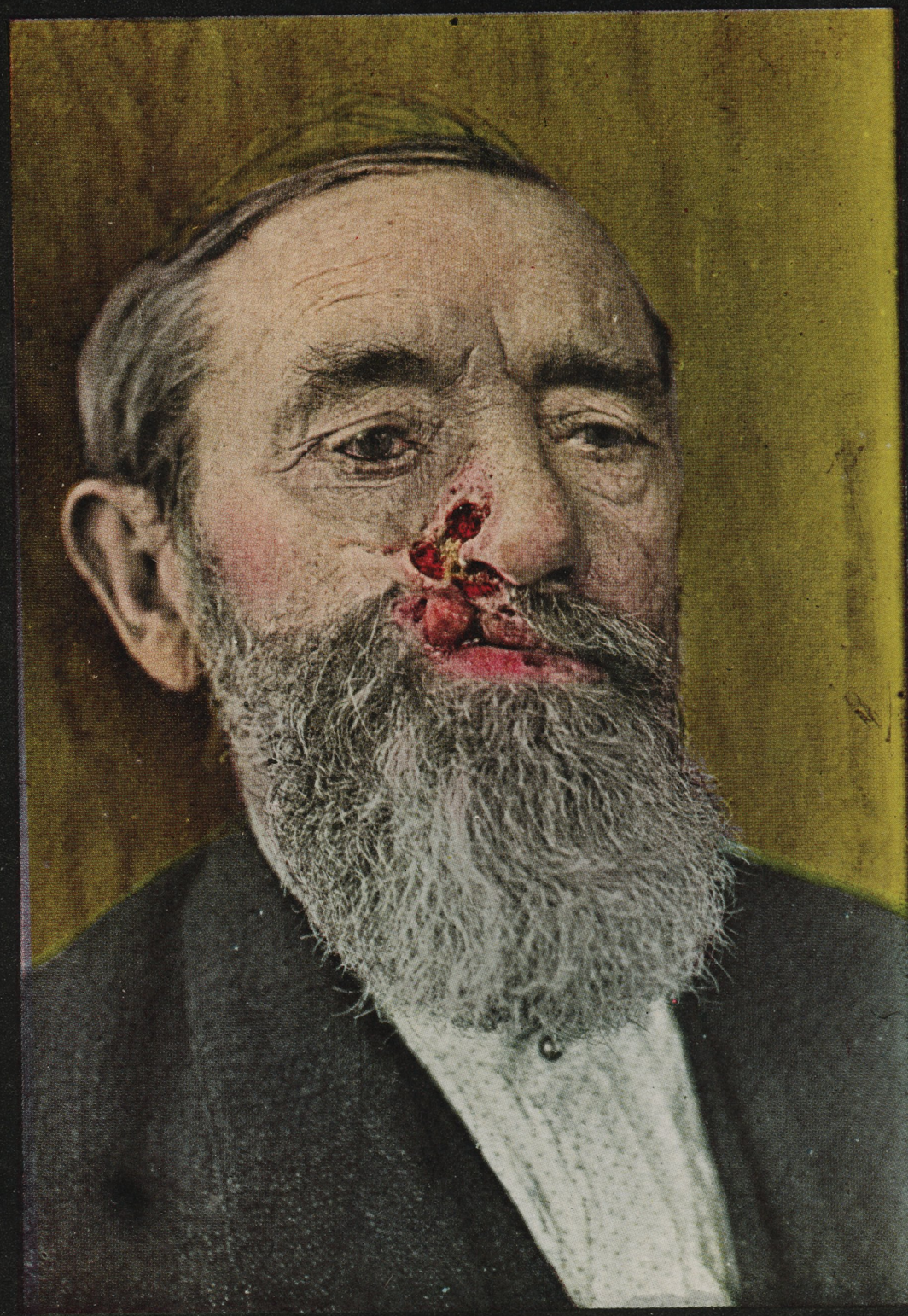

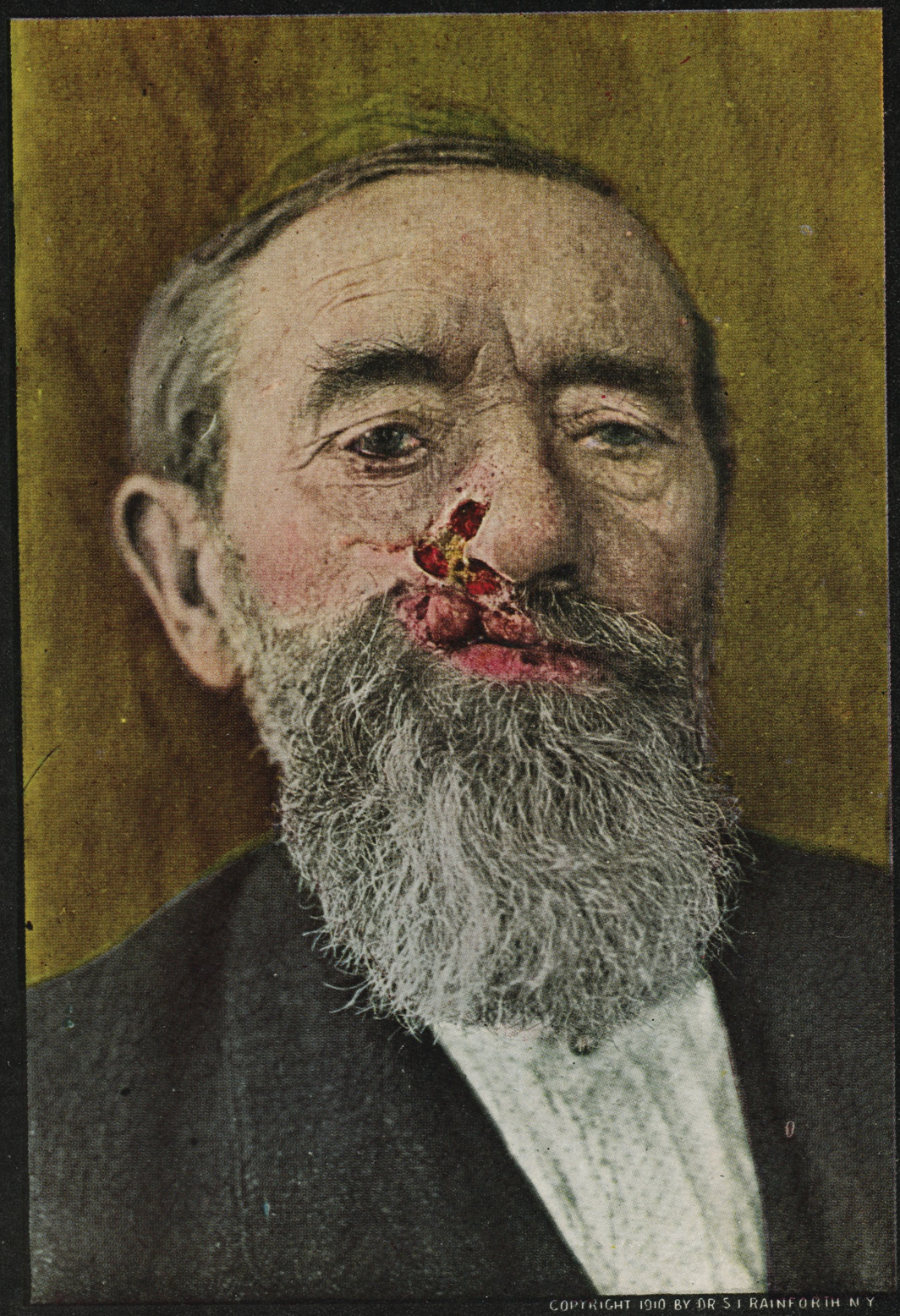

EPITHELIOMA

Ulcus epitheliomatosum

Epitheliomatous ulcers, like epitheliomatous tumors, may be classified as superficial and deep. The superficial is variously known also as Rodent ulcer, Jacob's ulcer, Cancroid ulcer, Ulcus exedens, and Noli me tangere. When first formed it is shallow and roundish, with sharp edges and an elevated, waxy, telangiectatic border. The floor may be crusted, moist, or covered with a varnish-like glaze. It is red or brownish red and often slightly uneven or mammillated. The ulcer may remain almost stationary for years and then increase in size, or it may spread slowly and steadily from the start. In its progress it usually becomes irregular in outline, Sometimes the waxy border disappears in great part and only a few nodules of it remain. Quite rarely cicatrization occurs in the older portion of the ulcer. With increasing activity, in some cases, the raw base may sprout forth pink or red masses of vascular tissue resembling exuberant granulations, but much more firm. These masses sometimes assume papillomatous or cauliflower-like forms. The superficial ulcer ultimately becomes converted to the deep form, but not as a rule for several or many years, and until such change occurs the epithelioma exhibits very little tendency to involve lymph glands or to propagate by metastasis. The deep ulcer is like the other except that its delicately vascularized waxy border is often much more prominent and the edges of the ulcer are usually steeper and sometimes undermined. The floor is more irregular because of the tendency of the growth to encroach far beyond the skin upon muscle, fascia, cartilage and bone. There is apt to be a more pronounced secondary inflammation, with consequent greater vascularity and tendency to bleed, with pain, redness, infiltration and purulent discharge, though the last is never profuse, as it is with syphilitic ulceration, for example. The destruction is usually steadily progressive and relatively rapid. The only evidence of any tendency to recovery is the rare formation of scar tissue in an old part of the ulcer. Neighboring lymph glands sooner or later become involved. Lancinating pains are often experienced as the result of nerve filament implication. The prognosis is always grave and especially after glandular involvement. **DIAGNOSIS:** A *syphilitic ulcer* usually starts earlier in life, spreads with greater rapidity and is associated with or follows other manifestations of the disease. It is often multiple, frequently reniform or horseshoe shaped, with a more marked tendency to cicatrize. The discharge is generally free and distinctly purulent. The syphilitic ulcer is not painful. Its margin rarely bears any resemblance to the roll-like, waxy, vascular edge of the epithelioma. *Lupus vulgaris* begins at a much earlier age. Its ulcers are shallow, with soft and often undermined edges. The tendency to the formation of scar tissue is pronounced, and apple jelly nodules are frequently to be found. **TREATMENT:** The treatment of the superficial ulcer has already been given under Epithelioma superficiale. An extensive ulcer need not be treated all at one operation. It is better to make several applications of the carbon dioxid upon different parts of the lesion. If papillomatous masses spring up under the eschar it is an indication that the destruction has not been thorough. The crust should be removed, the masses curetted away and the part again frozen with a longer application of the carbon dioxid. The deep ulcer is not suitable for congelation. It should be completely excised together with the neighboring lymph glands. If the epithelioma is inoperable the carbon dioxid may be used to check its progress. Some cases have been greatly benefited or even cured with the X-rays.