DERMATOLOGICAL CONSIDERATIONS ON THE NOSE

M. K. Polano, M.D.

We have to think always of tuberculosis, syphilis and malignancy when dealing with an ulcer of the skin. Our first patient, a woman of 63 years gave, when we first saw her, an impression of lupus vulgaris. But looking more closely we saw that no lupus nodules where present and that the inflammatory process had destructed not only the cartilago but also the bony-skeleton of the nose. Our suspicion that this was a tertiary syphilis was confirmed by strong positive serological syphilis reactions and a rapid improvement on specific treatment.

Tuberculosis of the nose is in most cases a lupus vulgaris. In many cases the starting point of this very chronic and disfiguring inflammation, which may destruct large portions of the face, is in the nose. Lupus vulgaris is in most cases caused by an external infection by only little virulent tubercelbacilli in a person with a positive allergy for tuberculosis and who often is in a poor general state of health. Before the advent of internal treatment of tuberculosis, it was very important to examine in cases of lupus vulgaris the vestibulum nasi carefully and to treat locally eventual present lupus foci in the nose. Lupus vulgaris of the nose may not always be destructive, it also may cause hypertrophic inflammations. For the diagnosis it is important to look for lupus nodules; small apple-jelly coloured spots, that may be seen more clearly after pressing the blood away with a diascope. They are most easily found on the margin between normal en diseased skin. The diagnosis should be confirmed by the results of a biopsy — most convenient is a punch biopsy.

Another chronic specific inflammation was present in a patient who had consulted several nose specialists for an obstruction and swelling of the nose. Afterwards tumors on the skin of the breast arose. (fig. 1). Acid fast bacilli could easily be demonstrated in the nose discharge which established the diagnosis leprosy. Under specific treatment the obstruction of the nose disappeared. In leprosy disfiguration of the nose is a symptom often to be seen.

Carcinomata of the nose occur in a great variety. They may ulcerate but they certainly not always do. Basal cell carcinoma may appear as the classical Jacobs ulcer: ulcus rodens, an ulcer with a pearly border. But it may also appear as an transparent red, flat tumor, with teleangiectasiae. Other basalcell carcinomata do not ulcerate, but cicatrise directly, which may make their diagnosis difficult. It is self evident that in every case in which a carcinoma is suspected this suspicion should be confirmed or rejected by a biopsy.

Small basalcell carcinomata, and there is no reason to let them grow big, are easily cured by caustic doses of very little penetrating Röntgen irradiation. As a second choice surgery of electrodesiccation may be considered. A recurrence is always a serious occurrence. It may be caused by

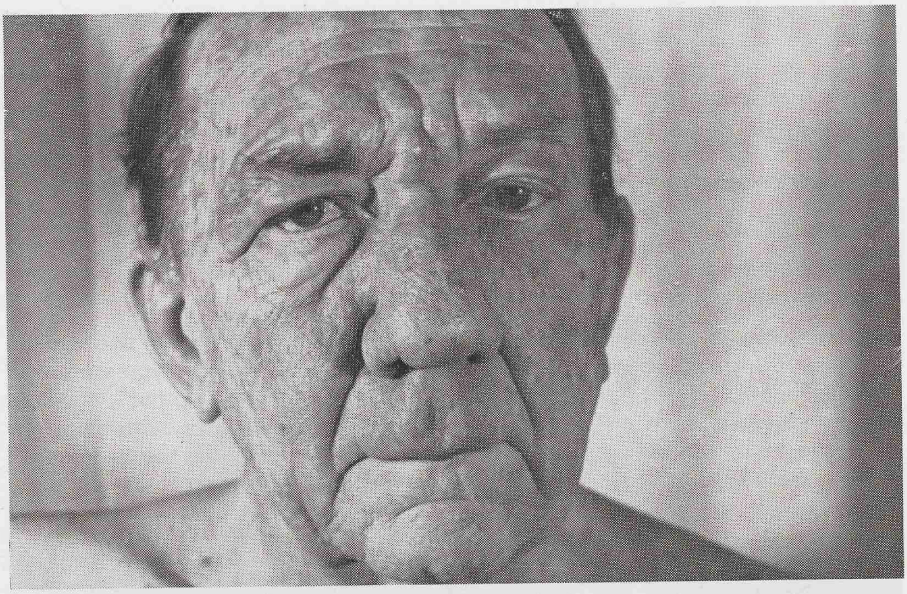

Fig 1: Lepra of the nose; Lépre du nez.

treating a to small area, or by a very penetrating carcinoma. The safest thing to do in such cases is to excise the tumor and to close the wound only after a pathologist has examined all borders of the excised piece of skin. When not all borders are free from carcinoma, the wound should be excised a new, till they are. Particular caution is necessary when a cancer is situated in the corner between nose and eye or at the nose entrance, because the spread may be here tridimensional, which makes the tumor rapidly inaccessible for current methods.

Squamous celle carcinoma is generally in the beginning a warty tumor which bleeds rather easily, later on big ulcers may arise.

Since 1950 we have learned to recognise a tumor which up till that moment was considered as a spinocellular carcinoma, but which in fact is a benignant growth. It grows rapidly and looks in most cases like a crater with a big horny plug. Histological the differential diagnosis of such a Keratoacanthoma and a highly differentiated spinocellular carcinoma is hardly possible, but the history of rapid growth, (month or weeks) against the long history of the real spinocellular carcinomas, with a similar histological appearance, makes often the diagnosis possible on clinical grounds. When the tumor is not treated it disappears in a couple of months spontaneously, as a treatment simple curettage is sufficient. As the diagnosis has always to be confirmed by the course, a follow up is necessary.

In older people, especially in those who have been strongly exposed to the sun during their lifetime, often irregular keratoses occur which bleed easily on scratching. Histologically they prove to be intraepithelial malignancies. When they are left untreated, infiltrating squamous celle carcinoma may

arise from them. Though there is no immediate danger, it is safer to treat keratoses seniles directly. This may be done by curettage, with of without subsequent electrodissication or with very superficial Röntgen irradiation. Clinically, differentation for squamous cellcarcinoma and seborrhoïc keratosis is necessary. A carcinoma is a more elevated tumor as a senile keratosis. Seborrhoïc keratoses are absolutly innocent growths appearing as yellow or brown, sometimes flat tumors with irregular surface, which seem to be stuck on the skin. Histologically these prove to exist out of a regular proliferation of basal cells. Their importance is that they may be annoying from cosmetic point of view and that they may be mistaken for cancers, or, when they are black, which is not too rare, for melanomata.

In sarcoïdosis rather often skin manifestations are present, two typical types have a predelection for the nose. In the "lupus pernio" type violet-red intumescences of nose tip and ears occur. (fig. 2). In the other type only slightly elevated more or less violet plaques arise. Often it is surprising how insignificant the clinical pictures seem to be, and how typical the lesions are when examined histologically when examined histologically.

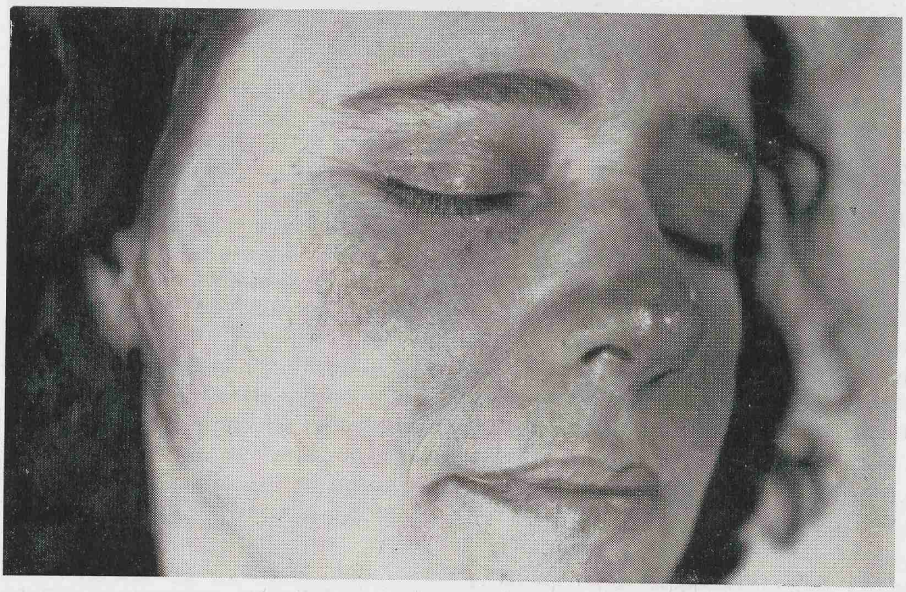

Fig. 2: Lupus pernio.

Another disease with a predilection for the nose is the rosacea. It is a disorder in which the determining pathological process is a passive hyperaemia, in which, on the skin of the nose and it surroundings, papules and pustules may arise. On the nose itself it moreover may cause hyperplasia of the sebaceous glands, which may develop into a true rhinophym. In many cases the patients suffer very much from the fact that their disorder is so

conspicuous and also from the jokes that are made because of the supposed relation with alcohol abusus. As a matter of fact rhinophyma may occur in patients who never touched alcohol. Climatological influences seem to be important and also internal disorders. Gastro-intestinal disturbances and hormonal influences are considered to be of etiological interest. To specify them is not yet possible.

Art has given ample attention to this disease in painting and in literature. Chaucer and Shakespeare describe it: on the painting by Ghirlandajo of Count Sasseti the diagnosis may readily be made (fig. 3).

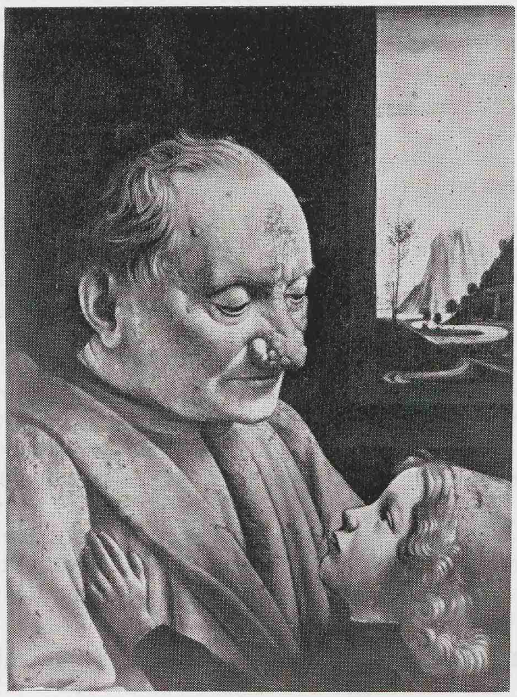

Fig. 3: Rhinophyma in a painting; Rhinophyma dans l'art. (Ghirlandajo)

In rhinophyma we may attain considerable improvent by simple cutting away the excessive growth with the diathermic loop or with cold steel. No transplantation is necessary afterwards. This is due to the fact that in the woundbed many tips of sebaceous glands are still present. Lobitz has shown that cells of cutaneous appendages may dedifferentiate to normal epithelial cells, which cover again the denuded corium.

The chronic discoid lupus erythematodes is often localised on the nose. The diagnosis should in the first place be based on the analysis of the skinlesions, which consist out of red patches with follicular hyperkeratosis. In the older lesion central atrophy arises. The well-known batlike distribution

of the lesions, in which the nose represents the body of the bat, may be an aid in the diagnosis, but is certainly not always present. An other diagnostic aid is the worsening of the lesions after sunexposure. Histopathology may be of diagnostic value. Typical are a liquefaction degeneration of the basal layer, a patchy inflammatory infiltration, combined with follicular hyperkeratosis and oedema of the superficial layers of the corium. In chronic discoid erythematodes systemic symptoms are generally absent, the L.E. phenomenon is always negative.

A newly described skin disorder that may sometimes be localised on the nose and that perhaps is closely related to the erythematodes, is the lymphocytic infiltration of the skin, described by Jessner. We see red infiltrated disseminated brownish plaques without follicular plugging. On histopathological examination only patchy lymphocytic infiltrations are found, which are bigger than those of the erythematodes.

Various kinds of generalised eczema may also impair the nose. I will only mention those, which have a predelection for the organ of our common interest. Those are the seborrhoic eczema, an erythematous-squamous kind of eczema that perhaps has some aetiological connection with hyperfunction of the sebaceous glands, which are always well developped on the skin of the nose. One of the predilection places of this eczema is the nasolabial fold, from which it may spread to other parts of the face. The other is the eczema solare, caused by an allergic reaction to ultraviolet irradiations. As the nose is the part of our face that is most exposed to sunrays, it is easily understandable that the infiltrations due to this condition are often localised of the nose.

To close I want to mention an other point of common interest of nose and skin specialist: the nose as a bacterial focus. We assume that furunculosis and other chronic staphylodermas may be maintained by bacteria in the nose. More directly we correlate a chronic pyoderma of the upperlip, the sycosis subnasalis, to a condition inside the nose. This very stubborn and for the patient annoying and often exasperating disorder is maintained by a chronic discharge from the nose. The treatment of the skin with antibiotics and corticosteroids may only be succesfull if the nose specialist cures the nose.

CONSIDÉRATIONS DERMATOLOGIQUES CONCERNANT LE NEZ

Description de quelques affections cutanées qui ont une prédilection pour le nez. La syphilis tertiaire détruit non seulement la peau et la partie cartilagineuse, mais également la partie osseuse. Au contraire le lupus vulgaire laisse l'os indemne.

Les carcinomes de la peau ont une prédilection pour la face et la peau du nez. En cas de diagnostic précoce le pourcentage des guérisons peut atteindre 100%.

L'irradiation aux rayons X très peu pénétrants est le traitement de choix; l'électro-coagulation et l'excision peuvent également donner des résultats satisfaisants. Le kérato-acanthome, tumeur guérissant spontanément, doit être differencié du carcinome spinocellulaire.

Dans la lèpre le facies léonin peut commencer avec un élargissement et une obstruction du nez. La recherche des bacilles de Hansen dans le nez est

capitale pour le diagnostic. La sarcoïdose, maladie de Besnier-Boeck-Schauman, atteint très souvent le nez: soit sous forme de lupus pernio, soit sous forme de plaques isolées. Des altérations histologiques considérables peuvent exister, quoique les lésions cliniques soient peu importantes. Parmi les autres maladies cutanées au niveau du nez nous notons l'acné en rosace qui peut être compliquée par un rhinophyme, le lupus érythémateux et l'eczéma séborrhéique.

Dans le lupus érythémateux on trouve des lésions érythémateuses à hyperkératose folliculaire et souvent de l'atrophie centrale.

Dans les formes chroniques discoïdes l'état général n'est pas atteint, le phénomène L.E. est négatif.

Tous les eczémas peuvent atteindre le nez. L'eczéma érythémato-squameux, suintant ou non suintant, que l'on nomme eczéma séborrhéïque ou eczématide et l'eczéma solaire ont une prédilection pour le nez et le sillon nasolabial.

Prof. Dr. M. K. Polano,
Afdeling Dermatologie,
Academisch Ziekenhuis,
Leiden, Nederland.