

CUTANEOUS NEOPLASMS

NORMAN PAUL

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By

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WITH EIGHTY ILLUSTRATIONS

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PREFACE TO FIRST EDITION

IN a country in which there is a great prevalence of Cutaneous Neoplasms, this book is written with the object that it may be of assistance in stimulating further interest in their diagnosis and treatment.

It will also, I trust, act as a warning against the reckless exposure to sunlight. For it must be remembered that in many cases we are the arbiters of our own fortune as regards the development of certain cancerous and precancerous diseases of the skin. Through ignorance or failure to protect ourselves against the damaging effect of strong and continuous sunlight, often upon a skin insufficiently protected with pigment, we are prone as age advances to develop these growths.

Sun bathers should be warned. As we sow, so we reap, and the fertile seeds of keratoses which are often the first whispers of oncoming malignant disease, and malignant disease of the skin itself, are being daily and extensively sown on our beaches, and will mature with advancing years.

I have to acknowledge my indebtedness to the writings of various authors.

NORMAN PAUL.

143 MACQUARIE STREET,
SYDNEY, AUSTRALIA.
19th January, 1933.

PREFACE TO SECOND EDITION

It has been suggested to me that I should publish a second edition of my book.

I did not consider that any good purpose would be achieved by rewriting the original work. However, realizing the importance of the subject-matter, especially to Australian Students and Practitioners, I preferred to incorporate a description, with photographs, of some further growths, both benign and malignant.

I again direct attention to the dangers of undue exposure to strong sunlight.

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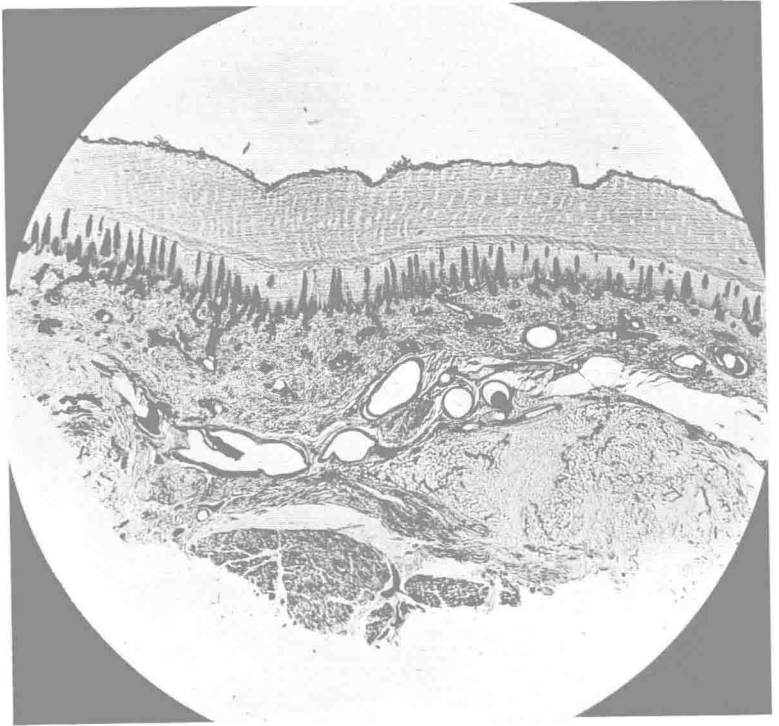


FIG. 1.—Normal Skin, showing vascular supply.

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CUTANEOUS NEOPLASMS

INTRODUCTION

SOME STATISTICS OF HOSPITAL AND PRIVATE PATIENTS

DURING a period of sixteen months to October 1932 the Radium Department of the Sydney Hospital treated :

Rodent Ulcers.	.	.	.	.	602 cases
Epitheliomata (skin)	.	.	.	.	161 cases
Keratoses	.	.	.	.	394 cases
Cutaneous Horns	.	.	.	.	33 cases

For purposes of comparison with those treated in private practice, I propose only to record those hospital cases that came under my direct care.

The tables will show the incidence of these growths in males and females ; in hospital and in private practice.

SYDNEY HOSPITAL

	Males	Females	Total
Rodent Ulcers	137	80	217
Epitheliomata	61	20	81
Keratoses	94	89	183
Cutaneous Horns	8	6	14

PRIVATE PATIENTS TREATED BY THE WRITER DURING A PERIOD OF FOUR YEARS

	Males	Females	Total
Rodent Ulcers	120	100	220
Multiple Rodent Ulcers	29	13	42
Rodent Ulcers and Keratoses	19	27	46
Total Rodent Ulcers			308
Epitheliomata	68	35	103
Keratoses	89	123	212
Cutaneous Horns	3	4	7

DERMATITIS SOLARIS CHRONICA

Definition.—The term *Dermatitis Solaris Chronica* will be used, as it was in a previous publication, [1] to designate a degenerated condition of the skin, appearing only upon exposed parts, and particularly associated with advancing years. This degeneration is proportionate, not to years, but rather to the exposure to sunlight. It is characterised by irregular macules or areas of a pink or brownish pigmentation; and keratoses, which may ultimately develop into cutaneous horns, or into basal or squamous-cell epitheliomata; and all may be silent witnesses of previous solar damage.

Etiology.—Strong and prolonged sunlight is the causative factor in its production. Fair-complexioned persons, or those least protected by melanin, are most susceptible. The condition is a very prevalent one in Australia. Colquhoun of Melbourne recorded a case with a similar condition following the continued application of ultra-violet light to the trunk, and an analogous condition may be produced by the X-rays.

Symptoms

DISTRIBUTION.—The lesions are localised to exposed parts such as the face, lips, ears, neck, dorsum of the hands, fingers, and forearms. The margin of the upper lid may be affected, and shows a tendency to the development of cutaneous horns. Surf bathers are commencing to present themselves with *Dermatitis Solaris Chronica*, and I have under treatment such a case at present. In this patient there is a moderate-sized epithelioma of the scalp. The face has had a number of lesions treated, whilst on the upper part of the back and shoulders are numerous keratoses and pigmented macules with several rodent ulcers. Another patient shown at a recent clinical meeting was a fisherman who was unaccustomed to wear shoes, and presented on the dorsum of both feet keratoses and a slow-growing epithelioma similar to those seen on the hands.

Signs and Symptoms.—The scattered circumscribed pigmented spots or areas of various sizes, with a pinkish or brownish coloration, are amongst its earliest signs. These pigmented patches are probably the first indications that the normal balance of wear and tear has been lost, and form an attempt to protect the underlying tissues from the actinic rays of light, which these colours are able under normal circumstances to absorb. If these patches of pigmentation fail to maintain this balance of tissue economy, then the epidermis proliferates as a further means of protection to the subjacent tissues. This proliferation may appear as a slight scaly roughness, or be more pronounced and appear as raised, rough, circumscribed, somewhat warty-looking lesions, the size of a split-pea or larger, and either dry or greasy in appearance. It is upon the patches of pigmentation that these epidermal proliferations or keratoses most frequently, though not invariably, arise.

These hyperplastic lesions have sometimes been described under various names, viz. senile or seborrhœic keratoses, but it would, in the writer's opinion, be more appropriate to adhere to the term *keratoses solares*, by which I previously described them. Their existence only on exposed parts demonstrates that the senility of the skin is not their causative factor. Under this nomenclature, seborrhœic warts, which occur in greatest numbers upon covered parts such as the back and chest, would be excluded and regarded as a separate and independent condition.

Sometimes the keratoses of solar origin are dry and of a greyish colour, whilst others are greasy and of a greyish to greyish-black colour. In the former the horny mass is firmly adherent and removed with difficulty, being due to epidermal hyperplasia. The latter type occasionally occurs on the face, where the sebaceous glands may show increased activity, and here sebaceous material and degenerated cells enter into the composition of these keratoses. The sebaceous material, like the pigment, appears to be thrown out for protective purposes, and may even tend to form diffuse patches. In this stage they can readily be removed, and

frequently show on their under surface spine-like processes, which have arisen from the pilo-sebaceous follicles. Beneath these, degenerative changes not infrequently take place, with the production of ulceration of the surface layers of the epidermis, whilst the deep layers show proliferative changes. In these malignant ulcers progress may be comparatively rapid if pus be allowed to collect beneath them.

Keratoses are sometimes so numerous that a pin can hardly be placed between them, and recently I saw such a condition on the forearms of a young man from Queensland.

Itching may be a subjective symptom.

Sometimes these keratoses disappear spontaneously, but not infrequently they develop into cutaneous horns, basal, and squamous-cell epitheliomata, and all gradations of growth may occur between them.

Keratoses on the dorsum of the hands and fingers almost always give rise to squamous-cell growths, and not infrequently these are of slow growth. Irritation, such as their constant removal on the face by shaving, and friction on the dorsum of the hands and fingers, may aid their further development. On rare occasions one sees associated with marked *Dermatitis Solaris Chronica* of the face a peculiar protective mechanism of the skin of the dorsum of the hands; the integument is thickened, tough, and of a peculiar mauvy-pink colour, in which tints of brown, yellow, and pink are noticeable.

Pathology.—When this condition is marked, the skin in general presents those changes which we are accustomed to see in the senile skin. These are represented by a degeneration of the elastic and collagenous fibres of the corium, with some scattered cell collections and dilatation of the capillaries. The epidermis is in general thinned, and the brown patches are represented by accumulations of pigment mainly in the deeper layers of the epidermis, both intra and extra cellular, as well as in the upper portion of the corium. The telangiectases are due to the compensating dilatation of vessels resulting from the disappearance of others.

Keratoses

1. EPIDERMIS.—(a) *Dry Type*.—In this there is a marked hyperkeratosis, often composed of closely compacted lamellæ of horny cells.

(b) *Greasy Type*.—The epidermal thickening may be composed of horny cells, often parakeratotic sebaceous material and detritus from disintegrated cells.

2. The prickle cell layer exhibits marked variation; whilst the early lesions show but slight increase, all gradations of hypertrophy of this layer up to actual infiltration of the corium are to be seen. This layer sometimes assumes a verrucose appearance.

3. The corium shows cellular infiltration, which becomes marked when prolongation downwards of the interpapillary processes takes place.

Diagnosis

1. Seborrhœic warts are described on p. 98. They occur in greatest numbers on the trunk, but it is the lesions which may occur only on the face, particularly about the forehead and temporal regions, which are liable to be confused with keratosis solares. Seborrhœic warts are early a light buff tint, later they assume a brownish, and then a blackish colour. They are somewhat uniformly elevated and rounded or oval in shape, as opposed to the more irregular shape and uneven elevation of keratosis solares. It is not uncommon to see both conditions in the same patient.

2. Keratosis following the administration of arsenic, and the application of X-rays.

3. *Lupus Erythematosus*.—In this the patches are usually larger, more inflammatory, at least around the periphery inside which is a whitish scaly surface. Sometimes on the tip of the nose *Lupus Erythematosus* may appear rough and warty without inflammatory signs.

4. *Early Basal and Squamous-cell Epitheliomata*.—Keratosis solares undergoing development into these can be recognised by further elevation, but perhaps better by the touch. On palpation, keratosis give only a superficial