TRICHOTILLOMANIA DUE TO THREADWORMS.

BY

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THOUGH the psychic perversion of hair avulsion (auto-epilation) cannot, strictly speaking, be classified amongst diseases of the skin, it is not infrequently referred for treatment to a dermatologist. Hallopeau first described the habit and suggested the name of trichotillomania at a dermatological demonstration in Paris in 1889,¹ and in this country Pernet² has twice shown cases at clinical meetings. The literature on the subject is mainly French (Voisin,³ Féré,⁴ Raymond,⁵ Dubreuilh and Magne,⁶ and Crutchet⁷). A detailed description of the disease, with six cases of his own (seventeen in all), was published by Wolters⁸ in 1907, and in this monograph the etiology is very fully discussed.

According to the majority of these authors, the perversion may be associated with epilepsy, general paralysis of the insane, and imbecility, and is fairly frequently observed in asylums and institutions for the demented.

The hair of the moustache and of the eyebrows may be abraded reflexly and epilated, as a result of pruritus, and the habit of tearing the hair occurs also, as is well known, in hysteria, and has been observed in epidemic form in religious revivals and other exalted or depressed conditions of the mind.

So far as I am aware, however, the etiology which undoubtedly produced the "tic" in my patient has not been recognized hitherto. Although certain associated symptoms such as nail-biting, pruritus, convulsions, tumidity of the stomach, etc.—well-known accompaniments of helminthiasis—are described by the French authors enumerated, in some of their cases of trichotillomania the possibility of oxyuris as a common cause for them all does not seem to have occurred to any of them.

Mrs. C. brought her son to me for consultation on February 8th, 1922. He is six years old, and has never had a serious illness, although he looks pale and delicate, and has a coated tongue. Both parents are normal, and there is no history of hereditary disease on either side.

The boy was first noticed to pull out his hair when three years of age, and the habit had become severe enough to produce the considerable disfigurement illustrated by the photograph. The scalp is noticed to be denuded mainly in the left frontal area, and epilation was mostly with the right hand, and at times quite subconscious, so that the child would simultaneously "play with a toy with his left hand and pull out his hair with the right." The habit was not practised during sleep, and there was nothing to suggest that local pruritus in any way disturbed him. Latterly he had been turning his attention to his mother's hair.

The scalp itself appeared to be somewhat deficient in sebaceous secretion, but was not otherwise abnormal or irritated, and the hairs which I epilated (without protest) showed no evidence of dystrophy or other nutritional disturbance.

I was assured that the boy was quite bright mentally, and took a normal interest in his surroundings. Drugs prescribed to "quieten the nerves," and punishment, or threats directed against the continuance of the practice, had all proved unavailing. Inquiry elicited the fact that the appetite was exceedingly capricious, and that threadworms had been noticed in the stools, and treated ineffectively from time to time since the age of eighteen months. The indications were obvious, and the anthelmintic treatment recommended by Still⁹ was instituted at once.

On February 22nd the mother reported that the "hair pulling" had ceased. Relapse has not occurred to date (March 25th), the anaemia and appetite are improving, while the risk of reinfection by unhatched ova is being obviated by the continued administration of iron sulphate (Still).

REFERENCES.

- ¹ Hallopeau: *Ann. de Derm. et de Syph.*, 1889, p. 441. ² Pernet: *Society for the Study of Diseases of Children*, 1904, vol. v; *British Journal of Dermatology*, 1915. ³ Voisin et Darac: *Soc. de Méd. de Paris*, December, 1909. ⁴ Féré: *T. chez les paralytiques généraux*. ⁵ Raymond: *Tic d'une femme qui s'épile. Journ. de Méd. Intern.*, 1902, p. 195. ⁶ Dubreuilh et Magne: *La trichotillomanie. Journ. de Méd. de Bordeaux*, 1905, p. 449, and in further publications. ⁷ Crutchet: *Thèse de Paris*, 1905. ⁸ Wolters: *Med. Klinik*, Nos. 23 and 24, 1907. ⁹ Goodhart and Still: *Textbook of Diseases of Children*, 1906.

Memoranda:

MEDICAL, SURGICAL, OBSTETRICAL.

TREATMENT OF INFLUENZA BY SALICIN.

DURING the recent epidemic of influenza I treated 54 cases by the administration of large doses of salicin—20 grains every hour for twelve hours, and then 20 grains every two hours for the next twelve hours. The ages of these persons ranged between 74 and 16 years. Four when seen had a temperature over 104°. The next day (with one exception, when the temperature was 99°) all the patients were normal or subnormal, and remained so; they were up and about the house the day after. There were no complications or sequelae. Ten had temperatures of over 103°, of whom one the next day was 99.2°; the rest were normal. They ran the same course exactly. Thirteen had temperatures of over 102°, and were well in two days. One of these, however, after going out, developed an attack of follicular tonsillitis, to which he is very subject, and which ran its usual course to complete recovery. Twenty-two had temperatures of over 101°, and 15 over 99°. They all rapidly recovered without any drawback. In no single instance was there any bronchitis or pneumonia, nor was there any mischief left behind. The attack of tonsillitis though *post casu* hardly be considered *propter influenza*, as on several previous occasions this person has been treated for that complaint; and he had been out at his work for four days before starting it. These 54 cases follow in direct sequence more than 3,000 others which have been treated since 1891 in the same manner with the same results: no ill effects from the salicin; no complications; no sequelae; no deaths.

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GONOCOCCAL SEPTICAEMIA.

THE following case goes to prove that gonococcal septicaemia or pyaemia must occur, otherwise secondary infective involvement of other parts of the body away from the usual point of infection could not take place. In the case described below positive blood cultures were obtained on two occasions and on each a skin rash appeared which it was thought might possibly be associated with this condition.

A man, aged 38, was admitted to the surgical wards at the Paddington Infirmary with acute synovitis of the right knee. A history of gonorrhoea three months previously was supported by the condition of the prostate, which was hard, tender, and nodular; the seminal vesicles were palpable. He ran a temperature of from 102° to 104° F., and appeared more toxic than the local conditions warranted. The knee gradually settled down under treatment.

About two weeks after admission intense pain occurred over the outer side of the right thigh. This pain appeared to be localized to the deep fascia, and an acute metastatic involvement of this structure was considered probable. A few days later venous thrombosis occurred in the superficial femoral vein of the right leg about the middle of the thigh, and the leg became very oedematous. Gentle prostatic massage yielded pus and blood from the posterior urethra, and gonococci were found in the smear; previous examination had been negative. A generalized adenitis throughout the body then occurred. The cervical glands in the anterior triangle of the neck were visibly enlarged, and were very tender on palpation, and a free purulent discharge from the urethra commenced.

Ever since admission the patient's temperature had ranged from 102° to 104°, and about three weeks after admission his general condition was much worse. His pulse rate rose at times to 140, and he had frequent rigors, but neither at this time nor in the subsequent course of the disease was there any clinical evidence of endocarditis. A papular eruption appeared at this stage. It was most marked on the extensor surfaces of the forearms and backs of the hands, and on the legs below the knees; large hyperaemic spots were also present. These eruptions faded away in the course of a few days. The next complication was the sudden onset of severe pain over the localized area in the region of the internal semilunar cartilage of the left knee-joint. There was no fluid in the joint then, but a few hours later the joint was hot, painful, and tender, and was fully distended with fluid. Epididymitis of the testicle followed next day, and the right testicle became similarly involved a few days later.

Another crop of papules then appeared, associated with large hyperaemic spots half an inch in diameter as before. A blood culture at this time gave a pure culture of gonococci, from which a vaccine was prepared. The rash disappeared in about three days, and with its disappearance there was a slight improvement in his general condition. A week later another series of rigors occurred, associated with a high temperature and prostration. Hyperaemic areas and papules appeared on the arms. Blood culture was again positive for gonococci. One papule on the hand formed a pustule, but no growth of organisms was obtained from the pus. During the course of the disease arthritis pains and