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A CASE OF PELLAGRA.*

By Howard Fox, M. D.,
New York.

In 1883, Sherwell reported a case of pellagra in his service at the Long Island College Hospital (*Journal of Cutaneous and Venereal Diseases,* 1893, No. 5, p. 142). Nearly twenty years later a second case was seen and reported by the same writer (*Transactions of the American Dermatological Association,* 1902, p. 76). Both of these patients were Italians, one of them a sailor, the other an immigrant. Both of them died at the hospital. At the December meeting of the New York Dermatological Society, Dr. J. A. Fordyce stated that he had seen an undoubted pellagrin three years previously in his service at the City Hospital. This case, occurring in an Italian woman did not seem of sufficient interest at the time to report. Dr. Claude Lavinder, of the Marine Hospital Service, informs me that he has lately seen a case of pellagra at the Marine Hospital at Staten Island. There is also at present a patient in the Manhattan State Hospital for the Insane, in which the diagnosis of mild pellagra was made three months ago by Dr. Roy Van Wart, of New Orleans. At the present time, however, the case presents no characteristic symptoms of the disease.

It was recently my privilege to present before the New York Academy of Medicine the first case (to my knowledge) to be shown before any medi-

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cal society of this city. This case, which the Academy of Medicine authorized me to bring to New York, was formerly under the charge of Dr. J. M. Daves, of Blue Ridge, Georgia. Through the efforts of Dr. Bernard Wolff, of Atlanta, it was possible to bring the patient to New York in time to be presented at the recent "symposium" on pellagra.

CASE.—The patient, H. C. H., is a farmer, fifty-one years old, born in Blue Ridge, Fannin County, Georgia, where he has lived most of his life. His father died at fifty years of age of an unknown disease. His mother died at sixty-three of the "grippe." The patient is the father of thirteen children, eight of whom are living and healthy. Four died as infants. Two of these were twins, two others members of a triple birth. One child was born dead at full term. The patient's wife had never had any miscarriages and had always enjoyed good health. No member of his family had ever suffered from a disease similar to the present one.

The patient had always been a considerable drinker of whiskey. He gave no history of syphilis, but admitted having suffered from an obstinate attack of gonorrhœa when about eighteen years old. At twenty-four he suffered from an attack of malaria, lasting six months. With the exception of these illnesses he had always enjoyed good health till about two years ago. Since then he had gradually "fallen down" in general health and strength.

The first definite sypmtoms noted were a gradual loss of appetite and an occasional "roaring" in the ears. The latter symptom had been constant for the past ten months. Previous to this time the tinnitus had occurred in attacks lasting a few days.

About the first of April, 1908, the patient noticed a redness and swelling of the backs of the hands, which he at first ascribed to a sunburn. The redness was followed by scaling, which lasted for two months. There were a few "blisters" upon the hands at first, but except at the outset there were no subjective symptoms whatever. After the disappearance of the eruption the hands looked entirely normal. During the following winter the patient's general health improved.

About the end of March, 1908, an eruption similar to the first appeared on the backs of the hands. This was also followed by scaling several weeks later, leaving the hands smooth, though darker in color. During the past ten

months there had been three or four such attacks of redness and scaling of the hands. At no time had the hands become entirely normal. The attacks had reappeared in spite of precautions taken by the patient to protect his hands from the sun by wearing gloves and by using bland ointments. There had never been any oozing from the affected area nor had there been any subjective symptoms except as before said at the outset of the attacks. Six months ago there was an eruption of the face and of the dorsal surfaces of the feet somewhat similar to that of the backs of the hands. This has now disappeared, leaving the skin in apparently normal condition.

The patient stated that his tongue had been red during the past summer. According to Dr. Wolff it presented a fiery red appearance when seen two months ago. He had not suffered from severe diarrhœa, except for a short period of a few weeks recently. His bowels have been "more or less loose" during the past summer.

The patient had become more and more depressed since the beginning of his illness and despaired of ever regaining his health. He did not suffer from sudden fits of anger or excitement. His memory, according to his statement, became very poor.

Examination showed the patient to be a poorly nourished man of medium height. His facial expression was very dull. He was slow in answering questions, his memory was evidently poor and he was mentally depressed. The pupils were equal, moderately dilated, and reacted normally to light and accommodation. His tongue was slightly redder than normal. The mucous membranes of the lips and mouth were practically normal in appearance.

The backs of the hands presented a symmetrical bluish red area looking like a fading eczema. This area covered the backs of the wrists, extending slightly around the radial side to the anterior surface. The distal border of the area did not quite extend to the first interphalangeal joints. The skin was smooth and had an atrophied appearance, though to the touch it did not feel very abnormal.

The heart, lungs, and abdominal organs were apparently normal. The pulse was regular in force and frequency, slow, full, and showed marked thickening of the peripheral arteries. There was no tenderness over any portion of the spine. The gait was apparently normal. There was no ataxia. There was some slight rigidity of the muscles of the legs. The patellar reflexes were moderately increased, especially on the left side. There was no ankle clonus, no

Babinski reflex. There were no sensory changes in the skin. The cutaneous reflexes were normal. Examination of the urine showed no abnormal constituents.

An examination of the blood kindly made by Dr. Elizabeth Finch was as follows: Hæmoglobin (Fleischel), sixty-six per cent.; red cells, 4,264,000; white cells, 9,500. Differential leucocyte count showed: Polynuclears, 278, 55.6 per cent.; large mononuclears and large lymphocytes, 22, transitionals, 16 = 38, 7.6 per cent.; small mononuclears and small lymphocytes, 141, 28.2 per cent.; eosinophiles, 37, 7.4 per cent.; mast cells, 6, 1.2 per cent. No nucleated red cells. Red cells pale, but apparently normal in size.

An examination of the nose, throat, and ears kindly made by Dr. D. Bryson Delavan, showed the following: "Nasopharynx: Typical chronic catarrhal inflammation of the upper nasopharynx and Eustachian tubes with obstruction of the latter. Ears: Condition appeared to be characteristic of the above. No apparent connection with the general disease. Left Ear: Watch ticking audible; tuning fork audible at one inch; tympanum thickened, opaque and much retracted. Right Ear: Watch ticking audible two feet; tuning fork audible six inches; tympanum slightly thickened, much retracted. Nose: Extension of spur on left side of septum. Small ridge on right side of septum."

That the case is an undoubted one of pellagra would appear from the history of the recurring eruption upon the typical sites, loss of appetite, red tongue, diarrhœa, general weakness, mental depression, exaggerated reflexes, and general arterial sclerosis. The patient was examined by Dr. J. W. Babcock and Dr. J. J. Watson, who pronounced it to be pellagra of a mild type. Dr. Babcock remarked that "if this were not a case of pellagra then the disease did not exist in the United States." Dr. Watson considered the chances of ultimate recovery to be excellent.

The patient is at present in the Skin and Cancer Hospital in the service of my father, Dr. George Henry Fox. He has improved somewhat during the past month since he has been at the hospital. The case is by no means as marked as some that

I saw during a recent trip to the South. It would have been difficult, however, to have presented a more marked case, considering the season of the year and the distance the patient had to travel. The object in presenting the case was to aid in calling attention to a disease which presents a serious problem in the United States although it is as yet practically unknown in New York.

I am greatly indebted to Dr. Bernard Wolff, of Atlanta, and to Dr. John A. Wyeth, through whose assistance I have been enabled to present the case. For aid in making a neurological examination I wish to thank Dr. Edward D. Fisher.

616 Madison Avenue.