

Present condition.—The diseased area upon the left side is irregularly oval shaped, being about three inches by one inch in diameter and extending from the zygoma to a point one inch below the angle of the jaw. The epidermis of this region is smooth, shining and atrophic; by pressure it is thrown into radiating folds. The patch is whitish but presenting a mottled reddish appearance due to a superficial telangiectasis. The aural border of the patch is considerably raised above the level of the skin and exhibits, to the touch, marked infiltration, keloidal in character. The hair follicles and the mouths of the sebaceous glands are entirely absent over this area.

Upon the right side there was a triangular patch one and a half inches by three-quarters of an inch. The border is markedly infiltrated as upon the opposite side. There is atrophy of the hair follicles but the atrophic appearance of the skin is not as marked as on the left side. Below this patch are several follicular pustules and the disease seemed to be spreading in this direction. Acne lesions were present upon other portions of the face.

There were no vesicles or blebs present.

DISCUSSION.

Dr. ALLEN—There exists a disease, call it lupoid sycosis or ulerythema sycosis, which differs from lupus erythematosus. I am surprised to hear that this disease resembles lupus vulgaris, but to me, the lesions appear more like lupus erythematosus than lupus vulgaris. Lupoid sycosis is in my opinion a distinct disease.

Dr. DUHRING—The experience with this disease has been so limited that we have to view the clinical appearances with much care. I have seen a few cases, some of them ill defined and others well marked. Both cases I thought were characteristic examples of this disease. Lupoid sycosis was a disease which presented many clinical pictures; some writers describing it as resembling lupus vulgaris, others as lupus erythematosus and others as acne. When I looked at the first case I thought it presented features more like lupus vulgaris than lupus erythematosus; so it might be mistaken for the former disease. The second case resembled more an acne and resembled a case which had been under my observation for a year and the man was getting well under mild treatment (sulphur ointment). The hairs were returning, which showed that the hair follicles had not been destroyed. Others who had seen the case were surprised at the return of the hair. I had been inclined to class it with the sycosis but now altered my opinion. The prognosis in this disease was not so unfavorable as others had supposed, since in one case I have seen the hair return. In the second case the idea of parasitism had not occurred to me except perhaps in connection with the lesions on the neck.

Dr. FORDYCE—Until we know more about the pathology of lupus erythematosus it will be difficult to classify this disease. The case is very like lupus erythematosus because of the sharply defined edge of the lesion. The microscopic picture also resembles closely the same disease. The presence of nests of small cells and the absence of giant cells would cause me to group it under lupus erythematosus rather than sycosiform.

Dr. SCHAMBERG—These cases present different types of the disease and they agree in many respects with Dr. Duhring's case. In the latter the skin was soft and there was no inter-follicular scarring. All the cases of this disease are preceded by sycosis and one case was more like lupus erythematosus, but there had been no scales, whereas in the other patient blebs had made their appearance at one time, a lesion which never appears in lupus erythematosus. Blebs did not occur in Duhring's case; I think that pressure of the collection of cells on the neighboring nerves might have caused the bleb formation. I have never seen such deep infiltration of cells, in the corium, in lupus erythematosus.

THE SYMPTOMS AND NATURE OF ERYTHEMA MULTIFORME.

Presented to the Section on Cutaneous Medicine and Surgery at the Forty-eighth Annual Meeting of the American Medical Association, held at Philadelphia, Pa., June 1-4, 1897.

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By the term erythema multiforme I understand a disease characterized by certain tolerably well-defined erythematous lesions upon the skin, which undergo a variable evolution with a tendency to run an acute course and to recover spontaneously. The lesions are chiefly erythematous in type and are superficial, their

seat being in the corium, especially in the papillary layer. They are not hyperemic but are distinctly exudative in character. They consist of macules, maculo-papules, papules, papulo-vesicles, vesicles and blebs. They manifest a disposition for one form to pass into another, thus frequently, but not always, constituting a multiform eruption, hence the name erythema multiforme, originally proposed for the disease by F. Hebra. While therefore a notable variety of lesions frequently, but not always, characterize the disease, it must not be supposed that every exudative erythema is necessarily an erythema multiforme. There are certain polymorphous erythemata which are to be classed as erythema exudativum which are not instances of erythema multiforme, as for example erythema scarlatinoides. In the several cutaneous manifestations of erythema multiforme there are characters common to all the varieties of lesions, as regards their form, shape, outline, their occurrence together or in proximity, color, evolution and involution, which stamp them as being merely different inflammatory expressions of one process. They constitute a group of peculiar inflammations, for the most part erythematous lesions, to which we give the name erythema multiforme. They may be distinctly marked in their general features, constituting easily recognizable dermatoses, or only faintly pronounced, so that possibly the diagnosis can be made only by observing the case for a few days and noting the evolution of the process. In my own field of observation many more of the latter than the former cases present themselves. Well-defined cases, such as are usually selected by authors to illustrate atlases of the diseases of the skin, are comparatively rare in Philadelphia. There occur, as I view the subject, a number of cases of acute, ill-defined erythematous diseases which are difficult to classify because they show so little that is distinctive, and yet if they are followed from the beginning to the end of the cutaneous manifestations, will usually give evidence that they are actually faint expressions of erythema multiforme. In defining disease authors, I think, are inclined to adhere too closely to recognized types of diseases and do not allow sufficiently for variations. Having only defined types in mind the clinician may fail to recognize the disease before him because it falls short of the accepted sharp definition.

As already intimated the predominant idea the world over of erythema multiforme comprises an acute disease, running usually a course extending from one to three weeks and which may relapse or recur at shorter or longer intervals. The lesions, whether in the form of macules, papules, vesicles or blebs, are inclined to be sharply circumscribed, and especially in the case of macules, to be marginate. The color is a bright, vivid or deep red, often a raspberry red. The maculo-papules, papules and papulo-vesicles are three forms frequently occurring together or in sequence, are peculiar in that they almost invariably undergo in the course of their evolution central superficial necrosis. As they grow and extend in size they break down in the center, forming a slight or marked depression and a crust, the latter often being insignificant. This is one of the characteristic features of the maculo-papular, papular and vesico-papular varieties of the disease. It is not only a clinical but also a histo-pathologic feature. Where the process inclines to manifest itself on the skin as a broad erythematous lesion, occu-

pying a small area, or, it may be, the greater part of the general surface, margination in the form of arcs and segments of circles is common. This is often, but by no means always, due to the confluence of several lesions. The mere fact of confluence will not give rise to these peculiar forms, other factors, in connection especially with nerve influence, being, I believe, accountable for it. The angio-neurotic or vasomotor nature of the disease is exemplified not only in this feature but in many other ways. But this observation does not inform us of the intimate nature or the cause of the manifestation. I may here refer to features which every clinician has observed, but what authors fail to dwell upon sufficiently, that the nervous system influences the cutaneous manifestations of the disease in a remarkable manner. There exists in connection with most of the somewhat diverse lesions a notable tendency to spread on the periphery while healing or disappearing in the center. It presents many of the features of herpetism. The process in its course is much like that of *tinea circinata* due to the presence of a fungus. It has often occurred to me to query why the natural lesion and the evolution of these two processes, due to entirely different causes, so far as we are able to determine this point, should be so much alike in many particulars. One is due to some unknown cause acting from within, the other from a well-known cause acting from without, yet the lesions and their evolution possess features which link them from a clinical standpoint. So much so is this the case that until within the last thirty or forty years these diseases were confounded by the most experienced dermatologists. The question of interest is to determine what part, if any, the peripheral nerves or the central nervous system play in the production of the circinate lesions of *tinea circinata*.

Having decided in outline the general character of the local manifestations, it may be inquired what, if any, are the constitutional or general symptoms. Do the latter always occur and thus form a part of the disease? In approaching this subject I desire to lay special stress on the observation that in the descriptions of erythema multiforme in text books, very little is said about the general symptoms. They are, I think, oftener present than is usually conceded. If this be true it would show that they are almost as much a part of the process as the cutaneous manifestations. This I believe to be the case in many instances. The general symptoms, however, are more variable in form than the manifestations upon the skin, and for this reason probably are overlooked or are not taken into account in viewing the entire process. In mild cases, of which a goodly number have come under my observation, they may be trivial. I will refer first to the milder symptoms. They naturally vary somewhat with the age of the patient, but in adolescents or young adults consist of malaise, lassitude, aching in the limbs and trunk or joints, loss of appetite, furred tongue, constipation, fever in a variable degree, often slight, parched lips, and the like. It may be observed that such symptoms are in no way peculiar, being seen in a multitude of acute diseases. This is true, but they nevertheless constitute in many instances, a part of a process of which the cutaneous symptoms are the most striking. The amount of the cutaneous disturbance, however, by no means always indicates the gravity of an entire disease. Thus, by way of example, in dermatitis exfoliativa the cutaneous manifestations may be severe and the

general symptoms slight, while on the other hand in some cases of the eruptive febrile diseases, as measles, the cutaneous are slight and the general symptoms pronounced. If we note the general symptoms in a sharp attack there may exist distinct rheumatoid symptoms, including articular stiffness, swelling or pain, localized or fugitive, together with all the symptoms enumerated as liable to be present in the milder forms of the disease. These and other, sometimes graver, symptoms may make their advent suddenly or gradually before or with the appearance of the eruption. I would interpret them, as I would the eruption itself, as being in many instances due to an infection, similar in nature to that which occurs in certain other erythematous efflorescences upon the skin, as for example, rubella and pityriasis rosea. I believe, then, that what we call erythema multiforme is in reality a general disease, in many instances, of an infectious nature. Of the precise nature of the infection we know little or nothing. I venture the opinion, however, that the cause is probably allied in nature to those which give rise to influenza and similar diseases, and probably to those which occasion some cases of so-called pityriasis rosea. I say advisedly some cases because I think it will be found that several diseases have been included under the heading pityriasis rosea, some acute, others chronic in course.

There is another group of cases, much smaller than those mentioned, that are well known, and which generally pursue a chronic course. The symptoms are more general and graver in character than in erythema multiforme, the lesions being hemorrhagic. The general symptoms are similar or like those I have briefly outlined as occurring in some cases of severe erythema multiforme, but they are more pronounced, and in addition hemorrhages occur, slight or severe, which may relapse or recur in the intestinal tract or elsewhere. The cutaneous lesions are hemorrhagic and not erythematous; that is to say, that take on a hemorrhagic character either in the beginning or soon after, the erythematous character being for the most part or wholly wanting. These cases belong to the hemorrhages of the skin rather than to the erythematata. They possess much in common with infectious purpura, and I think should be regarded as examples of that disease. I make this observation because some writers of late have been disposed to consider them as erythema multiforme. Thus, we note that Osler has recently reported an interesting series of these cases, designating them erythema multiforme. The latter title, in my opinion, is inapplicable to these cases, which if they are investigated will be found to possess the symptoms of purpura rheumatica much more definitely than of erythema. If we group these purpuric cases with the erythematata it will become necessary to change the definition of erythema, which we are by no means prepared to do. I grant that the causes which may give rise to some cases of erythema multiforme may in like manner be concerned in the production of some forms of purpura, and I am of opinion that such is sometimes the case. But this fact does not make them one and the same disease. One cause may give rise to several diseases, in one case involving internal organs, in another instance the integument. The points to which I have directed special attention are the following:

1. That erythema multiforme is a disease of the skin, having a clearly outlined definition as regards the cutaneous lesions.

2. That general or systemic symptoms are often obviously recognizable, and occasionally are severe.

3. That we should distinguish between erythema multiforme and other forms of exudative erythema, not every exudative erythema being an erythema multiforme.

4. The term erythema multiforme should be confined in its employment to characteristic inflammatory manifestations, especially of the superficial strata of the skin, and that where pronounced hemorrhagic lesions occur in the integument, as well as elsewhere, the disease should be viewed as purpura.

5. Erythema multiforme is probably not infrequently an infectious disease, both the general and local symptoms pointing to this conclusion.

DISCUSSION.

Dr. BAUM—I have seen both varieties of erythema multiforme on the same patient, *i. e.*, the erythematous variety on the upper extremities and the hemorrhagic lesions on the legs. I think the disease due to a vasomotor disturbance. I recall a case of this disease in which there were present alternating bullous and hemorrhagic lesions. A relapse had occurred after the death of a sister and it presented the large bullous variety in the hands. I think there were lesions also in the bowels, because there was marked irritability there.

Dr. BULKLEY—I consider it an infectious disease and due to an auto-intoxication. I have seen many cases of this disease in recently landed immigrants. I advise the administration of Startin's mixture and a calomel purge. The rheumatic element occurs sometimes and I regard it as another symptom.

Dr. HARTZELL—All the cases classed under this disease do not belong there. Erythema multiforme exhibits special features of an infectious disease. There are joint affections which are rheumatoid in character, but it is not rheumatism. I do not think the course of the disease is at all influenced by treatment. A number of cases are due to various poisons, *e. g.*, drugs, but the lesions should not be classed as erythema multiforme.

Dr. POLLITZER—The cutaneous lesions are only symptoms of a general disease and the affection is due to some disturbance of the blood vessels. Pathologically there is an erythema accompanied by an exudate and the hemorrhagic form is only one of degree. I do not think it correct to classify the purpura which sometimes follows the ingestion of quinin, with the thrombosis of endocarditis.

Dr. COOK—I think erythema multiforme a group of diseases due to neurotic influences.

Dr. GILCHRIST—I consider the cutaneous lesions are probably the expression of a general affection. I have examined numbers of microscopic sections taken from four or five cases of the erythematous variety of this disease and also from one case of the bullous form. The results of my observations seemed to point to the fact that the cutaneous lesions were brought about by some toxin or some micro-organisms which could not be demonstrated, forming or developing directly beneath the epidermis. The polynuclear leucocytes wandered out into this region and appeared, in the vesicular variety, to become disintegrated or killed as soon as they had wandered out. This condition seemed to point to the fact that the poison was a powerful one. This remarkable microscopic picture could not be explained by any neurotic influences, nor by any alteration in the vessels. The bullous and hemorrhagic varieties of the disease were only one of degree.

With reference to immigrant dermatitis, a good deal of experience was had with this affection in Baltimore, since it was a considerable port of entry for immigrants. I would not class this group with erythema multiforme but would consider it as a separate affection. In the treatment of erythema multiforme I have found sodium salicylate very efficacious.

Dr. DUHRING—Most of the speakers agree with me that there is more in this disease than appears on the surface. I consider Hebra's definition, which was given thirty-five years ago, just as applicable today and could not be improved upon. Hebra, however, did not touch upon the constitutional symptoms. Erythema multiforme is not hemorrhagic. Although the causes are identical, yet all the varieties are not infectious. Immigrant dermatitis I would call erythema exudativum. The cases of erythema multiforme I have seen in Philadelphia are milder than those seen in New York, London, etc.

ON VARIOUS FORMS OF CUTANEOUS TUBERCULOSIS.

Presented to the Section on Cutaneous Medicine and Surgery, at the Forty-eighth Annual Meeting of the American Medical Association, held at Philadelphia, Pa., June 1-4, 1897.

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The affections of the skin produced by tuberculosis have shown such a variety of form that they offer nearly the same interest as those arising from syphilis. On account of the complex construction of the skin the tubercular lesions must present a different appearance according to the organs and tissues of the skin involved. When the glands of the skin are affected we see lichen scrofulosorum or folliculitis; when the lymphatics are affected, the disease manifests itself in the form of tubercular gumma, and as verrucous cutaneous tuberculosis, or lupus, when the papillary layer or the derma is invaded.



Figure 1.

The cause of these eruptions is the tubercle bacillus, which is found in the structure of the skin. We have, however, other cutaneous eruptions where no tubercle bacilli are present, and they are the result of its toxic products. The toxic power of the tox-albumins has been already demonstrated, and it gives the explanation of those forms of lupus erythematosus and of lupus pernio of Hutchinson. In these cases the tubercle bacillus may be in the internal organs far from the skin or in the mucous membranes near the affected skin, and the toxins are the cause of the eruption which is only symptomatic and persistent on account of the persistency of its cause.

The most superficial form of tubercular erythema is considered a serious symptom for the future of the patient. Erythematous eruptions in form of roseola