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A CASE OF ERYTHEMA SCARLATINIFORME.

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THE comparatively rare occurrence of this disease is sufficient excuse for the publication of notes of this case, which, in addition, has some special points of interest.

Mrs. R—, aged 48 years, was first seen on October 10th last, and gave me the following history: Ten years previously she had suffered from a slight eruption on the chest, very like the present rash, but it yielded promptly to treatment. The first sign of this illness was a rash on the front of the chest, which was accompanied with itching and burning of a mild type.

The condition when I saw it was distinctly scarlatiniform in its character and of a dull red hue. Careful inquiries were made to ascertain if there were any cause. No plants were found in the house of an irritant type, no soaps other than the common bar were in use, and no remedies had been applied to the skin; lastly, no new under-clothing had been put on recently. No drugs were used before this outbreak, except occasional aperients. The only likely ætiological factor was intestinal toxæmia, and to account for this there was no history of recent faulty feeding, but only that of constipation and old-standing indigestion. The tongue was thickly coated with a white fur, and the temperature was normal.

She was ordered a lotion of boric acid and calamine and given a purge of calomel. Next day the rash had spread over the chest to the neck and face, and during the six days following it gradually advanced till the whole body was involved. There was very great tension on the face where the eyelids were markedly swollen, a similar condition appearing on the lower extremities.

Pari passu the burning sensation and itch became very severe, and at the end of ten days the patient was acutely ill and exhausted from loss of sleep. The temperature never rose above 99° F., but the pulse became very rapid.

After the first day she was ordered 5 minims of vinum antimon. every four hours, but this had to be stopped in a day or two, as the patient felt so faint, and in its place 10 minims of tinct. strophanthus was prescribed.

Within a fortnight the skin of the chest commenced to peel, and this exfoliation, which took place in large pieces, extended gradually to the other parts of the body. Some of the pieces were as large as a sheet of ordinary writing-paper. The rather unusual element of complete generalised alopecia and shedding of all the nails was introduced, a state of matters which I have never seen previously recorded, although it might almost have been anticipated in a severe case such as this.

Four months later the patient was quite well, and the hair had all grown in again.

While aware that the subject is a vexed one and that the differentiation of the cases is not easy, I feel that the following divisions can be made with some surety, and, indeed, this has already been done by others.

(1) Pityriasis rubra pilaris (Devergie). (2) Exfoliative dermatitis following on the use of some external irritant such as iodoform or mercurial inunction. (3) Exfoliative dermatitis as a sequel to Eczema, Psoriasis, Lichen, etc.; this may be combined with the preceding. (4) Toxæmias.

From the history given this case naturally falls under the last head. Continuing this line of thought the eruption may be regarded as Nature's attempt to eliminate the poison. If this is so, then is it some poison which is more powerful in its effect on the skin than others, or is it that the skin is more susceptible in some individuals than in others? The last seems to me the more likely explanation.

This patient had slight *Seborrhœa capitis*, but many have this and do not suffer from the condition under discussion.

In some diseases there are indications of poisoning such as *indicanuria* and *eosinophilia*, but none were found here.

Examination of the blood and urine in *Dermatitis herpetiformis* has shown that these phenomena often precede a fresh outbreak, and these may have been present in this patient before the eruption appeared.

One may therefore regard the skin condition as Nature's attempt, more or less successful, to eliminate the poison, and, as it is eliminated, there are not the indications in the blood and urine. Further, the poison in its passage is so strongly irritant that it produces the dermatitis.

The rational treatment of the disease is therefore by intestinal antiseptics, and among these carbolic acid is frequently used. Stelwagon gives this remedy in very large doses, watching closely its effect on the kidneys. He recommends twenty to thirty grains daily in glycerine and water, and considers that the usual half to one grain are useless.

In any future case I should be inclined to try this or lactic acid ferment. There is always one reservation, that however valuable these remedies may be in chronic intestinal toxæmias, one need not be surprised at a partial failure here where the mischief is already done. The trial is justifiable in the hope of mitigating the symptoms.

The following other case, though milder, might be also classed as a scarlatiniform erythema.

R. D—, male, aged 23 years, brewer's labourer, came up to the out-patient department of Edinburgh Royal Infirmary on May 18th, suffering from a diffuse rash involving the whole body except the face. The rash was similar to the former case and was accompanied with slight itch.

The history revealed the facts that seven years ago he had suffered from a similar attack, and that up to a month ago he had been taking capsules for *gonorrhœa* for a period of six weeks or so. Absolutely no other suggestive points could be ascertained—the digestion was normal and the tongue was fairly clean. The suggestion of its being a drug rash at once occurred to one, but a month is too long even for a latent effect.

A boro-calamine lotion was ordered and two days later the condition had subsided.

Is this, again, a toxæmia, and are these well recognised recurring cases always toxæmic?

GRANULOMA ANNULARE.*

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(Continued from page 229.)

XXVI. Audry's case, *Annales de Derm.*, 1904, p. 9.

Female, aged 50 years, who for eight months had had lesions "like those described by Colcott Fox and Dubreuilh." On both hands, especially on the right, on the lateral border of the middle and ring fingers, there were rings formed by thin edge of violaceous-pink colour, very firm consistence, slightly scaly and shiny; these ringed patches seemed formed by the juxtaposition of hard pink nodules. The lesion commenced with a nodule which healed in the centre and spread peripherally. The skin enclosed was almost absolutely normal. There was no pain or itching. Histological examination showed a condition of affairs "like Dubreuilh's case."

XXVII. Model of case of Quinquaud's (dated 1891) in the St. Louis Hospital Museum.

Identified from model by Crocker as clinically like his cases of *Erythema elevatum diutinum*. Dr. Wickham, the courteous administrator of the Museum, was unable to furnish any further details than those contained in the catalogue, viz.:

"No. 1599. *Fibromes multiples nodulaires des extrémités*. Diagnostic histologique: *Fibrome fasciculé, Mains*."

It is interesting in this connection to call attention to Dr. Hyde's addendum to Dr. Montgomery's case (p. 252). Was the case, clinically regarded by Hyde and Montgomery as *Granuloma annulare*, histologically as keloid, of the same type as this St. Louis model? (*vide* below).

XXVIII. Dr. T. D. Savill's case, *Brit. Journ. Derm.*, 1905, p. 23.

Male, aged 44 years, with a persistent ringed eruption situated upon the neck, chest, and upper limbs. The condition had lasted for eight months. From the scanty notes of the case, which Dr. Savill has been kind enough to lend to me, it would appear that the diagnosis at first suggested was *tinea*, then *syphilis*, and

* Paper read at the Dermatological Section of the Royal Society of Medicine on June 18th, 1908.