Society Transactions

NEW YORK ACADEMY OF MEDICINE, SECTION ON DERMATOLOGY AND SYPHILIS

DR. JOHN E. LANE, *Chairman*

Regular Meeting, Oct. 5, 1920

VERRUCAE OF FEET. Presented by DR. TRIMBLE.

The patient, aged 36, was a man from Porto Rico. There was no history of any similar condition or tuberculosis in the family. He gave no history of a previous illness bearing on the condition presented, and denied any venereal history. He stated that his occupation was that of a fireman, and that he had previously worked in Porto Rico as a laborer in the sugar and tobacco fields.

The condition began on the left foot twenty-five years ago as a small verrucous lesion about the size of a small pea. The lesions gradually became larger and more numerous, some of them running together. After five months other lesions appeared on the right foot. The lesions on the hands followed scratching of the lesions on the feet—as the patient remarked, after getting blood on the fingers from the feet. He had received no treatment. The lesions were on the hands and legs, on the dorsa of the feet and on the penis, as well as a few on the trunk. They were dark brown and verrucous in type. The greater part were discrete, but they had become confluent over the dorsa of the feet.

DISCUSSION

DR. HERMAN GOODMAN said he had seen the patient at the meeting of the Clinical Society of the New York Skin and Cancer Hospital, and he agreed with Dr. Trimble that it was ordinary verruca. Among 12,000 drafted men in Porto Rico, he had seen at least thirty cases as extensive as this one. The coffee plantations on which the patient had worked are all moist, and the men and women work barefooted. They are constantly in contact with the moist ground and get these hypertrophic warts on the lower extremities.

LUPUS ERYTHEMATOSUS CIRCINATUS OR SARCOID? Presented by DR. SCHEER.

William O'D., 27 years of age, a native of the United States, an engineer, presented himself at Dr. Fordyce's clinic on October 4 with a lesion on the left cheek of two months' duration. It began as a "pimple," which enlarged after picking so that when presented it was the size of a twenty-five cent piece. The center of the lesion was flat, the follicular openings slightly gaping. The skin was of a violaceous red color, with a raised infiltrated border topped with thick scales which when raised revealed small depressions. The scales showed many small projections, which fitted into these depressions. Histologically the section resembled sarcoid.

FOLLICULITIS DECALVANS. Presented by DR. HOWARD FOX.

W. L., a man, 30 years of age, born in Russia, a carpenter by trade, had lived in the United States for the past ten years. The disease appeared suddenly and without apparent cause about four months ago, attaining its maxi-

mum development within a week. He had never before had any disease of the scalp as far as he was aware. No members of his family were similarly affected. The eruption did not cause any subjective symptoms.

On examination, the greater part of the vertex was found to be covered by closely crowded, circular, discrete, completely bald patches averaging from one-quarter to one-third inch in diameter. These presented slight redness and numerous fine nutmeg-like pin point follicular keratoses. On palpation of the scalp, great inequalities of the surface were detected, consisting of ridges and depressions. There were no crusts or stiff hairs of favus, and a microscopic examination of the hairs showed no fungus. There was also an absence of the redness and scaling of lupus erythematosus, and there were no cutaneous lesions except those on the scalp. The patient was being treated with the quartz lamp.

PARAPSORIASIS LICHENOIDES. Presented by DR. WISE.

N. A., a boy of 12, born in Poland, and under the care of the Vanderbilt clinic, had had the disease for six months. The patient presented a generalized maculopapular eruption, the lesions varying in size from that of a large pinhead to that of a pea. Some were pale, others pink, and others red. There was no itching. Many of the lesions were slightly indurated, especially those on the neck. Treatment had been of no avail, the lesions persisting despite the use of chrysarobin ointments.

ONYCHOMYCOSIS (FIVE CASES). Presented by DR. HOWARD FOX.

These cases, from Ellis Island, were shown through the courtesy of Dr. J. W. Kerr of the U. S. Public Health Service. All of the patients were immigrants from Europe, who had arrived in the United States during the past month. They showed various dystrophic changes in the nails of fingers and toes, clinically characteristic of onychomycosis, and confirmed by microscopic examination. In each case the diagnosis was trichophytosis of the nails, though this was not culturally differentiated from favus. The individual records were:

S. G., a man 27 years of age, born in Poland, gave a history of having had the nail condition for four years. No member of his family had been similarly affected. The disease was confined to the middle finger of the right hand and ring and little finger of the left hand. The toe nails were not involved.

A. T., a woman 55 years of age, a native of Poland, stated that the nails had been diseased for thirty years. None of her family were similarly affected. She had never been treated. Four fingers of the left hand showed the presence of onychomycosis.

B. L., a woman 64 years of age, born in Poland, gave a history of having had diseased nails for about thirty years. No member of her family had had a similar disease. All the nails of the right foot, four of the left foot and all the nails of the left hand were affected.

A. G., a man 38 years of age, born in Portugal, stated that the disease had first appeared fourteen years ago. None of his family or friends had been similarly affected. The nails of the fingers and toes were diseased.

N. R., a man 30 years old, born in Italy, gave a history of nail disease since childhood. He had two brothers who had a similar condition. He had served for six years in the Italian army. All the fingers of the right hand, except the index finger, were involved.

DISCUSSION

DR. J. W. KERR, chief medical officer at Ellis Island, said that at Ellis Island a careful watch was kept for favus of the scalp and nails and many cases had been found, especially in recent months. Dr. Fox, on visiting the island in his official capacity occasionally, had been greatly interested in this class of cases and had asked that these patients be shown tonight. The diseases among aliens which were of interest to the dermatologist were grouped under what was called Class A (11), generally known as loathsome contagious diseases, including syphilis and other venereal infections, yaws and other mycotic infections. The medical inspectors were constantly on the lookout for them on account of their chronicity and importance to the public health. Favus is an exceedingly difficult disease to treat by any method, and the patients under treatment usually remain under their care from three to six months. After treatment by the roentgen ray, it is necessary to hold the patient for several weeks after the hair grows out in order to determine whether the causative organism is present, since that is the only criterion by which cure can be determined.

It was gratifying to have the members of the Section observe these cases of favus and ringworm of the nails, loathsome contagious diseases which were rather readily curable. It had been found that on removal of the nail and treatment of the nail bed the infection can be eradicated. This was different from the experience with disease of the scalp. It was the general experience that patients with favus of the nails were not likely to have favus of the scalp. This had proved to be an interesting observation to him, but one well known to dermatologists with experience.

EPITHELIOMA OF THE PENIS. Presented by DR. L. SPIEGEL.

L. J., an Austrian and a machinist by occupation, an unmarried man under treatment at the Lenox Hill Hospital and Dispensary, presented a sore on the penis of about five weeks' duration. He gave a history of a chancre fourteen years ago for which he received no treatment. He denied any sexual exposure during the last eight years. The lesion was irregular and crater-like in character, situated on the dorsum of the penis at the junction of the inner surface of the prepuce and corona glandis. It was about 2.5 cm. in diameter, the edges being hard and pearly, the base red and granular in appearance. There was a profuse serous discharge. There was no glandular enlargement. The Wassermann reaction was + + + +; there were two antigens.

Microscopic examination of the biopsy specimen showed a neoplasm consisting of strands and alveoli of stratified squamous epithelioma in which pearl formation was extensive and mitotic figures rather common. This epithelial new growth was invading the connective tissue surrounding the neoplasm in all directions. Three intravenous injections of the arseno-benzol brand of arsphenamin—a dose of 0.5 gm. each on September 26, 28 and 30—caused no improvement of the ulceration.

ACQUIRED FACIAL PIGMENTATION, WITH PROBABLE POLY-GLANDULAR TROUBLE. Presented by DR. WISE for DR. THORNLEY.

E. W., a young man 18½ years of age, under treatment at the Vanderbilt clinic, had had the condition two months; it was said to have followed sunburn. He presented an irregular mottled chloasma-like pigmentation of

the face, backs of the hands and in the axillary folds. He also presented gray hairs in the scalp, and pubes, effeminate hair distribution and wide spacing of the perineum.

DISCUSSION

DR. WISE said that the case was interesting from the standpoint of endocrine disturbance. The patient had been seen by Dr. Casamajor, who suggested suprarenal and dyspituitary trouble, but nothing definite. It was interesting that a young man of 18 should have a suddenly acquired pigmentation of the face which was not chloasma. The feminine distribution of the pubic hair and the graying of the scalp hair made the case interesting from the point of view of the ductless glands.

DR. LEVIN said that the pigmentation was dependent on the endocrines. Besides the points mentioned, the patient had long extremities, long fingers with broad distal phalanges, large ears, prominent malar eminences, overgrowth of the eyebrows with a meeting of the hairs over the nose, a low downgrowth of the scalp hair on the temporal regions and forehead and a separation of the incisors.

A radiograph of the skull might show a large pituitary gland or a crowded gland enclosed in the sella turcica with the clinoid processes approaching one another. In these conditions, the suprarenals are more or less exhausted and with the disturbance in the chromaffin system the regulation in the pigment deposits is affected and patches of abnormal pigmentation appear. This is all part of a compensatory endocrine syndrome.

In a patient seen recently at the hospital, of about the same age as the boy presented, similar signs were observed, and the blood pressure proved to be low. Addison's disease was suggested, and this diagnosis was later corroborated by internists. This patient should be studied for hypo-adrenalism and for a possible beginning Addison's disease.

DR. HIGHMAN said he hesitated to discuss disturbance of the endocrine glands, though he was willing to concede the general principle that every one is the sum total of the interplay of the various endocrines—physically, morally, and mentally—but the entire subject is still in the speculative stage, and we do not know what we mean when we apply endocrinology to dermatology. Dr. Highman had no desire to cast a slur on the subject, however. It is evident from what we know of the suprarenal gland that it has a strong effect on pigmentation, but what the pituitary gland may do in these conditions we can only conjecture, and until we have more specific knowledge, we should proceed slowly. What we have heard tonight simply amounts to saying that the man has brown spots because he has them.

LICHEN PLANUS ANNULARIS. Presented by DR. PAROUNAGIAN.

F. McD., aged 25, Irish, single, a laborer, had been in this country for the past six years. There were a few scattered lesions on the forearms. About six weeks ago the patient noticed lesions on the glans penis. These did not itch. On the buccal surface of the right cheek was an annular white lesion of lichen planus. The lesions first appeared on both legs about two years ago, and have persisted. New lesions occasionally appear on the feet and legs. These itch moderately. A Wassermann test was made on October 4, but the report had not been received. There was no history of syphilis.

CASE FOR DIAGNOSIS. Presented by DR. PAROUNAGIAN.

Louis T., aged 25, a Cuban negro, married, a cigarmaker, two years ago had had gonorrhea, and treatment was administered by injections. He complained of itching and burning near the anterior end of the penis. A physician had cauterized a urethral abscess, which resulted in a fistula back of the meatus. Another doctor was then consulted; he gave three injections into the arm vein. Following this, the patient developed severe edema of the penis and inability to urinate. No Wassermann test was made. A third physician who opened the urethra to allow urination, split open the anterior portion of the urethra. The patient stated that the wound healed but never closed properly. About three weeks ago itching developed, first on the back. One week later, an eruption appeared all over the body. The patient then took some "blood pills" for about a week. At Lenox Hill Hospital he was given a brownish ointment which relieved the itching but did not influence the eruption. He had had no local applications for the past four days.

The patient could not speak English well. A tentative diagnosis of pityriasis rosea was made, and further suggestions were requested. Dr. Parounagian said he would endeavor to watch the case and report on it at the next meeting, but there were a great many more lesions on the face than when Dr. Fox saw it first, and the entire extremities were involved.

DISCUSSION

DR. HOWARD FOX thought the case unquestionably one of pityriasis rosea. The diagnosis seemed clear from the duration (three weeks) and the presence of generalized superficial, dry, scaly, discrete patches with a circinate tendency. The presence of lesions on the neck or face did not rule out pityriasis rosea.

ARSPHENAMIN DERMATITIS. Presented by DR. PAROUNAGIAN.

J. H., an Englishman, 40 years of age and single, who presented himself for treatment at Bellevue clinic, sixteen years ago had had a chancre, for which he received treatment by mouth for two and a half years. About three months ago a Wassermann reaction of + was obtained by the board of health laboratory. He therefore received ten injections of arsphenamin and sixteen mercurial injections at the Post-Graduate Hospital. Following the eighth injection of arsphenamin, he began to suffer from intense itching, erythema and a "goose-flesh" appearance of the skin. There was no weeping or moisture of the skin. About three weeks after the appearance of the generalized rash, his skin began to peel. For the past week he has had numerous pustules. The Wassermann reaction at Bellevue was + on Sept. 22, 1920.

RETARDED ROSEOLA. Presented by DR. PAROUNAGIAN.

C. M. J., from Dr. Parounagian's clinic at Bellevue, aged 35 and single, was born in the United States, a ship's storekeeper, had had an exposure nine months ago, and a chancre developed on the foreskin three weeks later. Circumcision was performed one week after the appearance of the sore. He had received one injection of arsphenamin and mercury pills for a few days. He had had no further trouble until two months ago, when a rash appeared on the cheeks and forehead. It disappeared in about two weeks.

A month ago he developed a rash on the trunk, arms and thighs. For the past three days this has been marked, especially on the arms. There was

no itching. The right tonsil showed small mucous patches; the left tonsil showed folliculitis. There was some general congestion of the throat. The inguinal glands were enlarged, discrete, shotty, but not painful. The epitrochlears were negative; the anterior and posterior cervical glands were moderately enlarged. The Wassermann reaction, Sept. 28, 1920, was + + +.

LICHEN NITIDUS. Presented by DR. PAROUNAGIAN.

Z. M., a Greek, 19 years of age and single, a bus boy, first noticed the lesions about a year ago. He stated that for the past year he had lost weight, although he felt well and strong. He had never had a severe illness, and he denied venereal disease.

The lesion consisted of minute shining papules, mostly follicular in character, more pronounced on the flexor surfaces and most noticeable on the chest, back and genitals. There had never been any itching. The dorsum of the tongue showed whitish plaques of a membrane-like appearance. The lesions on the glans penis were annular, with a good deal of scaling and some pigmentation. The scrotum was studded with shining, irregular papules, closely resembling lichen planus. The Wassermann reaction was negative on Sept. 28, 1920.

DISCUSSION

DR. WISE said that the lesions on the shaft of the penis and back of the neck were characteristic of the disease as described in the textbooks, and were similar to those demonstrated by Dr. Trimble last year; but he was puzzled by the large papular lesions on the glans penis. If one saw only the glans penis he would think it was lichen planus, but the combination of the two was unusual. There was no relationship between the two, and any diagnosis should be corroborated by microscopic examination of the lesions on the back of the neck and on the glans.

DR. LANE said that the lesion on the penis covered the whole glans and was not limited to the site of the circumcision scar. He did not remember whether lichen nitidus had been described as affecting the glans. When he first saw this lesion he had considered it lupus erythematosus, but on closer examination he had considered it lichen planus. He agreed with the diagnosis of lichen nitidus on the shaft of the penis.

DR. WISE said that the lesions on the glans penis were almost the size of a lentil, altogether different from the pinhead lesions on the shaft. The lesions appeared to him like two entirely different conditions.

DR. PAROUNAGIAN said that when he first saw the case he had remarked that the lesions on the penis looked like lichen planus, but after considering all the symptoms together, he had decided it was not that.

PHAGEDENA OF PENIS: MIXED INFECTION. Presented by DR. PAROUNAGIAN.

M. W., a seaman, aged 22 and single, born in the British West Indies, had had a chancre at the sulcus eight and a half months ago. Later he developed a balanitis and a circumcision was performed three months after the appearance of the chancre, but the wound never healed. The phagedenic ulceration destroyed a large part of the skin of the penis, and ulceration of the corpus spongiosum produced a loss of a large part of the anterior urethra.

At Kings County Hospital on July 27, the Wassermann reaction was + + + +. He was given six arsphenamin and five mercury injections. At the end of this treatment the Wassermann reaction was +, but the genital ulceration remained unimproved.

He appeared at the Bellevue clinic on September 22. The Wassermann reactions on September 22 and 28 were both negative. A Ducrey examination made on September 24 was positive. He had received arsphenamin on September 23, 27, 30 and on October 4. On September 30 and October 4 the ulcerated area was irrigated with arsphenamin solution, 0.1 gm.; this was followed by slight improvement. Suggestions as to treatment were requested.

DISCUSSION

DR. TRIMBLE asked whether the man had syphilis also.

DR. PAROUNAGIAN replied in the affirmative; but the man had had the chancre eight and a half months ago.

LICHEN PLANUS NODULARIS. Presented by DR. SCHEER.

Mrs. S. E., from the Vanderbilt clinic, aged 52 years, had lesions located on both legs, and there was one patch on the left elbow. There were numerous nodular discoid elevated, reddened and indurated lesions scattered over the legs and knees, associated with itching. The patient had had eleven roentgen-ray treatments, $\frac{1}{4}$ units (skin distance) once a week, resulting in great improvement. Previous treatment had not been beneficial. The mucous membranes were free. The Wassermann reaction was negative.

POSTARSPHENAMIN PIGMENTATION: ARSENICAL KERATOSIS.

Presented by DR. HERMAN GOODMAN.

A man, aged 32, had had a chancre on March 1, 1920, followed by an adenopathy of the groins and a general eruption in April. The Wassermann reaction was + + + +. Arsphenamin treatment was instituted during the secondary stage of the disease. The patient received twenty-two injections, receiving injections twice a week. Treatment was then interrupted because the eruption appeared; it was renewed until a total of thirty injections had been given. No mercury injections had been given. The patient received drops and rubbings. It had not been practicable to get into communication with the doctor who treated the patient to learn the dosage and preparation used. The patient was seen for the first time the previous night at the West Side Dispensary (service of Dr. Leo Michel). He had previously made one visit to the Post-Graduate Dispensary in New York.

DISCUSSION

DR. HIGHMAN said that he had had an opportunity to examine the patient by daylight at the Post-Graduate Hospital, and he very much doubted the history of syphilis. He was told that the patient's Wassermann reaction was positive, and that he had received arsphenamin, but the pigmentation seen last week suggested the pigmentation left by lichen planus. At that time also the patient said the eruption itched. Whether or not he had had syphilis, the remaining pigmentation was quite characteristic and was much more likely to be that of a faded lichen planus than the result of arsenic.

DR. LAPOWSKY inquired concerning the kind of lesions on the lower extremities.

DR. HIGHMAN replied that they were just such simple small brown pigmentations or spots as were seen after lichen planus—precisely as shown tonight.

DR. WISE inquired whether it would be possible to get an arsenic reaction from a piece of tissue. Had any one obtained arsenic from the tissue in such a case?

DR. HIGHMAN replied that Unna had described an arsenic reaction, but that he himself had not been able to make it work.

DR. GOODMAN said that the absence of lesions on the mucous membranes influenced him against accepting a diagnosis of pigmentation following lichen planus. He believed that the pigmentation was on the site of the secondary syphilitic eruption. The keratoses present about the waist, where there was irritation from the wearing of a belt, led him to believe it to be the result of arsenic. Should the patient permit, a section would be taken for further study.¹

FOLLICULITIS CHRONICA ATROPHICANS. Presented by DR. ABRAMOWITZ.

Lena W., aged 22, a Russian Jewess, was referred to Dr. Fordyce's clinic by Dr. Thornley of Gouverneur Dispensary. The eruption was of about five years' duration and was located on the chest, back, back of the thighs and extensor aspect of the extremities. It consisted of many fine comedo-like plugs, with depressed scars about the size of a pinhead and smaller. These were scattered diffusely over the above areas, with an occasional follicular pustule here and there.

DISCUSSION

DR. WISE said he had seen the patient for the first time during the evening. Dr. Trimble had suggested the diagnosis of acne keratosis, a name given by Crocker to a condition characterized by blackheads and subsequent atrophy. He himself had never before seen a case of this kind.

DR. TRIMBLE expressed the opinion that the case would come under the classification he had mentioned. Crocker had reported two or three cases and called them acne keratosa. In Crocker's cases the lesions were located on the face and shoulders. He, himself, had seen another case in which the arms and face were involved. The malady was something like acnitis, the only difference being that there were little horny spines which eventually fell out, leaving punctate atrophy as in this case. The lesions in this instance were more numerous than in the case he had seen, but he was convinced that it was acne keratosa, described by Crocker.

DR. ROSEN said that he had examined the case carefully at the clinic. He had never before seen a case of the same type. The active lesions looked like the lesions of a lichen scrofulosorum. A few of the lesions on the upper extremities were possibly acnitis. The microscopic picture would probably reveal some form of tuberculid of the skin.

TUBERCULOUS GUMMAS. Presented by DR. LEVIN.

M. R., a married woman, aged 45, was born in this country and had always been well. Her family and past history were negative. The condition began about fifteen months ago with a swelling of the left leg. The swelling was

1. The patient was seen the next night. He brought a report of a negative Wassermann reaction from the Post-Graduate Hospital. He was leaving for another city within twenty-four hours.

painful, softened slowly, and formed an ulcer at the end of two months. New swellings gradually appeared over the lower extremities and back, which also tended to ulceration and healed slowly. When the patient first came under observation, two months ago, there were about a dozen large pea-sized to cherry-sized hard and soft growths scattered over both lower extremities. The skin over the lesions was normal and purplish in color. An unhealthy quarter-dollar sized ulcer with undermined purplish edges was present on the front of the left leg. Under observation, the new hard nodules grew slowly to involve the skin, softened and ulcerated. Scattered over both lower extremities were numerous hard and soft subcutaneous nodules which showed a tendency to become confluent and form soft matted-together masses. The skin over these nodes was purplish red in color. On the left leg and on the outer aspect of the right thigh were half-dollar sized, irregular unhealthy ulcers with granulating floors and undermined edges. The discharge from these ulcers was purulent.

Pathology: Tuberculosis. The Wassermann reaction was negative.

LEUKODERMA PSORIATICUM. Presented by DR. ABRAMOWITZ.

Mary B., 10 years of age, born in the United States, was brought to the Vanderbilt clinic with extensive macular leukodermatous patches on the forehead, trunk and extremities, and with typical psoriatic patches present on different parts of the body. There was no definite history of using chrysarobin nor any signs of chrysarobin dermatitis. The patient had been using white and black salves, but denied that they stained her clothes.

EPIDERMOLYSIS BULLOSA ACQUISITA. Presented by DR. WISE.

Mrs. G. C., aged 21, exhibited a condition with which she had been suffering for eight months. She presented evidences of healed vesicles and bullae on the bends of the elbows, the hands, face and feet. The middle finger of the right hand, ulnar side, presented an active vesicle due to pressure from the adjoining ring. The skin of the elbow region showed moderate atrophy. There were epidermal cysts on the fingers and on the shells of the ears. The lesions arose both spontaneously and as a result of traumatism.

The term *acquisita* was included in the title of the case because the patient was the first member of the family to show the conditions.

DISCUSSION

DR. LAPOWSKY said that "*acquisita*" meant acquired, not hereditary. If the term acquired were introduced in *epidermolysis bullosa*, it could only mean that the patient was the first in the family who acquired the *epidermolysis bullosa*. In expressing such a condition it would be better to use a more descriptive form, as "first in the family," and not the word "*acquisita*."

DR. ABRAMOWITZ said that the patient was positive that she had never had the condition before nor had any member of the family or relatives had the disease, and that this disease occurred after a normal confinement. She had had lesions on the nose and in the mouth, and some on the body, which seemed to have cleared up under arsenic which she had been receiving. She had never noticed that her skin was vulnerable in any way, particularly to injuries that produced blebs or bullae. She said that sensitiveness was acquired since she had had the first attack of bullous eruption after her confinement. There was no consanguineous marriage.

Dr. WISE said that Dr. Lapowski's point was well taken, but that name had been used long before by others. It was applied to cases in which the family history for generations back was obtained and was negative. Why the patient should have lived for twenty-one years without any previous manifestation of the condition was a question.

LUPUS ERYTHEMATOSUS DISSEMINATUS. Presented by DR. BECHET.

B. H., a female adult from the service of Dr. Trimble at the University and Bellevue clinic, stated that the eruption had been present for thirteen months. It began on the nose and soon thereafter appeared on the cheeks. In July, 1920, the fingers and backs of the hands became involved. A few weeks later the eruption appeared on the chest, neck and arms. These lesions consisted of various sized plaques with symmetrical spots on the extensor surfaces of the third phalanges of the fingers. They were sharply margined, of a rather dusky red color and slightly scaly. There was congestion and slight atrophy at certain points apparently undergoing involution. Burning and itching, so frequently complained of in this type of lupus erythematosus, was also present. The patient appeared to be in good health. A physical examination proved negative. The patient's mother, four brothers and one sister had always been well. Her father had died of gastric carcinoma several years before.

Dr. BECHET said that the lesions were quite large, one of them on the back of one hand being almost 2 inches in diameter. He had observed them for two months, and in that time there had been no change in their appearance. There were no papules or vesico-bullae. The plaques were dry, slightly scaly, and in a good light were atrophic in the center. The face was greatly involved. In view of these facts a diagnosis of disseminate lupus erythematosus seemed more obvious than erythema multiforme.

CARCINOMA OF TONGUE. Presented by DR. PAROUNAGIAN.

T. D., a man of 51, born in the United States, a bartender, gave a history of chancre a year ago, which received only local treatment. He entered the Bellevue clinic on Aug. 2, 1920, with a history of ulceration of the tongue of four months' duration, which was gradually increasing in size. Examination showed an irregular ulcer on the left side of the dorsum of the tongue, about 2 inches from the tip. Another isolated area was present on the left lateral aspect of the tongue, anterior to the first one. The anterior cervical glands on the left side were enlarged. The Wassermann reaction on August 2 was + + +. The treatment consisted of arsphenamin, 0.15 gm., administered on August 5, 12, 16, 19 and on September 9, 16 and 23.

On August 31 the patient was referred to the General Memorial Hospital for radium treatment. It was not thought wise to use radium. On September 7, Dr. Douglas in consultation advised against operation.

The patient was having increasing pains in the tongue and for the last few weeks had complained of pain in the throat and difficulty in swallowing.

DERMATITIS HERPETIFORMIS (PAPULAR FORM). Presented by DR. WISE.

Louis S., a Russian Jewish pedler, 52 years of age, applied at the Vanderbilt clinic for treatment of a skin trouble of seven years' duration. The trouble disappeared during the winter and spring but recurred during the summer.

The eruption consisted of pruriginous papules—some of them excoriated—located on the extensor surfaces of the extremities and on the back of the shoulders.

PRECANCEROUS DERMATOSIS? XERODERMA PIGMENTOSUM?

Presented by DR. L. CHARGIN.

A woman, aged 35, an Italian, married and the mother of four children, since early childhood had been affected with freckle-like spots which were located especially on the upper chest, arms and face. The lesions increased

Precancerous dermatosis.

in size and in number, in the course of years, making their appearance on the back, abdomen and legs and becoming especially thick on the neck and face.

At the time of presentation, the face, neck, upper chest and arms were greatly affected; while the back, abdomen and legs showed numerous but scattered lesions. The lesions consisted of freckle-like spots—most of them with a slightly raised and verrucous border—small atrophic areas with similar borders, crusted and fungoid tumor masses and cutaneous horns. The flat lesions were for the most part yellowish or brownish in the center with darker pigmented borders; many of them, however, were distinctly red. Most of the

verrucous lesions were darkly pigmented. The tumor formations were red and irregular over the surface as well as in outline. Scraping the flat lesions, a pellicle was easily removed, revealing a moist red, slightly oozing surface. The lesions varied in size from that of a pinhead to that of a twenty-five cent piece; they were for the most part in close apposition, and in many areas were confluent. The tumor formation varied in size from that of a pinhead to 2½ inches in their longer diameter.

The tendency to epitheliomatous degeneration began about three years ago, and at the time of presentation there were about a dozen lesions. Under the right eyelid and on the back of the right hand were cutaneous horns.

The patient complained of no subjective symptoms, and her general health was good. The urine and blood Wassermann tests were negative. None of her offspring was similarly affected, but a brother of the patient was said to be suffering from a mild type of the affection.

Dr. Chargin said that though the patient presented many of the characteristics of xeroderma pigmentosum, there was absence of others, such as the telangiectasia, the general thinning or parchment-like skin. After making a biopsy, Dr. Highman reported precancerous dermatosis.

MORPHEA. Presented by DR. ROSEN.

Elizabeth F., aged 37, presented a patch of morphea on the left flank in the waist line, roughly triangular in outline and about 6 inches long, the base being about 3 inches. The patch was pink in color and was slightly indurated. There were three smaller patches on the right side of the abdomen.

CHICAGO DERMATOLOGICAL SOCIETY

Regular Meeting, Oct. 20, 1920

C. A. BAER, M.D., *Presiding*

ARSENICAL HYPERKERATOSES. Presented by DR. H. N. COLE.

A man, aged 22 years, with a history of epilepsy of nine or ten years' duration, four years ago had first noticed papular lesions on the palms and soles that were becoming keratosed. At that time he was told that arsenic had not been used, and that he had been given only sodium bromid.

Two or three of the lesions had been treated experimentally with radium, which caused temporary disappearance. The patient then consulted another physician who administered roentgen therapy; he subsequently returned to Dr. Cole with a more acute case of keratosis. He had received no arsenic since first seen but had formerly received arsenic with sodium bromid over a long period of time. Hyperpigmentation was present under the arms.

ARSENICAL HYPERKERATOSIS AND PIGMENTATION. Presented by DR. WAUGH.

A boy, aged 9 years, had received Fowler's solution for chorea two years previously, beginning with a dose of 5 minims after meals which was gradually increased to 10 minims. Three or four months later the patient's mother noticed a roughness of the palms which later spread to the dorsal surface of both hands and fingers. The plantar surfaces were similarly involved.