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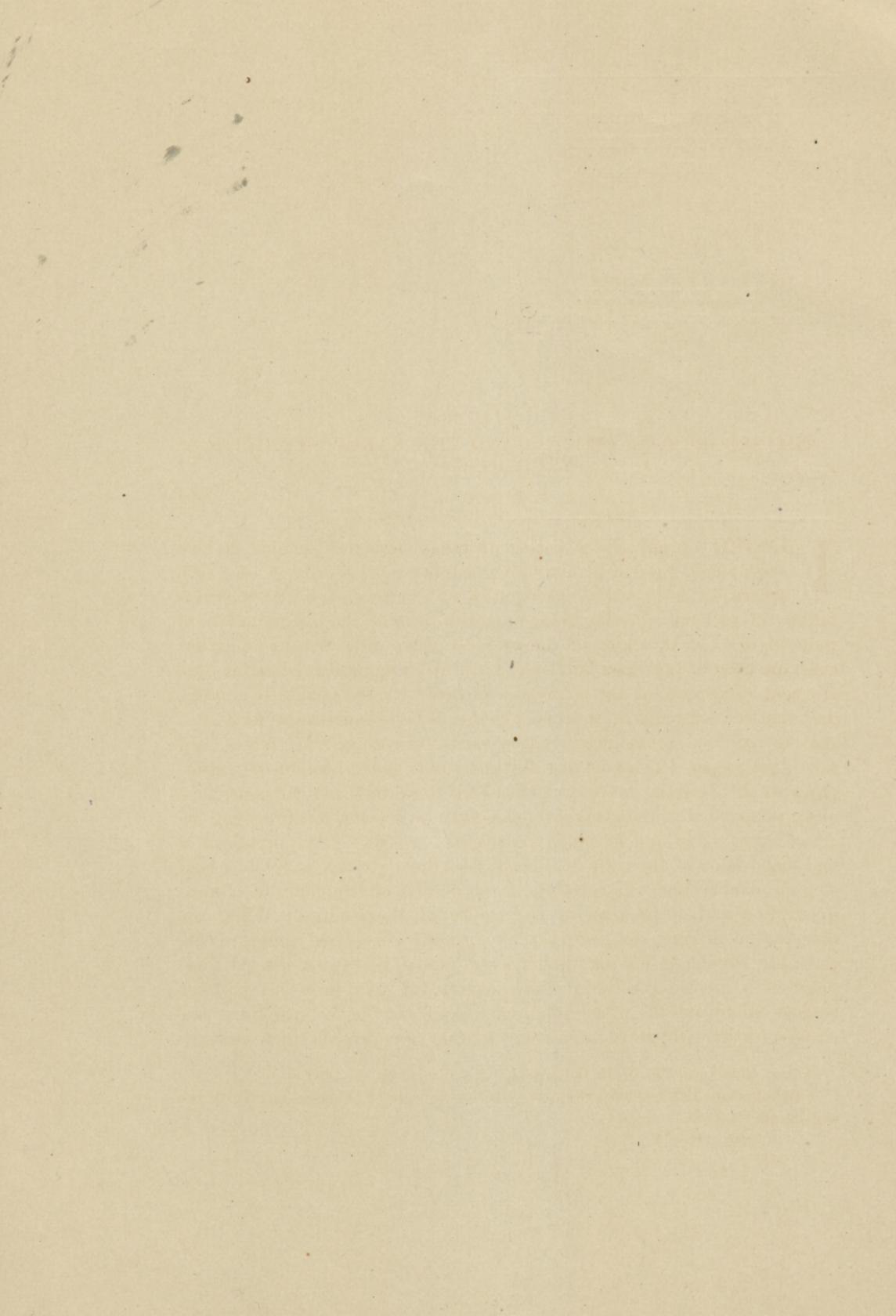
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*presented by the author -*





## THE SEBORRHOIC PROCESS AND THE EARLY SYPHILITIC ERUPTIONS.\*

By R. W. TAYLOR, M. D.,  
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I DESIRE to call the attention of the society this evening to two cases which present in a striking manner the coincidence of a true seborrhœa developed synchronously with general syphilitic manifestations in patients suffering from an active form of the infection. I am induced to do so by reason of the evidence these cases present in partial substantiation of the views lately put forth by Unna,† who claims the very frequent occurrence of the seborrhoic process with the syphilitic process, and that the existence of the two together is not a mere coincidence, but that in reality a pathological relation exists between them. While I am not as yet prepared to accept in full Unna's wide generalizations in considering as one essential morbid condition all the varied and polymorphous changes included in the general term seborrhœa, I think his investigations are of great value and of much prospective benefit. His simplification and elaboration of the fully developed seborrhoic eczema is really a bold step in advance, and will certainly be productive of simplicity in clinical description and of progress in the matter of therapeutics. While the observation of some cases of what we formerly considered simple seborrhœa has convinced me that perhaps the process was really the starting-point of a morbid condition which eventuated in a true but peculiar eczema, others, on the other hand, have been wanting in symptoms and clinical features which we have from tradition come to look upon as essen-

\* Read before the New York Dermatological Society, Feb. 25, 1890.

† Syphilis and Eczema Seborrhoicum. *British Journal of Dermatology*, November and December, 1888.



tial to the eczematous process. In studying these cases, particularly those of the second class, the suspicion has entered my mind that in many seborrhœa may tend to produce eczema by reason only of the *slight* but *continuous* irritation of the vessels of the skin, which Unna lays such stress upon. The subject is on all sides so interesting that it should be carefully studied upon patients as they present themselves. True conclusions can only be reached through careful clinical observation, aided in a measure by reading.

It has seemed to me particularly fortunate that chance has, within a short time, thrown in my way two cases affected with both seborrhœa and syphilis, which present such well-marked features that no stretch of the imagination is required to see in them that pathological relation of the two morbid states or symbiosis which Unna has so cleverly elaborated. While I have seen and am daily seeing many cases in which a more or less mild or severe, limited or extended seborrhœa complicates syphilis, I am not convinced that the interlocking of these morbid processes is so very frequent as Unna is disposed to think.

The gist of Unna's paper is centered in an able presentation of the claim that a pre-existent seborrhœic process is, by reason chiefly of its inherent mild or active hyperæmia, and of its anatomical peculiarities, very commonly the forerunner of syphilitic symptoms, and that the distribution and course of the latter are largely affected by, and may even actually depend upon, the extent, intensity, and course of the former. Unna says: "Wherever secondary syphilis presented itself, I found not only that it corresponded exactly in its distribution, but even in the intensity of the inflammatory symptoms, with the seborrhœic process, and that, in fact, it trod exactly in its footsteps." I am willing to admit this pathological sequence and relationship, but I must add that, with a wide field of observation before me, I have not observed them in this country to the extent that Unna claims they exist. As a corollary of this symbiosis, I think we must admit that in many cases syphilis, particularly in its early and hyperæmic stages, tends to awaken a latent seborrhœic condition, and that the latter may be produced *de novo* by syphilis, probably through its subacute continuous hyperæmia. Further than this, it may be stated without question that such a seborrhœa, excited by syphilis, has much to do in fixing the localization, extent, intensity, and duration of the syphilitic lesions themselves. In other words, that, once fairly started, the two morbid processes go hand in hand in producing lesions which are frankly seborrhœic to the eye, or which appear like amalgamations of seborrhœa and syphilis.

Unna's zeal and enthusiasm in this subject are very commendable, but I can hardly go as far as he does when he states that the papular syphilides, large and small, when covered with yellowish greasy epithelial scales,

are the outcome of a remarkable symbiosis and synergy of seborrhœa and syphilis. This is only true in certain cases. In very many instances, in which I have watched the growth and development of these lesions, there has been no seborrhœic complication whatever until the papules had been fully formed; then, slowly or rapidly, traces of seborrhœa might be observed. To my mind, in cases like these, the growth and vascularity of the papules tended to induce hyperæmia in the coil glands; in other words, a secondary or accidental (not essential) seborrhœa occurred in limited areas in which a syphilitic process was going on. This may seem to be a small point, but at the present time the subject is far from being matured, and it is better to claim too little and then to get more, than it is to claim too much and then have to relinquish a part.

Admitting, therefore, that seborrhœa may prepare the ground for syphilis, let me present my cases which prove that syphilis may be the fore-runner and the excitant of seborrhœa.

M. D., Irish, married, a woman of previous excellent health and fairly good habits, entered Charity Hospital February 22, 1890. Four months ago she suffered from an ulcerated nodule on the inner side of the left labium minus. This lesion was contracted from her husband, who was suffering from secondary syphilis. Toward Christmas the patient noticed that she had grown weak and had lost flesh, and that various tegumentary troubles, to be detailed further on, had become developed. She now suffers severely from nocturnal pains seated in both tibiæ, and has an ulcer on the left tonsil.

Tracing her tegumentary lesions from the upper to the lower parts of the body, we find evidences of both seborrhœa and syphilis; in other words, this case presents in a wonderfully striking manner an interlocking of the seborrhœic and syphilitic processes, or symbiosis. The members of the society, upon examining the case, will find the following varied phenomena:

The scalp shows in a marked degree a true syphilitic alopecia which, beginning in a slight fall of hair, soon developed into a general thinning, which has now nearly laid bare the vertex and occiput and a rim of the lateral portions. The nutrition of the hairs is seen to be much impaired. In these features there is nothing very unusual, though it is not very common to see such a radical alopecia from syphilis.

It must be remembered that previous to infection this woman's hair was thick and strong, and she had not at any time been troubled with dandruff. Besides the alopecia with such a typical syphilitic physiognomy, we find all over the head small and large spots and patches of dull yellowish-red hyperæmia, without sharp outline, and in some places confluent, which are more or less covered with adherent fatty epithelial scales. Some of the older spots present a typical mild salmon-color. In other words, a true picture of seborrhœa capitis may be seen. Moderate

and mild seborrhœa is not an uncommon accompaniment of specific alopecia. On the scalp, therefore, there exists a well-marked syphilitic alopecia complicated with a typical seborrhœa.

At the margin of the hairy scalp we see a well-marked, but irregular, rim of what looks like, and probably is, simple patchy seborrhœa, and which certainly would be thus diagnosed by a competent observer, except for the history of the case. There is no evidence of true syphilitic papules; therefore we must look upon this patch as an aborted or pseudo *corona Veneris*. Upon the forehead, near the temples, the affection is developed in a decidedly ringed form, similar to those we find on the back and over the sternum in uncomplicated seborrhœa.

Upon the nose, at the outer angle of the left eye, and in front of each ear we find small and large patches of seborrhœa, in its typical ringed form, which are of reddish-yellow hue, and which show a decided tendency to heal in the center. Upon the labio-nasal furrow there are irregular patches, and on the upper lip rings of the same character. There is nothing suggestive of syphilis in the foregoing patches and rings except in the sites of the eruption at the scalp margin and in the labio-nasal sulcus.

Upon the lower lip and chin the seborrhœic lesions are most markedly typical, and they present a very striking picture. The lesions are seen to be in the form of dull reddish circles, the margins of which are decidedly elevated and annulated (more so than elsewhere), covered with typical scales and inclosing a yellowish-red, healing, slightly scaling central and somewhat depressed surface. By the fusion of these annular patches we see that festooned outline is produced which has graphically been called "polycyclic." While elsewhere the seborrhœic processes have produced a typical picture of seborrhœa, here upon the chin, though the lesions are also typical in appearance, they, when viewed together with the labio-nasal and *corona Veneris* patches, suggest strongly a syphilitic complication.

In Fig. 1 the alopecia and the patches on the chin are very clearly shown, the whole presenting a very marked appearance. Owing to the rapid involution of the patchy lesions upon the vertex, forehead, and nose, and to their then very light color, the picture fails to show them as they existed when the patient was shown to the society. The appearances presented by the lesions upon the chin may truly be called classical, and they are very suggestive of the disseminated and grouped patches, which, however, lacked the annular outline and sharp margination.

At the occipital scalp-margin there is a diffuse patch of seemingly simple seborrhœa, and on the neck well-marked rings of the same nature.

Scattered over the arms, particularly upon the posterior and outer aspects, we find a disseminated, mottled, declining roseola, typically syphi-

litic in appearance, and over the forearms irregular-shaped, reddish, scaly patches, without much thickening of the skin, which might, with equal propriety, be called seborrhœa or syphilitic papules in the process of absorption and desquamation. In the light of a syphilitic history, we might

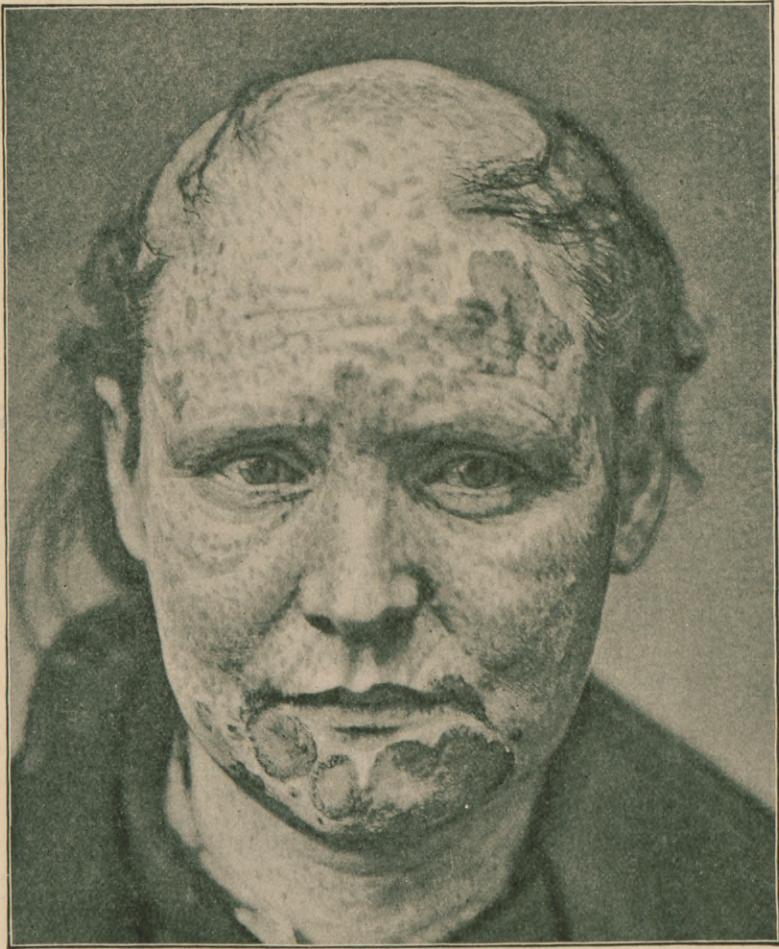


FIG. 1.

consider them the result of that form of infection, but in its absence a diagnosis of the simple affection would be warranted.

As on the arms, so on the abdomen we find a typical and striking background of fading roseola, and on the sides of the trunk several well-marked rings of what seem to be undoubted seborrhœa, since they are not distinguishable from the ordinary seborrhœal rings as we find them,

especially between the shoulders. In addition, there are scattered over the trunk deep-red and purplish patches, which may be roseolous, but which I think are the remains of seborrhoeic patches, which have lost their characteristic appearance by pressure or friction.

On the outer and anterior aspects of the legs the same symbiosis is observed as we found upon the trunk and arms. In this case we observe in a remarkable degree the coexistence of two orders of lesions—seborrhoeic and syphilitic—and I think that the conclusion is fairly warranted that the syphilis provoked the development of the seborrhoeic process, since nothing suggestive of it had ever been seen in the patient before the period of syphilitic infection.

In addition to this interesting case, let me call your attention to another, a photograph of which I now present:

The patient is a woman, twenty-six years old, and the mother of three healthy children. She never had any sickness and gives a very clearly negative history as to acne, seborrhœa, or any erythematous condition of the face.

In November, 1889, she presented a hard chancre at the left labial commissure, which was followed by general adenopathy, and later by rheumatoid pains and a general papular syphilide.

The skin lesions upon the face are of most interest to us. A view of the picture presents a marked syphilitic physiognomy. In the middle of the forehead we find a cluster of lesions which can be traced to the glabellar region, around the eyes, over the nose to the labio-nasal groove (with a few outlying ones on the cheeks), on the upper lip, near the nose, and all over the chin from the margin of the lower lip, together with a number on the neck.

Now, careful examination of the eruption showed that it was composed of sharply defined, regular and irregular, round or oval, slightly thickened patches of brownish-red and scaly skin. The scales were of the characteristic dirty-yellow, greasy seborrhœal character, and when removed revealed a shining reddish surface. At the margins of the lesions the loosened scales produced a fringe-like appearance.

To the trained observer in syphilis the picture was so striking that a diagnosis of that disease would be made at once from the peculiar distribution and configuration of the eruption, which Unna calls the "facies seborrhoica." But I can well understand that in the minds of many a doubt might exist as to its nature, and that it might, from the appearance of the lesions themselves, be thought to be an aggravated case of seborrhœa. Others might regard the patches as syphilitic roseola complicated with seborrhœa. Elsewhere upon the body, particularly on the forearms, the eruption was so typical in appearance that it would be hard to mistake it for anything else than a papular syphilide. In this case there was no tendency whatever to the development of the annular form of lesions, nor was there any evidence of seborrhœal symbiosis in the eruption be-

yond the face and neck. It was a marked instance of the patchy form of seborrhoea in the second grade of the process as so truly and admirably described by Unna. Under treatment the affection declined and the scales fell off and left spots of the size of the patches, which were of a typical pale salmon-color and very persistent.



FIG. 2.

Besides these cases of extensive syphilo-seborrhoea, we frequently see, especially about the face, coexisting with the erythematous and the papular syphilide, a few or several patches of seborrhoea, which form but a small and sometimes insignificant proportion of the whole eruption.

These cases certainly show evidence of marked deviation from the

normal standard of development of syphilitic processes, and they warrant the suspicion that, in addition to the specific cause, some other pathogenetic factor was at work. For years we have explained the peculiar features presented by this class of cases with the statement that a seborrhœal process was set up in the portion of the skin involved by the syphilitic lesion, and that it was a simple complication which modified external appearances more or less. Unna, I think, clearly shows that this explanation falls rather short of the real facts of the case. This observer considers these eruptions as mixed infections, due to an interlocking of the seborrhœic and the syphilitic processes. It is, I think, unfortunate that he does not put himself squarely on record as to the nature of the seborrhœic process. From the context of his essays one is led to believe that he thinks it is caused by some micro-organism, but a careful reading fails to reveal a precise statement. H. G. Brooke,\* however, who is a staunch admirer and follower of Unna, states clearly his belief in the parasitic nature of seborrhœa.

Whatever may be the primary cause of seborrhœa we can not now state; facts, however, like these already presented clearly show that one of the actions of syphilis, particularly in early hyperæmic stages, consists in the development of a true seborrhœa, which may present a simple seborrhœic physiognomy, or which may be modified by the syphilitic impress and present a somewhat composite appearance. In the cases detailed the seborrhœic process was undoubtedly produced *de novo* by the syphilis, and the result was a symbiosis, or, as Unna tersely calls it, an interlocking of the two morbid processes. It is important to remember that as yet we have only reached the stage of clinical observation, and that a definitive statement concerning these hybrid lesions can only be given after careful and extended microscopic studies have been made.

In other cases it may be found that an antecedent seborrhœa, by reason of its inflammatory processes, predisposes the skin (wherever it exists) to the development of syphilitic lesions—erythematous, papular, or even tubercular. A striking instance of this symbiosis, in which “syphilis treads in the footsteps of the seborrhœic process,” as Unna graphically puts it, is detailed at length in his very interesting paper. I myself have seen several similar and convincing instances of the same combination and sequence. Unna very truly says that “a miliaria rubra can bring about the outbreak of a *small* papular syphilide of the trunk; an accidental attack of scabies may cause a preference for the interdigital folds and gluteal prominences as a place of predilection of the exanthem.” In fact, I may add that almost any simple inflammatory infiltration and con-

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\* The Relationship of the Seborrhœic Process to some other Affections of the Skin. *British Journal of Dermatology*, June, 1889.

dition of the skin in subjects of active syphilis may take on a syphilitic nature and behavior.

The especial predilection of early syphilitic eruptions upon the scalp and face to take on a seborrhoic physiognomy is undoubtedly due to the richness of these parts in sebaceous and sweat glands, and the peculiar arrangement and distribution of the latter are the causes of the configurations of the eruptions, which, from their constancy of occurrence, we have come to term classical.

Finally, I may emphasize the fact that where the seborrhoic and the syphilitic processes coexist, the lesions may be strikingly seborrhoic in appearance, or they may present more or less modification due to the specific process.

When the proper cases present themselves I hope to be able to consider this coexistence of seborrhœa in the later stages of syphilis, in order to determine whether there is a true symbiosis, or whether it is an accidental or secondary condition.







