in real intelligence and the latter in physical power. The best human beings are those in whom there is a considerable admixture of the characteristics of both sexes, with an interplay of the elements, and it appears to me that for a man to be what is commonly known as "successful" he must possess a considerable amount of the mental attributes of the female, and the "successful" female must possess a considerable amount of the physical attributes of the male. The so-called "war of the sexes" is therefore about as absurd as any other war, and the question as to who fights whom, and on which side, must often be difficult to answer.

Of late years sex problems have been more openly discussed, and certain advantages have accrued from this. On the other hand types of sexual activities between persons of the same sex have been dragged into the light from the relative obscurity that previously had partially concealed them, and at times even have been exalted by certain authors to such an extent as to become a menace to society, a great deal of harm resulting. The position regarding them therefore needs some clarification. There are individuals with certain male externals who have an excessive amount of the female in them, and females with very obviously excessive amounts of the male apparent in their appearance, movements, and general mannerisms. Some of these indulge in sexual perversions, and the natural resentment that is felt against these activities is often toned down by the illusion that this is a glandular problem and so calls for sympathy and not drastic opposition. No one would justify excessive violent attacks by a male on a female because of the activity of the secretions of his sex glands. Again, it is true that the aggressive sexual female has often a great deal of the male in her, but this is not regarded as a justification for gross sexual activities on her part. The case to which I have referred in detail shows that it is possible for an individual to have a very considerable mix-up of elements and yet confine "her" sexual activities entirely and successfully to the "opposite" sex.

The causative factors of homosexuality and Lesbianism are not to be found, therefore, so much in the secretions of the gonads as in the type of the individuals concerned. Their behaviour should not be regarded as justifiable on the ground of these glandular secretions, nor should it be held that it is impossible for them to learn and cultivate an adequate control. In this matter the legal and medical professions are often found at variance and are often led away from the main issue, the former being more interested in upholding "the majesty of the law," and the latter in attempting to find a cause for the behaviour and to supply a suitable remedy. It is just as possible for the participants in these practices to learn control as it is possible to control any other bodily desires, normal or abnormal. It is vital that they should be made to realize that their practices are not excusable on the grounds of the secretions of the sex glands, as, failing this, they are dealt with drastically by the law—and justly so—for the obvious benefit of the herd in which we live.

The December issue of *Medical Life* is an Army Medical Library number commemorating the centenary of the foundation of the Army Medical Library at Washington. In addition to other papers, it contains greetings from the Royal Society, the oration delivered on the occasion by Sir Humphry Rolleston (of which an abridged version appeared in our issue of November 28, 1936), and a portrait of the late medical historian, Colonel Fielding Hudson Garrison.

DERMATITIS ARTEFACTA: A NOTE ON AN UNUSUAL CASE

BY

E. W. PROSSER THOMAS, M.A., M.D.

Registrar, Skin Department, St. Thomas's Hospital

The term "dermatitis artefacta" is reserved for those cutaneous lesions which are produced by the patients themselves with intent to deceive. It does not therefore include the group of self-inflicted dermatoses known as neurotic excoriations in which the patients neither intend nor practise deception but are the victims of an irresistible desire to pick, scratch, or otherwise injure the skin, nails, or hair (trichotillomania); this impulse in some instances may have originated in a pre-existing or existing true dermatosis, such as scabies or acne (*Brocq's acne excoriée des jeunes filles*). Such cases are quite distinct clinically and psychopathologically from the group of "feigned" eruptions to which the ensuing remarks are confined and of which the case reported is an example.

Diagnosis

Dermatitis artefacta is by no means a rare condition, but to anyone who has not previously encountered it the possibility that he is dealing with a self-produced dermatosis might not easily come to mind, and it is probable that a number of cases, especially of the milder type, are missed.

The diagnosis may be comparatively obvious or extremely difficult. The subjects may be men or women, but the great majority are women. They are usually young—between 15 and 25 years of age. There may be nothing in their past histories suggestive of any psychological abnormality, and they are not the type of person commonly called "nervous"; on the contrary, they often present a curiously unemotional, almost indifferent, attitude on examination, which is reflected in their facial expression to such a degree that their physiognomy, though difficult to describe, may be quite distinctive and of valuable help in diagnosis. This apathy, if it may be so called, is neither to their environment nor to their interrogator. They are often intelligent, perhaps above the average, and answer questions with apparent frankness, though they do not care to volunteer much information concerning themselves or their condition. Their apathy is only towards their disease, and in this direction their lack of interest is so unnatural as to be striking. They rarely complain, and may regard a number of heavily infected discharging lesions with what appears to be almost a complaisant and contented eye.

The lesions themselves present great variety in shape, size, and character, as would be expected from their aetiology. They may be linear, striped, band-like, disk-shaped, or have a fantastic outline. They are constant only in one particular—that they do not conform to the lesions of any recognized dermatosis. Their border is important; it is usually sharply defined, pointed, or angular, and may have a thin line of erythema between it and the surrounding skin, which is probably quite healthy. If a liquid agent has been used there may be one or more drop-shaped or streak-shaped subsidiary lesions, caused by spilling or running. The location of the lesions is important. They naturally occur in places easily accessible to the hand: the left arm and side of the body are therefore favourite sites, but the face or neck,

buttock or legs, may be chosen. The lesions have a habit of appearing, multiplying, or relapsing during the course of a night, and are not preceded by any local cutaneous disturbance. The distribution may be totally unsymmetrical or impossibly symmetrical.

The agents employed to produce these lesions are also of great variety: they may be chemicals, such as carbolic or sulphuric acid, silver nitrate, caustic soda, or lysol; all kinds of instruments, such as knives, forks, brushes, etc.; or simply the finger-nails or manual rubbing or pinching. The character of the lesions themselves consequently varies according to the type of agent used. Anything may be encountered from simple erythema to extensive tissue destruction. The superaddition of pyogenic infection further complicates their nature and appearance, and the infected lesions may be particularly difficult to identify.

Most perplexing, however, is the psychopathogenesis. It is true that in a certain number of the cases the motive appears to be to excite sympathy, to evade work, or to secure compensation, but even in these patients, as Goldsmith (1936) points out, the fact that the method chosen of achieving the purpose is a false one, and that the self-produced illness is usually out of proportion to the often trifling advantage gained, makes manifest the existence of a specific psychic abnormality. There are, moreover, many cases in which it is impossible to define a motive of any kind.

The following case report of a patient recently under my observation, although an extreme example of the condition, illustrates some of the points mentioned concerning difficulty both in diagnosis and in definition of motive.

Case Report

The patient was an unmarried woman, 31 years of age. Apart from tonsillectomy and appendicectomy she had been healthy until the age of 22. She stated that all her life she had occasionally suffered from chilblains, and had had "numb feelings" in her fingers. There was nothing noteworthy in her family history.

HISTORY

About nine years previously, while she was training as a nurse, a small lesion like a chilblain appeared at the extremity of her left little finger. It rapidly became black and began to extend. Amputation was performed at the distal interphalangeal joint. The wound healed normally and remained healthy. A few weeks later, however, a similar area of dry gangrene began around the nail of the left ring finger. The patient was then admitted to hospital in London, where a diagnosis of Raynaud's disease was made. Alcohol was injected into the tunica adventitia of the left brachial artery. It also became necessary to deal with the affected finger by amputation, although there had apparently been some improvement in the lesion following the injection. She was discharged from hospital about ten days later.

After a few months, however, a new patch of gangrene appeared; this time the left middle finger was affected. Amputation was again resorted to owing to signs of rapid extension of the gangrene. From then on similar lesions continued to develop at intervals of six to seven weeks, the scar of the latest operation often being the site of the new gangrene. The disease was confined to the left upper limb. The succession of amputations (some thirty-three in all) resulted in the complete removal of the arm up to the glenoid fossa of the scapula. The operation of left cervical sympathectomy was also performed. During the intervals between operations the patient stated that she had felt perfectly well, except for spasms of pain in the stump, for which she had received injections of heroin. Whenever she was not in hospital she pursued a normal life, and kept up her swimming, badminton, and other exercises. The last of this

series of operations had taken place about three weeks before I saw her.

She was a pleasant-looking intelligent girl, apparently in the best of health. There was an operation wound at the shoulder, practically healed; otherwise nothing abnormal, physical or mental, could be discovered. She stated that she had come to London for some manipulative treatment to her neck as a last chance of curing her complaint. She was very cheerful—remarkably so when one considered the ordeals she had suffered during the past nine years and the imminent possibility of the development of yet another patch of gangrene. She spoke of this being likely to appear in about three weeks' time, which would make an interval of some six weeks after the last operation, this being the interval she had become accustomed to expect. As, however, there was now nothing remaining of her left arm that could be amputated, she did not quite know what would happen to her should the gangrene reappear at the shoulder, and presumed that if it did she would die. She made no complaint, hoping for the best from the new treatment, and impressed one as being an extremely brave girl.

TREATMENT

A few days after beginning treatment, which apparently consisted merely in light massage to the neck, she was found in a faint outside her bedroom. She could not remember what had happened, but stated that she had had similar attacks during the past few years for no obvious reason. She also developed retention of urine, and required catheterization. This, too, had happened a number of times previously, sometimes when she had been in hospital. A few days later an attack of aphonia came on and lasted five days. She then said that she often lost her voice: one attack had persisted for ten weeks. She also mentioned that she was subject to sleep-walking.

After a short rest following the fainting attack she resumed massage for about a week, and then came an urgent message to see her. She was rolling about in convulsions of pain, and a new patch of gangrene had appeared. Morphine had to be given, and later that day several injections of heroin, which, though they quieted her to some extent, seemed to have little effect on the spasms of pain. On examination there was a circular gangrenous-looking area about the size of half a crown in the middle of the operation scar. The epidermis was unbroken. In the centre it was black, but faded gradually towards the periphery. The edge was sharply demarcated by a thin zone of erythema from the surrounding skin, which was normal and healthy. To one side of this lesion was another, of a curious shape and character: it was a small triangle, of which the border only was erythematous. There was also a third tiny nondescript erythematous lesion.

A diagnosis of artefact was made, and the following day the patient was admitted to hospital. She was most unwilling to go, but was persuaded by her father, who had been sent for from the country. On admission her right arm was immediately put up in a splint to prevent possible interference. The gangrenous-looking area began to diminish without treatment of any kind. From the moment of arrival at hospital she did not complain of pain, and it was difficult to believe that only a few hours earlier she had urgently needed heroin. By the end of a week the principal lesion had resolved considerably and the small erythematous ones had vanished. She then left hospital.

Commentary

This case presents the remarkable picture of a self-inflicted dermatosis maintained intermittently over a period of nine years, and achieving so successful a deception both in London and the provinces as to result in the piecemeal removal of an entire limb. The evidence leaves no reasonable doubt as to the diagnosis: recurring areas of dry gangrene confined to one arm and affecting the skin only (at operation the underlying tissues were found to be normal) do not conform with the lesions of any recognized disease; the peculiar nature of the latest lesions

themselves and their spontaneous resolution when interference was prevented; the characteristic mental attitude of the patient; and the occurrence of other psychopathogenic manifestations, such as aphonia, retention of urine, somnambulism, and fainting attacks, all indicate the diagnosis of artefact of hysterical origin. That the deception should have been practised with such drastic effect is striking but by no means unique. According to Eller (1929), many cases have been cited in the European literature of amputations of one or more limbs having been performed on patients presenting large areas of gangrene of "idiopathic" origin, which subsequently were proved to be due to the application of caustics by the patients. Simpson (1917) refers to a case recorded by Heidingsfeld of a woman who had serenely permitted the complete amputation of both breasts and one leg, and had given consent for the removal of an arm, before her condition was recognized. The lesions were those of gangrenous dermatitis and had been variously diagnosed as syphilis, tuberculosis, and malignancy. In addition to the operations she had received intensive salvarsan therapy.

Another extreme case, reported in the *Presse Médicale* (June 10, 1908), was of a man of 30, who produced black gangrenous patches on his arm with caustic potash. He consulted fifteen doctors in turn, and preserved their names, addresses, and diagnoses, which had included those of trophic lesions, neuritis, myelitis, syphilis, and tubercle. He had received a variety of treatment, including stretching of the brachial plexus. Finally, amputation of the arm was performed. The other arm then became affected, after which his condition was recognized and apparently he was cured by psychotherapy. Lancashire (1922), who alludes to this case, cites one under his own observation of a young lady, a musician, who repeatedly developed lesions on her face and neck on the days when she was engaged to appear at a concert. It was impossible to define a motive, and she privately confessed that some uncontrollable impulse made her mutilate herself in this manner on the very day when to do so would prove most disastrous for her. Of the milder type of case, more generally encountered, an instructive example was reported by Gardiner (1930). The patient was a woman of 26, who suffered from a bullous eruption of the chin, neck, and sternum. Even after admission to hospital the lesions continued to appear, until it was discovered that the patient was producing them herself in the bathroom by means of fly blisters, which were found concealed in her handkerchief. Fly blisters were also found in the bed she had vacated at home.

"Belle Indifference"

It seems certain that a number of these patients are hysterical. The peculiarly calm mental attitude, previously mentioned as being so often met with in subjects of dermatitis artefacta, is apparently a characteristic feature of hysteria and was described by Janet as *belle indifférence*. This attitude can be understood when it is realized that hysteria is a special type of reaction to difficulties; that the physical symptoms represent the solution of some problem of everyday adaptation; and that they are misinterpreted by the patient's consciousness (Henderson and Gillespie, 1936). In the present case this *belle indifférence* was very striking, as also were other hysterical stigmata, such as aphonia, retention of urine, and fainting attacks. A further question of great interest is that of dual personality. May hysterical subjects produce their lesions and not be conscious afterwards of having done so? Devine (1933) states that it is not necessary to suppose that the

hysteric is aware that his symptoms originate in his imagination, and that, even in the case of self-inflicted lesions, it would seem that his capacity for self-deception blinds him as to their origin. Dore (1926) reported the case of a girl of 19 with lesions on her arms. Stoddart considered her case to be one of dual personality, the patient being unaware that she produced the eruption herself. O'Donovan (1927) also inclines to the view that the patients possess a double personality, on which account it is practically useless confronting them with their misbehaviour. MacCormac (1926) wrote to some patients who had been treated at the Middlesex Hospital and found that of five who responded one had either forgotten that she had produced the lesions herself or was unaware of having done so, as she inquired whether the skin condition was liable to recur now that she was married, and if it would have any effect on her future children; another patient seemed to have no recollection whatever of her dermatosis, and stated that she had never been in the Middlesex Hospital. Simpson (1917) also remarks that one of his cases had apparently forgotten that she had consulted him previously with the same condition, although on that occasion he had informed her that he knew she was producing the eruption herself. MacCormac believed that the explanation lay in the habit of burying the memory of unpleasant events in the subconscious mind rather than in the theory of double personality.

These and other perplexing questions concerning the psychopathogenesis of dermatitis artefacta can be clarified only by co-operation between dermatologist and psychologist in a series of cases.

REFERENCES

- Devine, H. (1933). *Recent Advances in Psychiatry*, p. 242. J. and A. Churchill Ltd., London.
Dore, S. E. (1926). *Brit. J. Derm. Syph.*, **38**, 306.
Eller, J. J. (1929). *Med. J. Record*, **129**, 481.
Gardiner, F. (1930). *British Medical Journal*, **1**, 282.
Goldsmith, W. N. (1936). *Recent Advances in Dermatology*, p. 100. J. and A. Churchill Ltd., London.
Henderson, D. K., and Gillespie, R. D. (1936). *A Text-Book of Psychiatry*, p. 448. Humphrey Milford, Oxford University Press, London.
Lancashire, G. H. (1922). *British Medical Journal*, **2**, 504.
MacCormac, H. (1926). *Brit. J. Derm. Syph.*, **38**, 371.
O'Donovan, W. J. (1927). *Dermatological Neuroses*, p. 25. Kegan Paul, Ltd., London.
Simpson, C. A. (1917). *J. Cutan. Dis.*, **35**, 493.

C. Spampinato (*Policlinico*, Sez. Chir., February 15, 1937; p. 95) has collected 130 cases, of which four are original, of dislocations of the cervical vertebrae, exclusive of the atlas, which he classifies as follows: (1) complete dislocations; (2) subluxations; (3) unilateral; (4) bilateral; (5) forward dislocations; (6) backward dislocations; (7) dislocation of a single vertebra; (8) multiple dislocations; (9) pure dislocation; (10) fracture-dislocation. In eighty-eight out of 122 dislocations there was no spinal paralysis, while in twenty-four the dislocations were complicated by paralysis. Among 102 cases in which the dislocated vertebra was identified the fifth came first (40 per cent.) and then in order of frequency the fourth (21 per cent.), sixth (14 per cent.), third (12 per cent.), second (11 per cent.) and seventh (5 per cent.). As regards treatment, in cervical dislocation without spinal symptoms, if the patient is seen at once, reduction under general anaesthesia should be tried, but if this is not successful continuous extension should be employed. If the dislocation is accompanied by spinal symptoms reduction should be first tried, but if this fails, operative or expectant treatment should be carried out. In some severe dislocations that cannot be reduced without operation spontaneous improvement resulting in complete recovery may ensue.