DERMATOLOGIC CLUES TO INTERNAL DISEASE

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TO RUTH
FOR HER PATIENCE
AND UNDERSTANDING

PREFACE

THERE IS AN APPARENT NEED for the correlation of the manifestations of skin disorders with those arising in some visceral dysfunction. The association between skin diseases or cutaneous abnormalities, and internal disorders or disease patterns is not a new concept. The skin must be considered not as a covering separate from the rest of the body but as a distinctly functioning and protective cloak which has nervous, vascular and hormonal intercommunications with the visceral organs and the central nervous system. This is emphasized from time to time by many an internist and dermatologist. The former has frequently found that the detection of certain cutaneous alterations and the recognition of their character are of considerable help in solving difficult problems in differential diagnosis. The dermatologist, on the other hand, has oftentimes been able to bring relief to patients in instances of obstinate skin disease by recognizing the primarily internal source of the dysfunction and thereby employing the logical therapeutic measure.

THE SUBJECT MATTER will be presented in the form of concise descriptions of constitutional diseases exhibiting associated skin changes. Diseases of the skin of significance or diagnostic aid in the province of internal medicine will also be included. The descriptions will be listed alphabetically and briefly, avoiding lengthy dissertations and disconcerting theoretical controversies. Diseases adequately described in standard texts, such as common skin disorders and the exanthemas, are not included.

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I am obligated to Dr. Joseph Globus, Editor-in-chief of the Journal of the Mount Sinai Hospital, for his advice, suggestions and stimulating interest in the publication of this volume. It was the original suggestion of Dr. Globus that a correlation of skin changes with internal disorders would be a useful addition to medical literature.

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H. T. B.

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ACANTHOSIS NIGRICANS

This skin disease is so frequently associated with carcinoma of the internal organs that its positive diagnosis may be considered an indication for exploratory laparotomy. The cutaneous changes are primarily brownish pigmentation of the axilla, neck, mouth, face or abdomen. In addition, small, warty or papillomatous tags

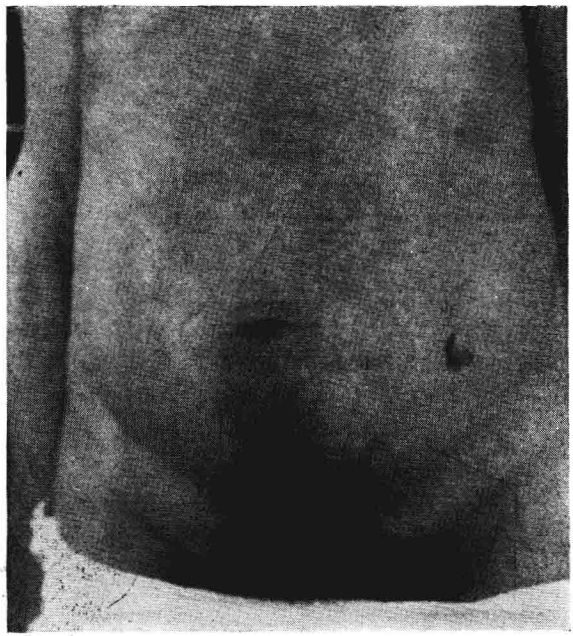

Fig. 1. Acanthosis Nigricans.—Triangular brownish black pigmentation on the abdomen associated with carcinoma of the lung.

are present and the normal skin markings of the involved sites are exaggerated. Approximately 50 per cent of all cases are associated with cancer, especially of the stomach (fig. 1).

ACROCYANOSIS

In this condition the skin of the hands from the wrists to the finger tips becomes a persistent blue-red color. The palms are cold and

sweaty. Acrocyanosis differs from Raynaud's disease in two ways. The first difference is that the skin of the fingers and hands is diffusely involved. The second point relates to the ease with which the color changes from blue to red when warmth or friction is applied to a small area, while the rest of the skin remains cyanosed. This cannot occur in Raynaud's disease because relaxation of the spasm in the proximal vessel must occur before flow can be restored through the skin of the distal parts of the finger. In acrocyanosis it is the arterioles that are in spasm, while in Raynaud's disease the spasm involves the larger vessels.

ACRODYNIA

Pink disease or erythredema may be a juvenile variant of a deficiency of the vitamin B complex, possibly premature pellagra. In addition to the associated general changes of restlessness and irritability, the child presents an erythematous, scarlatiniform eruption of the face and body. The hands and feet are pinkish red, pruritic and sensitive. The eruption is often associated with and followed by desquamation.

ACROMEGALY

Individuals with long-standing acromegaly show alopecia, sparing the lateral and posterior margins of the scalp, and generalized hypertrichosis. In the full-blown case, however, the scalp hair may be normal in addition to the striking hirsutism of the body. Women may develop heavy beards. The beard and mustache are bristly and the eyebrows bushy. The individual hairs become coarse, thick, wiry and oily. The skin is usually coarse and thickened with increased brownish pigmentation. Numerous soft fibromas of the skin are found in acromegalics. The excessive activity of the sweat and sebaceous glands leads to enlargement of the pores, seborrhea and hyperhidrosis. The tongue is enlarged and prominent, the lips negroid. The nails are thickened and brittle and grow rapidly. It is characteristic of the skin in acromegaly, in contradistinction to myxedema, that it can be lifted in folds. If the scalp itself is thrown into thick folds it is termed cutis verticis gyrata ("bulldog scalp"; fig. 2).

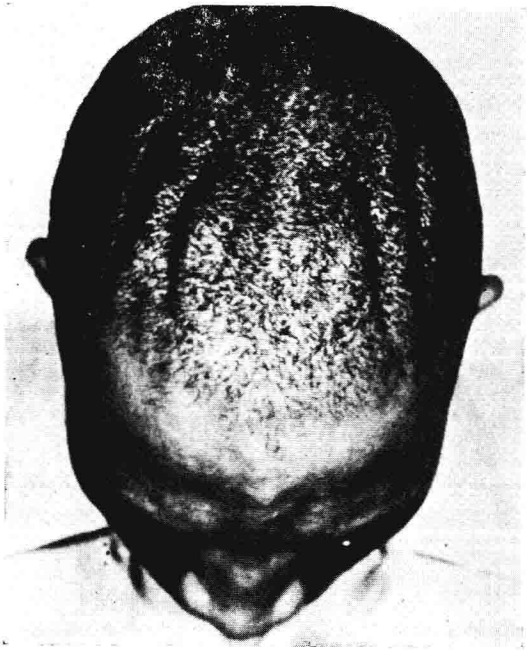

Fig. 2. Cutis Verticis Gyrata.—The scalp is divided into several thick folds, usually on a basis of pituitary dysfunction.

ACROSCLEROSIS

This term is limited to those cases displaying Raynaud's phenomena (intermittent arteriolar spasm of the upper extremities producing successively pallor, cyanosis and erythema) and scleroderma of the distal parts of the extremities, face and neck. The skin of the hands and fingers is smooth, shiny and tense with a pale or cyanotic color. The finger tips are frequently scarred and ulcerated with defective, abnormal nails. The fingers may be flexed and stiff. The face is ironed-out, taut and with lessened wrinkling properties. Unlike scleroderma, acrosclerosis affects women primarily and pursues a slow course. It is very important that these diseases be classified separately because of the vast difference in the prognosis, which is comparatively good in acrosclerosis. In other words, this disease does not go on to involve the entire body but remains limited to the face and extremities; it is not associated with the classic, waxy, hidebound, atrophic skin; remissions are not uncommon and the mortality is only one third of that encountered in scleroderma. Sclerodactylia is merely a less severe form of acrosclerosis.

ACTINOMYCOSIS

Primarily cutaneous actinomycosis is rare. It is usually observed secondary to infection elsewhere and its appearance on the skin follows progressive infection through the subcutaneous tissue outward to the surface. At first it is a small nodule which becomes progressively larger and ulcerative. Through the ulceration or adjoining sinus tracts, pus may be expressed. It is in this pustular discharge that the characteristic yellowish sulfur granules are found

Fig. 3. Actinomycosis of the Face.

(yellowish or white flakes when spread out on a slide). The lesions may become quite large and confluent to form a nodular, board-like induration dotted with sinus tracts (figs. 3 and 4). The diagnosis is established by finding the granules in the discharge and not by cultures, which may yield harmless but culturally similar saprophytes.