An Address

ON

THE TREATMENT OF SOME COMMON DISEASES OF THE SKIN.

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GENTLEMEN,—When your chairman, Dr. Redfern, did me the honour to invite me to address you on this occasion it occurred to me that it might perhaps be more acceptable if I put together some rough notes of certain methods of treatment which I have found useful in some of the commoner diseases of the skin, rather than that I should inflict upon you an elaborate essay upon some special subject. I must first of all apologise for the very fragmentary nature of my communication, and secondly I must disclaim any idea of particular originality in the measures that I am going to recommend. Many of the remedies that I shall mention are as old as the hills and I dare say are well known to you, and others are merely modifications of methods of treatment recommended by others. I was once present when an eminent specialist deprecated the admission of general practitioners into a certain special society on the ground that he did not see why specialists should give themselves away or give away their "tips," unless for a special fee. Fortunately, some of us still believe that we belong to a scientific profession and are sufficiently imbued with the Hippocratic spirit to be above such contemptible small-mindedness. At any rate, most of us specialists are always ready to impart all we know—little though it may be—to any brother practitioner who may consider it worth his while to listen to us either at the hospital or elsewhere.

I propose on this occasion to speak particularly upon the treatment of the following common diseases—eczema, psoriasis, impetigo, acne, and ringworm.

ECZEMA.

That the numerous cases of cutaneous eruptions which are included under this name have more than one pathological cause most dermatologists are agreed. There can be no doubt, however, that the ubiquitous microbe is at the bottom of many of them, and it is to my mind more than probable that there is more than one microbe the growth and development of which in the skin will produce the inflammation, irritation, exudation, and exfoliation which are more or less characteristic of "eczema."

As with other microbial infections, moreover, another factor is necessary for the production of the disease: the micro-organisms will not flourish if the soil or cultivating medium—i.e., the tissues and juices thereof—be not suitable. Some of the modern dermatologists, especially on the continent, are, I fancy, rather inclined to ignore this latter factor and to depend too much upon purely external applications in the treatment of eczema. On the other hand, there can be no doubt that the older practitioners relied too much on internal medication in this and in many other diseases of the skin. I feel sure that in most cases the best results are obtained by simultaneous external and internal remedies. Our aim should be to get the whole system—all the organs of the body—in a thoroughly healthy condition as well as to destroy the microbes or prevent their growth, and we must see to the digestion, to constipation, to the kidneys, to the circulation, and even to the nervous system—to everything, in fact, which may directly or indirectly influence the condition of the tissues and fluids of the skin.

I frequently give with benefit an iron and magnesia mixture—e.g., the *mistura ferri aperiens* of most hospital pharmacopœias—with a little *nux vomica* as a digestive tonic, or sometimes an alkaline bitter mixture with an aperient if necessary, and if able I regulate the diet as far as possible. As a

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rule I recommend simple, plainly-cooked food, the avoidance of much sugar, tea, strong coffee, pastry, cheese, beer, acid and sweet wines, or much alcohol in any form. Externally, the applications will vary with the form of the eczema, its acuteness, extent, position, &c. In acute inflamed cases, antiseptic, protection, and reduction of inflammation and exudation are to be aimed at, and either powders, pastes, liniments, ointments, or zinc gelatins may be employed. Many cases do well with what we at Blackfriars call the "*unguentum hydrargyri cum plumbo*," which contains 10 grains of acetate of lead, 10 grains of calomel, 20 grains of oxide of zinc, 20 grains of ointment of nitrate of mercury, and one ounce of vaseline. But occasionally an eczematous skin will not stand an ordinary ointment, and a modification of Lassar's paste may then be tried—e.g., three drachms each of zinc oxide and starch, 10 grains of salicylic acid, and one ounce of vaseline, or a calamine liniment containing one drachm of carbonate of zinc and half an ounce each of olive oil and limewater. When the weeping and inflammation are excessive a powder thickly dusted on is sometimes effective—e.g., half an ounce of starch, two drachms of oxide of zinc, and one drachm of powdered borax or boric acid. Many cases of acute eczema which have resisted other applications have yielded in my hands to the zinc-gelatin treatment (of Pick and Unna)—viz., half an ounce of gelatin, three drachms of oxide of zinc, one ounce of water, and half an ounce of glycerine, and I generally add 10 minims of ichthyol. The mass melted in a glue-pot and painted over forms an elastic, protective, and soothing covering. In all cases, immediately before applying any of the above, I order the parts affected to be well bathed with a very dilute antiseptic lotion. In preference I use a lotion containing half a drachm of creolin to a pint of soft boiled water, because it is effective as an antipruritic as well as being an antiseptic and—an element of importance in hospital practice—because it is inexpensive. Other weak antiseptic lotions are no doubt equally as good.

In dry eczemas and where there is but little inflammation, tarry ointments are usually very efficacious. Our favourite one at Blackfriars is the so-called "*unguentum petrolei compositum*." This contains half a drachm of alcoholic solution of coal tar, 10 grains of ammoniated mercury, and an ounce of vaseline. Creolin is sometimes with benefit substituted for the alcoholic solution of coal tar and I dare say that the *liquor picis carbonis* would also do.

As with the acute eczemas I always advise bathing the parts affected with a weak tarry lotion before applying the ointment night and morning, or even, if the eruption be extensive, a tepid bath containing from half a drachm to one drachm of creolin or other tar product to about six gallons of water. Soap is generally detrimental in eczemas, especially in the acute form, and I frequently recommend a muslin bag filled with bran to be used as a substitute. A warm sitz bath night and morning with rather more creolin in it—say one drachm to two gallons—I have found very useful in obstinate cases of eczema of the perineum and anus. In these cases, too, I have sometimes found the addition to the tar ointment of 10 grains of sulphur or 25 grains of ichthyol to be of good effect. This is applied immediately after the bath.

In eczemas of the limbs I keep the ointment bandaged on, and I am sure that careful bandaging of the legs from the foot to the knee is an important adjunct to the treatment, especially when varicose veins are also present, as they often are. There is one matter that I should like to point out in the treatment of eczema. It is a mistake to use strong ointments—a fact that, I believe, was first recognised by the elder Startin, the founder of Blackfriars Hospital for Diseases of the Skin, and which has not yet been grasped by the editors of the British Pharmacopœia, for the official ointments therein set down are mostly too strong in skin cases.

PSORIASIS.

Although I regard the constitutional element in psoriasis of even more etiological importance than in eczema, seeing as we do among its other features its tendency to occur in several members of the same family, and in gouty and rheumatic subjects, I have come to the conclusion that external treatment is, comparatively even, of much greater use in this disease. As with eczema we ought to consider the state of the internal organs as well as any "diathesis" which may be indicated. I believe that the older practitioners were often right in giving alkalies and diuretics in these cases, but I have long become convinced that there is

no particular drug administered internally which can fairly be regarded as a specific for psoriasis. As for arsenic, I consider that its vaunted specific efficacy in the treatment of this disease is little short of a medical myth. I could produce notes of numerous cases in which its persistent exhibition for years has produced no effect either in removing the efflorescence, or in preventing its recurrence after its removal by external treatment. If, as perhaps happens occasionally, the patches disappear during a prolonged course of the drug, it has only been, according to my view, either after the patient has been made very ill, the nutrition of all the tissues having suffered—the skin with its patches of psoriasis along with the rest—or from the effect of concomitant measures. We frequently, indeed, see the efflorescence of psoriasis temporarily vanish during some other intermediate severe affection—gastritis, fevers, influenza—and I have even seen the spots go when a patient has meanwhile contracted syphilis.

Thyroid gland is another much vaunted drug which I have also discarded in the treatment of psoriasis. Some years ago I tried it extensively in the disease, and came to the conclusion that although in a few cases it undoubtedly caused the exfoliation and disappearance of the spots, in the majority it had no effect, and, indeed, frequently made the patients very ill without doing much good to the psoriasis. Even in those cases in which the results were good the rapidity of cure was by no means greater than with the ordinary external methods of treatment, nor was there any less tendency to recurrence. The external application of chrysarobin undoubtedly removes the efflorescence quicker than anything else. As an ointment, however, it has its drawbacks—ruining the patient's clothes, and producing severe and disagreeable erythema in tender parts and inflammation of the eyes if accidentally carried thereto. I use it now always in the form of a solution, to be rubbed in only on the patches which are situated on the extensor surfaces where the skin is less tender—e.g., 40 grains of chrysarobin, 10 grains of salicylic acid, and one ounce of solution of gutta-percha (in chloroform), this forms a film which, when dry, does not stain the linen. As it peels off it is to be replaced every day or two—generally until an erythematous blush appears around. A more or less saturated solution of chrysarobin in benzine, rubbed into the patch, and then when dry painted over with collodion or the liquor gutta-perchæ is also very effective. For other parts of the body I usually order a strong tar or creolin ointment—e.g., one drachm of creolin, 10 grains of ammoniated mercury, and an ounce of vaseline, often also with the addition of from 10 to 20 grains of salicylic acid. If possible I make the patients soak themselves for a quarter of an hour or 20 minutes every night in a warm bath containing creolin and then thoroughly inunct the patches with the ointment.

For psoriasis of the scalp, the most efficacious treatment in my experience is an ointment containing a drachm of ammoniated mercury and three and a half drachms each of soft soap and vaseline to be well rubbed in every night. By these measures thoroughly carried out the most inveterate cases can, I believe, be "cured" in a few weeks; and I am not aware that the affection then shows more tendency to recur than after any other method of treatment. Indeed, I know several old patients who were so treated who have had no return of their psoriasis for many years.

IMPETIGO.

Everyone who visits the out-patient department of the West London Hospital is surprised at the enormous number of cases of impetigo that we see there and I have no good explanation of the fact that the disease is so prevalent in Hammersmith and the neighbourhood. In most skin clinics the cases of eczema are by far the most numerous; at Hammersmith the impetigo cases certainly predominate. Fortunately it is a disease easily cured and by the good old-fashioned remedy—ammoniated mercury ointment.

I do not approve of the crusts being removed by poulticing. Warm oil or a weak, warm antiseptic lotion ought to be sufficient. I generally order a weak creolin lotion for this purpose, the ointment to be applied immediately afterwards and re-applied night and morning. If pediculi are present, as is usually the case in the heads of our London School Board children, I recommend a thorough nightly washing with soft soap and hot water immediately before applying the ointment. If this treatment be kept up for some weeks

the young pediculi are dealt with as they come forth from the nits and the pediculosis is soon eradicated.

ACNE.

This is another common affection which in my experience can be cured with certainty and in a comparatively short time by a judicious combination of internal and external remedies. I believe that unless the skin is in a more or less unhealthy state the pus and comedo-producing organisms do not perform their nefarious function. The majority of acne patients will give some indication of dyspeptic trouble, constipation, &c., and the rosaceous cases particularly of flushings of the face, &c., and not infrequently they give a history of their faces being worse at the menstrual period. Most of them I find to be benefited by the tonic and aperient iron and magnesia mixture between meals, others by an alkaline bismuth mixture before food. In all cases I recommend the application to the spots every night of the compound sulphur ointment of Blackfriars which contains 30 grains of sulphur, 10 grains of ammoniated mercury, 10 grains of sulphide of mercury, and an ounce of vaseline, slightly varying the quantities in particular cases and adding oxide of zinc if there be much inflammation. Occasionally the old sulphur and lime-water lotion does well, but I find as a rule that the above ointment does better. Before its application I make the patients bathe the face with hot water and a 10 per cent. ichthyol soap well lathered on. This is to be done again in the morning and very often I tell them to keep the lather on for as long as possible. But a still more important part of the treatment, in my opinion, is the cautious application to each pimple of the tiniest driplet of pure carbolic acid, just liquefied with a little water, as recommended many years ago by Dr. Walter Smith of Dublin. As a rule, one application aborts and cures the pustule. The rapid efficacy of this application is particularly apparent in those very bad cases of recent alcoholic acne. In indurated cases where subcutaneous abscesses have formed and where the pustules are large and deep I puncture them, and with a small blunt-pointed hypodermic syringe needle, with the orifice apical. I thoroughly wash out the cavity with some antiseptic lotion—1 in 1000 sublimate, 1 in 20 carbolic, izal, or chinolol. I do not think it matters much which—in fact, I treat it as one would treat antiseptically an ordinary surgical abscess. I think it always well to remove as many comedones as possible in acne cases, and for this I use the comedo extractor which has been made for me by several London instrument makers.

RINGWORM.

As we all know, many cases of ringworm of the scalp can be easily cured by the application of iodine tincture and liniment, Costa's paste, turpentine, or even common ink. When, however, the fungus gets deep down into the hair follicles it is not so easy to get at, and the case even in the most experienced hands may last for years. During the past 15 years I think I have experimented with most of the methods, and the number is legion, that have been proposed for the treatment of ringworm. I am now advising the following measures in the majority of cases. The scalp to be shaved every fortnight and calico skull caps to be worn day and night, an ointment consisting of one drachm each of pure carbolic acid and salicylic acid to the ounce of vaseline to be well rubbed in with a stiff brush night and morning over the patches, and the rest of the scalp slightly smeared over with the same ointment. Twice a week I have the scalp lathered with hot water and a soapy mixture containing two ounces of soft soap, two drachms of glycerine of carbolic acid, and two drachms of glycerine of boric acid, to be followed immediately by an application of the ointment. Once or twice a week, if possible, I use immediately after the washing my special pump which forces in by the atmospheric pressure any parasiticide liquid which you may wish to use. The area of scalp beneath the bell simply becomes impregnated with the fluid, making the soil very unpleasant at least for the undesirable trichophyton. I generally employ pure creasote and sometimes equal parts of ozonic ether and guaiacol which penetrates readily. Before using this machine it is as well to remove as much fat as possible from the follicles by swabbing the patch with ether. Many cases that have resisted other methods of treatment for years have in my hands yielded to this.

CONCLUSION.

I think, gentlemen, that I have now wearied you enough, but before concluding I should like to express my opinion

that we are in this country in a great degree handicapped in the treatment of diseases of the skin from the fact that we cannot always have the various necessary measures thoroughly carried out. It may be all very well for the hospital patients and for very wealthy people who have the time to devote and who can afford to go to the West End nursing homes. In a large number of cases, however, the initial prescription and the occasional visit to the skilled practitioner are deemed sufficient; the circumstances of the patient's home rarely lend themselves to thorough inunction, suitable baths, &c., and, indeed, are seldom adequate, and the result often is that the case "hangs fire." The continental patient suffering from a disease of the skin is, on the other hand, better off. He goes to an experienced special practitioner who admits him into his private hospital at a cost varying according to his means, is seen and dressed every day by the practitioner himself or by his assistants, with frequent modifications of treatment as indicated, and I am obliged to admit is often cured quicker and more satisfactorily than he would be in this country. I have myself more than once—an admission which I regret to have to make—felt constrained to send patients who were above the hospital class to Aix la Chapelle, to Hamburg, and to other places abroad, because I conscientiously knew that their cases would be more thoroughly dealt with and at less expense than in a London nursing home. I have only now to thank you for listening to these very desultory remarks. I hope, however, that some of the measures which I have mentioned may prove of use to some of you.

THE ETIOLOGY OF RHEUMATIC FEVER.

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THE etiology of rheumatic fever has proved to be a problem of such complexity that it is necessary to state at the very outset of this paper the scope and object of the research. The various results that had been already obtained by investigators were in themselves our first difficulty, for they necessitated the employment of widely different methods to enable us to cover the ground already traversed. Our first intention was to obtain, if possible, some definite facts from which as a basis we might make further advances, and the discovery and isolation of micro-organisms in the form of diplococci in eight successive cases of rheumatic fever afforded us this opportunity. When we had obtained these diplococci in pure culture Mr. H. G. Plimmer undertook a series of inoculations into animals and the results that followed provided us with further data. Finally, microscopic investigations of the human and animal tissues have been another source from which we have obtained facts which we believe to be of considerable importance. The methods that have been used and the conclusions that have been obtained from these three sources are detailed in this paper, together with a brief historical survey of the work of others upon this subject.

There are many points of interest that are suggested by these results; but the most important fact deducible from our researches, as detailed below, is *that this diplococcus which we have isolated is a cause of rheumatic fever*. It is to this conclusion that our results seem irresistibly to lead. We are not, however, in the face of the results of others, in a position to state that these diplococci are invariably present in rheumatic fever, nor are we able to claim that they are the only cause of this disease.

AN OUTLINE OF THE HISTORY OF THE BACTERIOLOGY OF RHEUMATIC FEVER.

Before giving an outline of our results a historical survey of the subject is appended sufficient to indicate the various views that are, and have been, held, and to do justice to others who have made investigations upon this question. This outline cannot claim to be exhaustive, but it does, we hope, give due credit to those who have already expended much labour in attempting to discover the true

cause of rheumatic fever. In 1892 Fraenkel¹ called attention to a paper by P. Guttman upon the etiology of rheumatism and its complications. Guttman described a case of very acute rheumatism with exudative pericarditis complicated by abscesses in the kidneys and muscles from which the staphylococcus pyogenes flavus was isolated. This micro-organism was obtained from the pericardial exudation and the abscesses but not from the joints. Guttman expressly stated that this was not a case of true rheumatism, nor did he consider this organism, if it were the cause of the rheumatism in this case, to be the sole cause of rheumatic fever. Leyden also concurred with this opinion. In the same year Sahli² discovered the staphylococcus pyogenes citreus in the synovial membrane of the joints in a case of rheumatic fever and also in the pericardial exudation. He considered rheumatic fever to be due to a staphylococcus infection but left it an open question as to whether or not the condition was due to an attenuation of the organism. Netter³ also isolated a streptococcus from a case clinically resembling rheumatic fever but following acute suppurative otitis media. Lanz⁴ in 1893 published a paper upon experimental results connected with suppurative polyarthritis. From the pus of an abscess of the brain operated on by Kocher he isolated a bacillus. This on intravenous injection into rabbits caused death in 23 days. Suppurative polyarthritis resulted and the bacillus was again isolated from the joints. To this organism he gave the name of bacillus pyogenes foetidus liquefaciens. In 1894 Maragliano⁵ obtained diplococci and staphylococci from a case which commenced clinically as rheumatic fever and ended as a septicæmia. This writer also insisted upon the relationship between rheumatic fever and suppurative affections. At this time Chvostek⁶ and Singer⁷ published papers upon the micro-organisms found in the urine of patients suffering from rheumatic fever. Singer found as the result of the examination of the urine in 17 cases that the staphylococcus pyogenes aureus was frequently present, and when present was to be found in considerable numbers, but became less as the disease declined. He associated this occurrence with the rheumatic process. Chvostek, though recognising the importance of Singer's investigation, doubted the validity of his conclusions. Dana⁸ in 1894 isolated a diplococcus from a case of chorea following rheumatism. The organism was found in the meninges of the brain and spinal cord. Charrin⁹ found streptococci in cases of rheumatic fever. Sacaze¹⁰ made the interesting suggestion that some external wound, often insignificant, might be the site of infection in rheumatic fever. In 1896 Lubarsch,¹¹ in a paper upon the streptococcus group and the diseases caused by them, alludes to an exhaustive paper by Buss of Bremen upon the relation of angina faucium to rheumatic fever. Buss¹² in this paper came to the conclusion that the throat and intestines are in many instances the sites of the entrance of the rheumatic infection.

The clinical importance of the angina faucium that occurs in rheumatism had long been recognised. It was mentioned by Trousseau¹³ in his "Clinical Medicine" and Dr. Kingston Fowler¹⁴ in 1880 published an account of 20 cases of acute rheumatism ushered in by tonsillitis; Dr. Cheadle¹⁵ further insisted upon this clinical fact in 1888 in the Harveian Lectures upon the rheumatic state in childhood.

Achalme¹⁶ introduced a new field for investigation by a series of papers upon the bacteriology of rheumatic fever dating from 1891. He discovered a bacillus in the blood of patients who succumbed to rheumatic fever and by his subsequent researches confirmed this observation. His results

¹ Deutsche Medicinische Wochenschrift, No. 46, p. 809.

² Etiology of Acute Rheumatism, Correspondenzblatt für Schweizer Aerzte, 1892, vol. xxii.

³ La Semaine Médicale, 1892, No. 7, p. 48.

⁴ Experimental Bacillary Suppurative Polyarthritis, Centralblatt für Bacteriologie, 1895, Band xiv., p. 269.

⁵ Infections from the Pyogenic Micro-organisms, Riforma Médica, 1894, Nos. 67 to 68.

⁶ Verhandlungen des Congresses für Innere Medicin, 1897, p. 99.

⁷ Wiener Klinische Wochenschrift, 1894, No. 26, p. 449.

⁸ The Microbic Origin of Chorea, American Journal of Medical Science, 1894, p. 31.

⁹ La Semaine Médicale, 1894, p. 376.

¹⁰ The Role of the Staphylococcus in Acute Articular Rheumatism, Archives Générales de Médecine, 1894, p. 513.

¹¹ Pathology, 1896.

¹² Deutsches Archiv für Klinische Medicin, 1894, vol. liv., p. 1: The Bacteriology of Acute Rheumatism.

¹³ Clinical Medicine, vol. ii., p. 466.

¹⁴ THE LANCET, Dec. 11th, 1880, p. 933.

¹⁵ Harveian Lectures on the Rheumatism of Childhood, 1888.

¹⁶ Comptes Rendus de la Société de Biologie, 1891.