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Contributors

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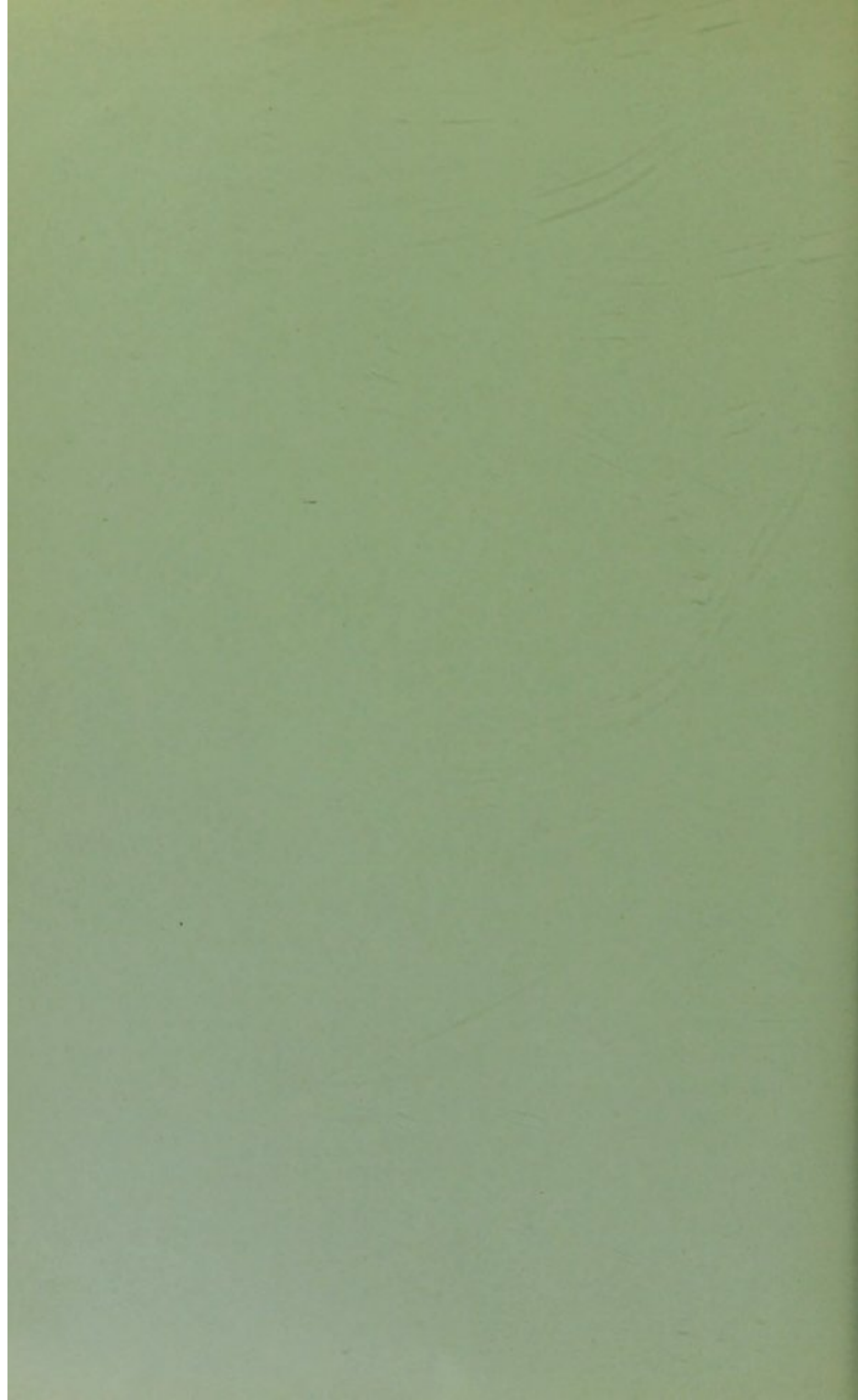


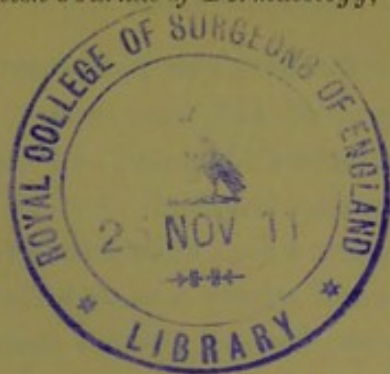
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Rolleston





HERPES FACIALIS IN SCARLET FEVER.

By J. D. ROLLESTON, M.D.,

Assistant Medical Officer, Grove Fever Hospital, London.

THE occurrence of facial herpes in scarlet fever has been noted by various writers such as Fereol, Girard, von Jürgensen, Saint Paul, von Pirquet, and Lafforgue, but no statistical data have hitherto been published. Schamberg estimates its frequency at 3 per cent., at the same time acknowledging that he has no available figures. Having recently investigated this eruption in diphtheria I thought that a similar inquiry in scarlet fever would be of some interest. The present note is based on observations made on 413 cases of scarlet fever in the course of the last few years at the Grove Hospital. Herpes facialis was noted in twenty-seven cases, or 6·5 per cent., a figure slightly exceeding that found by me in diphtheria, in which it occurred in 4·2 per cent. of 1370 cases, and about the same as that occurring in influenza, in which it was found by the German investigation committee to exist in 6·0 per cent. (Schamberg). Scarlet fever, therefore, comes fourth in the list of acute infectious diseases in which figures of the frequency of Herpes facialis are available, following at a long distance pneumonia, malaria, and cerebro-spinal meningitis, in each of which it occurs in about 40 per cent. In twenty-three cases the lips alone were affected, in two the nostrils as well; in one the right cheek only, and in one the nostrils and the right cheek. None of the cases showed the extensive distribution, atypical localisation, and relatively long duration which are characteristic of the eruption when it occurs in cerebro-spinal meningitis. The lesions in every case healed rapidly, and left no scar. Like the facial herpes of diphtheria the eruption in scarlet fever showed no predilection for young children, thus differing from the other complications of the acute exanthemata, but occurred at all

ages, except in early infancy. The youngest case was three years old, although twenty-four of 413 were below that age. The sexes were almost equally affected: fourteen, or 7·4 per cent., were males; twelve, or 5·2 per cent., were females.

The seasonal distribution which shows that the eruption was most frequent in the autumn and winter was as follows: January, 1 case; February, 3 cases; March, 1 case; April, 0 cases; May, 1 case; June, 3 cases; July, 1 case; August, 5 cases; September, 4 cases; October, 3 cases; November, 3 cases; December, 2 cases.

The facial herpes of scarlet fever resembles that of diphtheria in being essentially a phenomenon of the acute stage. In all but five it occurred within the first week of disease. In two it was noted on the ninth, in one on the twelfth, in one on the twenty-eighth, and in one on the thirty-first days. Possibly in the last two cases the scarlatinal virus was not responsible for the appearance of the eruption.

In addition to the cases of facial herpes an instance of Herpes pro-genitalis was noted, in which the eruption occurred on the twelfth day of disease, in a girl, aged 5 years, in association with a vaginal discharge.

Herpes zoster, an occasional sequela of acute infectious disease, was not observed in the present series. Moureyre, on the other hand, noted three examples of zona among 496 cases of scarlet fever with lumbar, supra- and infra-orbital distribution respectively. Girard has reported a case of femoral herpes which developed after the acute stage had subsided. In Letulle's case herpes occurred along the course of the lesser sciatic nerve during the incubation period, the rash of scarlet fever appearing fifty hours later.

Pflugbeil has recently drawn attention to the occurrence of generalised herpetiform eruptions as a sequel to infectious disease, and has collected from literature seven cases following diphtheria, three following gonorrhœa and cerebro-spinal meningitis respectively, one following malaria, and six following typhoid fever or septic infections resembling it. Apparently no instances have yet been recorded of these eruptions following scarlet fever.

No diagnostic importance can be attached to Herpes facialis in scarlet fever, the eruption being almost equally frequent in scarlet fever and diphtheria, and much commoner in angina due to other

causes, in which, as shown in my previous paper, it was found in 13·1 per cent.

As regards the prognostic value of Herpes facialis, which is stoutly denied by Hebra and Kaposi, it may be stated that, as in diphtheria, the eruption was more frequent in the severe than in the mild cases, being found in thirteen cases, or 12·6 per cent. of the former, as compared with fourteen cases, or 4·1 per cent. of the latter. In spite of its greater frequency among the severe cases, none of those presenting the eruption proved fatal, so that it cannot be regarded as an unfavourable sign.

Though a bacteriological examination of the throat made in a few of my cases did not reveal the predominance of any organism other than a streptococcus, the possibility of a pneumococcal infection in Herpes labialis must not be forgotten, even in the absence of a pulmonary localisation. In an interesting paper on pneumococcic angina at the onset of scarlet fever, Lafforgue has recently recorded three cases in which the faucial symptoms, instead of being due to the streptococcus, were associated with the pneumococcus in almost pure culture. Though none of his cases had pneumonia nor any pneumococcal localisation beyond the angina, two presented extensive labial herpes.

According to Schamberg, the three varieties of herpes—H. facialis, H. progenitalis, and H. zoster—are due to the development of some toxin which has a special affinity for nerve-tissue, especially for the cells of sensory ganglia. This hypothetical toxin is not due to any definite micro-organism, and the eruption may, therefore, follow various infections. The frequency of herpes in some diseases such as pneumonia and its rarity in others still require some explanation.

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