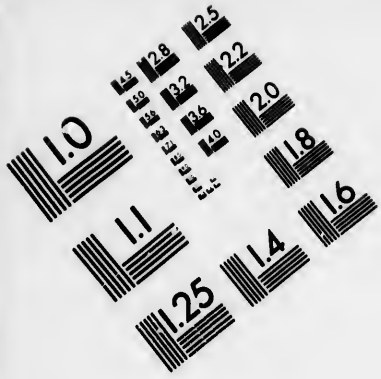

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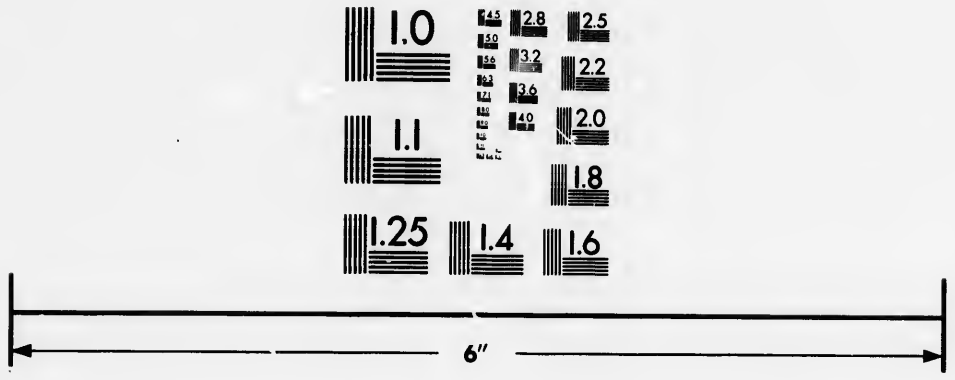

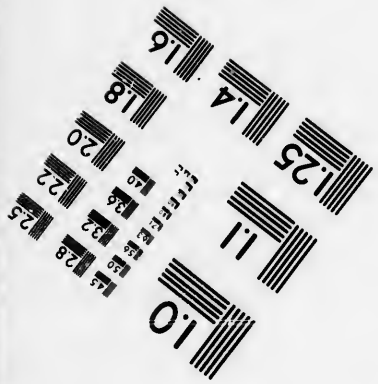

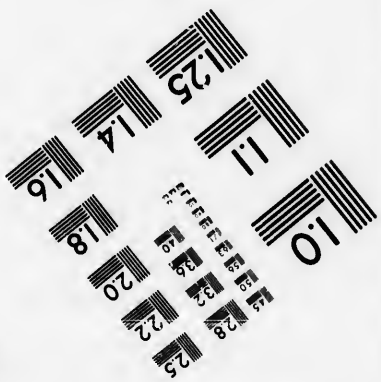

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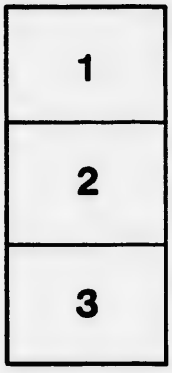

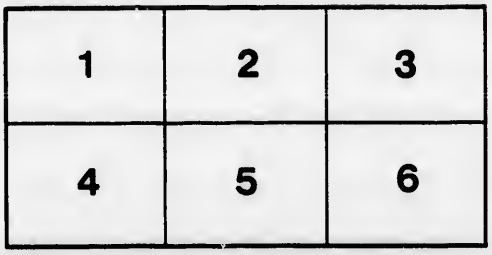

SOME CASES OF FEIGNED ERUPTIONS.

BY

FRANCIS J. SHEPHERD, M.D., C.M.,

Surgeon to the Montreal General Hospital;
Lecturer on Diseases of the Skin,
McGill University.

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SOME CASES OF FEIGNED ERUPTIONS.[1]

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THE simulation of various diseases has been resorted to in every age, and by all classes of society. When the purpose is to avoid conscription, work, or duty, the simulator is usually a male; when to excite sympathy and interest, or to obtain notoriety, a female. In some cases the malingering or simulation is apparently motiveless. Of course, mendicants from time immemorial have simulated diseases which are peculiarly abhorrent to the passer-by, such as sloughing ulcers, running sores, scabs, contractures, etc, but this is for the purpose of provoking pity and charity. In some cases, since the introduction of railways and modern machinery, persons simulate nervous symptoms and spinal injuries for the sake of obtaining compensation, and this, when obtained, results in a permanent cure. A remarkable case of simulation of disease has lately been exposed in France. A man simulated locomotor ataxia so perfectly that the great Charcot and many other prominent Parisian physicians were deceived. He went from hospital to hospital, and, finally, was sent to Notre Dame de Lourdes, where he was miraculously cured, and was kept as an example of what our Lady of Lourdes could do, to the mortification of many members of the medical profession. However, he was detected committing a theft of money from his spiritual doctors and they

[1] Read before the Twenty-first Annual Meeting of the American Dermatological Association.

had him arrested. He then confessed everything, including the fact that he had been shamming, and that the miracle of cure was performed by himself. Mania is another form of disease which is often simulated, and is sometimes most difficult to detect.

The fact that skin diseases are often feigned is well recognized, and in some cases the deception is so clever that the fraud may for a long time go undiscovered, especially if the patient falls into the hands of medical men who have no sense of humor, for such are easily imposed upon.

The common forms of eruption which are simulated are the erythematous, bullous, and vesicular, for these are easily produced by irritants, such as Spanish fly, mustard, acids, etc., and repeated applications of such unguents, as pointed out by the late Dr. Hilton Fagge, give rise to appearances which differ from those we are accustomed to see as the result of the use of the same substance as a local remedial agent.

Heat and friction with the fingers are often made use of to produce lesions of the skin. According to the late Mr. Startin, tartar-emetic ointment has been used successfully to simulate lupus.

Local gangrene, which has been called erythema gangrenosum, spontaneous circumscribed gangrene, etc., according to the late Dr. Tilbury Fox, is always the result of artificial production. He says repeated applications of nitric acid or Spanish fly will cause gangrene, or, first, the application of Spanish fly, and on top of this nitric acid. It is well known to surgeons that the heat produced by a rubber bottle filled with hot water will produce gangrene of the skin in patients whilst unconscious from ether.

One of the cases reported below is an example of the spontaneous gangrene, and, taking all things into consideration, although no absolute proof was forthcoming, the case is doubtless one of feigned eruption.

It goes without saying, that it is most important to have a knowledge of real disease in order to detect a simulated one. The fact that most of these feigned eruptions differ from any known skin disease, both as to their situation, symmetry, and common appearance, together with the looks, history, and general conduct of the patient, must lead any intelligent and observing practitioner to suspect the fraud. That there is no known cause for the deception, or that no benefit can accrue to the simulator, goes for nothing. To excite interest and draw attention to herself is a sufficient inducement to a hysterical woman. I am inclined to believe that, on

account of the large audience, cases are seen more frequently in the public clinics than in private practice.

In the two cases of large bullous eruptions of the cheeks, I omitted to test the acidity of the fluid, and so lost the opportunity of deciding whether or no the lesions were produced by an acid. Mr. Startin (*Brit. Med. Jour.*, January 8th, 1870) relates a case where he detected a fraud by getting an acid reaction of the bullous contents with litmus paper.

Case I. *Gangrenous Patches of Skin on the Arms.*—Amelia B., aet. 30, a servant employed in the Montreal General Hospital, was brought to me by the lady superintendent in July, 1890, and was said to be suffering from a peculiar eruption of the skin, which had been coming out for the previous week or ten days. The eruption was on the back of both hands and forearms, and consisted of a number of circular patches about the size of a 10-cent piece. Some of the patches were quite dry, hard, and gangrenous, and of an almost black color; others were shiny, and of a dead yellowish color, and quite insensitive; and some, again, were merely red and inflamed. Around the edges of each patch was an inflammatory areola, and a slight line of demarcation was already beginning to form. In some of the patches a number of concentric rings could be made out very distinctly, looking as if they were produced by a metal disk. I at once said that the eruption had been produced artificially, but the patient indignantly denied it, and the people in authority over her scouted the idea. I said no more patches would appear if she were carefully watched and a bandage put over her hands and arms. She was admitted into one of the wards, and the hands and arms covered, first with absorbent cotton, then with a dextrine bandage. At the end of a week the bandages were removed and no fresh spots were seen; some of the old ones had disappeared, and in others the sloughy skin had come away, leaving superficial ulcers, which soon healed. The lesion was evidently produced by the bottom or cover of some metal box, or other similar article, heated to a high temperature. The object of the trick I could never discover, unless it was to get off her work. Apparently she was not in any way hysterical.

Case II.—Elizabeth B., aet. 44, a sturdy, thick-set woman, with a stolid appearance, was employed as cook on a large dairy farm near the city of Montreal. Came to my skin clinic July 4, 1894, complaining of troublesome blisters on the cheeks.

She said that, it being the haying season, she was pressed against her will into the field work, and all the previous day was loading

hay. The weather being very hot, she sweated a good deal, and frequently wiped her face with her apron. She said there was milkweed and poison-ivy in the hay, and to this she attributed the condition of her face. Her face was quite well when she went to bed, but on awaking in the morning it was all red and swollen, her eyes

FIG. 1.

were closed, and she had numbers of large blisters on her cheeks. The blisters rapidly increased and coalesced. (Fig. 1.)

On examining her I found that on each cheek were several huge blisters, extending from the lower border of the orbit to the inferior maxilla; there was also a patch of large vesicles on her forehead,

but the eyelids, eyebrows, and hairy parts of scalp had escaped, as also had the lips. Around the blisters the skin was red and inflamed. The edges of the eruption were quite sharply defined. A few days later, having abstained from haymaking in the interval, she returned almost well, a slight reddening of cheeks and forehead being all that remained of the original eruption. From the situation of the eruption, its sharp definition, and the general appearance, I came to the conclusion that it was artificially produced by cantharides, carbolic, acetic, or other acid, the object being to avoid further work in the field. From what she told me she seemed to dislike exceedingly going into the fields, because she thought it was not her proper work, and I have no doubt at all that some blistering agent was applied to produce the eruption. The eruption resembled no known disease of the skin.

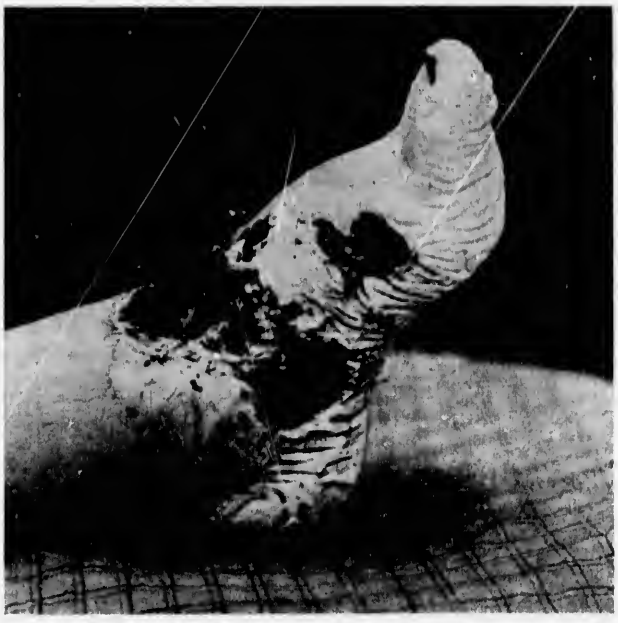
CASE III.—Laura R., aet. 28, living at home, came to the hospital October 15, 1893, complaining of eruption on the chest.

She was a nervous woman, who had most of the hysterical stigmata, such as occipital pain, insensitive throat, and no corneal reflex, of considerable intelligence. She said that some two years before croton oil had been applied to her chest for some lung trouble, and that ever since a croton-oil rash came out at intervals, in fact, that it never went away entirely. On examination a typical croton-oil rash was seen covering her chest, breasts, and between them. She seemed to take quite an interest in showing the eruption to the class of students, and was not at all abashed in having her breasts uncovered. A placebo was prescribed, and I did not see her again for a month. She came back November 15th, with each cheek covered with a huge blister, half full of fluid; on right side the blister was quite baggy. They were very similar in appearance to those seen in the case of Elizabeth B. The blister did not invade the eyelids, mouth, or nose. There was considerable inflammation about the blister, and the eyelids were swollen and red. It looked exactly as if the cheeks had been painted with some blistering fluid, or had been burned. The croton-oil rash on the chest had almost disappeared, and she said it always did this when the blisters came out on her cheeks. When the blisters first came out the rash began to disappear on the chest, until it went quite away. The blistering rash on the face usually, she said, lasted ten days, and afterward she had no symptoms of any kind for perhaps a month. She returned again in a week, and there was only a slight redness where the blisters had been, and there was no rash on her chest. I told her to come back when she felt the blisters coming out on her cheeks. She did so in a month. Her cheeks

were flaming red, hot, and somewhat swollen, but as yet there were no blisters. I wanted her to remain in the hospital for observation, but she declined, promising, however, to come back in a day or two.

This she did, and her cheeks were as the first time, each covered with a huge blister. She now tells me that sometimes she has no blisters for six months. The croton-oil rash at this time was almost imperceptible. She frequently returned to the clinic to show herself, the croton-oil rash being the favorite exhibition with which she

FIG. 2.



was pleased to entertain the students. No doubt her object was to excite sympathy and interest, and to be looked upon as an exceptional case. The girl was distinctly hysterical, both in her appearance and actions.

CASE IV.—Eliza C., aet., 24, waitress, was admitted into the Montreal General Hospital October 13, 1896, for gangrenous patches on the left foot and leg. The following is the history bearing on the case:

Four years ago she had a severe attack of typhoid fever. After convalescence had been established some time, she felt a severe pain in the left groin. This was followed by rapid swelling of the whole leg, which in two days reached its maximum, and afterwards gradually subsided. There was always present a sharp pain, which sometimes prevented sleep. When the swelling had disappeared from the leg there was a tendency to edema of the foot if she stood about much. A year later ulcers broke out on the dorsum and inner side of left foot. She said they looked very much like those she had now, and that there was dead skin which had to be separated. She was treated for these sores in hospital, and the scars are plainly visible. In January, 1894, the sloughing of skin came again in the same foot and leg.. The skin now turned black, but when it came away did not leave such deep scars as formerly. Last March, 1896, she had another attack of the same kind of sores, for which she was treated in this hospital, and was discharged, cured, after a few weeks, the ulcers left by the sloughs being healed by skin-grafting. Since discharged from hospital she has been quite well, except that the left foot was inclined to swell. A week ago foot and leg became inflamed and swollen, and a day later the skin became discolored in patches, and around the dark discoloration there was considerable inflammation. On entering the hospital the following note was made of her condition:

"Patient is an intelligent, healthy looking, well-nourished girl, with a bright complexion; pulse and temperature quite normal. Several scars are seen about the calf of leg and dorsum of foot, and one bluish mark above the knee, which, she said, was due to a bullet wound, from the accidental discharge of a revolver. The exit of the bullet is also seen in the outer side of leg, above the tuberosity of the tibia. Over the foot and ankle are several white scars, due to former ulcers. On dorsum and inner side of the left foot, reaching as far as the great toe, are four well-defined necrotic patches of skin of various sizes, from half an inch to five inches in length. The largest patch, five inches long and two broad, is on the dorsum of the foot; the smallest a little below, and the two remaining ones on the inner side. There are a few very small patches in various parts of dorsum and outer side of foot. The foot is swollen, but the inflammatory reaction is very slight. All the patches are quite black, and around each is beginning a line of demarcation." (Fig. 2.)

There is nothing abnormal about the girl, and hysterical stigmata are not present. In a month the sloughs had separated, leav-

ing deep ulcers, and these were slow to heal; in fact, it took two months more before they were healed. Some of my colleagues contended that this was a case of localized gangrene following typhoid fever, and due to some interference with nutrition; in fact, an arteritis. This view was held by Dr. Armstrong, under whose care she last was, and who has kindly allowed me to make use of the case. Seeing that the toes and extreme periphery of feet were not involved, we could hardly put it down to Raynaud's disease. There was no blueness of extremities, nor any appearance of circulatory disturbance. Again the sloughing patches followed the course of no one nerve, the portions of skin involved being supplied by the external and internal saphenous and musculocutaneous nerves. Again, I found out that the girl was an inveterate cigarette smoker, and was addicted to liquor. The lesions might have been produced by the burning end of the cigarette. How the eschars were produced was a puzzle, but I have seen exactly similar ones produced by burns and scalds, and the application of too hot rubber water bottles to [illegible]ts coming out of ether. As to the object of the girl, it might [illegible]n to excite sympathy, and also to get back to the hospital, w[illegible] the peculiarity of her case excited the interest of the numerous students who had work to do in the ward, and she also was the subject of an occasional bedside clinic by the surgeon in charge. These, with the idle life, are quite sufficient inducements to such a girl to mutilate herself in this way. Perhaps the original foot lesion was due to accident, and the subsequent ones to design. The recurrence of the attack was a suspicious circumstance to my mind, as were also the intervals of complete good health between the periods of ulceration. I have since learned that before leaving the hospital this girl came running out of the ward kitchen, where at that time there was no fire, with her clothes on fire. The fire was promptly put out by the nurses. This circumstance I consider as confirmatory evidence, and makes me suspect still more strongly the artificial character of the gangrene. I am acquainted with no disease in a young, healthy person to which this corresponds.

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