

1921

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BENCHIMOL, JL., and SÁ, MR., eds. and orgs. *Adolpho Lutz: Dermatologia e Micologia = Dermatology and Micology* [online]. Rio de Janeiro: Editora FIOCRUZ, 2004. 620 p. Adolpho Lutz *Obra Completa*, v.1, book 3. ISBN: 85-7541-043-1. Available from SciELO Books <<http://books.scielo.org>>.



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Contributions to the History of Medicine in Brazil. Dermatological Reminiscences*

by
Dr. Adolpho Lutz

(1921)

The following notes refer to skin diseases observed by me during a period of forty years interrupted only by a few longer absences from Brazil. A large number of the observations were made in the coffee zone or in the capital of the State of S. Paulo. Many other cases were seen in Rio de Janeiro, the federal capital or in other states of Brazil. Not only the frequency, but also the absence of certain diseases seems of interest as it also furnishes many etiological indications.

For instance, I only saw two cases of genuine *Psoriasis* in Brazilian patients and a few other imported cases. It is interesting to note that one of the Brazilian patients was working with a foreigner, who had very intense psoriasis, when he acquired the disease.

I never observed *Mycosis fungoides* in Brazil, but saw two cases of this rare disease in New York. The second was consequent on placing the patient in a bed by the side of the first. These two parallel cases show that even in quite sporadic diseases the possibility of direct or indirect transmission cannot be excluded.

Another disease which is almost entirely lacking in the rural zones of Brazil I know is *Lupus vulgaris*. I attribute this disease to the inoculation of bovine tuberculosis by insect bites. The cattle in the interior of Brazil is seldom tubercular but bovine tuberculosis is common in milk cows kept in cities. I saw two autoctonous cases of *Lupus* in cities of S. Paulo and Rio de Janeiro, both incipient.

Other diseases which are rather common in the Dermatological Clinics in Europe, such as *Lichen ruber*, *Lupus erythematosus*, *Epitheliomata* and *Rhinoscleroma*, I found rare among patients in the interior of Brazil. In the large cities with a mixed population, partly composed of immigrants, the pathology of the skin is more cosmopolitan in character.

Some more or less congenital diseases such as *Ichthyosis*, simple *Angiom*, all sorts of *Naevus*, dermoid kysts and *Recklinghausen's* disease are neither very rare nor unusually common. *Lipomata* and *Fibromata* occur as elsewhere: sebaceous kysts are rather frequent.

* Published originally as "Reminiscências dermatológicas", *A Folha Medica*, v. 2, n.19, p.145-6, 1921-1922, and also as *Reminiscências dermatológicas. Segundo Congresso Sul-Americano de Dermatologia y Sifilografia*. Tip. San José 938, *El Siglo Ilustrado*, Montevideo, 1922. In the edition of this same article found in *Memórias do Instituto Oswaldo Cruz*, t.44, fasc.1, p.1-6 (Portuguese), 7-12 (English), March 1946, there is the following editor's note: "These reminiscences were written by the late Professor A. Lutz in 1921 when he was drawing up his memories of a long medical career. It is now published as one of the series: Contributions to the History of Medicine in Brazil". That is the edition chosen to be reproduced here [N.E.].

The most prevalent diseases are those connected with climate, local habits and fauna.

Hot climate causes profuse perspiration which in its turn produces prickly heat, or dyshydrosis and furunculosis of the axillae sweat glands. This affection is mostly left unmentioned in text books on Dermatology, though it is rather common in hot countries. *Dermatomycoses* are also favoured by perspiration and *Eczema marginatum* may invade the skin out side its usual seat.

Excessive perspiration and the bites of insects and arachnids produce violent itching. Like in scabies scratching with the finger nails may produce impetiginous, ecthymatous and furunculous processes. They are due to pyogenic cocci and are sometimes incorrectly named pyodermites for short. They often leave superficial ulcers, especially on the legs of children, which in popular language are called wounds or “perebas” in Brazil. They may lead to either acute nephritis or to spirillar infections, from which phagedenic ulcers may result. *Miyasis* as a complication is rare.

The habit of going barefoot and exposing the legs favours all sorts of infections through parasites. *Necator americanus*, *Larva migrans*, *Tunga penetrans* and the organisms responsible for *Mycetoma* and phagedenic ulcers usually invade the body through the feet.

Other kinds of ulcers also tend to become localized on the legs. Some of them attack the feet and lower parts of the legs simultaneously and produce a hard elephantiasis hypertrophy. These affections have not been well studied as yet. They may take the form of large groups of simple warts, or of fibrous nodes, or may become papillomatose and keratotic. The latter forms named “*Mossy Foot*” by Thomas have been attributed to Leishmaniasis. I doubt whether this etiology applies to all cases but further parasitological and therapeutical information is very much needed before the subject can be profitably discussed.

Cutaneous Leishmaniasis may occur on any exposed part of the skin, a fact which is in agreement with its supposed transmission by *Phlebotomus*. This genus of Diptera is not ubiquitous and in Brazil it is unknown in some extensive and populous regions. It only became familiar in S. Paulo and around Rio after the building of railways. Cases of *Leishmaniasis* are rare and sporadic. This also applies to some phagedenic ulcers. Large numbers of cases may occur in certain regions but they are not really common diseases.

Blastomycosis caused by *Coccidioidis immitis* and *Sporotrichoses* are rare and always sporadic. This is also the case in venereal granulomata and phagedenic chancres.

Besides the etiologic factors already mentioned some others play a role in the etiology of ulcers. Among them are syphilis, leprosy, ankylostomiasis and varicose veins. The ulcers formerly seen in parasitic anaemia were more like phagedenic ulcers than like common ones, but were cured by expelling *Necator americanus*. An attenuated virus may be responsible for them.

The same may be said about certain trophic ulcers seen in cases of leprosy which cannot be entirely explained either by diminished sensibility or by the bacillus, which may be absent from them. Nor can simple ulcers be attributed solely to the presence of varices. Some reveal their syphilitic origin by being easily cured with iodide preparations even when they do not have the appearance of gummatous lesions. Most of them have the aspect and localisation characteristic of simple ulcers and may be cured by rest without specific treatment, but the cure is seldom permanent.

This is an important problem as shown by the fact that in the capital of the State of Pernambuco there is a hospital for ulcerous patients that generally houses over a thousand

cases. Of those I examined, only a few were due to Spirillosis and none to Leishmaniosis. The greater number seemed to be syphilitic. The abundant material provided by such institutions deserves to be used for the study of both etiology and therapeutics.

I would like to briefly mention a few exotic diseases introduced with slavery. The principal one is *Framboesia tropica* which is now growing rare. The Brazilian name *Boubas* should be reserved for this disease but in the state of S. Paulo it is in quite general use as a synonym for syphilis. I only had a very few cases of yaws in my private practice but saw a larger number in dermatological wards. The possibility of transmission by an insect should be investigated.

Ainhum is almost extinct nowadays. I only saw one case in my practice. A focus of *Filaria medinensis* existed for many years in the state of Bahia but is now only of historical interest.

The large number of ectoparasites, both periodic and permanent have two different functions in dermatology. They produce a local irritation and they serve as transmitters of localised or general infections. Scabies is not very rare, head lice are very common. The other kinds of lice are with a few occasional exceptions almost unknown in Brazil. The larve of Thrombiidae and Ixodidae are extremely irritating; so are some species of *Simulium* and of Culicoides and to a lesser extent some Culicidae. Tabanidae and some species of *Phlebotomus*.

Several diseases transmitted by insects affect the skin, such as *exanthematic typhus*, which has been observed several times in S. Paulo and in Belo Horizonte, the capital of Minas Gerais. *Dengue* occurred sometime ago in Rio and more recently in S. Paulo. *Miliaria epidemica*, observed in S. Paulo many years ago also seems to belong to this group. It is very well characterized by high fever and abundant sweating. Exanthema is constant but it is not specific, being only due to perspiration. Mortality is very high but there are no recidivism.

Inflammatory nodes produced by the bites of ticks, which may persist for several months and be very similar to anatomic tubercles, are not uncommon in Brazil. In other cases, groups of infiltrated nodes or glands may be observed, and they also may be very persistent. Some cases of *Pseudoleucaemia lymphatica* seem due to infections through the bites of ticks.

Many years ago, I treated a case of multiple lymphomata distributed over the whole body, with increasing doses of an arsenical Fowler's solution during two months without results. I decided, nevertheless, to continue the treatment and during the third month the lymphomata disappeared entirely. Much later I was called into consultation for a similar case, the patient being a young girl whom I had known since her birth. Two colleagues had made a very unfavourable prognosis based on the clinical symptoms and examination of the blood. Having the former case in mind, I suggested the use of the same treatment. I had the great satisfaction of obtaining a complete cure within a reasonably short period of time by the internal administration of the same arsenical solution. The interesting point about this case is the fact that the lymphoms appeared after a visit to a farm where the patient was very badly bitten by ticks. In both cases the cure seems to have been complete and definitive. I believe that *Ixodidae* sometimes inoculate a virus. Acid fast and pseudo diphtheric bacilli should be looked for, as they have sometimes been found in similar cases.

While discussing diseases whose transmission may be due to insects. *Leprosy* should be mentioned. I have seen a large number of incipient cases and have come to the

conclusion that in many of them the initial lesion was an erythematous plaque which may well indicate the point of inoculation. This lesion generally occupies a part of the skin normally left uncovered. Many authors believe these erythemata to be consequent on nervous and vascular lesions. The spots, which occupy the middle line of the body, do not favour this theory. On the contrary, the process seems to spread on the skin in the same manner as a dermatomycosis, or a spot of oil on a sheet of paper. The same observation applies to simple *Vitiligo*, which is rather common in Brazil and particularly noticeable in coloured persons. The etiology is unknown. It seems independent of other diseases.

I shall not discuss the cutaneous lesions due to the bites or stings of poisonous animals, which are also favoured by the habit of going bare-foot, but shall mention the dermatitis produced by the urticating hairs of some caterpillars as they are very liable to lead to wrong diagnoses. I was once asked to examine a lady who had suddenly developed an erythema of the face while travelling on a street car. I saw at once that it was due to the hairs of such caterpillars from the branches of trees which swept the open cars on an avenue.

General eruptions are not rare in persons sensitive to certain drugs such as mercurial substances, sublimate, iodoform etc. One of the most interesting case I saw was due to rubbing with a pencil of menthol against headaches. Not only did the forehead show striated crusts corresponding to the lines of contact but there was also a generalised eruption which lasted for some weeks.

Pellagra deserves a few words. It seems to be a sporadic disease. I did not have the opportunity to see it among patients treated by me. I did, however, observe fifty cases of a somewhat similar disease, in the interior of the state of S. Paulo, which I described under the name of *Pellagroid*.¹ It is characterized by inflammation of the mucous membranes, oedema and a hypostatic eruption, which is first red and then becomes livid and no longer vanishes on compression. It attacks mostly infants who are not breast fed. It lasts from two to three months and is often fatal, death following on extreme cachexis. During the last hours keratomalacia often sets in and may be so severe as to induce perforation of the corneas. After leaving that zone, some thirty years ago, I have never had the opportunity to see other cases of *Pellagroid*. Six or seven years ago, I was however informed by a physician from Puerto Rico that the same symptoms have been observed on that island where the disease is known by the singular name of "La Bonita".

I should like to mention another disease which I had the opportunity to see in the practice of a colleague in the interior of the state of S. Paulo. It was similar to a case of gangrenous ergotism as the gangrene was symmetric with mummification of the hands and feet. Unfortunately no information on the etiology could be obtained as the patient was an idiot and unaccompanied by anyone able to supply information.

I shall end by mentioning another skin disease which is not very rare in the northwestern part of the state of S. Paulo and some other areas around it. There is a more or less generalised dermatitis which at first shows the characteristics of *Ptyriasis rubra* and later of *exfoliative Dermatitis*, or *Pemphigus foliaceus*. It is chronic and prognosis is uncertain. There are instances of spontaneous cure but other cases have a long evolution

¹ See II. Monatsh. f. pr. Derm. 1885, p.433 & v. 1886, p.32-3.

and end fatally. If the disease were not so extensive as to occupy almost the whole surface of the skin, one might expect a certain benignity. It is, however, much more severe than *Tinea imbricata* or *Tokelau ringworm*, with which it has been confounded. *Tinea imbricata* is a completely mild affection which I have observed elsewhere but which does not occur in South America, not even among native Indians. *Caraté* or *Mal del Pinto*, is a different disease according to the information contained in the literature or obtained privately.

