**On rhinophyma or the Hammer-nose / by Balmanno Squire.**


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ON

# RHINOPHYMA;

OR

# "THE HAMMER-NOSE."

BY

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LONDON:

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1889.

# ON RHINOPHYMA.

RHINOPHYMA, (*ῥίς*, gen. *ῥινός*, *the nose*. *φῦμα*, *a tumour*) or the *hammer-nose*, is a condition which derives its importance from the very considerable disfigurement of the nose which it occasions. It affects preferably the male sex: but it occurs also in females, sometimes in a very exaggerated degree. It does not begin to be developed before middle age. It attains its maximum development in elderly men: and sometimes, though exceptionally, in elderly women. It is not of very common occurrence, although it is not a rare condition. It causes the unfortunate subject of it to present a somewhat ludicrous appearance, and usually at the time of life when a sacrifice of dignity can be least afforded; but worse than this it also, in the popular belief, carries with it an imputation on the character of the patient. It is commonly supposed to be the result of over-indulgence in good living, and in particular of a proclivity to alcoholic excesses. Unlike many of the defects to which the face is subject, it is absolutely incapable of being concealed by any device of whatever kind; and yet, curiously, the persons who are thus defaced rarely seek any assistance out of their misfortune, and are content to accept it as an inevitable disadvantage.

The name of hammer-nose accurately describes it in its typical form, but it is more commonly known under the name of bottle-nose. In Germany it is called the pound-nose (Pfundnase).

In its typical form the excrescence consists of three parts, namely, a lobe at each side and one in front. Of these the front lobe is by far the largest, the lateral lobes being quite insignificant in comparison with it. The two lateral lobes are each of them in contact with the front lobe, which is separated from them only by a more or less deep sulcus or crevice. The front lobe consists of a monstrous development of the tip of the nose, but not in a direction that might be expected. The enlargement affects mostly the two sides of the tip: namely to an extent quite out of proportion to any increment, that the tip may have acquired, either in front or on its under surface. So that, at a front view of the face, the nose has the shape of a hammer: the handle of the hammer being represented by the ridge of the nose, and the hammer-head by the bilateral enlargement of the tip. Point of the nose there is none. What has been the point is completely buried in the 'hammer-head.' So widely do the two halves of the 'hammer-head' stand out on either side: that, at a front view of the face, not only do they conceal the nostrils but also completely hide the wings of the nose: even although these are considerably spread out by the tumour developed on each wing. At a front view nothing is visible of the nose except its ridge, or rather its bridge, and the 'hammer-head.' At a side view of the face the excrescence, taken as a whole, appears wedge-shaped: the base of the wedge being formed by the anterior surface of the 'hammer-head,' and the truncated smaller end of the wedge by the posterior surface of the small tumour developed on the wing of the nose. Viewed from underneath, the outline of the nose, instead of being pear-shaped, is seen to be converted into a tolerably regular square: the nose being quite as broad at the fore part, as it is at the hinder part, of its under surface. At a side view of the nose, it can be seen that about one-half of the total superficies of the nose, visible from that point of view, is occupied by the rhinophyma. One might put it, that the excrescence corresponds pretty accurately to the 'fleshy' or readily-moveable part of the nose.

The considerable enlargement of the lower half of the nose, and that more in width than in any other direction:—the sprawling appearance, so to speak, of its tip and wings:—conveys the impression that the orifices of the nostrils must be vastly enlarged. As a matter of fact however they are somewhat diminished, being compressed laterally by the weight of the tumour attached to each wing. In this manner they lose the kidney-shape which is proper to them, and acquire a more elongated, even slit-like, form: but they never become sufficiently compressed, or otherwise interfered with, to hinder their function in any tangible degree.

To the touch, the fore-lobe and, equally, the lateral lobes are soft, but yet tolerably firm and elastic.

The colour of the excrescences very often does not deviate perceptibly from the normal tint of the nose: but occasionally the enlargement is of a rosy red or, in some instances, a bluish red colour: and teleangiectases may be developed in the hypertrophied skin.

The surface of the lobulated tumour is pitted with numerous shallow depressions:—the dilated orifices of the sebaceous ducts. At the centre of each of these depressions is a linear hilum:—the transferred opening of the duct.

On compressing one of the lobes of the swelling between the forefinger and thumb, numerous white threads of sebaceous matter issue from the centres of the shallow depressions, and exhale a sour and nauseating odour of quite a special quality.

The general surface of the tumour, in place of presenting the semimat aspect which is proper to the nose in its healthy condition, exhibits a somewhat lustrous and greasy sheen.

Such, then, is Rhinophyma in its typical phase: that is to say in the condition in which it most commonly presents itself when fully developed. It is, however, capable of undergoing considerable variations from the description above given. For example, in exceptionally extreme instances, the tumour attains almost colossal dimensions, so that at a front view it eclipses a large proportion of the face: extending downwards as far as the edge of the lower lip: outwards, on either side, as far as the prominence of the cheek-bone: and upwards, on either side, to within half an inch, or thereabouts, of the edge of the lower eyelid: forming a huge prominent lobulated mass as large as the fist. This is the condition to which, more especially, the Germans apply the name 'pound nose.' Even when the tumour has attained this extreme development, the nostrils remain patent and their function is but little if at all impaired. Not only the absolute size of the tumour, but also the number of its lobules, is subject to wide variations: thus, instead of there being only three, as in the case of the typical hammer-nose, there may be many. The form of the lobules is not always the same; in some cases they are, all of them, sessile: that is to say more or less hemispherical in shape, in other cases some of them are pedunculated and fig-shaped. Sometimes the nose, without being notably increased in breadth, will be greatly elongated, so as to project downwards over the upper lip. In this condition it resembles, somewhat, the red fleshy flap which hangs over the beak of the turkey.

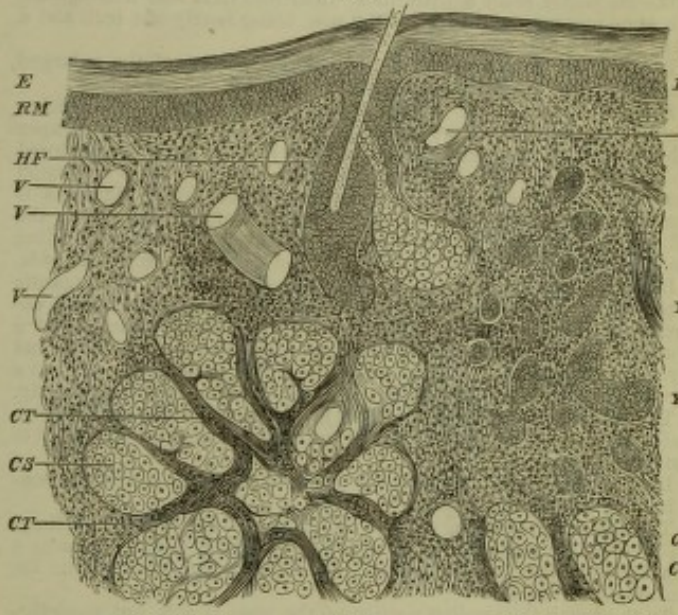
The colour of the tumours may be almost the same as the normal colour of the nose, or it may be rose-red, or bluish-red, or even a slate-grey.

When teleangiectases are developed on its surface, they may be very fine so as only to be visible on the closest inspection, or may be so large as to be readily noticeable. The colour of these enlarged blood-vessels may be red, or bluish red, or slate colour.

The lobules of which the tumour is composed never contain pus, they are soft but solid structures, nor do they ever undergo ulceration or cicatricial atrophy.

Beyond the inconvenience, arising out of the size and situation of the tumour, the patient experiences no kind of unpleasant sensation in it.

FIG. 1.




RHINOPHYMA.

*E*, horny layer of the epidermis; *RM*, rete malpighii; *HF*, hair-follicle; *YS*, sebaceous glands of young development; *OS*, *CS*, old sebaceous glands, greatly distended by an accumulation of nucleated cells which are undergoing fatty degeneration; *CT*, connective tissue dividing these glands into numerous lobules; *V*, bloodvessel cut through. Numerous embryonic cells are seen scattered throughout the papillary body, the cutis, and the subcutaneous connective tissue. (H. v. Hebra.)

THE HISTORY OF THE CASE represented in the coloured illustration is as follows: The patient, a widower residing in London, is sixty-five years old. He has had this enlargement of the nose for ten years, but says he has never been a drinker or a glutton. He qualifies this afterwards by explaining that, as to not being a drinker, he means that he never drank so as to get himself into trouble. For ten or twelve years, before the nose began to get enlarged, his nose had been red but not swollen. So that the enlargement of the nose began at about the age of fifty-five, but the redness at about the age of forty-three or forty-five.

He says he has had three attacks of erysipelas of the face in his life. The first attack was ten years ago, that is to say about the time that the enlargement of his nose commenced. The next attack occurred six years ago, and the last one four years ago.

As to his mode of occupation. From the age of ten to twenty-six years he was on 'the road' with waggons. From the age of twenty-six to thirty-three years he was a waggon-loader.

At the age of thirty-one he was 'taken bad in his head and eyes' and was in Guy's Hospital for six months. He was told that he had Iritis. As to his face, the disease affected him on the cheeks, but not on the nose. The eruption consisted in part of open sores, but it healed in about a month. His eyes were not quite right again for two years after this. However he denies having ever had syphilis, and

adds that he then had a wife and young family. After this he became a cab-proprietor and driver.

From the age of thirty-three to sixty years he was cab-driving. From the age of sixty to sixty-five years he has been a jobbing gardener. He has been very moderate in the matter of drinking since the age of sixty, but not before then.

As to the attacks of erysipelas that he speaks of: each of these three attacks lasted for from two to three weeks. He never had any sore throat at either of these attacks, nor did his wife or children ever contract the complaint from him.

He attributes the first beginning of the swollen condition of the nose to his first attack of erysipelas. The nose was never swollen before this attack, but up till then was merely red. At this first attack the nose and also the rest of the face were much swollen, but after the attack had passed off the nose remained permanently enlarged. At the second attack the nose was much more swollen than at the first attack. After this second attack the nose was left still more enlarged than before. At the third attack the nose was swollen still more considerably, and after this attack was left as it now is, that is to say considerably larger than before. His belief is, that the nose did not undergo any gradual increase of size in the intervals between the attacks, nor since the last attack, but attained its present dimensions by three somewhat sudden enlargements.

As to the kind of liquor that he habitually drank it was nearly always ale, namely old ale, hardly ever spirits, never wine. The quantity of ale that he consumed, when a waggoner, was on the average four or occasionally five pints a day.

He states that his complexion was always clear before his first attack of erysipelas, except as to the redness of the nose already mentioned.

At the present time the maximum outside breadth of his nose from ala to ala, measured by compasses, is one inch and seven-eighths or very nearly two inches. The same measurement in a healthy nose being one inch and a half.

The antero-posterior diameter of the nose, from ala-cleft to tip, is (alike on either side) a little more than one inch and five-eighths. The same measurement in a healthy nose being nearly one inch and a half.

The vertical measurement of the anterior portion of the enlarged part of the nose is nearly one inch and a quarter.

The enlarged portion of the nose, viewed in profile, is wedge-shaped: the base of the wedge being in front and the truncated apex behind. The enlargement consists of three definite parts, the enlarged tip of the nose, and the enlarged alæ. The enlarged tip is separated from each of the enlarged alæ by a deep sulcus. The right ala is much more prominent and it is considerably more enlarged than the left ala, perhaps half as much again; moreover the sulcus, dividing the ala from tip, is very much deeper on the right than on the left side.

But the great bulk of the enlargement is formed by the gigantic hypertrophy of the tip of the nose which forms a hammer-head enlargement, the two sides of which completely obscure the alæ at a front view of the face. This hammer-head measures one inch and three-quarters across, so that the nose is of this portentous width at a distance of rather less than only three-eighths of an inch from the tip.

The distance from the upper lip (just at the junction of the columella with it) to the vertical line of greatest prominence of the tip of the nose is one inch.

It may be said, roundly, that the whole of the lower *half* of the nose is implicated by the swelling.

The sulcus between the ala and tip, on the left side is fairly shallow; but that on the right side is, at its deepest portion, as much as over a quarter of an inch deep. The opposed sides of the latter sulcus are semi-raw and moist.

To the touch the swollen portion of the nose is soft, but nevertheless fairly firm and elastic. Its surface is coarsely pitted. All of the pits are extremely shallow, and present at the central portion a faint linear or triangular hilum (something like the hilum of molluscum pendulum). They have the appearance of blind pits rather than of the orifices of practicable ducts. However, on compressing the enlarged nose-tip firmly between the finger and thumb, a number of white threads of sebum start out from the pits: causing on the aggregate a fairly considerable issue of sebaceous matter, which has an extremely acid and somewhat nauseating smell.

The nostrils are quite patent and in no way impaired as to their function, but they are obviously narrowed and the left one is slit-like. They are evidently compressed laterally by the weight of the swelling. On the bridge of the nose are comparatively fine teleangiectases, and on the bridge and glabella are spots of acne rosacea, i.e. pimples and pustules. On both cheeks are many coarse teleangiectases, and a few pustules of acne rosacea, and numerous depressed punctate scars each of about the size of a hempseed: this condition occurring chiefly on the front of the sides of the cheeks, rather than on the front of the cheeks. On the chin are lesser and fewer teleangiectases than on the cheeks, and a few faded pimples of acne rosacea. On the forehead are faint indications of the pimples of acne rosacea. However, notwithstanding this, he says that he never had any permanent eruption or pimples on his face, neither when a young man nor since.

The patient may be regarded as presenting a typical example of the condition known as the hammer-nose. Previous to the development of this condition it appears, from his account, that he had for long been the subject of acne rosacea affecting chiefly the nose. At a still earlier period of his life, namely at about the age of thirty, it is pretty obvious that he suffered from an ulcerating syphilitic eruption of the face, the scars of which still remain, and that he was simultaneously affected with syphilitic iritis: not that there is any reason whatever for supposing that his syphilis was in any way concerned with the production of his present condition. However, his acne rosacea, which did not become sufficiently developed to attract his attention until ten or twelve years after his attack of constitutional syphilis, must be regarded as having conduced very considerably to his present state. Still more obvious is the influence of his repeated attacks of facial erysipelas in favouring the enlargement of the nose.

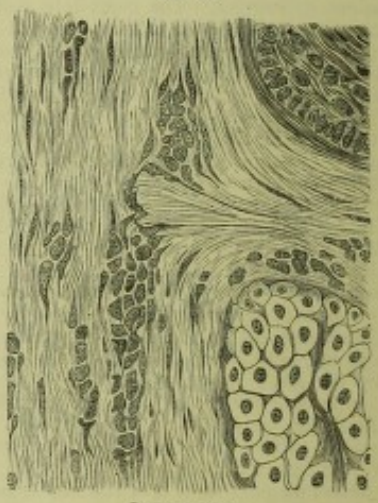
For the rest, the occupations he has followed from his boyhood up till now have always kept him much out-of-doors and under circumstances which involve much exposure of the face to wind and weather, and moreover during the later half of his life in the comparatively inactive condition of cab-driver. During by far the greater part of his life he has also been unduly exposed to the temptation of drinking very much more alcohol than was good for him and for nearly half a century has been a rather free beer-drinker.

*Causation*—From the time of Sennert[1] till now it has been the custom of almost all writers on diseases of the skin to describe Rhinophyma as an advanced grade of rosacea or 'acne rosacea' or 'gutta rosacea.' Rhinophyma accordingly has often been described under the name of 'acne hypertrophica.'

The lesser grades of rosacea are constituted by patches of uniform redness of the skin, often variegated by teleangiectases, on which patches after a while of furfuraceous scales or pustules or reddened tubercules become developed.

By many authors rosacea is regarded as a condition more or less distinct from acne. But some, while holding this view, nevertheless consider some of the more acne-like phenomena of rosacea as constituting, when present, a combination of acne with rosacea. By others, rosacea and acne are described as one and the same condition. In one of the most recent treatises on skin-diseases, that of Hardy[2]: while rosacea is dissociated from acne, Rhinophyma is described as a variety, not of rosacea, but of acne: and is stated to be a result, in some instances, of acne simplex: in some, of acne indurata: although, in other instances, a result of rosacea. My own view is, that rosacea is a disease quite distinct from acne; furthermore, I think that the pustules and tubercules, which so commonly present themselves as a principal feature of rosacea, do not permit of being interpreted as a combination of acne with rosacea. Moreover I regard Rhinophyma as a disease quite distinct from either acne or rosacea.

Fig. 2.



Rhinophyma.

Portion of the cutis which is penetrating a sebaceous gland so as to develop lobules. Development of new connective tissue fibres from embryonic cells which are aggregated in nests. (H. v. Hebra.)

Between acne and rosacea there are essential differences. Acne is a disease of adolescence and early adult age. Rosacea is a disease of adult, but mainly of middle, age. The normal map of acne is the circumferential part of the face, and includes also the nape, the back, and the breast. The normal map of rosacea is restricted to the more central portions of the face, namely to the glabella, the front of the cheeks, the nose, and the chin. The teleangiectases characteristic of rosacea are absolutely wanting in acne.

Now as to Rhinophyma. It is not a disease of adolescence, of early adult, or of middle age. It is essentially a disease of old age. It is not met with until after the age of fifty. It is obviously a disease quite distinct from acne. The changes wrought in the sebaceous glands by Rhinophyma do not necessarily entitle it to be regarded as a variety or grade of acne. It would be as reasonable to class vespertilio, in which the sebaceous glands form the chief seat of the disease, as a grade of acne. Rhinophyma can scarcely be regarded as a variety of rosacea. It is true that its normal map, the lower nose, corresponds to a portion of the normal map of rosacea: but then it also corresponds to a portion of the normal map of Lupus. Rhinophyma presents often teleangiectases, and they are a prominent feature of rosacea also: but teleangiectases of the face are not by any means peculiar to rosacea: nor are teleangiectases of the nose peculiar to rosacea and Rhinophyma conjointly. Many persons who are past middle age present teleangiectases of the nose, sometimes even in a very exaggerated degree, who have never been the subjects of rosacea, and who are quite unaffected with Rhinophyma. In cases of rosacea in which the nose happens to be one of the regions or the only region affected, there is doubtless often considerable swelling and redness with marked tuberosity of the nose. But the phenomena present are simply those of a chronic inflammatory swelling, and not as in Rhinophyma those of a permanent growth or tumour. The fact even that rosacea sometimes precedes and co-exists with Rhinophyma, is not a proof that Rhino-

[1] Practicæ Medicinæ. Liber quintus. Pars prima (De Tumoribus). Caput 31 (de gutta rosacea). Paris, 1641.

[2] Traité pratique et descriptif des Maladies de la Peau. Paris, 1886.

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phyma is an advanced grade of rosacea. Rosacea, even when it has affected the nose for many years, is never followed by Rhinophyma until after the age of fifty has been attained. On the other hand Rhinophyma is capable of appearing, at or after that age, in persons who have never been affected with rosacea.

The view that I take of Rhinophyma is that it is simply one of the degenerations of old age: that it is a disease quite distinct from rosacea, and equally distinct from acne: that the pre-existence of rosacea is one amongst the predisposing causes of Rhinophyma, but has no other relation to it.

Independently of rosacea, repeated attacks of facial erysipelas when occurring at about the age of fifty are potent predisposing causes of Rhinophyma. Hereditary predisposition also plays a part in the causation of Rhinophyma, I have known the disease to affect father and son.

As to other predisposing causes, if any, of Rhinophyma very little information has been collected: owing to the fact that almost every author has regarded Rhinophyma and rosacea as one and the same thing, and has adopted the popular belief that both are alike due, in most cases to alcoholism, in many cases to indigestion, in some few instances to total abstinence from alcohol, and in the female to disorder of almost any kind of the uterus. Most writers have assumed, as a matter beyond cavil, that when any one of these somewhat diverse causes is absent some one of the others must be present. Certainly none of these conditions is incompatible either with rosacea or Rhinophyma: but I am able to affirm in the most positive manner that, in the majority of cases that I have met with, every one of these conditions has been absent. Even those writers, who are disposed to make some reservation as to alcoholism being the customary cause of rosacea, have no doubt as to alcoholism being the almost invariable cause of Rhinophyma. The popular belief, that this is so, is amply shewn. In every country artists and actors are in the habit of representing drinkers as affected with Rhinophyma. But the belief is not justified in fact. Alcoholized persons are not exempt from either rosacea or Rhinophyma, and no doubt such persons constitute a fairly notable proportion of every class of society: but, judging from such information as I have been able to obtain, I am not disposed to regard alcoholism as being in any way concerned in the causation of Rhinophyma. I have also reason to doubt the reality of some other alleged causes of Rhinophyma, such as out-door occupation, residence in towns, and prolonged exposure to cold.

*As to the diagnosis* of Rhinophyma it is requisite to take into consideration the facts: that the disease does not make its appearance until old age has been entered on, namely at about the age of fifty or even somewhat later: that it affects old men far more frequently than old women: that it is almost invariably confined to the nose, namely the fleshy part of the nose: and that it never leads either to ulceration or to the formation of scars.

Lupus in some respects resembles Rhinophyma. For example lupus is especially prone to attack the wings and the tip of the nose. It is in many instances to be met with affecting the nose only: and often in such cases it is for long restricted to the fleshy part of the nose. It is apt to cause considerable and long-persistent swelling together with redness of the lower half of the nose: and it produces tubercules which give the nose a more or less lobulated appearance. Moreover like Rhinophyma it is unattended with either itching or burning sensations.

But lupus is never an hereditary disease, while Rhinophyma is sometimes transmitted from father to son. Lupus commences usually in childhood, and almost always before adult age. It is apt to extend up the mucous membrane lining the nostrils. The tubercules of lupus are much smaller than the lobules of Rhinophyma: and when lobulation of the nose is produced, as happens in hypertrophic lupus of the nose, the lobes are subdivided by the presence of clustered tubercules on their surface. The enlarged nose of lupus is very much softer, and much less elastic to the touch, than a nose enlarged by Rhinophyma. The colour of the tubercules, or of the lobes, of lupus is a more or less *brownish* red. In lupus, the surface of the swollen nose is not pitted, as in Rhinophyma, by the enlarged orifices of sebaceous ducts: nor does it exhibit comedones. On the other hand it often presents, here and there, cicatrices. But, although these cicatrices may be produced quite independently of ulceration: nevertheless, at some portions of the swollen nose, ulcers are usually to be found. In such case these ulcers are commonly found covered by dry hard prominent scabs. In some instances, a portion of one of the wings of the nose will be found to have been destroyed by the ulceration.

By the smell alone, it is possible to make a diagnosis between Rhinophyma, and lupus of the nose. No one who has ever smelled, at close quarters, the face of a person affected with lupus of the nose: and has similarly inhaled the odour of the sebaceous threads which issue, under pressure, from the pores of a Rhinophyma: can possibly fail to distinguish the peculiar pungent, yet musty, stench of the former: from the special acid and nauseating, but somewhat faded smell of the latter.

When lupus of the nose has progressed so far as to cause any considerable loss of substance: or when any other part of the face, or any other region, is coincidently affected with lupus: it is no longer possible to confound this condition with Rhinophyma.

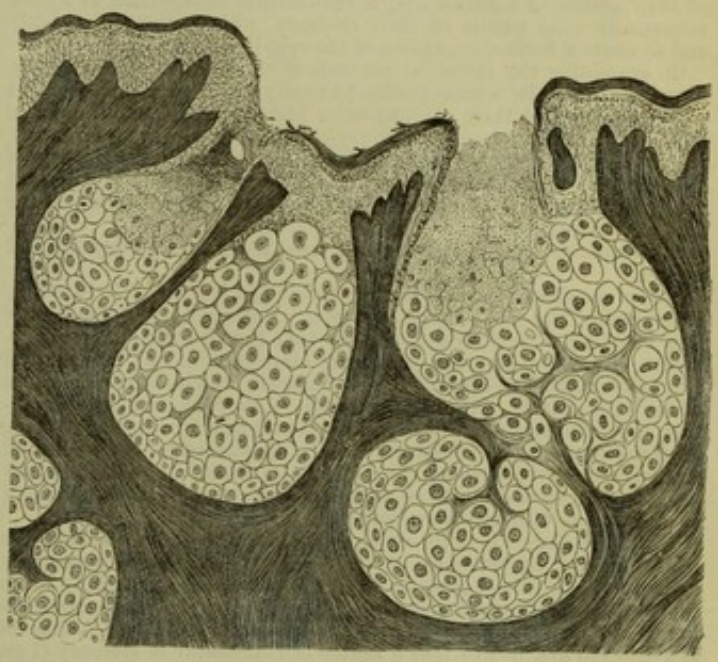
The syphilitic eruption which is distinguished under the name of the tubercular syphilide, or rather one of its varieties, namely, the clustered non-ulcerating variety, may resemble Rhinophyma in some degree. This clustered syphilide sometimes affects the nose only, and especially the fleshy part of the nose: causing considerable tumefaction and nodulation, with redness also of the lower half of the nose. The syphilide may make its first appearance at about the age that Rhinophyma begins, and it similarly fails to excite any sensation whether of itching or burning.

But the tubercules of the syphilide, in their earlier stages at least, are firmer and more resistant to the touch, than the lobes of Rhinophyma: moreover their surface is tense and shining. In their later stages, when their substance is getting soft and flabby, they acquire a coppery hue: and their surface becomes slightly scaly. Those that have quite disappeared have left, in their place, a depressed indelible cicatrix: which retains for some time a tawny-brown colour. In some instances the tubercules ulcerate, and become covered with dark green crusts under which are formed cicatrices of the kind just described. A nose enlarged by the tubercular syphilide never presents pitted depressions, nor does it yield on pressure the white sebaceous threads, or the characteristic odour of Rhinophyma. Teleangiectases are never present in the syphilitically enlarged nose. Moreover the history of the case will generally elicit the fact, that the disease has increased far more rapidly than is usual in the case of Rhinophyma. When there is also coincident ulceration of the mucous membrane of the nostrils, or of the buccal cavity, or of the pharynx, this will greatly assist the diagnosis.

Rodent ulcer (flat epithelioma), when it commences on the tip, instead of as usual on one of the wings, of the nose: may, at a certain stage of its progress, present a decided resemblance to Rhinophyma. The end of the nose becomes considerably enlarged and broadened, so that it acquires a snout-like shape somewhat similar to the 'hammer-nose': and since the condition is almost as slow in developing itself as Rhinophyma commonly is, and often makes its appearance at about the age that Rhinophyma begins, a mistake is possible.

But, if the swelling have attained any notable size a fairly large ulcer will have established itself in the centre of it. If the swelling be smaller, the centre of it will be depressed and scab-covered. But, whether large or small, the swelling will evince quite a stony hardness to the touch: and its circumferential portion will be distinctly whiter than the surrounding skin. Moreover the sebaceous pitting proper to Rhinophyma will be absent.

FIG. 3.



RHINOPHYMA.

Section through two sebaceous follicles situated close to one another, with two comedones, which open in common on the surface. It can be seen that the fat-cells within the glands are, nearly up to the commencement of the duct, nucleated, whereas in the duct itself they contain only a finely granular substance and have lost their nuclei. (H. v. Hebra.)

Vespertilio ('lupus erythematosus'), although it sometimes affects the lower part of the nose, never gives rise to any considerable swelling. When it affects the fleshy part of the nose it is almost always present also on some other part of the face. The circumferential raised portion of the patch is scab covered, and is surrounded by a narrow red indurated areola: and the centre of the patch is a depressed supple cicatrix.

The *Histology* of Rhinophyma has been investigated by Rokitansky,[1] Gustav Simon,[2] Biesiadecki,[3] Piffard,[4] and Hans von Hebra.[5] Rhinophyma may be ranked as amongst the homologous tumours, that is to say it consists only of such structures as are found in the normal

[1] Lehrbuch der pathologischen Anatomie. Dritte Auflage. II Band. Vienna, 1856.

[2] Die Hautkrankheiten durch anatomische Untersuchungen erläutert. 2. Aufl. Berlin, 1851.

[3] Anatomija patologiczna gruczolów skórnych przez Prof. Alfreda Biesiadeckiego. Cracow, 1874.

[4] An Elementary Treatise upon Diseases of the Skin. New York, 1876.

[5] 'Das Rhinophyma' Vierteljahresschrift für Dermatologie und Syphilis. IV. Heft. Vienna, 1881.

skin. It is in fact a pseudo-hypertrophy of the skin. The new-formation consists, in its earlier stages, principally of embryonic connective-tissue, which later on undergoes development into mature connective-tissue. As a result of this localized increase of connective tissue, both within, and also immediately beneath, the substance of the corium: a considerable thickening of the skin, and of the subcutaneous connective tissue is produced. With this thickening of the skin is associated, dilatation of the smaller bloodvessels of the skin, and also new formation of small bloodvessels. Furthermore there is a notable dilatation of the sebaceous follicles, which are distended with solid sebum, and are also greatly hypertrophied. The epidermis however remains unchanged.

The thickened skin contains many connective tissue cells, as well as migratory cells derived from the multiplied and dilated bloodvessels, and furthermore numerous embryonic cells with nuclei. Many of the embryonic cells are undergoing conversion into connective tissue. The embryonic cells are arranged in groups.

The bloodvessels of the affected skin are much more numerous, and of much greater size, than is proper to the normal condition.

The sebaceous glands are notably enlarged, some of them in only a moderate degree, but others acquire, a very considerable increase of size. Their ducts also are greatly dilated.

Thus to the considerable thickening of the skin and of the subcutaneous connective tissue, induced by the new formation of connective tissue: there is added a further potent cause of increase of substance, namely the great increase in size of the sebaceous follicles imbedded in these structures.

The sebaceous glands are, however, not only greatly enlarged. They also possess a greater number of lobules, which are separated from one another by strong bundles of connective tissue.

The distension of the glands, produced by the undue proliferation of their epithelial constituents, is still further contributed to by the abnormally solid nature of their contents, which escape sluggishly and so cause a further expansion of the cyst-like structure.

On examining the epithelial contents of the sebaceous glands, it is found that the cells remain nucleated nearly up to the commencement of the duct, where their contour fades and their nucleus disappears. The duct contains a greasy, dingy-coloured, finely granular mass, interspersed with darkly pigmented particles. This mass consists of the débris of the gland-cells. The dark particles in it are derived from the débris of the layers of pigmented epithelium with which the wall of the duct is lined.

*The treatment* of Rhinophyma is in most instances a purely surgical matter.

When the disease is only recently developed it is possible to obtain resorption of the new connective tissue. But when the tumour is of long standing, as it generally is by the time that it comes under observation, one cannot count on producing absorption of the now mature and long-established connective-tissue-growth which is the chief cause of the enlargement. Nevertheless, even in its fully developed condition, the 'hammer-nose', or even the 'pound-nose', is capable of being rendered less unsightly, and even of being somewhat diminished in size without having recourse to very radical measures. That is to say the redness may be diminished and with it so much of the enlargement as may be due to increased vascularity.

When the disease is in its earlier stages, it is possible to reduce the dilatation and hypertrophy of the sebaceous glands by repeatedly kneading the enlarged nose between the fingers and thumb so as to express the sebaceous accumulation, and by applying various stimulating applications, for example an Ointment of the Red Iodide of Mercury (15 grs. to 1 oz.), or a Lotion of Perchloride of Mercury (1 gr. dissolved in 1 fl. oz. of Rectified Spirit). Such applications, moreover, assist materially in promoting absorption of the new connective tissue formed in the substance of the corium and of the subcutaneous areolar tissue. When by such means the thickening and, coincidently, the pitting of the nose have become materially lessened, the skin will then have become sufficiently prepared for attacking the teleangiectases at the best advantage. This may most conveniently be done by means of the process of multiple linear scarification as first devised by myself. For this purpose my multiple linear scarifier, which I have recently figured elsewhere,[1] offers many advantages. In obliterating the dilated bloodvessels by means of scarification care should be taken that so far as possible the incisions be made in a direction transverse to the direction of the larger branches, and not as is sometimes done in a direction parallel with them. It will be found that on the alæ and tip of the nose the direction of the larger twigs is vertical, that is to say parallel with the length of the nose. Accordingly the direction of the little cuts should be horizontal. In executing them it will be an advantage to insert the forefinger of the left hand, for some little distance, into the nostril of the side on which the incisions are being made. The pulp of the finger introduced into the nostril should face outwards. There is a three-fold reason for this precaution. Not only is the wing or tip of the nose, as the case may be, supported firmly while it is pressed on by the instrument: but the part operated on is also flattened out so that the numerous incisions, which are made at one sweep of the instrument, are all of fairly uniform depth: moreover the operator's sense of touch is employed not only in his hold of the instrument but also in the counterpressure he makes on the part that is being operated on. The obliteration of the teleangiectases is not the only advantage obtained by multiple linear scarification: it also ensures, and that in a very marked degree, a still further subsidence of the thickening of the skin. I find it advantageous to defer the employment of scarification (in the treatment of early Rhinophyma) until after the distension of the sebaceous glands and the pitting of the skin have been somewhat reduced by 'massage' and the use of stimulating applications. Otherwise the incision of the irregular surface, and of the distended follicles opening on to it, is apt to produce a conspicuous and very odd-looking burrowed pitting of the skin which it is impossible to remedy.

When the enlargement of the nose is of long standing and has acquired notable dimensions, when for example it is in the condition represented in the coloured illustration, the treatment that I have described as effective in the earlier stages of the growth will still be of some avail in moderating the disfigurement: that is to say it is capable of diminishing in some tangible degree the enlargement, the redness, and the coarsely pitted appearance of the nose.

Nevertheless, when once the disease has attained a fairly considerable development, the most speedy, the most effective, and on the whole the best means of treating it is to deal with it surgically. As regards the pedunculated or fig-shaped excrescences, when such are present, the best means of abolishing them is to snip them off at their narrowed base with a pair of curved scissors. It is excrescences which are developed on the wings of the nose that, as a rule, lend themselves most to this easy way of riddance. But in dealing with sessile or hemispherical lobes of the tumour, and more particularly with the snout-like enlargement of the tip of the nose, the surgeon has to elect between two distinct methods of operation. The one is to attempt an operation of the so-called 'plastic' kind, or, if need be, several small operations of this character: in other words, to excise in one or more places a wedge-shaped piece of the thickened skin: the base of the wedge being formed by the surface of the skin, and the thin end of the wedge by the line of junction, deep in the tumour, of the two converging incisions. The outline of the base of the wedge must be spindle-shaped. After the wedge-shaped piece has been removed, the sides of the wound are brought together. The other method of operation is of a more sweeping kind: sessile lobules are shaved off, and, in the case of the snout-like enlargement of the tip and indeed of the enlarged alæ as well, the nose has to be literally carved out anew from the tumour in which it is concealed. The former method, which perhaps may be regarded as somewhat of the nature of a compromise, has the advantage of leaving the nose covered with skin: but has the disadvantage of leaving a raised linear scar, or a retracted cicatricial cleft, as the case may be, at the line of junction of the apposed raw surfaces: moreover, at the best, the operation can never produce a wholly satisfactory result from the point of view of shape. It is not like a matter of excising, and uniting the cut edges of, skin which is thin and glides readily over the subjacent structures; as, for instance, in the operation performed on the skin of the orbit for one of the kinds of entropion.

Fig. 4.

The Author's Ablation-knife.

In the case of Rhinophyma all skin that is left on either side of the removed wedge is enormously thickened, and so the result obtained is necessarily far short of a complete abolition of the growth.

Now the more thorough method, that of complete ablation, has it is true the disadvantage of leaving the nose with a cicatricial covering in the place of true skin: but, if neatly performed, it restores the nose perfectly to its original shape. In performing this operation considerable assistance is afforded by the fact that as a rule, even in very advanced cases, the actual margin of the nostrils is quite unaffected by the growth: so that an accurate starting point is afforded around the margin of each nostril. Then again, at the upper margin of the tumour, the swelling rises abruptly so that an accurate line of departure is presented there also. Still further assistance can be gained by introducing the forefinger of the left hand far up the nostril of the side that is being operated on, the pulp of the finger-tip being held outwards. The reasons for this manœuvre are much the same as in the case of multiple linear scarification. It is perhaps scarcely necessary to say that some familiarity with the art of drawing is a considerable assistance in a procedure of this kind. The bleeding, which is apt to be copious, is readily arrested by adjusting the concavity of a small sponge over the nose, and by making pressure on the sponge for some time. The raw surface heals quite speedily owing to the considerable number and the deep situation of the sebaceous glands in the fleshy part of the nose. The remains of these glands, which are left after the operation, afford numerous starting points of epithelium so that the wound soon skins over. The form of knife most suitable for performing the operation of complete ablation of a Rhinophyma is figured in the text. F. v. Hebra[1] records a case in which the considerably elongated tip of the nose was removed by the elastic ligature devised by Dittel but such a method is not very well suited for the performance of a plastic operation.

B. S.

24, *Weymouth Street, Portland Place*, 1889.

[1] On Lupus vulgaris. London, 1888.

[1] 'Zur Therapie der Acne rosacea,' Wiener medizinische Wochenschrift, Nr. 1 1878.