

KELOID.

Synonym: Alibert's Keloid.

Definition. Keloid is a firm, elastic, connective tissue growth of the corium, resembling a scar.

Description. The surface of the growth is white or whitish-pink, darker in the negro. It is situated in the skin and is traversed by dilated blood vessels, or projects above it and tends to assume a rounded form with irregular, lateral projections which bear a fancied resemblance to a crab's claw.

The growth originates from a scar but may occasionally appear spontaneously. The lesion is usually single but may be multiple, especially when following scars resulting from small-pox. The growth is not coterminous with the scar but extends beyond it.

The growth occurs on the sternum in fifty per cent. of the cases though



Fig. 62.—Impetigo Contagiosa.

it may be seen in any region of the body and is especially common on the face and neck of negroes from razor cuts, or on the lobe of the ear as a result of boring for ear rings.

Keloid is usually painless but is occasionally sensitive and may be the seat of burning and itching. It is rare before puberty. The growth develops in a few weeks and remains stationary or continues to grow until it may attain great dimensions. In young subjects it sometimes undergoes spontaneous involution.

Etiology. The immediate cause of keloid is unknown. It is much more common in negroes than in white people and in the great majority of cases originates from a scar.

Diagnosis. Keloid is distinguished from hypertrophied scar by its tendency to spread beyond the limits of the causative cicatrix, and the peculiar claw-like arrangement of its lateral processes.

Treatment. Removal of the growth is sure to be followed by recurrence. Pressure with an elastic band, deep scarification, excision, among

the mechanical measures, have at times yielded good results. Electrolysis, using the negative pole with four or five milliampères of current, may, when several times repeated, succeed in removing small growths.

Mercurial ointment continuously applied with a view to promoting absorption may be given a trial.

The injection of a twenty per cent. solution of creosote in olive oil, or of thiosinamin, ten to twenty drops of a ten per cent. alcoholic solution, or in solution in glycerine and water equal parts, are also recommended.

As a rule the growths successfully resist all efforts at permanent re-



Fig. 63.—Impetigo Contagiosa (Unna).

moval. Several cases of disappearance of the keloidal tumors have been reported with the use of the x-rays.

KERATOSIS FOLLICULARIS.

Synonyms: Ichthyosis Sebacea Cornea; Psorospermosis; Darier's Disease.

Definition and Description. Keratosis follicularis is a rare, chronic disease of the skin presenting as a primary lesion, pin-head to pea-sized papules projecting above the skin, capped with small, yellowish, gray or brownish, hard, dry, adherent crusts which, when detached, show upon the under surface horny plugs or projections which fit into the pilo-sebaceous openings; the edges of the latter being everted and firmer than normal. The crust, armed with the projecting point, has been compared in appear-

ance to a carpet tack. The crust, easily removed by squeezing between the fingers, is rapidly reformed.

The lesions are at first discrete but as the disease progresses become confluent and certain portions of the body, as the face, scalp, sternal and lumbar regions become covered with a continuous crusted sheet. The anterior aspects of the extremities are frequently involved and the palms and soles show fine dots like pin pricks. On opposing skin surfaces, such as the intergluteal region, by confluence and compression of the lesions, vegetating papillomatous masses are formed which frequently present a



Fig. 64.—Impetigo Simplex (Bockhart) (Unna).

central pit and discharge a foul, puriform material. On the back and face, when unoccupied by the eruption, large comedones with redness and oiliness of the skin are observed.

Keratosis follicularis runs a slow, progressive course and does not materially compromise the general health. It is exceedingly rare and seems to show a preference for men rather than women.

Etiology. Darier believed the disease to be due to protozoa bodies called psorosperms, but this view has been abandoned as these coccidia-like bodies are now known to be transformed cells. The exact cause of the disease is unascertained.

Pathology. The disease is a keratosis of the epithelial layers of the sebaceous gland ducts and hair follicles. The changes occur chiefly in the epidermis, the corium being but little altered.

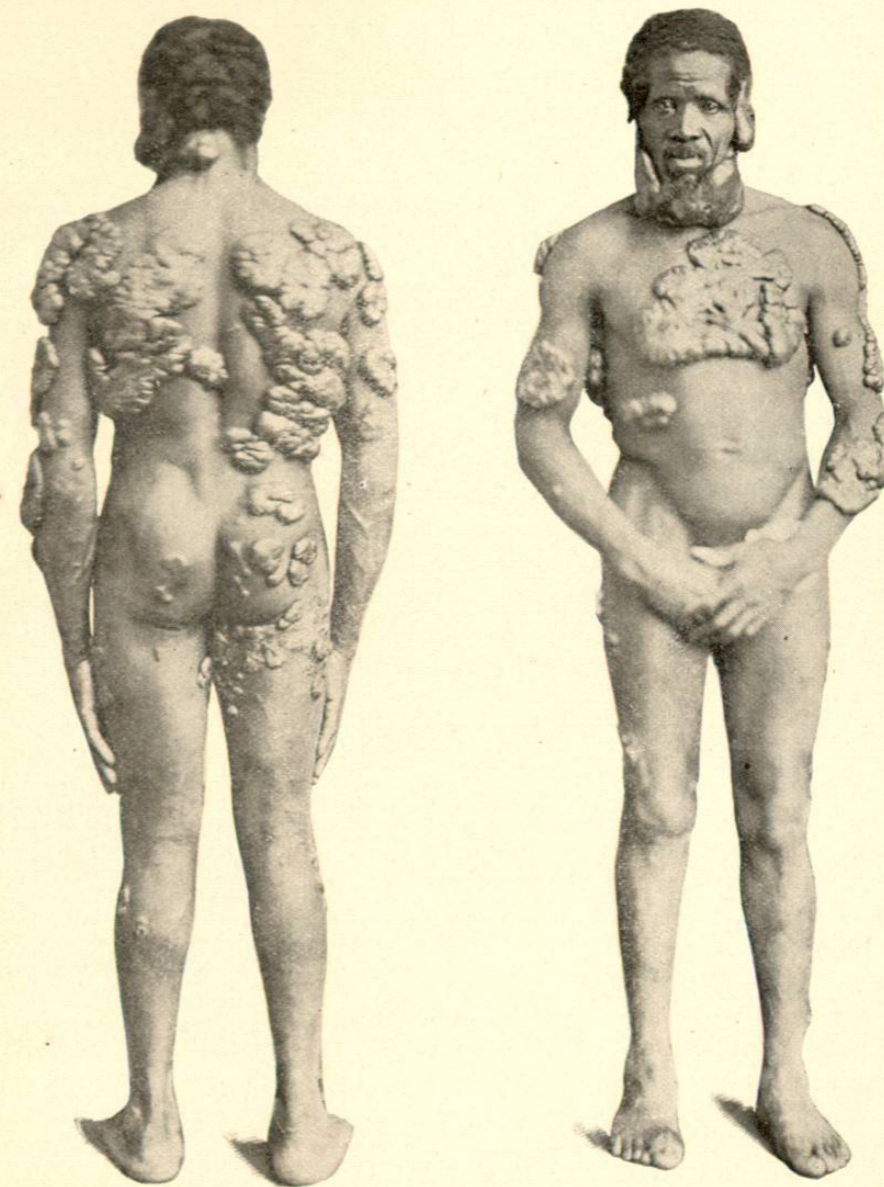


Fig. 65.—Keloid.

Diagnosis. In established cases the diagnosis is based upon the presence of horny plugs and the papillomatous masses in the groin and between the nates.

Treatment. Treatment does not yield satisfactory results. Vigorous friction with green soap, followed by salicylic acid powder has been recommended.

Schwimmer advises destruction of the lesions with the thermo-cautery. Grindon believes that residence in a cold climate favorably affects the disease.

Zinc chloride solutions may be used on the horny, confluent masses.

KERATOSIS NIGRICANS.

Synonym: Acanthosis Nigricans.

Definition and Description. This is a very rare disease, only about thirty cases having been reported. The lesions consist of patches of pigment, yellowish, brown or nearly black, appearing more or less abruptly upon the face, neck, axillæ, groins, abdomen, thighs and genital organs or upper extremities, including the back of the hands. The buccal mucosa and tongue may also be affected. The implicated skin is thickened, its lines deepened and in some parts is covered with fine, papillary, wart-like, proliferating outgrowths, being especially marked in the axillary, umbilical and inguinal regions. Most of the cases reported have been associated with cancer of the internal organs.

Diagnosis. Keratosis nigricans is diagnosed by papillomatosis on opposing skin surfaces, and keratosis with diffuse and discrete warts.

Treatment. In the absence of specific indications treatment is without effect.

KERATOSIS PILARIS.

Synonyms: Lichen Pilaris, Pityriasis Pilaris.

Definition and Description. Keratosis pilaris is a chronic, hypertrophic affection characterized by pin-head sized, rounded or conical, epidermal accumulations about a hair follicle. The usual seat of the disease is the extensor surface of the extremities.

The lesions consist of pin-head sized, closely aggregated, dirty-white, horny papules or elevations occupying the site of the hair follicle. These papules may be picked off with the finger nail, producing a minute, punctate hemorrhage. The hair pierces the papule or lies twisted beneath the horny sheath, or is broken off and shows as a central black point. The skin is harsh and rasp-like to the feel. There are no subjective symptoms. The disease is chronic and is worse in winter.

Keratosis pilaris is a common affection, occurs after puberty and chiefly among those who are not cleanly in their habits. There is, however, a disposition to the affection in certain individuals, and in such instances it is not due to neglect of bathing.

There is an affection closely resembling keratosis pilaris but which

exhibits spiny, epidermal pegs, easily removable, projecting from minute red papules which develop acutely in patches. This has received the name of *lichen spinulosus*.

Diagnosis. Keratosis pilaris is easily identified. Cutis anserina ("goose skin") is temporary; the miliary papular syphilide is reddish, grouped, solid, more or less generalized and coexists with other signs of syphilis. The papule of lichen scrofulosorum is larger and occurs on the abdomen.

Treatment. The affection is readily cured. Scrubbing with green soap and water is usually sufficient, with persistence, to effect a cure. A mild salicylic ointment or a lotion of salicylic acid, borax and glycerine will also serve the same purpose. Surface friction, with cold baths and massage, are commended.

LENTIGO.

Synonyms: Freckles; Ephelis.

Definition and Description. Lentigo is a small, circumscribed patch of pigment occurring chiefly upon the exposed parts of the body. The patches appear as pin-head to pea-sized, round or irregular, yellowish, light or dark, deposits of pigment usually situated upon the face, especially the cheeks, and the back of the hands. They make their appearance first in early childhood, are particularly common among blond and red-haired people and are more conspicuous in summer. They may disappear when the age of maturity is reached or continue through life, especially in red-haired individuals.

Freckles may be sparse or very numerous, covering the entire face and be more or less abundantly distributed over the general surface, including the extremities and genital organs. Mulattoes are frequently densely freckled, the pigment being very dark and persistent.

Etiology. Lentigo is probably due to changes effected in the skin by the chemical rays of the sun light, but as this does not explain their appearance upon the covered parts of the body it is likely that there are other causes as yet unknown.

Freckles, pathologically, consist in a localized increase of the normal pigment in the rete mucosum.

Diagnosis. Lentiginous pigmentation is symptomatic in xeroderma pigmentosum and senile atrophy of the skin, and may be the forerunner of pigmentary moles. Ordinarily freckles present no difficulty in diagnosis.

Treatment. Freckles are easily removed with discutients but are prone to recur. Lemon juice, a solution of bichloride of mercury, ten grains to the ounce of alcohol, resorcin, two drams to the ounce of alcohol, are all competent to remove the blemish. Acetic acid and sulphur made into a

paste, pure carbolic acid, saturated solution of salicylic acid in alcohol, are also recommended.

Bulkley advises the following:

℞		
	Hydrarg. Bichlorid.,	gr. v.
	Acid. Acetic. Dil.,	ʒij.
	Boracis,	gr. xl.
	Aquæ Rosæ,	ʒiv.

M. Sig. Apply night and morning, at first lightly, later vigorously.

Small freckles may be removed by electrolysis. A current of one or two milliamperes is used and the needle connected with the negative pole is introduced parallel with the skin and immediately beneath the pigmented area.

The following ointment is suggested by Hardaway:

℞		
	Hydrarg. Ammoniat.,	
	Bismuth. Subnit.,	āā ʒj.
	Ung. Aquæ Rosæ ad,	ʒj.
	M. Ft. Ung. Sig. Apply locally.	

LEPRA.

Synonyms: Leprosy; Elephantiasis Græcorum.

Definition. Leprosy is an endemic, chronic, infectious disease caused by a specific micro-organism, the *bacillus lepræ*, showing a predilection for the cutaneous and nervous systems and inducing morbid alterations in accordance with the structures concerned and, as a rule, terminating fatally.

Geographical Distribution. Leprosy is widely distributed, though in all likelihood less so in modern times than anciently. It is prevalent in different parts of Asia, Africa, Japan, Oceanica, and to some extent in South America and the West Indies, and exhibits isolated colonies in Norway, along the Baltic littoral, and in North America.

Etiology. Leprosy is due to the *bacillus lepræ*, the invasion of which is favored by climate, defective hygiene, unwholesome food and the concomitants of filth. The *bacillus lepræ* may be isolated from the leprosy lesions and resembles very closely the tubercle bacillus, but with differences sufficiently marked to establish its identity.

The mode of transmission of leprosy is still *sub-judice*. It is by some observers regarded as contagious through inoculation with pus or inhalation of the *lepra bacilli*; by others as hereditary. Inoculation experiments have not been convincing.

Period of Incubation. The period of incubation of leprosy has not been determined. It varies within wide limits and has been placed at from three to thirty years.

Prodromal Symptoms. There are certain prodromal symptoms marking the period of invasion and preceding the eruption by several weeks or as much as a year. The prodromata may be severe, mild or entirely lacking. When typical they consist of malaise, chilliness, fever of an intermittent or remittent type with sweating, weakness and prostration, deep-seated pains and nervous disturbances.

Varieties. Three clinical forms of leprosy are described, the *tubercular*, the *anæsthetic* and the *mixed*, the last named being a blending of the two preceding. These types do not represent entities but conspicuous clinical variations.

Tubercular Leprosy. Accompanied by more or less febrile movement, erythematous patches from the size of a pea to several inches in diameter appear symmetrically upon the face, extremities, less frequently the trunk. The patches are at first red, raised, slightly hyperæsthetic, later they become darker in color and less sensitive. The crop of patches disappears and is followed by others which in turn fade or remain as pigmented macules presenting a certain amount of thickening. Nodules or raised, infiltrated masses then begin to form from the areas of pigmented, thickened skin or independently of them. The nodules or tubercles are from the size of a pea to that of a hen's egg. They may be grouped, discrete or coalescent. The skin covering them is coarse and oily, pink in color, turning darker with the age of the lesion. When the nodules occur on the face the natural lines are deepened, the skin is puffed, glistening, furrowed and corrugated, giving a leonine expression to the countenance (*leontiasis*). The eyebrows become thinned and fall out, the nose broadens, the ears, particularly the lobes, are thickened and nodular. Blebs and macules are interspersed among the tubercles and infiltrated areas. The hair of the scalp is usually spared. The nodules after a time become yellowish or dark brown in color and ultimately undergo absorption or ulcerate and become transformed into indurated, keloidal masses. The ulceration which is most frequent about the fingers and toes is superficial or deep, involving the tissues to the bone. It may heal under treatment or pass into a condition of phagedena. The mucous membrane of the mouth, throat and nose is frequently implicated; the eye is involved in lepromatous infiltration and may be completely disorganized.

Constitutional symptoms are irregular fever, disordered digestion, cough and general flagging of the forces.

The duration of life in the tubercular form of leprosy is four to twelve years, the subjects dying from tuberculosis, exhaustion, renal or intestinal complications.

Anæsthetic Leprosy. In this form of leprosy the nervous system bears the heaviest strain. Prodromal symptoms are variable and consist in malaise, a sense of chilliness, hyperæsthesia of the skin, lancinating pain along the course of the nerves, especially the ulnar and peroneal, itching, numbness, localized loss of sensation of pain or touch, one or both. Associated with pain, bullæ develop upon the fingers, the skin becoming shining and glossy. Within a year, pale, yellow macules appear on the back, shoulders, thighs and abdomen. They are few in the beginning, gradually becoming more numerous; they spread peripherally and tend to whiten and

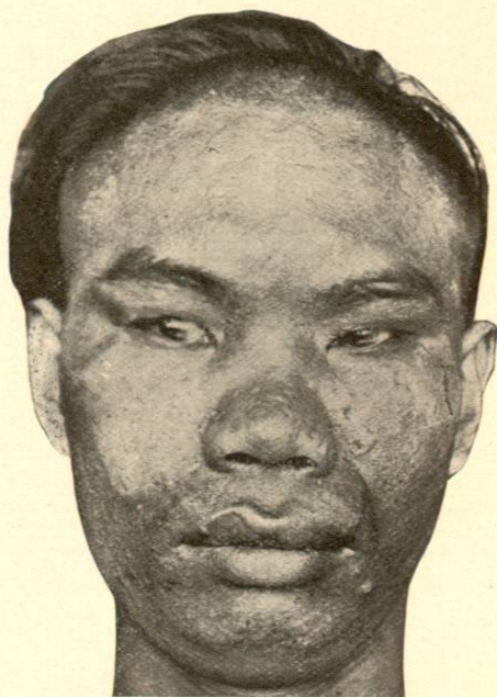


Fig. 66.—Lepra (Ohmann-Dumesnil).

atrophy in the centre, producing a lesion somewhat resembling leucoderma. Anæsthesia is present in the atrophic spots and along the course of the affected nerves. Bullæ are common and may become the seat of deep and destructive ulcers. The affected nerves, particularly the ulnar nerve at the elbow joint, are thickened and corded.

Paralysis often occurs and is followed by muscular atrophy, the muscles of the thenar and hypothenar groups and the interossei being those most often affected. The last two joints of the fingers are flexed, the first straight, the nails like talons giving rise to the claw-hand, or *main-en-griffe*. Ulceration may also occur with loss of members. The bones of the fingers undergo necrosis or absorption, the nail being often spared. This condition is known as *lepra mutilans*. The mucous membranes of the nose and

throat are affected with loss of sensibility. The eyes may be involved, phlyctenules and keratitis with opacity being present. The nails and hair show atrophic changes. Sexual appetite is diminished from testicular atrophy.

The duration of life is usually ten to fifteen years, death occurring as a direct result of the disease from marasmus, long-continued ulceration and gangrene.

Mixed Leprosy. This variety presents a commingling of the symptoms characteristic of both the tubercular and the anæsthetic types.

Diagnosis. When the disease is well developed the diagnosis is easy. The development of patches of anæsthesia on the skin of a person residing or having resided in a country where the disease is prevalent, should arouse a suspicion of leprosy. Tuberculosis, syphilis, ainhum and various skin diseases, as erythema, psoriasis, parasitic affections, vitiligo, keloid, scleroderma, may be temporarily mistaken for leprosy, but the benign course of the skin affections and the characteristic features of the diathetic disorders are sufficient evidences of non-identity with leprosy.

The advanced stage of leprosy resembles syringo-myelia.

The discovery of the bacillus lepræ in the fluid from the bullæ and in the tissue from the lepromata puts the diagnosis beyond doubt.

Pathology. The presence of lepra bacilli leads to the deposit of granulation tissue chiefly in the skin and peripheral nerves, accompanied by a low form of inflammation. The process is of slow course and evolution.

Treatment. Tonics and supportive treatment with attention to the symptom-details are productive of good.

For specific treatment, chaulmoogra oil has been used for a long time. The dose is five minims, to be increased until the limit of tolerance is reached.

Gynocardic acid, derived from chaulmoogra oil, may be given in doses of from one-half to forty-five grains daily.

Hoang-nan, or its derivative, strychnine, has been recommended.

Gurjun oil is highly considered by some and is to be given in the form of an emulsion in doses of half an ounce daily. Both chaulmoogra and gurjun oil may be used locally.

Resorcin, ichthyol and chrysarobin have been employed as local applications.

Crocker secured favorable influence with the hypodermic injection of sozoidolate of mercury, one-fourth grain twice to three times a week.

Carrasquilla's serum, while exerting a beneficial influence in a few cases, is disappointing and the injections are not free from risk.

Ulcers are treated on surgical principles and with as much success as ulcers from other causes.

In deference to the contagious theory of leprosy, segregation is advisable.

LEUCODERMA.

Synonyms: Vitiligo; Piebald Skin.

Definition and Description. Leucoderma is a localized loss of pigment in the skin and is manifested by variously sized and shaped, milk-white patches surrounded by a zone of hyperpigmentation.



Fig. 67.—Leucoderma in Negro (Dr. Ohmann-Dumesnil).

The patches develop between the ages of ten and thirty and are situated chiefly upon the face, genitals and hands. They may be single or multiple. In the latter case there is a tendency to symmetrical distribution. The skin involved is of a fish-belly white, the surrounding integument deeply pigmented, shading off into the normal color. The blanched area is otherwise normal or the seat of a slight anæsthesia or itching.

Leucoderma is more frequent among the dark than the white races. The so-called piebald negro is an instance of excessive and spectacular development of leucoderma.

The affection is slow and progressive and tends to spread by conjunction of neighboring patches or by isolated appearances. Occasionally the whole surface of the skin is more or less involved in the process of depigmentation. As a rule, the patches after a time cease to appear, or to spread, and remain stationary, persisting throughout life. Rarely the pigment is spontaneously restored. The hairs in the affected skin usually, but not always, lose their pigment and become blanched.

Leucoderma is more conspicuous in summer than in winter, owing to the accentuation of the pigmented border from tanning, the white area remaining unchanged. In blonds the loss of pigment is scarcely noticeable during the winter.

Etiology. Leucoderma is regarded as a tropho-neurosis. Mental emotion, depression, the extremes of heat and cold, appear to have an influence as exciting causes.

Diagnosis. Leucoderma is to be distinguished from chloasma by the absence in that affection of pigment loss; from morphea by the bacon-rind texture of the affected patches in the latter disease.

The peculiar milk-white patch, surrounded by a heavily pigmented zone, is so characteristic as to render mistakes in the diagnosis of leucoderma highly improbable.

Treatment. The white patches may be rendered less noticeable by removal of the circumjacent pigment with discentients, such as were described under lentigo and chloasma. Pure carbolic acid is as serviceable for this purpose as any of this numerous class. The white areas may be stained temporarily to approach the normal color of the skin by applications of walnut juice, permanganate of potash or tincture of iodine.

Efforts to induce the deposit of pigment by electric stimulation or irritant applications are usually futile.

Tattooing, if the patches are small and conspicuous, presents possibilities for disguising the blemish.

Prognosis. So far as restoration of the lost pigment is concerned, the outlook is highly unfavorable. Occasionally the pigment spontaneously reappears.

LEUCOPATHIA UNGUIUM.

Synonym: Leuconychia.

Definition and Description. Leucopathia unguium is the term applied to the white spots seen in the nail shaft of young people. They are caused by the entrance of air between the lamellæ, and are formed at the matrix and carried forward by the growth of the nail. Exceptionally the whole nail is involved.

The condition indicates a slight trophic disturbance or is due to mechanical injury from cutting or forcing back of the nail fold at the lunula. Toe-nails are not affected.

Treatment. A discontinuance of the cutting or rough handling of the nail fold will probably prevent the appearance of the blemishes.

LEUCOPLAKIA.

Definition and Description. Leucoplakia is an affection of the mucous membrane of the mouth, tongue, vulva and occasionally of the glans penis. Its usual situation is the dorsum of the tongue and inside of the cheeks.

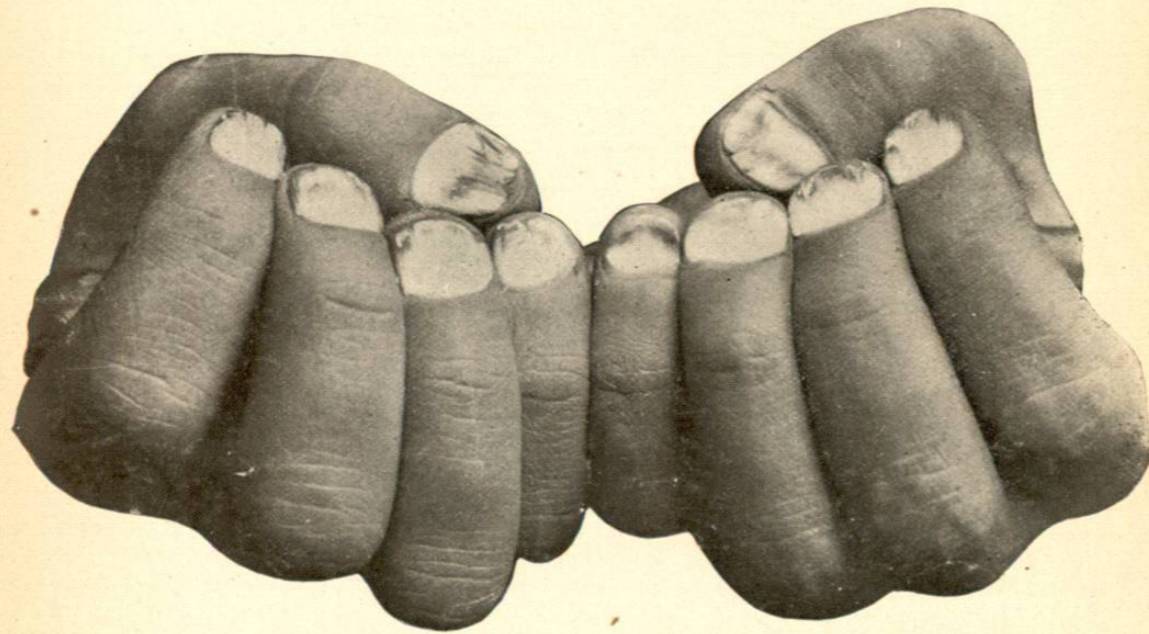


Fig. 68.—Leuconychia (Dr. P. G. Unna).

It consists of irregular, slightly elevated, hard, glistening, white patches. On the tongue they resemble bits of white celluloid let into the tissues. The affection may be limited or of considerable extent; the patches are single or multiple. It is of slow progress, undergoing change very gradually. The surface may become roughened, ulcerated and the lesions have been known to become epitheliomatous.

Subjective symptoms are absent or consist of a sensitiveness to hot and cold substances when taken into the mouth.

Etiology. The cause of leucoplakia is not known. It may result from syphilis, psoriasis or other cutaneous disease attended by increased cornification; excessive smoking; strong alcoholic drinks; acid and highly seasoned food, nervous and gastro-intestinal disorders.

Diagnosis. Leucoplakia may be confused with a mucous patch but the latter lacks the epithelial hardening and the dirty-white pellicle covering it is readily removed.

Treatment. The solid stick of nitrate of silver may be bored into the patches, or a twenty per cent. solution of chromic acid, or the acid nitrate of mercury, may be applied at frequent intervals. Unna advises exfoliating the patch with repeated applications of resorcin paste. The smaller patches may be excised. Antisyphilitic remedies appear to have no effect.

LICHEN PLANUS.

Synonym: Lichen ruber planus.

Definition. Lichen planus is a pruritic, inflammatory affection presenting small, flat, smooth, shining, polygonal papules of a dark-red, yellowish or livid lilac color.

Symptoms. The affection is of slow development and is seen chiefly upon the anterior aspect of the forearms, wrists, inner surface of the knees, back of the neck, less often upon the trunk. The lesions are discrete, occurring in groups or disposed somewhat symmetrically in bands. The papules are of the size of a pin-head or larger, polygonal, the angles being determined by the skin lines, closely aggregated in groups, usually flat and frequently centrally pitted or depressed. The color of the papules, when the skin is stretched, is shining or burnished; later the lesion is capped with a small scale and the color becomes duller, red or brownish. Occasionally the lesions are arranged in rings or strung out in a line resembling a necklace, some of the lesions being nodular or keloidal (*lichen ruber moniliformis*). Sometimes they are vesicular or bullous. The skin of the palms and soles is often the seat of considerable thickening (*tylosis*). With long duration of the disease especially upon the lower extremities, coalescence of the papules occurs and produces heavily pigmented sheets of dense infiltration with a horny, verrucous surface and bordered with fresh, discrete lesions.

Subjective symptoms vary in intensity. As a rule the itching is severe and at times so great as to destroy sleep and impair the general health.

Etiology. Lichen planus is a dermo-neurosis and chiefly affects neuropathic individuals.

Pathology. The horny layer is thickened, the rete cells enlarged and lengthened. Localized cell accumulations separated by a fine, fibrous network are found in the corium, just beneath the epidermis. The papillary vessels are enlarged and tortuous.

Diagnosis. The flat, discrete, angular papules situated upon the front of the wrists and about the knees, of a vivid or lilac color, are so characteristic of lichen planus as to negative confusion in diagnosis.

Treatment. Attention to the general health and regulation of diet and hygiene are demanded. Tonics and alteratives are required as a rule.

In chronic cases arsenic is the chief reliance and must be pushed to the limit of tolerance. Bichloride of mercury, one-twelfth to one-twentieth of a grain, three times daily, is frequently of great service.

Alkaline and vapor baths are useful for the relief of itching. Alkaline diuretics and saline aperients are beneficial.

Locally the appropriate treatment is somewhat similar to that of psoriasis, but the applications are less stimulating. Leistikow recommends the following:

℞
Hydarg. Bichlor., gr. 1-x.
Acid. Carbolic., gr. xx.
Ung. Zinci Benz., ʒiij.
M. Ft. Ung.

Or:

℞
Acid. Carbolic., gtt. xx.
Hydarg. Bichlorid., gr. j-v.
Creosot. min. ij.
Collodii, ʒj.
M. Sig.

Paint on twice a day.

Tarry applications are serviceable, as are also salicylic acid and resorcin pastes for the thickened patches.

Prognosis. The disease, as a general rule, is obstinate and prolonged, but with persistence may be cured.

LICHEN RUBER.

Synonym: Lichen ruber acuminatus.

Definition. Lichen ruber is a rare and serious disease of the skin, characterized by pin-head or split-pea sized, reddish, acuminate papules, with horny centres which tend to become generalized or even universal.

Symptoms. The lesions appear upon the trunk, extremities or genital organs as millet-seed or larger papules which are firm, discrete, bright or dark red, with a waxy, vesicular look on oblique view. The papules are covered with an adherent, white scale. They increase in number rapidly with constant evolution of new papules but without increase in dimension of the individual lesions. Close aggregation produces patches or sheets of dull-red thickened skin, covered with thin, grayish or white scales. In severe cases the entire surface may become involved. The skin becomes pachydermatous, inflexible, deep fissures form about the flexures of the joints or the face, the eyelids are everted, the palms and soles leathery and thickened.

the hair thinned and the nails brittle and distorted. Itching is more or less marked. The patient finally succumbs to malnutrition or intercurrent disease.

Etiology. The cause of lichen ruber is unknown. The disease is rare and has been observed in both sexes between the ages of ten and forty.

Pathology. The pathologic process consists in hypertrophy of the cells of the horny layer with imperfect keratinization. The rete is also hypertrophied and its vascularity increased. The cutaneous muscles are enlarged.

Diagnosis. Lichen ruber is distinguished from eczema, psoriasis, pityriasis rubra pilaris and lichen planus by its firm, acuminate papules capped by horny scales, its preference for the extensor surfaces, more extensive implication of the skin and grave constitutional accompaniments.

Treatment. Tonics, alteratives, such as arsenic, pushed to the physiological limit, and abundant nutrition are indicated in the constitutional treatment.

Local treatment consists of mildly stimulating antipruritic ointments; massage; oily inunctions; alkaline, starch and bran baths.

LICHEN SCROFULOSORUM.

Definition. Lichen scrofulosorum is a chronic disease of the skin characterized by miliary, red, yellowish or livid papules, grouped or arranged in circles and occurring chiefly in scrofulous subjects, especially children. It is classed among the tuberculides.

Symptoms. The lesions are seen principally upon the lateral aspects of the trunk and back of the neck, rarely upon the extremities, and consist of small, slightly conical, red papules arranged in groups or circles. With age the papules become capped with scales and the color fades to a light fawn, and on disappearing leaves yellowish spots. The groups may cover large areas and lend a "goose-skin" appearance to the surface. The affection runs a slow course with intermittent augmentation of fresh papules. Other evidences of scrofula are usually present and the disease is not infrequently associated with acne. Subjective symptoms are absent.

Etiology. Childhood and the strumous diathesis are the predisposing factors.

Diagnosis. The diagnosis is established by the characteristic, indolent, red papules arranged in circles or groups on the trunk of scrofulous children.

Treatment. Cod liver oil internally and externally always cures the eruption. Externally owing to its disagreeable features, cod liver oil may be replaced by a weak oil of cade or thymol ointment, which proves equally as effective.

LUPUS ERYTHEMATOSUS.

Definition. Lupus erythematosus is a cutaneous cell infiltration producing circumscribed, variously shaped and sized, red, irregularly scaly,

slightly elevated patches which spread peripherally and show a tendency to central atrophic scarring.

Varieties. Four varieties of lupus erythematosus are recognized clinically (Crockier). They are the *circumscribed* or *discoïd*; the *disseminated*; the *telangiectasic*; and the *nodular*.

The *circumscribed* or *discoïd* variety affects chiefly the head, face, nose, ears, fingers and toes. In the "flush zone" of the face red spots first appear which spread slowly and tend to assume the form of a butterfly or a bat with outstretched wings, the nose representing the body, and the adjoining surface of the cheeks, the wings. The patches are bordered with a tracery of



Fig. 69.—Lupus Erythematosus (Ohmann-Dumesnil).

dilated capillaries and are raised at the edges, yellowish or reddish, irregularly covered with adherent, greasy scales and studded with comedones. They spread by the borders and leave smooth, soft, white, cicatricial areas. If the scalp be involved atrophic baldness follows and the scales removed show on their under surface tags which enter follicular openings. Recurrences may take place in the scars. Ulceration is rare. On the fingers and toes the disease occurs upon both the dorsal and the plantar surfaces and may simulate chilblains (*lupus pernio*).

The *disseminated* form is less common. Its patches are more numerous and of the erythematous rather than the seborrhœic type. The patches begin on the face and spread from thence to the body; new patches arise, so that often large surfaces are involved. Acute exacerbations are frequent

and attended with constitutional symptoms which may be of a grave or even fatal character. The lesions are frequently crusted and eezematoid in appearance but the removal of the crusts will reveal patulous follicular openings in the skin beneath, which is one of the hallmarks of the disease.

Vascular or *telangiectasic* variety. This form manifests itself upon one or both cheeks in persistent, non-desquamating, red or yellowish, circumscribed patches, with marked dilation of the capillaries and thickening. It is of very slow growth and is sometimes found associated with lupus erythematosus elsewhere.

The *nodular* type is very rare and presents scattered, round or oval, brownish-red, raised nodules upon the face and forehead, varying in size from a pinhead to a bean. When closely assembled, they coalesce and form small, erythematous patches with a raised edge and show central atrophic changes.

Lupus erythematosus affects, but not exclusively, the portions of the body where the sebaceous glands are most abundant. It may also occur upon the mucous membranes. It is not common. Its course is leisurely and intermittent, lasting from ten to twenty years.

Etiology. The disease is twice as frequent in women as in men. It is more frequently observed in cold countries and seldom begins before adult age, between twenty-five and forty-five. Seborrhœic individuals and those with a tubercular family history are predisposed. It may originate from erysipelas, scarlet fever, or from some external agent, such as heat or cold, which produces a superficial dermatitis. The etiological relation of lupus erythematosus to tuberculosis is a matter of dispute. It is maintained by some writers that the disease is due to the toxins of the tubercle bacillus.

Pathology. There is an inflammation of the skin with small, round cell infiltration which undergoes fatty degeneration and produces tissue atrophy. The sebaceous glands are first hypertrophied, finally atrophy and disappear.

Tubercle bacilli have not been found in the tissues.

Diagnosis. Lupus erythematosus is to be distinguished from lupus vulgaris which develops in childhood, shows deep-seated, discrete papules or nodules, with ulceration and destruction of tissue; from rosacea which displays ill-defined patches with pustules, papules and telangiectases, with hypertrophy of the tissue rather than atrophy. Circinate syphilides may resemble lupus erythematosus but are more rapid in evolution and show a firmer infiltration which does not pale on pressure.

Treatment. Internally arsenic, iodide of starch, iodide of potassium, and phosphorus are all relied upon by some authors. Quinine in doses of five to eight grains three times a day is recommended. Salicin and ichthyol have been given with benefit. Disturbances in the general health require correction.