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IN TWENTY VOLUMES

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DISEASES OF THE SKIN

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Hidroadenitis.

Hidroadenitis, as described by Dubreuilh," is constituted of disseminated or isolated lesions. Even where these are very numerous in any one locality they are not grouped in patches except in rare instances and over limited areas.

The eruptive element shows itself as a minute nodule the size of a pin's head or grain of millet, hard, indolent, sharply defined, situated deep in the skin or even subcutaneously, scarcely causing an elevation of the overlying epidermis, which remains entirely unaltered. The presence of the lesion is hardly perceptible excepting to the touch, to which it gives the sensation of a grain of lead deeply embedded in the skin. This nodule grows in size very gradually and becoming adherent to the skin makes one mass with the latter. The skin then shows an elevated, red, inflamed papule deeply seated in the skin and which may attain the size of a pea. The lesion at this stage sometimes assumes a coppery tint, which causes it to resemble a syphiloderm so closely as to deceive the observer. Cases have thus been treated for syphilis.

When the lesion has attained its full development it is sometimes surmounted by a vesicle and sometimes goes on to suppuration. In the vesicular form, as observed by Bronson, the vesicle is not elevated, rather countersunk, and it frequently presents in its centre a minute crust raised by the underlying fluid. Dubreuilh has had occasion to observe under the microscope the beginning of this process. The crust occupies the sudoriparous orifice, and the congestive exacerbation continuing its evolution in the neighborhood leads consecutively to a fluid exudation in the epidermis, which raises up the crust with the horny layer of the epidermis. At the end of several days the vesicle may dry up and crust or a new suppurative process may follow.

When the lesion terminates in suppuration a small whitish point appears at the summit of the papule, which, when pricked, gives exit to a drop of pus. Pollitzer has observed the exit of a core like that of a boil in some of these cases. Pick has seen the entire nodule emptied out in the form of a soft mass of waxy consistence. When the pustules are small, covered with a thin epidermis and exposed to the air, they may dry up and crust over without breaking open, and a papule results with a brown adherent crust countersunk in the derma. No pus is found under the crust, but only a minute ulcer with excavated pits. If the lesion is larger, if the thickness of the epidermis or the protection of the clothing prevents desiccation, suppuration
takes place, the little abscess opens externally, and a crust forms from the desiccation of the pus which exudes. In some cases this is followed by desiccation, leaving a flat or sunken scar from a millimetre to a centimetre in diameter, according to the size of the precedent lesion. This cicatrix is at first red or pigmented but later becomes white.

The eruption may show itself in almost any part of the body, but the genitals have never been observed to be affected. Other parts, as the inguinal region, the popliteal space, the bend of the elbow, the abdomen, and the upper and middle portions of the back are rarely or slightly affected. The regions of predilection are certain portions of the face, the scalp, extending to the neighboring localities, as the anterior and lateral parts of the neck, the ears, and the inferior maxillary region, also the lumbar region and the extensor surfaces of the limbs. On the upper limbs the eruption predominates about the bend of the elbow, running up the posterior aspect of the arms and extending downwards on the extensor surface of the forearms, being especially marked upon the backs of the hands and fingers. The principal foci are generally observed upon the lower limbs, the thighs and the knees, and on the backs of the feet. It is sometimes observed upon the palms and soles. It has been supposed to occur also upon the buccal mucous membrane. The eruption of hidrosadenitis extends by the appearance of single new lesions. Sometimes a few appear at a time, or a number may develop in rapid succession at intervals. There is no general outbreak, however. It may be remarked that when the eruption is abundant the lesions develop more rapidly and suppurate more freely. In any case, however, a certain number of lesions become arrested in their development, become absorbed, and disappear without suppuration. There are no general symptoms which can be said to belong properly to the eruption. Lassitude, anemia, and digestive disturbances are sometimes met with, however.

Hidrosadenitis is an affection of slow development and long duration. Most cases persist for six months to a year.

The causes leading to the eruption are not known. The heat of summer causes an aggravation of the symptoms, but the general conditions just mentioned cannot positively be asserted to be of etiological moment.

So far as is known, hidrosadenitis is a purely inflammatory disease of the sweat glands. No microbes have been ascertained to be involved in the process, although the question of its microbic origin cannot be said to have been settled. The hair follicles in the neighborhood of the lesions are not usually involved. Barthélemy has
observed inflammatory lesions of the hair follicles and sebaceous glands, but such inflammation appears to be secondary.

The disease is not, properly speaking, a folliculitis or folliculitis as Brocq has called it, nor an acne or acnitis since the process does not involve the sebaceous glands or the hair follicles. The name hidrosadenitis therefore seems most appropriate.

**Diagnosis.**

The affection with which hidrosadenitis is most apt to be confounded is *acne varioliformis* (Hebra), *acne pilaris* (Bazin), and some cases of hidrosadenitis have been published under these titles. The *acne necrotica* of Boeck is seated upon the face and trunk and begins as a minute papule with a hair issuing from its centre. This papule grows little by little, takes on an edematous appearance, and shows a minute hemorrhagic point of a violaceous color which is highly characteristic. When it has acquired a certain dimension it becomes surmounted by a soft adherent crust which extends and covers the entire lesion. This crust covers a deep ulcer and only falls off when cicatrization is complete. It is derived, not from an exudation but from the necrosed derma; there is no suppuration.

*Acne pilaris* of Bazin, or *acne varioliformis*, is situated on the forehead just at the border of the scalp, in the beard, and in the fold of the ala nasi. The lesion, characterized by a yellow crust, usually contains a hair at its centre, does not suppurate, and terminates by a cicatrix; in addition, it is readily cured. Neither acne necrotica nor acne varioliformis begins by a deep intra- or subdermic nodule. The various forms of *folliculitis* are distinguished by the central hair and never occur on the palms or soles. The eruption known as hydroa vacciniformis (Bazin), summer eruption or *summer prurigo* (Hutchinson), is a disease of summer time only, is caused by light and heat, and is highly pruritic. The case published by Lukasiewicz under the name of *folliculitis exulcerans* is likewise to be distinguished from the affection under consideration. In this case the eruption forms groups with a centrifugal tendency. The lesions are not suppurrative but ulcerative, and form deep ulcers with a granular bleeding basis and a tendency to spread. Moreover, periostitis and violent pain in the bones and in the articulations are experienced. The lesions can only be cured by curettage. In Dubreuilh’s opinion, Lukasiewicz's disease is a granuloma which begins in the skin as a collection of embryonal cells with epithelioid and giant cells, and which reaches the surface and ulcerates but does not suppurate. The glands are only involved by subsequent invasion. Perry gives a representation of hidrosadenitis.
Under the name of *hidrosadenite phlegmoneuse et abces sudoripare*, Verneuil describes an affection of the sweat glands which also has been called sweat furuncle, and which occurs chiefly in the axilla, groin, around the nipple and anus, but also on the scrotum and perineum, the labia majora, the face, the thighs, the external auditory meatus, the palms, in fact at times on almost all parts of the surface excepting the soles. The disease often accompanies pruritic affections of the skin, particularly those of a parasitic nature, and is probably due to implantation of germs in scratching. Want of cleanliness, rough handling and friction, irritant applications, medicinal or other, the repeated introduction of foreign bodies into the external auditory meatus, etc., are among the exciting causes. As predisposing causes may be mentioned profuse sweating in the axillae, groins, genitals, etc., during hot weather, violent exercise, pressure of a bandage or splint, fissures occurring about the nipples in nursing, purulent discharges from the female genital organs, hemorrhoids, constipation, and, as has been mentioned above, various parasitic affections of the skin.

**Symptoms.**

The clinical appearances presented by phlegmonous hidrosadenitis differ somewhat according to the locality affected. In the axillae the affection is commonly observed during the summer, and in young persons more or less careless in their habits, when the axillae are constantly bathed in acrid and malodorous perspiration and provided with an abundant growth of hair.

The phlegmonous lesions may appear upon one or both sides simultaneously or successively. They may be single or multiple, sometimes confluent. They vary in size from that of a pea to that of a pigeon's egg. When fully developed they are, on an average, about the size of a cherry. They usually appear at the summit of the axilla, rarely at its circumference. When there are several they are usually seen at various stages of development. When discrete, the lesions present the typical appearance of an abscess; globular in form, with a hemispherical furuncular outline rising from the skin, and freely movable between the fingers and over the subjacent structures. At first firm and of an indolent appearance, without any change in the color of the skin they become at a later period red and inflamed, and soften at first at the summit and afterwards through the entire mass. When the disease centre is superficial or when there are numerous closely packed lesions the appearance presented is different. In the first case the skin becomes involved at an early period, it reddens, indurates in the form of more or less regular discoid plates movable
under the skin and slightly elevated above the surrounding surface. Later the plaque seems to become segmented, several prominent points appear upon its surface, separated by fissures of greater or less depth and which may show isolated points of fluctuation when the skin covering them becomes thin. When the phlegmons, at first separated, become packed together by their several growths, they become deformed by mutual pressure and display irregularly shaped prominences separated by fissures dependent upon the folds of the skin.

The last-described variety of phlegmonous hidrosadenitis is that usually observed upon the surface of the skin, generally when the integument is thicker and is raised up with more difficulty. The skin here is inflamed almost from the first, while redness, tenderness to the touch, and pain in movement are also perceived at an early period. The globular phlegmon, on the other hand, remains latent for some days and develops in the loose subcutaneous tissues, showing local reaction only when the skin itself becomes distended and ready for perforation. This form of hidrosadenitis may become the point of departure for sudoriparous adenoma.

Phlegmonous hidrosadenitis of the margin of the anus was formerly called by Velpeau “hemorrhoidal abscess.” It does not, however, occur in the hemorrhoidal tumors themselves but in the tissues around the margin of the anus to the distance of about an inch. The tuberiform abscess, as Verneuil has called it, sometimes forms in the radiating folds, sometimes in the smooth margin around the anus, and may be single or multiple to the number of four or five. Usually only one occurs at a time, but relapses are common. The anal abscess may become transformed into a perineal abscess. Verneuil describes a case of the kind. Fistulous tracts not unfrequently form, but these never communicate with the intestine, a point of importance in connection with the distinction which should be made between this affection and the ordinary ischio-rectal abscess.

Hidrosadenitis of the anal region manifests itself first in the form of anal pruritus. The patient scratches himself during sleep, giving rise to fissures, excoriations, and crusts. After a time, on washing himself or in some other accidental manner, the patient perceives a small subcutaneous irritation the size of a cherry stone, hard, sharply circumscribed, mobile under the skin, and not markedly adherent to the latter. There is no spontaneous pain although the tumor is sensitive to the touch, and, sometimes at the moment of defecation gives rise to a slight tenesmus. For three or four days the process remains in this stage, but the induration increases and elevates the skin, which becomes adherent; the surrounding cellular tissue becomes involved in the phlegmonous process. The tumor, up to this time
globular, becomes changed to an irregular shape according to the region invaded. It becomes flattened by pressure of the buttocks, and elongated in the direction of the folds of the anus and extends in an oval form towards the rim of the scrotum and the perineum.

The growth continues, the skin becomes thinned over the centre of the tumor, and of a livid red color, exfoliates, and shows fluctuation in the neighborhood of the point where the induration originally appeared. At this period considerable pain is experienced; walking becomes difficult, and sitting down as well as defecation gives rise to extreme discomfort, which, however, is relieved upon lying down. The pain is, however, not severe and is superficial and evidently due to the secondary involvement of the skin. Left to itself the tumor breaks down and discharges even before the entire mass becomes fluctuating. Sometimes this process is less painful than even the slight puncture necessary to evacuate its contents.

Phlegmonous hidrosadenitis of the areola of the nipple and of the skin generally scarcely merits a particular description. Verneuil gives a very minute study of all the various forms of the disease, and the student may be referred to his voluminous paper for further details.

**Diagnosis.**

Perhaps the most important point which remains to be considered is that of diagnosis.

As regards abscess of the external auditory meatus, this differs from hidrosadenitis as met with elsewhere, inasmuch as there is no globular or hemispheric mass such as is observed elsewhere. It is impossible to find any fluctuating point where the bistourey can be used. The entire canal is red and tumefied. There is no superficial, acuminate projection as in furuncle.

In other localities, as in the ear, furuncle is the only affection with which phlegmonous hidrosadenitis is apt to be confused, and, in fact, the affection under consideration is almost always mistaken for furuncle. The distinction can be made, however, without difficulty.

Furuncle always begins at the surface and only later attains the subcutaneous cellular tissue, because it is seated in a pilous or sebaceous follicle and never in the deeper areolar cavities of the derma. At whatever period it may be examined it is always found surmounted at its centre by a conical elevation often perforated by a hair. When an opening is made at this point, only a minute quantity of pus exudes, and no relief from the pain is gained until after the relatively late discharge of the core, leaving behind it a gaping cavity in the centre of the induration.
Phlegmonous hidrosadenitis, on the other hand, always begins beneath the skin and only invades the skin subsequently. No conical elevation surmounts the lesion, and no discharge takes place until the lesion is opened by artificial means, when the affection rapidly heals up.

Sometimes, during the first days of the process, phlegmonous hidrosadenitis may resemble erythema nodosum or syphilitic gumma, but the course followed by these affections is so different from the disease under consideration that a short period of observation will settle the question.

TREATMENT.

The treatment of phlegmonous hidrosadenitis consists in cleanliness and antiseptic precautions, with appropriate means for the prevention of excessive sweating. When ripe, the abscess is to be opened, whereupon a speedy cure results.

Bibliographical References.

7. Aubert: Lyon Médical, December 27, 1891.
13. Andrés: St. Louis Medical and Surgical Journal, December 7, 1887.
29. Robinson: Journal of Cutaneous and Genito-Urinary Diseases, August, 1898.
32. Perry: Atlas of Rare Skin Diseases, Part 3, 1890.