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I. HENRY ERNEST MICHELSON

Reference is made in the general Medical-Faculty Minutes of October 10, 1899 to Max Vander Horck, Professor of Diseases of the Skin and Genito-urinary organs and Departmental Head. He served with distinction in this capacity until his death December 5, 1911. He was a man held in high esteem by his associates, both in the United States and abroad. He apparently did not publish a great deal but was an excellent teacher and organizer. His memory will be commemorated at a special dinner in April by the dermatologists at which time an address will be made by Dr. Otto Foerster of Milwaukee. Among others, John Butler, his former pupil, will review his life.

July 1st, 1926. Associate Professor Henry E. Michelson was made Director of the Division of Dermatology and Syphilology. Prior to this time, the departmental affairs had been administered by committees. July 1, 1928, Dr. Michelson was made full professor and Director of the division, a position which he now occupies.

Dr. Michelson has been most active in promoting the affairs of his department. Since he took it over, splendid progress has been made especially in opportunities for the training of young men in his special field. A review of their accomplishments today is most interesting. His efforts at improving the organization of his unit and giving the students better teaching is exemplified by the amazing interest in Dermatology by Minnesota graduates. Our graduates inform us that dermatological conditions are very common in gen ral practice and that they have been able to put into practice his teaching with most satisfactory results. Few men on our staff display such well balanced enthusiasm in all their activities and certainly none are better liked and respected by their associates. It is with pleasure that we turn over this meeting to Dr. Michelson and his associates.

Dr. Michelson was born in Bismarck, North Dakota. Following graduation from his local high school, he entered the University of Minnesota where he received a B.S. degree in 1910, M.D. 1912. He served an internship in the City and County Hospital, St. Paul, 1912-13, which was followed by practice in Virginia, Minnesota 1913-15. At this time, he became a member of the Division of Dermatology.

He is a member of the Hennepin County Medical Society, Minnesota State Medical Association, American Medical Association, Minnesota Dermatological Society, American Dermatological Association, Chicago Dermatological Association, Vienna Dermatological Society and the following fraternities: Beta Theta Pi, Nu Sigma Nu, and Alpha Omega Alpha. He is a corresponding member of the French Dermatological Society and a contributor of the Archives of Dermatology. In 1921, he studied abroad (London, Paris, Vienna). In addition to many local honors, he was recently recognized by election to the membership of the Chicago Dermatological Society [illegible].

II. DERMATOLOGY

The specialty of dermatology presents to the medical student an important branch of special pathology. It is a broad department, which although to a certain extent complete in itself, is intimately associated with all of the other departments of medicine.

In dermatology, we have the privilege of observing and studying the disease process on exposed parts of the body where the morphological evolution, the minute changes and the ease of biopsy allow a unique opportunity to gather many of the pertinent facts about a condition. We also may see the direct effect of our treatment and accordingly our therapeutic measures have become more exact and more effective than in some of the other fields.

Syphilis has been traditionally bound to dermatology because the early signs are in the skin as are many of the later recurrences, which [illegible] to dermatologists to [illegible] the potency of the drugs could so easily observed. [illegible]

studies and experiences of dermatologists have resulted in a very effective therapeutic regime against syphilis. The relative value of the different arsenicals, the proficiency of bismuth over mercury, the evolution of treatment by courses, the length of time of rest periods, the early recognition of refractive cases and hence the criteria for early malarial cures are only a few of the more or less stabilized facts which dermatologists have contributed in the field of syphilology.

Medicine passes through periods, even epochs of enthusiasm for certain procedures. Under certain leaderships, the chief activities of a specialty may be directed toward a chosen influence. In retrospect, we may see over-emphasis or lack of cognizance, but we must maintain a spirit of mutual respect and openmindedness towards our associates. We must borrow here and beg there if dermatology is to attach to itself facts which will allow us to understand and evaluate the causes for what we may have looked upon as closed subjects.

We must point out some of our contacts to illustrate this further. Surgery and dermatology have a very common ground in the field of cutaneous cancer. With general medicine, we study metabolic disorders. The effect of diet can be observed best in pediatric patients. Pharmacology and dermatology should be more closely related through drug eruptions. We almost feel as one with the department of pathology and through the fungus diseases our association with bacteriology is very close. Syphilis binds us closely to neurology and obstetrics. In fact, there is not a branch of medicine where a common bond can be so readily established as with dermatology.

Is there a trend in dermatology? If there is, I judge it is in the direction of allergy. The mechanism of sensitizations and the specific reactions to irritations has entirely changed the concepts of eczema and should studies in desensitization keep pace with the advances in our knowledge of sensitization then the therapy of some of these troublesome conditions would be greatly improved. Endocrinology also should be a great aid to us, for the physical state of the skin, brought about by internal secretions must play an important role in its susceptibility. This is best illustrated in the studies we are doing in acne.

The activities in dermatology are divided between abstract investigations and concrete studies. A review of some of the past publications and papers to appear in the near future may be of interest.

SUPERFICIAL LYMPH GLANDS

A number of years ago, I became interested in a histological study of the superficial lymph nodes in early syphilis. This work has been carried on not only in syphilis but in other diseases. Dr. Carl Laymon is now summarizing our findings and the outstanding fact established is the finding that a specific organism does not evoke an identical reaction in lymph nodes. For example, the spirochete does not bring forth a standardized pathological reaction. The skin seems to be much more consistent in its response. This has made us realize systems react against infection and that the state of allergy seems to become stabilized in the skin with much greater certainty than in the lymph nodes. The finding of tuberculoid structures prompted us to investigate the nodes in tuberculous subjects. Our intimate association with Glen Lake Sanatorium has made this possible and a publication soon to appear will give the results of this work. Suffice to say, the microscopic examination of a superficial lymph node is not pathognomonic for syphilis or tuberculosis.

H.E.M.

III. ABSTRACTS:

SOME RECENT PUBLICATIONS

1. SYSTEMATIZED AMYLOIDOSIS

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Read at the American Dermatological Association Meeting, Chicago, 1935.
Accepted by Arch. Dermat.

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Many of you may remember a patient who was admitted on the medical and dermatological services a number of times in 1931 and 1932. Our interest was aroused by a macroglassia which differed from any we had previously seen. The patient was also suffering from generalized aches and pains which had been diagnosed as chronic arthritis. He also had a chronic albuminuria. As the condition progressed, it was shown that the patient had a Bence-Jones proteinuria, although no definite evidence of myeloma was ever demonstrated. The deposit in the tongue and on scattered cutaneous areas are identified as amyloid. Since none of the usual causes of amyloidosis could be found, the entire subject of amyloidosis cutis was reviewed in an attempt to classify the case.

In the skin, as in many other organs, local deposits of amyloid are occasionally seen, possibly resulting from chronic inflammatory changes. The first report of this localized type of cutaneous amyloidosis in the American literature was by Dr. Winer in 1930.

In cases of generalized amyloidosis resulting from tuberculosis or chronic pus infections, skin changes are also reported, though rarely.

In addition to the localized and generalized forms of amyloidosis, there have been a small number of cases discussed in the European literature in the last decade as "systematized amyloidosis." In most of these cases there has been extensive involvement of the tongue, mucous membranes, skin, and both smooth and striped muscle. In none was any underlying inflammatory process demonstrated.

Only once has a dermatosis been described as associated with Bence-Jones proteinuria, and years later the patient was shown to have had amyloidosis of this systematized type. We recorded our case in the hope that future study may be directed along the line of investigation of these cases of systematized amyloidosis to determine a possible relationship to myelomas with Bence-Jones proteinuria.

Amyloidosis of the skin presents a rather typical eruption consisting of grouped, shiny, translucent papules usually associated with a dull brown color change in the surrounding skin. The amyloid deposits can be seen in sections of the skin and may be identified by staining reactions, although often only with considerable difficulty.

2. THE TUBERCULODERMAS OF THE FACE

H. E. Michelson

Accepted by J.A.M.A.

The lesions of cutaneous tuberculosis are often seen on the face. Dr. Louis Winer and I made a careful review of the various types and were able to make up a table. We especially emphasized the primary tuberculosis complex comparing it with Ghon and Ranke's work in the lung. The paper was presented before the A.M.A. in Milwaukee and the discussion was lead by Dr. Marion Sulzberger of New York, a former pupil of Bloch's and Jadassohn's. He stressed the fact that hyperallergy often preceded anergy and that in cutaneous tuberculosis, the tuberculin reaction was of great value in determining the resistance of the host.

3. LEUKEMIA CUTIS

Francis W. Lynch and
H. E. Michelson

The cutaneous manifestations of leukemia have been recognized for fifty years and have been well classified; they have been observed in all forms of leukemia. These changes can be divided into two large groups: (1) true leukemia cutis, in which the lesions are composed of a leukemic infiltrate; and (2) the leukemides, in which the microscopic picture is not diagnostic, but the eruptions have been seen in sufficient number that the relationship must be more than accidental.

In the specific changes we see papular, nodular, or tumorlike lesions usually on the face, often producing the typical leonine facies. More diffuse involvement, even generalized exfoliation

is also seen. We have several cases in this group to report, including one occurring in the aleukemic stage.

Among the specific changes we also observed a massive involvement of the genitalia in a patient having monocytic leukemia.

Among the non-specific changes observed in leukemia are two groups in which we have been particularly interested. About twenty-five cases of herpes zoster have been recorded as occurring in leukemia. About one-half of these were of the generalized form. Such a case was observed here last year. In spite of the hemorrhagic and necotic nature of the eruption the microscopic picture would have given no lead toward a diagnosis of leukemia. We have also had two cases of zoster of the usual segmental type to add to those previously reported in Hodgkin's disease.

The second group of leukemides which we have followed with interest for a number of years consists of purpuric changes observed in the skin. A few observers have described specific infiltration of the vessel wall as the cause of these tiny hemorrhages; others believe they result from a toxic injury of the vessel wall. We have a small series of cases which will be studied in detail in an attempt to determine the mechanism.

4. DERMATOLOGIC CONDITIONS OF THE FETUS

Francis W. Lynch, M. D.

From the Archives of Dermatology and Syphilology, December, 1932

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Because of the observation several years ago of a spontaneous abortion leading to the birth of an infant covered with bullae, interest was aroused in fetal dermatological conditions in an attempt to classify the findings. During the sixth month of pregnancy, about four weeks after vaccination of the mother, a still-born fetus was delivered, presenting an eruption consisting of umbilicated pustules and flaccid bullae. This occurred during an epidemic of smallpox. Similar cases have been described in the past as intra-uterine variola.

In an attempt to establish a definite differential diagnosis, the entire field of congenital cutaneous conditions was reviewed and a classification presented. The clinical appearance, history, and the microscopic picture established the case as belonging to the group of infectious diseases, with the pathology placing the condition in the variola-vaccinia group.

A study of the infectious diseases in pregnancy demonstrated that the fetus may be influenced in several ways: (1) as a result of disturbances in the maternal metabolism; (2) following pathologic changes in the uterus or placenta; and (3) infection of the fetus may take place. Chicken-pox, measles, and scarlet fever have occasionally been observed in the fetus, and it was possible to find 47 cases in which the eruption of smallpox was observed at birth. The mortality in this series was 81%. Five infants were born of mothers who had been exposed but did not suffer from variola during pregnancy because of immunity gained by previous vaccination. It was interesting to note in twin pregnancies that the involvement of the two infants was not necessarily related.

Because of the recent vaccination of the mother in the case reported here, the effects of vaccination in pregnancy were reviewed, and it was found that such vaccination seldom transmits immunity to the fetus and rarely disturbs the pregnancy.

A number of cases of post-vaccinal eruptions of a vesicular and bullous nature have been recorded in the literature. The eruption in some of these was practically identical with that observed in this fetus, and it was felt that the eruption in our case may have resulted directly from vaccination of the mother although similar cases have previously been recorded as transmission of variola to the fetus. The existence of intra-uterine vaccinia has been denied by

Ballantyne who was one of the closest students of fetal pathology. Eight cases were found in which two possible etiologic factors were present: the exposure of the woman to variola, and successful vaccination. In these, as in our case, it may be that the eruption was pemphigoid vaccinia in the fetus resulting from vaccination of the pregnant woman.

5. STUDIES ON ELASTIC TISSUE IN FETAL SKIN

Francis W. Lynch, M. D.

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Published in Archives of Dermatology and Syphilology Jan. '34.

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Studies were carried out on the development of the elastic tissue in the fetus as observed in stained sections of fetal skin. It was found that previous observers had not agreed as to the time of the appearance of these fibers, and although local variations in the amount of elastic tissue in different areas in the adult are recognized, no attempt had been made to determine the extent of such variations in fetal skin.

The embryology of the skin was reviewed briefly with specific reference to only the most recent literature.

The development of connective tissues was reviewed with particular reference to their origin. From a study of the literature one is unable to draw definite conclusions as to inter- and intra-cellular development of connective tissue fibers.

In reviewing the function and characteristics of elastin fibers one is impressed with the recent tendency to regard the "elastic" fibers as a rigid network and the collagenous fibers as the elastic structure of the corium.

Sections of skin were removed from four areas on each of thirty-five fetuses from 3.3 to 60 centimeters in length, 18 of the fetuses being from 2.5 to 7 lunar months in age. Special stains were used for observation of epidermal and connective tissues, as well as specific stains for elastic tissue. It was found that as early as the third month there is a substance present in connective tissue cells and their processes, in vessel walls, and at the boundary between cutis and epidermis which accepts the resorcin fuchsin stain in a specific manner. This substance was not regarded as true elastin. In the fifth month there is definite evidence of elastin fibers in the blood vessels of the cutis, and in the corium proper early in the sixth month. In the eighth, ninth, and tenth months there was noted a difference between the relatively smaller number of elastin fibers in the plantar areas as compared with the greater number in abdominal, forehead, and cheek specimens. There is a period in the sixth and seventh months when there are apparently fewer elastin fibers than in earlier specimens.

This apparent diminution in the elastic fibers had not been previously described. The significance is not clear.

6. GENERALIZED ANGIOMATOSIS

John Madden

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Accepted by J.A.M.A.

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Generalized telangiectasia may be an important sign of constitutional disease, or the small lesions may only be blemishes of cosmetic importance. The cases of hereditary haemorrhagic telangiectasia are by far the more important because of a higher percentage of fatal terminations.

In classifying multiple telangiectasia, the following subdivisions are quite distinct, although there are numerous border line cases which might fall in no one group:

I. Primary Telangiectasia. This class can include hereditary hemorrhagic

telangiectasia, certain cases of familial hematuria, and epistaxis, not due to blood disease, in which no obvious telangiectases have been seen; also familial cases of telangiectasia without hemorrhage, and certain possible examples of atavism without family history.

II. Secondary Telangiectasia. This group includes generalized telangiectasia dependent upon constitutional diseases such as liver disease and leukemia, and angiomatosis occurring in pregnancy.

III. Nevoid Telangiectasia. This type may be present at birth, appear early in life or even in old age. Generalized, punctiform, capillary ectasias which occur in people beyond middle life, and spider telangiectases which appear at any age may be included in this subdivision.

Weber sums up the difficulties in classification in the following manner:

First, in some cases lesions that have developed ("been acquired") in adult life are associated with more or less similar lesions that were present at birth and are therefore vascular nevi.

Second, lesions that morphologically belong to different classes of telangiectasia and hemangiomata may occur simultaneously in the same individual.

Third, it is probable that lesions caused or excited by the same factors (traumatic, toxic, etc.) may differ structurally or in form (morphologically) in different individuals according to the inherited constitutional predisposition, and that different causal factors may sometimes give rise to the same structural and morphological type of lesion.

The exact cause of generalized angiomatosis is speculative and not based on fact. Many authors expressed widely divergent opinions. Although it is often difficult to separate the constitutional factors from the exciting factors, both must exist in every case of generalized angiomatosis. The underlying constitutional factor of heredity is present in most cases of primary angiomatosis in addition to various exciting factors such as trauma, irritation, and congestion. The patients with other types of angiomatosis also must have some hidden constitutional predisposition as well as the more apparent exciting cause.

These theories are not only borne out in generalized angiomatosis, but apparently hold true in localized telangiectasia as well.

Heredity is noted in most cases of the primary type of angiomatosis, but does not occur in the other groups.

Telangiectasia, of course, is present in all types of angiomatosis. The number of telangiectatic vessels in the skin is no indication of the extent of the lesions in other organs of the body. In hereditary hemorrhagic telangiectasia the lesions are usually present at birth, but they become more numerous and more noticeable as the patient grows older. The lesions are always multiple and usually more numerous in the skin of the face and the mucous membranes of the mouth and nose. The secondary type of telangiectases associated with constitutional disease have no sites of predilection. They usually become more numerous as the accompanying constitutional disease progresses. The telangiectases generally disappear when the associated disease is cured.

Hemorrhage is one of the most important symptoms in the primary type. There seems to be very little evidence favoring the view that there is an underlying hemorrhagic diathesis or blood dyscrasia causing the hemorrhages. The bleeding may be apparently spontaneous or caused by trauma, irritation, mechanical or vasomotor congestion. Hemorrhages can take place in any organ of the body, but most commonly occur as recurrent epistaxis. The usual history is that of repeated small hemorrhages but occasionally single hemorrhages result in death. Certain cases of "essential hematuria" seem to be examples of primary angiomatosis. Hemorrhage is rare in the secondary or nevoid groups of angiomatosis. When it occurs, it is almost always caused by direct trauma to the telangiectatic vessel.

Blood findings are normal in the primary types of generalized angiomatosis except when there is a secondary anemia from repeated hemorrhages. The blood changes in the secondary group are those found in the associated disease, such as leukemia. When the disease accompanying the telangiectasia has no blood changes the blood findings are normal. The blood in the nevoid type is normal.

Splenomegaly is rare in primary angiomatosis, it occurs in secondary angiomatosis only as a sign of the accompanying constitutional disease, and has not been noted in the nevoid type. In these cases splenomegaly follows repeated hemorrhages and probably is the result of long standing stimulation and demands on a blood forming organ.

The most important step in making a diagnosis is to properly classify a case in which angiomatosis is the presenting sign. After a case has been properly grouped, the diagnosis is comparatively easy.

Complications are very rare in the secondary and nevoid types of generalized angiomatosis, but they are common in the primary type. Nearly all of the complications are caused by hemorrhage. The prognosis in secondary and nevoid angiomatosis is good. The prognosis in primary angiomatosis must be guarded, because a fatal hemorrhage or hemorrhages leading to a fatal complication may occur at any time.

The treatment of the primary type of generalized telangiectasis deals with the prevention of hemorrhage and stopping immediate hemorrhage. The nevoid and secondary types rarely bleed. The use of calcium, horse serum, and the like presuppose an abnormality in the blood which does not exist. Hence they are of no value.

Generalized angiomatosis is an important clinical sign, and patients with this condition should not be dismissed without a careful investigation.

Cases from all three groups are reported.

7. XERODERMA PIGMENTOSUM
A Study in Light Sensitivity

F. W. Lynch, M.D.

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Accepted for Publication by the Archives of Dermatology and Syphilology

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Some of you will perhaps remember a case which we presented to this group a little over a year ago. She was a little girl from Dr. McQuarrie's service in the hospital, suffering from a sensitivity to sunlight which is known as xeroderma pigmentosum. She had at that time several carcinomatous lesions on the face which Dr. Peyton treated. This case stimulated an interest in cutaneous conditions brought about by sensitivity to sunlight, and we became particularly interested in studies which have attempted to demonstrate the particular radiations involved in each disease.

There are a great number of diseases related to light sensitivity; some are regarded as true sensitizations while others have a less direct relationship. Xeroderma pigmentosum, hydroa vaccinale or aestivale, prurigo aestivale, eczema solare, and urticaria solaris are usually regarded as true sensitizations. Some authors group the pruriginous and eczematous eruptions and believe there is no sharp division between them. Certain drugs are also capable of evoking a sensitization to light.

It has been quite definitely demonstrated that the rays which produce erythema on normal skin are those between 250 - 315 mm. In a few cases longer rays have also been shown to produce this reaction. In this latitude, altitude, and climate it is known that rays shorter than 290 rarely reach the earth's surface, all of the shorter ones being filtered out by the atmosphere.

Urticarial reactions can apparently be evoked by either ultraviolet or visible radiation. Prurigo aestivale patients have been shown to be sensitive

to visible radiation in most instances. Most workers have demonstrated sensitivity in hydroa aestivale and vaccinale to ultraviolet radiations. This is in contrast with studies on experimental hematoporphyrin sensitization in which the sensitivity may be in the field of visible light.

In the literature there were found seven cases of xeroderma pigmentosum in which studies on sensitivity had been recorded. In this condition there is sensitivity only to radiations shorter than visible light. In most cases this sensitivity includes roentgen and similar radiation. Martenstein and Bobowitsch have formulated a theory that the sensitivity to ultraviolet radiation in early cases later moves down the spectral scale to the shorter radiations. In spite of the somewhat similar observations on sensitivity in hydroa vaccinale and xeroderma pigmentosum, there are essential differences in the clinical picture and the presence of hematoporphyrin products in the former. The genetic factors (male predominence in hydroa as contrasted with equal sex tendency in xeroderma) also may be assumed to indicate a basic difference between these conditions.

Studies were carried out on our patient using glass filters which transmitted groups of radiations in various wavelengths, and the following observations were made:

Even on previously unexposed parts the xeroderma pigmentosum patient, who on first exposure to sunlight in infancy responded with a marked erythema (but not vesiculation), responds with erythema and pigmentation to doses which would evoke vesiculation on normal skin.

Microscopic examination of the skin twenty-four hours after radiation sufficient to produce erythema showed a deviation from the normal reaction. Changes in the cells of the stratum spinosum usually observed in normal individuals were almost entirely lacking in the child having xeroderma pigmentosum; whereas a heavy layer of parakeratosis was observed which was not seen in the normal child.

As a result of these studies this child was demonstrated to be most sensitive to radiations between 280 - 310 millimicrons.. No observations were made as to the result from radiation outside the ultraviolet field.

Since few radiations shorter than 297 millimicrons reach the earth's surface it is the sensitivity to radiations of 297 - 310 millimicrons which is of prognostic importance to the patient and these constitute the radiations from which the patient must be protected.

It is apparent that similar studies must be carried out on a greater number of patients and in a more detailed and exact manner before one will be able entirely to clarify even the visible manifestations of this disease. Studies along this line must parallel biochemical and genetic studies if we are finally to understand the interesting group of diseases caused by sensitivity to radiation.

8. CULTURE OF THE TUBERCLE BACILLUS BY THE LOWENSTEIN METHOD

Carl W. Laymon

- - -

Published in the Arch. of Dermat. & Syph. July 1933.

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Attempts to culture tubercle bacilli from the blood were made as early as 1884. Lowenstein began his work in 1905 and since 1924 has attracted considerable attention both in Europe and America. Since 1930, especially, interest in tuberculous bacillemia has been renewed due to the fact that many investigators have been unable to duplicate Lowenstein's results.

In general, Lowenstein and his coworkers have obtained positive cultures from the blood in about 50% of tuberculous patients, including pulmonary, bone and joint, cutaneous, genito-urinary, intestinal, and eye tuberculosis. Besides the tuberculous cases, positive cultures have been claimed in acute and chronic polyarthritis, chorea, multiple sclerosis, schizophrenia, and retro-bulbar neuritis.

Most of the investigators not working with Lowenstein have obtained completely negative results both in the tuberculous and non-tuberculous cases.

Briefly, Lowenstein's method consists in centrifugating citrated blood, destroying the erythrocytes with acetic acid, washing with distilled water, and innoculating the sediment on an asparagin-egg medium. Positive cultures are supposed to appear in from 3 to 8 weeks. From Sept. 1931 to May 1932, after testing Lowenstein's medium and finding it satisfactory, we made 140 blood cultures from cases of pulmonary, bone and joint and cutaneous tuberculosis, as well as lupus erythematosus, rheumatic fever and erythema nodosum. Not a single positive culture was obtained.

In an attempt to explain the discrepancy between the results of Lowenstein and those of other workers, G. S. Wilson, English bacteriologist, has stated that many who have obtained a high percentage of positive results, have disregarded certain fallacies in technique. Acid-fast bacilli may occur in commercial distilled water, tap water, dust, human feces, and blood, and cannot be distinguished morphologically from tubercle bacilli. Another source of error may be artefacts, such as fibrin threads, oxalate, cholesterin and lecethin crystals, disintegrated leucocytic granules, etc. In the interpretation of animal innoculations many workers have apparently disregarded spontaneous tuberculosis, and other bacterial infections simulating tuberculosis. Wilson states that no acid-fast organism should be regarded as the tubercle bacillus until it has been conclusively proven to be such by cultural, morphologic and pathogenic tests.

More work will have to be done to entirely clear up this question.

9. PUSTULAR PSORIASIS

Carl W. Laymon

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Accepted for publication by the Urologic and Cutaneous Review

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The observation of a peculiar eruption, consisting of plaques with superimposed pustules, occurring in a male aged 67, stimulated interest in the subject of pustular psoriasis and related conditions.

It is well known that psoriasis is extremely varied in its manifestations, but the pustular type is a rarity, and worthy of study. The first case was reported by von Zumbusch, in 1910. Barber, in England, has seen several cases and has given the subject much consideration.

There are 3 types of pustular psoriasis:

1. Cases with pustules on the palms and soles, with or without other more typical lesions of psoriasis.

2. Ordinary widespread psoriasis, which becomes pustular.

3. Pustular psoriasis which proceeds to a generalized exfoliative dermatitis.

The disease is most often confused with a pyogenic infection ACRODERMATITE CONTINUE, which appears on the extremities following trauma, and is thought to be due to a staphylococcus. The organisms can be recovered from the lesions, while in pustular psoriasis the contents of the pustules are usually sterile.

The histological findings are those of an ordinary psoriasis plus a heavier infiltrate in the cutis and cavities in the epidermis which are thought to be enlargements of the micro-abscesses found in chronic psoriasis.

10. PSEUDOXANTHOMA ELASTICUM

S. E. Sweitzer
and
Carl W. Laymon

- - -

Published in the Brit. Jour. of Dermat. Dec. '33.

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Pseudoxanthoma elasticum is a rare disease characterized by multiple ivory-like papules occurring usually over the body folds such as the axillae, groin, and neck. The disease was first regarded as a distinct entity by Darier in 1896, and was, up to that time, thought to be a special type of xanthoma. The histology shows a degeneration of the elastic tissue in the middle layers of the cutis.

Our case was in a boy 14 years of age, and was a typical example of the disease both clinically and histologically.

Pseudoxanthoma elasticum is also of interest to the ophthalmologist due to its association with angioid streaks of the retina, which also may be due to elastic tissue degeneration.

It is felt that this syndrome may be characteristic of generalized defective elastic tissue.

IV. ABSTRACTS

STUDIES TO BE REPORTED LATER

1. NECROBIOSIS LIPOIDICA DIABETICORUM

Drs. Michelson and Laymon

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This is a lipoid disturbance of the skin occurring in severe diabetes, and seen only rarely. The observation of such a case has made it possible to study the disease, and the report, which will appear later will include a consideration of the other cutaneous lipoidoses. This paper is to be presented in New York before the American Dermatological Association. This will be the first American report and study of this condition.

2. PROJECTS

John Madden

- - -

A. A two-year's study of dermatitis herpetiformis and herpes gestationes with particular reference to the relation of the diseases to the halogens.

B. An effort to determine the diagnostic value of eosinophilia and why it appears in certain skin diseases.

C. A study to determine whether measles protects against poisons and the effect of whole blood and serum from patients who have and have had measles or psoriasis.

3. ACNE VULGARIS

F. W. Lynch

- - -

In cooperation with Dr. Diehl and his staff, we have started a study of acne vulgaris to be carried out this year. For the present the study will be chiefly statistical in nature. An attempt will be made to establish a definite correlation between those factors which are usually treated as responsible for the production of acne: diet, constipation, menstrual disturbances, and the use of cosmetics. In a rather incomplete review of the literature, no definite studies along these lines have been found.

An attempt will also be made to determine the relationship of acne to hair color and texture, seborrhea, and also to eye color. Studies similar to this were carried out several years ago at Bloch's clinic at Zurich on about 4,000 school children.

Since the treatment of acne, though fairly satisfactory, is not on an entirely rational basis, attempts may be made later to carry out some work along that line.

4. SOME OBSERVATIONS ON ACRODERMATITIS CHRONICA ATROPHICANS

Drs. S. E. Sweitzer
and
Carl W. Laymon

- - -

To be presented before American Dermatological Meeting in New York, June '34.

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The literature on this comparatively rare condition has recently been thoroughly reviewed by Oppenheim in Jadassohn's Handbook. During the past two years, four interesting cases were observed which presented some unusual symptoms which form the basis for this report.

5. THE SUPERFICIAL LYMPH NODES IN SYPHILIS, VISCERAL TUBERCULOSIS, AND BANAL INFECTIONS

A Comparative Histologic Study

Carl W. Laymon

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Ph.D. Thesis Subject

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Four years ago, a histologic study of the superficial lymph nodes in early syphilis was made by Dr. H. E. Michelson. It was found that two distinct types of reaction occurred, the non-specific or banal, and the tuberculoid, characterized by epithelioid and giant cells. This study is being continued and extended to include a comparison of the superficial nodes in visceral tuberculosis and non-specific infections to determine the frequency of the tuberculoid reaction in diseases other than syphilis in order to determine the significance of its presence in superficial lymph nodes.

V. UNDERGRADUATE TEACHING

The presentation of dermatology and syphilis offers to the teacher the privilege of case demonstrations. We have shown this fall to the junior class 83 cases of skin diseases and 22 cases of florid syphilis. It is our desire to teach the student how to diagnose and treat the more ordinary skin diseases and be able to realize when a case is rare enough to require special study and diagnosis. As obvious as skin diseases are, the art of inspection is not developed to a high degree in general diagnosis. We know that the eye is the most valuable one sense in dermatology and next we must be able to interpret what we see. This accounts for the difficulties that the general practitioner has with skin diseases. He is able to see the condition, but he is unable to describe it in words which he may in turn translate into a diagnosis. Hence, we believe in showing all of the cases we possibly can and we are able to do so because of the marvelous cooperation that we receive from Dr. Sweitzer, chief of the General Hospital service and a professor on our staff. To him and to Dr. Madden who has a service at the Ancker Hospital we are most gratefully indebted as should every student here be. Without them, our material would be greatly curtailed and our teaching would have to be with lantern slides.

It has been my custom to enlist the services of our entire staff for the lectures. I do this to avoid a stale repetition which is apt to creep into a repeated lecture.

The division conducts its own seminars, has its own pathological conferences and maintains a very active interest in our dermatological society--The Minnesota Dermatological Society. The minutes of this organization are published in the Archives for Dermatology and invite comparison with any similar organization anywhere.

A word about the help given us by Dr. J. C. McKinley is not amiss. In our library, through his interest, we have acquired a splendid dermatological section. Almost all of the active international journals are on file and the special books are constantly being added to.

And so, in this very brief resume' of activities, we want to emphasize our intense interest in our specialty and sincerely believe that this interest sets up the momentum which makes for a progress

which is not selfishly limited to a narrow field.

VI. TWO MEETINGS WE HAVE HAD

1. MEETING

Date: January 18, 1934

Place: Recreation Room, Nurses' Hall

Time: 12:15 - 1:10

Attendance: 118

Program: Chronic Gastritis

Discussion: R. W. Koucky
L. G. Rigler
I. McQuarrie
C. J. Watson
R. Morse
R. Johnson
E. J. Carey

Theme: R.W.K.: Slide of stomach taken from middle of ulcerated area. Shows abnormal gastric glands. It appears that there is loss of parietal cells and increase in the fibrous stroma. Note infiltration throughout with lymphocytes, but no true follicles. Condition very similar to that seen in jejunum. Interpretation of findings uncertain as we did not take the bone marrow. No suggestive evidence of leukemia except in liver (?). Final interpretation probably represents some form of inflammatory reaction in upper gastro-intestinal tract, a type of lesion seen in association with dietary deficiency.

L.G.R.: Patient examined several times with diagnostic disagreement. One opinion was probable carcinoma rather well confined to pyloric end of stomach. Note stenotic area in prepyloric region, rather irregular; balance of stomach normal. Good deal of obstruction. Scirrhous carcinoma infiltrating stomach wall might cause this stenosis. Other members of our staff felt that condition could be ulcer with diffuse fibrosis. Condition remained rather constant through several examinations. Chest examinations show terminal pneumonia.

C.J.W.: It seems to me that leukemia has not been ruled out. This disease does not necessarily have to be generalized as some do not have any lesions in extra-medullary tissue. Case history was then related which brought out this point. Another point favoring leukemia is diffuse polyposis of the jejunum, also a manifestation of leukemia. Liver changes in this patient were certainly suggestive of the foci seen in leukemia.

I.McQ.: Our present day interpretation of gastric findings is much different than a few years ago. Today, we use total chloride determinations as an index of the ability of the glands to secrete acid as duodenal regurgitation may change the original picture. Many other questions have not been answered about gastric secretion, ex., discrepancies between chemical findings of the blood and stomach. Why the cells do not do their work properly is difficult to explain. This is a most interesting subject which requires more thought and investigation before we get the final answer.

R.M.: It is my impression that few individuals are free of gastritis. It must be a very common condition. There is a great deal of confusion in terminology. The hypertrophic type from an x-ray standpoint is frequently referred to as hyperplasia and still this has not yet been demonstrated to be the result of an inflammatory change. The relationship between certain changes in the mucous membrane such as polyposis is perfectly evident. We have also seen a type of gastric lesion which we have interpreted as atrophic. Some of these observations have been made entirely from the x-ray standpoint.

The controversy over what constitutes the normal mucosa goes on. These slides illustrate the structure and appearance of normal mucosa from a recent German publication.

X-ray illustrations of hypertrophic gastritis are now shown. Some of this tissue was obtained for microscopic study and illustrates very well the actual condition. There is congestion and [illegible]

places marked edema. A small amount of exudate is present; in some, actual cystic gland formation is present. Slides are next shown illustrating the various points. Next slides show types of chronic exudative gastritis in which changes in cell types have occurred. This is associated with erosion in the mucous membrane which could be a cause of blood in the stool. Other slides are next shown illustrating variations in this condition. Pathologists admit atrophic gastritis. We believe other forms are also present. This whole subject is of intense interest to me and I have enjoyed very much coming over to discuss it with you.

L.G.R.: We have been making the diagnosis of hypertrophic gastritis for some time. Many clinicians now recognize this diagnosis but the majority of pathologists are still unconvinced. I want to show you slides of x-rays merely to illustrate type of appearance upon which this diagnosis is based. This is a film of the stomach in which a small amount of barium is given. Mucosa is fairly well outlined showing longitudinal folds going up and down. Here is a gastric ulcer on lesser curvature associated with tremendous enlargement of folds of mucosa. Defect here gives rather typical signs. At another angle, individual folds can be made out. Also get large and small polypoid lesions or simply hypertrophic enlargement of folds. Note the slide of another case. This is a constant change and does not vary from time to time. It is different from carcinomatous infiltration as it does not show involvement in the deeper layer. In this case, the exaggerated form seen in leukemia is illustrated. This is a specimen which the pathologists have recognized as chronic gastritis. It shows beautifully close correlation between the pathological picture and the roentgenogram.

R.M.: I admit that the clinical and laboratory side of our cases is very incomplete. In one, we were simply able to get tissue removed in association with an ulcer.

R.J.: In some of these cases, the enlargement is due to edema. I saw a very striking case in a man who had symptoms of ulcers for 8 years. He was operated on because he was unable to work. We could not find any ulcer of stomach but marked edema was present. Following removal of foci of infection, gastric condition became better at once.

E.J.C.: This discussion this afternoon should stimulate all of us to pay more attention to this condition. There is an enormous amount of material from the clinical x-ray standpoint, but very little anatomical correlation except for the few slides illustrated by Dr. Morse. In pernicious anemia, we have been able to demonstrate in a few cases actual atrophy of mucous membrane. This was possible by putting formalin down in stomach tube immediately after death. This could be done in other conditions in which the examination will be probably be done. Fixation of gastric mucosa is obtained in this way. The clinical picture of hypertrophic gastritis is apparently still obscure. There is this gap in our knowledge which we should bridge.

2. MEETING

Date: February 1, 1934.

Place: Recreation Room, Nurses' Hall

Time: 12:15 - 1:08

Attendance: 123

Program: Tissues and Autopsies

Discussion: W. A. O'Brien
Introduction of guests:
Angus Cameron, Northwest Clinic, Minot, N.D.
Lester R. Dragstedt, Professor of Surgery, University of Chicago.

Theme: The American College of Surgeons insists on the examination of all tissues removed at operation before approval of the hospital is made. Pathologists, in order to arrange their good service in this type of work, should have a clinical viewpoint,

We examine or save all tissues removed at operation except tonsils. The only positive finding in tonsillar tissue is an occasional reaction (about 1%) simulating tuberculosis. We have learned as the result of Dr. Michelson's studies that the reaction in lymphoid tissue we often label tuberculosis may be due to other factors. In many cases, it would undoubtedly be better to speak of this reaction as tuberculoid, if we do not demonstrate the tubercle bacillus. There are other debatable points in tissue interpretation, notably in Fallopian tubes removed at operation showing minimal signs of infection.

All operative and biopsy tissues should be preserved for future study. We have found that approximately two-thirds of all of our tissues can be stored in test tubes. After the specimen is covered with formalin, oil is put on the surface. The tube should be labeled on the side and corked, and can be stored in the fruit cans which are discarded by the hospital kitchen.

The summary today of tissues examined in 1933 is illustrative of the character of the service here. These diagnoses are not necessarily final as far as grading is concerned. Note the large number of tissues in all subdivisions labeled "inflammatory." According to Dr. Rector's survey of cancer in Minnesota, the largest number treated here and at the Mayo Clinic was tumors of the head and neck. Note also rectum, uterus and breast.

We do not make a diagnosis of acute catarrhal or chronic appendicitis. In one series of 500 gall-bladders reported from elsewhere, the surgeon noted that a chronically diseased appendix had been removed in each case. We have found in some of the infected gall-bladder cases an actively inflamed appendix. The absence of normal gall-bladder is to be noted. Some observers believe that the minimal inflammation seen in some cases is not to be considered abnormal. We have undoubtedly been too liberal in making the diagnosis of chronic mastitis and endometrial hyperplasia.

The autopsy situation for the past six years is of interest. Note that we have a percentage of 73%. The increasing percentage from 1928 to 1931, inclusive, gave promise of better things. In 1932, the percentage fell and we are apparently starting to climb again. Last year, we had more deaths and more autopsies than ever before. It must be remembered that in the best interests of our organization and science in general that we must make a real effort to secure an examination in every fatal issue.

Your attention is called to the new tumor records (page 195). We intend to use them as master index cards rather than follow-up sheets. It is most important that the cards should be filled out at the time the patient is in the hospital. We hope that you will all use these cards and help us gather this data.

At this time, Dr. Angus Cameron, of Minot, a former member of our faculty and at one time a member of our surgical staff, was introduced. Dr. O. H. Wangensteen introduced his guest, Dr. Lester Dragstedt, of Chicago. He commented on his early arrival in Minneapolis and the energetic morning program which had been arranged for him. He expressed his keen interest in what he had seen. Later in the afternoon, he addressed the medical students in the Todd Amphitheater.

Gertrude Gunn,
Record Librarian.