

Dermatology.

ON SOME CUTANEOUS DISEASES.

CLINICAL LECTURE DELIVERED AT THE UNIVERSITY HOSPITAL.

BY LOUIS A. DUHRING, M.D.,

Professor of Dermatology in the University of Pennsylvania.

CASE I.—ALOPECIA AREATA.

GENTLEMEN,—The first case I show you to-day is one of alopecia areata, occurring in a child five years of age. On the occiput she presents a well-defined smooth spot devoid of hair. The disease is a chronic one, and usually begins as one or more areas, which gradually enlarge and finally coalesce, or may remain stationary for a variable length of time. The skin soon shows signs of altered nutrition. After a time colorless down or normal hair may appear on the bald area. This drops out usually and grows in again, or it may remain, the scalp sooner or later returning to a normal condition. The diagnosis from ring-worm of the scalp, in most cases, is not difficult. The prognosis is usually good in young persons, though at times the disease yields only after a long period.

Arsenic is generally indicated, but often it fails. Locally, a lotion composed of carbolic acid f3i and alcohol f3vii is of benefit, and will be used in this case. In obstinate cases it is sometimes useful to blister with carbolic acid. After an epidermic eschar has formed, this must be discontinued for a week or longer, and then reapplied. Chrysarobin is of even greater value, but, unfortunately, is not safe, unless applied under the observation of the physician.

CASE II.—TUBERCULAR SYPHILODERM.

The lesions presented by this woman are of two years' standing, and are now in a stage of involution. This form of the disease usually appears a long time after the initial lesion, as a late manifestation. It often comes on insidiously. The lesions may terminate finally by absorption, leaving a pigmented spot, or, as in this case, by ulceration. No history of syphilis can be obtained from this patient,

which is often the case with the tubercular syphiloderm, especially in women. This eruption is not infrequently the first manifestation of syphilis presented upon the skin, sometimes several years after the initial lesion. The treatment which will probably be found of most benefit here is as follows:

R Hydrarg. iodid. rub., gr. ii;
Potass. iodid., ℥i;
Aquæ menth. pip., q. s. ad f℥vi.

M. et sig.—One teaspoonful with water t. i. d. after meals.

It is well to vary the vehicle from time to time, using elixir of calisaya or syrup of orange-peel as a substitute for peppermint water, since the same remedies must be used more or less continuously for a long time.

CASE III.—ULCERATING TUBERCULAR SYPHILODERM.

The next patient, a middle-aged woman, is also suffering with a tubercular syphiloderm. She presents a tubercular eruption upon her hands and wrists, together with numerous characteristic scars. The lesions have existed about a year. In places they are pustular, and they tend to sink in and destroy the cutaneous tissues. The skin in other places has become thickened and scaly. Some lesions present a tendency to the characteristic horseshoe form.

The constitutional treatment will be similar to that last ordered for the previous case. Locally, a plaster of mercury and salicylic acid will be applied and worn constantly. This is a better method than rubbing in an ointment. These plasters, made of various medicaments and strengths, will be found extremely useful in many chronic skin affections.

CASE IV.—IMPETIGO CONTAGIOSA.

This boy, aged ten, has been suffering with the disease about one week, and now presents numerous discrete pustules and vesicopustules, pea-sized, superficial, and having the appearance of being stuck on, which, with the other symptoms, serves to characterize it from ecthyma. Drying up in a few days, the crusts drop off, leaving no trace. As a rule, the tendency of this disease is toward spontaneous cure, which may be materially aided by the following ointment:

R Hydrarg. ammoniat., gr. xv;
Ung. zinci oxid., ℥i.—M.
Sig.—Apply thrice daily.

CASE V.—LUPUS ERYTHEMATOSUS.

This woman has been before us on several occasions, and you will recognize the disease as lupus erythematosus. There are several circumscribed, dark-red, chronically-inflamed patches, covered with greasy scales, on each side of the face. There is also a small patch on the ear, which is not an infrequent seat of this disease, though it usually affects the nose and cheeks. She has been using a salicylic acid paste on one side and sulphur ointment on the other. Both sides have improved, but the paste seems to have had the better effect. The sulphur ointment will be discontinued and a mercurial plaster substituted. These plasters are cut to fit the lesions, and should be worn constantly.

CASE VI.—ACNE.

The next patient presents a typical case of papular and pustular acne, affecting the nose, cheeks, and chin, and extending over a period of five years. The disease is inflammatory, usually chronic, and may appear in the form of papules, pustules, tubercles, or a mingling of these lesions, usually upon the face, but sometimes upon the back and chest, particularly in men. It is a common affection, and generally appears between the ages of fifteen and twenty-five, though it may last until the age of forty or fifty. As in this case, the lesions are often sluggish and indurated, when stimulating remedies are required, such as Vleminecx's solution. This must be diluted with from one to three parts of water, and the skin moistened for periods of ten or twenty minutes twice a day. After some days more or less exfoliation usually occurs, when the remedy may be discontinued and sulphur ointment substituted. It is usually necessary in the treatment of acne to change remedies at frequent intervals, as generally they lose their power in a short time. Then, too, different cases yield to different lines of treatment, some improving more rapidly under the application of a lotion, while others yield more readily to an ointment. Frequent bathing of the face with hot water, drying before remedial application is made, is useful in some cases. Of all remedies the one suited to the largest variety of cases is sulphur, though corrosive sublimate, white precipitate, and other mercurials are also useful. As a lotion the following formula will be found of value:

R Sulphur. præcip., ʒ iss;
 Acid. boric., fʒ ss;
 Ætheris, fʒ i;
 Aq. Coloniensis, fʒ ss;
 Alcohol., q. s. ad fʒ vi.—M.

Sig.—Apply with the sediment as a wash twice daily.

CASE VII.—PSORIASIS.

This large and stout woman, of forty-five, presents an inflammatory disease of the skin, of eight years' standing, occupying the back of her hands and forearms, the palms being free. The lesions, which are somewhat modified by treatment, are superficial, confluent, scaly patches. The skin has become thickened and infiltrated. The disease usually disappears during the summer, but returns in winter. It is a chronic affection, some patches remaining indefinitely. It is an inflammation, produced by hyperplasia of the rete mucosum; is not contagious, and usually yields to treatment, though recurrence is the rule. Arsenic is of value, especially in the chronic form of the disease, though local remedies are those to be especially relied upon. Liquor potassæ and other alkalies are of service in some plethoric subjects, and this woman will be given ten drops of the former, three times a day, largely diluted with water, to be continued for a few weeks. The scales may be removed by frequent alkaline baths. An application of tar-ointment with salicylic acid, fifteen grains to the ounce, rubbed in from ten to twenty minutes twice daily, is useful. Chrysarobin, ammoniated mercury, and pyrogallic acid are also all valuable remedies.

CORNU UNGUALE.

CLINICAL LECTURE DELIVERED AT THE ST. LOUIS COLLEGE OF PHYSICIANS
AND SURGEONS.

BY A. H. OHMANN-DUMESNIL, M.D.,

Professor of Dermatology and Syphilology in the St. Louis College of Physicians
and Surgeons, Missouri.

GENTLEMEN,—Cutaneous horn, while not a rare affection, is sufficiently uncommon always to excite more or less interest. As a rule, you will find that it occurs most frequently about the face and the genitals of males. Foulerton has divided these growths into horns which are the result of the overgrowth of a toe-nail, those which are derived from atheromatous cyst-walls, and finally the papillary horns, which take their origin from warts or papillomata, this last category being by far the most frequent in occurrence. The horn of cutaneous origin is always keratodermic in origin and in form, as well as in structure. It is a true hypertrophy of the horny layer of the skin, and its growth seems to be almost indefinite so far as length is concerned, whereas it is always limited so far as the extent of its base is implicated.

In the case which I wish to present we have such a one as is unique, so far as I have been able to find after a careful examination of the literature of affections of the skin. It is one whose appearance does not seem to correspond at all either to the general description or the morphological elements of cutaneous horn. You will observe that the subject is a young man, a little over thirty years of age (Figs. 1 and 2), of mixed Mexican and American descent, who states that he has been affected with his present condition since birth. Upon an examination you will observe the following. Growing perpendicularly from each finger- and thumb-nail there is a horn whose base is the size of that of the nail, and whose length is about four inches. All these horns show a slight curvature towards the dorsum of the hand. They are firmly attached to the nails, and are movable only so far as the attach-



FIG. 2.—Cornu unguale, dorsal view.

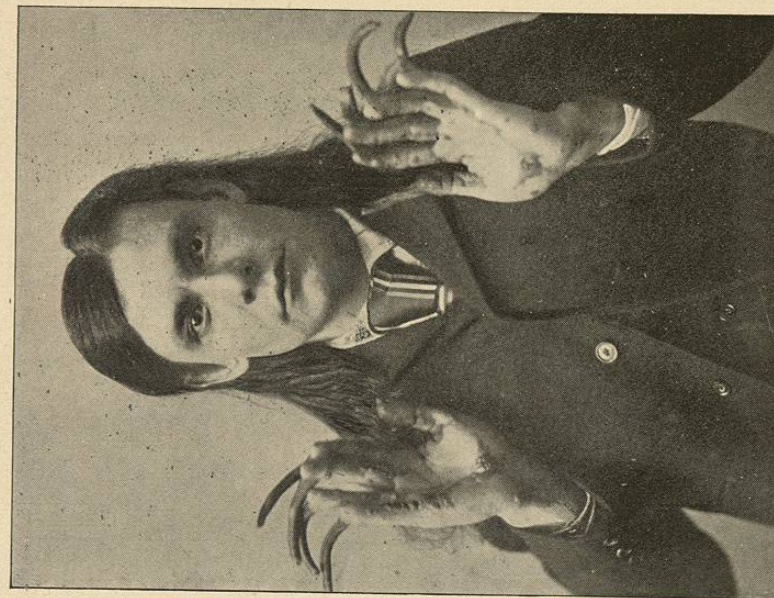


FIG. 1.—Cornu unguale, view of palms.

ments of the nails will permit. There is no marked pain connected with ordinary movement, this being elicited only when the movement is so great as to affect the bed of the nail. The horns are not perfectly round in cross-section, but seem to be more or less ribbed, as we find in the case of cutaneous horns. One of these horns, the one on the second left finger, has been broken off, and the patient states that this was done accidentally, and he felt no particular pain or discomfort except at the time when this accident occurred. Upon examining the palms of the hands you will find that a curious condition exists. We have here a condition which simulates very closely tylosis, yet it is not tylosis, because these horny masses are congenital and not acquired. You will find that in the right hand, near the wrist, in the centre of the palm, there is a large horny mass, more or less fungous in external appearance, attached firmly to the skin, which is freely movable upon the connective tissue beneath. On the ulnar side, a little below this, there is a pea-sized excrescence, while the palmar surfaces of the thumb and little finger are involved by similar horny growths, which occur in a more or less linear shape, all the other fingers being also the seats of small masses of horny tissue. The left hand is similarly affected in the lower portion of the palm near the wrist, while the ulnar edge of the palm has three of these small, horny formations; the thumb and little finger are also involved on the palmar surfaces by linear masses of this same hypertrophy of the horny layer, the other fingers not being so extensively implicated, but still showing well-defined formations, which are circumscribed in character. The condition which you observe upon the hands exists also upon the feet, but as the subject derives his living from an exhibition of this peculiar deformity, and does not show his feet, he pares the horns off his toe-nails. They are continually growing, and grow comparatively rapidly. The soles of the feet are implicated in the same manner as the palms of the hands, particularly in that part of the anterior portion which is a little posterior to the digital clefts in the centre. This causes him a great deal of pain, on account of the pressure occasioned in locomotion and by the constant growth of these horny masses, aided as it is by the stimulation afforded through the pressure occasioned by standing and walking, which makes the tenderness in those localities still more accentuated. The heels suffer equally, and along the external borders of the soles there are numerous small horny masses disseminated in the same manner as that in which we find them upon the hands.

This unique condition is one of rare interest, not only on account of the fact that it is the only one in existence, but also because it seems

not to share one particularly well-known element of all keratodermic growths,—that is, of having occurred as the result of some external irritation. In his case the growth is entirely congenital. He was born with this peculiarity. And the peculiarity further lies in the fact that the hypertrophy of the nail—which this certainly is—is not of the form in which we usually find it. As you are aware, nails when they hypertrophy generally do so in their length; and when they hypertrophy in their thickness there is a certain limit to the amount of growth which takes place. The thickness may be as much as a quarter of an inch, but it stops there, and the nails are then ribbed, or have longitudinal or transverse furrows, or there may be one thick longitudinal rib, such as you frequently see as the result of accident. But in this case the growth seems to have taken place according to the disposition of the laminae of the nails, just as you observe in cutaneous horn occurring upon the skin, where the hypertrophy takes place by horizontal accretions,—that is, in the same direction in which the layers of the horny tissues are disposed. These horns, furthermore, resemble ordinary cutaneous horn in their morphology in this respect, that they are ribbed longitudinally, and the examination of a portion shows that there is horizontal striation as well,—that is, there is a double striation, a condition which is commonly observed in cutaneous horn. The horny hypertrophy occurring on the palms and soles is not due to any friction, nor to any external stimulation or irritation, for the subject has never worked, and has carefully avoided all such means as would irritate his palms and soles, except so far as he could not avoid walking. He has found out one thing, however, and that is that irritation will rapidly increase the growth of the horny tissue in those places where it already exists, and there is a marked tendency in the other portions to the formation of tylotic patches, showing that there is an inherent susceptibility to a proliferation of the elements of the horny layer of the skin.

This deformity does not particularly incommode the subject in the ordinary duties and functions to which his hands are supposed to respond. He can pick up pins and needles; he rolls his own cigarettes; he puts his hand in his pocket and takes out whatever articles he may wish to have; and in general it is only through some unforeseen accident that any injury is likely to happen to him, and the attachment of the bases of these horns to the distal phalanges of the fingers is so firm that, as you see, one of the horns was broken off before the nail was torn away from its bed. A close examination fails to show any indication of a nail as we generally understand it. We can

see that the lower surface is attached in a normal manner to its bed, but there is no border of a free nature such as we observe in the normal nail. It seems rather to be round or oval in shape, and the growth is upward instead of being in the direction of the distal extremity of the fingers. So far as can be judged, these horns are very light. While the tissue is hard and resisting, there does not seem to be any marked density occurring in connection with it. A prominent feature in which it differs from ordinary horny growths is the fact that we do not have that little raised border around the growth which we usually observe in cutaneous horn. If there be any particular form to be observed, it is that the external surface arising from the nail is rather curved, with a tendency to be conical for a certain distance, while the entire growth itself is somewhat smaller at its distal than at its proximal extremity.

There is no irritative process to be observed about the bases of these growths, such as we are accustomed to see in any considerable cutaneous horn, and the conclusion to be derived from this is that there is no tendency for it to assume an epitheliomatous process, which, as you know, is the normal termination of cutaneous horn. It may be argued that the patient is yet too young for any malignant process to set in; but, on the other hand, the length of time—over thirty years—during which these growths have existed would certainly have some influence in producing, if not a malignant process, at least an ulcerative and destructive one, were there any tendency for such a condition to arise. Even in the horny growths of the soles of the feet and upon the nails of the toes, although there is subjective friction and irritation, and all those causes which would naturally predispose to ulceration, we find that there is merely pain, and that there is no evidence of any irritation of an inflammatory nature; in fact, it is a question in my mind whether a great deal of this pain is not purely neurotic in character, for the distribution of the hypertrophy of the palms and soles is very suggestive of a neurotic element for its origin, and we know that there are cases of horny growths of papillomata of a warty nature in which a distinct neurotic element can be traced as an etiological factor. In addition to this, it has been observed that the prolonged administration of arsenic is sometimes the cause of horny growths in the hands. Tylosis of the hands due to the prolonged administration of arsenic is not a rare occurrence, any more than are the objective symptoms of herpes zoster and other herpetic affections, and, as we know, the prolonged administration of arsenic has an influence upon the nerves, particularly those which are concerned in tropho-

neurotic changes acting upon the cutaneous surface, and especially upon the horny layer of the epidermis.

The tendency of these growths, as manifested in the present instance, is to grow indefinitely, and after a certain time a condition will be observed such as we see in this case,—viz., a change in the direction of growth, this direction being in a spiral, and then continuing in this manner for an indefinite period of time. I have had occasion to see this same condition occur in a mule. There was an hypertrophy of the hoofs, which, as you know, correspond to the human nails, and this hypertrophy had been permitted to go on. It was of such an extent that the hoofs grew to the length of seven or eight feet, the general form being that of a spiral, after having grown in a straight direction for probably eight or nine inches. This is the only other analogous condition which I have ever had occasion to observe. The present condition will continue indefinitely, as I have stated, unless the growth be cut, and thus limited in extent.

So far as treatment is concerned, there is but one thing to do, and that is to prevent any further growth. The patient is averse to having this done, from the fact that he makes his living by exhibiting his deformity. But in case such a step should be necessary or desirable, it will be well to bear in mind that the mere cutting of the growths will not accomplish the purpose. It is absolutely necessary to destroy all those elements which participate in the proliferation of the horny cells which go to produce the growth, and in order to do this it is absolutely necessary to take the nail and separate it from its bed, seeing also that no particle is left in contact with the matrix; and, further, to use the electro-cautery and destroy the entire nail-bed and matrix thoroughly. If but one small particle be left remaining, it will form the focus for a new development and the starting-point of a new growth.

So far as the tylosis of the horny formation which occurs upon the palms and soles is concerned, this may be relieved by removing the greater portion by means of the knife, followed by the energetic use of keratolytic agents. But this will not be sufficient. The tendency of this hypertrophy and horny layer to remain must also be overcome, and, as it seems to be of neural origin in this case, probably the best method would be the use of general nerve tonics, such as are especially directed to the sympathetic system, and to the tropho-neurotic elements of that system. In that way, by bringing about a better condition of the nerves, and giving greater tone to the so-called trophic nerves, the proneness to trophic disturbance which is manifested in this case by this peculiar horny growth will be par-

tially, if not entirely, overcome, and ordinary irritation, such as is encountered in the daily vocations of life, will produce no more than the common callus which nature throws around as a protective against these irritating influences.

So far as a prognosis is concerned, there need be very little fear entertained as to the ultimate results in this case. As I have stated already, the horns may continue growing indefinitely, unless they are prevented from doing so by being cut off. The horny growths in the palms and soles would seem, from present indications, to have a tendency to take on the following form: the first, middle, and ring fingers will very probably be affected in the same manner as the thumb and little finger,—that is, there will be a linear distribution of the horny masses, and this may not be limited to the fingers, but may also encroach upon the palm, and it would not be surprising to see the entire palms and the entire soles affected by this growth unless there be some means taken to prevent it. I have already indicated the method which should be employed. If it were necessary for the individual to engage in manual labor, he would suffer in proportion to the amount of horny growth present, just as he now suffers rather acutely from the disseminated growth which occurs upon the soles. However, even under such circumstances, even with the involvement of the entire palms and soles, the trouble would be amenable to rational treatment, for it must not be forgotten that this growth involves only the horny layer of the epidermis, and, although there may be some slight implication of the cutaneous layer of the true skin, it is only a compensatory hyperplasia for the better protection of the layers underlying the hypertrophy which is present. As it is now, a peculiar feature is present in the case. The pulps of the fingers are not affected. There is normal sensation present in them, as well as sensibility, and the touch is rather delicate, as is shown by the fact that the individual can pick up the finest needle, can thread a needle, and can seize very small particles of various materials placed upon a surface limited in extent. He can distinguish between smoothness and roughness. In fact, he is quite dexterous, in spite of the deformity which exists. Sensibility of the nail-bed is not so great as we observe it normally, and this is probably due to the fact that it has been subject to more or less irritation.

One other point to which I wish to direct particular attention in connection with the appearance of these horns is this: the nail-fold, as you will observe, is somewhat dimly marked, and it has grown over the surface of the horn for a considerable distance, a condition which

is not uncommon in those who do not take proper care of their nails. You will find that there is a tendency in a great many to the formation of pterygium of the nails, as it is called. The nail-fold becomes firmly attached to that portion of the nail which overlies the lunula, and is gradually dragged along by the nail itself during its slow growth. But there is a limit even to this. You will find that after a certain length has been attained the pterygium does not become any greater. Even in this case, where there is so enormous an hypertrophy of the nail-tissue, the nail-fold is comparatively small in proportion to the amount of surface involved. The fact of finding this fold is a very important one in the recognition of the trouble, for it is proof positive that the affection is hypertrophy of the nail, as one of the most marked morphological characteristics of the nail still remains, and upon examination it will be found that, although there is also an extension of membrane from the palmar surface, by feeling carefully the free border of the nail can be indistinctly made out,—another proof of the fact that there exists an hypertrophy of the nail, occurring in an aberrant manner, it is true, but still an hypertrophy of the nail. It is for this reason that I have called the disease cornu unguale, or nail-horn, because it is a true horn springing from the nail, due to hypertrophy of the nail, and composed of the same morphological elements as the nail, and not having its origin, as ordinary cutaneous horn has, in papilloma, or wart.

INDEX TO VOLUME IV. (SECOND SERIES.)

A.

- Abbe, Robert, M.D., 208.
Acetanilide in treatment of croupous pneumonia, 90.
Acetate of potassium in treatment of cystitis coexisting with hypertrophy of the prostate, 271.
Aene, 366.
 history of case, 366.
 treatment, 366.
Aconite in treatment of follicular tonsillitis, 359.
Acupuncture in treatment of rheumatism, 76.
Acute croupous pneumonia, 87.
 history of cases, 87.
 diagnosis, 89.
 etiology, 89.
 prognosis, 89, 90.
 treatment, 90.
Acute pleurisy, 12.
Acute purulent conjunctivitis and ophthalmia neonatorum, 341.
After-treatment of laparotomies, 326.
Alcohol, zincated, in treatment of chancre, 282.
Aloin, belladonna, and strychnine pill in treatment of paralysis agitans, 135.
Alopecia areata, 364.
 history of case, 364.
 differential diagnosis, 364.
 prognosis, 364.
 treatment, 364.
Amaurosis uræmica, 340.
Ammoniated mercury in treatment of psoriasis, 367.
Ammonium salts in treatment of nasal catarrh, 346.
Amyl nitrite in treatment of angina pectoris, 44.
Anders, J. M., M.D., 61.
Angina pectoris, 26.
 definition, 26.
 causation, 27, 43.
 appearance of, in early morning hours, why, 30.
 treatment, 44.
 drug, 44-47.
 preventive, 46.
Anginoid attacks due to subacute inflammation of the aorta, 92.
 history of case, 93.

- Anginoid attacks due to subacute inflammation of the aorta, differential diagnosis, 94.
 etiology, 95.
 prognosis, 95.
 treatment, 95.
 hygienic, 95.
 medicinal, 96.
Antifebrin in treatment of angina pectoris, 47.
 of sciatica, 85.
Antipyrin in treatment of acute croupous pneumonia, 90.
 of angina pectoris, 47.
 of chancre, 283.
 of epilepsy, 92.
 history of case, 92.
 of sciatica, 85.
Aortic lesions as a cause of angina pectoris, 30.
 history of cases, 31.
Aortic regurgitation as a cause of angina pectoris, 27.
Appendicitis, 256.
 history of cases, 256, 257.
 treatment, 257.
Appendicitis; operation; recovery, 196.
Aristol in treatment of chancre, 283.
Arsenic in treatment of angina pectoris, 47.
 of fatty degeneration of the heart, 63.
 of psoriasis, 367.
 of tumor of spleen, 212.
Arsenical poisoning as a cause of polyneuritis, 99.
Ashurst, John, Jr., M.D., 176.
Ashton, William Easterly, M.D., 310.
Atelectasis pulmonum or allied conditions, consequences of, and the diagnostic difficulties they cause when complicating other diseases, 18.
 history of cases, 19-23.
Atkinson, I. E., M.D., 79.
Atropine in treatment of angina pectoris, 47.

B.

- Bacterial origin of rheumatism, 75.
Balzer, Doctor, 281.
Belladonna in treatment of follicular tonsillitis, 357.