A NOTE ON CUTANEOUS TELANGIETASES AND THEIR ETIOLOGY: COMPARISON WITH THE ETIOLOGY OF HÆMORRHHOIDS AND ORDINARY VARICOSE VEINS.

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Every doctor is familiar with the hair-like branching lines formed by dilated cutaneous venules, when they are distributed so as to form a girdle round the trunk at a level more or less corresponding with that of the insertion of the diaphragm. Edward Blake, in 1877, described this ring of dilated vessels as the “cingula athletica, a pathognomnic sign of pulmonary vesicular emphysema when it occurs in the gouty,” and the condition has often been attributed to the increased intrathoracic venous pressure associated with pulmonary emphysema, chronic bronchitis, etc. E. Schweninger described and figured the condition in 1897, and Dr. E. Kingscote finds that it is invariably to be observed in asthmatic patients after middle life in a more or less marked degree. Kingscote has “frequently observed such a zone of congested vessels in the præcordium and hypochondrium in cases of cardiac dilatations and enlargements of the liver and spleen respectively; in fact, whenever there is interference with the blood flow in the azygos veins, owing to pressure by an enlarged viscus.” Solis Cohen says he has given the term “costal fringe” to the peculiar telangiectases following the outlines of the costal arches. He has found the “costal fringe” in a patient associated with factitious urticaria, and he says it likewise occurs in some cases of hepatic cirrhosis.

I do not deny that this fringe of telangiectases may be excited by chronic dyspnoea, excessive action of the diaphragm, frequent coughing, and increased intrathoracic venous pressure of any kind, such as arises from chronic bronchitis, emphysema, asthma, whooping-cough, etc. Nor do I deny even that it may occasionally disappear when the exciting cause has been removed. Dr. Symes-Thompson has kindly furnished me with an excellent illustration of this. A man, when about 50 years of age, suffered from whooping-cough, with “acute emphysema.” The terminal venules near the costal margins became very manifest, but in the

1 See the coloured illustration given in his book on “Constipation,” second edition, London, 1900.
2 Mitth. a. d. dermat. Klin. d. k. Char.-Krankenh. zu Berlin, 1897, S. 47. I have not been able to see this paper, but it is quoted by Kingscote, “Asthma,” London, 1899, p. 78.
3 “Asthma,” London, 1899, p. 78.
4 “Vasomotor Ataxia,” Am. Journ. Med. Sc., Phila., 1894, vol. vii. p. 135.
course of about six months they practically disappeared, though later on in life they became slightly dilated again. Kingscote has likewise observed that the zone may become fainter in asthmatic patients under appropriate treatment, and in some cases entirely disappear. What I maintain is that the “costal fringe,” like cutaneous telangiectases in other situations, sometimes occurs in the absence of any obvious exciting cause.

Cutaneous telangiectases are, indeed, by no means limited to the costal fringe. They may occur, scattered or in groups, on almost any part of the body. One of the commonest situations is on the back of the thorax, on each side of the spinal column, in the upper interscapular region. In this situation, I think, a few hair-like telangiectases can be found in 50 per cent. of healthy young adults.

A healthy man, æt. 34, whom I examined for life assurance last July, had a remarkable arrangement of telangiectases over the front and sides of his thorax. They formed a rounded arch crossing the sternum at the level of the second intercostal space, and resting on lateral columns of telangiectases on each side of the thorax just outside the nipple lines; the base of each lateral column was formed by a considerable group of telangiectases about the level of the diaphragm, and the central part of the front of the chest was quite free. This man told me that the curious dilated vessels had existed as long ago as he could remember. He likewise had telangiectases on some other parts of his body.

Similar telangiectases are often present on the face, even in young persons, and even in the absence either of special exposure to weather or of frequent flushing of the skin from any cause, such as indulgence in stimulants. The spider-like “stigmata” on the face, etc., consisting of fine hair-like lines radiating from a red central spot, which occur in young persons as well as in alcoholics and patients with cirrhosis of the liver, are, I believe, merely a variety of these telangiectases, towards which alcoholism acts as a predisposing cause in some cases. Crocker says that such stellate telangiectases form part of the symptomatology of xerodermia pigmentosa.

Cutaneous telangiectases of a reddish or bluish colour are fairly common in the lower extremities, and are often associated with ordinary varicose veins. Symmetrical groups of such telangiectases are frequently to be observed in the outer parts of the thighs and above the patelle. Often some of the telangiectases on the thighs are larger than telangiectases in other situations; all sizes of dilated veins occur on the outer part of the thighs, from hair-like telangiectases up to the size of ordinary varicose veins (external femoral set of varicose veins).

In 1901, I saw an anaemic and cachectic girl, æt. 15, on whose

1 Loc. cit., p. 78.
pale face the dilated terminations of cutaneous venules were very conspicuous. She had similar telangiectases on the right leg. It may be just worth while mentioning that a subsequent post-mortem examination in this case showed the presence of some perihepatitis and scarring of the liver; for congenital syphilis, according to E. Fournier,¹ has in some cases been associated with remarkable dilatation of superficial veins in the head.

As to etiology, I regard the formation of all cutaneous telangiectases as to some extent allied to nævus-formation (angioma). Telangiectases of the skin may arise, like minute cutaneous nævi, at any period of life and in the absence of any obvious exciting cause, though their development may, like that of minute nævi, be encouraged by some cachectic condition of the body. Thus, alcoholism and cirrhosis of the liver predispose to cutaneous telangiectases, and a senile condition of the skin predisposes to minute cutaneous nævi.² Cutaneous telangiectases, however, unlike nævi, are frequently induced by obvious exciting causes. Thus, in the lower extremities at least, increased pressure in the veins must be admitted as an exciting cause of cutaneous telangiectases, just as it must of the ordinary varicose veins. In regard to the "costal fringe" of telangiectases, we have already alluded to factors which must be admitted as exciting causes in some cases. In the face, exposure to rough weather often induces telangiectases, and a frequent connection between local hyperæmia (frequent flushing from dyspepsia, alcoholic indulgence, etc.) and telangiectases of the nose is universally acknowledged. The spider-like kind of telangiectasis in patients with hepatic cirrhosis, etc., seems often to be induced by a small inflammatory papule in the skin.

In short, I would say for cutaneous telangiectases, as for haemorrhoids and ordinary varicose veins, that although exciting causes are often present, they are often apparently absent. Predisposition varies so much, that telangiectases may occur in the skin of some young persons in the absence of any recognisable cause, or from some trivial cause, such as friction from the clothes; and in other persons facial telangiectases may fail to develop in spite of frequent flushing and considerable exposure of the face to rough weather.

I now come to the comparison of the development of cutaneous telangiectases with that of haemorrhoids and ordinary varicose veins. Though passive congestion in the portal system (from any of its numerous causes) and overfeeding (and general functional

¹ "Des Dystrophies Veineuses de l'Hérédo-Syphilis," Rev. d'hyg. et de med. infant., Paris, 1902, tome i. p. 26.
² The abundant presence of minute cutaneous nävi has by some been supposed to be of importance in the diagnosis of internal cancers, but this view has, I believe, already been quite given up.
over-activity of the alimentary canal), as well as local irritation\(^1\) from chronic constipation, inflammation of the mucous membrane of the rectum, etc., are admitted exciting causes of haemorrhoids, they do not sufficiently account for their occurrence in all cases, especially in very young patients. What, however, may be termed the "new formation" or "angioma" theory of G. Reinbach\(^2\) is sufficient to explain the peculiar disposition of some persons to develop haemorrhoids, even when special exciting causes are apparently absent.

Similarly, in regard to ordinary varicose veins of the lower extremities, although venous pressure and inflammatory conditions are probably the usual exciting causes, a peculiar, sometimes hereditary, tendency towards varicose veins must be admitted in many cases. In extreme examples, indeed, varicose veins may be congenital, or almost congenital, and definitely associated with nævus-formation in the affected extremity.\(^3\)

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THE STOOLS OF DYSENTERY AND THE PROGNOSTIC INDICATIONS DERIVABLE FROM THEM.

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Much information can be gained from an inspection of the stools in dysentery, both with reference to the extent of the process going on in the intestinal canal, and also as regards the prognosis of the case. The dysenteric stool should always be seen by the physician at his visit to the patient, and the best method of preparing them for inspection is that practised at the General Hospital, Calcutta, instituted by Dr. Goodeve, a good account of which appeared in this *Journal* for 1900, vol. vii., by Colonel Macleod, Professor of Tropical Medicine at the Army Medical School, to which the reader is referred. The article in question is well worth studying.

\(^1\) On local inflammatory conditions as causes of haemorrhoids, see Quenu, "Étude sur les Hémorrhoides," *Rev. de chir.*, Paris, 1893, tome xiii. p. 200.

\(^2\) "Path.-anat. u. klin. Beitr. z. Lehre von den Hämorrhoiden," *Beitr. z. klin. Chir.*, Tübingen, 1897, Bd. 19, S. 1; and "Hämorrhoiden im Kindesalter," *Mitth. a. d. Grenzgeb. d. Med. u. Chir.*, Jena, 1903, Bd. xii. S. 272.

\(^3\) Examples of this are to be found in some of the published cases of overgrowth of an extremity, associated with, and possibly dependent on, developmental overgrowth of the blood vessels of the part, such as Roxburgh's case in a child aged 5 years (*Rep. Soc. for Study Dis. in Children*, London, 1902, vol. ii. p. 222), and Kellock's case in a child aged 8 years (*Trans. Clin. Soc. London*, 1903, vol. 36, p. 254). In regard to the view that varicose veins are venous overgrowths, allied to venous angiomata, see Mr. A. Pearce Gould's Lettsomian Lectures in *Trans. Med. Soc. London*, 1902, vol. xxv., p. 132.