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Reprinted from The Journal of Cutaneous Diseases, Including Syphilis, for April, 1913

REBMAN COMPANY
1123 Broadway
NEW YORK

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THE CLASSIFICATION AND NOMENCLATURE OF ACQUIRED CUTANEOUS SYPHILIS.*

By George Henry Fox, M.D., New York.

MANY years ago, when I had the enthusiasm of youth and more time than practice, I undertook the study of cutaneous syphilis from nature in the Venereal Clinic of the old New York Dispensary. A finer opportunity for this study I have never seen elsewhere. Such a clinic, indeed, does not exist at the present day, for cases were then common which, owing to the modern advancement in diagnosis and treatment, are now rarely, if ever seen.

With selected patients stripped and standing before me, I endeavored to write a full and accurate description of everything I saw, and after accumulating a large volume of notes it occurred to me to compare these with the text-book descriptions of cutaneous syphilis. On doing so, I found many discrepancies which I attributed to my lack of experience in careful observation. I also found, greatly to my surprise, that much of what appeared on the pages of various authors was merely a repetition of what I had read in the admirable work of Bassereau (Affections syphilitiques de la peau, 1852). Since then, it has often seemed to me a great pity that men of wide experience in the study of disease should be so greatly hampered, as we all are, by tradition and a slavish adherence to the *dicta* of other writers. As a result of this our literature is burdened with many misstatements of fact and many erroneous views.

As to the classification of syphilitic eruptions, I will not occupy your time by discussing the literature of the subject, from Gaspard Torelli, who in 1498 described three forms each of moist and dry syphilis, to Plenck, Alibert and Willan, who laid the foundation of our present system. I will merely mention slight variations in the classification used by modern writers and what appear to me to be errors and absurdities. Please bear in mind that I am speaking only of the acquired form of syphilis.

The true syphilides are those uncomplicated with suppuration or ulceration, but in a practical classification it is necessary to include all the clinical pictures produced by the action of pyogenic microbes

* Read before the 36th Annual Meeting of the American Dermatological Association, St. Louis, Mo., May 23-25, 1912.

upon syphilitic cellular deposits in the skin and hence pustular, crustaceous and ulcerative conditions cannot be overlooked.

The simplest and most natural division of the syphilodermata is into two classes, viz., the early and the late. They might be termed with tolerable accuracy the first year eruptions and the subsequent eruptions, for, during the first year and mostly during the first half of it, we meet with disseminated eruptions of a macular, papular and pustular type, while in later years and usually after a period of rest, we have eruptions limited to a portion of the body of a nodular, squamous or gummous type.

Hutchinson makes an intermediate or post-exanthem period between the so-called secondary and tertiary stages, when the lesions are only exceptionally symmetrical, but this seems to be as unnecessary as it is confusing.

Ricord's commonly accepted division of syphilitic manifestations into three stages has never seemed to me quite satisfactory. The chancre or initial lesion no more deserves the name of primary syphilis than does the vaccination pustule the name of primary variola. But it is in the distinction between the secondary and tertiary stages that the student is most apt to be puzzled, and when superficial eruptions often appear twenty years or more after infection and deep deposits with ulceration may occur at a very early stage, most physicians, including ourselves, are often in doubt as to whether these lesions are to be classed as secondary or tertiary.

I fully agree with our late associate, Dr. Hyde, who claimed that Ricord's scheme was incomplete and that its distinctions were wholly artificial, and I heartily wish that the terms primary, secondary and tertiary syphilis could be expunged from our vocabulary.

As to our syphilitic nomenclature, it must be admitted that it is both careless and confusing. In looking over text-books on syphilis, a novel feature of the more recent ones is found in the great number of illustrations. In large measure these serve the purpose of an atlas accompanying the text. But these illustrations are usually labelled with no apparent system and many of them bear titles which are manifestly incorrect. I have furnished photographs to several of my text-book-writing friends and have repeatedly been surprised as well as amused to read the titles which have been given them.

A glance at these portraits is sufficient for the expert to recognize them at once as old and familiar friends, and the word syphilis is so plainly written in the characteristics of each eruption that a faulty diagnosis is scarcely possible. But if any skilled dermatologist, looking at one of these illustrations, were asked to name

the form or variety of the disease which is before him he would in many, if not most cases, give a different name from that which the author has chosen for the title of the picture. This confusion in our syphilitic nomenclature is largely the result of carelessness and our failure to agree upon any definite system. I know that our individual experience must of necessity vary, and that terms which have been used by one for many years seem most appropriate and are reluctantly set aside. But the subject seems to me to be a matter of importance and well worth the consideration of this National Association. In formulating my own views of syphilitic classification and nomenclature I have no desire to unduly urge them upon others who may hold different views, but I trust that some uniformity of opinion and practice may be the result of this presentation of the subject.

The most important point to be borne in mind in the selection and use of terms applied to cutaneous syphilis is the complete separation of the early and late forms. These are clinically distinct and should not be confounded, as they often are, by the careless use of names.

One of the first things we learned in our study of dermatology was the statement that a tubercle is a solid lesion larger than a papule. Yet we learned later to call the lesions of leprosy tubercles, even when they are much smaller than the papules of erythema multiforme. And in like manner we learned to call the lesions of early syphilis papular in spite of the fact that they may be larger than the tubercles or nodules of late syphilis. To call an eruption papulotubercular, as Fournier and others have done, seems to me like speaking of an early-late eruption. It promotes a confusion of ideas which ought not to exist.

In my arrangement of the clinical forms of acquired cutaneous syphilis I have omitted the vesicular and the bullous, which are described at more or less length in every text-book and which I firmly believe are practically non-existent. After forty years of clinical experience I can truly say that I have never seen a vesicular syphilide. No atlas, to my knowledge, portrays any such eruption, and no one has ever shown me a photograph of one. I will admit that if one were to sit up nights and constantly watch the transition of a papule into a pustule, a little clear serum might be detected, but that there is any clinical form of cutaneous syphilis worthy of the name of vesicular syphilide I flatly deny and, therefore, enter my protest against its continued use in dermatological literature. Nor does a well-developed bulla, so common in hereditary lues, appear in the course of acquired syphilis when the patient is not suffering from iodism. A slight elevation of the epidermis through the effusion of

a sanguinolent or purulent fluid does not constitute a true bulla, and even if we did have now and then a single bullous lesion, it certainly would not justify the oft-used term of bullous syphilide.

In my "Photographic Illustrations of Cutaneous Syphilis," published over thirty years ago, I included in the late forms, the pustulo-crustaceous and the ulcerative syphilides, which I now regard as a mistake. While crusting is very common in late eruptions, a well-formed pustule is seldom if ever seen. These crusted lesions result from the softening and suppuration of nodular and gummous deposits. While deep ulcers constitute a striking feature of many late eruptions, ulceration is always secondary and frequently occurs in the early as well as the late forms of syphilis.

In offering suggestions as to the proper classification and nomenclature of cutaneous syphilis, I do not claim that they are complete or beyond criticism. Nor do I ask you to accept them if they do not accord with your own experience. But I can assure you that these suggestions are based upon what I have seen in the clinic and not upon what I have found in my library.

As already intimated, I would divide the early eruptions into three forms: the macular, papular and pustular; and the late eruptions into three forms: the nodular, squamous and gummous, as shown in the accompanying table.

ERUPTIONS OF ACQUIRED SYPHILIS.

Forms.	Varieties.	Descriptive Adjectives.
	EARLY.	
Macular.	Roseolar.	
	Annular.	
	Vitiligoid.	
	Maculo-Papular.	
Papular.	Miliary	Disseminate, corymbose, annular.
	Lenticular	Disseminate, corymbose, hypertrophic, confluent, squamous.
	Discoid	Moist, annular, confluent, squamous.
	Papulo-Pustular.	
Pustular.	Acuminate	Crustaceous.
	Obtuse	Crustaceous.
	Ecthymoid	Crustaceous, rupial, ulcerative.

LATE.

Nodular.	Agminate	Confluent, squamous, cicatricial.
	Circinate	Squamous, crustaceous, ulcerative.
	Serpiginous	Crustaceous, ulcerative, cicatricial.
Squamous.	Diffuse.	
	Circinate.	
Gummous.	Diffuse	Verrucous, crustaceous, rupial, ulcerative.
	Tuberous	Ulcerative, cicatricial.

Early Syphilides.

Macular Form. The ordinary disseminate macular syphilide may be called the roseolar syphilide to distinguish it from the rare circinate variety. Bassereau called attention to the fact that some macules are flat and smooth, while others are slightly elevated. Taylor mentions both an ephemeral and a persistent variety, and some German writers speak of a "grossfleckige" and a "kleinfleckige" roseola. But it seems unnecessary to make subdivisions of this variety of the macular syphilide based on a few exceptional cases.

The circinate variety is commonly recognized, though of rare occurrence. It is usually seen as a relapsing eruption. Its rareness is indicated by the fact that few pictures of it are to be found. A striking case, labelled "Circinate Erythematous Syphilide," in Taylor's work, is manifestly a raised circinate papular eruption.

The so-called pigmentary syphilide is, strictly speaking, not a syphilide at all. Indeed, it is neither pigmentary nor syphilitic. The dark reticulation which some have described as the pigmentary syphilide is a secondary feature of this affection. The whitish macules are first developed and constitute the disease, as they do in ordinary vitiligo, and, therefore, the term vitiligoid or leucodermatous syphilide is more appropriate than the term pigmentary syphilide.

To the objection that this leucoderma is not a manifestation of syphilis, but like a syphilitic scar, a mere indication of preëxistent syphilis, it may be urged that it is so often seen in syphilitic subjects, developing on the site of former syphilitic lesions, that it seems justifiable to class it with the syphilides even if it be not one of them.

The cases in which congested macules are slowly undergoing a

transformation into papules and those, more numerous, in which macules and papules coëxist, may be considered as a hybrid form and called, as is customary, the maculo-papular syphilide.

Papular Form. Among the syphilides the papular form presents the greatest variation in clinical appearance and in the terms commonly used to express this variation a vast amount of confusion prevails. The same eruption pictured in various text-books is variously named, and the names in common use do not always convey a distinct picture to the mind.

There are three varieties of the papular form of syphilis which ought to be recognized by all, viz., the miliary, the lenticular, and the discoid. The lesions seen in these varieties are quite unlike each other and impart to them a distinctive character. Whether the lesions are disseminated or grouped, larger or smaller, rounded or flattened, is of comparatively little importance, and as both of these conditions often exist in the same eruption, such features alone do not serve as well as the shape of the lesion for a basis of classification.

The miliary, or follicular syphilide, presents a quite distinct and characteristic appearance, which I need not describe in detail. The lesions are conical and approximate the size of millet seeds, from whence comes the name. Sometimes the lesions are so numerous that the skin of the trunk and extremities is studded with small conical elevations, but in most cases the eruption appears in a corymbose or clustered form. The central "bull's-eye," which is often, though not always, present in the clusters of the corymbose lenticular papular syphilide, is rarely noted in the miliary groups.

The lenticular papule, a solid, fleshy lump of varying size, but usually about the size of a lentil, is the most common lesion of early syphilis. To call an eruption of such lesions the small, flat papular syphilide, as is often done, is certainly incorrect, since these lesions are very apt to be rounded and sometimes even hemispherical. These papules are usually disseminate, but often occur in greater number in certain localities. Sometimes they appear in groups, and often with a larger papule in the centre, and constitute a corymbose or corymbiform eruption. This arrangement of lesions in a group or circle with a central "bull's-eye" I have long since pointed out as often occurring in mycosis fungoides and other dermatoses.

Occasionally, the papular syphilide, especially upon the face, presents smooth, rounded tumors, much larger than the ordinary syphilitic papules, and to this eruption the descriptive adjective "hypertrophic" has been justly applied.

To the third variety I have applied the term "discoid papular syphilide" in place of "large flat" papular syphilide, as it is shorter, more descriptive, and not so likely to be applied, as is the latter term, to the lenticular type of papule. Lenticular lesions may be quite large, even hypertrophic, and they always flatten as they disappear and, therefore, the term "large flat papular syphilide" is apt to appear vague and confusing. In many text-books we find illustrations of the fading lenticular syphilide bearing this erroneous title.

This discoid lesion is the initial stage of the condyloma latum, the annular and the squamous papular lesions and most of the confluent patches seen upon the face. It is distinctly nummular in character and is most frequently seen upon the face and neck. In certain regions, as beneath the female breasts, in the groins and around the anus, these discoid lesions acquire a moist surface and constitute the moist papular syphilide (condylomata lata). Even upon the face or other normally dry surfaces, a discoid lesion with a moist pellicle is occasionally seen which bears a striking resemblance to a mucus patch. Discoid lesions are prone to become scaly, and upon the trunk and flexor aspects of the extremities quite thick scales sometimes form, as in psoriasis, and constitute a squamous papular syphilide. This variety must be carefully separated from the smaller and scaling lenticular papules, as also from the true squamous syphilide of the palms and soles, which occurs only in late syphilis. Discoid lesions of the face are often slightly crusted and confluent and strongly resemble patches of seborrhœa or eczema.

When the scale or moist pellicle or smooth redness disappears from the centre of these discoid lesions, we have left a raised peripheral ring, which may be termed the annular papular syphilide. In rare instances, and especially among negroes, these rings may be concentric, as sometimes occurs in ringworm, and by confluence they may form gyrate and other picturesque patterns.

When papular lesions of either the lenticular or the miliary type tend to slight suppuration, as they frequently do in weak and dissipated subjects, or when papules and pustules coëxist, we have another hybrid eruption, which is on the border-line between the papular and the pustular forms of syphilis and is usually termed the papulo-pustular syphilide.

Pustular Form. While the papulo-pustular type of syphilis is of quite frequent occurrence, the typical pustular syphilide, in which all the lesions suppurate, is comparatively rare. In naming its varieties, one may feel forced by tradition to follow the unfortunate custom of employing names of some non-syphilitic eruptions. To

these varieties the terms acneiform, varioliform and ecthymaform are usually applied, while Neumann and others have described eczemaform and impetigoform eruptions. This is a shade better than using names like acne syphilitica and ecthyma syphiliticum, but I much prefer the terms acuminate, obtuse and discoid to indicate the character of the pustules.

These three varieties correspond to the miliary, lenticular and discoid varieties of the papular syphilide. The acuminate pustular syphilide is the small conical or follicular eruption. The obtuse variety is composed of larger rounded pustules and bears a sufficient resemblance to variola to be sometimes mistaken for it.

There is no varicelliform eruption outside of the books, although a few pustular lesions sometimes become umbilicated, as they do in both variola and varicella. In most cases of the pustular syphilide there are no well-developed pustules, as in acne or variola, but, instead, a softening and suppuration of the papular lesions. Indeed, this syphilide is very often a purulent rather than a true pustular eruption.

The discoid or ecthymaform variety needs no comment.

In the drying of pustules another distinct clinical picture is often produced, and we have a crusted pustular syphilide. The crusts in some cases are conical or like a small snail shell and some have termed them rupial, but they do not constitute the classical rupia or oyster-shell crust met with occasionally in late syphilis.

Through persistent suppuration or violent removal of the crusts by friction of the clothing, ulcers of various size are liable to ensue, and we have then an ulcerative pustular syphilide. When suppuration is most active at the periphery of the crusted lesion, we may have a circinate ulcerative, discoid pustular syphilide.

Late Syphilides.

We now come to those syphilides which usually occur from two to twenty or more years after infection, and which should be carefully distinguished in our nomenclature from the early or first-year syphilides. Their clinical features are quite distinctive and so should be the names which we apply to them. All names which do not clearly indicate that the eruption belongs to the early or to the late stage of cutaneous syphilis should be discarded.

As in early syphilis, we have three forms of eruption, viz., the macular, the papular, and the pustular, so in a later period of the disease we also have three forms, viz., the nodular, the squamous, and the

gummous. While I am perfectly aware that this scheme fails to include all the forms of syphilis described in the text-books, I venture to assert with confidence that it includes all the cases you will ever meet with in the clinic.

Nodular Form. The long-used term "tubercular syphilide" I have often found to be a stumbling-block to the student, who naturally associates it with the tubercle bacillus, in which he has become interested in the medical clinic. I have also found that many physicians have the idea that this syphilide is in some way tuberculous as well as tubercular. The name nodose, or nodular, I have used for many years in teaching, and after consultation with various colleagues I am pleased to find that most of them approve of the change.

Squamous Form. The squamous syphilide, which should be carefully kept separate from the scaling papular syphilide, as it is widely separated from it in point of time, is clinically a distinct form of syphilis, and usually appears upon the palm and sole. I know that some will claim that it is in fact a nodular eruption, but owing to the thickness of the epidermis upon the palms and soles the nodules are not apparent. But please bear in mind that this proposed scheme is clinical and not pathological.

Gummous Form. The word gummous is shorter than gummatous, quite as correct and expressive, and is already used by German writers. Why should we not use it?

The word rupia carries with it a clinical picture of a peculiar crust. We have rupial lesions, but no rupial syphilide. Having excluded the bullous syphilide with which rupia has usually been associated in the text-books, the question arises in what form of syphilis does rupia occur. In the early pustular form we sometimes see small conical limpet or snail-shell crusts which are of a rupial character, as well as the larger oyster-shell crusts. But the latter are apt to be seen in their highest degree of development in late syphilis. Beneath such a lesion I have assumed that there is a superficial, diffuse, gummous deposit and, therefore, have used the term rupial as a descriptive adjective for this peculiar crusting, which may occur in both the pustular and the gummous forms of syphilis.

In the diagnosis of syphilis the main point is to recognize the disease. The particular form or variety of eruption is of far less importance, but as this subsidiary diagnosis has often an important bearing upon the stage of the disease, upon the appropriate treatment and upon the prognosis, it possesses a value which is certainly worthy of recognition. Since we are all forced to classify in some manner and to name the various forms of cutaneous syphilis, is it not

possible for us, as members of this National Association, to agree upon the best practical classification and to be in greater accord with one another in the use of names? To further such a desirable end is the aim of this paper.

In describing the various syphilides most text-book writers, even those with a large experience, are sadly hampered by what their predecessors have written. Their respect for authority and tradition is highly commendable, but it surely is unfortunate when it leads them to a parrot-like repetition of terms and to the description of eruptions which they themselves have never seen.

When we consider the common forms of syphilis with which we are all so familiar and leave out of question the rare, unique and exceptional cases seen scarcely once in a lifetime, does it not seem possible and practicable for the members of this Association to agree upon the use of certain terms, not only for our own convenience but for the sake of our professional brethren who look to us for guidance, and particularly that large class in which we are all interested—the future students of dermatology?

Explanation of Plates.

Fig. 1.—This patient had a chancre in July, 1893, followed by a roseolar macular and miliary papular eruption in August and September. The annular macular eruption appeared in November and was photographed in December, about five months after date of initial lesion.

Fig. 2.—This patient, whose husband had an eruption in August, 1892, gave birth to a child in March, 1893, who showed evidence of infection in August. The mother presented an eruption of macules and discoid papules in May and was photographed in July. Some of these discoid papules had a moist surface, almost like that of a mucous patch. The centre dried into a very thin, dark crust, leaving an elevated ring at the periphery. Two lesions at the margin of the umbilicus presented the appearance of, and were, in fact, condylomata lata.

Fig. 3.—This photograph shows the tendency of the discoid papule to heal in the centre like ringworm and present an annular form, an eruption more frequently seen in negro syphilitics.

Fig. 4.—Showing the thick, psoriasiform scale sometimes seen upon the discoid papule and quite unlike the slight scaling presented by some lenticular papules in their disappearing stage.

Fig. 5.—Showing the lenticular papules of an unusual size, very much larger indeed than the "tubercle" or nodule of late syphilis. These lesions often soften and suppurate, and may even become ulcerative and crustaceous. No distinct pustule is ever formed, yet, in accordance with tradition, it is commonly called a papulo-pustular syphilide.

PLATE VII.—To Illustrate Article on "Classification and Nomenclature of Acquired Cutaneous Syphilis," by Dr. George Henry Fox.

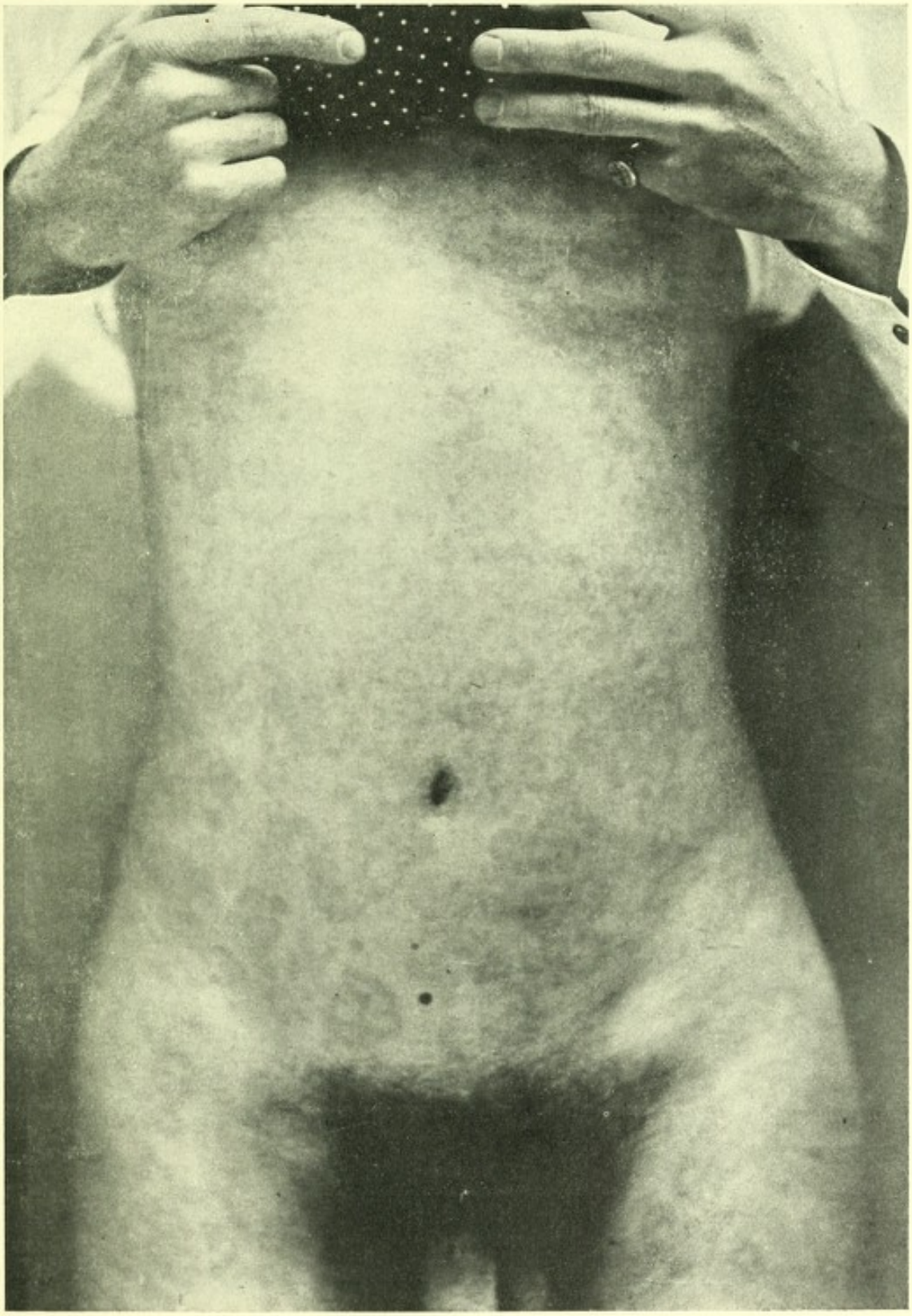

Fig. 1.

Annular macular syphilide.

PLATE VIII.—To Illustrate Article on "Classification and Nomenclature of Acquired Cutaneous Syphilis," by Dr. George Henry Fox.

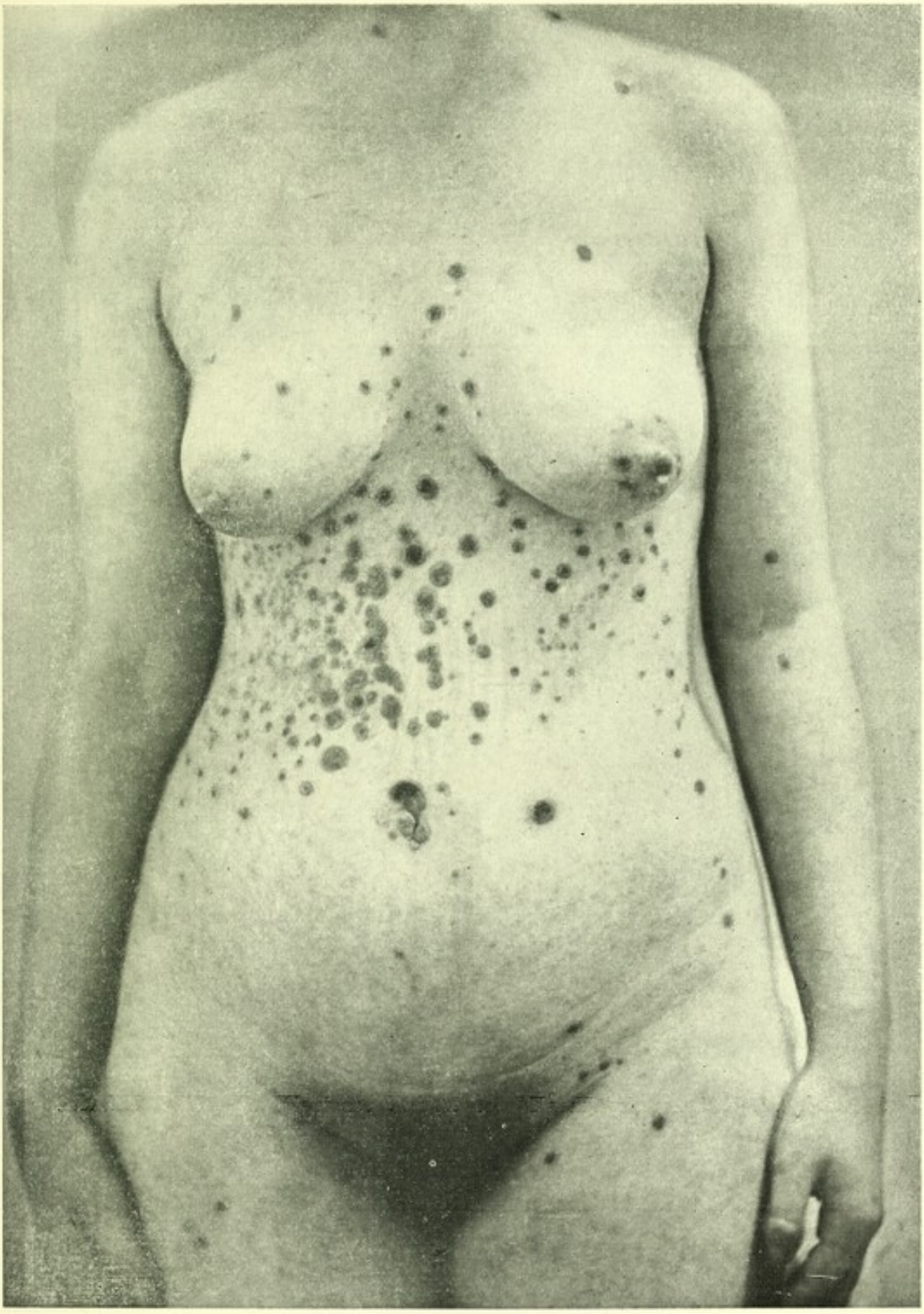

Fig. 2.

Discoid papular syphilide (with moist and annular lesions).

PLATE IX.—To Illustrate Article on "Classification and Nomenclature of Acquired Cutaneous Syphilis," by Dr. George Henry Fox.

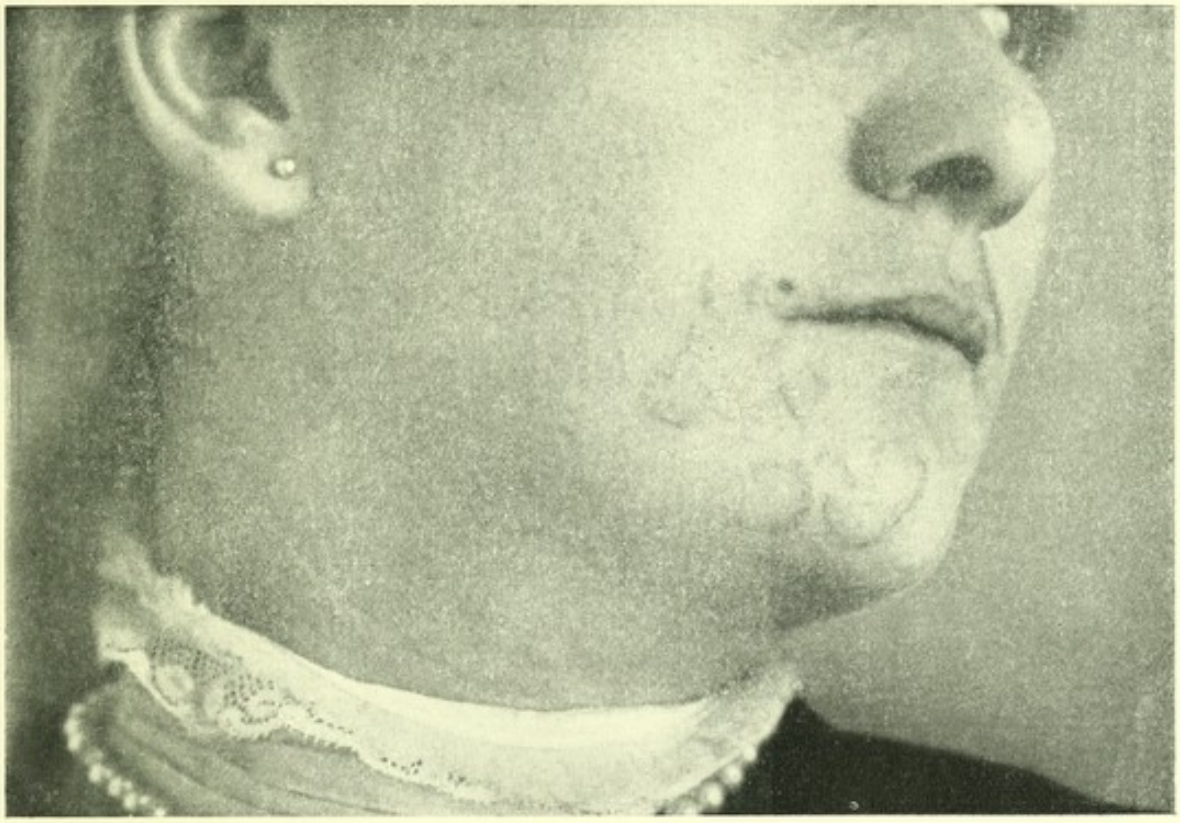

Fig. 3.

Discoid papular syphilide (annular type).

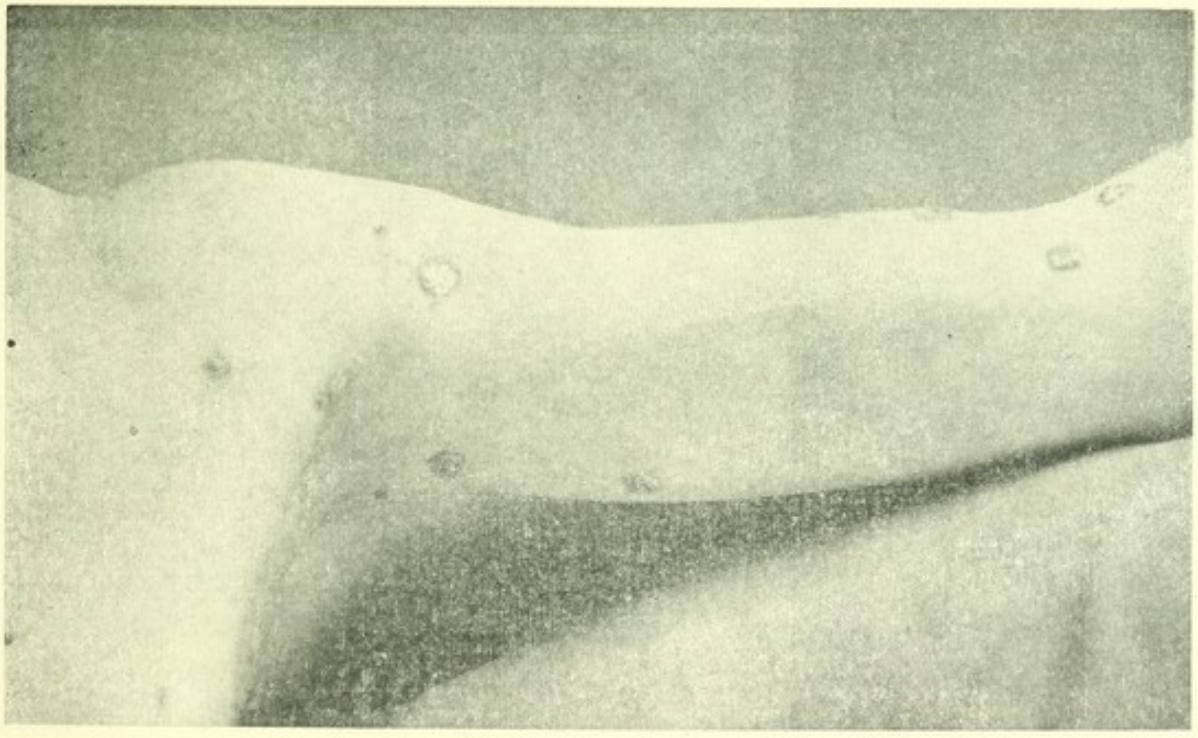

Fig. 4.

Discoid papular syphilde (squamous type).

PLATE X.—To Illustrate Article on "Classification and Nomenclature of Acquired Cutaneous Syphilis," by Dr. George Henry Fox.

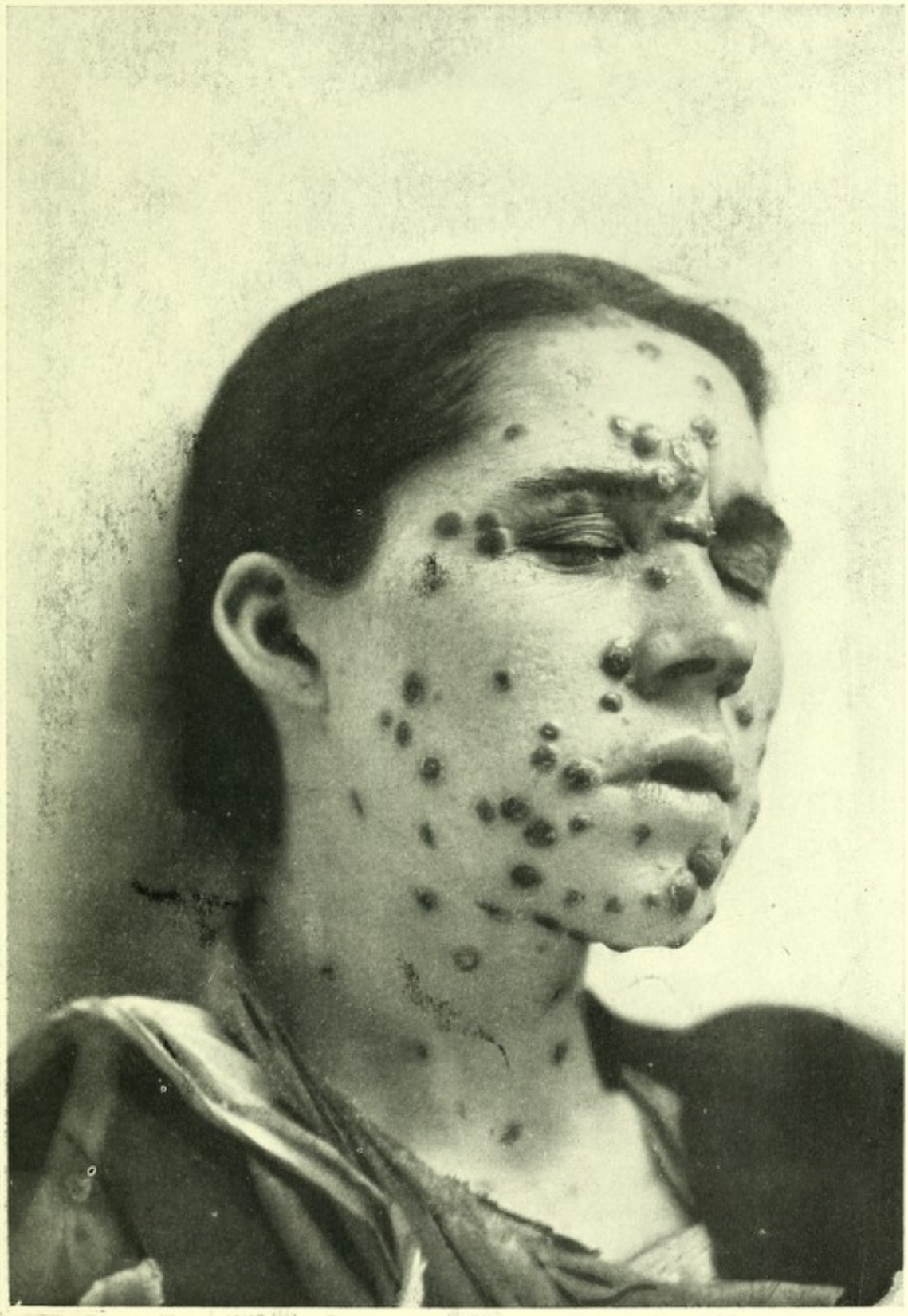

Fig. 5.

Papulo-pustular syphilide (with hypertrophic lesions).