Sensation is unaltered, as a rule, but there may be an increase or a diminution of pain and tactile sensibility. Itching is sometimes present.

Patches of erythema with scattered pigmentation and telangiectases are frequently noted and the borders of the patches may exhibit a lilac line. The mucous membranes of the mouth and vagina are sometimes implicated.

The *atrophic* form is preceded by a stage of œdema and infiltration. The skin becomes dry, hard, pigmented and parchment-like. When the disease is well-established the joints are held in a condition of anchylosis

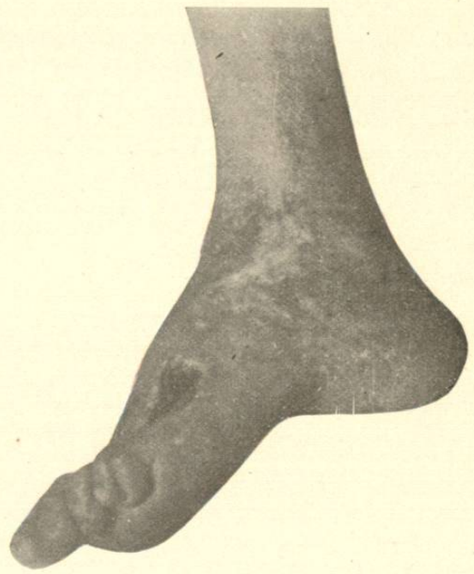

Fig. 92.—Scleroderma with Trophic Ulcer.

and the subcutaneous tissues undergo atrophy and absorption and the limb, or limbs, affected become reduced to skin and bone. The face is drawn, mask-like and expressionless. The lips are drawn away from the teeth, the eyelids everted and the conjunctivæ inflamed. Trophic ulcers form which are often painful and difficult to heal. The hand, if involved, shows the condition known as *sclerodactylia*, the fingers being stiff and distorted.

In both varieties, the general health may remain unaffected for a long time.

Etiology. Both forms of scleroderma are seen chiefly in young and middle-aged women. It is probably due to a vaso-motor defect. The neurotic temperament, depressive influences, gout, rheumatism, malaria, are considered as predisposing factors to the disease. The thyroid gland and the pituitary body have been regarded as possible seats of causation.

Pathology. The pathological findings show a local obstruction to the blood supply by pressure from new tissue, or thickening of the vessel walls, narrowing its calibre.

Diagnosis. The hard, bacon-rind appearing, adherent skin with pigmentation and telangiectases, constitute a plain index of the identity of the disease.

Treatment. Tonics and alteratives may be given with benefit to the general health. Pilocarpin has been recommended to increase the sweat secretion. Thyroid gland extract has proven serviceable in some cases and the iodide of potash is worthy of a trial. Thiosimamin in doses of ten to twenty minims of a fifteen per cent. alcoholic solution, given by deep hypodermic injection, has been recommended.

The local treatment consists in massage and friction of the hardened patches, with oil and the application of mildly-stimulating ointments, such as one per cent. salicylic acid. If the sclerodermatous areas are sensitive an ointment of menthol or thymol may be used.

Electrolysis has been recommended for use in small, localized patches in the same manner as in the treatment of nævus. It may be followed by the application of mercurial plaster.

Prognosis. Recovery usually follows in the infiltrated variety though it may exist for years. In the atrophic form recovery may also take place with permanent deformity and crippling.

The general tendency is toward increasing disability, the formation of ulcers, and death.

SEBORRHŒA.

Under the titles of alopecia and eczema seborrhœicum have been described conditions with which seborrhœa might be included, but in deference to the fact that these conditions are too imperfectly understood to admit of dogmatic statements, seborrhœa is permitted to remain in its older and established sense.

Definition. Seborrhœa (*sebum*, suet, *rheo*, I flow) means an excessive secretion of the sebaceous glands.

Two varieties are described, *seborrhœa oleosa*, and *seborrhœa sicca*, or the oily and greasy, and the dry, forms.

Seborrhœa Oleosa. This variety is observed chiefly on the skin of the face, especially the forehead and nose, and may be limited to these localities. The skin is greasy, shining, unctuous to the touch, and on close inspection usually shows dilated sebaceous gland orifices and, not infrequently, particularly upon the nose, droplets of oil standing out from the patulous openings. The face has a dingy, unwashed appearance from the admixture of dust and dirt which readily clings to the oily surface. Formed and unformed comedones, together with acne lesions, are frequent concomitants of oily seborrhœa.

The condition generally begins on the scalp, the hair becoming lank, damp-looking and sometimes emitting a butyric acid odor. The affection proceeds downward, involving the face, sternal regions, back and genital region, and may occur, in fact, wherever the sebaceous glands are numerous.

The amount of seborrhœa varies; it may be slight in degree or very copious. This condition is termed by Unna *hyperidrosis oleosa*, for a part at least, of the secretion is from the coil glands.

Seborrhœa Sicca. This form of seborrhœa is more common than the foregoing and presents greasy scaliness of the skin of a varying degree and in the same regions affected by oily seborrhœa. The scales accumulate in grayish or yellowish masses and are situated upon a slightly hyperæmic base. The superposition of the yellowish scales upon the subjacent hyperæmic tissue gives a salmon tint to the affected skin.

Seborrhœa sicca of the scalp constitutes a form of dandruff (*pityriasis capitis*). The scales are moderate in quantity or very abundant, involving the entire scalp or certain portions, and may be arranged in a ring form. They are greasy and heavy, or thin, dry and papery, and, being easily detached, fall in a shower on the coat collar and shoulders. The two forms of seborrhœa are commonly combined on the scalp.

There is a variable amount of itching present. The hair loses its vitality, becomes dry and lustreless, and falls out. From the scalp the process spreads downward, and the eyebrows, beard, mustache, ears, and hairy sternal region may be involved and present greasy, yellowish scales (*seborrhœa corporis, eczema seborrhœicum*). In infants are found about the vertex, large, yellowish, scaly plates, which are not the remains of the *vernix caseosa* as they re-form when removed.

Etiology. Anæmia, debility, gastro-intestinal disorders and individual peculiarities of the skin are regarded as causal factors in the production of seborrhœa. Some authors hold the affection to be contagious and assert that it is due to a parasite. Brook, of Manchester, England, believes that there is an additional parasite responsible for seborrhœa with dermatitis and ring-formed lesions.

Diagnosis. Seborrhœa is distinguished from *eczema* by the presence in the latter of itching, exudation, more or less inflammatory redness and infiltration.

Psoriasis, especially of the scalp, shows thick, imbricated scales and crusts with the hair but little affected. *Lupus erythematosus* exhibits sharply-defined patches with adherent scales and atrophic scarring. *Ringworm* resembles seborrhœa corporis but is not so diffused, is more regularly circular and examination reveals the fungus in the scales. Ringworm of the scalp shows the characteristic stubby, broken hairs, and the trichophyton may be found in the hairs and scales. *Pityriasis rosea* is never crusted, occurs on the abdomen and extremities, shows salmon-colored, wrinkled centres to the patches, and is but little influenced by treatment.

Treatment. General treatment consists in the correction of defects in the general health, with regulation of diet and insistence upon the observance of the rules of hygiene, combined with appropriate exercise.

As the affection is usually located on the scalp, treatment should be directed especially to this region. The surface is freed from scales by shampooing with the tincture of green soap or with tar soap. Sulphur, in the form of an ointment, one dram of the precipitated to an ounce of cold cream, is thoroughly rubbed into the scalp and allowed to remain on over night; it may then be washed off in the morning to avoid the disfigurement of having the hair noticeably greasy during the day. This manœuvre should be repeated every night for a week or ten days, then pretermitted, then discontinued, to be resumed at intervals. This plan is usually sufficient to relieve the dandruff and arrest the disease. It is, however, prone to recur and requires a repetition of the treatment.

Ammoniate of mercury in cold cream or petrolatum may be used in the same manner:

℞

Hydrarg. Ammoniat.,	gr. xx.
Acid. Carbol.,	gt. v.
Ung. Aq. Rosæ,	ad ℥j.

M. ft. ung.

Resorcin is highly regarded and may be used in the form of a lotion, such as the following, recommended by Crocker:

℞

Acid. Acetic.,	ʒss.
Resorcin.,	ʒj.
Aq. Cologniensis,	℥iij.
Glycerin.,	ʒj.
Aq. Rosæ,	ad ℥vij.

M. Sig. Apply to the scalp with pipette twice daily.

The following lotion is well recommended by Van Harlingen:

℞

Ol. Amygdal.,	ʒj.
Acid. Carbolic.,	gtt. xx.
Ol. Limonis,	ʒj.
Aq. Destil.,	℥iij.

M. Sig. Apply locally.

Or:

℞

Hydrarg. Bichlorid.,	gr. ij.
Resorcin.,	ʒj.
Chloral. Hydrat.,	gr. xx.
Alcohol.,	ʒj.
Aquæ Rosæ,	ad ʒiij.

M.

Seborrhœa of the body is best treated with ointments and pastes containing sulphur, resorcin or salicylic acid.

Mild sulphur ointments, or salicylic acid gr. xv. to olive oil ʒij, are serviceable for the seborrhœa of infants.

For seborrhœa of the face, ether with a few drops of olive oil to prevent excessive dryness is very useful.

Boric acid solution; three per cent. resorcin in alcohol; the lotio alba, or dry sulphur with starch and zinc oxide applied after rubbing a little white vaseline along the margin of the lids to prevent the powder from entering and irritating the eye, all yield good results.

Prognosis. Seborrhœa sicca is readily curable but tends to recur and on that account requires prolonged treatment.

Seborrhœa oleosa is very obstinate but sometimes disappears under treatment or from improved general health or change of climate.

STEATOMA.

Synonyms: Atheroma; Sebaceous Cyst.

Definition and Description. Steatoma is a rounded, firm, elastic tumor elevated above the skin and varying in size from a pin-head to a pear. These tumors occur wherever there are sebaceous glands, but are seen most frequently on the scalp, neck, face and back.

Steatoma may be single or multiple. The skin covering the tumors is normal in color or pale from pressure, occasionally reddened from inflammation.

The tumors are freely movable, elastic and sometimes fluctuating. With age, they become firmer and harder. They attain a definite size and then remain stationary, occasionally becoming inflamed and ulcerating.

Unless irritated, steatoma is painless. When situated on the neck, a small central opening is often observed; on the scalp, the surface of the growth is hairless and in this position is called a wen.

Etiology. Steatoma is due to retention of sebaceous matter. By some writers it is regarded as a new-growth allied to dermoid cyst.

Pathology. The contents of a steatoma consists of free fat, cholesterin, epidermal cells and sometimes miniature hairs. It varies in consistence with the character of its contents and may be firm and hard, semi-solid, doughy or fluid. Its contents is often of an intensely foul odor.

Diagnosis. Steatoma is distinguished from *lipoma* by the lack of mobility and lobulated character of the latter; and from *gumma* by the more or less rapid formation of gummatous tumors and their tendency to break down and form ulcers.

Treatment. Incision and enucleation of the entire cyst is the only effective treatment. Under cocaine anæsthesia a crucial incision is made over the growth and the tumor is dissected out and delivered without rupture of its capsule, if possible.

Recurrences are inevitable if a portion of the enveloping membrane is left.

SYCOSIS.

Definition. Sycosis is an inflammatory affection of the bearded face, caused by pyogenic micro-organisms.

Symptoms. The disease begins as a rule on the upper lip of young adult males and may be limited to that locality but usually spreads to the chin and neighboring hairy parts of the face.

The lesions consist of grouped, acne-like, papules or pustules, each pierced by a hair. The pustules are firm, larger than a pin-head and have rather thick walls. They rupture after a time and dry into thin crusts, entangling and matting the hairs. The hair itself is not usually affected but becomes somewhat loosened in the follicle as a result of suppuration, especially in the later stages of the disease when the whole length of the follicle is involved and it may be drawn out without much pain.

The lesions may be few and scattered, or numerous involving the entire bearded face. Small cutaneous abscesses, with enlargement of the glands about the angle of the jaw are not infrequently noted. Small areas of infiltration and thickening of the skin occasionally give rise to fungating lesions. Severe, inveterate and neglected cases may show considerable scarring, shallow and atrophic, or at best, a thinning of the beard.

When sycosis affects the upper lip alone it is usually due to infecting discharge from the nose, as a result of catarrh of the mucous membrane. It may be accompanied by inflammation and crusting; the *vibrissæ* become the subject of a suppurative folliculitis and the nasal mucosa is red and swollen.

Sycosis as a rule is limited to the hairy regions of the face but in exceptional instances it affects the eyebrows, axillary and pubic regions.

The disease is exceedingly chronic and, with periods of comparative quiescence, lasts indefinitely.

The subjective symptoms are more or less marked and consist in burning, itching and a feeling of tension.

Etiology. Sycosis is a contagious disease due to the invasion of the hair by pus micro-organisms. It may be conveyed in the barber's shop by

means of infected razors, towels or shaving brushes. Nasal catarrh, eczema, exposure to the weather or the application of an irritant may be enumerated among the causes which contribute to the occurrence of sycosis.

Pathology. Sycosis is a follicular and peri-follicular inflammation due to the white or yellow *staphylococcus*, or more rarely to a bacillus called by Tommosoli *bacillus sycosiferus fœtidus*. The pus is auto- and hetero-inoculable. The sebaceous and, more rarely, the sweat glands are secondarily affected.

Diagnosis. The presence of firm pustules pierced by a hair, and occurring on the bearded face, is highly suggestive of sycosis. *Eczema* is not usually confined to the hairy regions, and is not so inflammatory as sycosis

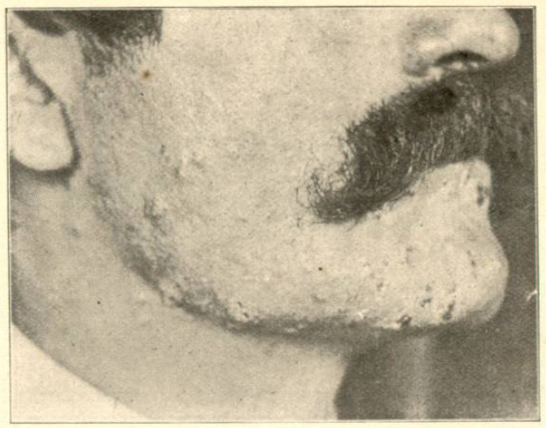

Fig. 93.—Sycosis.

nor so chronic. *Ringworm* of the beard (*tinea barbæ*) begins as a scaly spot, which spreads peripherally does not show preference for the upper lip, early affects the hairs, presents tubercles, nodules or elevated lumpy masses in the skin which are studded with pustules. The hairs contain the ringworm fungus. *Syphilis* is rarely confined to the bearded face and its lesions are found simultaneously in other parts of the body. *Acne* affects the non-hairy parts of the face in preference and shows comedones and lesions independent of hairs. A vigorous beard is usually a corrective of acne.

Treatment. General treatment consists in the correction of errors of diet and hygiene and the elimination of any factor which tends to promote hyperæmia of the face. The condition of the digestive organs should receive careful attention. Internally calcium sulphide, one-tenth of a grain, may be given three times a day, or oftener. Calomel or grey powder in samll doses are sometimes beneficial. Cod liver oil, arsenic and iron may be required.

Locally the crusts must be removed and the hairs epilated. The epilation should be thorough. The beard must be shaved or cut close.

During active periods of the disease, Lassar's paste, zinc oxide ointment, boric acid ointment, diachylon ointment or black wash are serviceable and should be employed in the form of spread plasters applied at night and followed by a dusting powder during the day. Stearate or oxide of zinc will serve for the latter purpose.

Subacute stages require more stimulating applications, such as the ammoniate of mercury in ointment, one dram to the ounce; or sulphur, beta-naphthol, salicylic acid, resorcin or ichthyol in ointment. The following will be found useful:

℞

Ung. Diachyli,	
Ung. Zinci Oxid.,	āā ʒss.
Ung. Hydrarg. Ammoniat,	ʒiij.
Bismuth. Subnitrat.,	ʒjss.
M.	

Lotions such as the lotio alba, or resorcin, bichloride of mercury, 1:1000, are also serviceable.

The chief ends of treatment are to keep the beard short; epilation of the hairs in the affected area; and the use of sedative, stimulating and antiseptic remedies according to the stage of the disease.

In very obstinate cases the green soap and diachylon treatment, such as was described in connection with the treatment of chronic eczema, may be essayed.

The X-rays have proven very useful in sycosis. Under their use epilation is rendered unnecessary, as the hair falls out and the pustules cease to form. When the hairs reappear and there is a renewed tendency to pustulation, the raying should be resumed.

Prognosis. Sycosis is an exceedingly obstinate affection and great perseverance is required to effect a cure.

SYPHILIS CUTANEA.

Synonyms: Syphiloderma, Lues Venerea, Dermatosyphilis, Syphilidé.

Definition. Syphilis is a chronic, contagious, specific disease, acquired by inoculation or hereditarily, and showing in some part of its course a marked predilection for the skin, mucous membranes and nervous system.

The cutaneous manifestations, with which alone a work of this nature is concerned, present certain general characteristics as to distribution, color and configuration, course, duration and subjective symptoms.

Distribution. The syphilodermata are divided into the *early* and the *late*.

Those which appear early in the course of the disease are caused by localized hyperæmia and a variable amount of small-cell infiltration, and are more or less generalized and symmetrical. They show a preference for particular regions, such as the margin of the scalp at the hair line, the angles of the mouth, the folds between the nose and lip, the ano-genital region and the palms and soles. The lesions constituting the eruption vary greatly in number and extent, being abundant, or sparse and scattered, and at times even so slight as to escape attention.

The later lesions are not so generalized nor symmetrical and show a marked tendency to grouping.

Configuration and Color. The lesions of syphilis cutanea tend to assume a round or oval shape, especially the earlier manifestations. The later eruptions are circinate, segmental or serpiginous. In negroes an annular form is frequently seen about the nose and lips. The color of the syphilides varies considerably. The recent macular eruptions are rosy,

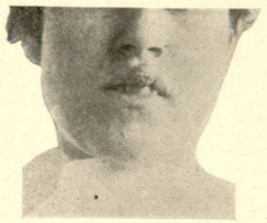

Fig. 94.—Chancre of Lip (Ohmann-Dumesnil).

giving place to a dusky red, coppery, then brownish or yellowish. The papular and tubercular lesions are reddish-brown, coppery or raw-ham colored.

Polymorphism. The early or secondary eruptions frequently appear intermixed, macules, papules and pustules being visible at the same time. The more generalized the eruption, the greater the uniformity as a rule.

Course and Duration. The early eruptions of syphilis are rather rapid in evolution. The macular rash is established in a week or ten days and tends to remain apparent for ten days to three weeks, then fades out. The papular is somewhat more leisurely, remains visible for one or several months and undergoes involution, frequently leaving isolated lesions which linger indefinitely. Relapses are common. The later or tertiary lesions are more indolent and display a much greater tendency to become chronic.

Syphilis is a comparatively chronic disease and is influenced by circumstances connected with the general health and habits of the patient. Individual lesions show a tendency to metamorphosis into another type, thus continuing the affection into a state of inveteracy under varying forms.

Subjective Symptoms. Subjective symptoms are usually absent in the syphilides. In copious macular rashes itching is sometimes complained of,

and it may be present to a slight extent in the papular and pustular syphiloderms. Gummatous lesions and those situated upon the mucous membranes and muco-cutaneous surfaces are sometimes painful.

Peculiarities of the Syphilides.

1. The syphilides are sharply-defined, dense and uniform cellular infiltrations of the papillary body and corium and differ from one another only in size.

2. These cells are not fitted to undergo permanent organization into connective tissue but always undergo involution and disappear either by absorption or purulent degeneration.

3. The syphilitic infiltration of the skin always enlarges and disappears in the same direction, viz., centrifugally, hence the peripheral parts are relatively the most recent and exhibit all the characteristics of fresh infiltration. The oldest parts are in the centre and are the first to disappear (Kaposi).

4. In syphilitic efflorescences, the papule is the dominant lesion or prototype of syphilis cutanea. It may be large or small, dusky-red or coppery, sparse or abundant, and shows a tendency to break through the apical epidermal covering and leave a fringe around the base (the *collarette* of Biett or Rollet). It may be converted into a secondary form, an infiltrated patch or undergo superficial ulceration.

5. The scales are thin, grayish or dirty-white, usually scanty and are often found surrounding a lesion rather than covering it, as in the palmar and plantar syphilide. The crusts of cutaneous syphilis are thick, bulky, of a greenish or blackish color from admixture of pus, blood and dirt and are generally seen covering an area of superficial or deep ulceration.

6. The ulcers are superficial in the early lesions; in the late stages they are deeper, punched out, more or less painless, rounded, horse-shoe or bean-shaped.

7. Scars resulting from ulceration depend upon its extent and situation. Superficial scars following shallow ulceration, are smooth, pliant, sometimes pigmented and show follicular pitting; those from deeper ulcers take somewhat the form of the causative lesion through smaller, and are satiny, pliant and smooth. They may be the seat of keloidal growth, especially when situated about the joints.

Types of Syphilis Cutanea. The syphilides are arranged under the following forms: the *macular*, the *papular*, the *pustular*, the *bullous*, the *tubercular*, the *gummatous*.

The Macular Syphilide. The macular syphilide is erythematous in character and is also called syphilitic roseola. It developes seven to nine weeks after the initial lesion and may be slight and evanescent, merely a dusky mottling of the skin. When fully established and pronounced the eruption consists of pea- to dime-sized, rounded or oval, sometimes slightly elevated, discrete macules of a pink or dusky-red color.

The eruption tends to generalization but is most abundant on the sides and front of the abdomen and thorax, and the flexor surfaces of the extremities. The face, back and hands usually escape.

The extent and intensity of the eruption vary greatly, being influenced by the temperature, hot baths, clothing, alcoholic excesses or by the character of the patient's skin.

The color in the later stages of the eruption does not entirely disappear on pressure. The lesions become of a dull, coppery or yellowish hue

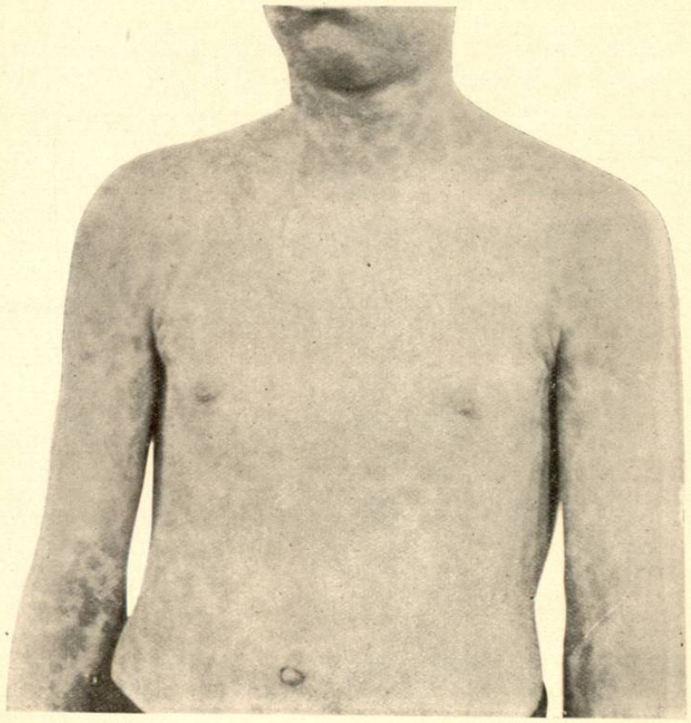

Fig. 95.—Macular Syphilide (Dyer).

and fade out in two weeks or a month, leaving faint dirty stains which persist much longer. Relapses or recurrences sometimes take place in the form of annular or segmental lesions.

Synchronous with the appearance of the macular rash the throat is tumefied, the tonsils often presenting points of shallow ulceration and there is general glandular enlargement.

Diagnosis. The macular syphilide most resembles *measles* but is distinguished from it by its comparatively afebrile course, is not epidemic,

lacks catarrhal symptoms, coryza and is not followed by desquamation. The absence of catarrhal symptoms and fever is sufficient to distinguish it from *scarlet fever* and *rötheln*. It is differentiated from *tinea versicolor* in that the latter is a scaly affection presenting chamois-skin patches, and is due to the *microsporon minutissimum*, which may be sought for in doubtful cases.

The coexistence of lesions in the mouth and the polyadenitis will aid materially in the establishment of a diagnosis of syphilis.

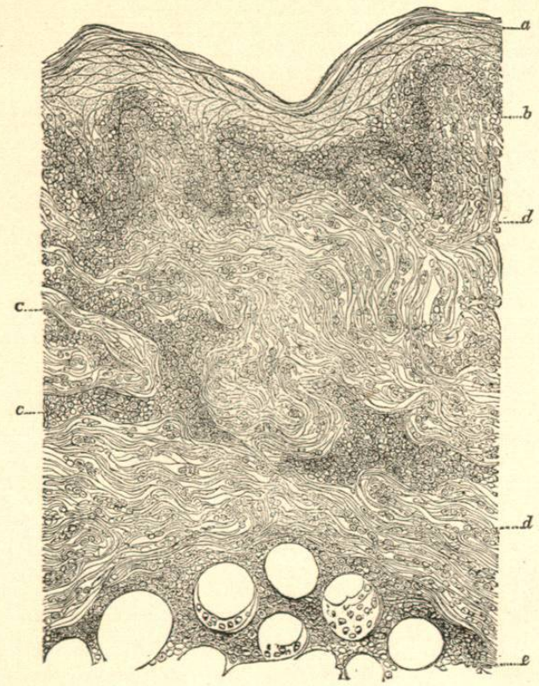

Fig. 96.—Syphilitic Papule from the Thigh (Schamberg). a, Epidermis; b, Rete malpighii; c, Cell infiltration in the corium and panniculus apiposus; d, New formation of connective tissue.

The Pigmentary Syphilide, or syphilitic leucoderma, is a variety of the macular form and is seen chiefly on the sides and back of the neck in brunette women, as a *cafe-au-lait* spot or spots alternating white and brown, closely assembled and lending to the skin a reticulated appearance. It is not secondary to preëxisting lesions but is an original pigmentation upon an apparently normal skin.

The Papular Syphilide. The papular syphilide occurs in two varieties with individual modifications, the *small* or *miliary*, and the *large* or *len-*

ticular. The *miliary* papular syphilide occurs in two forms, the small and the large. It succeeds the macular eruption or takes its place, occurring in the first six months of the disease.

The larger type of miliary papular syphilide presents millet seed or pin-head sized, firm, dense, rounded or acuminate papules. Sometimes if inflammation is marked the summit of the lesion becomes vesicular or suppuration occurs and a pustule is formed. The papule is smooth or capped, with a minute scale, or its base is surrounded by an inconspicuous scaliness.

The eruption is more or less abundant, grouped or disseminated, and is seen chiefly on the arms and face. The groups contain ten to thirty ele-

Fig. 97.—Annular Syphilide (Ohmann-Dumesnil).

ments and are often arranged in a circinate form or in arcs of circles. Small pustular lesions and larger papules are found associated with the eruption.

The color of the lesions is at first a rosy red which becomes brownish or violaceous. The papules are situated around a hair follicle. They flatten down and disappear leaving a pigmented pit.

This form of papular syphilide is not very common.

The small, miliary papular syphilide is rarer than the foregoing and consists of widely disseminated, grouped papules the size of a small pin's head, at first bright-red, becoming yellowish or fawn-colored. The papules sometimes show a horny centre. The groups are irregularly rounded or ring formed.

The eruption occurs during the first or second year of the disease.

The Lenticular Papular Syphilide. The lenticular papular syphilide may also occur under two forms, the small and the large.

The small type is one of the commonest of the manifestations of cutaneous syphilis and may be seen at any time within the first year; exceptionally in the form of a relapse during the second year. It occurs as firm, flattened, lentil to split-pea sized papules which spread peripherally and are capped with a small scale. The scale covering the papule becomes detached and there is a fringe of epidermis surrounding the base of the lesion. The scale is dirty white, thin, loose and, in its collar-like arrangement, highly characteristic. The papule is at first of a bright-red color but with age becomes brownish-red or yellowish, and on the lower extremities, darker, even livid.

The eruption is usually abundant and affects the flexor surfaces of the limbs, the trunk, face, mouth, nose and forehead where, at the border of the hair, it encircles the scalp like a diadem and constitutes the so-called *corona veneris*. On the scalp the papules are less numerous and tend to become pustular and crusted.

The eruption if untreated lasts for months and finally disappears leaving a bluish-gray, very persistent pigmentation. The papules sometimes flatten down and form discrete scaly patches.

There are no subjective symptoms except occasionally slight itching.

The large lenticular papular syphilide frequently follows the small type or occurs as a relapsing manifestation of syphilis. The lesions are rarely numerous, less inclined to form groups and are seen with especial frequency upon the forehead, about the mouth, on the nose, posterior aspect of the trunk, front of the limbs and in the genital and anal regions. On the trunk the long diameter of the papule is parallel with the ribs. The lesions are from one-eighth to three-fourths of an inch in diameter, raised above the surface, flattened and tend to form patches which are sparsely covered with adherent scales. The patches are infiltrated, bright-red in color becoming, with longer duration, a deep-red or raw-ham color.

The *Papulo-Squamous* or *Squamous Syphilide* is an alteration of the large papular or tubercular syphilide and is caused by a coalescence of the papules or flattening and extension of the individual lesion. It may be a late manifestation of syphilis. The surface of the patch is irregularly scaly, the scales being dry, grayish-white and rather firmly attached. The eruption, when occurring at an early period, is more or less generalized, later it usually represents a relapse and is limited in extent. It does not show preference for the knees and elbows, and in this respect falls short of a close resemblance to psoriasis.

A palmar and plantar syphilide forms from a papular eruption as a late and limited manifestation. It appears in variously sized, round patches with well-defined red margins. Several patches unite and form serpiginous or crescentic lesions which spread over the palm or sole. The border of

the patch is infiltrated, red, raised and scaly. A large, perfect circle may be formed, gyrate figures produced or the circle may be broken into unequal segments. Fissuring is apt to occur about the joints of the fingers. The eruption is usually limited to one palm or sole and in this respect differs from circumscribed eczema, and psoriasis, which are usually symmetrical, the latter, in addition, being rare in this locally.

The *moist* papule is formed from the papule by pressure where the skin surfaces are in close contact, as in the cruro-genital, inter-gluteal, axillary regions, and the angles of the mouth; and by heat and moisture, as upon the mucous membranes. The papule becomes flattened, its surface macerated and exuding a thin, mucoid, foul secretion. Patches may be built up by coalescence of lesions either on a level with the skin, forming a mucous patch, or above it in the form of rounded, pinkish, sodden elevations secreting a thin, grayish fluid. The latter appearance constitutes the *condyloma latum* and is highly contagious. Mucous patches in the mouth, tongue or vagina appear as opaline plaques, and resemble the eschar of nitrate of silver.

The *circinate* or *annular* syphilide is a modification of the papule and is formed by a central depression and flattening of the papule producing a complete or partial ring, with rounded, elevated borders. It is generally seen about the face, upon the forehead, nose, lips and neck and usually coexists with mucous patches, condylomata lata and seborrhœa. It is rather common in negroes.

Diagnosis of the Papular Syphilide. The miliary papular syphilide is diagnosticated from *papular eczema, lichen ruber*, and *lichen scrofulosorum* by its distribution, course, history, absence of subjective symptoms and by the concomitant evidences of syphilis.

The squamous or papulo-squamous syphilide is differentiated from *psoriasis*, which it sometimes resembles, by its preference for the flexor surfaces, the color of the patch, the scanty, loosely attached dirty-white scales which, on removal, do not cause any points of bleeding to appear; and by the uniform size of the patches. *Squamous eczema* of the palms and soles is generally symmetrical, its patches are itchy, infiltrated, lack definite outline and occur also upon the dorsal surface.

The Pustular Syphilide. The pustular syphilide may occur within the first year, or as a relapse at a later period. It is always found in debilitated, ill-nourished individuals and is due to superadded infection with pus micro-organisms.

The pustular syphilide may be an original efflorescence or follow upon the macular or papular types. It occurs in the form of *small* or *miliary*, and *large* or *lenticular pustular syphiloderms*.

The Miliary Pustular Syphilide. This form makes its appearance in the first six or eight months and consists of disseminated or grouped, more or less generalized, discrete, millet-seed to pea-sized, acuminate pustules

situated upon a papular base. The pustules usually involve the hair follicle and may be seen pierced by a hair (*acneform syphilide*).

The eruption, as a rule, is abundant especially upon the limbs where groups of twenty or more lesions may be formed and if closely aggregated, coalescence sometimes occurs. The pus dries and forms a small crust which falls off leaving a certain amount of pigmentation and minute pitting, neither of which is permanent.

Fresh crops of pustules appearing may continue the eruption, if unaffected by treatment, for months.

The Lenticular Pustular Syphilide. This variety may result from a softening of a papule, or is a papulo-pustular eruption from its inception. The lesions resemble the miliary but are larger, less apt to form groups, are more or less generalized and are usually situated upon a firm papular base of a dull-red color. A rise of temperature may attend the outbreak of the eruption. The larger lesions sometimes show a central depression or umbilication (*varioliform syphilide*). The contents of the pustules soon dries and forms a thick, greenish-yellow or black crust which when removed is often found to conceal an area of superficial ulceration. Transient pigmentation may follow healing of the lesions. Relapses may occur and are usually localized.

The form of the pustules may show difference both in the miliary and the lenticular eruptions. The pustule of the miliary variety instead of being acuminate may appear flattened, discrete and about as large as a pea. The pustule dries and forms a heavy, uneven crust. Several of the lesions may coalesce and form a crusted patch which covers shallow ulceration. This variety of syphilide is seen in the latter half of the first year and occurs upon the nose, about the mouth, scalp, thighs and genital organs and resembles impetigo (*impetiginous syphilide*).

This variety may also appear under the form of flat, dime-sized, widely-scattered pustules which rapidly dry and form crusts situated upon a coppery-red base which undergoes superficial erosion. These lesions are observed principally upon the trunk, back, shoulders and antero-exterior aspects of the legs and are fairly numerous. The crusts at times are thick, laminated, of a greenish or black color and partially cover an area of irregular ulceration which may be superficial or deep and secretes a thin, yellowish fluid. This lesion is termed the *ecthymaform syphilide* from its resemblance to that pyoderm. The peculiar, laminated, crusted condition is known as *rupia* and may also occur with the bullous syphilide and is usually a tertiary manifestation of the disease. When it occurs precociously it is apt to display a marked malignancy.

Diagnosis of the Pustular Syphilide. The pustular syphilide is generally recognized as an accompaniment of other manifestations of syphilis. The large, acuminate pustular syphilide may resemble *small-pox*, but is distinguished from it by its indolent, afebrile course and absence of shotty