THE WHITFIELD TRADITION OF THERAPY*

BY

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Arthur Whitfield was a great man; and he began to practise dermatology in London in the days of the giants—days when Colcott Fox taught him much, when Pringle was a gay expert in dermatology and sartorial perfection, when Radcliffe Crocker published his unrivalled textbook on diseases of the skin. He must have met and probably argued with Jonathan Hutchinson. He enlarged his experience of dermatology and dermatologists by travelling to, and often staying to study in, the clinics famous at that time in Germany, Austria, and France. He knew and learned from their great dermatologists; and in turn the great ones from all over the world came to see him and share their experience. Most of these, of course, he long survived, for it was not until 1947 that he was lost to us. One who had, it seems to me, much in common with him, thought like him, and was his friend, has died only this year and left a gap that cannot be filled; I speak, you must know, of Dr. H. W. Barber, who, in his knowledge both of dermatology and of the good things of life, was very like Dr. Whitfield; we mourn their loss but can be glad of the broad traditions that such as these have left us. But, as well as broad traditions of thought and practice, they have left behind particular and more especial notions of treatment which often seem good to those who learn them and who still use them. Sometimes these notions are well known to a wide circle, sometimes they remain unbroadcast. Every skin department has its ideas carried on from each senior to his junior, and every skin department worth its salt thinks its own ideas are the best. I was lucky enough to look after a few of Whitfield's in-patients when I was a house-physician, but most of what I have learned of his ways has been passed on to me, sometimes modified a little, by my senior colleague at King's College Hospital, Dr. Sydney Thomson, in whose debt because of this—and for many other reasons—I shall always be.

Some of Whitfield's Wrinkles

Many of you will know of Whitfield only because he had an ointment. Many men have their names irrevocably attached to syndromes—and the purists often disapprove of this, although I must say I enjoy the synopsis of medical history it provides. It might well be said that what the patient wants first is treatment and only secondly a diagnosis. Therefore there is much honour and glory in having your name attached to an ointment—an honour that few apart from Lassar and Whitfield have achieved. It is an interesting dermatological exercise to think of other examples; it would make a good subject for an after-dinner quiz. To me it is an interesting fact that after some 50 years it is very doubtful whether in practice there is any fungicidal preparation better than Whitfield's ointment. People have modified it from time to time, perhaps changing the base, perhaps adding something like undecylenic acid, of which the best to be said is that at least it does no harm—

but I have a feeling, sentimental if you like, that the original formula takes some beating; and here it is:

Benzoic acid	25 gr. (1.6 g.) (5%)
Salicylic acid	15 gr. (1 g.) (3%)
Soft paraffin	120 minims (7.1 ml.) (25%)
Coconut oil	to 1 oz. (28 ml.)

But treatment of a fungus infection is not simply a matter of a pot of Whitfield's ointment. Diagnosis comes first. As Whitfield said: "The ideal treatment of any skin disease should, of course, be based on an accurate knowledge of its aetiology and the possibility of removing the cause. Unfortunately, however, there are many cases in which our knowledge is not sufficiently advanced to enable us to deal with them in this rational manner." Fungicidal preparations are often fierce, and I must stress the need of being happy about the diagnosis before starting treatment with them. Every skin lesion on the feet, for instance, is not due to a fungus infection. How often dermatologists see things such as contact dermatitis of this area, simply sweaty and macerated feet, true eczemas, psoriasis, and the rest distorted and exacerbated by the latest fungicide.

Fungus Infections of the Feet

Whitfield was one of the first to divide fungus infections of the feet into three groups, one, two, or all of which may be present in the same patient. Firstly, the interdigital; secondly, the infection of the instep; and, thirdly, that hyperkeratotic form which may be diffuse over the soles or localized, particularly to the heels in middle-aged women, and which is difficult to differentiate among other things from psoriasis, from eczema, and from the callous skin of an overworked or architecturally inadequate foot.

Whitfield knew of the difficulties of treating ringworm of the feet, especially of the toes, "when the thick horny layer between and beneath them renders it almost impossible to get the parasiticide in contact with the fungus." He therefore produced a lotion for the purpose of stripping the horny layer and exposing the fungus. This is:

Benzoic acid	180 minims (10.7 ml.) (5%)
Salicylic acid	120 " (7.1 ml.) (3%)
Acetone	2 oz. (57 ml.) (25%)
Spirit. vin. methylat. industr.	to 8 oz. (230 ml.)

This is used, after trimming away all flaps of frayed skin and removing roofs of any vesicles and pustules, as a wet dressing four times a day. Strips of gauze soaked in the lotion are put between the infected toes. These dressings are continued for a week, and it is an exceptionally hard horny layer which can withstand this keratolytic onslaught. Thereafter the ointment is rubbed into the affected areas twice a day until clinical cure seems to have happened, and for yet four more weeks after this. Even that is not the end: for two years a simple foot-dusting powder such as the compound powder of salicylic acid is regularly used. There are many proprietary powders which will serve the same purpose. Whitfield always stressed the need for attention to the details of treatment.

There is much to be said for washing the feet carefully with soap and water before each treatment, drying thoroughly with a soft towel, and rubbing away debris and fragments of dead skin. The towel obviously is kept for this purpose only, and it must regularly be boiled. Cotton undersocks should be worn and boiled after each day's use. At night cotton socks should be worn. Footwear can be infected by a fungus; perhaps it is not too obsessional to suggest that it should be washed well with 10% formalin and allowed to dry for 24 hours. Separate bath mats for foot-fungus victims give some confidence to other members of the family. I believe that if all these things are done, cases of athlete's foot mostly get well. But cold weather and the retreat of the fungus into invisible winter quarters often lulls into false security: in the spring the fungus, like Caesar's legions, becomes active again, no less formidable, no less infuriating. The battle must be steadfastly and boringly carried on if cure is to be achieved. Whitfield, it

*Read in the Section of Dermatology at the Joint Annual Meeting of the British Medical Association, Canadian Medical Association, and Ontario Medical Association, Toronto, 1955.

is interesting to note, had some difficulty in collecting a series of these cases nearly 50 years ago. By 1921 he was writing at greater length in his textbook on this condition: "Since the war, it has become really common." What would he have said now when fungus infections are so prevalent that, whatever the skin condition, almost the first thing we consider is a fungus infection? Many dermatologists at necropsy will be found to have the words *Trichophyton rubrum* written on their hearts.

The famous ointment, of course, is valuable for treating ringworm elsewhere in the body, but even Whitfield had no certain cure for that condition we do not wish on our worst enemies, ringworm of the nails.

Treatment of Psoriasis

Psoriasis, to quote the master, "is a disease with regard to which we may say that we have a strong influence over the eruption at any given time but none over the ultimate course." Local treatment is of great importance, and, generally speaking, the less elegant—or can I say the muckier—the local application the better the results. The chrysarobin of Whitfield's day has given place to its close relation dithranol, which is surely the most efficacious thing to use on psoriasis. Half per cent. dithranol in Lassar's paste, as recommended by Dr. Ingram, of Leeds, is, as the history books and the "bookies" say, a good thing. But do not put it on the head and neck, and never on angry psoriasis. Combined with tar in a daily bath and with sunlight treatment—the Ingram drill—it is highly successful.

However harmless to the body general psoriasis may be, there is no doubt that patients afflicted by the disease suffer much and miserably from self-consciousness of their condition. They know only too well that conspicuous lesions lead their neighbours to think that they have some awful contagion. It is a pity that we have not yet educated people to know that scarcely any skin condition is contagious and that scarcely any skin condition is due to diet or lack of cleanliness. Psoriasis, fortunately, usually spares the face and hands, but on the scalp it is all too common. I think it unusual for psoriasis of the scalp not to respond to the following regime. On two nights a week the dilute ointment of mercury nitrate is rubbed well into the affected parts of the scalp. Mercury, indeed, is one of the things most efficient against psoriasis. On the following morning the unpleasant ointment is removed with a simple shampoo. On the other nights and each morning some of this cream is applied:

Liquor carbonis detergens ..	60 minims (3.6 ml.)
Salicylic acid	10 gr. (0.65 g.)
Emulsifying base	to 1 oz. (31 g.)

If and when the lesions on the scalp are controlled, the mercury ointment can be dropped.

Internal treatment plays a part, too, in the control of psoriasis. Whitfield liked arsenic, especially for those whose psoriasis began in childhood. Nowadays we regard this drug as dangerous, and rightly so; hands ruined by arsenical hyperkeratoses are no pleasant testament to therapy. Therefore it must be used with discretion. It will sometimes work the oracle in difficult psoriasis when other things, even the most up-to-date steroids, have failed. Small doses, say 3 minims (0.18 ml.), of Fowler's solution, given never longer than for six weeks, can be tried. If a consultant is to be defined as one who can always suggest to a baffled colleague yet a new line of treatment, then sodium iodide is another remedy for psoriasis to be kept up the consulting sleeve. I have a feeling that it is of value in the arthropathic type of psoriasis.

This brings me to the question of focal sepsis. Whitfield recognized, as we all do, that generalized, blood-spread, guttate pattern of psoriasis common particularly in children 10 days after tonsillitis. Something reaches and damages the skin, psoriasis appearing at the site of the trauma.

Whitfield grew up in dermatology at a time when focal sepsis was as fashionable as an operation for that new disease appendicitis, and it was almost a routine to remove the colon to free a patient from harmful toxins. Whitfield thought that something absorbed from organisms in the gut could damage the skin in the same way as something from dirty tonsils. He described a little-known condition called by him dermatitis colonica, in which there is always a marked excess of the *Streptococcus faecalis* in the stools. I have no doubt this entity exists; indeed, I have seen it. Inevitably, therefore, he used to treat psoriasis—particularly if it began after puberty—with intestinal antiseptics such as creosote, dimol, and kerol. Nowadays one of the insoluble sulphonamides is worth a place in the team.

Finally, what about psoriasis when the first attack is after the menopause? Many of these patients have a raised serum cholesterol; I am not suggesting that there is any clinical evidence of myxoedema, but the response to thyroid is very often quite remarkable. I do not think one should be too hesitant about the dosage. I commonly start with 1 gr. (65 mg.) twice a day: some physicianly colleagues disapprove, but I have seen no trouble from this source. It seems to me to be especially helpful in cases of psoriasis affecting the ano-genital area, in which site the proper diagnosis can be elusive. Of course, there is a fanciful modern modification of this, which is the giving of heparin because of its effects on lipids. In moderate dosage, and in my hands, heparin proved quite useless. This line of thought may perhaps result in something emerging which will help at least some psoriatics.

Warts

I hope I will not be thought a little childish if I refer to two methods of treating warts. Warts vulgar, warts plane, warts plantar, warts filiform, warts in their thousands, warts fighting a lone battle—these invade our skin clinics in battalions. Their very numbers make it impossible for us to shoot them all down by mechanical means; we start with gentler methods of persuading them to disappear, with the patient doing the work. Remember always that you must be firm and confident with warts, looking them straight in the eye and telling them they must go. Without such certainty of success, any treatment will fail; even with it, failure may sometimes occur, but this fact must be kept from the wart and from the patient. For plantar warts we mostly use 3% formalin according to the treatment scheme devised by Dr. Sydney Thomson. A small bottle, the mouth of which is just bigger than the wart, containing a little 3% formalin, is held upside down over the wart for 10 minutes, night and morning; not 9 minutes, not 11 minutes, the patient is firmly told. Before each application, debris and callus are to be removed if the best results are to be obtained. In three to four weeks success is common. Multiple warts can be treated by simply resting the affected part or parts of the sole for 10 minutes in formalin in a suitable flat container; some of the cases treated this way will get very dry and cracking skins, which brings the treatment to a premature end. For small flat warts, where very numerous, as often seen in children, this old lotion of Whitfield's works like a charm—perhaps as a charm:

Mercury biniodide	2 gr. (0.13 g.)
Salicylic acid	60 minims (3.6 ml.)
70% Spirit	to 1 oz. (28 ml.)

dabbed on every two hours and left to dry. As Whitfield said, it is a most valuable method, and it is quite free from risk—which is something that cannot be said for all our treatments. Whitfield's ointment used under strapping and applied once a day will on occasion remove the single wart. One final Whitfield tip about warts: freezing with carbon dioxide snow is more efficient if the wart is first soaked in water for a few minutes. Water creeping into the interstices of the wart not only macerates the horn but, being itself quickly frozen by the snow, carries the freezing effect deep and very rapidly into the wart.

The Problem of Pruritus Ani

Some would have us think that the problem of pruritus ani is a thing of the past: either the psychiatrist or hydro-cortisone will solve the difficulties. Both of these modern wonders may, however, fail; in which case I have seen this old-fashioned drill succeed. Soap and water are kept off the itching area, which is cleansed twice a day with something inert like nut oil, except after defaecation, when cotton-wool and normal saline are used. Twice a day 2% camphor and 1% phenol in a zinc cream is applied. Sometimes a little menthol is added. Whitfield, indeed, liked camphor, and he devised a zinc and ichthyol cream which differs from most others in containing camphor. It is a wonderful preparation, and this is it:

Wool fat	..	..	60 minims (3.6 ml.)
Ichthyol	..	..	20 gr. (1.3 g.)
Camphor	..	..	10 gr. (0.65 g.)
Olive oil	..	..	$\frac{1}{2}$ oz. (14 ml.)
Zinc oxide	..	..	$\frac{1}{2}$ oz. (15.5 g.)
Solution of lime	..	..	180 minims (10.7 ml.)

A friend of mine, who from time to time advises a well-known firm on dermatological matters, has persuaded them to put it on the market, and I gather that it is proving a great success. This cream, of course without the ichthyol and the camphor, makes a nice, cooling zinc cream.

Dermatology, like the world, is divided into two spheres of activity, the east and the west. That is to say, some clean with soap and water, the rest have an Eastern devotion to oil. On evolutionary grounds, we were surely not meant to put plain water on our skins. Think how people rush to the seaside and even into the isotonic sea; it must be the call in the blood of fishy forebears. The effect of simple water is always to cause oedema and maceration of the epidermis, especially if it is denuded. The effects, too, of its alkalinity are harmful.

There are therefore few skin diseases which are not helped by banning soap and water. The alternatives are several—normal saline, nut oil, olive oil, or liquid paraffin. Whitfield liked the first of these. A useful extension of the same principle is the use of 1/2,000 mercury perchloride made up in a normal saline in both acute and chronic sepsis—particularly the latter. Ulcers on the legs, for instance, do extremely well on this lotion even in comparison with the exciting new remedies whose effects so often are but transiently brilliant.

Conclusion

These things you may think naive, old-fashioned, and outmoded. You may prefer to believe all that you read on the attractive and colourful literature and blotting-paper which clatters through the letter-box with all the numbing effect of machine-gun fire. The hypnotic and incessant suggestions of advertisers, whether they have something good to sell or not, the clamour of patients half but excitedly educated in medicine by the latest digest, lead us only too easily to neglect the old and get on with the new. As the cynic has said, there are two sorts of general practitioner—the first sort knows no dermatology and regrets it, the second knows no dermatology and boasts about it. Often, indeed, the only dermatological literature the student or practitioner ever reads is what he receives free from the advertisers. I would urge him to think on these things and consider some of the simple remedies. In Whitfield's hands they worked; he prescribed them with dignity, with authority, and with confidence, understanding the whole patient and his disease. These qualities all can strive to acquire; add to them a knowledge of a few simple remedies and what they can do, and an awareness that blondes are dangerous, and you will succeed in treating skin diseases as well as, if not quite with the happy self-confidence of, an old general practitioner friend of mine who says he can diagnose no skin disease but can treat them all.

TREATMENT OF BLOOD DISORDERS WITH A.C.T.H. AND CORTISONE

THIRD REPORT TO THE MEDICAL RESEARCH COUNCIL BY THE PANEL* ON THE HAEMATOLOGICAL APPLICATIONS OF A.C.T.H. AND CORTISONE

In two previous reports (M.R.C. Haematology Panel's Report, 1952, 1953) experience in using A.C.T.H. (corticotrophin) and cortisone in a variety of haematological conditions was described. It was found that favourable responses, including complete remissions, were obtained in a high proportion of patients with acquired haemolytic anaemia and idiopathic thrombocytopenic purpura, but that in other haematological conditions results were less favourable. It was also noted that the good effects of treatment were usually temporary and could be maintained only by continued administration of the hormones.

The present report describes two further years' work and summarizes the Panel's experience of the use of A.C.T.H. and cortisone in haematological conditions.† It includes some details of the results of maintenance therapy and a discussion of the value of hormones in the treatment of acute leukaemia.

Dosage

As a result of previous experience, dosage tended to be higher in 1953–4 than in 1951–2, and most patients received at least 200 mg. of cortisone a day in their initial course of treatment. Cortisone tablets for oral administration became available towards the end of 1951, and from that time onwards the proportion of patients treated with cortisone rather than A.C.T.H. steadily increased.

Results

As in the previous reports, responses have been divided into "complete" and "partial," a complete response being defined as one in which the clinical condition and the blood findings returned approximately to normal and a partial response as one in which the improvement was of less extent.

Haemolytic Anaemia

Twenty-eight further cases of acquired haemolytic anaemia were treated. Since the results were similar to those obtained previously, the Panel's total experience has been pooled and is summarized in Table I. A partial or complete response was obtained in 39 out of 48 cases (81%). When a favourable response occurred this was always apparent within two

TABLE I.—Responses to Administration of A.C.T.H. or Cortisone in Patients with Acquired Haemolytic Anaemia

Year	Total	Response		
		Nil	Partial	Complete
1951	10*	2	8	
1952	10	2	3	5
1953–4	28	5	15	8
	48	9	39	

* One case originally included in the 1951 report has been omitted as the disease now appears to be congenital rather than acquired.

*Members of the Panel: Professor L. J. Witts (chairman), Dr. C. J. C. Britton, Professor L. S. P. Davidson, Professor L. J. Davis, Professor A. Haddow, Sir Lionel Whitby, Dr. J. P. Wilkinson, Dr. P. L. Mollison (secretary).

†Most of the patients were treated by members of the Panel or their staffs; however, some of the patients referred to in this report were treated by Drs. J. V. Dacie, J. O. P. Edgcumbe, D. A. G. Galton, J. D. Nabarro, R. B. Thompson, and W. Walker.