which any surgeon could testify that a perforation of the skull only half an inch across could not possibly have been made by a bullet measuring an inch in diameter.

No. 1603 ARCU STREET.

ART. VI.—*On Lupus Erythematosus*.¹ By W. H. GEDDINGS, M. D., of Aiken, South Carolina. (Communicated by E. GEDDINGS, M. D., Professor of the Institutes and Practice of Medicine in the Medical College of the State of South Carolina.)

Our knowledge of *lupus erythematosus* dates from the time of Bielt, who is said to have described it in his lectures (1828), and to have given it the name of *Erythème Centrifuge*. The choice of the name was unfortunate, the term *erythema* being usually employed to designate an acute affection, whereas the disease in question is characterized by its exceedingly chronic course. In 1851 Cazenave² published an account of the disease, and applied to it the name of *Lupus Erythematosus*—a name which has been since adopted by most English and German dermatologists. Hebra³ was familiar with the affection several years before Cazenave's description appeared. Looking upon it as an independent disease in no way connected with *lupus vulgaris*, he applied to it the name of *Seborrhœa Congestiva*; a name which he afterwards abandoned, not because he had changed his opinion in regard to its nature, but on account of his reluctance to add another to the thousand and one terms which encumber dermatological literature. Devergie⁴ describes as *Herpes Crétacé*, a very chronic disease of the skin, which is located on the face, and is characterized by an eruption of round, sharply-defined red spots, covered with white opaque scales, the borders of which are slightly elevated. This description applies so exactly to our *lupus erythematosus* that I feel but slight hesitation in pronouncing it to be identical with that disease. The same may be said of Bazin's⁵ *lupus acnéique*.

Lupus erythematosus almost always attacks the nose and cheeks, and when fully developed assumes the form of a butterfly, the efflorescences on the nose representing the body of that insect, and those on the cheeks the

¹ Syn.—*Erythème centrifuge*, Bielt. *Seborrhœa congestiva*, Hebra. *Scrofulide erythemateuse*, Hardy. *Scrofulide maligne erythemateuse*, Bazin. *Herpes crétacé*, Devergie.

² *Annales des Maladies de la Peau*, 3me année, 3me vol. p. 297.

³ *Zeitschrift der K. K. Gesellschaft der Aertze*, Band 1, 1845, p. 40. *Constat's Jahresbericht über die Leistungen der Dermatologie im Jahre, 1845*, p. 226.

⁴ *Traité pratique des Maladies de la Peau*, p. 162, Paris, 1857.

⁵ *Leçons sur la Scrofula*, pp. 215-525, Paris, 1861.

wings. The diseased patches are slightly elevated, of a bright red colour, and covered with rough, white, dirty yellow, or greenish, firmly adherent scales. The periphery of each patch is of a deeper red, and more elevated than the rest of the diseased surface.

This is the picture one usually sees when the disease is fully developed; to be able, however, to recognize it in all its forms, we must go more into detail and study it in its various stages of development.

Lupus erythematosus first makes its appearance in the form of small, bright red, sharply defined, slightly elevated spots in the centre of each, of which the enlarged outlet of a sebaceous gland is seen, the latter filled with a dried-up yellow mass, consisting of epithelial cells and inspissated sebum. These plugs cannot be readily pressed out, as in simple comedo, and the attempt is usually followed by more or less hemorrhage. These primary efflorescences gradually enlarge until they coalesce with each other, and form the above mentioned patches; a process which is resisted by the formation of new spots, or papules, between the original efflorescences. The epidermis on the surface of the patches is exfoliated and combines with the dried sebum, forming rough, dirty, yellow, or greenish scales. These scales are at first distinct, but like the efflorescences, upon which they are seated, they join together, and form a rough and uneven mass. When these scales are removed, an operation which almost always occasions some pain, their under surface presents little processes, corresponding to the outlets of the sebaceous glands, out of which they have been torn. The skin under the scales is red, but presents no trace of the moist secretion observed in eczema.

I have had but one opportunity of studying the development of lupus erythematosus on the trunk and arms. In that case the disease first appeared in the form of hard lumps about the size of a pea, and exceedingly painful. In the early stages of their development, they are situated in the subcutaneous cellular tissue, and covered with apparently normal skin, so that their existence can only be detected by the sense of touch.

These tubercles gradually approach the surface, flatten out, and become converted into circumscribed red patches, which subsequently assume all the appearances which we have described as characteristic of lupus erythematosus. Prof. Hebra informs me that this mode of development is exceptional, and that the disease usually commences with red spots differing in no respect from those on the face.

Lupus erythematosus never ulcerates, the excoriations that are sometimes met with on the scalp never extending into the corium. In the course of time, often after the affection has lasted for years, small white spots appear in the midst of the reddened surface; these gradually enlarge, until the whole mass is converted into a thin depressed cicatrix, which remains for life. Fortunately this cicatrix is so thin that it occasions but little disfigurement.

Localization.—As above stated the disease almost always appears upon the nose, and on the cheeks, frequently assuming the butterfly form, a portion of which at least will rarely be found wanting; either the body or one of the wings will almost always be present—almost as constant is the localization of the disease on the under lip, which becomes reddened, slightly swollen, and covered with a few thin scales. The ear also is a very frequent seat of the eruption. Sometimes the disease is so extended that it takes possession of the whole face and neck. In such cases the skin is of a bright red colour, and covered with thin shining scales.

Lupus erythematosus frequently attacks the scalp, causing circumscribed alopecia. Here the disease commences with small round spots, which gradually enlarge on their periphery, and are surrounded by the characteristic elevated red border. The hair, with the exception of the fine lanugo, falls out, leaving bald patches, covered with dirty yellow scales which are softer, and can be more readily removed than those on the face. The skin under the scales is at first red, but as cicatrization advances, it becomes white, and presents an appearance which might be mistaken for a patch of favus, from which the crust has been removed, or, when more extended, for alopecia areata. The patches vary greatly in size; the largest that I have seen were the size of the palm of the hand. In this situation the diseased patches are occasionally excoriated.

When the disease attacks the trunk it is usually confined to the back and upper portion of the chest, and never extends below the ribs. On the arms the eruption offers no peculiarity in its distribution. On the hands it is usually met with on the ulnar border, but not infrequently extends a short distance over the palmar surface. Here, as well as on the fingers, the diseased patches are dark, red, and swollen, presenting an appearance which might be mistaken for chilblains, were it not for the thick scales on their surface. On the palmar surface, owing to the absence of sebaceous glands, the scales are much dryer and harder than elsewhere.

I have had an opportunity of examining one case in which, after appearing on the face, scalp, trunk, arms, and hands, the disease also attacked the feet.

Subjective Symptoms.—Patients with lupus erythematosus seldom complain of itching, unless the scalp is affected. The itching, when present, is usually combined with a burning sensation. On the hands and fingers, as well as on the feet and toes, the disease is exceedingly painful.

Diagnosis.—The characteristic features in lupus erythematosus are the exceedingly chronic course of the eruption, its localization on the nose and cheek, in the form of a butterfly; the presence of dirty yellowish scales on its surface, and the bright red, somewhat elevated border of the diseased surface. If in addition to these signs there is a slightly depressed white cicatrix in the centre of the efflorescence, there will be no difficulty in recognizing the affection. When, however, the disease is seen in an early

stage, or when it assumes an unusual form or appears on some part of the body where we are not accustomed to see it, the diagnosis is sometimes extremely difficult, and I know of cases where the best dermatologists have erred.

In its early stages, it may be mistaken for papular or tubercular erythema, but may be distinguished from these diseases by its exceedingly chronic course, and the presence of the enlarged outlet of a sebaceous gland in the centre of the papule. Erythema papulatum is usually confined to the back of the hands, and to the ankles, seldom attacking the face, and then only the forehead; localities in which lupus erythematosus is seldom or never seen. Lupus erythematosus sometimes simulates chronic eczema, but may be distinguished from that affection by the dry surface which it presents after removal of the scales, and by the absence of vesicles on the periphery of the efflorescences. The itching, even when present, is never so intense as in eczema. It may also be mistaken for psoriasis of the face. Such an error could only occur when the scales of the latter have been removed, in which case the presence of psoriasis on other parts of the body, especially on the elbows and knees, will reveal the true nature of the affection.

From papular syphilis it may be distinguished by the absence of the cachectic appearance, and other general symptoms characteristic of syphilitic affections, as well as by the bright red colour of the diseased patches, their very slow growth, and the obstinacy with which they resist the best directed antisyphilitic treatment.

When it is confined to the scalp, it may be mistaken for three diseases, viz: alopecia areata, herpes tonsurans, and favus. In alopecia areata the patches are clean, white, and polished, as though they had been shaven with a razor; in lupus erythematosus they are usually covered with dirty, yellowish, greasy scales, and surrounded by a bright red border. In herpes tonsurans the hair on the diseased surface does not disappear as completely as in lupus erythematosus, but looks as if it had been badly cut, or, in other words, as though it had been patched. The presence of characteristic fungi would put an end to all doubts as to the nature of the disease. The concave appearance of the bald patches occasioned by favus will be sufficient to prevent their being mistaken for lupus erythematosus.

Prognosis.—There is no disease in which the prognosis is so uncertain as in lupus erythematosus. Some cases will yield to the simplest treatment, while others, and such unfortunately constitute a large majority, persist for years in spite of the application of the most energetic caustics.

The cicatrix produced by lupus erythematosus is indelible, but it is so thin and so slightly depressed, that it produces but little deformity. The disease does not interfere with the general health of the patient, and were it not for the disfigurement, would occasion him but little annoyance. I

know of one case in which the disease disappeared in consequence of an attack of erysipelas, but returned a few months afterwards.

Ætiology.—Lupus erythematosus does not appear to be dependent upon any constitutional disease; those cases that have fallen under my observation were all on strong, and in other respects, perfectly healthy individuals. In Cazenave's cases also the general health of the patients remained unimpaired. Age appears to exercise but little influence on the production and course of the disease. I have known it to attack persons of almost every period of life from childhood to old age. The youngest that I have seen was a boy twelve years old, who was attacked with the disease at the age of nine; and the oldest a man of seventy-four. It, however, seldom makes its appearance before the twentieth year. Wilson² states that in twenty-four cases it occurred four times between the ages of seventeen and twenty; fourteen times between twenty and thirty; three times between thirty and forty; twice between forty and fifty; and in one case the patient was seventy-one years old.

It is more frequent on women than on men.

The disease may be called a rare one. I have observed it only twenty times in upwards of 3500 cases of skin disease; that is in the proportion of 1 to every 175. This average would appear to be large, as observations in other years show the disease to be much less frequent.

Bazin³ mentions a case in which the disease was developed from frost-bites on the nose and cheeks. The redness at first disappeared in summer and returned in winter, and finally became permanent. The red surface afterwards became the seat of lupus erythematosus. The value of this case in an etiologic point of view is rather impaired by the fact that there were also several patches of lupus erythematosus on the scalp which could hardly have been produced by the action of a low temperature. Most French authors assert that the disease is due to a scrofulous diathesis. It is not to be denied that lupus erythematosus may sometimes develop itself in scrofulous individuals, but that this is always or even generally the case is a mistake, as in but one of the twenty cases upon which these observations are based was there any sign of scrofula. Bazin has recorded a case of lupus erythematosus in which constitutional syphilis supervened. I mention this case to show that there is no causal connection between the two diseases; the most prominent authorities on syphilis not admitting the possibility of a new infection as long as the original poison remains in the system.

Lupus erythematosus sometimes appears as a consequence of the seborrhœa which occurs after an attack of variola.

¹ *Annales des Maladies de la Peau*, vol. iii. p. 299.

² *Journal of Cutaneous Medicine*, vol. i. p. 273.

³ *Leçons sur la Scrofule*, p. 524.

Pathological Anatomy.—During the past year I have had two opportunities of studying the pathological anatomy of lupus erythematosus. The result of my observations in the first of these cases was read before the Academy of Sciences in Vienna, and published in the reports of that institution.¹ A couple of months after the publication of the above, a patient died in Prof. Hebra's wards with patches of lupus erythematosus on the face, neck, and scalp. This case afforded me ample opportunity to verify my former observations. The result was most satisfactory, the appearances coinciding in every respect with those which I had previously described.

Lupus erythematosus commences with a marked enlargement of the sebaceous glands, which are frequently increased to twice their normal size. On some preparations the accompanying hair may be seen pressed aside, or bent like a bow by the enlarged gland. The increase in the size of the gland is due to enlargement of its individual cells. There are, at this stage of the disease, evidences of considerable hyperæmia in the neighbourhood of the gland, the vessels being distended and filled with blood corpuscles. The fibres of connective tissue in the vicinity of the gland lose their sharply defined contour, and appear to have undergone softening. They do not lie close to each other as in normal skin, but are separated from one another by small lacunæ. This softening of the fibres, and their separation, are the result of an exudation of serum from the distended vessels in the neighbourhood of the gland.

The hyperæmia and serous exudation gradually extend along the excretory duct to the hair follicle, and thence upwards to the superior layers of the corium in which they diffuse themselves. While the hyperæmia is extending upwards the tissue around the gland becomes the seat of true inflammation. Numerous cells make their appearance around the base of the gland, filling up the interstices between the softened fibres. These cells, although for the most part round, are sometimes irregular and provided with little processes. They are about the size of the white blood corpuscles, and enclose a nucleus which assumes a bright red colour when the preparation has been laid in a solution of carmine.

This infiltration of cells follows in the wake of hyperæmia, and diffuses itself throughout the papillæ and upper layers of the corium. The cells, which are at first sparsely scattered in the interstices of connective tissue, soon become so numerous as to render it almost impossible to distinguish the individual fibres and the vessels running into the papillæ. The papillæ themselves become broader, and the line of demarcation which separates them from the stratum Malpighii, is not so distinctly defined as in normal skin. The stratum Malpighii itself is much increased in thickness, and

¹ Geddings. Zur Anatomie des Lupus Erythematosus, Sitzungsbericht d. k. Acad.d. Wissenschaften, II. Abth. Marz. Heft, 1868.

the corresponding cells of the epidermis adhere very firmly, and form little processes which dip down into the enlarged hair follicle. In the course of time, retrograde metamorphosis takes place in the cellular infiltration. The newly-formed cells become filled with molecules of fat and shrink up, the intercellular substance too becomes opaque and contracts. The result of this shrinking of the cells and intercellular substance is the thin white cicatrix peculiar to lupus erythematosus.

Although lupus erythematosus usually commences in the neighbourhood of the sebaceous glands, this cannot always be the case, as we have seen that it sometimes attacks portions of skin in which these structures do not exist, *e. g.*, the palms of the hands, and the volar surfaces of the fingers. This induced me to examine the condition of the sudoriparous glands. In both cases, particularly in the second, I found evidences of hyperemia and cellular infiltration around the sweat glands.

Whatever may be its starting point, the disease always extends upwards, and diffuses itself in the superior layers of the corium, never attacking the deeper layers except the tissue in the immediate vicinity of the sebaceous and sweat glands. The above-mentioned appearances teach us that lupus erythematosus is a peculiar chronic inflammation of the skin, starting out from the neighbourhood of the glandular apparatus, and confining itself to the upper layers of the corium. Its mode of development, and the fact that it attacks only the superficial layers of the skin are sufficient to distinguish it from lupus vulgaris, as none of the numerous authors who have investigated the pathological anatomy of the latter disease, except Rindfleisch, have ever been able to trace its origin to the glands of the skin. I myself have examined four cases of lupus vulgaris, but could find nothing similar to the appearances observed by Rindfleisch.

I will now state, in a few words, those points of difference between lupus vulgaris and lupus erythematosus, which have been deemed sufficient to induce Professor Hebra, and other dermatologists, to look upon them as entirely distinct diseases. Both attack the face, manifesting a great predilection for the nose and cheeks. Lupus erythematosus, however, is very prone to break out on the scalp—a locality in which I have never seen lupus vulgaris, although I have looked for it in that situation in upwards of one hundred cases. It is true that many cases are mentioned in the literature, in which the ulcerative form of lupus vulgaris is said to have attacked the scalp. Some of these may have been lupus, but by far the greater majority were syphilitic ulcers; indeed, it is now a generally conceded fact, that non-syphilitic ulcers seldom or never break out on the scalp. Another distinctive feature in the distribution of the eruption is, the almost constant affection of the lower lip in lupus erythematosus; that locality being seldom or never the seat of lupus vulgaris. The absence in most cases of lupus erythematosus of the signs of scrofulous habit, so frequently met with in ordinary lupus, is another evidence of the diversity of the two diseases.

Another fact which goes far towards establishing the individuality of lupus erythematosus is, that it seldom makes its appearance before the age of twenty, and that it is most commonly developed during the prime of life; whereas, lupus vulgaris almost always commences at or before the age of puberty. These facts, taken in connection with the distinctive anatomical features already mentioned, are sufficient to warrant the assumption that lupus vulgaris and lupus erythematosus are two separate and distinct diseases, in no way connected with each other. It is much to be regretted that Professor Hebra ever relinquished the name (*Seborrhœa congestiva*) which he first applied to it. The few points of resemblance existing between the two diseases, such as the predilection for the nose and cheeks, and their healing by cicatrization without previous ulceration, render it all the more important that they should not be classed together under one generic name. It is to be hoped that a reform will soon take place in our dermatological nomenclature, which, without being so sweeping and confusing as that proposed by Mr. Erasmus Wilson, will, nevertheless, enable us to apply more distinctive and appropriate names to affections so widely different in their character as lupus vulgaris and lupus erythematosus, as well as to two forms of elephantiasis.¹

Treatment.—Lupus erythematosus is the most difficult of all skin diseases to treat. The fact that the disease occasionally gets well of itself, leaving only a flat thin cicatrix, admonishes us to be careful in the selection of our remedies, and not to make use of those caustics which produce thick and uneven scars. The first step in treatment is, to remove the scales, for which purpose strips of linen, soaked in oil (any oil will answer), should be applied to the diseased surface, over which a piece of flannel should be bound. This application is to remain on until the scales become so soft that they can be rubbed off with ease. After this preparatory treatment has been completed, any of the numerous remedies which have been proposed in the treatment of this disease may be applied. The simplest treatment is that with potash soap (*sapo virid.*), which should be applied as follows: Moisten a piece of flannel with lukewarm water, and lay a small quantity of the soap upon it, and then rub the diseased patch with it until a good lather is formed, after which some of the soap should be spread upon a piece of flannel and laid upon the diseased surface. The

¹ An erroneous statement has crept into the English translation of Hebra's work on the diseases of the skin, which, if uncorrected, will lead many to question the writer's claim to the discovery of the primary seat of lupus erythematosus. It is there stated that Neumann, who published a paper on this disease in the *Wiener Medicin Wochenschrift*, 1867, had informed him that the sebaceous glands were the seat of the disease. No mention is made of this in the above mentioned paper, neither does Dr. Neumann assert any such claim. Professor Hebra's attention was called to the error, and he has since frequently asserted the priority of the writer's claim when lecturing on this disease.

frictions are to be repeated daily, reapplying the flannel after each operation. After the third day, the treatment should be suspended and a new epidermis allowed to form. As soon as this has taken place, the part should be well washed with water, to determine whether the new epidermis is healthy. If it stand the washing, the disease may be considered cured; if not, the whole process is to be repeated. This simple treatment will, in some few cases, effect a cure; but in the majority it will be found necessary to resort to more energetic remedies. Hebra has sometimes effected a cure by cauterizing the part with strong liq. ammoniæ. It should be applied with a brush made of picked lint. After each application the diseased surface pours out a fluid not unlike that which we see in a case of moist eczema. The ammonia should be applied daily. Another application is a solution of iodine in glycerine: *R. Iodinii, ʒj; Glycerioi, ʒj; Potass. iodid. ʒss.—M.*

It should be applied three or four times daily, until a thick brown crust is formed. Its application should then be suspended until the crust falls off and enables us to see the condition of the skin underneath. Should it be necessary, the caustics should be reapplied. The application of iodine and glycerine is exceedingly painful.

Neumana¹ has obtained good results from the application of Rochard's ointment. To be efficient it must be made stronger than usual: *R. Hyd. chlor. mit. ʒj; Iodinii pur. gr. viij; Lene igni fus. adde Ungt. commun. ʒij.—M. f. ungt.*

The ointment should be spread upon a piece of linen and applied for forty-eight hours, during which period it should be changed twice. The inflammatory reaction produced by the ointment should be treated with cold applications. When the affected part becomes smoother, and fewer depressions are to be seen on its surface, the disease may be looked upon as approaching a cure.

Lac sulphur, in the form of a paste, has been recommended. It is prescribed as follows: *R. Loet. sulph., Spts. vini rect., Aq. destillat., aa ʒij.—M. f. poste.* Spread over the diseased surface.

After the crust has fallen off, and the reaction has subsided, the paste should be reapplied. Should all the above remedies fail, a strong solution of caustic potash should be used: *R. Potass. fusæ, ʒj; Aquæ, ʒij.—M.*

The solution should be applied with a pencil made of picked lint. Immediately after the application, the part should be rubbed with cold water until a lather is produced. This latter procedure is necessary in order to prevent the potash from destroying the healthy as well as the diseased tissue. When the disease is located near the eye, that organ should be carefully closed and protected before any of the above applications are made.

¹ Leidor Neumann, Wiener Med. Wochenschrift, 1863, p. 645.

Carbolic acid has been applied with varying success, sometimes effecting a brilliant cure, while at others it has proved perfectly worthless. Much depends on the quality of the preparation. It loses its strength when kept a long while.

Tar has also been recommended as a good application in lupus erythematosus. The best preparations are the ol. cadin, and ol. rusci, of which the latter is preferable on account of its agreeable odour.

The epidermis should be removed by means of soap frictions, or otherwise, after which the tar should be applied with a stiff painter's brush. After each application the part should be powdered with starch. The operation should be repeated twice a day, taking care to rub off the old tar before it is applied fresh. I am informed that Dr. Maurice Kohn, of Vienna, has obtained very good results from the application of emplastrum hydrargyri to the diseased surface.

Arsenic, our great sheet anchor in the treatment of chronic cutaneous affections, exerts no influence upon the course of lupus erythematosus. The same may be said of mercury, cod liver oil, and other internal remedies, all of which have been repeatedly tried without success.

CASE.—*Lupus erythematosus of face, scalp, trunk, hands, and feet; peculiar development from tubercles in the subcutaneous tissue; disappearance of the eruption in consequence of an attack of erysipelas, and its subsequent return.*—Gabrielle Hackenberg, 23 years old, was admitted 25th of June, 1866, with red, slightly-elevated efflorescences on the nose and cheeks, as well as on the scalp, over the occiput, and on both ears.

The patient stated that the red spots first made their appearance in October, 1863. The case was at first mistaken for eczema, and treated with ung. diachyli. During the month of July, new efflorescences appeared on the neck, back, and arms. The last were more deeply seated than those on the face, and somewhat painful. Examination of the genital organs revealed nothing except slight leucorrhœa from the uterus. By the end of July the disease had assumed all the characters of lupus erythematosus. On the 5th of September the affection had extended over the whole face and forehead. Ordered, R. Tinct. mlat. ferri, $\mathfrak{z}$ ss; Liq. potass. arsenit. $\mathfrak{z}$ j; Aqua menth. $\mathfrak{z}$ iv.—M. S.—A tablespoonful every day at dinner.

During the month of September the local treatment consisted in penciling the diseased surface with spts. saponat. alc. (sapo virid. dissolved in alcohol). In October the diseased patches were enoterized with a solution of caustic potash, $\mathfrak{z}$ j to $\mathfrak{z}$ j water. The cauterizations with caustic potash were continued throughout the month of November; the solution used was, however, much stronger ($\mathfrak{z}$ j to $\mathfrak{z}$ ij) than the one first employed. In December the disease attacked the volar surface of the fingers, and the face became the seat of an erysipelatous inflammation.

Treatment.—Cauterization of the patches with caustic potash in solution, painting them with tar, cold applications, etc. etc. In January fresh tubercles made their appearance, and some of the old ones became flatter. Efflorescences appeared also on the soles of the feet. Patient suffered with diarrhœa, but had no fever.

February. Many of the red spots had disappeared and were replaced by white cicatrices. The patient complained of nausea after taking the arsenic.

mixture. The treatment consisted in the application of *sapo virid.* to the diseased surface and cold applications.

March. Up to this time the patient had taken $\mathfrak{v}\mathfrak{j}$ of *Liq. potass. arsenit.* The soap applications were continued.

April. The efflorescences were repeatedly cauterized with carbolic acid, and once with sulphuric acid and glycerine, $\mathfrak{z}\mathfrak{j}$ — $\mathfrak{z}\mathfrak{j}$. Patient left the hospital on the 4th of May, having derived but little benefit from her energetic and painful treatment. During the summer she occasionally presented herself as an out patient, and was cauterized with *liq. ammon. pur.*

In the autumn she was attacked with erysipelas, after which the *lupus erythematosus* disappeared entirely, leaving white depressed cicatrices, not unlike the pits occasioned by variola. Two months later the disease reappeared. The above is an extract taken from the case-book of the General Hospital at Vienna.

At present (Dec. 15th, 1867), there are numerous red slightly elevated spots scattered over the face, and partially covered with dirty yellow scales. These scales contain a large amount of fat, and may be removed without difficulty. They are provided on their under surface with numerous minute processes, which correspond with the outlets of the sebaceous glands, from which they have been torn. The surface of the efflorescences after removal of the scales is of a bright-red colour and slightly depressed in the centre. The efflorescences, when not confluent, are about the size of a lentil. The redness disappears to a great extent under pressure, but not entirely. On the nose and on both cheeks there are red patches formed by the confluence of the above mentioned spots. On the forehead there is also a red patch, about half an inch in diameter and much more elevated than those on the cheeks and nose. This patch, unlike the others, was developed from a tubercle. Between these efflorescences, and scattered over the face, may be seen the remains of a former eruption in the form of round, white, slightly depressed cicatrices. In some situations, particularly on the nose, the cicatrices are the seat of a fresh eruption.

The lower lip is much swollen, and covered with thin scales which exfoliate from time to time.

On the scalp the efflorescences are not so red as those on the face, and the scales more greasy and softer. In this situation the disease sometimes occasions considerable pruritus, and the efflorescences are not unfrequently excoriated. On the chest and back there are a few efflorescences scattered here and there, occasionally in little groups of three or four. On the arms the efflorescences are very numerous, and much more prominent than elsewhere. Their mode of development in this situation and on the trunk is peculiar. They commence with tubercles about the size of a large pea, which are so deeply seated that their existence can only be ascertained by the sense of touch. The tubercles gradually approach the surface, giving rise to circumscribed red spots which, in the course of time, become somewhat elevated. They afterwards flatten, rough scales appear upon their surface, and by degrees the efflorescences assume all the appearances which have been described as characteristic of *lupus erythematosus*. The patient, who is quite intelligent, and whose assertions may be relied upon, states that about two months usually elapse before the tubercles become covered with scales. During the whole period of their development, they are exceedingly painful, but as soon as the flattening takes place the pain disappears. Traces of the old eruption, in the form of white cicatrices, may everywhere be seen between the existing efflorescences. On the forearms there are a

few patches similar to those just described. The hands and fingers are also seats of the disease; the latter much swollen and very painful. On the fingers the efflorescences sometimes suppurate.

This case presents many very interesting as well as instructive features; it illustrates the exceedingly chronic, obstinate, course of the disease, and its persistence in spite of the best directed treatment. I would call special attention to the disseminate form of the eruption; its appearance on the trunk and upper extremities; its involution after an attack of erysipelas; and its subsequent return. The development of the disease on the trunk and upper extremities, from tubercles, is an interesting feature, which appears thus far to have escaped observation, as no allusion is made to it in any of the works on this subject.

ART. VII.—*Exsection of the Trunk of the Inferior Dental Nerve, together with that of the Second Branch of the Fifth Pair of Nerves beyond Meckel's Ganglion, for severe Facial Neuralgia.* By GEO. C. BLACKMAN, M. D., Professor of Surgery in the Medical College of Ohio, Surgeon to the Samaritan Hospital, Cincinnati.

Mrs. S. J. M., æt. about thirty-five years, and mother of six children. Had enjoyed good health until 1852, when she began to suffer from "violent headache and toothache." At this time she resided in Canada, and was subjected to the most heroic medication without obtaining any material relief. She had also all of her teeth on the left side extracted, the only effect of which was to increase the pain. She consumed such enormous quantities of medicine, and "so many gallons of laudanum," to use her own expression, "that the druggists called to inquire what kind of a woman I was." In the year 1862, with her husband, she removed to Cleveland, Ohio, where she was treated by regular and irregular practitioners, as she states, without benefit, and in March, 1866, a portion of the left inferior dental nerve near the angle of the jaw was exsected. For some days after this operation, according to Mrs. M.'s account, her sufferings were increased. The pain then subsided, and did not return for several months, when it became more severe than ever, confining her to her bed the whole of the succeeding winter. She states that so great was her torture, she entreated that the operation should be repeated, but as the first had given only temporary relief, it was declined, and for some nine weeks medication was again resorted to, which, like all previous attempts, failed to produce any benefit. I first saw Mrs. M. in December, 1867, and learned from her the sad history which we have just related. During the half hour that she was sitting in my office, she had two attacks of her terrible paroxysms, lasting from three to five minutes, the left side of her face being drawn into a hideous expression, and the pain extending along not only the course of the inferior dental nerve but from the upper lip along the branches of the trunk of the second branch of the fifth pair of nerves. The patient informed me, that for the past eleven years, on an average, she had had fifty of these paroxysms in twenty-four hours, during profound sleep, as well as in her waking hours.