Eponymous dermatological contributions linked to Josef Jadassohn

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Josef Jadassohn was born in a Jewish family on September 10, 1863 in Liegnitz, Silesia (now Legnica, Poland), which is a town located about 80 km west of the capital of Silesia (now Wroclaw). He completed his primary and secondary education at Liegnitz, followed by medical schooling at Gottingen, Breslau, Heidelberg and Leipzig. Josef Jadassohn passed his final medical examination at Breslau in 1886. Thereafter, he was offered residency by Albert Neisser, Chairman of the Department of Dermatology at the University of Breslau.[1] Despite his interest in pathology, he believed that general pathological questions could be studied in the field of dermatology, and thus accepted this position. He was intrigued by the pathogenetic mechanisms of diseases and considered studying their functional pathology to acquire a better understanding. Following residency, he joined the same university as staff and eventually attained the position of chair of dermatology in 1917. During this period, he studied and categorized the dermatological diseases, based on etiology. He was intricately associated with multiple dermatological societies, apart from being an editorial board member of "Archiv für Dermatologie und Syphilis." One of his priceless contributions to dermatology was the "Handbook of Skin and Venereal Diseases," one of the most comprehensive dermatology textbooks. He resigned as chair of dermatology at the university in 1930. Nazi uprising in Germany forced his migration to Zurich, Switzerland, in 1934. Jadassohn was diagnosed with colon cancer in 1936, to which he succumbed on March 24in the same year.[2,3]

His contributions to the field of dermatology are vast, and he shares the following eponymous dermatological conditions, along with his illustrious coworkers and students.

1. Jadassohn-Pellizzari anetoderma - In 1892, Jadassohn described a woman with erythematous macules on her arms which resolved as circumscribed atrophic lesions. He identified the loss of dermal elastic fibers in the atrophic lesions and attributed this process to perivascular chronic inflammatory cells. This condition was termed "erythematous anetoderma of Jadassohn."[2] Anetoderma is classified as primary or secondary. Primary anetoderma is further divided into one preceded by inflammatory lesions, which could be red papules (Jadassohn type) or urticarial lesions (Pellizzari type) and anetoderma without preceding lesions known as Schweninger–Buzzi type.[4]
2. Pityriasis lichenoides - It was first reported by Neisser and Jadassohn as two separate case reports in 1894. They described it as "peculiar psoriasiform and lichenoid exanthem," which was later named as pityriasis lichenoides chronica by Fritz Juliusberg in 1899.[2]
3. Nevus sebaceus of Jadassohn - It was first described by Jadassohn in 1895. His description of histopathological features included epidermal hyperplasia, large and well-formed sebaceous lobules, and absence of terminal hairs. He suggested its origin from abnormal embryonic development.[2]

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4. Patch testing - Josef Jadassohn is acknowledged as the father of patch testing. He first presented the results of his technique at the 5th Congress of German Society of Dermatology in Graz, Austria on September 23, 1895, when he was a young professor at Breslau University, Germany.[2] He described the eczematous reaction to mercurial compounds on intact skin in previously sensitized individuals. Bruno Bloch expanded his work while working at Basel in 1911 and developed a grading system for patch test reactions.[2,5] For this reason, patch testing is often called Jadassohn–Bloch technique.
5. Granulosis rubra nasi - It is a disease of eccrine sweat glands, first described by Jadassohn in 1901 as "nasi hyperhidrotic erythematosa micropapules dermatosis infantum."[6] Usually, it starts during childhood as localized hyperhidrosis on the central face, typically affecting the tip, alae and dorsum of the nose. This is followed by secondary changes like blanchable erythema, papulo-vesicles and pustules. It resolves spontaneously by late adolescence. His histological description of this condition included dilated eccrine ducts and periductal dense lymphoplasmacytic infiltration.[2,6]
6. Jadassohn–Lewandowsky syndrome - This syndrome is also referred to as pachyonychia congenita. It was described by Josef Jadassohn and his assistant, Felix Lewandowsky. Their findings consisted of markedly thickened nail plates, palmoplantar keratoses, disseminated follicular hyperkeratoses and leukokeratosis of the tongue.[2,7]
7. Jadassohn–Tieche nevus - In 1906, Max Tieche, a student of Jadassohn, first described a series of small dark blue to black spots on the face and extremities, which he called blue nevi. He attributed the blue color to the location of pigment in deep dermis.[2]
8. Borst–Jadassohn phenomenon - It was reported by Max Borst in 1904 as a microscopically well-defined nest of atypical keratinocytes within disorganized epithelium in invasive carcinoma of the lip.[8] In 1926, Jadassohn described a verrucous neoplasm with similar well-demarcated cluster of cells with small dark nuclei in the epidermis. Although originally considered as a distinct entity (intraepidermal epithelioma of Borst–Jadassohn), it is now regarded as a nonspecific morphological expression that can develop in many benign and malignant tumors like clonal seborrheic keratosis, Bowen's disease, actinic keratosis, hidracanthoma simplex and rarely epidermal nevi.[8] It is characterized by the presence of sharply defined nests of typical or atypical epithelial cells in the stratum spinosum of an acanthotic epidermis.[2,8]

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Conflicts of interest
There are no conflicts of interest.

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