Original Communications.

ON IMPETIGO CONTAGIOSA, OR PORRIGO.

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[Concluded from p. 555.]

Diagnosis. Impetigo contagiosa or porrigo contagiosa, differs from the *contagious furunculoid* described by Dr. Laycock in the *Edinburgh Medical Journal* for Oct. 1856. Dr. Laycock thinks that the furunculoid forms, viz.: simple furuncle, effusive inflammation of the derma (phlyctenæ), suppurative inflammation (ecthyma), carbuncles, gangrenous inflammation, phlegmon (diffuse inflammation of the cellular tissue) and whitlow are associated as to cause with epidemics of eruptive diseases, due to the action of virus prevailing epidemically. A good many of these forms are erysipelatous; the character of the result depending upon the nature and extent of the tissue affected—communicable from one to another, and from one part to another, it is affirmed. Reference is only casually made to this class, with the view of showing that confusion has been carefully and completely avoided.

No confusion of the disease with variola or typical vaccinia can arise; but the disease may very fairly be confounded with pemphigus, ecthyma, rupia, eczema impetiginoides, and impetigo simplex.

Pemphigus. Impetigo contagiosa is umbilicated on the surface; the contents are puriform, not watery; the blebs are all round, and not oval or distended, as in pemphigus. The smaller pustules are conjoined. The scabs are yellow, flat, and adherent. The disease, too, affects the face and the scalp, where it is seen to develop as isolated spots, commencing from little pustules. Lastly, it is contagious, and often traceable to vaccination. All these latter features are wanting in pemphigus.

Ecthyma is made up of phlyzacious pustules. There are no umbilicated pustules or blebs, but more induration at the base. The eruption does not occur on the head and face, as a rule; it is not contagious; and it does not break out in the superficial wet-leather-looking ulcerations, with a dark red blush about them. The ulceration is *deep*, and the areola well defined, in ecthyma. Besides, the history of the case is different from that of impetigo contagiosa.

Rupia. Impetigo contagiosa never possesses the scabs of rupia, the bloody or sanguinolent contents of the apparent blebs. The latter, in rupia, are not umbilicated. Rupia does not occur on the face or head, in the way that impetigo contagiosa does; but it has a history of great debility or of syphilis, and occurs chiefly in adults; whereas the other is almost peculiarly limited to the child.

Eczema Impetiginoides. Impetigo contagiosa, when on the face near the mouth, may assume the aspect of eczema impetiginoides; but we mostly find scattered around the edge of the patch little minute pustules, which show the origin of the disease, perhaps in conjunction with characteristic pustuloids or ulceration elsewhere. But impetigo contagiosa may be positively limited to the face; and then careful examination will show that the patch is made up of the fusion together of little circular ulcerations. There are not only cracks, but distinct ulcerations of a circular form.

Scabies. I have positively seen the disease mistaken for scabies. When seated about the back, but-

tocks, or legs, it may certainly present a rough likeness to the severe form of scabies seen in unhealthy subjects—a form of disease which is quite familiar to those who have attended Dr. Jenner's *cliniques* on skin-diseases. But scabies does not occur on the face, and but very rarely, if at all, on the head; though it is certain that it may give rise to eczema capitis by mere sympathetic irritation. At all events, impetigo contagiosa develops from pustules; it possesses no vesicles with cuniculi; nor can the acarus be found. It does not attack the buttocks of children by preference. Itching may be absent. The eruption is not multiform, yet characteristic in the pustuloid stage. The contagious quality of the lymph is distinctive; inoculation will settle any dispute in forty-eight hours.

Impetigo Simplex (non-contagiosa), a degree of eczema, is not confined to age; is not so amenable to treatment; always follows or accompanies eczema; *always* develops out of the latter, on the scalp. In other words, it is not a *primary* form of disease, and it is non-contagious. There is more redness around the base of the pustule in impetigo simplex.

There may be but one spot in impetigo contagiosa, and that is usually absolutely characteristic.

The character of the eruption (its circular form and umbilication, etc.); the isolation of the several spots, as a rule, on the general surface; its connexion with vaccination; its occurrence chiefly in the child, and on the face and head particularly, assuming in the latter situation the aspect of circular, isolated, well defined, flat, yellow granular-looking scabs, developed from primary pustules; the implication oftentimes of the mucous surfaces; its contagious quality especially; the results of inoculation; its similitudes; the character of the ulceration and the tint of the areola,—mark impetigo contagiosa as an essentially distinct disease. *Impetigo rodeus*, I suppose some would name the severer cases; but this designation really refers to a mixture of several ulcerating diseases.

The subject of impetigo contagiosa was brought before the notice of the Harveian Society, in December last year, by myself; and, in the accounts in the medical journals, Dr. Hillier is reported to have said that "I had mixed up several diseases under the head of porrigo". Now, it is evident that not only was my differential diagnosis and description of the disease very full, but that the confusion, if any, existed in Dr. Hillier's own mind—probably brought about by the hold which the unfortunate word "porrigo" obtains over dermatologists. There can be no question that many of Willan and Bateman's cases of "porrigo larvalis" were instances of the disease now under notice. The references made to porrigo tonsurans and porrigo scutulata, etc., were introduced into the discussion in the face of the opening remarks of my paper, which were framed to show the absolute separateness of parasitic disease and (as I called it) impetigo contagiosa. Dr. Hillier's remarks afford additional proof to my mind that the word porrigo is a most undesirable one in the nomenclature of skin-diseases, though the great authority of Mr. Erasmus Wilson still sanctions its retention, restricting its use to the parasitic group. Porrigo, if it be a derivative from *porrigere*, to stretch or spread out, is certainly very descriptive of impetigo contagiosa of the scalp; but it would appear to signify rather "squamous"—"a porro, quia, ut porrum in tunice involucri, ita cutis velut in squamas resolvitur," as lexicographers have it. All confusion will be best avoided by rejecting *in toto* "porrigo".

Another point worth noticing is the occasional rarity of impetigo contagiosa. Always keenly alive to anything of interest in skin-disease, during the whole course of my stay at University College I rarely saw

impetigo contagiosa. Now and again cases occurred which have been categorised as impetigo; and yet which, in some way, would not fit the ordinary descriptions of the latter, but which are now capable of appreciation. Nor have I seen the disease so well developed, or in such an amount and extent, as during the past year at the Farringdon Dispensary; and, therefore, it is not at all unlikely that many who read these remarks may at first demur to them, and, indeed, imagine that at present there cannot be sufficient data from which to arrive at a trustworthy conclusion. Indeed, if my memory serve me, the objections already made have come from those who, although engaged in extensive skin-practice, have yet seen comparatively little of the disease.

Treatment. Clinically speaking, we find, in treating the disease—

1. That many cases get well if left alone; but this is a tedious affair.

2. That a more efficacious plan of treatment is that in which the internal administration of cod-liver oil and iron is combined with the local use of soothing applications—*ex.*, zinc ointment.

3. That a still more successful plan is to give cod-liver oil and iodide of potassium internally, and to apply externally sulphur ointment—a plan of treatment recommended and sanctioned by my colleagues.

I think we may safely conclude that the latter is the “basis” of successful treatment. It must be remembered that the disease occurs among the lower orders, and especially in delicate and strumous subjects; that it also follows vaccination, and is eminently contagious. Nature is able sometimes to carry on the suppurative and desiccative processes quietly, and to overcome further mischief by the establishment of convalescence; but there evidently is a low state of vital power, which antagonises this good effect, and leads to ulceration; hence we must always enjoin a tonic plan of treatment. At the outset, we may have a good deal of febrile action; this must be kept within due bounds by the ordinary means.

The local treatment is most important. The chief point is to remove all scabs (pediculi, according to my own observations, are rare). The scabs must be removed, and the medicaments applied to the subjacent sore surfaces. Sulphur ointment is the best. Solution of nitrate of silver, the solid salt itself, zinc ointment, iodide of potassium ointment, acetate of lead lotion, or benzoin, may also be used. Sulphur has probably no very special charmed action in this disease, any more than in other cases—*ex.*, lichen, psoriasis, pityriasis, etc.

We must be careful to prevent all methods and modes of contagion; but, with the exercise of the greatest care, the disease will in all probability spread from one to several members of the same family.

CASE I. (August 24th, 1863.) R. G., aged 6 months, was vaccinated eight weeks ago. The operation succeeded admirably; but the spots never actually healed up. Four weeks ago (a month after vaccination), a place “broke out”, about the size of a three-penny-piece, on the arm; it was like “a little flat bladder. At the present time, there is one on the nose; one on the left thigh, of the size of a split pea; and another, about as large as a fourpenny-piece, on the right leg, with a cluster of the size of a florin, made up of five circular slightly confluent pustules; at the back of the thigh is a place of the size of a shilling. The centre in each is depressed, the edge raised into a border about one-eighth of an inch broad. There is not the least history or evidence of syphilis. There is no blush around the little bullæ. The patient was ordered quinine and zinc ointment.

Aug. 28th. There was another spot on the belly,

and one on the knee. The other spots are now surrounded by an annulus of soddened-leather aspect.

Sept. 11th. The eyelids are swollen. The face is one mass of scab, of ordinary “porriginous” character. There is a fresh place on the arm, which looks like an angry bulla, depressed in its centre. The old spots have enlarged by centrifugal increase, and are partly scabbed over. The one on the belly has attained the size of a shilling. They discharge a viscid secretion, especially in the morning. The general health is “good” (?) There are spots on the head.

Sept. 14th. The patient has high fever; the urine is febrile. The spots have increased in size; are inflamed; and they discharge freely. The leg is red, swollen and oedematous, tender, and hot. Saline aperients were ordered.

Sept. 18th. The patient was better in every way.

Oct. 5th. The places have scabbed over with flat crusts, and some have dropped off, leaving dull red dusky stains.

The child quickly recovered, under tonics and zinc ointment. Sulphur ointment did not agree with it.

CASE II is very instructive. It was seen August 28th, 1863, for the first time. E. B., aged 2½, was bitten in the arm by another child affected with so-called “impetigo of the head” (seen). On the arm is a patch, of about the size of a shilling, in the site of the bite; and this patch, when compared with others which exist elsewhere, is clearly seen to be the most advanced in duration and changes; in fact, here the disease evidently first showed itself outwardly. Immediately contiguous are four or five little blebs, of about the size of threepenny-pieces, circular, raised slightly, and looking like little flattened blisters; they are not confluent. The fingers of the right hand are also affected. On the forehead is one bulla, and on the cheek another. The child is ill and fretful. The history given by the mother is this: that, on the fifth day after the bite, the child was awakened by fever and vomiting; it could not sleep. The marks of the teeth then became hard; they “gathered”, and ran into sores. On Sunday (20th), the eighth day after the bite, the third day of the eruption, the child began to “break out” all over, first the bites, then the fingers and thumb, then beneath the elbow, on the forehead, and chin. The bite, as the mother described it, “came out like scalds”. Some of the spots are scabbed, in the way imagined to be characteristic of “porrigo”. There is very little discharge; but the spots, which have assumed a pustuloid aspect, contain a gelatinous fluid, filling up an ulcerated pit. The general health has always been good. The mother has a spot on her neck. Another little boy, a brother, has two very characteristic spots of so-called “porrigo” on his abdomen.

CASE III was that of the father of two children who had been under my care for “porrigo”. He was an intelligent man, who described the history of the disease very well indeed. He had a spot on the back of the left hand, at the root of the little finger; and one also at the point of the elbow. He noticed the disease as a “bladder-like humourous head”, which kept spreading centrifugally. At first the spot was of the size of a shirt-button; now it is as large as a shilling, dull red at the base. Yellow matter oozed away at first; now there comes “pale blood”, or matter. The patient did not feel ill. The spot at the right elbow-joint enlarged for ten or twelve days, with a little “humourous ring”; the centre of the spot being depressed, and the lymphatic gland above the right elbow being enlarged. (Oct. 23rd, 1863.)

CASE IV. A. D., aged 12 months, was seen on Monday, October 29th, 1863. On the previous Tuesday, one of the eyes became inflamed—“blood-shot”;

the lid became rapidly swollen, with at first little discharge, the lids sticking together; and at the same time a great many "pimples" made their appearance on the face. Last Saturday (Oct. 27th)—*i. e.*, two days since—the child seemed ill, feverish, and cross, and was attacked by a severe cough. On one of the shoulders, near the root of the neck, appeared four umbilicated bullæ, of about the size of split peas, slightly confluent, with two others quite isolated. They have the aspect of scalds. There is a great "running" at the nose. The eye is inflamed, and discharging pus. The external part of the ear (the pinna) is sore; and on the inner aspect is one pustular spot, of about the size of those on the back, depressed in the centre, looking just like some examples of variola. With cod-liver oil and zinc ointment, the child got well; the later progress of the case showing the peculiar crusts of "porrigo".

This was a good example of so-called bastard vaccinia—a transition stage, it would appear, between vaccinia and impetigo contagiosa. The changes as to time and character were different from those of variola or vaccinia; and yet, in external aspect, one could not fail to see some relation. The disease lasted about a month. I have never seen the exact like of the case before, and at first it puzzled.

CASE V. E. D., aged 2 years, seen September 3rd, 1863, was vaccinated four months ago. The operation succeeded admirably, and the sores left healed up perfectly. The child is in good health, and there is no evidence of scrofula in the family history. It appears that an elder brother was laid up with small-pox, and this child was vaccinated in consequence. There is a "porriginous" spot on the left arm, at the seat of vaccination; also on the right arm, between the buttocks, on the head, and on the right thigh. There are on the left arm six circular spots in the six separate punctured (vaccinated) places; they are dull red, quasi-squamous, depressed below the surrounding integuments, feel harsh; their colour goes by pressure. There is no copper stain; and immediately joining is a yellow crusted spot. Just above the elbow is a circular patch, made up of aggregated spots, and freely crusted, of about the size of a shilling. On the forearm are two more; and above the wrist another place, of the size of a sixpence. Between the buttocks, the two spots are about as large as a shilling, and possess a raised thickened edge, with depressed centres, and an ulcerating surface. Cod-liver oil, administered internally, was the sole remedy used.

The above five cases are quoted as illustrations rather of the more uncommon instances and aspects of the disease.

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TARTARISED ANTIMONY AS A REMEDY IN STRUMOUS OPHTHALMIA.

By EDWIN CHESHIRE, F.R.C.S., Senior Surgeon to the Birmingham and Midland Eye Hospital.

I HAVE so frequently prescribed tartar emetic, generally in combination with opium (but often alone), in strumous ophthalmia, as well as in acute corneal and conjunctival inflammations, and with such marked success, that I have no hesitation in suggesting to my professional brethren a more extensive use of the remedy in the treatment of those obstinate, and frequently protracted, affections of the eye.

In cases of strumous ophthalmia, where there was excessive photophobia, I have found the internal administration of tartarised antimony, in doses varying from one-twentieth to one-twelfth of a grain, accord-

ing to the age of the patient, to be attended with the most decided benefit; and its efficacy has been singularly marked, where quinine, steel, arsenic, and cod-liver oil, had each, in its turn, been tried and failed. No remedy that I know of so completely or so permanently removes the photophobia, which is such a distressing symptom in strumous affections of the eye.

In phlyctenular ophthalmia, and in vascular cornea or pannus, uncomplicated with a granular condition of the palpebral conjunctiva, or with inversion of the cilia (trichiasis), a continued course of tartar emetic, in small doses, arrests the progress of the affection most effectually, and with it may be combined the early use of local stimulants, a combination which may be continued, if necessary, for a lengthened period without injury to the general health; in fact, the patients who have taken tartarised antimony under my care, both at the Eye Hospital and in private practice (and I have prescribed it very extensively), have almost invariably told me how much stronger and more energetic they felt during the time they were taking the remedy. I am aware it has long been the practice of ophthalmologists to administer a single emetic dose of tartarised antimony, as a beginning to the treatment of strumous ophthalmia; and that it has occasionally been given in combination with bark and quinine; but it does not appear to have been resorted to as a remedy, *per se*, for the cure of strumous affections of the eye. It is quite true, in the case of the little strumous patients, while under treatment, that they were usually placed on milk diet; and, when the photophobia was severe, attention was paid to the exclusion of light, which would probably assist in promoting a favourable result; but the same diet was generally resorted to, and the same care to exclude light was taken, when the treatment had consisted of cod-liver oil, quinine, etc., and yet often with an unsatisfactory result.

UNLICENSED LUNATIC ASYLUMS. Mrs. Sophia Leander, of Zion House, Turnham Green, was charged on Monday, with unlawfully receiving into the house occupied by her more than two lunatics, such house not being an asylum or hospital registered under the provision of the Act of Parliament. The magistrate sent the case for trial at the Sessions; Mr. Leander giving bail for the appearance of his wife. Dr. Christie, superintendent of the Hackney Lunatic Asylum, stated that he had inspected Zion House, in company with Mr. Luttridge, one of the Lunacy Commissioners. There were about eighty inmates. He examined four or five of the patients, and found them to be persons of unsound mind. The premises were certainly not proper for the accommodation of so many persons in this condition.

PHILADELPHIA MILITARY HOSPITALS are models of cleanliness and good order. From all quarters they extort praise and admiration. We have at present the South St. Hospital, an old silk factory, with about 250 beds; the Christian Street, with a like number; the Filbert Street, about 400; the West Philadelphia or Satterlee, accommodating 2,500 patients; the Chestnut Hill, or Mower, about 3,000; the Turner's Lane, the Nicetown and the Germantown Hospitals, each of much less proportions. Four of these were built as army hospitals, and are models of the kind, being splendidly ventilated, and supplied with every means to restore the health of the sick or wounded patriots who may be brought under their shelter. In addition, we have an officers' hospital at Camac's Woods, where officers are furnished with hospital attendance at a reasonable rate. (*American Medical Times.*)