action may well explain the development of pleural and abdominal fluid. It is also unknown whether the peritoneum reverts to its normal state; the presence of fibrosis would seem to suggest that it did not.

Presentation of these cases usually stimulates a discussion amongst the audience regarding similar cases that have been seen. This occurred in 1942 at the Association of American Physicians meeting in Atlantic City, and it was following this meeting that the author was convinced that this case was similar to the one described by Dr. W. Herrick.

One is led to the belief that similar diagnoses would be made if physicians were more alert to the syndrome. One also feels, that those patients considered to be cases of inoperable abdominal malignancy, deserve a laparotomy, particularly if pleural fluid also exists.

In the present instance the patient was aware of the unfavourable diagnosis originally made, and underwent undue suffering as a result, and for almost two years remained bedridden, devoid of hope of recovery. The occurrence of such a miraculous recovery, to her, has been a spectacle which has impressed one with the importance of the syndrome. The combination of ovarian tumour with ascites and pleural fluid does not always mean cancer.

It is agreed that the final diagnosis of multilocular papillary cystadenocarcinoma constitutes another exception to the type of ovarian tumour which has ordinarily been associated with pleural and abdominal fluid. In this particular instance carcinomatous degeneration did exist, but as far as known had not metastasized, nor was the pleural effusion due to secondary metastases.

These exceptions, I feel, should be included in the syndrome as they seem to present the same features and respond in the same manner when removed as do the ovarian fibromata. It is probable that the mechanism of the hydrothorax is also identical.

**SUMMARY**

A case of multilocular papillary cystadenocarcinoma of the ovaries, associated with ascites and pleural effusion, is presented. This is an exception to the common type of ovarian tumour associated with Meigs' syndrome, but similar in the predominating signs and symptoms. Removal of the tumour likewise terminated the disease.

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**PSYCHOLOGICAL FACTORS IN SKIN DISEASE**

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A DERMATOLOGIST discussing the connection between skin diseases and emotional factors before a forum of psychiatrists, can do little more than present the problems with which he is confronted. He is a diagnostician and deals with a highly objective ocular specialty in which, to quote Stokes, "enthusiasm for the photographic, and dominance of the photographic type of mind, is a natural consequence of his case material". This and the involved terminology of both dermatology and psychiatry tends to retard co-operation.

With the adoption of a more functional viewpoint in diagnosis and research, the need for closer co-operation between the two specialties becomes obvious. Both the over-enthusiast and the skeptic among dermatologists help to confuse the issue. The skeptic will rightly point out that emotions are very rarely the etiological factor of skin diseases; he will say that the presence of both neurotic and cutaneous symptoms does not prove a causal connection; and that in some cases the neurotic symptoms will be the consequence rather than the etiology of the skin disease. The enthusiastic dermatologists may tend to over-estimate psychogenous factors; may omit to carry out accurate investigation of sensitizing agents; and may, using a loose terminology, blame "nerves" for a variety of skin diseases. The error lies with both extremes in over-stressing the factor of

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emotional disturbances as a pertinent etiological point, and omitting to study the more intricate inter-relationship of psyche and skin.

Until recently the study of the psychogenous in dermatology has been limited to conditions in which the connection was evident. Self-inflicted lesions, hysterical gangrene and the fascinating problem of stigmatization have been studied, and some patients with neurotic manifestations have been investigated by psychiatrists. Some change has been noticeable during the last few years. Stokes in his excellent review of the literature discussed more than 80 papers on this subject. He made the important statement that psychological factors rarely appear as the sole cause of a dermatosis. He argues against the "sole cause" attitude of mind and develops a viewpoint which recognizes a multiple causation and inter-relationship as more fundamental than a single isolated cause.

Both the psychiatrist and the dermatologist are confronted with the problem of specialization. Both have to be thoroughly familiar with their particular field of work and, at the same time, should not lose contact with the fundamentals of medicine and physiology. The study of psychosomatic relations in dermatology is based on a thorough understanding of the physiology of the skin and, to quote Stokes once again, "as soon as a dermatologist becomes aware of the fundamental physiology of the skin, out comes a paper on the psychologicaL background".

The pathogenesis of many skin disorders is connected with vaso-constriction and vasodilatation. A sudden flushing of the face is a normal physiological phenomenon frequently caused by emotions. It may be perpetuated or exaggerated and may give the basis for anatomic cutaneous changes. Our knowledge of this problem, which is one of the fundamental links between dermatology and psychiatry is still limited, but some light has been thrown on the subject by recent investigators. The normal person will blush on face and neck following an emotional stimulus or a histamine injection. Williams has shown that blushing in patients with atopic dermatitis occurs on wide areas of the body with special predilection for the cubital spaces—the favourite localization of this disorder. We have confirmed this observation, not only in atopic dermatitis but also in urticaria, toxic erythema and other skin conditions. We do know that histamine and H-like substances, as well as acetylcholine are released centrally and that emotions are one of the stimulating factors.

Gillespie, whose co-operation with the dermatological clinic of Barber has been setting an example for fruitful collaboration between psychiatry and dermatology, described, to quote one example, the case of a young man in whom perpetual blushing was found to be an expression of an Edipus complex with associated feelings of guilt with regard to his mother—later transferred to all women he saw.

The importance of the histamine-acetylcholine mechanism in the pathogenesis of skin disease cannot be over-emphasized. Grant and co-workers have presented evidence that urticaria in their cases was produced by the release of acetylcholine at the terminations of cutaneous nerves. Hopkins and co-workers described cases in which a generalized urticaria was brought about by exposure to heat. Urticaria was produced by the following stimuli: (1) Exposure to heat, partially or generally. (2) Exercise. (3) Emotional excitement, fear and anger. (4) Introduction of acetylcholine, parenterally.

We have observed identical cases in which histamine sensitivity was present and urticaria was produced by the same stimuli as above, substituting histamine for acetylcholine. Histamine desensitization was followed by freedom from urticaria in the case of an 18-year old girl who had been suffering from a heat urticaria for 8 years. Embarrassment was the chief factor in producing urticaria in her case but exercise or a hot bath was equally effective in producing her skin symptoms. Psychiatric examination revealed her to be immature emotionally. She was brought up in a very strict environment, had no opportunity of discussing her problems with her parents or friends and developed a feeling of inferiority. Such cases are good examples of emotional instability and a hypersensitivity to a known substance.

The connection between histamine sensitivity and allergic phenomena in the "asthma-hay-fever-eczema" complex is not yet understood. The psychological factor is, however, firmly established, thanks to the basic investigations of the asthma personality by Dunbar, Witt-
Heat regulation and the sweat mechanism are equally important links between psychological factors and skin conditions. Ziegler and Cash in an extensive study of skin temperatures among a large number of psychopathic patients observed a wide variability in reaction and concluded that cerebral heat control is centred in the hypothalamic region. The influence of sweat on the skin, on its pH, its acid mantle, and its defence mechanism, is of the greatest importance and has been extensively studied. Rogerson expresses the belief that hyperhidrosis of the palms has almost invariably a psychological background, and every dermatologist who has seen the epidemics of fungal infections, as well as the so-called dyshidrotic eczemas in medical students during examination time will readily concur. Gillespie reported the case of a woman whose hyperhidrosis began with her engagement to a man she did not love and continued because of the conflict between her sense of duty and her desire to dissolve the engagement. In some instances such connections are very obvious. Lately, I observed a male patient who was engaged in business transactions which involved interviews with bank presidents and other businessmen. This patient developed a palmar hyperhidrosis and interdigital "dyshidrotic eczema". Both hyperhidrosis and skin disease disappeared spontaneously with the successful conclusion of his business transactions.

Kuno's extensive review of the physiology of human perspiration gives great weight to the emotional factors. The apocrine sweat glands have been recognized as basically different in physiology from the eccrine glands (Schiefferdecker) and termed accessory sex glands by Way and Memnesheimer. They are markedly influenced by stimulation, by sexual and mental reactions and participate in the physiological sexual cycle. Kuno points out that there is much evidence to indicate that all sweating is centrally controlled through sympathetic fibres, and pituitrin injected into the region of the hypothalamus gives rise to extensive sweating which does not occur when it is introduced in other ways. The apocrine glands have a markedly higher pH than the eccrine glands and activity of the former tends to form a favourable environment for the growth and multiplication of ringworm; this is an excellent example of the long and complicated chain of events which may be started by an emotional stimulus.

In other cases, we observe the connection between psyche and skin without being able to determine the physiology of the skin changes. Gillespie enumerates various reasons why the skin is an organ of predilection for psychogenous manifestations. The skin is second only to the genital organs as the source of sexual excitement. According to Freud the entire body surface is an erogenous area in early infancy with special accent on perigenital, perianal and oral zones. By the mechanism of fixation or regression special sensitivities may linger on in certain areas in adult life. Sadger believes that perianal pruritus in old age may be explained by such a regression in some cases. Cutaneous masturbation; extensive scratching accompanied by sexual feelings, were described by Formia and Stokes. Pearson presented an interesting analysis of intensive scratching of a previous interdigital mycosis in two patients whose behaviour to their skin lesions was a form of childish autoerotism, to which they turned because they found it impossible to have adequate emotional outlets and social relationship in real life, due to fear. In one, over-restricted environment, threat of punishment, and lack of love, resulted in hatred and castration fear. In the other, fear of super ego, and social disapproval prevented the patient from carrying out her wish to leave home and fulfill her desires; these cases are of interest because by an emotional mechanism a skin disease of known etiology, a ringworm infection, was perpetuated.

Numerous examples could be cited in which such a mechanism is in operation. Gillespie observed a case of vulvar pruritus in an unsatisfied woman whose husband suffered from ejaculatio precox, and the case of a man whose perigenital pruritus commenced after the death of his wife, both patients admitting that they derived great pleasure from scratching. However, the question of pruritus cannot be explained on the basis of voluptuous sensations only. Brack, in an extensive and very involved article postulates a threshold susceptibility to itching. He claims that this threshold for pruritus differs under various circum-
stances in normal persons. Goldsmith points out that pruritus depends upon peripheral perception both for pain and touch and that itching is received centrally in the thalamus, the cortex having little to do with it. He further observed that in the normal skin slight itching and prickling sensations occur frequently; this is probably Brack's threshold of pruritus. The degree of attention to that sensation is usually so slight that it passes unnoticed but if attention is focused on it, actual pruritus occurs. According to Goldsmith this degree of attention focused on the lesions, rather than the itching sensation was the cause of the pruritus; this probably explains why some skin diseases usually non-pruritic cause intense pruritus in some patients, e.g., psoriasis.

I have seen a series of patients in which a combined mechanism seemed to be present. I have observed many cases of genital and perianal pruritus without anatomical basis occurring in European immigrants who have left their wives behind and could not afford, financially, to have them follow. Most of these men are devout Catholics and have infrequent sexual intercourse, perhaps once or twice a year, usually under the influence of alcohol. Such escapades are then followed by extensive feelings of guilt, frequently linked with the fear of having acquired a venereal disease. This focuses their attention on the genital organs and pruritus occurs. The pleasure derived from scratching seems to play a minor rôle. The perpetuation of pruritus then is easily explained by anatomical changes. Scratching causes loss of the horny layer, parakeratosis, and thickening of the skin, both by multiplication of epithelial cells and elongation of rete pegs, thus leading to the histological picture of lichenification. This thickening of the skin causes pruritus per se, which in turn leads to more scratching as well as to more intense focusing of attention on the regions affected, thus causing fear and apprehension. This is a perfect example of a vicious circle of psychosomatic relation, and such cases may well present difficult therapeutic problems.

While topical treatment is necessary to cure the lichenification some simple psychotherapy should be used to maintain the therapeutic results. A simple explanation of the mechanism, according to the grade of intelligence of the patient, alleviating the feelings of guilt, and the fear and apprehension, combined with some suggestion is often sufficient. A vast literature on the problem of pruritus has accumulated, many articles dealing with the question of menopausal genital pruritus. It is generally claimed that oestrogens, applied topically, by mouth or by injections, are helpful. In an analysis of menopausal symptoms it was found that only a small proportion of women suffer great inconvenience, chiefly those who have been frustrated in their emotional and sexual lives. It was claimed that the majority of symptoms have an emotional mechanism caused by a feeling of frustration and panic. Experiments have shown that in some cases of vulvar pruritus injection of pure peanut oil has had the same effect as an injection of oestrogens. I have sometimes observed a rapid healing of vulvar pruritus after hormone therapy, which was quite insufficient according to all standards; while in other cases full therapeutic doses were ineffective.

A careful case history is of great importance. Recently, I saw a middle-aged woman, complaining of pruritus on the soles for two years, treated unsuccessfully as dermatophytosis. No evidence of a mycotic infection was found and the facial expression and behaviour of the patient suggested emotional stress, though she denied emphatically any possible connection. Examination by a psychiatrist revealed that her married life was most unhappy. She resented chiefly the fact that her husband refused to take her out and stated that she has spent her evenings at home for many years, not going even to a movie. She felt most unhappy and thought of escaping from these restrictions, or in other words, she got "itchy feet". Such word symbolism or organ language such as "hard to stomach" or "I could not swallow that pill" often gives a short-cut to the correct diagnosis.

Another reason why the skin is often the site of manifestations of emotional origin may be the fact that the skin is more liberally supplied with pain afferents than other organs. It is, therefore, important in patients with deep-seated emotional trends, such as feelings of guilt, as the skin may be the site for self-punishment and masochistic tendencies. Many of the self-inflicted skin lesions may be cited in this connection. Gillespie reports a case of a young girl harbouring death wishes with
regard to her mother. She inflicted bizarre lesions on her forearms with a pair of scissors as a form of self-punishment as well as realization of her death wishes, replacing herself for her mother.

The skin is of course also an organ capable of being used as a vehicle of hypochondriac tendencies, and fear of cancer, syphilis and parasites is common. While some patients are of psychiatric interest only, skin diseases may be caused or more often perpetuated and aggravated by constant observation, scratching or picking as already discussed.

The skin is furthermore an organ of social importance connected with display and self-decoration. I hesitate to mention the use of cosmetics as a psychosomatic symptom. However, minor skin blemishes may assume great importance in some patients and constant observation and picking of acne is one of the known factors aggravating such a condition. Here, one might mention that a longstanding, itchy disfiguration of the skin may have a profound effect on the psyche and the emotional stability of the patient. Clearly, the presence of both cutaneous and emotional disturbance does not prove that the skin trouble is emotionally conditioned. O'Leary and Sulzberger both raise the question of the horse-cart relationship; which comes first and is causal, the dermatosis or the neurosis? In some allergic conditions both are part of a constitutional pattern and happen concurrently without causal relation.

A very frequent mechanism is to use a skin ailment as means of gaining sympathy and attention, or for some definite purpose such as a trip to Florida, or to avoid some work or appointment, or sexual intercourse with a distasteful partner, or generally to avoid decisions of any kind. This mechanism may occasionally be a causal fact or, more frequently, it operates in cases of allergic eczema, causing relapses and exacerbation. Every dermatologist could quote examples: I have recently observed a patient in whom a severe exacerbation occurred whenever the patient was about to begin a new job. She had strong feelings of inferiority, dislike for her mother and father-dependence and could successfully shirk any responsibility or decision by a new flare-up of her eczema. Children, especially first-born children, use this method to enforce attention when the birth of a younger brother or sister evokes jealousy and the feeling of being neglected.

Occupational dermatitis, caused by some specific contact, is frequently perpetuated by distaste for a special job. Anxiety about the future, general fidgetiness and subsequent picking and pruritus are other features met with in occupational dermatitis, and the question of compensation frequently enters the picture. Again an example of the correlation of emotions and a skin condition of known etiology.

The possible psychogenic correlates of allergic phenomena are still not well understood. The extensive work of British and Continental investigators has been greatly neglected in the literature of allergists on this continent. Hansen stated ten years ago that allergens operate only under certain conditions and psychic constellations. The patient may show sensitivity to a particular substance at one time and not at another. Patients occasionally claim that they break out in urticaria after eating some specific food, viz., tomatoes, whenever they are overtired or rundown but if feeling well, tomatoes are tolerated; skin tests are by no means infallible.

A patient may display an asthmatic attack produced by an injection beneath the skin, or an asthmatic attack which is elicted by injection into the patient by way of conversation of a topic which gets under his skin in a figurative sense.

Gillespie's analysis of the breathing relations of various emotional states to asthmatic breathing (conception of breathlessness and closed space and equivalent of asthma to weeping) is of interest and can be linked to Witkover's case in which opening a window and looking out into space could divert an attack. Diehl and Heinichen, could change the wheal-reaction of skin tests in controlled conditions under hypnosis, and these experiments have been borne out by Sahlgren and Marcus who succeeded in inhibiting the positive intradermal reaction to a substance to which the patient was known to be sensitive by suggesting in hypnosis that the injected allergen was a different substance. Even positive tuberculin reactions could allegedly be inhibited by hypnosis.
Most reviewers are sceptical of the remarkable feats performed by Kartamishev in hypnosis. One of his experiments consisted in producing a second degree burn with blister formation by application of a cold coin and suggesting in hypnosis that it was red hot. His therapeutic results using suggestion were most astonishing. While I have not witnessed his famous experiment I have talked to various dermatologists who were present and who described the controlled conditions of the experiment and I know Kartamishev, who is now chief of a large dermatological university clinic in Russia, and I feel that he is a most sincere and accurate investigator.

A few years ago we attempted oral desensitization to food allergy. The patient in question suffered from an asthma-eczema complex and was found to be sensitive to pork and lentils. Ingestion of minimal quantities of dialysates of this food protected him from asthmatic attacks and exacerbations of this eczema which otherwise occurred invariably after eating this food. This interesting case was posted for a demonstration before a medical society, and by mistake a different dialysate was given prior to a meal and found to have protective value. We found then that any placebo had the same effect, provided the patient believed it to be the protective substance and, further, to our amazement, it was found that pork hash presented as veal did not cause an allergic manifestation while veal, chicken and other substances presented as pork caused violent attacks. Skin tests were entirely inconclusive, and finally when the patient was told about his unscientific behaviour he gave up having asthma altogether.

While the concept of the mechanism of allergy, histamine sensitivity, and emotional factors, are still in a chaotic state, the impression that the allergic subject is a distinct personality has been gaining ground. I mentioned Dunbar, Witkover and Gillespie's work; and Rogerson's excellent summary of the asthma-prurigo child can be corroborated by the dermatologist. Most of these investigations have been made on asthmatics rather than dermatological patients and are too specialized to be presented by a dermatologist.

Stokes in a recent and excellent article summarized the personality of the eczema-prurigo patient as follows: (1) Deep-seated feeling of insecurity. (2) Easily developed feeling of inferiority. (3) Intense self-consciousness; not egotism, but rather ultrasensitiveness. (The character of Jacob in Thomas Mann's master work shows these features, and he also mentions his sensitive skin and inflamed eyelids.) (4) Lability of mental and physical reactions resulting either in adaptability or instability. (5) Intrinsic kinetic drive: as Stokes explains, 1,000,000 volt generator. (6) Aggressiveness and disposition to command attention—compensation for 1 and 2 plus 4. (7) All or none type of reactivity. No compromise in problems or in reaction to stimuli. (8) Higher than average I.Q. (9) Tension, expressed or repressed. (10) Restlessness, not due to instability, but to rapid exploration and exhaustion of a subject by a high pressure mind of exceptional capacity. Constant exhaustion of the possibilities of the moment leads to boredom and flight rather than to rest.

Stokes, in his recommendations as to the management of such cases, is profoundly sound but too involved to be reproduced. As example, I quote his management to relax tension in a shortened way.

(a) General talk and explanation of fundamental nature of tension. Attack on the obligatory by injunction not to do, as far as possible, what patient feels must be done. In severe cases no answering mail or telephone, and abolishment of all social obligations. Provision of sanctuary, own den, playroom, etc. (b) A lecture on the "don't give a damn attitude". (c) Drill in relaxation while waiting in doctor's waiting room, substituting shrugs for jaw-clenching and teeth-grinding. Stopping of all competition in work and sport, exercise in non-competitive sports, walking. It is understood that such a régime cannot work in deep-seated neurosis but is very helpful in everyday case of tension.

To complete the picture of psychosomatic relations in dermatology it will suffice to mention briefly a variety of skin conditions in which, explained or not, emotional causation or influence is known. Besides the numerous allergic conditions the dermatoses are linked with sweating and activity of skin glands in general like seborrhoea, acne, intertrigo and secondary myotic or bacterial infections, and such conditions as connected with capillary dilatation or constriction like rosacea, Ray-
raud's disease, etc. Some conditions have been observed for which no explanation is known so far. Eller described an increase of alopecia areata after the crash of the stock market in New York.

Lichen planus, a skin condition of unknown origin probably a virus disease, seems to occur often in times of emotional stress. Herpes simplex, definitely caused by a known virus tends to appear after various stimulants as heat, sun and emotional upset. Extramarital intercourse is a common trigger factor for herpes genitalis, an event to cause deep apprehension and fear in the unfortunate victim who invariably believes he or she has contracted syphilis. I recall the case of a medical student who experienced a urethritis, clinically resembling a gonorrhoea but bacteriologically sterile, after each extramarital intercourse, while legitimate intercourse never caused a similar symptom. In this case I was able to rule out chemical urethritis by use of prophylactics and it may be of interest to note that the patient was subject to an anxiety neurosis especially syphiliphobia. He had the compulsion not to touch doorknobs with his hands, and broke many glass doors in his attempts to open doors with his elbows.

As a last example I should like to mention the rôle of suggestion in dermatological therapy. The best known example is the success in treatment of warts, especially the flat variety. Verrucae which are infectious granulomata, transmissible and caused by a virus can be cured by suggestion in many cases. The mechanism is not known but capillary microscopic examinations reveal hyperaemia around the wart following suggestive treatment. Folklore is generally a good indicator of the susceptibility of a disease to suggestion. In every country of the world some magic procedures to cure warts are known, especially among rural populations. It may be anything from covering the wart with spiderwebs to burying toad-eggs on a crossroads at new moon; all these magic procedures are effective, if the patient believes in them. Besides these obvious examples it seems to be beyond doubt that a certain percentage of our therapeutic results is based on suggestion. I have often prescribed the very same ointment, accompanied by some promising words, which has been tried unsuccessfully by some other medical man, and got credit for a quick cure. I am sure that most of my colleagues have made the same observation. Especially suggestive is x-ray therapy which occasionally works even when the technician has forgotten to switch on the high power. Experiments with systematic fake irradiation bear out this observation. Suggestion therapy, however, is a short cut which cannot be used in most cases. Further research is necessary and today, when the existence of psychosomatic relations is conceded by most dermatologists, it is of importance to determine the scope and importance of this relation. Attempts to undertake psychological studies of supposedly non-psychogenous dermatoses side by side with the allegedly psychogenous are steps in the right direction (Obermayer, Becker, van Erve and Becker).

Dermatology as an investigative specialty is confronted with the problem of psychosomatic relation as the individual dermatologist is confronted with the problem of the therapy-resistant, emotionally conditioned case in his office. Collaboration with the psychiatrist will be indispensable for future progress.

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RÉSUMÉ

Il existe en dermatologie une multitude d'affections qui relèvent autant de la psychiatrie que des maladies cutanées proprement dites. On connaît les facteurs psychiques des urticaires acétylcholiniques et histaminiques; on sait également l'influence des émotions sur la thermo-régulation et sur les mécanismes de la transpiration. Il faut avouer qu'il existe encore beaucoup d'inconnu dans la physiologie de la peau. Les prurits reconnaissent souvent dans le mécanisme de leur production un élément psychique indéniable. La psychothérapie, seule, ou aidée des thérapies locales donnent des résultats parfois excellents. L'acné demeure une affection qui influence singulièrement la vie affective des sujets qui en sont atteints. Les dermatoses professionnelles ne sont pas exemptes de l'appel psychiatrique. L'hypnose a pu reproduire des dermatoses caractéristiques. On a parlé de personnalité asthmatique et allergique, enfin, certaines affections cutanées, comme les verrues, disparaissent par le suggestion. Les désordres cutanées sont des affections ectodermiques très voisines de la pathologie neuro-psychiatrique.

Jean Saucier