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REPORT OF AFFILIATED SOCIETY.

The St. John's Hospital Dermatological Society (incorporating The London Dermatological Society).

Meetings will be held at St. John's Hospital, 49, Leicester Square, at 4.15 p.m. on:—

Wednesday, January 23rd, Clinical Cases.
,, February 27th, Clinical Cases and Paper.
,, March 27th, Clinical Cases.
,, April 24th, Clinical Cases and Paper.
,, May 22nd, Clinical Cases and Annual General Meeting.
,, June 26th, The Prosser White Annual Oration.

A Meeting of the Society was held at St. John's Hospital for Diseases of the Skin, 49, Leicester Square, W.C.2, on Wednesday, October 24th, at 4.15 p.m. Dr. J. E. M. Wigley, the President, was in the Chair.

Clinical cases were shown as follows:—

Case 1, Dr. Griffith.—Large papular syphilide in a married woman, aged 22. The patient had a large papular rash on the trunk and limbs for 10 weeks. There was a general adenitis, and the Wassermann reaction was positive.

Dr. Wigley.—A case of a man aged 50, who gave a history of having Psoriasis for about 20 years. The condition gradually became worse during the war period, and three years ago, after being involved in a motor car accident, the rash appeared to him to take on different characteristics. It became markedly itchy for the first time, and this itching has continued to be very severe ever since. The rash was now widely spread; affecting the forehead, face, trunk, and limbs. It consisted of erythematous, and in places infiltrated, areas of irregular shape, enclosing areas of apparently normal skin. In places moist plaques were present, and there were a few raised, infiltrated tumours, which, together with the already described lesions, were very suggestive of Mycosis fungoides. A biopsy is in progress of being made, and there has been some definite amelioration of symptoms following a short exposure to X-rays.

Dr. Griffith asked whether in such early cases the pathological examination was really distinctive, and could help one in the diagnosis of early mycosis fungoides. He thought, however, that the case was of that nature.

Dr. Muende, in answer to Dr. Griffith said that, although the histological diagnosis of mycosis fungoides was frequently a difficult one, it could always be distinguished from psoriasis, but in its very early stages only with difficulty from eczema. Later, however, the pleomorphic cellular infiltration in the papillary and sub-papillary zones was usually sufficient grounds on which to make the diagnosis. All cases of mycosis fungoides do not take on the same characteristics, and occasionally one meets variations in which the microscopical appearances suggest lymphoblastoma, although the clinical appearances can in no way distinguish them from mycosis fungoides.

Case 2, Dr. Griffith.—A papular eruption of six weeks' duration in a man aged 22.

Dr. Brain said he thought the individual lesions were psoriasiform, but syphilis could enter into the diagnosis. He regarded the palmar eruption as being psoriatic, but advised a Wassermann reaction.

Dr. Peters thought there was an absence of typical scaling.

Dr. Wigley thought it was psoriasis, particularly as there was absence of any adenitis, or evidence of a primary lesion.

The Wassermann reaction was negative.

Case 3, Dr. Griffith.—A macular squamous eruption on the chest, particularly on the sides and in the axillæ; on the arms, chiefly in the anticubital fossæ, and also legs.

Dr. Brain considered the case to be either a secondary syphilide or a seborrhœic condition. If it was the latter it was probably on the border line between seborrhœic dermatitis and psoriasis. The number of lesions around the neck supported the diagnosis of syphilis.

Dr. Linn thought that although the distribution was seborrhœic in type, the individual lesions were psoriasiform.

Dr. Guthrie thought there was some similarity to Pityriasis rosea, although he was inclined to agree with Dr. Brain.

Dr. Cornick thought the condition was like psoriasis, and not syphilis, but strongly advised a Wassermann test.

Dr. Wigley thought that it was a case of psoriasis with an unusual distribution, and advised anti-psoriatic treatment.

Dr. Muende, in answer to a question said that, although the pityrosporon was not found in psoriatic patches when occupying the usual sites of predilection, it was not uncommon to encounter them when present in the axillæ or groins. He thought, however, that the presence of the bottle bacillus in psoriatic scales in axillary or inguinal lesions was merely fortuitous, as the medium found in these regions was highly suitable for the growth of this organism.

Case 4, Dr. Brain.—A girl aged 11, who had scurf on the scalp for 10 months, which later developed into a curious alopecia, which appeared to have some scarring, and was suggestive of pseudo pelade. Wood's light was positive, and although there were no obvious stumps, microsporon fungus was found.

Dr. Wigley thought that the clinical appearances were suggestive of two things: firstly, the remnants of a Kerion celsi which had cleared up, leaving a smooth shiny surface; and secondly, that the condition was a pseudo pelade. He drew attention to one of the remarks made by Dr. Sequeira, that every scaly condition on the head of a child should be considered as ringworm until you could prove that it was not.

Dr. Brain thought that if the condition was due to a fungus, it ought to be favus, but he could find no scutula.

Dr. Muende who had examined the patient in the laboratory, said that this type of case needed careful examination. Its festooned margin and early scarring were very suggestive of pseudo pelade, but close examination revealed the presence of a few grey lustreless hairs along the invading margin, and it was not difficult to find the fungus microscopically. He thought that the latter would probably prove to be of animal origin.

Case 5, Dr. Griffith.—Man (in-patient) about 48, a concrete worker who had been sent to Dr. Griffith as a case of occupational dermatitis. Two months ago the skin condition was in an acute inflammatory state and swollen. After a week or ten days, Dr. Griffith was surprised to see the rash appear as a bullous lichen planus.

Dr. Brain said that the present appearances were very much like Lichen planus; there was atrophy and pigmentation.

Dr. Wigley said that looking at the eruption now, with the pigmentation and even one or two remaining papules on the back, and the lesion in the mouth, the condition was extremely suggestive of a healing lichen planus.

Dr. Muende said he had had the good fortune, whilst in Vienna, of seeing a case which was not unlike the present one. When he saw the Viennese patient he had a typical widespread lichen planus, which, later, without the administration of arsenic, developed into a very severe bullous lichen planus.

Case 6, Dr. Brain.—A girl aged 12. Mother stated that an eruption under the skin was present for three weeks. Four days ago papular lesions appeared on the face. The physician who had sent the case suggested a diagnosis of Lupus erythematosus, but Dr. Brain regarded it as a case of Erythema multiforme. The patient had lesions on the hand which resembled Lupus erythematosus, but some of the lesions on the face were typical of erythema iris, although the lesions had a batswing distribution.

Dr. Wigley and Dr. Griffith agreed with Dr. Brain's diagnosis of Erythema multiforme.

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Case 7, Dr. Griffith.—A woman aged 38. Fissures at the corners of the mouth; smooth tongue; conjunctiva and mucous membrane of mouth pallid. The patient had lived in Australia for a number of years, and had received X-ray treatment for the fissures.

Dr. Bellringer mentioned that fissuring at the angles of the mouth was commonly seen in women in New Zealand in association with various types of anæmia, both primary and secondary, although it was also found in the absence of anæmia. He thought the immediate cause was due to streptococcal invasion of the weakened tissues, or spread of general reaction from the mouth. It was of value in this case to estimate the hæmoglobin of the blood, and if the latter was below 75 per cent., a blood count should be done. Looking through his figures of idiopathic hypochromic anæmia, he found that 85 per cent. of these cases showed either achlorhydria or hypochlorhydria. With regard to general treatment, he advised, in addition to massive doses of iron, a minute amount of copper sulphate (grains 1/16th to grains 1/12th to the dose). Vitamin in the form of brewer's yeast or marmite was also of value.

Case 8, Dr. Griffith.—A patient, male, aged 40, with a pustular dermatitis of five months' duration, affecting both hands. Dr. Griffith suggested the diagnosis of pustular psoriasis.

Dr. Wigley thought it was probably a case of an external dermatitis due to sugar soap or some other similar substance.

REVIEWS.

THE SCIENCE OF SIGNS AND SYMPTOMS.

By Prof. R. J. S. McDowall. 3rd Edition.
Messrs. William Heinemann. 1934. 21/-.

It is a healthy sign that this work should have passed through three editions within the space of a little more than two years, for it shows the demand that prevails for a thorough understanding of the rationalé of the signs and symptoms of disease. Symptomatology, and under this term the author includes both subjective and objective evidence of disease, is discussed by Prof. McDowall in a most interesting and comprehensive manner and is explained in as far as is possible on a physiological, or perhaps more correctly, a biological basis. It is this wide outlook on the problems of disease with the soundness of the conclusions drawn which makes this book one which can be constantly referred to with profit by all students of medicine.

WHAT OF THE CHILD?

By Andrew Kefalas, M.A., M.B., Ch.B.
William Heinemann, Ltd. Price, 5/-.

There is always room for sincerity and simplicity even in the somewhat overloaded literature of child welfare and education, so we may unhesitatingly welcome this little book which is well within the scope of the average intelligence and the average purse. The author, in a small volume of 180 pages, gives advice on the physical, mental and moral rearing of children, salted with a fair amount of prejudice and dogmatism, but not by any means without humour and common sense. Experienced parents and teachers will agree with many of his dicta, and equally heartily disagree with others. If only the questions that children asked were all as tactful as he suggests! After all, the problem of where the kittens come from is simple enough and raises no blush to the cheek of the modern parent, but what of the small and perfectly serious boy who says to his mother (in front of strangers at lunch) "But how do you *know* that Father is my father?"

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