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PITFALLS IN DERMATOLOGY.

A POST-GRADUATE LECTURE DELIVERED TO THE FELLOWSHIP OF MEDICINE AT THE MEDICAL SOCIETY OF LONDON, FEBRUARY 18, 1929.

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IN the diagnosis and treatment of skin disease there are many pitfalls for the unwary, especially for those who are not accustomed to see many skin cases in the course of their daily work. Many mistakes in diagnosis arise from the unfamiliarity of the physician with possible alternatives for

the diagnosis which he is at first inclined to make, and with the points in favour of each.

I propose therefore to talk to you about the differential diagnosis of a number of conditions commonly met with which are apt to be confused one with another. You will realize, of course, that the list is far from complete.

Take first the common condition, small-spored ringworm of the scalp. This is often confused with alopecia areata. The principal points to remember are, first, that small-spored ringworm does not occur in persons over the age of 14 years. The next point is the character of the skin surface. In ringworm this is scaly, and in alopecia areata smooth and shiny. The third point is the character of the hair stumps. In ringworm these are plentiful

and are present all over the surface of the affected patch. In alopecia areata they are usually scanty and only found near the periphery of the patch. The stumps themselves in ringworm are dull, inelastic, often bent in the middle and, if examined in liq. potassæ under in. objective, are seen to have a coating of spores in the form of a mosaic. In alopecia areata the stumps are shiny and elastic like normal hair, that is, they spring back to their previous position if the finger is drawn over them against the lie of the hair. They are also of the shape called "exclamation mark" (!), that is, they are of the normal thickness at the free end and very thin and depigmented at the inserted end.

Remember that not all the hairs in a patch of ringworm are infected, and it is no use sending hairs to a laboratory for microscopic examination unless you are able to select with the aid of a hand lens the hairs which are probably infected. A good method is to rub the suspected patch well with ether on a swab, to remove all grease, and then examine with a hand lens in a good light and look for short, dull, or whitish, bent hairs. Pull some of these out and, if you are going to examine them yourself, place them on a slide in liq. potassæ under a cover glass. Warm over a flame and then examine with $\frac{1}{8}$ in. objective. You will see, in infected hairs, parts where the hair is encased in a sheath of small, uniform-sized, perhaps polygonal, spores. Fat droplets sometimes provide a pitfall, but these are always of various sizes and never polygonal.

Examination by Wood's light in a dark room is a great assistance. This is light from a mercury-vapour lamp or other source of ultra-violet light passed through Wood's glass, the latter being a dark violet glass containing oxide of nickel. It allows certain of the long-wave ultra-violet to pass, but very little else. This ultra-violet causes hairs infected by small-spored ringworm to fluoresce and shine brightly with a greenish

light, while the normal hair looks only as though it had been lightly dusted with flour. By this means even one infected hair on an otherwise healthy scalp can be easily identified.

Hairs infected with large-spored ringworm are not nearly so easy to see, as they fluoresce less brightly and with a bluish tint. A pitfall in this method is that if the hairs have been recently painted with iodine or silver nitrate, or have had chrysarobin ointment applied, they will not fluoresce.

A form of ringworm which sometimes causes difficulty is due to a large-spored endothrix fungus, and is known as "black-dot" ringworm. In these cases the stumps are broken off level with the skin surface and appear as black dots somewhat resembling comedones. They have to be extracted with a needle or a comedo expresser for microscopic examination. This type does not die out at puberty and may be found in adults.

Difficulty may arise in the diagnosis between alopecia areata and syphilitic alopecia. In alopecia areata there are usually a small number of completely bald patches with sharply marked margins, and possibly exclamation-mark hairs. In syphilitic alopecia there are a large number of irregular small patches, none completely bald, involving most of the back and sides of the head and running into one another. The result is to give a "moth-eaten" appearance. Other signs of syphilis such as adenitis, a rash, or mucous patches will probably be present and will assist materially in the diagnosis. In neither of these forms of baldness is the skin scarred. There are, however, a number of conditions leading to patchy baldness in which the affected areas are scarred, the skin being atrophic and the follicles absent. Some of these are as follows:—

Pseudopelade or cicatricial alopecia, a rare condition in which numerous small atrophic bald patches occur, which coalesce to form irregular areas, generally on the

vertex. There may be a faint pink or violet halo about the hairs at the periphery of the patches.

Lupus erythematosus causes depressed bald scars on the scalp, generally an inch or two in diameter. The follicles have disappeared in the centre and at the periphery are filled with horny plugs. There is usually some erythema at the margin of the patch. Diagnosis is easy if typical lupus erythematosus is present on face, ears, or hands, but occasionally the disease is limited to the scalp.

Localized scleroderma (morphœa) may also cause depressed bald scars on the scalp, possibly pigmented, and perhaps with a violet-coloured border, but there is no plugging of the follicles as in lupus erythematosus.

Herpes zoster frontalis may cause scars in the distribution of the supra-orbital branch of the fifth cranial nerve, but there will probably be scars on the forehead, too, which will assist in the diagnosis.

Favus may cause extensive scarring on the scalp of an irregular type. Some of the yellow "favus cups" may still be present in places, and the "mousy" odour of the disease may be noticeable.

Kerion, an acute purulent inflammatory reaction to ringworm infection, may cause bald patches which are occasionally permanent. In the active stage the inflammation is obvious and infected hairs may be found at the periphery. Wounds and boils may also leave permanently bald scars. Permanent baldness due to over-dosage with X-rays in the treatment of ringworm can usually be recognized by the presence of other signs of an old X-ray dermatitis, i.e., scarring, pigmentation, and telangiectases.

Diffuse fall of hair has several causes, and it is important to distinguish them. A few weeks after an acute febrile illness, especially influenza, the hair may begin to fall rapidly all over the scalp. In such cases the prognosis is good and the hair will probably return to its previous strength and quality.

Seborrhœic infection of the scalp, whether of the oily or dry scaly variety, is one of

the commonest causes of diffuse fall of hair. The areas affected are the vertex and frontal regions. These are also the areas from which the hair first falls in men who have an hereditary tendency to early loss of hair. In hereditary early baldness and in the oily type of seborrhœa the prognosis is not good, but in the dry scaly type a good deal can be done.

Diffuse fall of hair in women after the menopause is often associated with hypothyroidism, of which there will probably be other signs to assist in the diagnosis.

Remember that alopecia areata sometimes involves the whole scalp very rapidly and is the commonest cause of complete baldness. When the hair has been missing for six months the chances of its return become progressively worse.

Scaliness of the scalp is due usually to one of three causes: ringworm, seborrhœa, or psoriasis. Ringworm of the scaly type is unlikely to be found in adults. In seborrhœa the scaliness is usually diffuse, or if patchy the patches fade gradually into healthy skin. There may be lesions of seborrhœa corporis over the sternum and between the scapulæ, or of seborrhœic dermatitis in the flexures.

Psoriasis of the scalp is usually patchy, and the patches have absolutely sharp margins. There is generally psoriasis on the body or limbs also, which gives away the diagnosis.

Pustular lesions on the scalp are not necessarily boils; they may be patches of kerion, that is, inflammatory ringworm. Inflammatory ringworms of animal origin occasionally occur on the scalp in adults; the diagnosis can be made by examining hairs for fungus.

Red scaly lesions on the forehead at the hair margin may be due to seborrhœa, psoriasis, or secondary syphilis. Examination of the scalp and of the rest of the body will usually clear up any doubt there may be.

A pitfall which catches many is the diagnosis between circinate impetigo contagiosa

on the face and ringworm. It is important to avoid this trap, because painting an impetigo with iodine frequently makes it worse. The principal point for diagnosis is that in impetigo the ring is made up of the continuous edge of one big blister whose centre has disappeared. Whereas in *tinea circinata* the ring is made up of a large number of small lesions, vesicles or pustules, set close together. In impetigo there may be elsewhere typical crusted lesions. Impetigo may also be confused with a patch of herpes recurrens on the face. Here again the fact that a patch of impetigo represents one big blister is helpful, for a patch of herpes is made up by the massing together of a number of tiny blisters. It is just as well to be able to distinguish these because, although there is not much difference in the treatment, the prognosis is different; impetigo is not likely to recur, while herpes recurrens may become a perfect pest to the sufferer from it.

Lesions on the beard region. Staphylococcal sycosis is familiar to all of you. Remember that ringworm infections can cause a somewhat similar condition which requires different treatment. Ringworm infections on this area tend to be much more nodular, and sometimes cause the formation of quite large purplish lumps. It may be difficult to find the fungus, as the heavily infected hairs fall out owing to the inflammation of their follicles.

A localized ringworm of the beard has to be distinguished also from a form of tertiary syphilide, which is not uncommon and is called *frambœsiform*. This is a warty plaque on the centre of the chin or about the angles of the mouth or nose which is easy to recognize when you have seen one or two. The absence of fungus and the presence of a positive Wassermann reaction (usually), and the effect of antisyphilitic treatment, will clear up the diagnosis.

A differential diagnosis sometimes has to be made between lupus vulgaris and tertiary syphilis of the tubero-serpiginous type. The principal points to remember are that lupus

is very slow and takes a year or more to do what syphilis will do in a month. In lupus vulgaris the edge of the lesion is irregular and contains apple-jelly nodules. The scar where the disease has nearly died out is fairly thick and contains apple-jelly nodules. If the nose is affected it is the tip, and the cartilages of the alæ which are likely to be lost. There is little or no tendency to spontaneous cure.

In tertiary syphilis of the type liable to be confused with lupus vulgaris the progress is relatively rapid; the edge tends to be made up of segments of circles, the nodular lesions are larger than the apple-jelly nodules of lupus and less translucent. The central scar is thin and may be pigmented and contains no nodules. I think this latter point is often of great assistance. The lesions tend to spontaneous cure in the centre while spreading at the periphery. If the nose is affected the bony bridge is more likely to be attacked than the cartilages. The Wassermann reaction will probably be positive, and the effects of antisyphilitic treatment will usually be rapid.

Confusion sometimes arises between rosacea and acne vulgaris, the more so as the two conditions may be present together. Acne vulgaris is typically a disease of the young from 14 to 30 years. Rosacea, of the middle-aged, from 30 to 50. The essential feature of acne vulgaris is the blackhead or comedon. Any redness there may be is the result of infection of follicles and tends to be localized. In rosacea the redness is the primary feature, and is diffuse, affecting the forehead, cheeks, nose, and chin. The chronic paralytic distension of the small vessels of the skin in these regions leads sometimes to hypertrophy of the sebaceous glands and secondary suppuration, but never to the formation of blackheads.

It is important to distinguish the two conditions, because in rosacea it is essential to treat the indigestion which is usually present, while in acne vulgaris the digestion is seldom at fault.

Rosacea may be confused also with lupus

erythematosus, in cases where the latter has caused symmetrical red patches on the cheeks. A close examination with a lens will probably reveal, in parts of the lupus erythematosus patches, a fine stippling, produced by the plugging of the openings of the follicles and the sweat-ducts with little, horny plugs. There may be other evidence of lupus erythematosus on fingers or ears, or depressed scars on the scalp.

The diagnosis of small tumours on the face provides a number of possible pitfalls. Remember that the possibilities are squamous-celled carcinoma, basal-celled carcinoma (rodent ulcer), molluscum contagiosum, sebaceous cyst, mole, wart, and boil, besides a few rarities with which I will not trouble you.

The squamous carcinoma is very rapid in its growth, and in a matter of weeks will reach a size that a basal-celled carcinoma would take years to attain. The squamous carcinoma also is more opaque than the basal, and may have a little scaly patch in the centre. The basal-celled carcinoma is very slow in its growth, relatively translucent, and the centre has a tendency to be depressed. Transitional forms are often met with, however, in which the diagnosis can only be made by section. Molluscum contagiosum is usually multiple, and the little pearly translucent tumours have each a dull spot in the centre through which the caseous mass can be extruded by pressure. They seem to lie upon, rather than in the skin. Sebaceous cysts are yellowish white and opaque in appearance, and the contents can be expressed through a puncture. A mole has usually a long history and it may be either soft or hard, and pigmented or hairy, or both.

A wart can usually be recognized by its rough warty surface, and there may be others, but sometimes a single wart of recent and rapid growth is very difficult to tell from a squamous epithelioma.

A boil is of course usually easily recognized, but a small infected epithelioma may be mistaken for one.

To come to the trunk, an important diagnosis sometimes has to be made between scarlet fever and recurrent scarlatiniform erythema. This may be very difficult, but the chief points to rely on are: in scarlet fever the onset is more acute, the throat more painful, and there may be vomiting. The temperature is higher (104° F.). The pulse more frequent (140-160). There are often enlarged lymphatic glands. The tongue in scarlet fever is furred, with red papillae projecting through the fur, and when the fur clears the papillae are still large, making the tongue rough. In scarlet fever the rash begins on the second day on the face, neck, or chest; it fades after six to seven days and peeling of the "perforative" type begins after the rash has faded. There may be some albuminuria and second attacks are rare.

In scarlatiniform erythema there may be a history of previous attacks, the onset is less acute, the throat less sore, there is no vomiting, the temperature is lower (100° to 101° F.), and the pulse less frequent. There are no enlarged glands. The tongue is at first furred, later smooth and bare, but never of the "strawberry" type. The rash begins after a few days of preliminary symptoms and usually starts on the limbs or trunk. The rash may last for weeks or months, but peeling begins on the second or third day while the skin is still bright red. This is perhaps the most important diagnostic point. The peeling is of the "branny" type. There is no albuminuria and the disease has a tendency to recur.

Of the maculo-papular rashes on the trunk, two which are often confused are pityriasis rosea and the macular secondary syphilide or roseola.

Pityriasis rosea usually begins with a "herald patch," which is slightly red and slightly scaly and lasts for a week or so before the general eruption begins. This, when it appears, comes out rapidly on the neck, trunk and upper parts of the limbs, the so-called "vest and drawers" area. The characteristic lesion of pityriasis rosea is a

pink, oval, macule tending, on the trunk, to have its long diameter parallel with the ribs. It soon becomes fawn-coloured and wrinkly in the centre, and then begins to peel from the centre outwards, so that a collar of scales is visible with its free edge towards the centre, and its attached edge at the periphery. One or two typical lesions can often be found on the flank, if the majority of the lesions do not show these characters. There is no adenitis or sore throat and the patient feels well. The eruption may itch quite considerably, or not at all.

The macular secondary syphilide occurs chiefly on the trunk. The macules tend to be round and evenly spaced. The follicles on them may be rather prominent. Some of the macules may be becoming papular and rather brownish and infiltrated. Other signs of syphilis can usually be found if looked for. Such are headache, alopecia, adenitis, mucous patches in the mouth, sore throat and, possibly, a primary sore and moist papules on the scrotum or at the anus. There is no itching. The Wassermann reaction also will be positive.

Another pitfall is provided by the diagnosis, in children, between varicella and lichen urticatus (or papular urticaria) of the vesicular type. This may be extremely difficult. In varicella there is generally some fever, the rash usually begins on the upper trunk and spreads downwards, lesions may be found on the scalp, and on the mucous membranes of the mouth and vulva. Itching is slight or absent. One attack usually protects. There may be a history of association with other cases or with a case of herpes zoster.

In lichen urticatus there is no fever, and the rash may appear anywhere on the trunk or limbs. It seldom affects the scalp and never the mucous membranes. The itching is very pronounced but ceases when the top of the lesion has been scratched off. The eruption may go on for weeks or months, and there may be a history of previous attacks.

Lichen urticatus may have to be diagnosed also from scabies, as both are extremely itchy and lead to scratching and secondary infection, so that the final picture may be much alike. Here let me remind you that the first thing to do when confronted with any itching eruption in any patient, of any age or station in life, is to exclude scabies. Many a case of scabies is missed because the doctor did not think of it as likely in a patient in such good circumstances. I remember a lady who had been itching for eighteen months and had been treated by all sorts of methods, including a prolonged stay in a nursing home on a strict diet, and yet got no better but rather worse; and all because no one had apparently realized that the trouble was scabies!

In scabies there are two types of lesion, the well-known "burrows" and also a red, follicular rash on the trunk, which is presumably toxic. The sites where one is most likely to find burrows are the ulnar borders of the hands, the front of the wrists, between the fingers, the anterior axillary folds, the buttocks, the inner sides of the feet and ankles, around the nipples in women and on the penis in men. An itchy rash distributed on these areas, or several of them, is generally worth treating as scabies, even if no actual burrows can be identified.

Another pitfall is provided by pediculosis corporis, for this is surprisingly common in elderly people, even in good social circumstances. The primary lesions are red pinpoint macules with pink halos, which represent the bites of the insect, but the most striking ones are the severe linear scratch marks which the patient makes on the backs of his shoulders. It may be possible to find the parasite by examining the neck or seams of the underwear or shirt, but often one has to rely on the scratch marks for a probable diagnosis. The pediculus, as Norman Walker remarks, spends its leisure on the clothes and only adjourns to the skin for its meals, so that it tends to bite places where the clothes make good contact with

the skin, such as the shoulders and the upper part of the buttocks.

Dermatitis herpetiformis is another itching disease which may be widespread and tends to recur. The lesions may be erythematous blotches, grouped vesicles, or bullæ, some of which are generally scratched and scabbed. Sites of old lesions are shown by scars and patches of pigment. A typical case does not suggest scabies particularly, but during the war most cases occurring in the troops were diagnosed as scabies, until, upon the failure of treatment, they were seen by a dermatologist.

I will not deal here with the differential diagnosis between primary syphilitic and other penile sores, for although the subject is one of the first importance it is thoroughly dealt with in many textbooks.

Let us now take the diagnosis of red, moist, irritating lesions in the flexures such as the groins, perineum and axillæ. These may be due to seborrhœic dermatitis, ringworm, intertrigo, or flexural psoriasis.

In seborrhœic dermatitis the patch is scaly with a definite, or sometimes a rather indefinite edge, and outlying red follicular papules, and the patient nearly always has seborrhœa of the scalp.

In ringworm the edge is sharply marked and the lesions are most active near the edge. Fungus can usually be found in scales, and if the toes are examined it is very likely that white sodden skin containing fungus will be found between the fourth and fifth toe on one or both feet.

Intertrigo, i.e., an infection of the moist epidermis of a flexure with streptococci, or possibly yeast fungi, has a less definite edge and is less scaly than ringworm.

Flexural psoriasis is usually of a uniform red colour with a sharp edge, and there may be recognizable psoriasis elsewhere.

Remember that it is generally worth examining the sodden peri-anal skin of a case of pruritus ani for ringworm fungus, since, if you find it you will be able to cure the pruritus without much difficulty. Here,

again, an inspection of the toes may be of use.

On the feet, plantar warts and corns are often confused, and it may be helpful to remember that most lesions of this sort on the plantar surface are warts, not corns. Warts usually have a somewhat uneven or "warted" surface, and there is usually at the edge of each a sulcus into which a small blunt instrument can be inserted. Corns have a smooth, domed surface with no sulcus at the edge.

On the arms papulo-necrotic tuberculides may be mistaken for boils. The tuberculides are indolent, compared with boils, being more purple, less red, and less tender. They leave characteristic depressed, oval, white scars, especially about the elbows and shoulders. There may be a history, or evidence, of tuberculous glands to assist in the diagnosis.

On the hands, again, papulo-necrotic tuberculides may be taken for broken chilblains, the more so as they are apt to occur in persons with a "chilblain-circulation," and to be worse in the winter. The tuberculides are smaller, more indolent and painless, and leave their characteristic scars, while chilblains are larger, more inflamed and painful, and their scars are irregular in type.

A simple eczema of the nipple is not uncommon, and should not be mistaken for Paget's disease. The principal points are that the eczema may occur at any age, and is often bilateral. It tends to get better and worse. The edge may be ill-defined, the surface is less bright red than in Paget's disease, there is no induration, and the nipple is not altered in shape. Paget's disease usually occurs after 40, and is unilateral. Its progress is slow but constant. The edge is well-defined, the surface is bright red, and there is pronounced induration, which is described as feeling like a penny wrapped in flannel. The nipple is flattened or retracted, and a biopsy or examination of scrapings will show the characteristic "round bodies."

There are two bullous eruptions in infants which it is important to distinguish, viz., bullous impetigo (*pemphigus neonatorum*), and the rare bullous syphilide. Bullous impetigo is never present at birth. It involves chiefly the trunk and may cover large areas. It does not occur on the palms or soles. It is not symmetrical. The baby is well-nourished and shows no evidence of syphilis. The mother or nurse may show the lesions of ordinary impetigo.

The rare bullous syphilide, on the other hand, is present at birth or appears within three to five days; it is symmetrical, chiefly on the wrists and ankles and on the palms and soles. The lesions dry up into reddish brown scabs, the baby is wizened and shows other signs of syphilis, such as papular eruptions about the mouth, enlarged liver and spleen, &c. *Spirochæta pallida* can be found in large numbers in the fluid from the bullæ.

There are two other eruptions in babies whose differential diagnosis provides a pit into which it is easy to fall; these are congenital syphilitic eruptions on the buttocks, and napkin rashes, sometimes called erythemas of Jacquet. Typical cases of each are easy to distinguish, but sometimes cases are not clear cut and are very difficult to decide about. The points to which you should attend are these. The syphilitic eruption is essentially a papular one, the papules are brownish red, and about $\frac{1}{4}$ to 1 in. across. They extend into the flexures and may be most marked there. There are probably other signs of syphilis present, e.g., the baby is wizened, has a hoarse feeble cry, snuffles, and a maculopapular eruption about the mouth and nose, and probably an enlarged liver and spleen.

The napkin rash, on the other hand, is a traumatic dermatitis due to wet and dirty napkins remaining in contact with the skin. It is therefore most marked on the convex surfaces of the folds about the baby's buttocks and thighs which get rubbed by the napkin, while the flexures escape. The

affected areas are red, not brownish, and may become excoriated to form shallow ulcers. There may be a similar patch on each heel where this has been in contact with the outside of the wet napkin. The baby is otherwise healthy and shows no eruption about the mouth.

Two other eruptions on this area may cause trouble in diagnosis, as they both extend into the flexures about the buttocks and thighs, viz., impetigo and seborrhœic dermatitis. Impetigo appears as bright red, shiny, moist, or excoriated areas with phlyctenular margins, chiefly in the flexures, with outlying smaller areas and, possibly, typical impetigo elsewhere. Seborrhœic dermatitis forms sharp-edged red sheets, covered with greasy-looking scales involving the flexures or the whole of the napkin area. It may be present also in the axillæ and on the face and neck. The mother or nurse probably will be found to have seborrhœa of the scalp.

Disorders of pigmentation sometimes cause difficulty. You are probably all familiar with chloasma uterinum, the brownish patches which appear on the forehead and cheeks, especially of brunettes, during pregnancy, and do not always fade away completely afterwards. Pigment also appears in the areola of the nipples and the middle line of the abdomen.

In Addison's disease, pigment, varying from light yellow to deep brown, and generally diffuse, appears, chiefly on the exposed parts, such as the face and hands, and on areas normally pigmented, such as the nipples and genitalia. Also where the skin is habitually compressed or irritated, e.g., round the waist, and on the mucous membranes of the mouth, conjunctiva, and vagina. There may be spots of deeper pigmentation on the diffusely pigmented areas. The low blood-pressure and asthenia will generally give the clue to the diagnosis.

Arsenical pigmentation is found in those who have ingested arsenic over long periods, either medicinally or by accident. It occurs

chiefly on the trunk and is diffuse, but deepest on areas normally pigmented. A characteristic feature is that the brown area is dappled over with lighter spots, as though it had been rained upon, the so-called "rain-drop pigmentation." Arsenical pigmentation is usually accompanied by keratoses on the palms and soles and possibly by other signs of arsenical poisoning.

There are two types of depigmentation which should not cause difficulty in diagnosis, viz., vitiligo and syphilitic leucoderma. Vitiligo occurs anywhere, often on the hands, face and neck. The areas are irregular, often large, the margins of the patches are sharp, and there is often hyperpigmentation around the patches. When the areas involved are large, sometimes it is difficult to decide which is the normal skin, the white or the dark. The convex edges of the white patches enable one to recognize that it is the white which is abnormal, while the dark is normal.

Syphilitic leucoderma is almost confined to the sides of the neck; the areas are small, oval, and of uniform size. They fade gradually into the darker areas, giving a very characteristic dappled effect.

Dermatitis artefacta is generally easy but sometimes difficult to diagnose. It always occurs on places which can be reached by the patient. The appearances are usually odd and not like any known skin disease. They may be produced in various ways, e.g., by applying lysol or carbolic acid to the skin, or merely by rubbing with a wet finger. The patients are usually women and often show evidence of hystēria, e.g., anæsthesia of the bulbar conjunctiva and soft palate, and suggestion anæsthesia to pin pricks. They often seem really to be unaware that they produce the lesions themselves, and it is generally impossible to persuade the sympathetic relatives, and sometimes even the family doctor, that the lesions are artificial!

I will close with a word about drug eruptions. Remember that acneiform lesions with comedones can be produced by chlorine

or tar, usually on the penis, scrotum, and arms, while bromides and iodides can produce pustular lesions resembling acne, but without comedones, on the face and back. Iodides may produce also fleshy masses resembling gummata or sarcomata on the face, forearms, and hands, and if these are mistaken for gummata the iodide may be pushed and the condition aggravated. Bromides may produce papillomatous masses covered with numerous points exuding pus, especially on the legs. These may persist for some time after the ingestion of the drug has been stopped, and so lead to difficulty in diagnosis.

PYELO-NEPHRITIS IN CHILDREN.

By HAZEL H. CHODAK GREGORY,

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THE term "pyelitis" has been used so widely and for so long that few pause to ask themselves whether there are, or ever have been, any anatomical grounds for that name. It has been assumed, and is generally taught, that an infection may arise in the urinary passages, either starting below as a result of urethral invasion, or above as a result of blood infection, and concentrate itself on the pelvis of the kidney which thus becomes the main focus of inflammation and pus formation. Variations of the term, such as pyelo-nephritis, pyelo-cystitis, indicate an extension of the inflammatory process upwards or downwards, but the assumption is that the pelvis is the actual site of disease. It is interesting to read in medical textbooks circumstantial descriptions of the appearance of the renal pelvis at various stages of so-called pyelitis, although it is probably true that, in children at least, no one has ever seen a simple pyelitis in the post-mortem room, and any pyelitis observed in the operating theatre will have been a