Syphiloderma papulosum circinatum / by I. Edmondson Atkinson.

prior to vaccination, and the appearance of this disease soon after. The health officer said that out of fifty or sixty thousand cases of vaccination, this was the only case he had seen of psoriasis. The speaker was only surprised that there had not been more. If we take the statistics of psoriasis, and compare them with the enormous number of people who have been vaccinated, it will be remarkable that there have not been more cases of this kind falling under our notice. In this connection he recalled the case of a lady who made an appointment with a dentist to take chloroform and have some teeth extracted. She came at the appointed time, and asked to have the operation postponed, as she did not feel well. She left the room, and fell dead on the steps. If she had taken the anæsthetic, there might have been another death from chloroform reported.

DR. ROHÉ said that no doubt more cases of psoriasis following vaccination have occurred that have never been reported, and he had been surprised that he could find no record of such cases. With regard to the remark of Dr. Taylor, referring to the appearance of psoriasis after scarlatina and measles, he said that they were not analogous, because in such cases there was present a general hyperæmia of the skin; he would merely say that in the first case there had not been a general hyperæmia, because the vaccination had not been successful.

SYPHILODERMA PAPULOSUM CIRCINATUM.[1]

BY

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THERE is a form of papular syphilitic secondary eruption, which, while it has received passing notice at the hands of numerous syphilographers, has not had given it the attention its peculiar characters deserve. I refer to the eruption that has, as its starting point, the large, flat papular syphiloderm, and to which the name heading this paper has been given by Dr. George H. Fox (Photographic Illustrations of Cutaneous Syphilis, p. 63, pl. ix.). Its peculiar feature is its centrifugal extension by a narrow border of elevation; while its central portions nearly or quite return to their normal limits as the process extends, very much as occurs in tinea circinata. The lesions differ essentially from the well-known annular or circinate eruption of papulo-tubercle so constantly present as cutaneous manifestations of late secondary and tertiary syphilis; for while these are nearly always expressions of the disposition of late syphilis to group its lesions in a circular arrangement, even at the moment of their development and at distinct intervals of space, so that

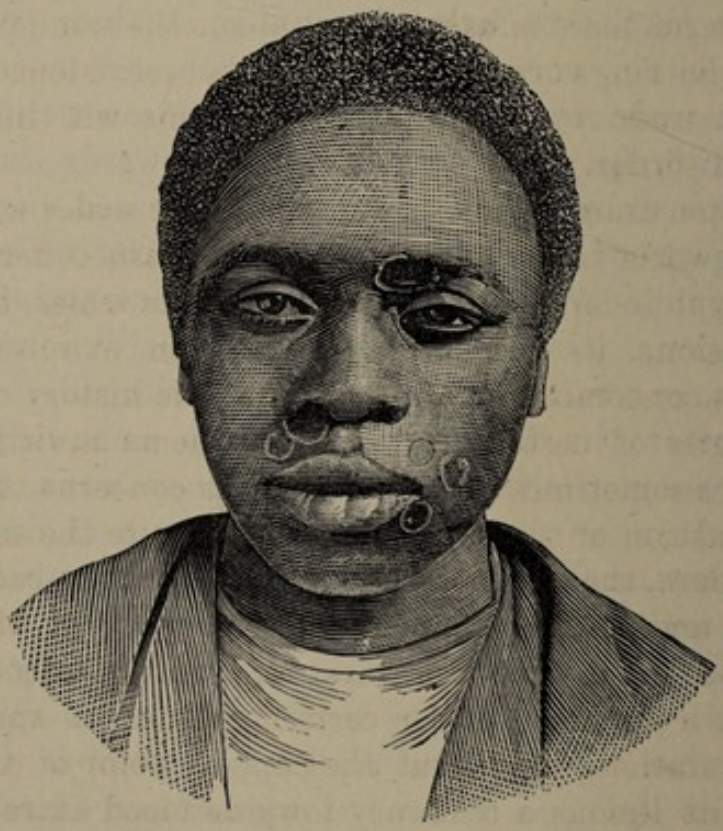
[1] Read at the meeting of the American Dermatological Association, September 1, 1882.

each group will represent a number of separate lesions, simply obeying the law of their distribution; the syphiloderma papulosum circinatum invariably begins in a single lesion, the papule, the location of which will correspond to the centre of the spreading lesion. All syphilographers describe the tendency of the flat papular syphiloderm to become depressed in the centre, and many of them describe phases of the process we are now considering. Bumstead and Taylor refer to one of these when they speak of examples of the flat papular syphiloderm, the margins of which "become elevated into distinct rims," or where an "annular crust of a dirty-yellow color may occupy the periphery of a papule;" and, again, where they say "not uncommonly in the retrogressive stage of these papules, particularly in late eruptions, absorption of the centre of the lesion occurs, leaving a ring which may be scaly, and which is itself finally absorbed without showing any tendency to centrifugal increase" (Venereal Diseases, p. 527). They assign the lesion to the middle and late secondary period of syphilis. George H. Fox (loc. cit.) enters more fully into the description of the lesion. "When the large, flat papules do not coalesce into scaly patches, they frequently tend to increase in circumference and present quite a different appearance. The centre of the papule becomes depressed as the elevated margin enlarges, and in this manner a circinate lesion is developed. Sometimes the surface of the papule becomes moist and presents an opaline or diphtheritic appearance, somewhat similar to the condition which is observed in mucous patches of the lips. The elevated margin of the disc is extremely apt to be eroded, and generally a thin, dark crust forms at the edge of the papule. . . . Sometimes the crust is yellowish, thick and friable, circular or crescentic in form, and with an inclosed area presenting a smooth surface, and a dull-crimson hue." Jullien (Maladies vénériennes, Paris, 1879, p. 703) likewise devotes a number of lines to this form of eruption which he illustrates with a very poor woodcut; he also notices a peculiar feature of the eruption, the tendency of the lesion to form two or more concentric circles ("Syphilide en Cocarde"). Kaposi (Syphilis der Haut und der angrenzenden Schleimhaut, Tafel xxxii.) figures a "syphilis cutanea annularis seu orbicularis" that corresponds to the lesion I am discussing, excepting that his plate represents both by the grossness of the lesion and the apparent scar formation, an advanced stage of syphilis, and would be more appropriately classed as papulo-tubercular or tubercular circinate syphiloderm. The lesion, the history of which I propose to write, belongs to the period of secondary syphilis, and may develop at any time from three months to eighteen months after the appearance of the initial lesion. It is essentially dependent upon the large, flat, papular syphiloderm, and the period of its evolution corresponds to that of this form of eruption. It affects the sexes equally,

and for the most part young adults. At my clinic, which includes a large number of persons of negro blood, the eruption appears to especially prevail in colored individuals. As is the case with syphilitic eruptions, one has usually the opportunity of studying its different phases upon the same patient. In its milder and more limited development, it affects preferably the face and neck, but when extensive, no part seems to escape it: back, breast, belly, thighs, arms, hands become invaded. Where the onset is acute and the eruption copious, fever may be present, and the lesions may form with almost the rapidity of those of the eruptive fevers. The lesions appear as bright or dusky-red discs, but little elevated in comparison to their breadth, and varying in size from that of a small pea to a diameter of two centimetres and more. Some remain without further development, or, within two or three days begin to desquamate in thin, fine scales, beginning at their peripheries. This desquamation either exposes a dry, smooth, reddened, and flattened elevation, or a moist surface which speedily forms a thin, straw-colored, or brownish scab, flattened and depressed towards the centre. After some days, these scabs fall off and leave pigmented spots. While these changes are going on in some lesions, others exhibit a more curious but less intense activity. While the peripheries of these papules show a scanty, fine desquamation, their central portions gradually sink down to the level of normal skin, and their borders extend centrifugally. A short interval suffices to convert the former papules into unelevated central areas, surrounded by narrow but abrupt borders of elevation, forming continuous rings of infiltration and continually throwing off fine scales. Rarely the eruption may be limited to a half-dozen of these spots, irregularly scattered over the face, neck, and shoulders.

The color of the central area will now be of a dusky-red color, slowly fading to a duller hue; while the border will be of a darker and more characteristic tint. The central area now continues to grow larger by the extension of the slightly elevated border, and all resemblance to the original papular lesion is lost. Instead, there is presented an appearance strongly suggestive of severe tinea circinata, which, indeed, it may so closely simulate that, without the previous knowledge of the patient's syphilis, the lesion may, upon superficial examination, be mistaken for ringworm. The elevated border will present a continuous narrow line of a slightly beaded appearance, and will throw off a fine branny desquamation. The central portion of the patch will usually resume its normal surface and thickness, but there will remain the deeper pigmentation; while its size will increase, and its shape will undergo modifications, altering the originally circular outline. In negroes, the ordinary pigmentation of the patches will be replaced by a simple increased intensity in the normal darkness of the skin.

These patches may reach a diameter equal to that of a half-dollar, and by the confluence of several, great irregularity of extent and outline may be attained. I have never seen any patch larger than the size just mentioned, nor do I know to what extent they may proceed if uninfluenced by treatment. It is likely, however, that spontaneous involution would destroy the patch before a much larger extent could be gained. In many patches a curious recrudescence occurs in their centres, whereby a new papule forms, and immediately proceeds to follow the course of its predecessor in extending peripherally, though, it is true, the extending border rarely forms a complete circle, but rather a segment of greater or less size, and not so sharply defined as the first one. Sometimes a third papule may develop within the pigmented inclosed space, and proceed to



extend in the same centrifugal manner. This photograph of a young negro man, whose initial lesion dated back only three months, the indurated remains of which were still to be detected, shows fairly well this tendency, as well as the extent of the separate lesions.

But small provocation is required to convert these lesions into mucous patches, and when the axillæ or groins are invaded, they readily become such. In a young woman, a negress, syphilitic eighteen months, the papular circinate syphiloderm developed within the buccal cavity, where the lesions, immediately becoming mucous patches, adopted the centrifugal extension, the narrow border assuming a pale opaline aspect. Unlike the usual course of syphilitic cutaneous eruptions, this form,

more especially when the rapid and excessive exfoliation of the epidermis lays bare the cells of the Malpighian layer, with the result of forming thin peripheral or general crusts, is often accompanied by a considerable amount of itching, as may be seen from the scratch-marks often present.

These lesions are apt to be mistaken for tinea circinata, psoriasis, or erythema multiforme. In the absence of a satisfactory history of the case and of a microscopic examination, this syphiloderm, when perfectly developed, may be perplexingly like ringworm. The spreading border, however, while delicate, is usually more sharply defined than in ringworm; while the color is usually of a deeper brownish shade, though the coloration of ringworm may frequently, especially in persons of dark skins, closely resemble that of syphilitic eruptions. The presence of itching will not serve a very good diagnostic purpose in these cases, since in the syphiloderm there is usually just about the same degree of itching as there is in the ringworm. Commonly the coexistence of a syphilitic history and of undoubted syphilitic symptoms will indicate the true nature of the disorder.

A microscopic examination of the epidermic scales will at once serve to exclude ringworm from consideration. Psoriasis differs from the circinate papular syphiloderm in the coarseness of its scales, the slower evolution of its lesions, its preferable location on extensor surfaces, the character of its concomitant symptoms, and the history of the patient.

The analogies of certain forms of erythema multiforme with this syphiloderm are sometimes great. So far as concerns the lesions themselves, the formation of the annular border is quite the same in each. In erythema annulare, the eruption is preferably upon the backs of the hands, feet, forearms, and legs, the face and neck; while in the syphiloderm, the breast, body, and face are most frequently affected. Erythema annulare shows a predilection for certain seasons, as spring and fall; is transitory in duration; is without the coppery color of the syphiloderm, and shows in its lesions a tendency towards blood extravasations, a less sharply defined transition from the central to the peripheral portion, and runs through its phases more rapidly than the syphilitic lesion. Very rarely erythema annulare may present a moist surface, over which a thin scab gathers, and then the resemblance to the moist form of this syphiloderm may become very close. Attention to the symptomatology, history, etc., will lead to a correct conclusion. This eruption, finally, is to be distinguished from annular lesions of late syphilis—the papulo-tubercular and tubercular eruptions that assume a circular or partly circular arrangement. Nearly all eruptions of late syphilis resume the annular distribution, but each circle will be observed to represent a compound lesion, composed of a group of papulo-tubercles or tubercles, each having been formed separately; while the circinate papular syphiloderm always

springs from a single lesion. In the former, the lesions are circularly arranged without being in contact; while in the latter, the peripheral border forms a continuous line of less decided elevation. It is, moreover, much less slow in its course. In the unusual event of a papulo-tubercular or tubercular lesion of late syphilis, following a centrifugal enlargement, as in the earlier papular syphiloderm, and as is represented in the already-mentioned plate of the atlas of Kaposi (see also Plate xxxi.), there can be no doubt that the lesions depend upon the same trophic influence, and that their anatomical differences are such only as those indicated in the clinical terms papule and tubercle. The later lesion would be appropriately denominated syphiloderma tuberculatum circinatum.

ACNE ATROPHICA OR LUPOID ACNE.

BY

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THE eruption to which attention is here called is one which not infrequently passes unrecognized, and one which has received very little mention in works upon diseases of the skin. Cases of it are, however, by no means rare, the following three striking examples being all observed in private practice within a period of about two years; while a number of others have presented themselves before and since. The importance of a correct diagnosis of this eruption can hardly be overestimated, as it is most commonly mistaken for one of the lesions of syphilis; it is also peculiarly rebellious to any but a rightly directed treatment. The characteristics of the eruption can be best judged from a brief report of the cases:—

CASE I.—Mr. Charles ——, aged forty-five, a spare, rather nervous gentleman, stated that he had always enjoyed good health, with the exception of what he designated bilious headaches. He had six healthy children, all living, and with no eruptions. He presented no physical signs of disease, and his bodily functions appeared to be perfectly performed; the bowels acted freely; there were no stomach symptoms, except that very rich food disagreed; the tongue was slightly coated and pale; the pulse 66; sleep good and refreshing.

About ten years previous to his first visit, March 23, 1880, the eruption had first appeared upon the forehead, just below the margin of the scalp, and since that time he had never been free from some lesions, generally about a dozen or so points existing at the same time upon some portion of the face and neck. The character of the eruption had remained the