

## KERATOSIS FOLLICULARIS.

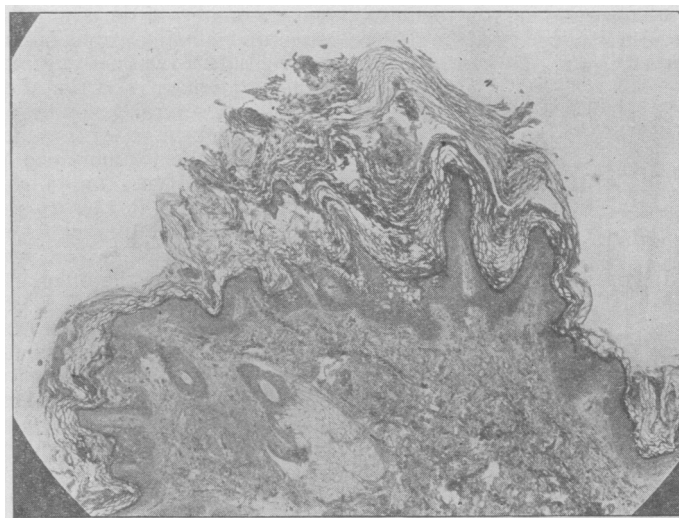
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THE occurrence of this disease is so unusual as to make it worth while to report when it is observed. So rare is it that Stelwagon (fifth edition) claims that only twenty-four cases have been recorded, two among the first being those of J. C.

as yet been invaded. The following is a description of my case:

Miss K., seventeen years old, a high school pupil, was sent to me by Dr. George H. Ingalls, who had treated her for some time without avail. The patient is a rather slight brunette of medium size and attractive appearance. She has never been ill with anything but the usual exanthemata of childhood. Her parents are people in good health and moderate circumstances.



Section of lesion.

White. Bowen has also reported one. Most frequently the lesions appear on the head and face. In this instance, however, these parts have not

For some years past, brownish areas have appeared in various places on her body and limbs; in the bend of the right elbow, on the anterior surface of the left leg two inches below the patella, on the abdomen in the median line below the umbilicus, and recently one is beginning to show on the neck just below the edge of the collar. These areas are of varying size, up to one or two inches in diameter, of irregular outline, and present the appearance of patches of dirt on the surface of the skin, being yellowish-brown or a darker shade of the same color. On examination, these are found to be appreciably elevated above the surrounding skin. There is no discharge or odor; there are no subjective symptoms. They grow very slowly; at first there is apparent only a deeper pigmentation of the skin, but some weeks or months later the patches assume a rough nutmeg-grater appearance and feel rough and hard to the touch. A biopsy was made for the pathological department of the Boston City Hospital which returned the following report:

"Microscopic examination of sections through one of the small lesions shows moderate elongation of the papillæ of the corium, marked thickening of the horny layer, which is piled up in loose flakes on the surface; slight thickening of the prickle cell layer in places and apparently a slight pigmentation of the lower layers of the epidermis. No inflammatory infiltration of the corium, no obstruction of mouths of sebaceous glands, no dilatation of blood or lymph vessels."

The accompanying photomicrograph illustrates this condition, while the photograph shows one of the larger lesions, though not as clearly as could be desired its rough elevated character. Treatment with various local remedies was without permanent effect. Ung. acid. salicylici, Emplast. acid. salicylici, Ung. resorcin, Dil. potass. hydrat., Sapo viridis and even curettage were employed in turn, but served only to improve the



Lesion in bend of elbow.

appearance of the patches temporarily. Excision was considered, but abandoned as impracticable on account of the probability of the recurrence of the disease beyond the borders of the incisions and the disfigurement of the scars. Liq. potas. arsenitis was used internally for a long period.

A course of treatment with radium in the x-ray department of the Boston City Hospital resulted in improvement of the condition of the area treated, the patch becoming thinner and assuming a more normal color. I am convinced that had this treatment been carried out with regularity for some months, definitely good results would have been attained, but the patient moved away to another city, and the case was lost sight of.

## Reports of Societies.

### WESTERN SURGICAL ASSOCIATION.

TWENTIETH ANNUAL MEETING, HELD AT CHICAGO, ILL., DEC. 19 AND 20, 1910.

THE President, DR. JOHN P. LORD, Omaha, Neb., in the chair.

#### DESMOID TUMORS OF THE ABDOMINAL WALL AFTER OPERATION.

DR. E. WYLLYS ANDREWS, Chicago, said he had seen only two cases of desmoid tumor in several thousand abdominal operations, both of which followed herniotomies. The rarity of this complication made it worth while to report these two cases. Most of those so far on record were of another type and followed pregnancy or injury of the fascia above the inguinal region. Keloid was distinct from desmoid in belonging to the skin. Although originating in scar tissue, as after burns or wounds, it always remained movable with the skin, and grew outward, not into the deep fascia. True desmoids were found not in the skin or external cicatrix, nor in the muscles, but in the fascia and aponeurosis, especially of the abdominal wall. Nearly all the reported cases had been in women after repeated childbirth. Histologically desmoid tumors were pure fibromata of the hard white form, like fibromata of the other parts, showing coarse whorls of cut fibers macroscopically like uterine myomata, and spindle cells microscopically with numerous fibrillæ between. The cells showed oval nuclei. Myomatous and even malignant degenerations might occur, as in similar growths elsewhere, but commonly they were benign. Desmoid tumors should be removed by operation inasmuch as the tendency was to grow larger and occasionally to start degenerative retrograde or malignant changes. Dr. Andrews then detailed the two cases that had come under his observation.

#### DISCUSSION.

DR. J. CLARK STEWART, of Minneapolis, said the point of greatest interest in Dr. Andrews' report was the analogy which he possibly showed between this class of tumors, desmoid tumors, as to etiology with keloid. Keloid arose largely from scar tissue. If they could show that any class of fibroid tumors also arose from the seat of traumatism, it would be an important point in their etiology and in their analogy to keloid. He doubted whether the term "desmoid" should be used. Desmoid was an old clinical term which meant just one thing to him and he thought it should be reserved for that one thing because it had no clear clinical or

pathological meaning disassociated from that one clinical condition. Originally desmoids were tumors of the posterior sheath of the rectus muscle and he must differ with Dr. Andrews that these tumors were found in the majority of cases in the upper part of the abdomen. The majority of the reported tumors he had run across had been found in the lower half of the abdomen and both pathologically and clinically they had very marked characteristics. Clinically they grew inwardly, so that ultimately they became covered only by peritoneum. They attained considerable size. Quite a number of the reported cases of desmoid tumors were undoubtedly sarcomatous and it was hard to differentiate a sarcoma under the microscope from the ordinary desmoid, and the after-history of these cases had shown several times they were sarcomas, yet he did not think there was any question about the malignancy of desmoid tumors as originally described.

DR. A. E. HERTZLER, of Kansas City, Mo., stated that he thought it was easy to fix the pathogenesis of these desmoid tumors. Any tissue like the fascia of the external oblique, or any tissue which contained a large amount of the original substance, would, when irritated long enough short of suppuration, give rise to this fibrous tissue hyperplasia. One saw the same tumors subperitoneally about the abdomen. They were histologically very much the same. Histopathologically they differed from fibroma in that they were long, with large, oval, vacuolated cells, many round cells and polynuclears. This point was sufficient to separate the desmoid tumor from the fibromatous tumor or any tumor analogous to sarcoma.

DR. ANDREWS, in closing, stated that as to the identity of keloid with desmoid, that keloid, although it appeared in scar tissue, never involved anything but skin. Keloids were confined to the skin, no matter how great the size they might attain, and were movable and free.

#### NON-SUPPURATIVE OSTEOMYELITIS.

DR. J. CLARK STEWART, of Minneapolis, stated that three distinct clinical conditions might be classed under this title. First, cases of ordinary osteomyelitis where, owing to the non-virulence of the invading germ, or to unknown conditions increasing in resistance of the individual, no necrosis was caused. In such cases there was no pus, no sequestrum, but instead in a certain number marked irritative reaction was set up and there was great overproduction of bony tissue resulting in a thickened, dense and painful enlargement of the bone attacked. These cases were quite common, regularly recognized and properly treated. Second, cases of injury, generally fracture, where a small piece of bone was entirely separated and died, forming about it a closed cavity of dense new bone in which it lay until absorbed but without suppuration. These cases differed entirely from those of the first class in that the irritant which caused new production of bone was not bacterial, or at least not primarily so, but a fragment of bone which remained practically aseptic. The third class, and the one to which he especially wished to call attention, differed entirely from both of the above by having no notable beginning, but an insidious onset although a febrile illness and a slight injury respectively antedated by two years the culmination of the disease by surgical interference. The disease was essentially chronic but progressive and regularly misdiagnosed and treated as rheumatism. He had only seen the lesions present in the tibia, but this must be accidental, as it might as well occur elsewhere. The etiology seemed absolutely wanting, as the two cases narrated had nothing in common, while the pathology and symptomatology were identi-