plate LV., Fig. 102.

Varicella, or chicken-pox, is a well-defined infectious disease which occurs sporadically or epidemically, especially among children, and which must not be confounded with variola. A more or less extensive eruption develops with moderate febrile symptoms, in which vesicles with clear contents rapidly form from spots or papules, on a base either not at all or only slightly inflamed. The vesicles have often irregular margins and they dry up after a short time to form crusts. As several successive crops generally follow one another, all stages of the varicellar eruption are usually present at the same time (Fig. 102). In eight to fourteen days the eruption disappears without leaving scars. The disease, which involves mucous membranes and the lips (Fig. 100), as well as the outer integument, is sometimes—but rarely—followed by nephritis.

Exceptionally severe cases occur, more particularly in adults, with high fever and sometimes with confluent eruption (Fig. 99). As the results of secondary infection ulceration and scarring may occur.

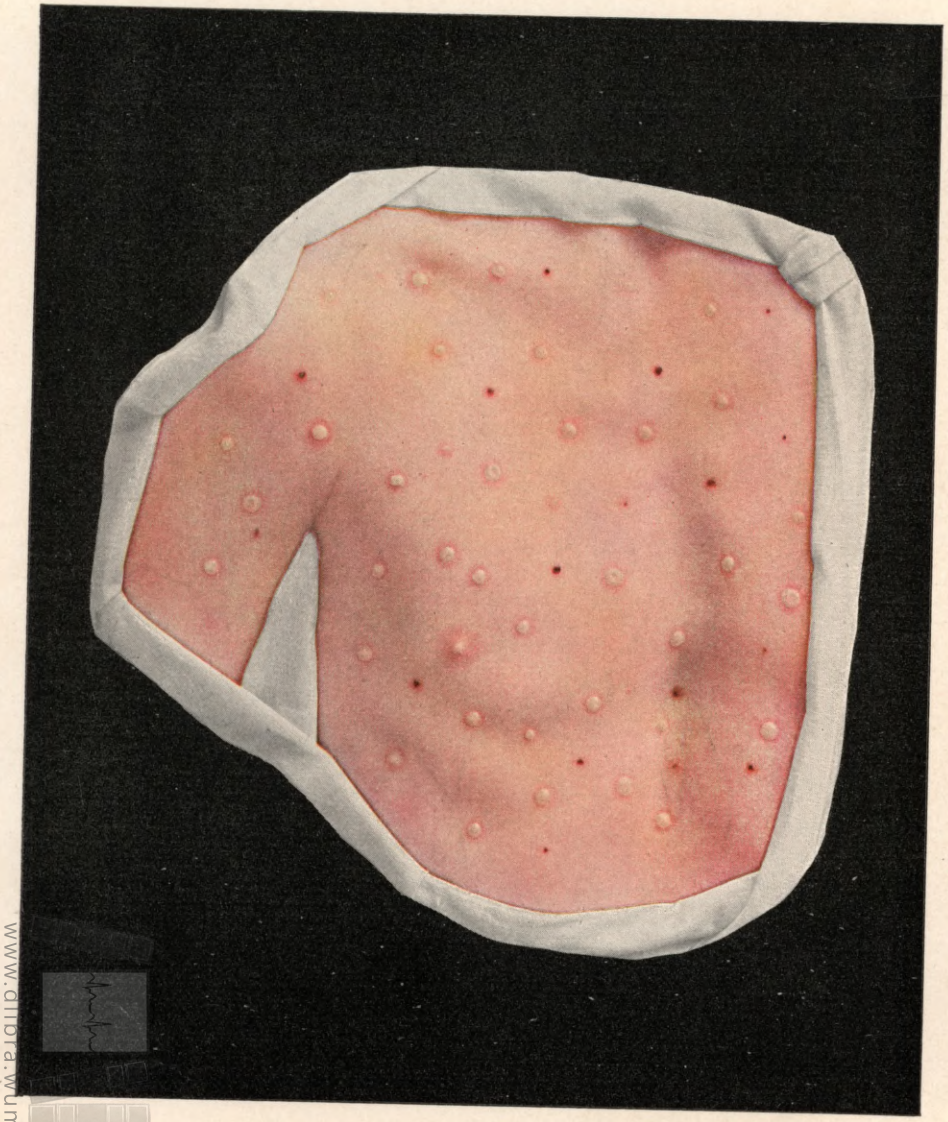
The **Diagnosis** is easy in typical cases; only in unusually severe ones can any confusion with variola or varioloid take place. As a rule, the generally favour-

able course of chicken-pox serves to distinguish it. In papular syphilis other manifestations of that disease can always be discovered.

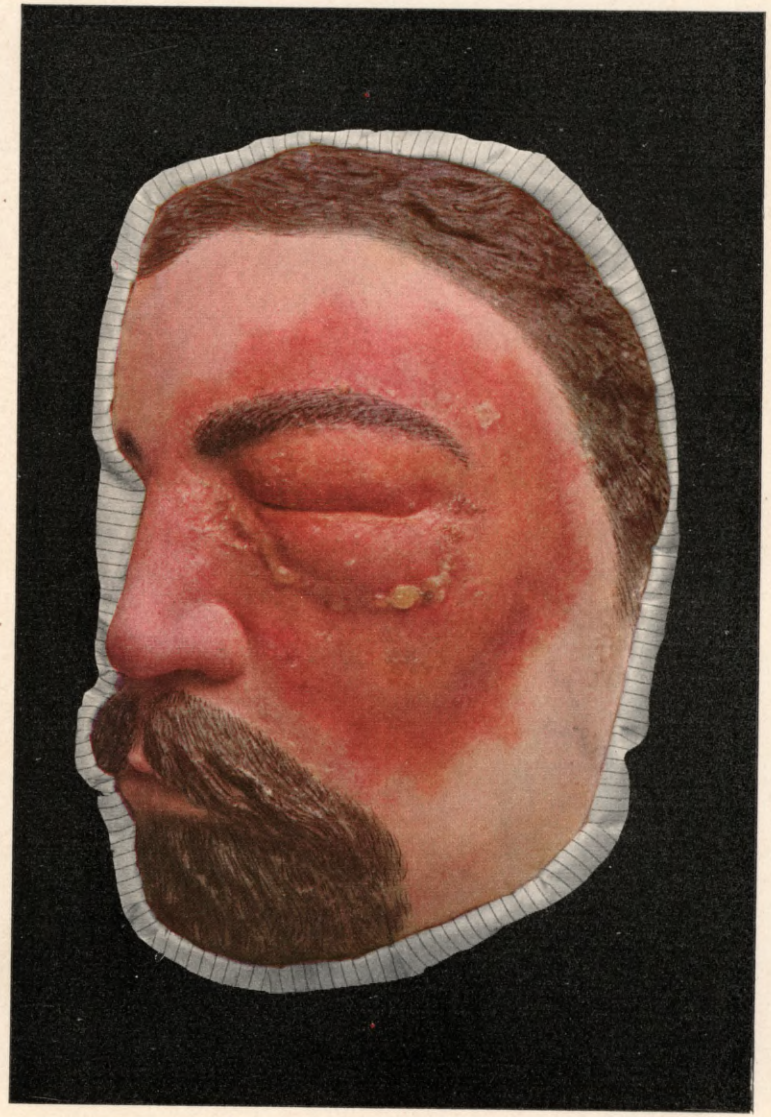
The **Prognosis** is favourable.

The **Treatment** consists of rest in bed and, if the rash is exceptionally severe, of protective dressings to prevent scratching and secondary infections. External application of alcohol quickly dries up the papules.

Fig. 99. Model in Neisser's Clinic in Breslau (Kröner). The patient, 43 years of age, was taken ill 5 days previously, with high temperature and severe general symptoms. The case was established as genuine by the fact of the attending physician being attacked by typical chickenpox.
Fig. 102. Model in Lesser's Clinic in Berlin (Kolbow).
Fig. 100. Model in Heubner's Clinic for Children in Berlin (Kolbow). The face is rather severely affected, scattered lesions being even present on the lips.



No. 102. Varicellae in infante (Chicken-pox).



No. 103. Erysipelas.

Erysipelas.

PLATE LV., FIG. 103.

The causes of this bacterial infection are streptococci. Erysipelas may occur wherever there is a solution of the continuity of the skin—after scratches and excoriations, after all injuries and operation wounds.

The disease usually commences by a rigor and high temperature (40°-42° C.). The affected skin is red, tense, somewhat glistening and slightly raised above the level of the rest of the skin (Fig. 103). The borders are well defined, distinctly raised and zig zag, so that the extension of erysipelas, especially on the face, has been compared to lambent flames. The infection may extend to the lymphatic vessels and thus give rise to lymphangoitis. There is itching and tension in the skin, and tenderness on pressure. There is considerable constitutional disturbance owing to high fever, headache and vomiting, which continue while the disease progresses. The temperature falls suddenly, the redness ceases to extend and the skin, after slight desquamation, resumes its normal condition in about a week from the onset of the disease. In migratory erysipelas the process may continue for weeks. In the majority of cases there is resolution, but sometimes erysipelas may cause cutaneous abscesses, and in the form of gangrenous, phlegmonous erysipelas may give rise to ulceration and extensive destruction of the skin,

especially on the eyelids and the scrotum with considerable swelling and œdema.

Relapsing erysipelas of the face and leg may cause elephantiasis. Erysipelas of the mucous membranes is generally difficult to recognize, except when it is an extension from erysipelas of the skin. The mucous membrane is swollen, œdematous, sodden and of a deep red colour. Constitutional disturbance is generally severe. Erysipelas of the buccal mucous membrane may occur after tooth extraction with dirty instruments. It may cause death by meningitis or œdema of the glottis. The average mortality of erysipelas is 10 per cent.

Diagnosis.—Erysipelas is so characteristic that it can hardly be mistaken for other affections. The advancing, irregular, raised edge distinguishes it from other inflammatory conditions.

Prognosis requires circumspection, especially in severe cases of erysipelas of the head. The patient should be isolated and the nurse should not come in contact with any other patient. In persons who suffer from recurrent attacks of erysipelas the ports of infection, eczema, rhagades, lupus, tuberculous fistula, ulcers of the leg, etc., must be carefully protected and proper formation of the skin over the wounds procured.

Treatment.—Serum therapy has so far proved useless. The patient should always be kept in bed. Diet same as in fevers. Cooling baths and compresses of liq. alumin. acet. (1%); resorcin or ichthyol (2%-5%); painting with pure ichthyol, collodion or iodine; ointment of Crédé, compresses of alcohol or salves of corrosive sublimate, the induction of passive

hyperæmia by surrounding the limb with adhesive plaster, injections in the surrounding parts of 3% solution of carbolic acid (this is very painful!) are recommended. If pain is very severe, scarifications are useful. The affected parts must be covered with antiseptic ointments to prevent infection and autoinfection.

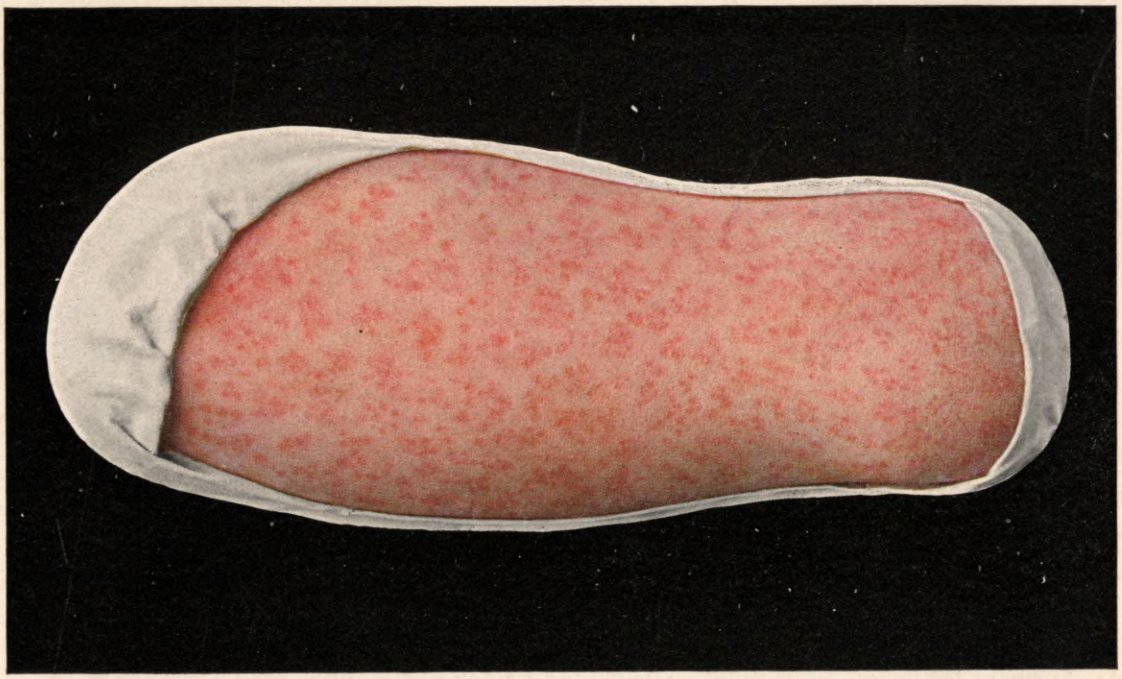
Fig. 103. Model in Riehl's Clinic, Vienna. (Dr. Henning).

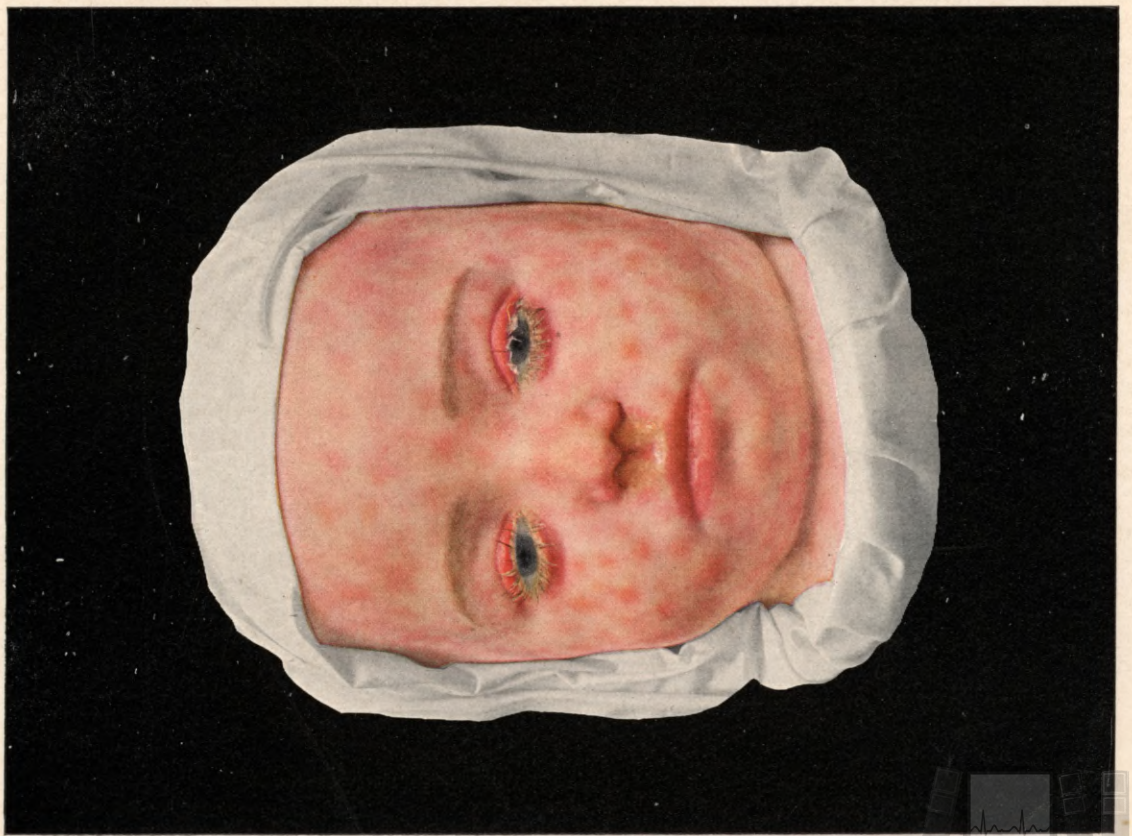
Morbilli. Measles.

Plate LVI., Figs. 104, 105.

Measles is an infectious disease commonest among children, which almost always occurs in epidemics; its virus is unknown; it is communicable from person to person directly or indirectly; and in most instances one attack affords lifelong immunity against another.

After an incubation period of about ten days febrile symptoms manifest themselves, with catarrhal phenomena implicating the mucous membranes—conjunctivitis, violent coryza, noisy cough—and swelling of lymphatic glands. Spotty redness appears on the palate and small white specks on the buccal mucous membrane. In four to six days after the onset of the malady the characteristic eruption appears—almost always first on the face—in the form of tiny red, follicular papules, surrounded by a slightly elevated, pale red zone of variable size (Fig. 104). When the rash attains its maximum, generally about two days after its appearance, numerous flat, wheal-like lesions are scattered over the whole body, which often coalesce, but always leave portions of skin unaffected; the follicular papules remain, however, recognisable (Fig. 105). The temperature, which usually reaches from 40 to 40.5° Centigrade (104-104.8° Fahrenheit), now falls rapidly, catarrhal symptoms diminish, the skin begins to pale and desquamate with branny scales, and after eight





No. 104, 105. Morbilli (Measles).

or ten days in a normal case convalescence sets in, which is seldom interrupted by fresh recrudescences.

Sometimes the eruption does not attain its full development; or it may occur in the form of vesicles or small papules, and it may ultimately become completely confluent. Hæmorrhagic and gangrenous eruptions sometimes, but very rarely, occur. The ordinary course of measles may be interrupted by complications which are frequent, especially affections of the eyes, ears, throat and lungs. Involvement of the kidneys and the supervention of noma are more exceptional. Whooping-cough and tuberculosis are of comparatively common occurrence as the result of severe, long-continued measles.

The **Diagnosis** of measles is not difficult in presence of an epidemic. As points in differential diagnosis it is to be noted that in scarlatina catarrhal symptoms are absent and the whole body surface is usually involved by the rash. In syphilitic roseola the presence of a primary sore and of indolent glandular swellings clear up the diagnosis.

Treatment consists chiefly in confinement to bed until desquamation ceases, in protecting the skin, in giving the dietary usual in febrile conditions and in guarding the patient from chills. The supervention of complications must be carefully watched for.

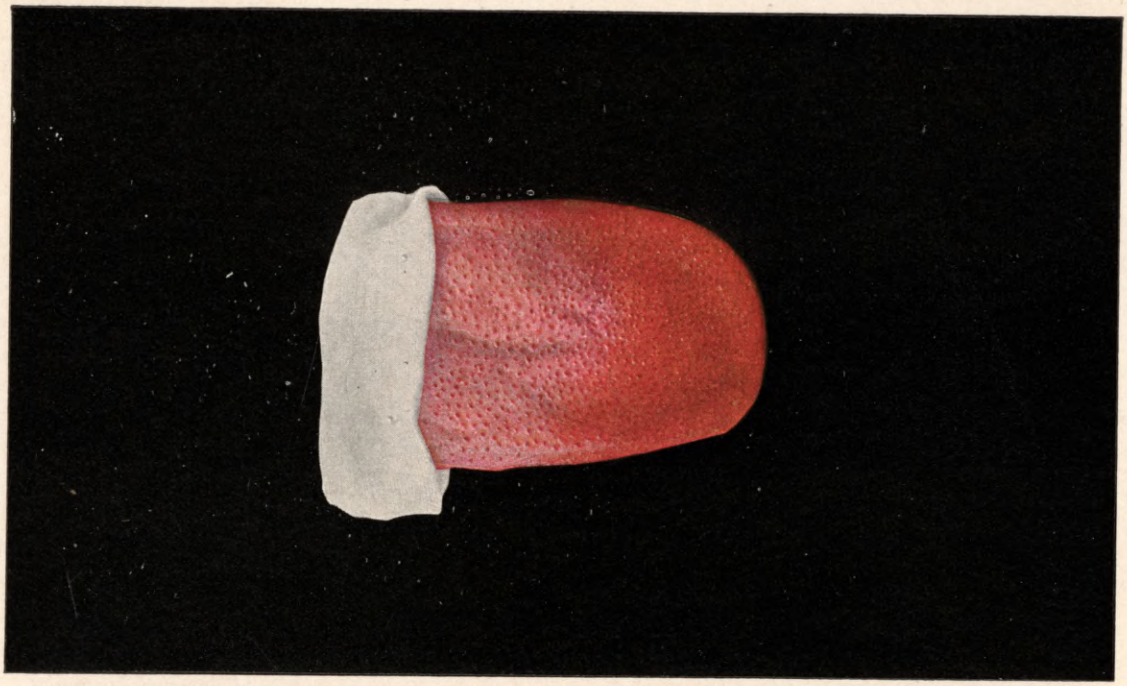
Fig. 104. Model in Schlossmann's Home for Infants, Dresden (Kolbow).
Fig. 105. Model in Neisser's Clinic in Breslau (Kröner).

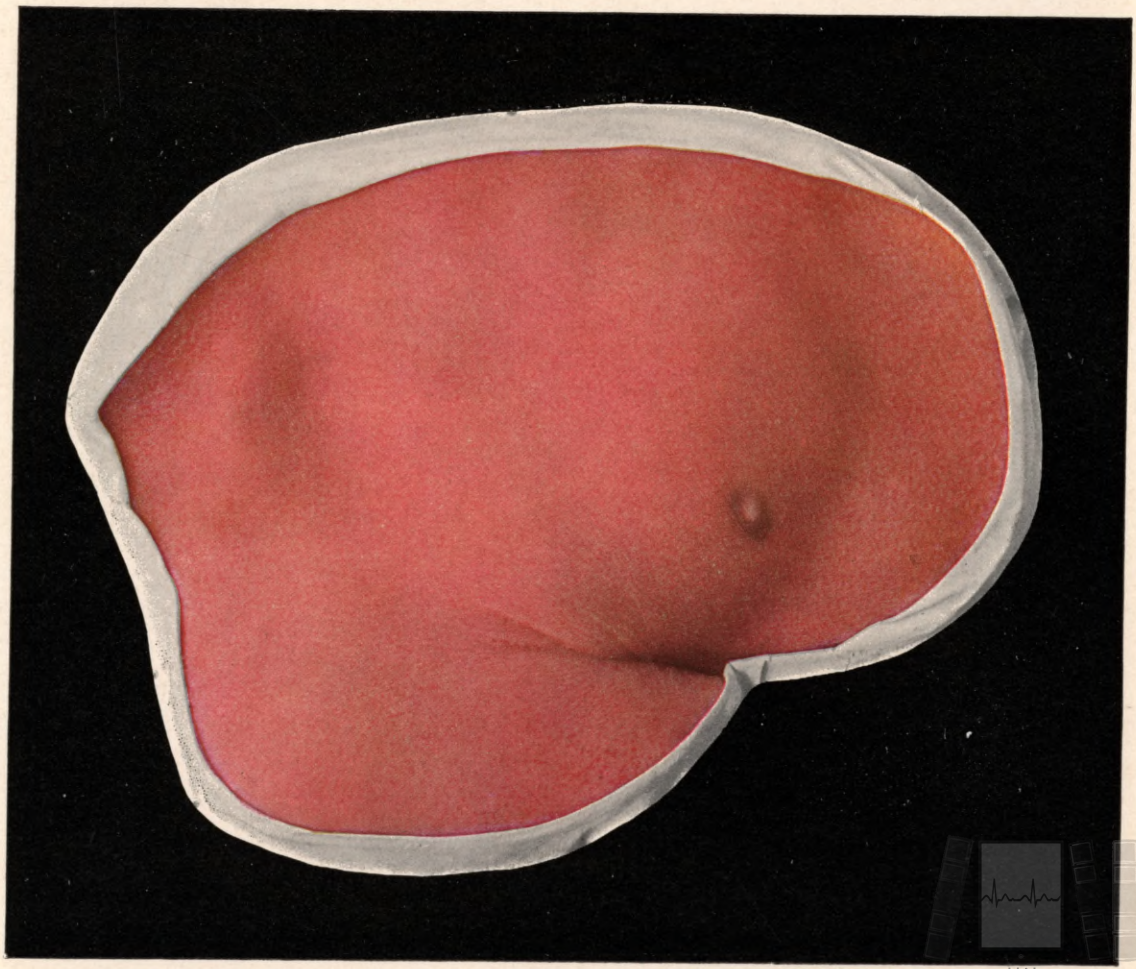
Scarlatina. Scarlet Fever.

PLATE LVII, FIGS. 106, 107.

Scarlatina is an excessively contagious disease, the contagium of which (?streptococci) is not yet definitely known; it maintains its virulence for a very long time and the disease is directly and indirectly communicable for an extremely prolonged period. Children from two to ten years of age are most frequently attacked, but adults may also suffer from it. Infection usually enters the organism by the mouth, but may do so by wounds of skin or mucous membrane (*e.g.*, in parturient women).

After a period of incubation lasting from two to eight days, the disease usually sets in suddenly with fever, sore-throat and nervous disturbances, soon after which the typical eruption appears. It consists of a countless number of closely aggregated, red points on a deep red, erythematous base (Fig. 106). The process is at its height on the third day after the onset of the disease. The entire surface of the body—with the exception of the chin and lips—is covered with a deep red exanthem, which looks still redder in the evening; general symptoms are very severe, the temperature being high and the pulse rapid. The tongue is coated from the first, and of a raspberry-red colour (Fig. 107); the sore throat may be of great intensity and may ultimately eventuate in parenchymatous or diphtheroid inflammation of the throat, and in more or less deep gan-





No. 106, 107. Scarlatina.

grene. In favourable cases the symptoms diminish after three or four days; the eruption becomes paler, gradual reduction of the temperature takes place, the discomforts produced by the sore throat subside, and convalescence sets in seven to nine days after the onset of the malady, with characteristic lamellar desquamation. Recovery is often, however, interrupted and retarded by scarlatinal nephritis.

Not infrequently the eruption shows variations from the type just sketched; thus, vesicles may form, or papular eruptions; more rarely measley, roseolous or hæmorrhagic rashes may appear. In very exceptional cases the eruption may be very scanty or entirely absent, while extremely severe general symptoms may be present, leading rapidly to a fatal termination.

Scarlatinal nephritis is the complication most frequently to be feared and generally shows itself in the course of the second week, often accompanied by fever, vomiting and œdema. It either soon passes off or causes death by uræmia, endocarditis, heart-failure, etc. The throat trouble may also prove fatal by producing extensive suppuration, necrosis and general sepsis. Other complications of frequent occurrence and gravity are affections of the ears and joints, and various paralyses.

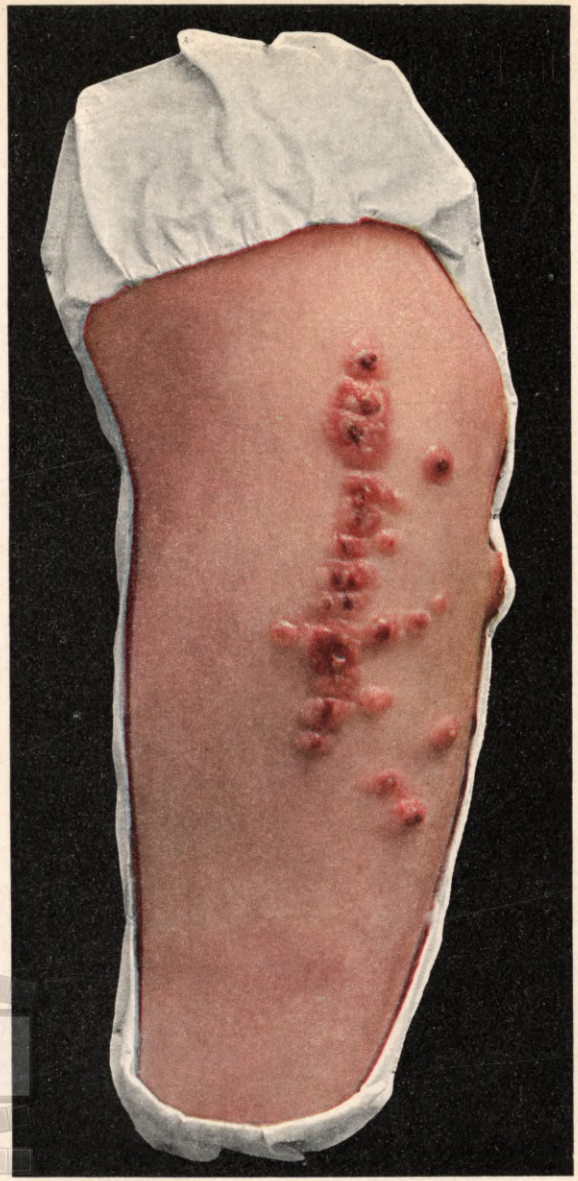
The **Diagnosis** of scarlatina is easily made from the typical rash, the sore throat, the desquamation in large sheets and the subsequent nephritis. Similar eruptions which develop in some subjects after the administration of certain drugs (belladonna, quinine, copaiba) never present the *ensemble* of symptoms of scarlatina.

Prognosis must always be very guarded in view of the frequent occurrence of complications.

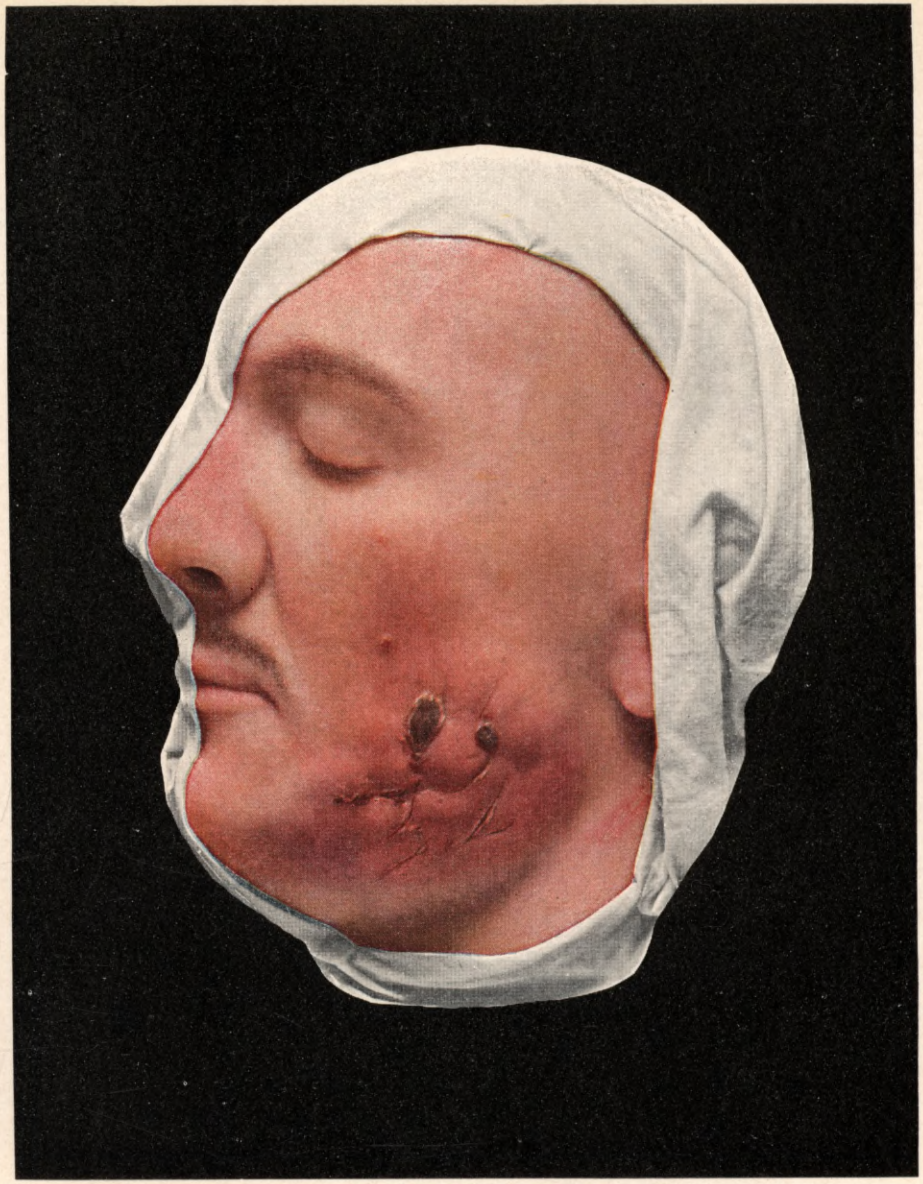
Treatment in cases which run a normal course consists chiefly of rest in bed and careful hygiene of the skin by frequent cleansings and subsequent inunctions, and of feeding as for other fevers. Of particular importance is the use of mouth washes and gargles of chloride of potassium, acetate of aluminium, ichthyol or peroxide of hydrogen, which may also be used as nasal douches. In diphtheroid sore throat submucous carbolic injections may be tried. Aural complications must always be watched for and the urine must be regularly examined; nephritis must be treated by dieting, or by baths, sudorifics, etc. Specific treatment by the injection of serums has hitherto yielded no definite results.

The possible communication of the disease to others must be obviated by the strictest and longest possible period of isolation of the patient and his attendants and by the most strenuous disinfection.

Fig. 106. Model in Neisser's Clinic in Breslau (Kröner).
Fig. 107. Model in Schlossmann's Home for Infants, Dresden (Kolbow).



No. 108. Anthrax (Malignant pustule).



No. 109. Actinomycosis.

Anthrax.

Pustula Maligna.

PLATE LVIIL, FIG. 108.

In anthrax the penetration of specific bacilli into a minute epithelial lesion causes fever and the development of a greatly infiltrated, red nodule on the summit of which a hæmorrhagic bleb forms. While the surrounding infiltration diminishes, the nodule becomes converted into a necrotic core or carbuncle. In rarer cases numerous smaller nodules form instead of a single nodule, and they may be arranged along scratch marks or any other epidermic lesion (Fig. 108). Simultaneously, or even independently of pustules, a peculiar, bluish or yellowish doughy œdema of the skin may show itself. The corresponding lymphatic glands become painful and swollen. The disease may cease by discharge of the core, or it may end fatally as the result of general infection of the intestine, lungs, etc.

The **Prognosis** is dubious in all cases; in visceral anthrax it is bad.

The **Diagnosis** is founded upon the peculiar hæmorrhagic nature of the "carbuncles"; on the history of contact with affected animals or their hides; finally, on the demonstration of the bacilli, their cult-

ures, and the results of their inoculation in guinea-pigs and mice.

The **Differential Diagnosis** can thus be established from common carbuncles.

Treatment has for its objects the closing of all points of entry for the specific micro-organisms and the limitation of the area of infection. Locally, destruction with Paquelin's thermo-cautery may be carried out, or injections of carbolic acid made into the affected tissues; very hot poultices and alcohol dressings may also be recommended.

Fig. 108. Model in Neisser's Clinic in Breslau (Kröner). The patient was a shepherd, whose case was published in full by Dr. Herrmann in the *Archiv f. Dermatologie,* vol. lxii., Nos. 2, 3. Eight days before the eruption appeared he had scratched his skin on a piece of bone while cutting up a dead cow. Most of the pustules corresponded to the scratch-mark. There was extreme swelling of the axillary glands. He died in three days.

Actinomycosis Cutis.

PLATE LVIIL, FIG. 109.

Primary actinomycosis of the integument, due to its direct invasion by the "ray-fungus," is extremely rare; as a rule the disease is secondary to disease of the jaw. Numerous abscesses and fistulæ develop in bluish-red, densely infiltrated skin, most commonly of the lower jaw, in the pus from which the characteristic yellow granules can be readily recognised microscopically. The disease occurs most frequently in millers, bakers, grooms, and in persons who are in the habit of chewing straw or grain.

The **Diagnosis** can only be definitely established by microscopical demonstration of the fungus, which also settles the differential diagnosis.

The **Prognosis** is favourable in localized cases only; in extensive cases it is dubious.

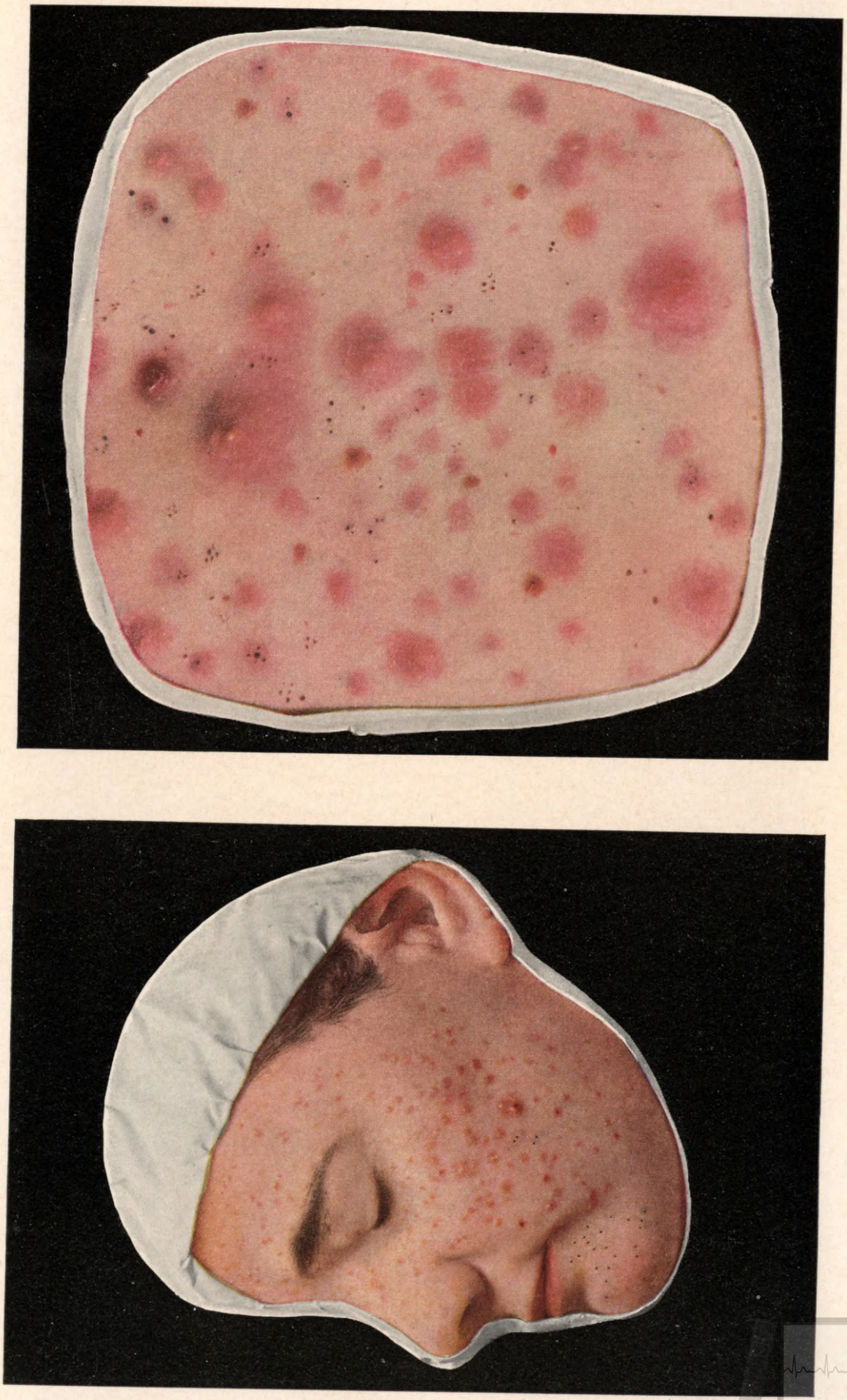
Treatment was formerly entirely surgical; it consisted of freely opening and scraping out abscesses and fistulæ. Lately, the internal administration of iodine preparations has yielded excellent results.

Fig. 109. Model in Neisser's Clinic in Breslau (Kröner).

Acne Vulgaris.

Plate LIX., Figs. 110, 111.

The commonest form of disease included under the name of Acne—or chronic inflammatory folliculitis—occurs in young persons, especially about puberty, in whom, owing to infection of the inspissated contents of the sebaceous ducts (*Comedones*), very obstinate suppurative changes occur, of widely varying depth and extent. Single acne-nodules, the contents of which consist of necrosed comedones and pus, often have a scab at their summit. After the evacuation of their contents they generally heal, leaving a scar or cicatricial pit, sometimes with pigmentation; but new eruptions always appear in the neighbourhood, so that the disease not only lasts for years, but may finally give rise to marked disfigurement. The seats of the affection are principally the forehead, nose and adjoining parts of the cheeks, the chin (Fig. 110), the chest, and the upper part of the back (Fig. 111). In the latter situation large, deep infiltrates not infrequently form from coalescence of the acne-nodules (*Acne indurata*), which leave irregular or keloid-like scars after their disappearance. Palpation of the skin of the face of patients suffering from acne often reveals the presence of a large number of nodules lying deeper than those visible on the surface; and the complexion is generally of a special, pasty, bloated appearance.



No. 110, 111. Acne vulgaris.

The **Etiology** of Acne is not yet fully cleared up; many morbid processes conspire to favour the existence of the disease. Thus, gastro-intestinal disturbances often coexist, but a peculiar seborrhœic condition is frequently present, which gives rise to the formation of comedones, and these, in their turn, are converted into acne-pustules by the usual pyogenetic organisms. The specific significance attributed to various bacteria found in the pus of acne-pustules is contestable.

The **Diagnosis** of Acne vulgaris is easily established by the presence of comedones and acne-pustules, and of all the intermediate stages between them. Somewhat similar syphilides may generally be differentiated without difficulty; and the futility of anti-syphilitic treatment, in dubious cases, eventually clenches the diagnosis.

The **Prognosis** of Acne may be regarded as favourable, but the malady is often of very protracted duration.

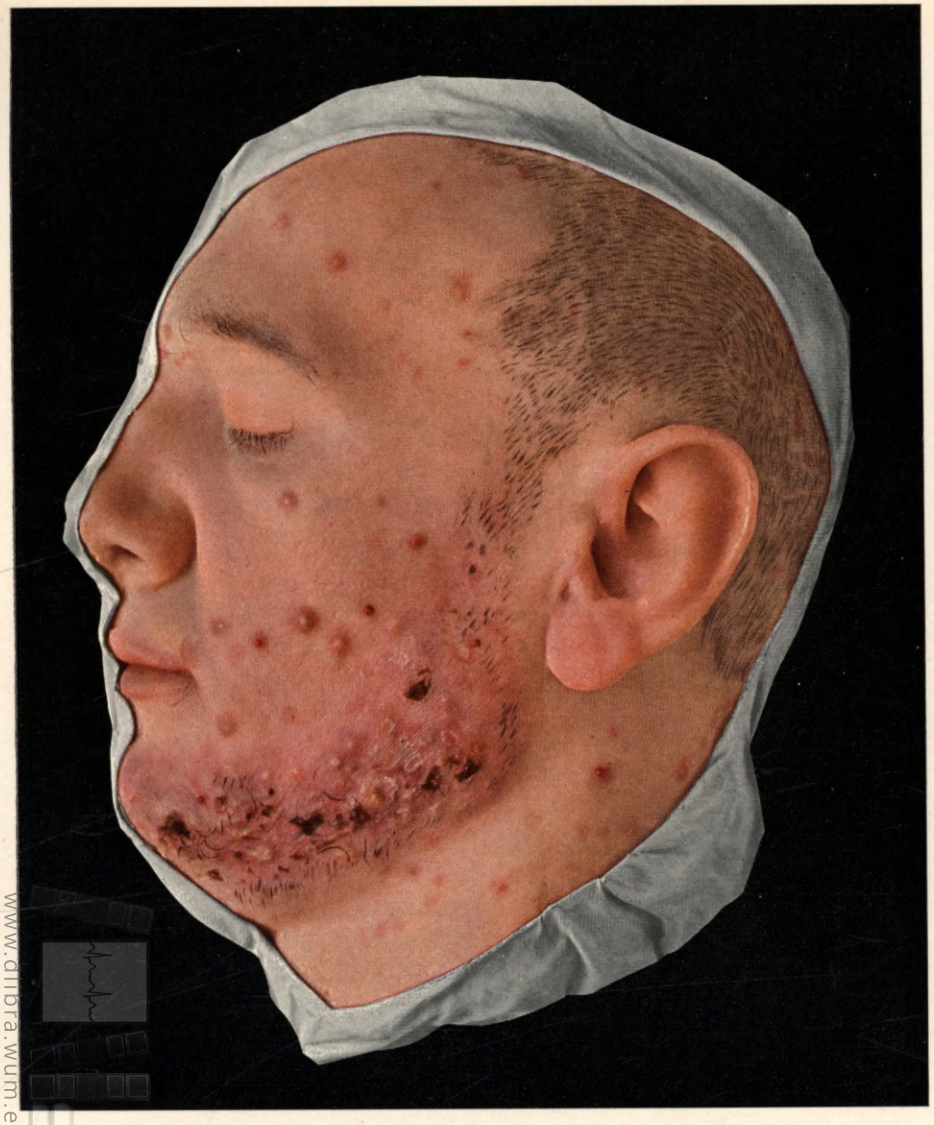
The **Treatment** must include the removal of all digestive disturbances which may be present, but we have never seen any useful results from strict dieting alone. Internal medicaments, such as ichthyol, purgatives and yeast, have yielded equally unreliable results. The local treatment must be carefully selected according to each individual case; for, whilst in some persons any powerful remedy provokes violent reaction, strong stimulating salves or pastes must be used in others.

First of all, comedones must be removed by expression, and the infiltrates and abscesses emptied by incision or poultices, or softened by mercurial plaster. The seborrhœa and associated comedo-formation ought to be combated, and this is best done by sulphur

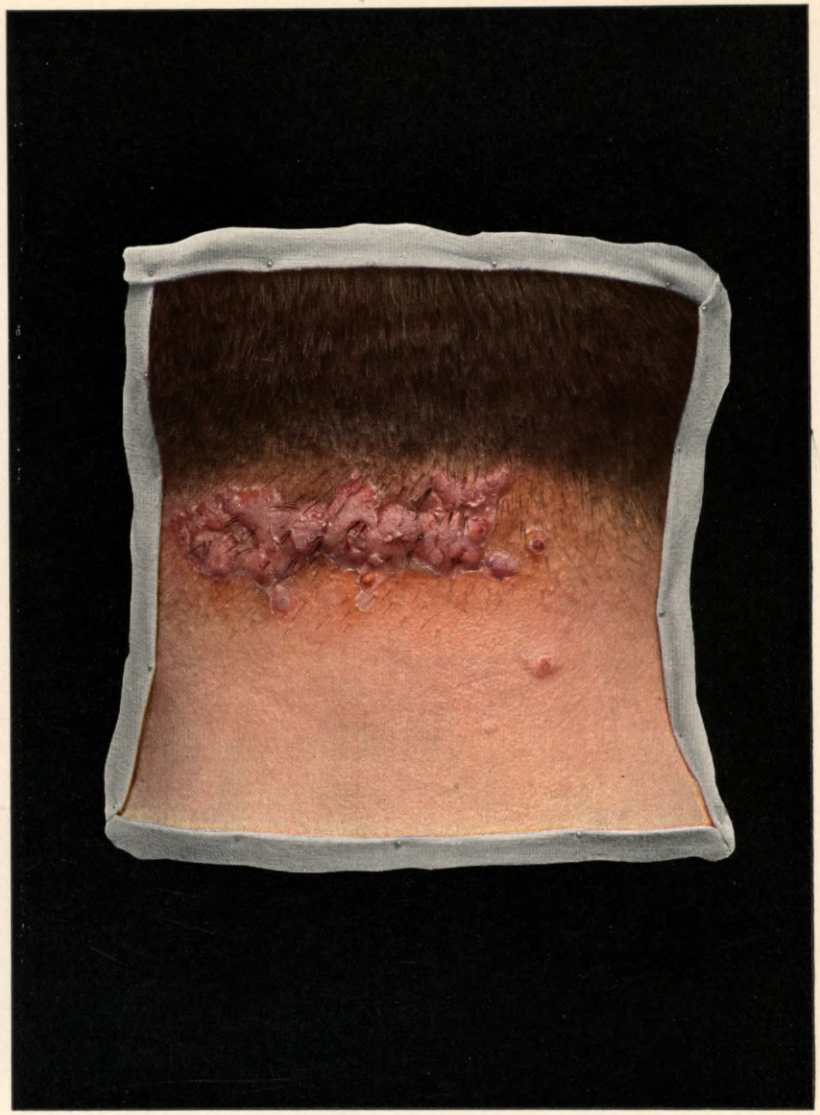
pastes or by washing; sulphur acts less satisfactorily in the form of ointments. The employment of sulphur and ichthyol soaps, or of spiritus saponis alkalinus and hot water, accomplishes the removal of excessive fat and opens the follicles, so that their contents can be evacuated. Subsequent vigorous scaling of the skin is of use, and may be carried out by means of resorcin-sulphur or naphthol (Lassar) paste, or by painting with tincture of iodine or iodine-glycerine. It is to be noted, however, that after the employment of any irritating application sufficient time must be allowed for complete disappearance of all signs of inflammatory reaction. In the intervals powders, cold creams, lanolin-cream, and similar substances may be used. In persons with very delicate skins the greatest care must be taken to begin with weak sulphur or resorcin-sulphur pastes, in order to reduce the irritability of the skin gradually.

After the cure of acne-nodules the formation of comedones must be prevented by washing with alcohol or warm water, using sulphur or "marble" soap. Sulphur-baths and touching the lesions with Vlemingkx' solution are especially worthy of recommendation in acne of the chest and back, but the latter remedy is to be avoided in the treatment of acne of the face.

Figs. 110, 111. Models in Neisser's Clinic in Breslau (Kröner).



No. 112. Folliculitis barbae (Sycosis).



No. 113. Dermatitis papillaris capillitii.

Folliculitis Barbæ. Sycosis.

Plate LX., Fig. 112.

Isolated or confluent pustules and nodules, penetrated by hairs and usually covered by scabs, sometimes result—especially in the male sex—from eczematous processes, or may develop without such preliminaries around the hair-follicles of the beard. The seat of predilection of sycosis is—as has been just stated—the beard (Fig. 112); but in rare cases the eyebrows, eyelashes, nasal, axillary and pubic hairs are involved; while in very exceptional cases the scalp is similarly affected. The malady is extremely chronic, and the individual follicular lesions heal only after the death of the hair and the formation of scars; while new foci of disease always arise, resulting in its protracted duration. The immediate causal factors of sycosis are acknowledged to be the common pyogenetic cocci, but the ground is usually prepared for them by some local irritation. After the disease has persisted for a long time the separate follicular lesions coalesce and form large infiltrated patches, at the margin of which only can the various stages of its development be recognized.

The **Diagnosis** is usually made without difficulty by the localization, the chronic course and the existence of nodules pierced by hairs. Ringworm of the beard is to be differentiated from sycosis by the pres-

ence at the margin of circular groups of lesions, by the greater amount of infiltration, and, finally, the demonstration of the fungus is decisive.

The **Prognosis** must be guarded on account of the extremely frequent relapses.

Treatment.—All circumstances which favour invasion by cocci must first be attacked—*e.g.,* eczema, nasal catarrh, etc. Then epilation must be practised to afford an outlet for pus, followed by poultices or moist dressings containing resorcin, 1 per cent., acetate of aluminium; corrosive sublimate (1:5,000); boric acid or ichthyol. Large abscesses must be opened and, ultimately, extensive persistent infiltrates assisted toward absorption by scarification, scaling pastes or salicylic and soap-plasters. Quite recently light-treatment has given good results; it must be administered with the greatest caution.

Fig. 112. Model in Freiburg Dermatological Clinic (Johnsen).

Dermatitis Papillaris Capillitii.

Acne-Cheloid.

Plate LX., Fig. 113.

This disease has also been called "Acne-Cheloid," although it has no relationship whatever with acne. The lesions are present on the neck at the margin of the hairy scalp, and consist of small, firm nodules covered with scab. Then these rise up close together and coalesce; very hard, pale red, raised plaques result, from which a few hairs emerge arranged in bundles, and these hairs are difficult to extract. Destruction of large areas is of rare occurrence. The disease is a distinct one; it gives rise to no pain, and is extremely tedious in its course; spontaneous recovery sometimes takes place after years. Its cause is unknown; the comparatively frequent occurrence of this rare disease in soldiers is striking, being possibly the result of the tight neck-band they wear.

The **Diagnosis** can be made without difficulty from the localization of the disease, the hardness of the nodules, and the presence of the characteristic bundles of hair.

The **Prognosis** as regards complete cure is very dubious.

The results hitherto obtained by **Treatment** are far from encouraging. The most efficacious remedy is a well-made mercurial plaster; but scarification, needling, epilation, electrolysis, and "light-treatment" may be tried.

Fig. 113. Model in the Freiburg Dermatological Clinic (Johnsen).

Ulcer from Roentgen Rays.

Plate LXI.; Fig. 114.

Röntgen Rays when applied in too heavy doses—it matters not whether this occurs in one or more successive applications (cumulative effects!)—produce on the epidermis certain changes of varying intensity. Frequently these remain latent for a considerable period, which also depends on the intensity of the overdose as well as on the susceptibility of the individual. Epilation (although growth of hair may return), dermatitis with subsequent pigmentation and at times atrophy, blisters with continued suppurating excoriations, ulcerations and even necrosis (Fig. 114), are among those untoward events. The resulting, very painful, excoriations are covered by a tenacious, varnishlike, yellowish-red, diphtheroidal crust which on removal lays bare deep-reaching gangrenous destruction of tissue penetrating even into the muscular and osseous substance. Concomitant fever and intense pain affect the general condition of the patient very markedly. The tendency to heal is very slow in the earlier stages of the affection, often it takes months, even years before cicatrization is completed; and even then the old sores may very suddenly break out again without apparent provoking cause. When blisters have been formed, and especially after ulceration, prominent atrophic scars with dark pigmentation—

sometimes also without the latter—and scattered teleangiectases remain behind.

Röntgenologists and those much engaged with Röntgen-ray work are open to these attacks, which come gradually and chiefly on the hands. They manifest themselves by atrophic, scarlike changes; the nails fall off and even epitheliomatous growths are formed on the fingers and hands.

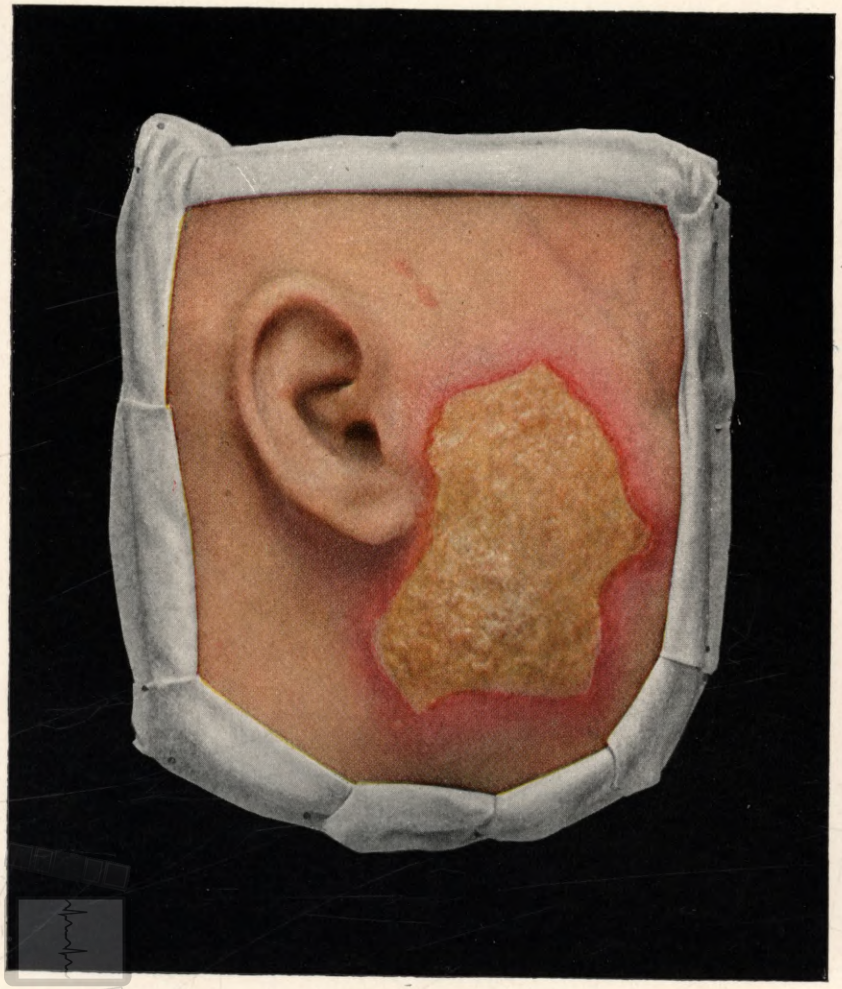
Anatomically this condition is mainly due to vacuolating degeneration of the tissue specifically of the vascular walls, which fact would in a certain measure account for the retarded tendency to heal.

Diagnosis is readily made from the characteristic picture and from the chronic course of the affection.

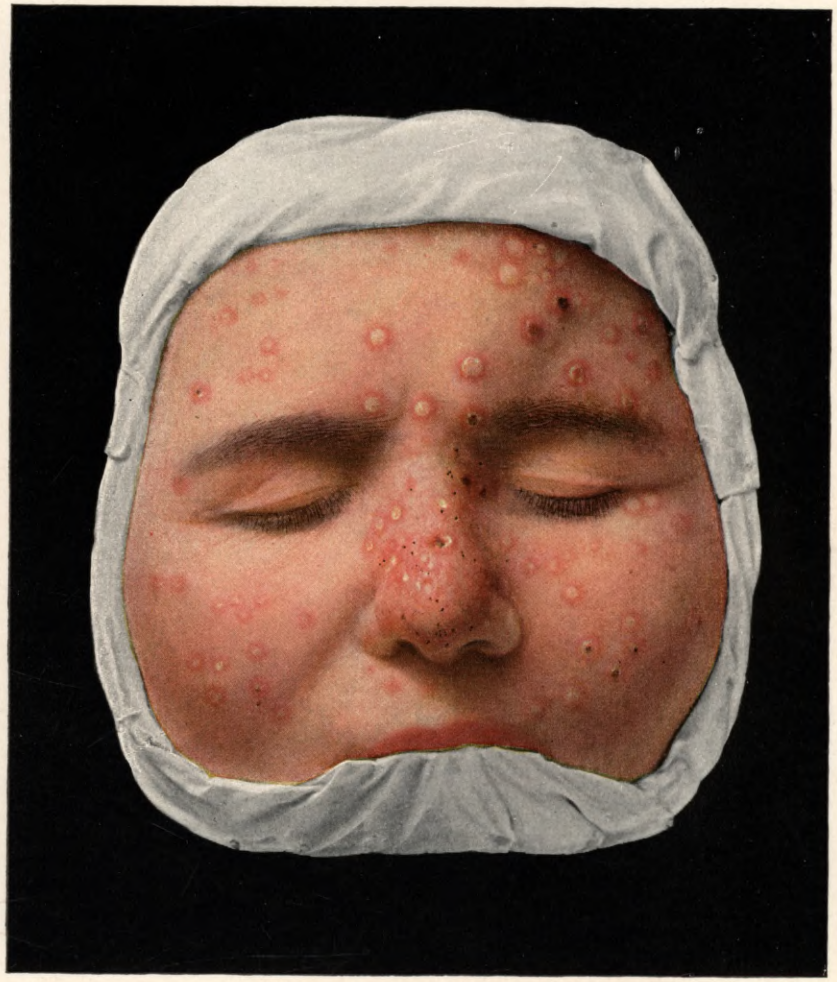
Prognosis is favourable if diagnosis has been timely established and the provoking cause is avoided.

Treatment. Application of ultra-violet rays. Bandaging with antiseptic salves, alternately moist or dry, is also recommended. To alleviate pain anæsthesin and orthoform may be employed.

Fig. 114. Model in Freiburg Dermatological Clinic (Vogelbacher).



No. 114. Ulcus e radiis Roentgen.



No. 115. Acne necrotica (varioliformis).

Acne Necrotica.

Acne Varioliformis.

Plate LXI., Fig. 115.

Small, reddish papules which soon show in the centre roundish, necrotic points of a yellowish, brownish, or blackish colour sometimes appear on the forehead at the margin of the scalp, more rarely on the chest and back. The epidermis in the process of healing spreads inward from the margin under the central necrotic scab; and after the scab separates a sharply defined, round cicatrix is left, strongly reminiscent of a small-pox scar, the margin of which gradually fades in colour (Fig. 115). The lesions are localized in the follicles, and sometimes cause considerable pain. The disease is comparatively rare; it occurs chiefly in men and in successive crops, so that it may last for years.

The **Etiology** is unknown, but an infection of some sort is supposed to exist.

The **Diagnosis** is not difficult after the formation of the typical scars. A form of syphilide is especially to be distinguished from acne varioliformis, but it usually produces deeper destructive changes.

Treatment.—Internal use of arsenic (Pill. asiat.), as well as external applications of sulphur-, resorcin- and pyrogallic-salves, heal up only sporadic eruptions, but do not prevent relapses.

Fig. 115. Model in Neisser's Clinic, Breslau (Kröner).

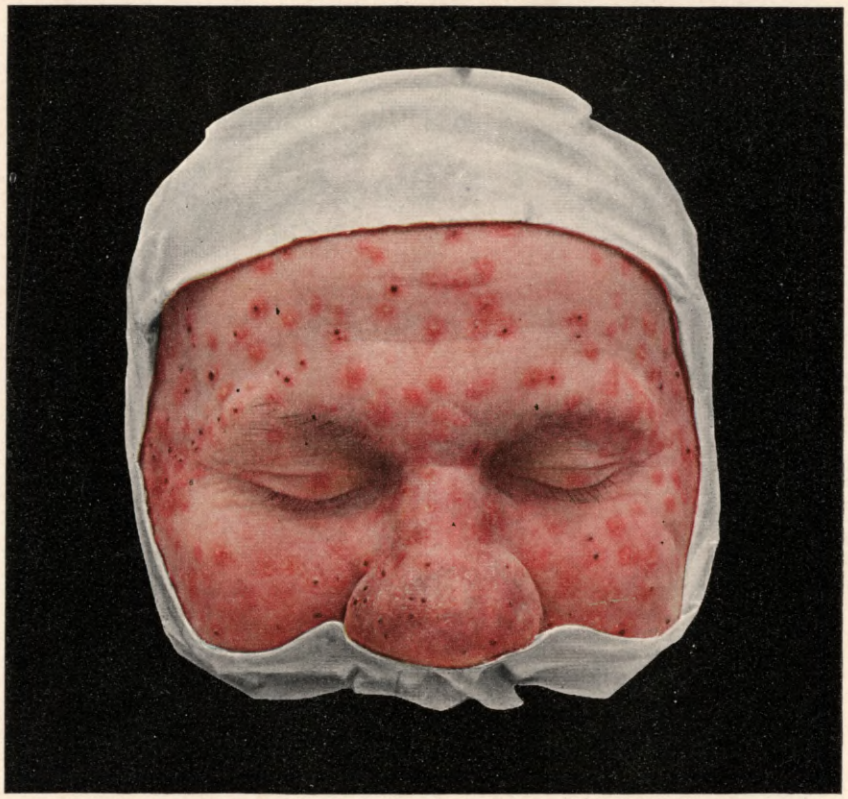
Acne Rosacea.

Rhinophyma.

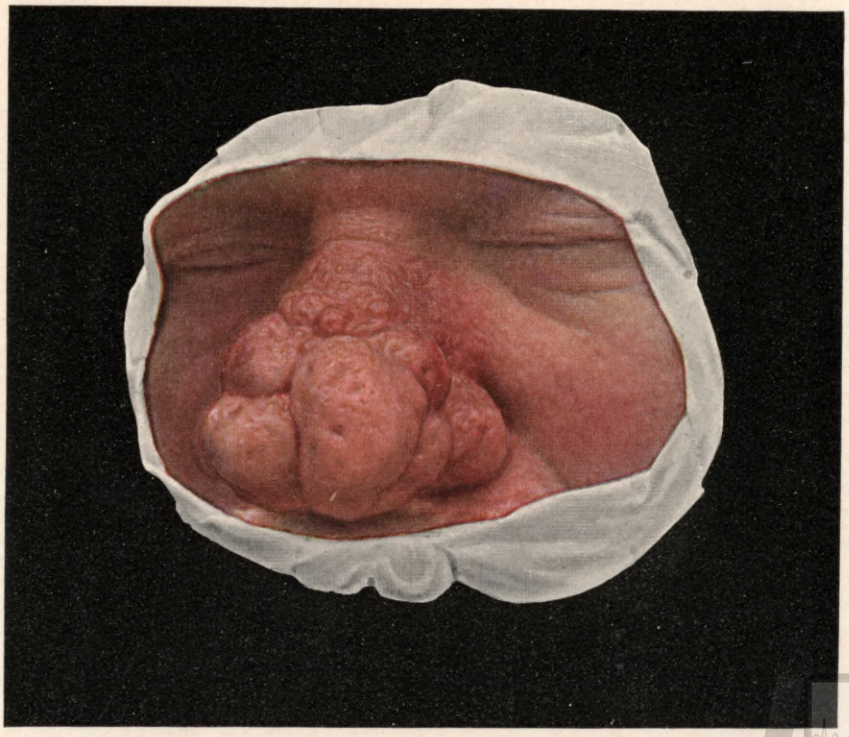
Plate LXII., Figs. 116, 117.

The disfiguring disease called Acne rosacea, or simply Rosacea, occurs in persons of middle or more advanced age on the face, chiefly on the nose. Like Acne vulgaris, with which it is often associated, it frequently is superimposed upon a seborrhœic basis. In its lower grades it consists merely of some reddening of the skin dependent on dilatation of the surface blood-vessels. In severer cases acneiform nodules form (Fig. 116), which do not usually, or even frequently, suppurate. In the highest grades of the disease, besides redness or bluish-red discoloration of the skin, a manifest dilatation, with tortuosity of the cutaneous blood-vessels, takes place, while marked hypertrophy of the sebaceous glands causes the formation of lumps, and results in the nose assuming a swollen, dissipated appearance (Fig. 117). This very chronic affection attains its severest forms in men only.

As regards **Etiology,** Rosacea is very often considered as mainly due to alcoholic excess, but disorders of the gastro-intestinal tract, of the uterus in women, or, finally, changes in the nasal mucous membrane, may be the starting-point of the condition. A specially favourable causative agent is prolonged exposure to



No. 116. Acne rosacea.



No. 117. Rhinophyma.

cold air, wind and vicissitudes of weather. Engine-drivers, cabmen, etc., are thus frequent victims.

The **Diagnosis** may generally be made without difficulty. Tubercular syphilides are of different tint and have a tendency to break down; while other symptoms of syphilis are almost always present. Typical nodules are to be seen in lupus vulgaris. In lupus erythematosus the morbid process spreads at the margin, with firmly adherent scales, while healing takes place in the centre.

The **Prognosis** is fairly favourable in the early phases of the malady; in severe cases it is usually dubious.

Treatment consists of first curing internal disorders and of eradicating ascertainable morbific agents.

The local treatment is very similar to that of mild and moderate forms of acne vulgaris—*e.g.,* rubbing in sulphur-resorcin pastes, or sulphur and ichthyol soaps, while in severe forms scaling pastes are very useful. Hyperæmia may be effectively combated by the use of a 40 per cent. resorcin paste till the skin is desquamated; and, subsequently, dilated bloodvessels may be slit up or destroyed by micro-thermocautery. Scarification and needling are often of use. In Rhinophyma the outgrowths may be removed with the knife till the normal form of the nose is restored, and the wounds generally heal easily by extension of epithelium from that of the sebaceous glands.

Figs. 116, 117. Models in Neisser's Clinic in Breslau (Kröner).

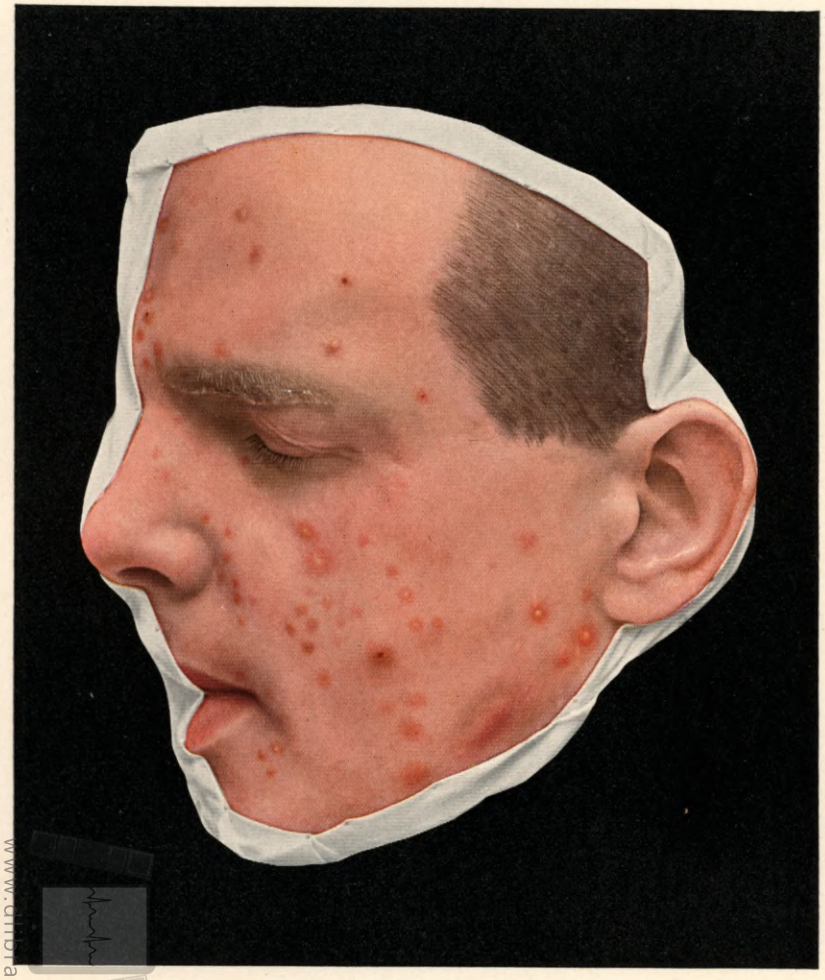
Toxicodermiæ.

Medicinal Rashes.

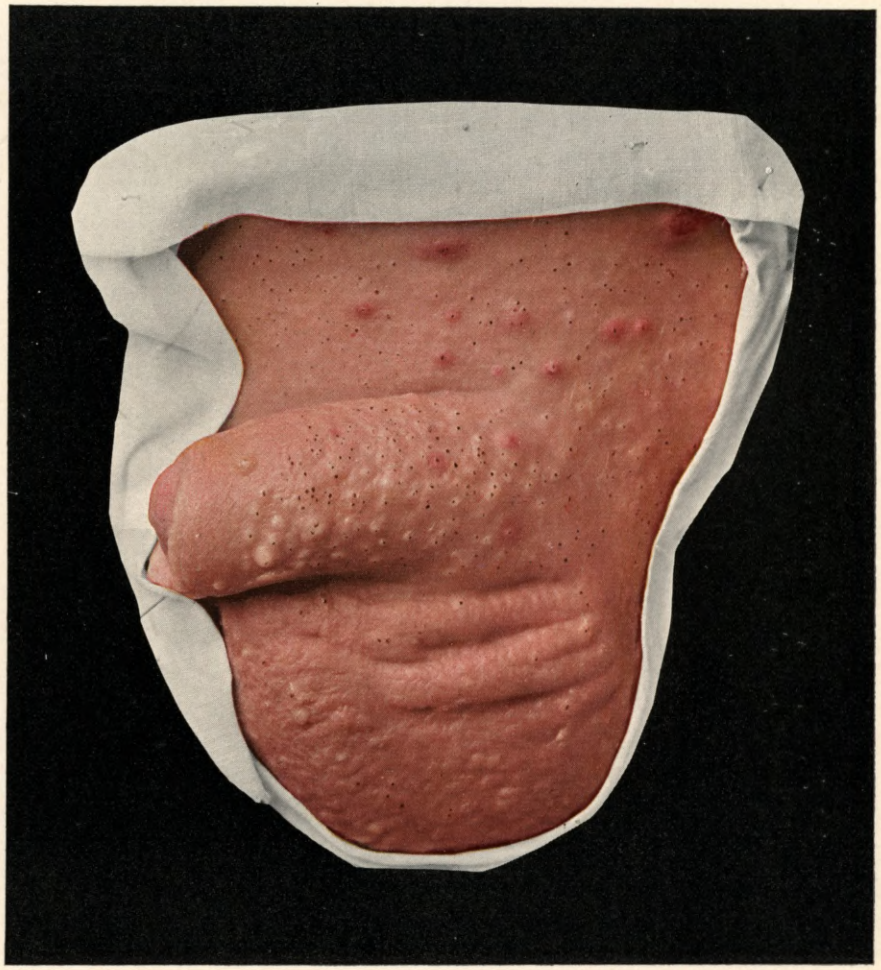
Plates LXIII.-LXVII., Figs. 118-125.

Eruptions appear in some specially predisposed persons after the absorption of certain medicinal substances, whether they get into the circulation by the mouth, the anus, by inhalation, or through the skin. These eruptions vary greatly in intensity and character, and may manifest themselves after the smallest doses, or, on the other hand, only after large quantities of the substances in question have been absorbed and eliminated by the follicles. Polymorphism is considered to be specially characteristic of such rashes; thus, they may be mere localized erythemata, macules, or papules, or may become generalized, hæmorrhagic, vesicular, and bullous forms of dermatitis. In some persons every dose of the drug evokes an eruption which in all subsequent attacks is usually localized in the same situation (mouth, genitals, extremities, more rarely the trunk); in others the drug may be tolerated at times. After stoppage of the causative drug recovery soon takes place, but pigmentation often remains behind.

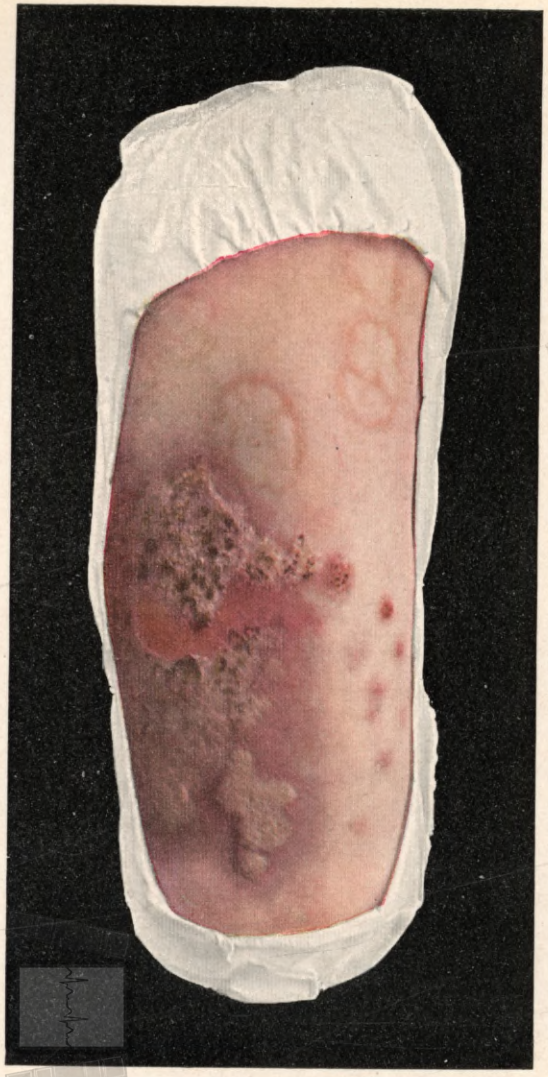
Antipyrin must first be mentioned among those remedies which rapidly cause an exanthem (Fig. 122) in the form of coalescing, large, urticarial-like wheals



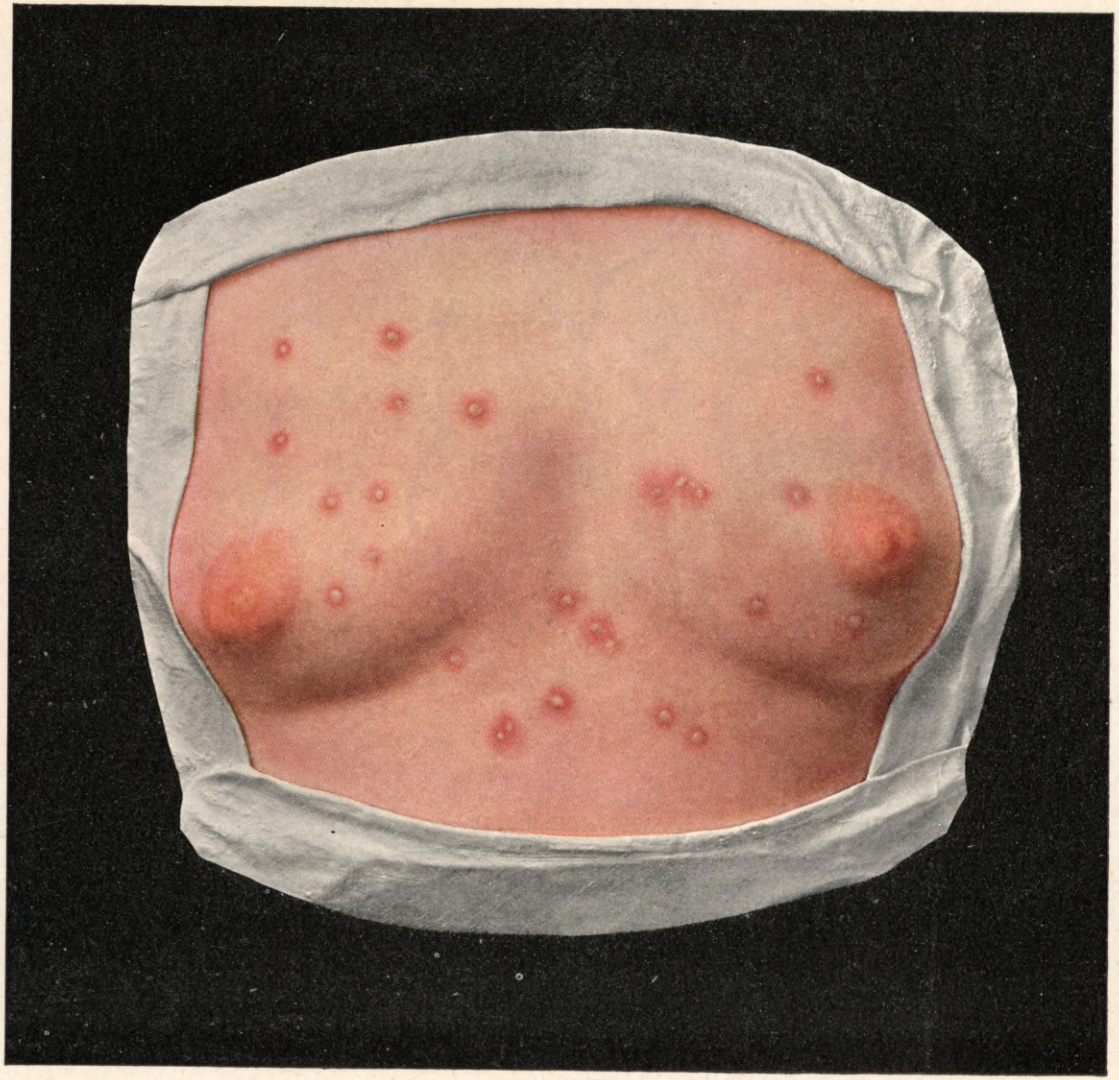
No. 118. Acne ex usu Jodi (Iodide Rash).



No. 119. Acne e fabricatione Chlori (Chlorine Rash).



No. 120. Toxicodermia ex usu Bromi (Bromide Rash).



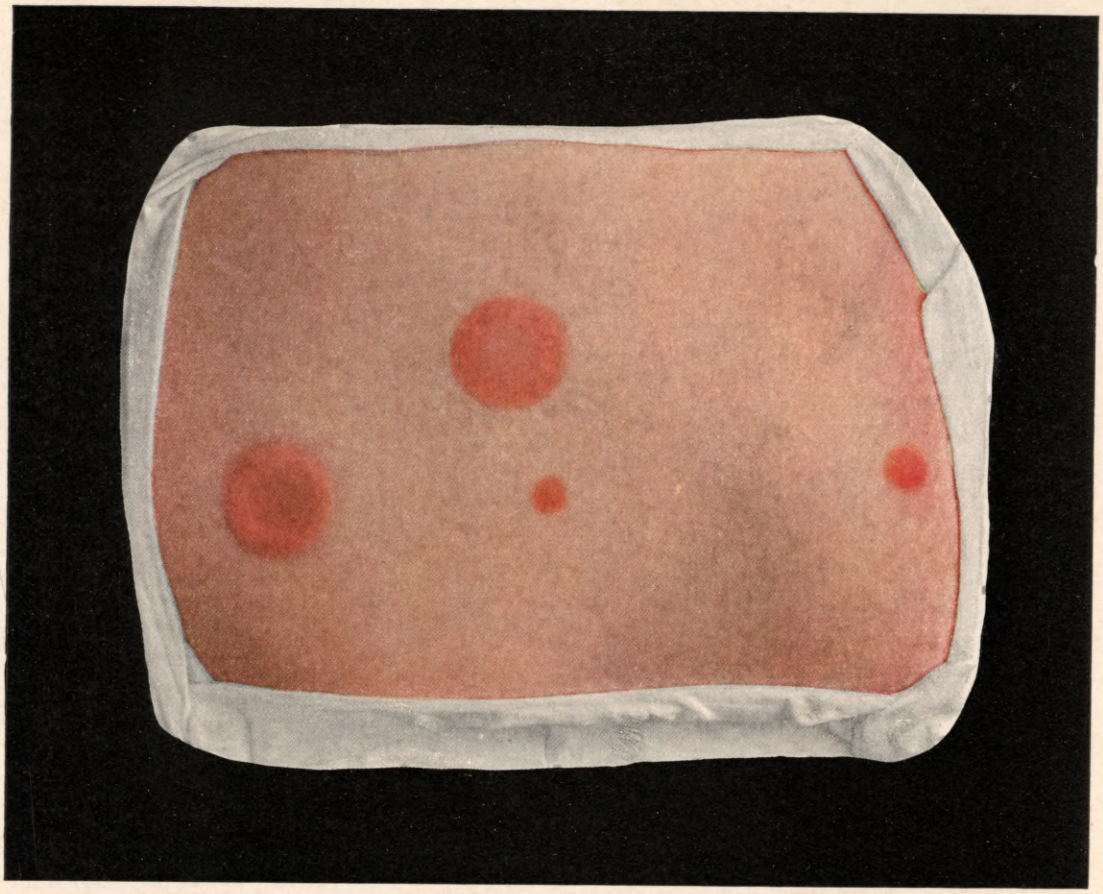
No. 121. Toxicodermia ex usu Jodi (Iodide Rash).

on the skin, and blebs on the mucous membranes. *Quinine,* besides a diffuse erythema with subsequent desquamation, also frequently provokes a hæmorrhagic eruption. *Opium* and its alkaloids, *Iodine* (Fig. 121), Mercury (Fig. 125), Atropine, Salicylic acid, Turpentine and various *Balsams* (Fig. 124) all may cause similar symptoms. Eruptions from *Mercury* are most frequently observed after the external application of that drug, especially after inunctions employed either for the cure of syphilis or for the destruction of pediculi pubis. They generally appear as fiat, livid or bright red papules, closely aggregated and generally universal in distribution. In predisposed persons, however, such eruptions may result—although not frequently—from the internal or subcutaneous use of mercury. Hydrate of Chloral, more rarely Phenacetin, and Antifebrin may also give rise to eruptions, while Tuberculin and the anti-toxin of Diphtheria must also be mentioned. *Iodine* and *Bromine* give rise to toxicodermiæ chiefly after prolonged administration, the former in the shape of pretty, acutely eruptive, acneiform pustules which closely resemble acne vulgaris (Fig. 118), while the latter provokes peculiar papular and papulo-pustular outgrowths on the skin (Fig. 120).

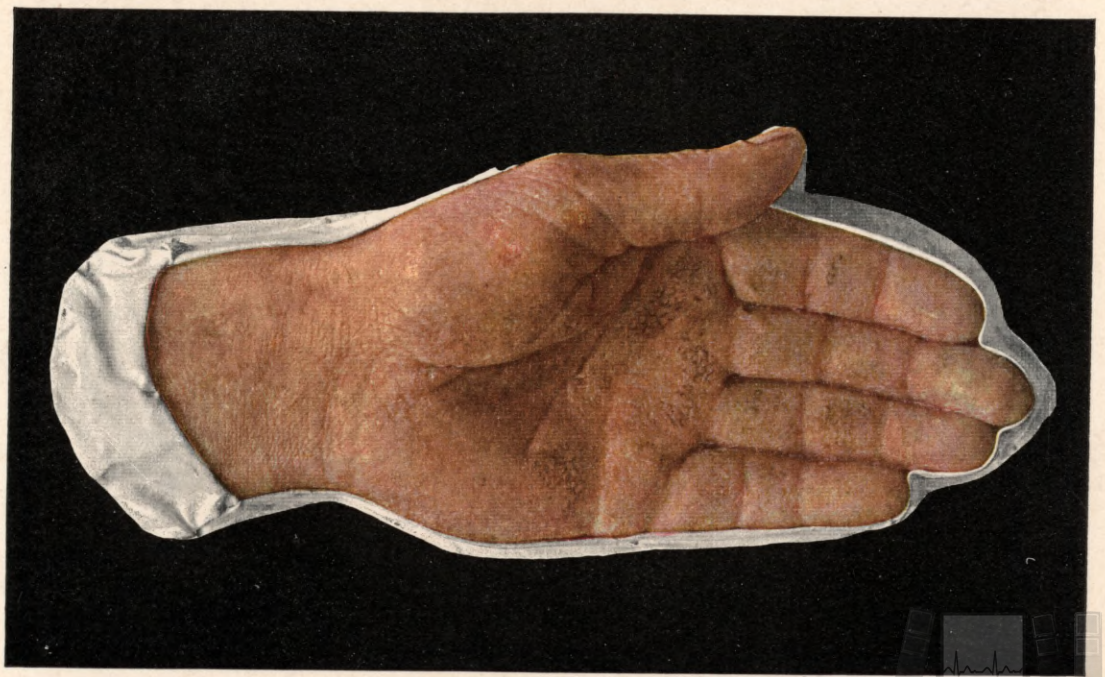
The appearance of zoster is a special effect of the administration of *Arsenic;* arsenical keratosis (Fig. 123) also occurs, in which the palms are covered with thick, dirty-grayish, horny masses, among them being very numerous cornified spines, originating round the orifices of the sweat-ducts. It is worthy of note that carcinoma may, although rarely, develop from arsenical keratosis. Finally, dark pigmentation, situated chiefly on the trunk, must be mentioned as another result of the use of arsenic.

Persons employed in the production of chlorine and

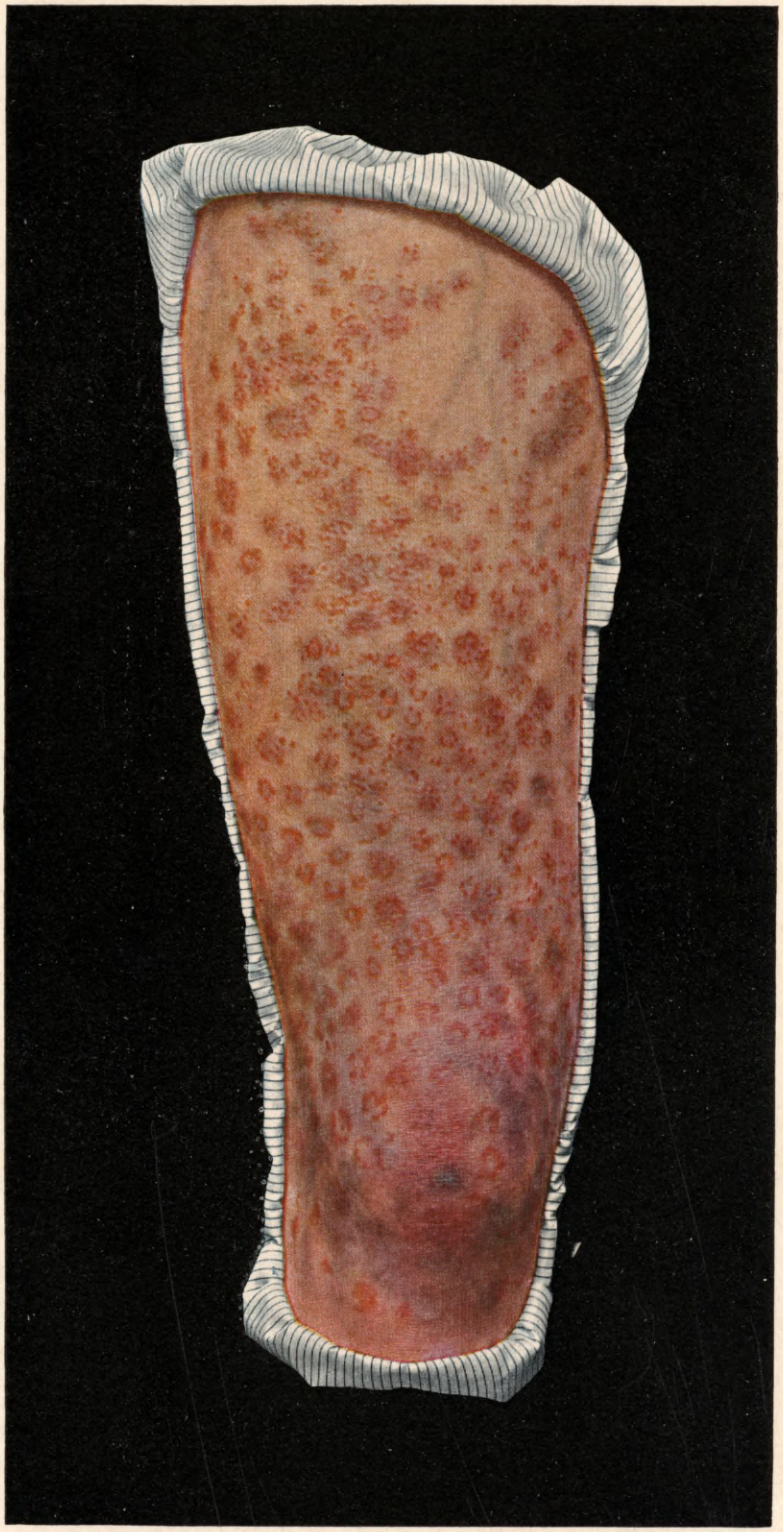
caustic soda by electrolysis of common salt are liable, after long periods of employment in certain departments of the works, to a progressive disease of the skin of the face, genitals and trunk accompanied by severe damage to the general health. The other parts of the body are affected to only a very slight degree. At first numerous closely agglomerated, tiny comedones form, especially around the eyes, in the temporal regions and behind the ears, as the result of which the face assumes a peculiar ashy-gray discoloration, a similar condition being also present in the genital regions. The comedones increase in number and size, finally completely blocking the follicles, so that they develop into small milia or cysts, on the apices of which the heads of the comedones show themselves as black points (Fig. 119). The chest and back exhibit a similar state of affairs, but only small comedones in varying number develop on the arms. In a certain proportion of cases—especially after prolonged exposure to the exciting cause—the comedones and cysts, particularly on the chest and back, are converted into painful nodules as the result of secondary infection, and these may coalesce to form extensive infiltrates. Even if the patient abandon his work, the disease may be greatly prolonged by successive exacerbations, but it finally recovers. Some of the patients die of tuberculosis. It is noteworthy that both women and children, even those who have never followed the occupation in question, may suffer from the disease, although generally to a very slight extent. Exactly the same disease has been observed in some workers in hydrochloric acid manufactories, and it is highly probable that the active agents in the causation of the disease are some tar-chlorine derivatives which, ingested by the mouth, provoke the ernption while excreted from the follicles.



No. 122. Toxicodermia ex usu Antipyrini (Antipyrin Rash).



No. 123. Toxicodermia ex usu Arsenii (Arsenical Keratosis).



No. 124. Toxicodermia ex usu balsami Copaivae (Copaiba Rash).

The **Diagnosis** of medicinal rashes is often very hard to establish, unless the history given by the patient is clear. One's thoughts must always turn to a toxic rash when a polymorphous eruption appears, which does not accord with any recognized type of skin-disease.

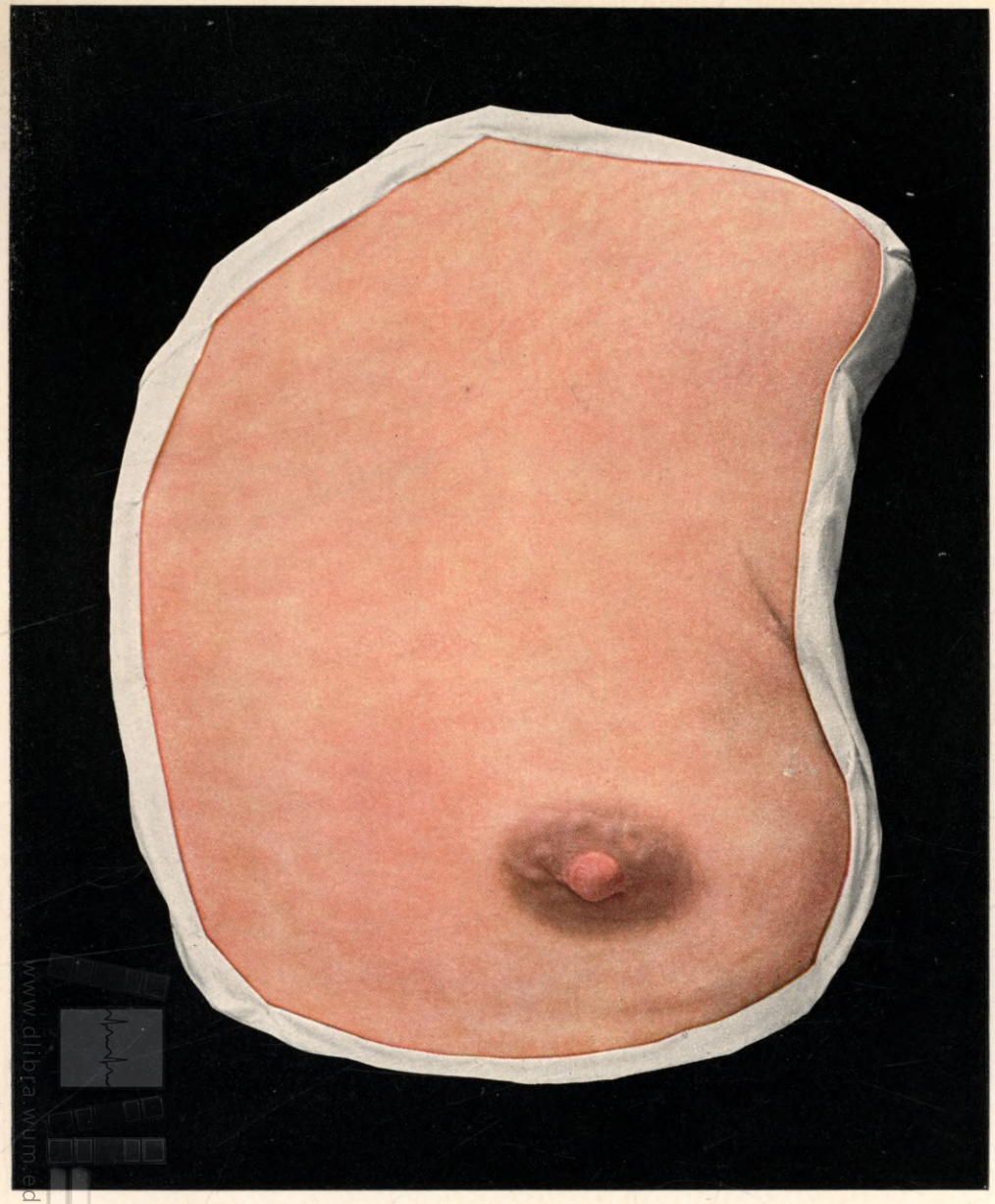
Antipyrin is one of the substances (like Migranin, Salipyrin, Pyramidon) which is frequently employed by the laity without a physician's prescription. Sometimes it is necessary, to confirm the diagnosis, to administer to the patient the drug one has reason to suspect. Chlorine acne is easily determined by the localization of the lesions and a consideration of the occupation of the patients.

The **Prognosis** is usually favourable; only after generalized erythema with colossal desquamation—*e.g.,* from quinine, do repeated attacks of exhaustion occasionally occur, which may have a fatal termination.

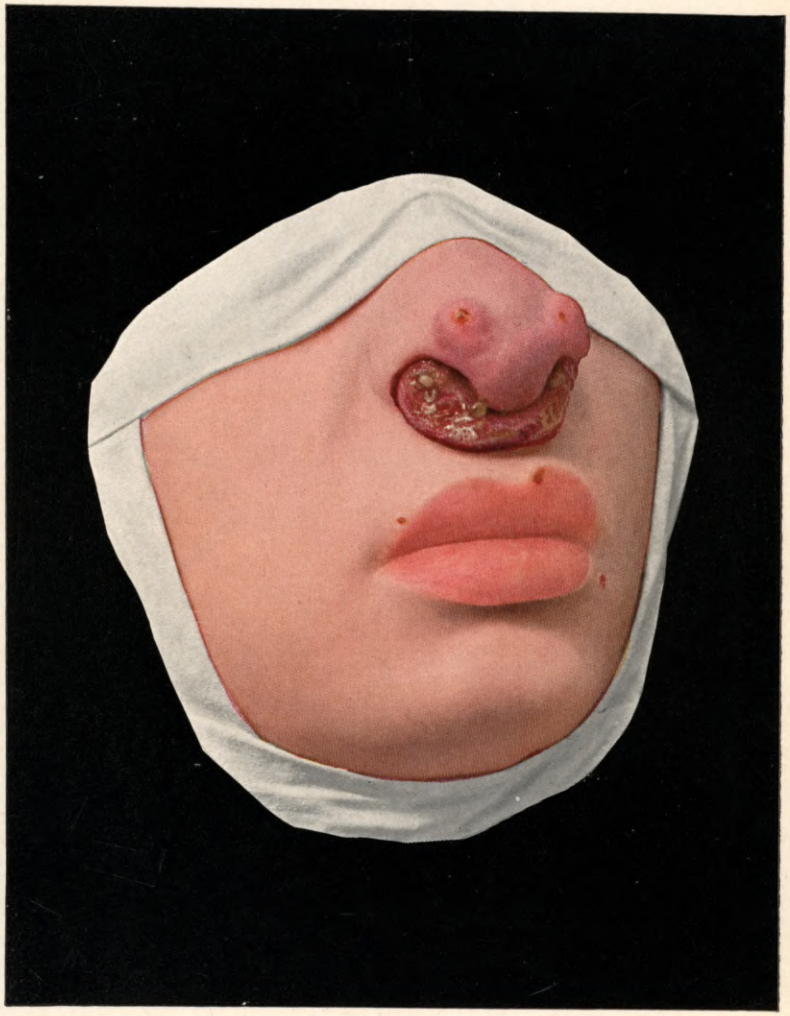
The **Treatment** usually results from the diagnosis; but in bromide-eruptions the cessation of the drug frequently does not suffice, and the outgrowths must then be treated by superficial thermo-cauterization, scarification or the sharp spoon. The removal of the horny masses of arsenical keratosis may be expedited by the use of macerating salves or plasters. The results of treatment of Chlorine Acne are not very encouraging. Most important is **Prophylaxis**; all workers in such works as have been referred to must be carefully observed, and must be immediately transferred to some other department on the first appearance of any comedones. There seems some possibility that the risks of occurrence of Chlorine Acne may be entirely obviated by modifications in the methods

of manufacture employed, in the sense of complete dissociation of the tar.

Figs. 118, 119. Models in the Freiburg Clinic (Johnsen).
Figs. 120, 123, 125. Models in Neisser's Clinic in Breslau (Kröner).
Fig. 121. Model in Lesser's Clinic in Berlin (Kolbow).
Fig. 122. Model in the Freiburg Clinic (Johnsen). An old medical man who, after every dose of Migranin, gets circumscribed urticarial eruptions on the buttocks, legs, shoulders and mucous membranes, which disappear after about a fortnight, leaving pigmentation.
Fig. 124. Model in Neumann's Clinic in Vienna (Dr. Henning). An hæmorrhagic eruption after copaiva.



No. 125. Toxicodermia mercurialis (Mercurial Rash).



No. 126. Rhinoscleroma.

Rhinoscleroma.

PLATE LXVII., FIG. 126.

This scleromatous condition of the nose and its mucous lining is caused by a specific encapsulated bacillus. It generally begins in the nostrils by the formation of a growth embedded in the nasal tissue, which is of ivory-like hardness, sensitive to touch, and covered by tense skin or mucous membrane. The condition may extend into the larynx, and thus give rise to respiratory disturbances. As a result, the nose appears thickened, often of a bluish-red colour, and sometimes portions of the hypertrophied and sclerosed mucous membrane protrude from the nostrils (Fig. 126). In process of time the disease may invade the greater part of the skin of the face, as well as the buccal and nasal mucous membrane, but neither general symptoms nor extensive ulcerative destruction of the new growth ensue.

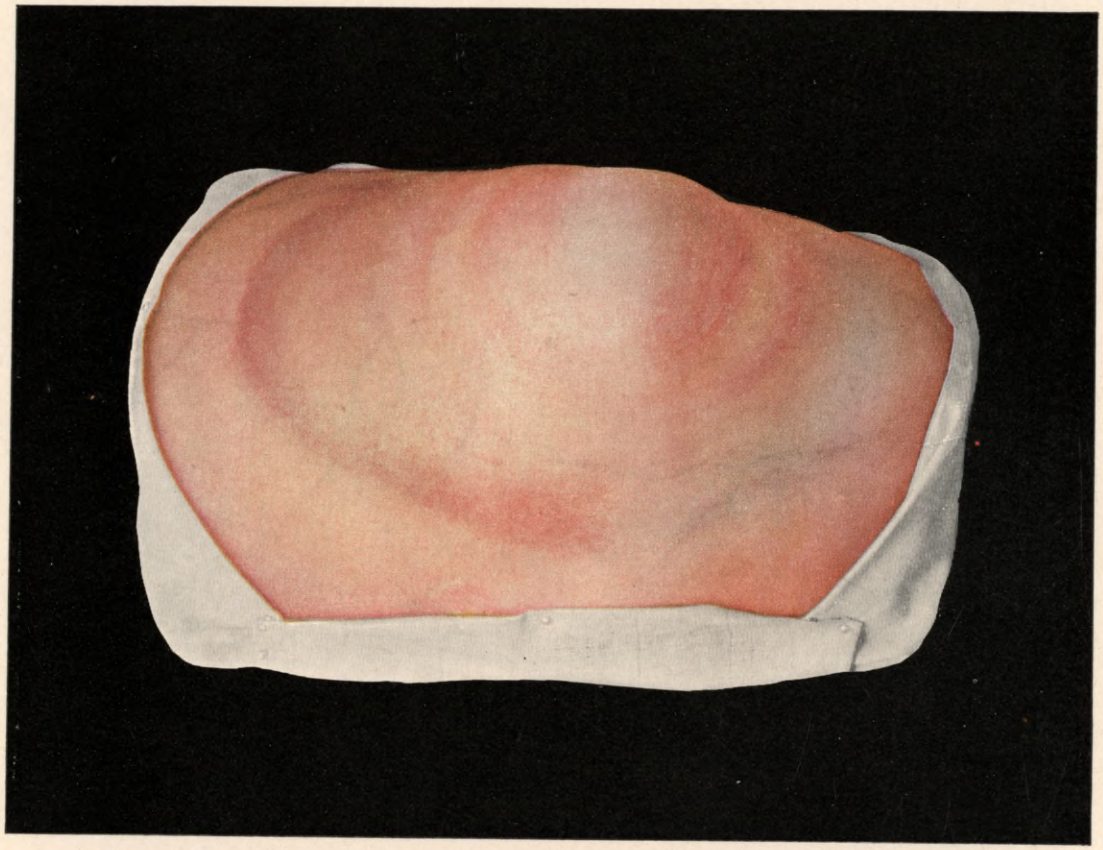
In some parts of the world rhinoscleroma is observed as an endemic condition; isolated cases are rare.

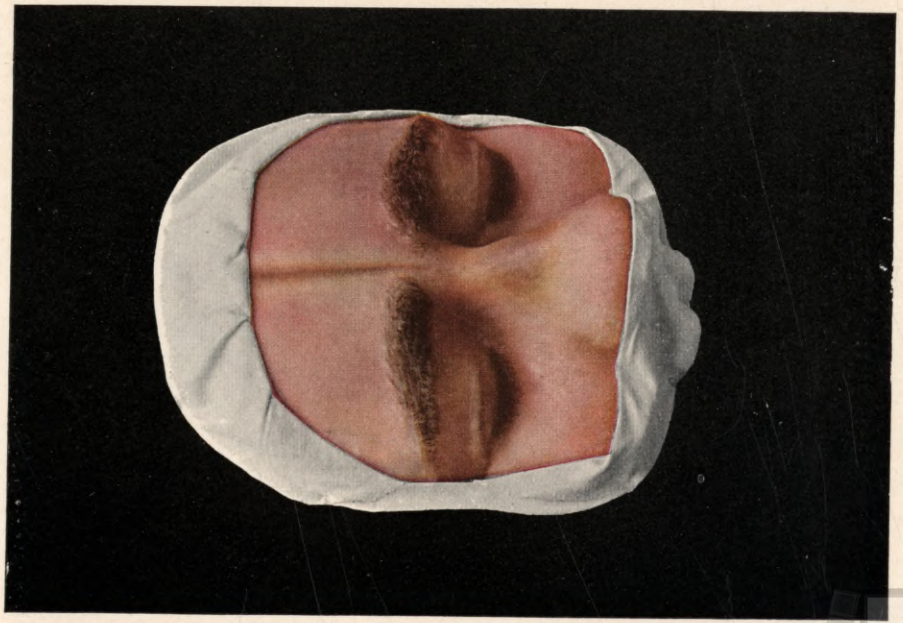
The **Diagnosis** is based upon the localization of the growth, and its slow extension.

The **Prognosis** is unfavourable as regards life only when the larynx is involved, and there is risk of asphyxia; but complete cure is never attained.

No satisfactory mode of **Treatment** is yet known. Surgical measures are productive of only temporary improvement, at the best. Caustics may be tried, such as pyrogallic acid, or chromic acid and nitrate of silver for mucous membranes. X-rays are also worthy of consideration.

Fig. 126. Model in Saint Louis Hospital, in Paris, No. 1615 (Baretta). Besnier's Case.





No. 127, 128. Sclerodermia.

Scleroderma.

PLATES LXVIII., LXIX., FIGS. 127, 128, 129.

Two stages may, as a rule, be differentiated in the disease described as Scleroderma of adults, in contradistinction to the Scleroderma of infants. Doughy swellings appear in the skin, with or without subjective symptoms such as pains in the limbs and neuralgiæ. These swellings gradually merge into woodeny, hard indurations; the sclerosed parts may occasionally be elevated above, although usually they are on a level with, the surrounding skin, and sometimes they are depressed below it. During this process the integument soon becomes of a reddish, bluish-red or brownish tint; subsequently the colour is a glistening brown, or it may remain natural. A lilac ring, which shows up pretty clearly from the normal coloration, is often present at the points of transition between diseased and healthy skin.

Universal and *circumscribed* forms are differentiated according to the extent of the disease. To the former belongs the complete, diffuse scleroderma, which usually runs a more rapid course and not infrequently recovers, as also symmetrical scleroderma of the scalp and extremities. The condition termed *Sclerodactylia* is the result of scleroderma of the hands, in which the skin of the fingers, as well as the

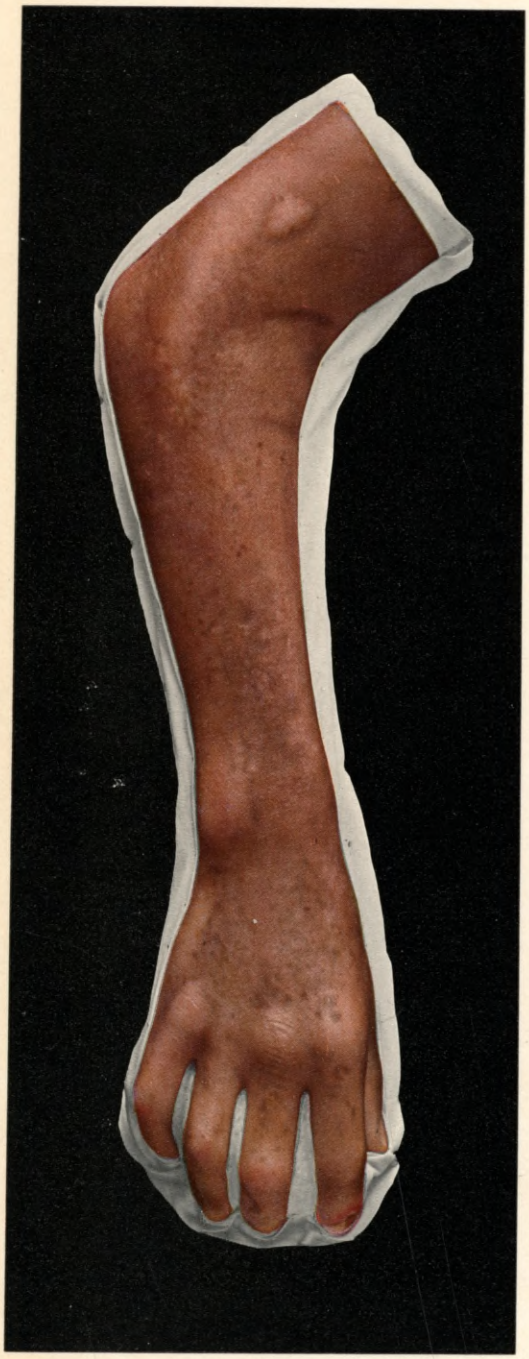
subjacent tissues, undergoes marked atrophy, so that the hands become clawed (Fig. 129).

The course of the circumscribed form is generally more chronic. It occurs in bands or discs (Figs. 127, 128) and often shows nerve-distribution. The mucous membranes may be affected in the same way as the skin, especially in circumscribed cases. Scleroderma causes considerable disfigurement; when situated on the face the skin looks stiffened, the expression altered; and when the affection is unilateral, it is often associated with hemiatrophy, the underlying muscles and bones being involved. The movements of the fingers are greatly crippled from contraction of the skin and subcutaneous tissue, so that considerable fissures may result and prove the cause of much pain. The reduction of temperature over the parts involved is noteworthy; sensation is at first unaltered, but may be subsequently lowered, in proportion as the secretion of the cutaneous glands is diminished.

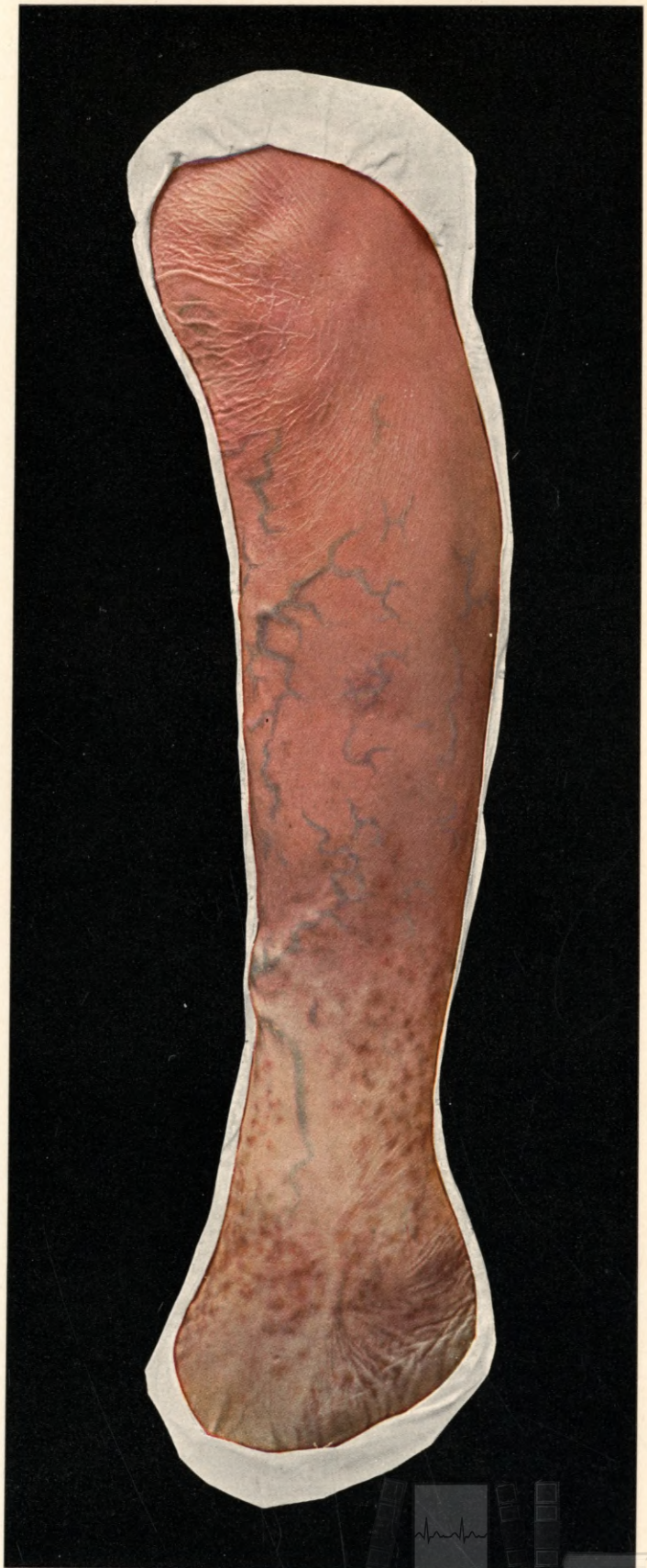
The course of scleroderma, apart from the universal form, is usually extremely chronic. The general condition of health depends upon the extent of the disease; in very extensive cases it is greatly impaired, and marked mental depression is usually added to the mechanical interference with various functions.

The **Etiology** is quite obscure. Some authors attribute it to disease of the nerves, others to changes in the bloodvessels or general nutritive disturbances.

The **Diagnosis** is easy in fully developed cases, especially when both stages are clearly manifested. Sclerodactylia may be mistaken for the local asphyxia of Raynaud's disease, but in the latter the skin is not adherent to the subjacent tissues nor is there any clawing of the hands.



No. 129. Sclerodermia diffusa.



No. 130. Atrophia cutis idiopathica.

The **Prognosis** must always be guarded.

Treatment may relieve local pain, but cannot arrest the progress of the malady. In addition to general tonic diet, baths are chiefly used, such as Turkish, seaweed, or sand-baths. Massage, salicylic and resorcin salves, mercurial and salicylic plasters, vigorous active and passive movements or, finally, preparations of thyroid gland, and thiosinamine injections or plasters, may all be tried.

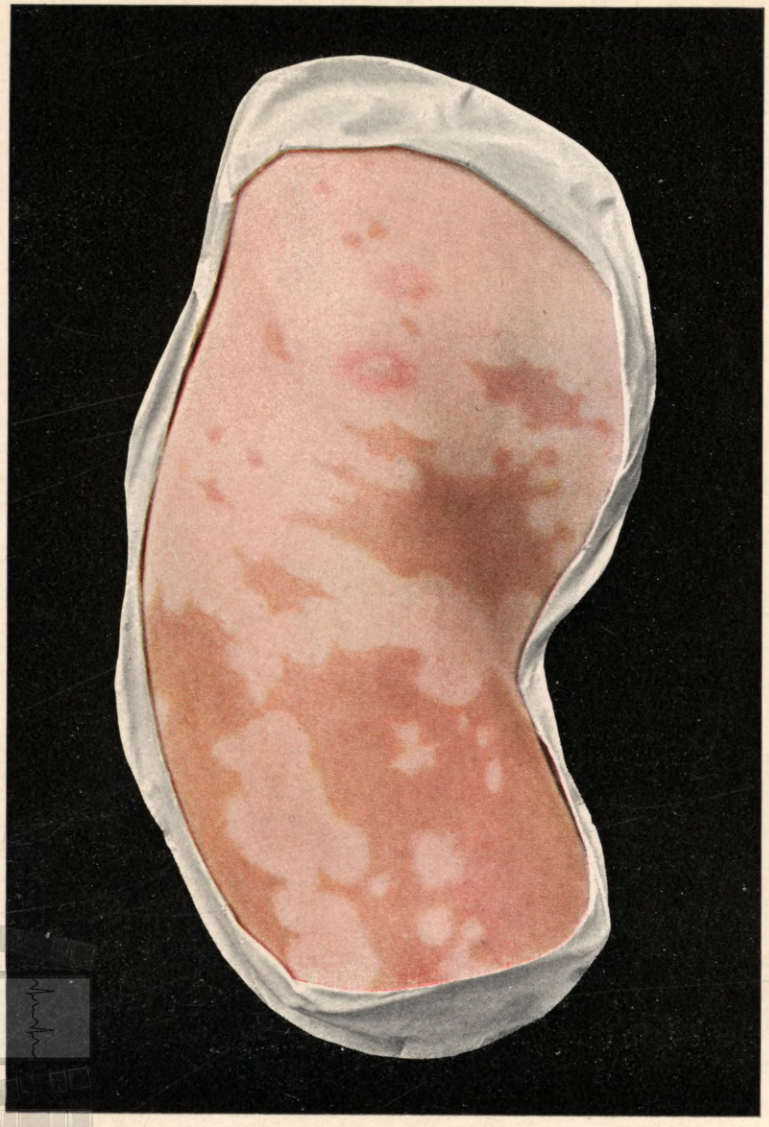
Fig. 127. Model in Neisser's Clinic in Breslau (Kröner).
Fig. 128. Model in Lassar's Clinic, Berlin (Kasten).
Fig. 129. Model in Freiburg Dermatological Clinic (Johnsen). The universal form of sclerodermia in a woman aged forty-two years, who was suddenly attacked with swellings about the ankles seven months previously. Ever since the skin of the whole body had been of board-like hardness, shiny and deeply pigmented, with scattered, lighter spots and excoriations here and there, especially about the anchylosed joints. The patient became intensely emaciated, and died of an acute pleurisy with effusion.

Atrophia Cutis Idiopathica.

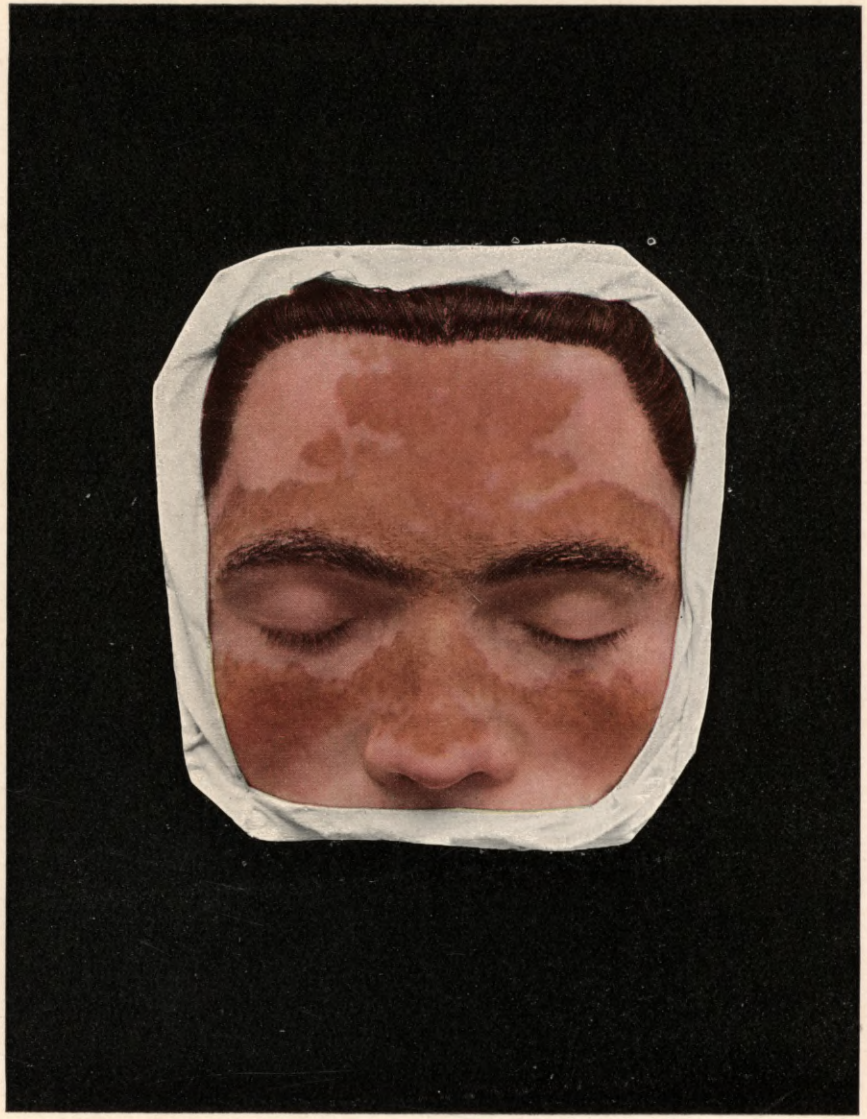
Plate LXIX., Fig. 130.

Idiopathic atrophy of the skin has only been recorded in recent years, although in a comparatively frequent number of cases. Its etiology is unknown. It is usually localized on the extremities, where either scattered spots or larger surfaces of skin and subcutaneous tissue shrink, while hairs and cutaneous glands atrophy until the skin—which is greatly thinned and in folds, like crumpled cigarette-paper—appears too big for the limbs which it covers. The colour of the diseased parts is whitish or reddish—the latter tint being especially marked on the recently affected parts, which exhibit patchy lividity—and is also pigmented, with a peculiar variegated appearance. The dilated and tortuous bloodvessels are visible through the transparent skin (Fig. 130). Inflammatory phenomena are present in the earliest initial stages, but the process, after attaining its maximum with more or less rapidity, remains stationary, and produces no important disturbance of sensation or of the general health.

The **Diagnosis** is easily made from the characteristic symptoms of the disease. It may be observed that atrophy of the skin, especially of the lower extremities, also occurs as a congenital condition.



No. 131. Vitiligo.



No. 132. Chloasma.

The **Prognosis** is favourable as far as general health is concerned, but absolutely unfavourable as regards recovery. Hitherto no improvement has been noted in parts once affected.

Treatment is unavailing; in the earlier stages warm baths and massage might perhaps be tried.

Fig. 130. Model in Neisser's Clinic in Breslau (Kröner).

Vitiligo.

Plate LXX., Fig. 131.

In addition to congenital absence of pigment, which is either universal (*Albinism*) or partial, and which is usually stationary, pigment may disappear from the skin without ascertainable cause (*Vitiligo*). The condition may be symmetrical, may follow the course of single nerves, or may have no determinate localization. It begins as circular, white spots, round the convex-spreading margin of which marked increase of pigmentation is recognizable, so that—strictly speaking—the condition ought to be described as a migration of colouring matter. There are no subjective symptoms or disturbances of sensation. When the disease is extensive, only scattered dark areas remain with concave outlines (Fig. 131). Serpiginous figures result from the coalescence of adjoining non-pigmented patches. The affection is generally incurable and slowly progresses, although the skin may assume a darker colour in summer; recovery may be said never to take place.

The **Etiology** is unknown, but sometimes general or nerve-disease is considered as its cause.

The **Diagnosis** is very easy in fully developed cases. Syphilitic leucoderma may be differentiated

from vitiligo by its localization, its accurately circular spots, and its less clearly defined margins.

No **Treatment** is of any avail. Such substances as mustard, cantharides, *etc.*, which cause pigmentation on normal skin have no effect on the diseased spots. If only a few pigmented areas remain, corrosive sublimate may be tried with caution, or peroxide of hydrogen, or resorcin-paste, to remove the pigmentation. If the disease is in a conspicuous place cosmetic measures may be employed.

Fig. 131. Model in Neisser's Clinic in Breslau (Kröner). On the abdomen there are two urticarial wheals.

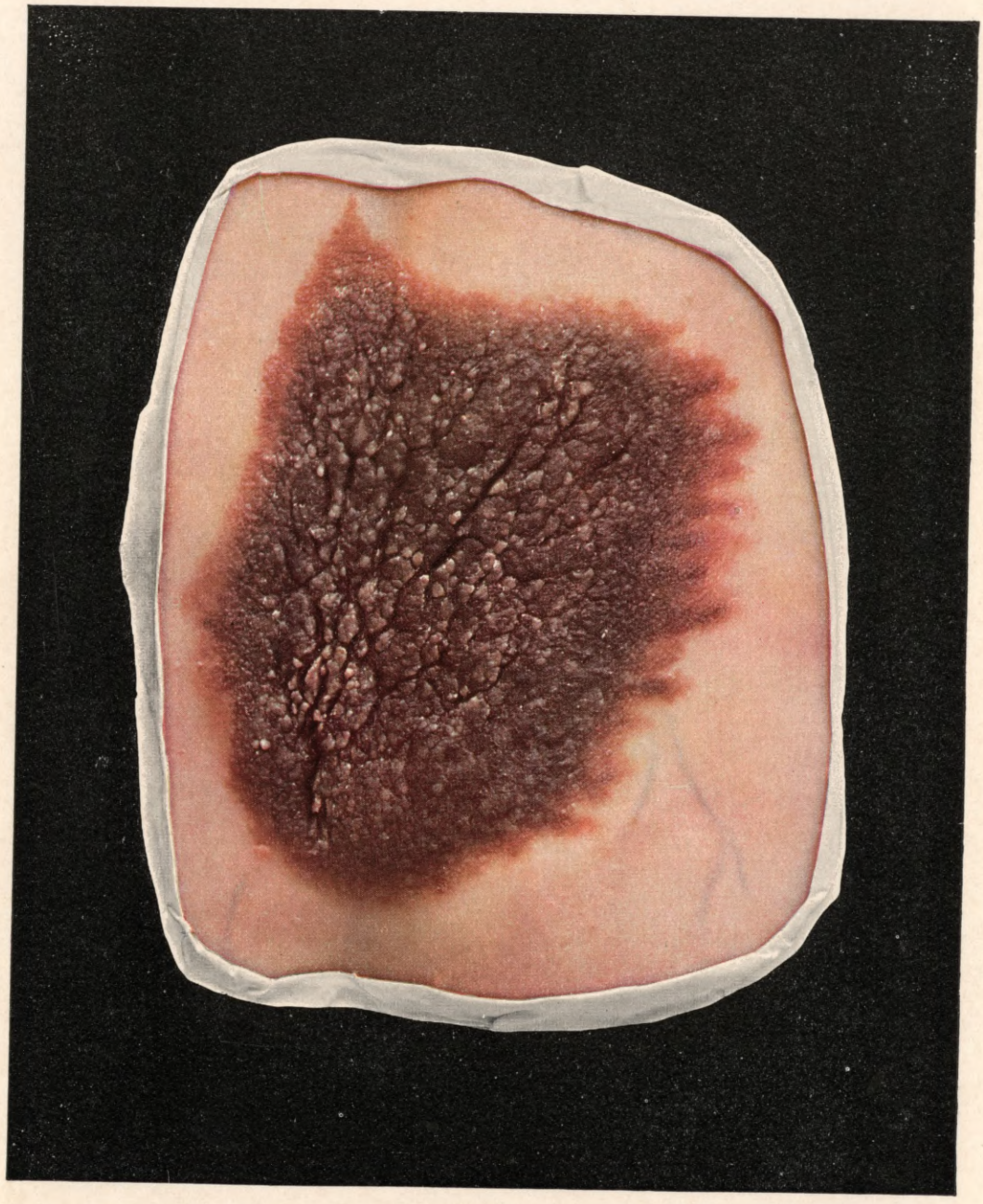
Chloasma.

PLATE LXX., FIG. 132.

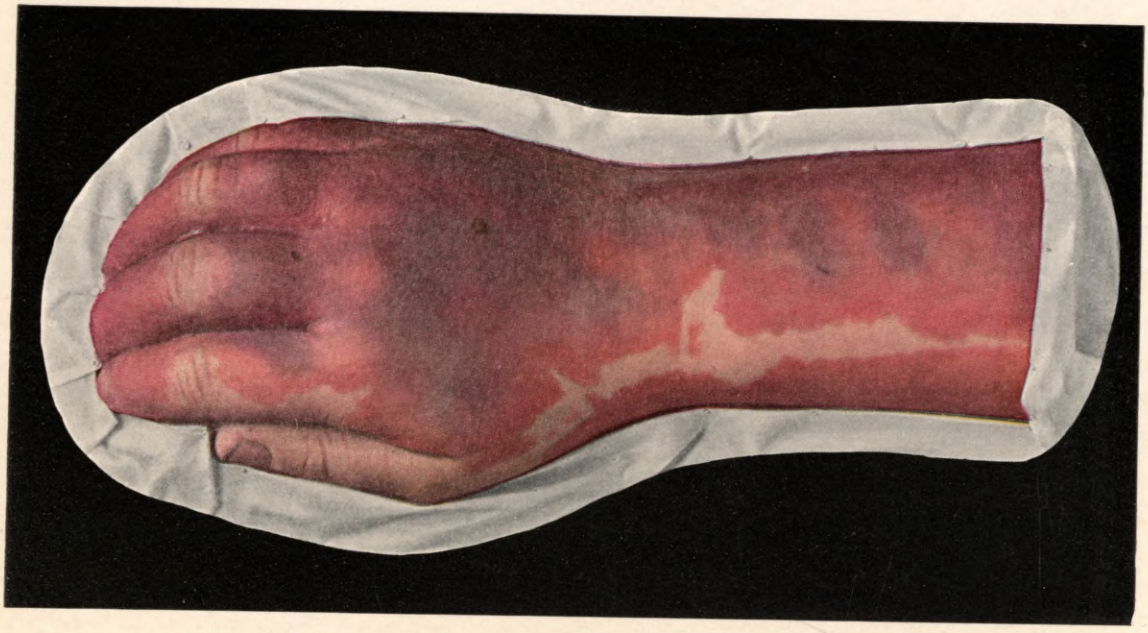
While a large number of patchy or diffuse pigmentations of the skin are due to external causes, or result from antecedent skin diseases (*e.g.*, psoriasis, lichen, pediculosis), there are other pigmentary skin affections which must be referred to diseases of internal origin. Pigmentation and bronzing constitute an important symptom of Addison's disease; after the prolonged use of certain drugs, especially arsenic, pigmentation, either in extensive sheets or in spots, occurs in predisposed persons; and the skin of patients suffering from various cachexiæ is very prone to abnormal discoloration.

Chloasma is a special form of hypertrophy of pigment which gives a characteristic, dark, mask-like tint to the skin, especially of the forehead, nose and cheeks. It may often be recognized as resulting from the coalescence of numerous small, brownish spots in the skin (Fig. 132). Pregnancy and diseases of the uterus may either give rise to the condition or may aggravate a congenital exaggeration of pigment. The colour disappears or diminishes after the removal of its cause. Remedies which provoke a vigorous desquamation of the deeper layers of epidermis act favourably, such as painting with 1 per cent. solution of corrosive sublimate in spirit or rubbing in resorcin-paste till free scaling ensues—but the results are seldom permanent.

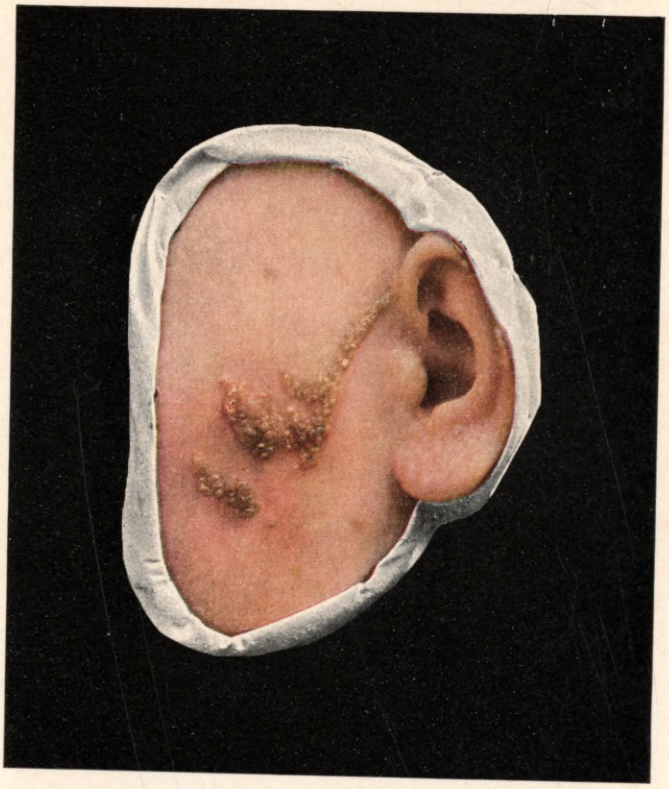
Fig. 132. Model in the Freiburg Clinic (Johnsen). The patient was in the ninth month of pregnancy.



No. 133. Naevus papillaris pigmentosus.



No. 134. Naevus teleangiectodes.



No. 135. Naevus linearis.

Nævi. Verrucæ Seniles.

Senile Warts.

PLATES LXXL-LXXIV., FIGS. 133-138.

There exist in many persons benign growths of the skin which contain one or several of its component parts and exhibit wide variations of size and arrangement; some are present at birth, but the majority develop later. Pigmentary nævi, among which freckles may be included, are the simplest of them, histologically. These are rounded or irregularly outlined spots of various sizes; they are sometimes unilateral, or they may be arranged along Voigt's lines.

In so-called "soft nævi"—or moles—new cell formation is present in addition to the excess of pigment, while the hairs and cutaneous glands may also participate in the hypertrophy. The surface is often of warty, papillary structure (*nævi verrucosi seu papillomatosi,* Fig. 133). These warty nævi exhibit very widely different characters, some being flat prominences, others semiglobular growths; and they are especially worthy of note as being frequently the starting-point of malignant tumors in old age (Fig. 136).

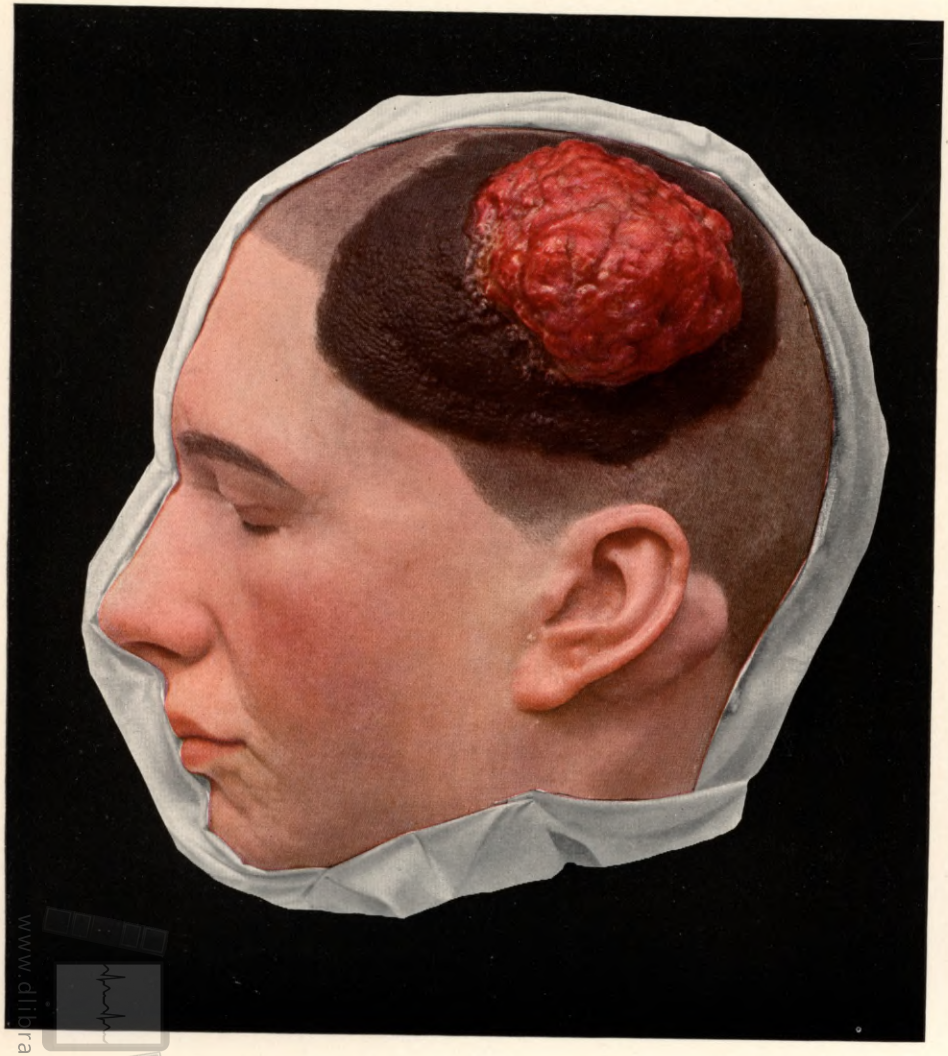
Vascular nævi (port-wine stains) (Fig. 134) constitute another group; they are generally present at birth, and most frequently on the face; or they may be unilateral and involve a great proportion of the surface of the body. Various grades of new vascular forma-

tion may coexist, from hypertrophy of the surface capillaries to increase of the larger and deeper vessels, so that the skin is disfigured by irregular, warty or bossy masses. As time goes on these nævi may disappear, partially or entirely, or they may increase by spreading at the periphery.

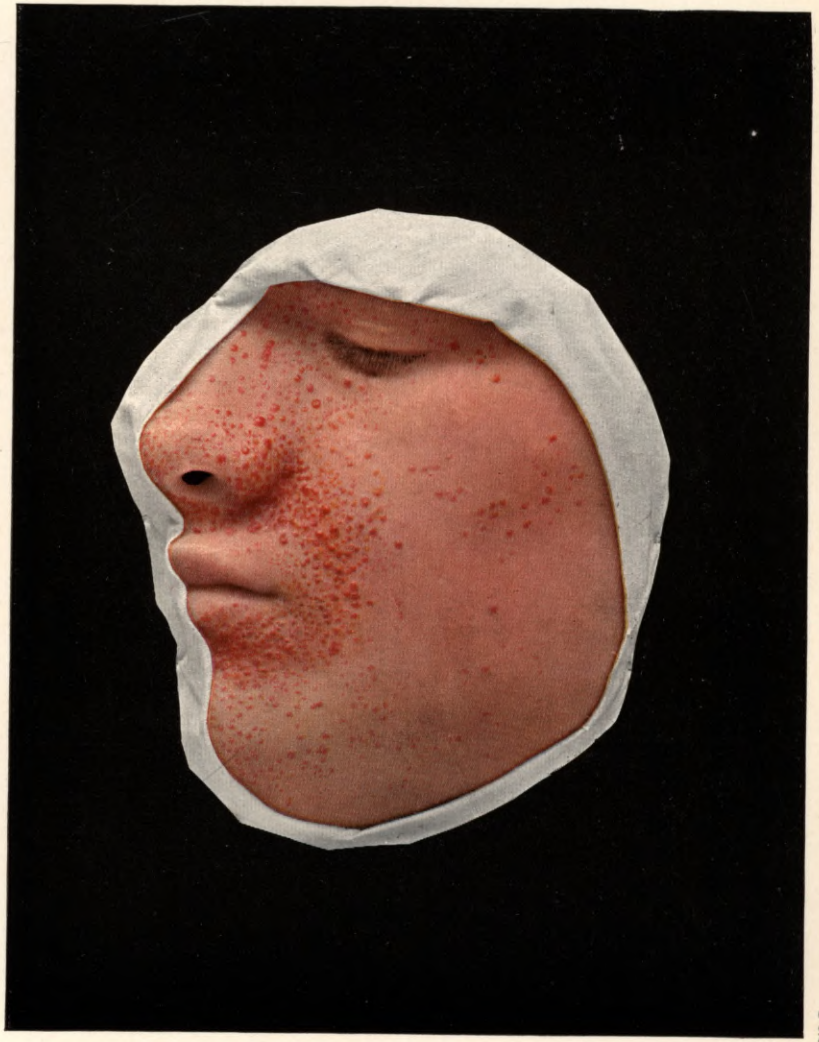
Nævi, in which hypertrophy of the cutaneous glands predominates, are called "glandular nævi." To this group belong the so-called *Adenomata sebacea* (Fig. 137), frequently in persons of weak intellect and in epilectics. They are characterised by the appearance about puberty of numerous yellowish or reddish nodular growths of various sizes, which are especially closely aggregated in the naso-labial folds. Hard, warty nævi are seldom present without the participation of pigment in excess.

The so-called "systematised" or unilateral nævi are of special interest; they are composed of all the different components of the skin, and often appear to follow the course of nerves (*nerve-nævi?*); but the influence of nerves on their existence does not permit of proof. They may spread in lines and patches, or their constitution by the coalescence of smaller, isolated nævi may be manifest (Fig. 135). Extension along the metameric lines is especially to be observed on the trunk.

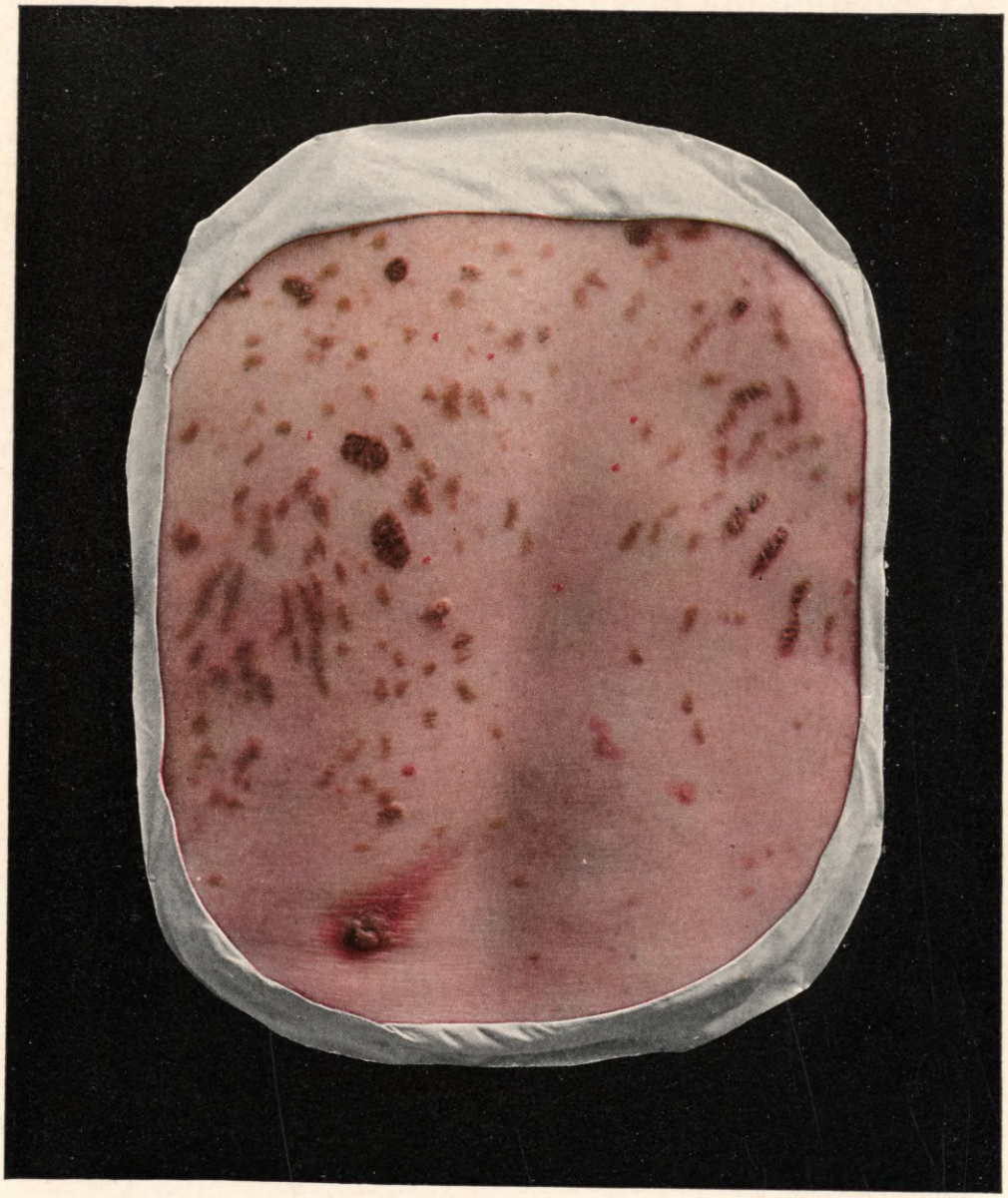
The so-called *senile seborrhœic* warts must be included among nævi; they usually arise after forty years of age, and in many people small angiomata (*Cavernomata senilia*) coexist. They are most frequently situated on the thorax and back, often very abundantly about the shoulders. Sometimes they show a band-like arrangement (Fig. 138). The lesions at first have a fatty feel and are of light-brown colour; afterward they become gray or brownish black, scaly and slightly granular on the surface. In size they vary from a lentil to a bean. The entire, flat growth may be



No. 136. Sarcoma e naevo pigmentoso.



No. 137. Adenoma sebaceum.



No. 138. Verrucae seniles; Cavernomata senilia.

removed by scratching, when the papillary layer—which bleeds easily—is exposed. Although transformation into malignant growths is very rare, it occasionally takes place.

The **Diagnosis** of nævi ought seldom to be a matter of difficulty. Their history, congenital nature, early development and subsequent stationary character are easy to establish.

The **Prognosis** is favourable, except in the very exceptional cases in which malignant degeneration occurs. Nævi are chiefly of importance on account of the disfigurement they cause.

Treatment must in most cases be surgical. Small pigmentary nævi are best removed by dabbing with a 1 per cent. solution of sublimate in spirit, till irritation ensues. In large, white moles electrolysis yields excellent cosmetic results. Vascular nævi may be caused to wither by superficial galvano-caustic needling, by high frequency currents, or by Finsen's light-treatment. Radium has not given satisfactory cosmetic results. Senile warts are best removed by scraping with the sharp spoon, the base being then touched with lunar caustic. There is, as a rule, no successful method of dealing with large nævi.

Figs. 133, 135, 137. Models in Neisser's Clinic in Breslau (Kröner).
Fig. 134. Model in the Freiburg Clinic (Johnsen). A girl, seventeen years of age, with an enormous *nævus flammeus* covering nearly the entire half of the body, and leaving but little healthy skin.
Fig. 136. Model in Von Bergmann's Clinic, Berlin (Kolbow).
Fig. 138. Model in Neisser's Clinic in Breslau (Kröner). On the lower part of the back is a carcinomatous tumor in course of development.

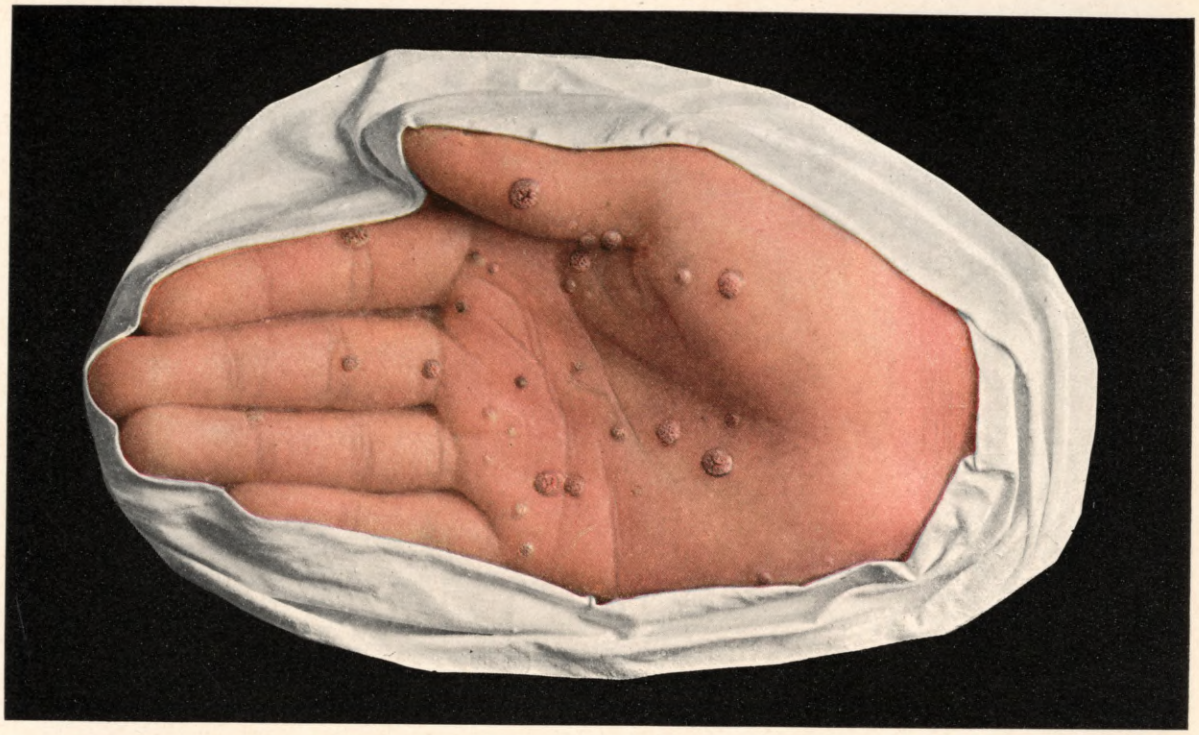
Verrucæ Vulgares.

Warts.

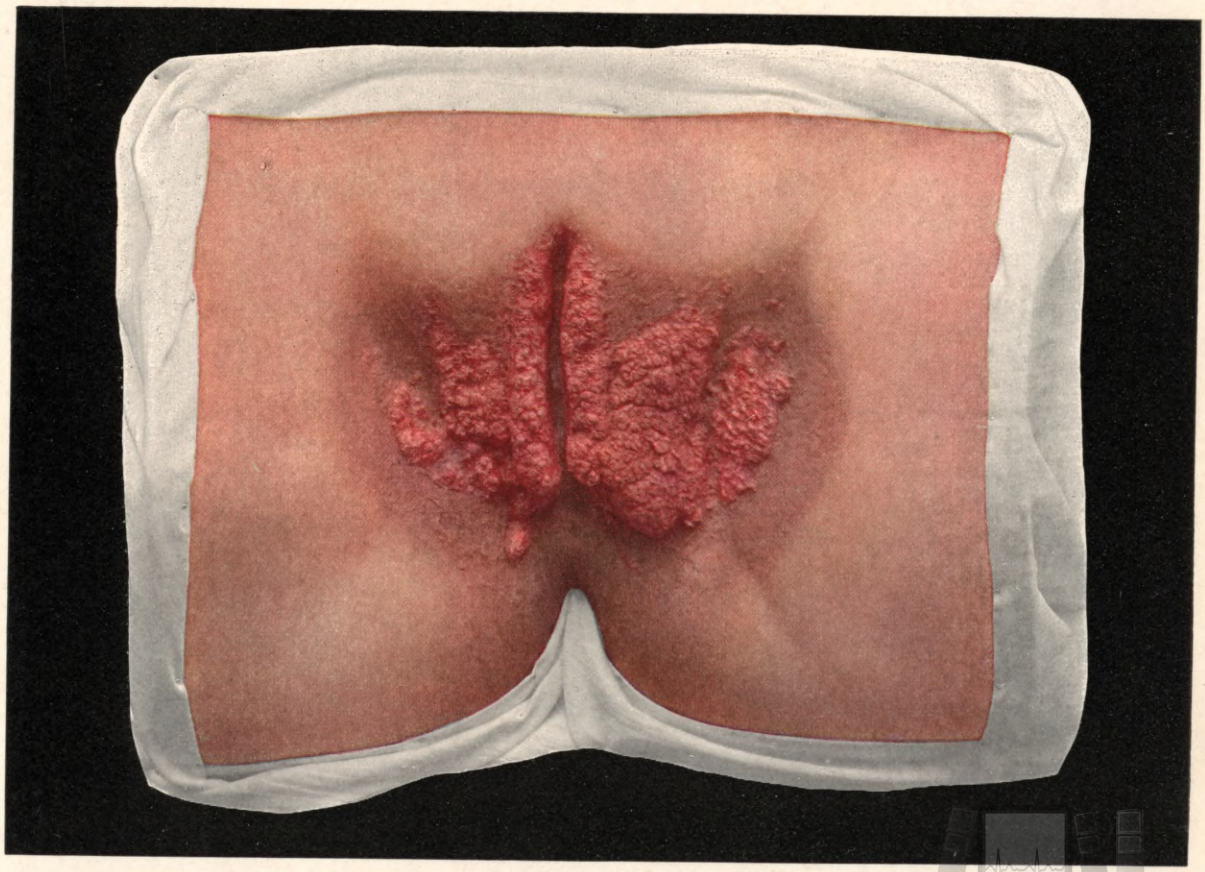
Plate LXXV., Fig. 139.

Common warts occur most frequently in young persons, less so in those of middle age, and chiefly on the hands, feet and scalp. They are generally flat, circular or polygonal in outline, and become split up on their surface as cornification increases, thus assuming a dirty-grayish colour; finally, they become of very firm consistence (Fig. 139). Strict differentiation of flat from hard warts appears to us unjustifiable. Their size is at first scarcely that of a lentil, but as they grow, they may become as large as a pea or bean. Often a number of recent warts are grouped round old ones. Successful inoculation-experiments have proved that warts are undoubtedly of infective origin, but they have an unusually prolonged period of incubation which may last for months. Subjective symptoms are present only when they are situate on the soles, where outward growth is impossible and the wart remains in the thickness of the skin, or when they are present along the sides of the nails and painful fissures occur.

The **Diagnosis** of common warts is generally easy, except when they are situate on the palms, and their secondary infection by organisms may then



No. 139. Verrucae vulgares.



No. 140. Papillomata.

pretty closely simulate syphilides. Lichen planus is of quite distinct colour, generally occupies different parts of the body, and itches. Arsenical keratosis and ichthyosis spread diffusely along the skin-surface, while "post-mortem warts" have always an inflamed border.

The **Prognosis** is favourable.

Treatment.—The internal administration of arsenic is often employed, and may, after a long time, prove efficacious. In almost all cases, however, the use of external means is necessary, and various caustics (*e.g.*, trichloracetic acid, fuming nitric acid, acetic acid) may be used. Electrolysis may succeed, or warts may be removed surgically under ether-spray or chloride of ethyl. It is often stated—but the statement is of dubious veracity—that if a central wart is removed, those round about disappear. Quite recently very rapid cures by light-treatment have been reported.

Fig. 139. Model in Lesser's Clinic in Berlin (Kolbow).

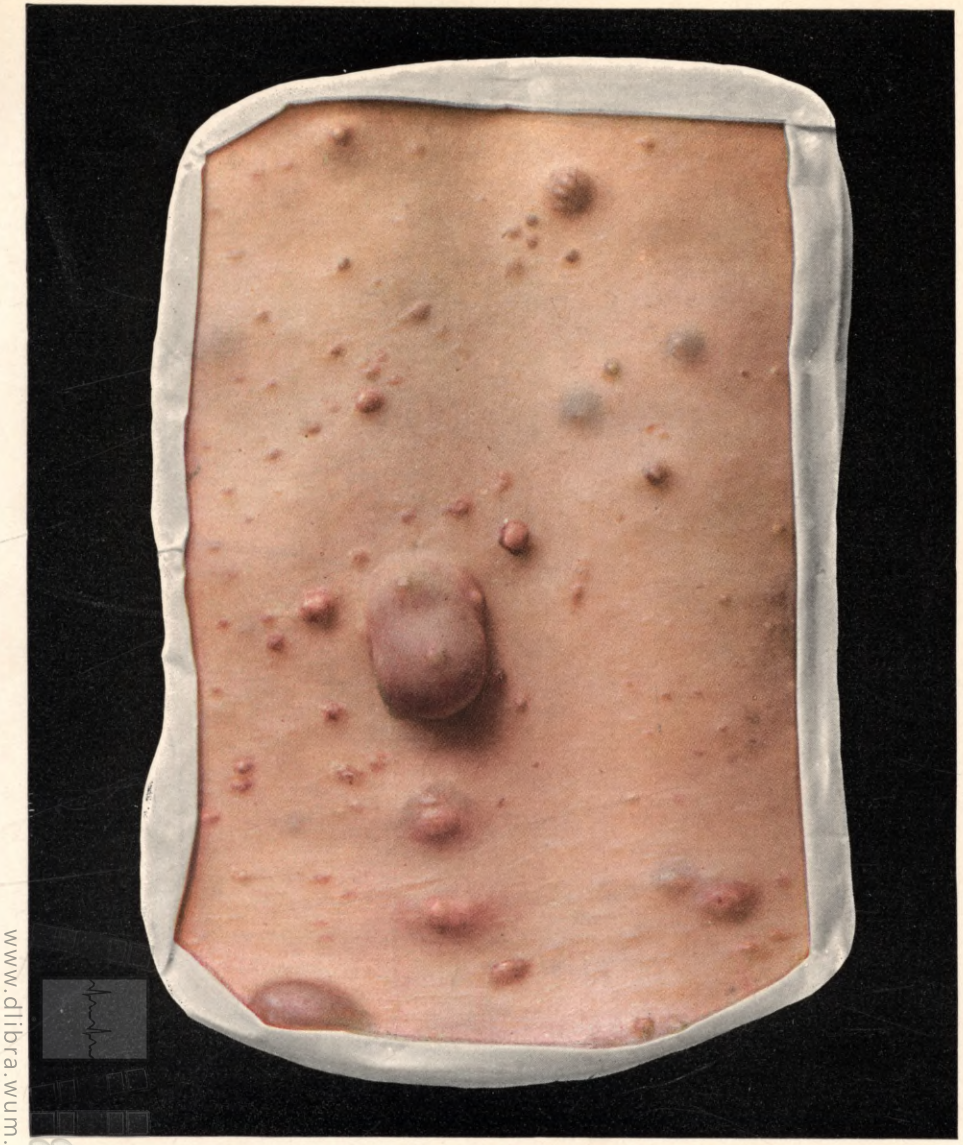
Papillomata.

Condylomata Acuminata.

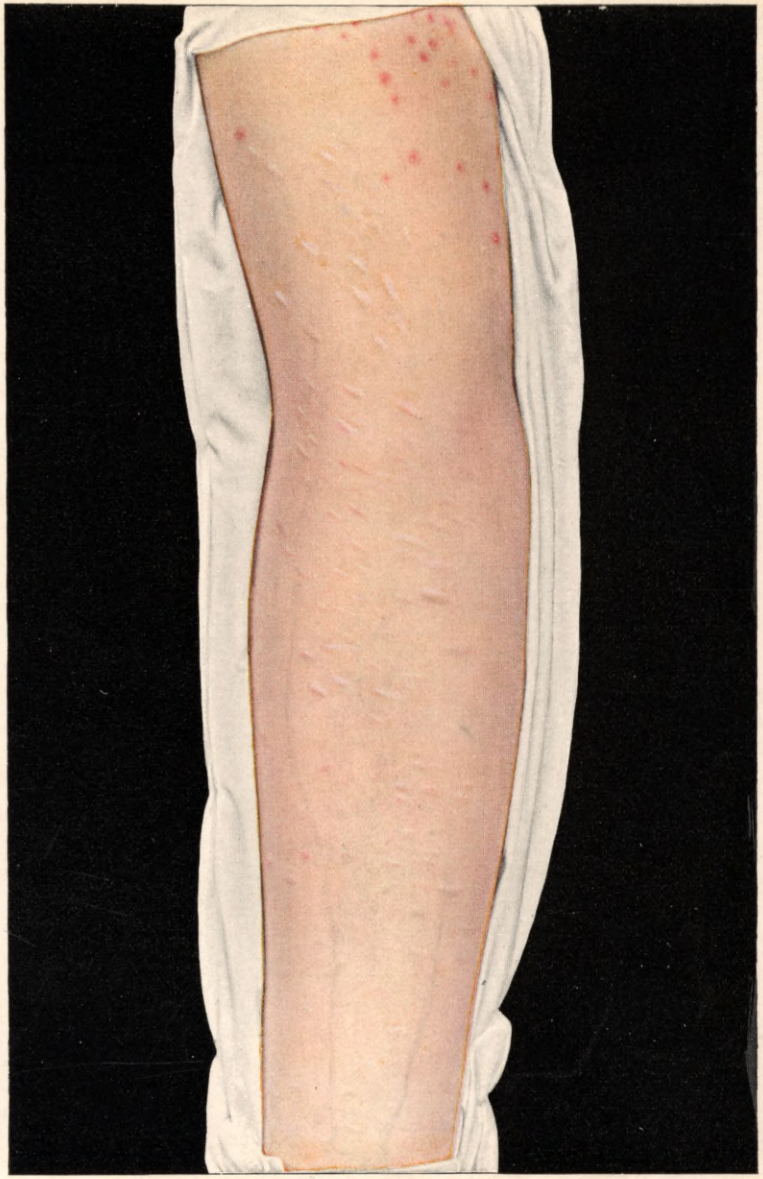
Plate LXXV., Fig. 140.

Papillomata are a form of benign growth which occur chiefly on the skin and mucous membrane of the genitals, and spread thence to the neighbouring parts of the thighs and over the perinæum to the anus. Cauliflower-like tumours result, which are made up of much-hypertrophied and divided papillæ, covered by thickened epidermis, and these subsequently coalesce (Fig. 140). Similar lesions sometimes affect the auditory meati, the nose and the lips. The surface of most papillomata is at first like mucous membrane, but a sort of cornification may subsequently ensue. A particularly offensive secretion is present between the separate, macerated papillæ, which make up the larger growths. As a rule there are no inflammatory signs about the surrounding parts; tumours as large as the fist may form by hypertrophy and extension, in cases of old standing.

Papillomata are usually provoked by the irritation of gonorrhœal discharge, but cases pretty often occur in which there is no gonorrhœa. The method of extension in crops strongly suggests the idea of an infective cause, but nothing is definitely known on the point.



No. 141. Fibromata mollusca.



No. 142. Dermatomyoma multiplex.

The **Diagnosis** of papillomata is easily made from their typical appearance, sharp demarcation, and distribution. The use of the term *condylomata* gives rise to some possibility of confusion with syphilitic papules; it had better be replaced by the name in use here.

The **Prognosis** is favourable.

Dryness and cleanliness of the genitals in both sexes, especially in persons suffering from gonorrhœa, must be observed as means of prophylaxis.

Treatment first consists in removing the cause —*e.g.*, gonorrhœa, balanitis, vulvitis, etc. Large papillomata may be snipped off with scissors. Numerous small growths are best removed with the sharp spoon, and their bases subsequently touched with nitrate of silver or liquor ferri sesquichloridi. Papillomata often disappear after simply keeping the parts dry and using powders, such as oxide of zinc or boric acid. Certain well-known caustics are frequently employed—*e.g.*, equal parts of caustic lead, savin-tops and alum (Gerhardt), 10 per cent. solution of resorcin, or formalin, or chromic acid. For very obstinate, horny papillomata, the application of thick resorcin-jelly or salicylic acid plaster-mull may be recommended.

Fig. 140. Model in the Freiburg Clinic (Johnsen). A maid-servant, nineteen years old. No gonorrhœa detected.

Fibromata Mollusca.

Molluscum Fibrosum.

Plate LXXVI., Fig. 141.

Single, isolated fibromata of the skin are comparatively seldom observed. Multiple, soft fibromata arising from nerve-sheaths (*neuro-fibromata*), are much more frequent and may be congenital, or on a congenital basis. They usually occur in extremely large numbers, and are of very various size; sometimes they lie fiat in the thickness of the skin, sometimes they are pedunculated, or may be enclosed in folds of the integument resembling boils (Fig. 141). After the disappearance of their contents an empty pouch or skin remains. Small or comparatively large nævi are often present in greater or less number along with the fibromata, which latter appear bluish and somewhat translucent owing to their deep situation in the skin. The skin over the growths is either normal or may present some dilatation of its bloodvessels or ducts. The tumours may increase to an enormous size and ultimately ulcerate on the surface. Severe pain must be mentioned as one of the subjective symptoms. The occasional occurrence of sarcomatous degeneration is also worthy of note. A very marked degree of disfigurement may be caused by the disease.

The **Diagnosis** can hardly present any difficulties.

The **Prognosis** is favourable, apart from the possible occurrence of malignant degeneration of the growths; but spontaneous absorption and disappearance of the disfigurement and pain are hardly to be anticipated.

Treatment is purely surgical, and ought to be limited to the removal of the largest and most annoying tumours.

Fig. 141. Model in Lassar's Clinic in Berlin (Kasten).

Dermatomyoma Multiplex.

PLATE LXXVI., FIG. 142.

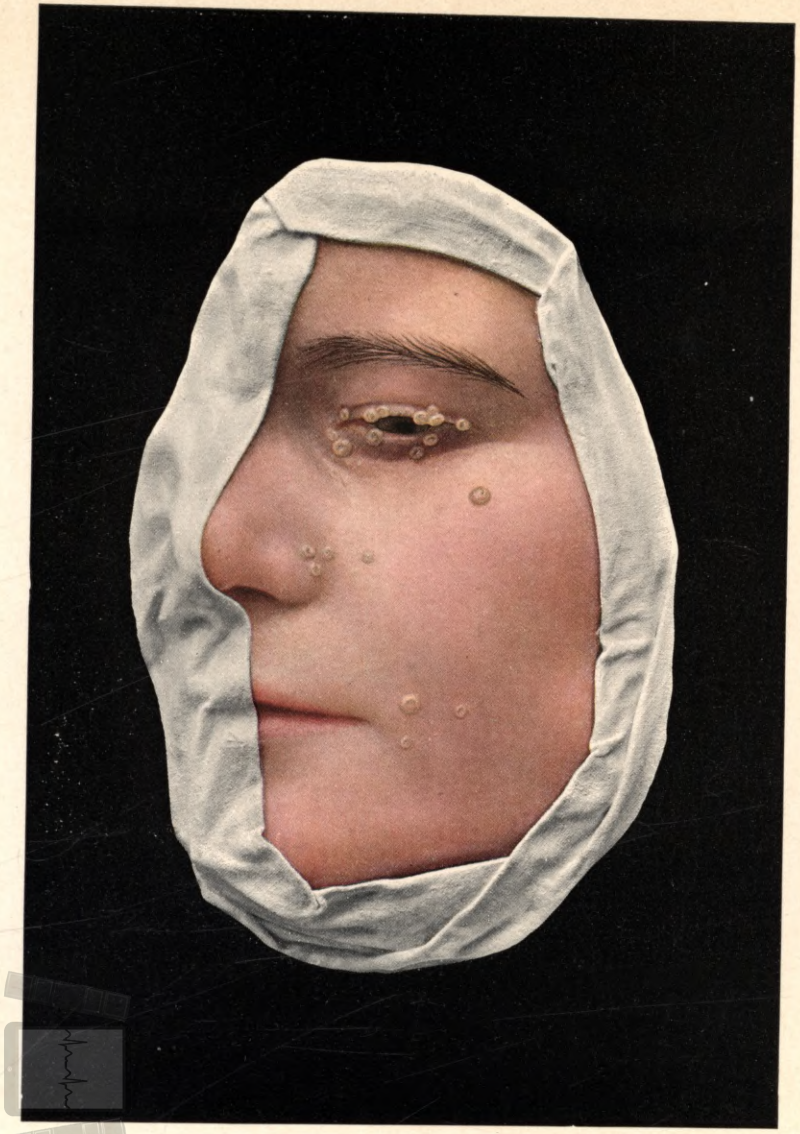
This disease is of rather rare occurrence. The *myomata* are located on the extremities and develop from the smooth fibres of the arrector muscles, where they form hard, round or oblong nodules of a whitish-reddish to red-brown tint, either in groups or diffusely scattered (Fig. 142). They are not only sore to the touch, but in many cases also give rise to very severe and painful neuralgic attacks. A reformation of the affected parts does not, as a rule, take place.

Diagnosis is facilitated by the presence of the characteristic nodules, their sensitiveness to pressure and the recurrent painful attacks of neuralgia.

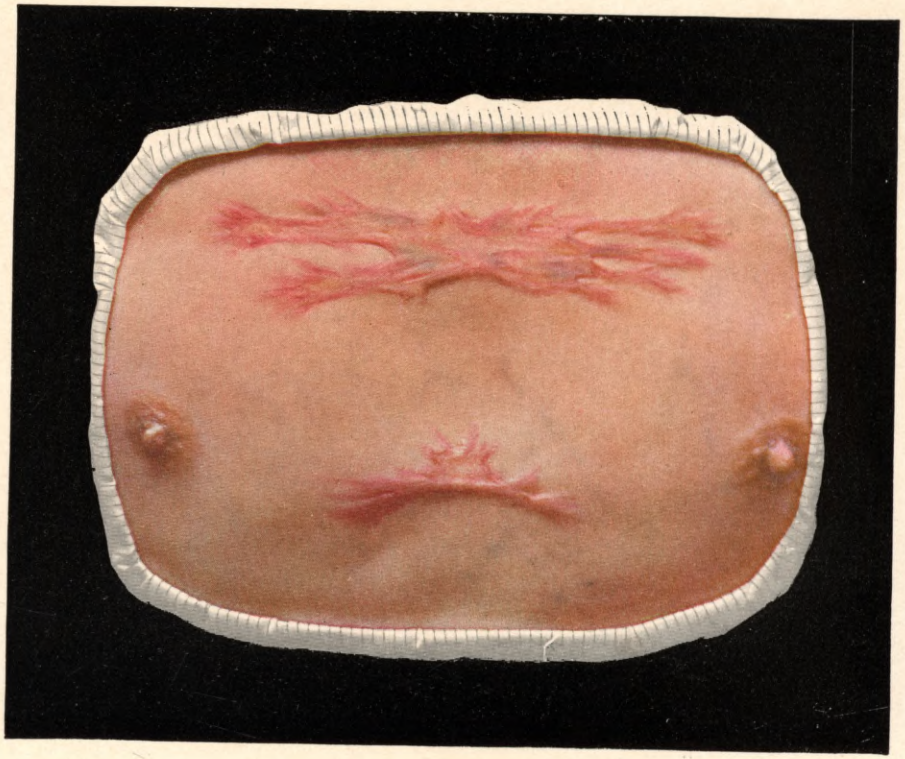
Prognosis is favourable in so far that the disease does not spread and that the nodules, when once surgically removed, do not grow again.

Treatment.—Only surgical interference is likely to give some relief. In a case treated by the author, after very extensive extirpation, the neuralgic attacks continued.

Fig. 142. Model in Clinic of Dr. Galewsky, Dresden (Kolbow).



No. 143. Mollusca contagiosa.



No. 144. Keloid.

Mollusca Contagiosa.

Plate LXXVII., Fig. 143.

Mollusca contagiosa are small, semi-globular, nodular growths which appear most frequently about the genitals in adults, but are commoner in children, and generally affect the face (Fig. 143) and scalp. They are of a pale-reddish, somewhat translucent tint, and gradually increase to the size of a lentil or pea, but occasionally may be bigger. In their centre there is a depression, sharply defined by a circular line, inside which the skin is of finely granular and dry appearance. A single molluscum is of rare occurrence; more frequently there is a crop of smaller and more recent lesions round an older one, while sometimes they are arranged in lines corresponding to scratch-marks. On firm lateral pressure the central portion can be completely squeezed out, and slight bleeding occurs; the plug thus evacuated is slightly hyaline in appearance, and numerous refractive bodies (*molluscum bodies*) can be observed in it under the microscope. After removal of its contents the nodule collapses. Mollusca contagiosa grow extremely slow, and remain unchanged for a long time. The cause of these undoubtedly infective growths is not yet ascertained, innoculation experiments having hitherto proved futile; some authors believe that they are due to minute organisms of the class of protozoa.

The **Diagnosis** can easily be made from their central depression. The microscopical demonstration of "molluscum bodies" in the plug they contain decides the point in doubtful cases.

The **Prognosis** is favourable.

The best **Treatment** consists of squeezing out their contents with a comedo-extractor or the fingers. Large mollusca may be surgically removed.

Fig. 143. Model in Lesser's Clinic in Berlin (Kolbow).

Keloid.

PLATE LXXVII., FIG. 144.

A distinction is drawn between true and false keloids according to their origin from pre-existing scars or from normal skin; but one can never exclude the possibility of the latter form arising from some very superficial injury. Keloids are flat, circumscribed tumours of ribbon-like or lumpy appearance. Outgrowths resembling promontories extend from their margins into the surrounding healthy skin, into which they gradually merge. The surface of a keloid is smooth, generally like a scar, and often is traversed by fine blood-vessels, so that it becomes of reddish tint, especially at the margin. Keloids may cause trouble by pain or great tenderness on pressure, as well as some disfigurement. Their cause is still unknown; racial proclivity (*e.g.*, in negroes) is often advocated, but some form of infectivity cannot be excluded. Their commonest seat is the præsternal region (Fig. 144), but they may occur on the face or any other part of the body, especially so-called "scar-keloids."

The **Diagnosis** may be based upon the localization, the pain and the peculiar knobby or band-like form of the tumours.

The **Prognosis** is unfavourable, as recurrences

almost always take place after operative removal, while spontaneous disappearance is of extremely rare occurrence.

Treatment is correspondingly devoid of result. Injections of thiosinamin, the application of 10 per cent. thiosinamin-plaster, and electrolysis may be tried; or, finally, free incision with subsequent skin grafting.

Fig. 144. Model in Kaposi's Clinic in Vienna (Dr. Henning).