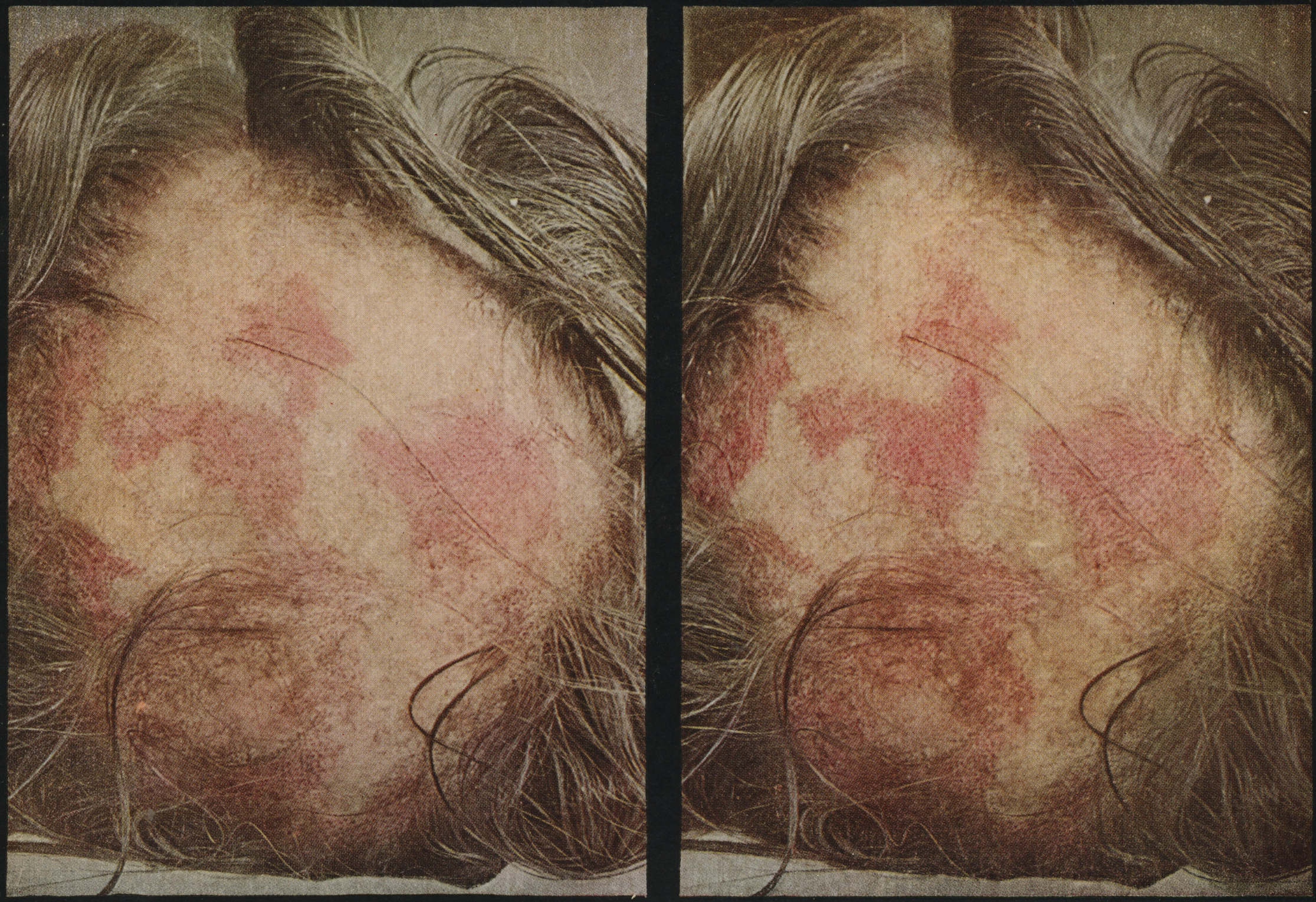

LUPUS ERYTHEMATOSUS

Synonyms: Lupus erythematodes, seu sebaceus, seu superficialis; Seborrhoea congestiva; Ulerythema.

Lupus erythematosus begins as a slightly elevated, broad, moderately inflamed papule, slowly spreading peripherally to form a patch which is covered irregularly by grayish or yellowish firmly adherent scales. Two or more such patches may become confluent. The borders are sharply defined, more or less raised, of a red or characteristic violaceous color, and often studded with enlarged sebaceous openings, The center of a patch generally, sooner or later, becomes cicatrized and atrophic, and sometimes transversed by telangiectases. The scar is delicate and pale, never puckered or deforming. Lupus erythematosus tends to be symmetrical in its distribution, and its favorite localities are the nose, cheeks, ears and scalp. It rarely occurs elsewhere. Not infrequently a lesion begins on the nose and spreads over the cheeks in a butterfly-shaped pattern. Patches on the scalp are usually secondary and associated with lesions on the face. On the scalp the inflammatory element is, as a rule, less pronounced, the scars are slightly depressed below the level of the skin and the alopecia is permanent. Burning and itching may or may not be present; they are not the rule. The general health is not affected. Lesions occasionally disappear spontaneously with or without scarring, but relapses are common and new patches usually arise as others retrogress. In the large majority of cases the patches are permanent and progressive, although the extension may be extraordinarily slow. Lesions practically never undergo malignant transformation. The disease usually begins after twenty and is twice as common among women as among men.

DIAGNOSIS: *Eczema* itches, changes rapidly in appearance, its patches often ooze, are seldom sharply circumscribed and never cause atrophy, and usually vesicles and papules are to be found. *Eczema seborrhoicum* may be sharply bordered, but its color is more yellowish and its scales more greasy, and patches on the face are nearly always associated with a seborrhoeic condition of the scalp. *Syphilitic* lesions are more yellowish red, more infiltrated, extend more rapidly, and are associated with other syphilitic manifestations. *Lupus vulgaris* begins earlier, does not tend to be symmetrical, is marked by the presence of tubercles and ulceration, and its scars are tough and fibrous. **TREATMENT:** Quinine is frequently prescribed in five-grain doses three times a day, the number of doses being gradually increased until the patient is receiving as much of the drug as he can tolerate, and decreased as the patches begin to fade. This medication is usually combined with the external application of iodine. Collodium salicylatum compositum applied daily will sometimes cause the disappearance of a patch. Finsen light and X-rays cure many cases. In some instances, however, the X-rays have aggravated the condition. Solid carbon dioxid, used as a caustic, yields the best results. A mass of carbon dioxid snow should be so moulded that one surface will completely cover a small patch, or a portion of the erythematous border. The surface of the snow should be moistened with ether and then applied to the lesion with firm pressure for from 30 to 90 seconds. The eschar which forms in forty-eight hours falls off in about ten days and leaves a smooth scar.