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ON THE  
DIFFERENTIAL DIAGNOSIS  
OF  
VARICELLA AND VARIOLA,  
WITH THE REPORT OF A CASE IN POINT.\*

BY ISADORE DYER, M. D., NEW ORLEANS, LA.

*Reprinted from the January, 1860, number of the New Orleans Medical and Surgical Journal.*

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*presented by the author.*

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In studying the eruption of diseases which affect the skin, there are certain essential points of consideration. These apply to all skin diseases and to the exanthemata as well.

Before going into the details of these points of diagnosis, I wish to make the general propositions: first, do variola and varicella differ, and, second, if so, in what do they differ?

In all eruptions, then, the location, the distribution, and the arrangements of the eruption are important, while the characteristics of the component lesions determine the disease.

The duration, course, history and attendant symptoms are important, but secondary considerations.

In considering variola and varicella along these lines, we see at a glance important differences.

*Location.*

Variola—face and extremities, particularly.

Varicella—trunk, particularly; face and extremities, unusually.

\* Read before the Orleans Parish Medical Society, December 14, 1895.



### *Arrangement.*

Variola—closely aggregated lesions, often confluent, particularly in the vesicular stage, clusters frequently seen.

Varicella—either single, widely separated lesions, never inclined to confluence, or in groups of two or three, maintaining throughout the integrity of shape and form.

### *Characteristics of the Individual Lesions.*

Variola begins as a hard, shot-like papule, as an efflorescence, even-involving the mucous membranes. After a distinct period, these change to vesicles, all lesions undergoing this change—umbilication customary. Lesions not umbilicated unusual in variola—vesicles change altogether into pustules, always deep seated, beginning always in the papillæ themselves, heal as scars, or pits after a long period of time.

Varicella lesions large, irregular in shape, spherical in form, globular at times, superficial always, rubbing off the skin easily. Papular stage indefinite, so short as often to be missed, and lesions seem to begin as vesicles. Often dry as vesicles, pustulating uncommon, umbilication rare, exceptional when it does occur, and then only in a few of a number of lesions. Eruption of lesions heals by drying, or peeling, leaving, at most, only a slight pigmentation—never scars, unless abscess from secondary pus infection. Pitting is never seen.

### *Course of the Eruption.*

Variola—slow, periodic changes in eruption from papular to vesicular or pustular; never find pustules and papules together. Never under three weeks, even in mild cases (Hebra, Liveing, Kaposi, Morrow). Usually four weeks or longer.

Varicella—rapid and irregular course, recurrent crops. May begin to heal on second day of eruption; find papules, pustules and vesicles side by side. No periodic change; usually completed in fourteen days. Sometimes less, rarely more.

### *History and Attendant Symptoms.*

Variola has prodromata more or less severe, but always present characteristic fever, angina common, headaches, fever

marked by exacerbation as the eruption becomes pustular. Depression throughout, more pronounced as the disease advances, and at the pustular change.

Finally varicella is not an uncommon disease, occurring independent of season and place.

Variola is epidemic and not concurrent otherwise, and is not a common disease. Is occurrent most in colder weather.

Varicella does not protect against variola.

Variola protects against variola, and recurrent cases of variola are rare, and occurring, occur in a modified form.

There is no case on record of a relapsing variola.

I have presented these different points, to the more saliently bring out the main features of the case I am about to report.

That there is some reasonable purpose in this report will likely appear to all, and I wish to ask the free discussion of the case as one of importance, not only in its own clinical features, but as exercising some direct reflection upon the individual physician's position in his relation to the official health authorities.

There may perhaps be some who believe that the patient deserves consideration also.

On November 8, I was requested by the visiting physician of one of the wards of the Charity Hospital to see a case of skin disease, to express an opinion upon it and to prescribe.

On entering the ward of the hospital, I met one of the house officers, who additionally invited me to see the case.

With the house officer and Dr. Menage, my associate at the hospital, I made a careful clinical examination with the following result:

The patient was a negress, about 20 years of age, in good physical condition, with the following skin manifestations:

I.—*The eruption* was distributed in discrete lesions over the chest, abdomen and back. On the face, there were a number of lesions, single, and widely separated. On the arms and legs, the lesions were fewer and sparsely located. On the tongue and over the hard palate, there were likewise discrete lesions.

II.—*The eruption* consisted of irregular-sized vesicles on the body and face, while the lesions on the tongue and the mouth were for the most part pustular. I called the attention of the gentleman with me to this phase of the eruption, and also to the fact that there was an absence of any other evidence of inflammation in the mouth and throat.

The lesions were rounded, hemispherical, and irregular in shape. It was only after a careful search that any umbilication was found. This could be seen only on two or three lesions on the right side just below the region of the floating ribs.

On questioning and cross-questioning the patient, it was discovered that she had experienced no prodromic symptoms whatsoever, and felt at the time of examination in excellent health.

The eruption had been out, she said, only two days, and had come out gradually. The lesions were more carefully examined, and were found to be loose walled, some even flabby. In touching one, on the belly, the walls gave way under my finger, the top slipped off, leaving a smooth, reddened spot behind, when the exudate was wiped away.

An unqualified diagnosis of varicella was made by me, which was concurred in by the house officer and by Dr. Menage.

The case was received by the hospital and admitted.

On the morning following I again saw the patient. There was plain evidence of resolution of the condition. Fully half the lesions on the face had dried. Those on the body had in many places been reabsorbed, leaving behind the little crumpled epidermis, which is customary after the resolution of a vesicle.

The general condition of the patient had not changed.

I advised treatment, and said that the case needed no especial watching, giving a prognosis of a few days.

The same night I learned that the patient had been sent by the Board of Health Inspectors to the small-pox hospital.

At the invitation of the President of the Board of Health, who had resented my repeated expressions of opinion in the case, namely: "that a case of varicella had been sent to the

small-pox hospital," I visited the pest-house on the 12th of November.

I found the patient in bed, in a room with another, sick with small-pox, I conclude.

She rose with ease at my request, and I for the third time made a careful examination.

I found the following state of affairs:

1. There were no lesions on the face. Some pigmented spots, dark or whitish red, marked on the site of the desiccated lesions.

2. There were no lesions of any sort in the mouth and no evidences of eruption except a little red spot on the right underside of the tip of the tongue, where a lesion might have been.

3. The body presented both vesicles and pustules in stages of disintegration, some flabby, some half peeled, some already dried and some having peeled, leaving whitish, smooth spots behind.

All the lesions on the arms and legs had dried.

4. There were no constitutional symptoms. In spite of repeated questioning and cross-questioning, the patient denied sore throat at any stage or time of the disease, and at this examination there was still no evidence of it.

I reiterated my expression of opinion in the case and passed the comment that such a clinical picture on the sixth or seventh day confirmed beyond peradventure my original diagnosis of varicella. I insisted that a case of varicella had been sent to the small-pox hospital, where she was confined.

The case remained at the pest-house notwithstanding.

On November 24 the patient applied at the Charity Hospital for admission in another service. On the following day the patient was the second time transferred to the small-pox hospital with a diagnosis of variola.

A few days subsequently I learned she was in the hospital with confluent small-pox. Within the past few days I was told that this patient had died of small-pox.

I might dismiss this subject without further comment, but I prefer, if not trespassing too much upon your time, to draw a few conclusions.

I would call your attention for consideration to the following points:

1. The character of the eruption in the case when I saw her.
2. The history and course of the eruption.
3. The date of admission and discharge from the small-pox hospital (November 9, November 18).
4. The date of readmission to the small-pox hospital (November 26).
5. The more than improbability of a recurrent attack of variola.

First. Because the patient was discharged from the pest-house not later than the 18th (if earlier, all the more argument, for variola even in varioloid types never runs a course of less than three weeks).

Second. The small-pox was manifested on the 23d, or just seven days after the discharge from the pest-house, and just sixteen days from the date of first admission to the pest-house.

The period of incubation of small-pox is from ten to fourteen days.

6. This suggests that small-pox was contracted in the pest-house.

7. It would be an unique case in medical literature to find a "mild case of varioloid," as diagnosed by the sanitary inspector, followed within a week or eight days by a typical case of true variola, confluent in type, and malignant in its history and outcome.

Gentlemen, we are entitled to differences of opinion, and the weight of proof rests with those who have the weaker side. I believe I have made a fair presentation of this case and its history.

When there is a reasonable doubt in such an instance much harm may result to the patient, and much discredit reflect upon the health authorities if a mistake is made in sending one with a similar disease to a hospital for small-pox, where death may be the forfeit of the patient.

*124 Baronne St.*







