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 and Paper read by Dr. R. R. Wettenhall, of Melbourne, on "The Practice of Dermatology in Melbourne, Australia."

,, February 27th—Clinical Cases.

,, 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, November 28th, at 4.15 p.m. Dr. J. E. M. Wigley, the President, was in the Chair.

Clinical cases were shown at 4.30 p.m., and at 5 p.m., Mr. Norman C. Lake, M.D., M.S., F.R.C.S., read a paper entitled, "The Surgery of the Sympathetic Nervous System in relation to Cutaneous Lesions." The clinical cases shown were as follow:—

Case 1, Dr. Goldsmith.—Patient, male, aged 63, came to the out-patient department on November 13th with a lesion of 3 weeks' duration. There was a red plaque over the sacrum, and within the red plaque two ulcerated crescentic areas. The raised edge around the ulcer was not at the periphery of the red plaque, but well within it. Dr. Goldsmith thought its growth too rapid for tuberculosis cutis, and considered that it was either a gumma or a squamous-celled epithelioma. The Wassermann reaction was negative. He had ordered mercury and iodide, and although no improvement was noticed after the first week, he said that there was an appreciable change for the better during the second week. The patient had had a similar lesion on the right thigh in January, which healed without treatment, leaving a scar. The section showed a definite granuloma: certainly not epithelioma, and it did not look tuberculous.

Dr. Muende supported the diagnosis of gumma and thought that the section showed evidence of repair taking place in the lesion with the formation of scar tissue.

Dr. Roxburgh agreed with the diagnosis of gumma and said that in his opinion it was not uncommon to find the histological appearances analogous.

Dr. Corsi thought that the only support one had in this case of it being gumma was the absence of evidence of it belonging to any other known condition. He agreed, however, that one should continue with antisyphilitic treatment.

Dr. Brain, in answer to a question, reminded the speaker that it was recognised that cerebro-spinal syphilis rarely followed cutaneous syphilis.

Case 2, Dr. Griffith.—A case of lupus erythematosus in a woman aged 43. The patient had been given a course of gold injections over a period of 8 weeks, which had finished a year ago. The patient showed remarkable improvement, and apparent cure.

Dr. Roxburgh thought that, on the whole, cases responded better to gold, although he had known of many cases which responded very well to bismuth.

Dr. McCaw said that although gold gave very favourable results, it was not infrequently associated with toxic disturbances, a complication which was rarely seen after bismuth therapy.

Case 3, Dr. Muende.—A case of lupus tumidus treated with moogrol. The patient, aged 41, had a patch of lupus tumidus about 1½ ins. in diameter on the right cheek since childhood. Dr. Muende had tried Krohmayer light treatment, but the result was unsatisfactory. After discussing the case with Dr. Cochrane, he started the patient on a series of intradermal injections of creosoted moogrol. Moogrol is the ethyl esters of hydnocarpus wightiana oil. Several injections, each of 0.1 to 0.2 c.cs. were given at a sitting. In all, twelve attendances were made over a period of 18 months. The treatment was a comparatively painless one, and he thought the result was satisfactory.

Dr. Corsi said that he had treated two cases with what appeared to be the same preparation, but made by The British Drug Houses, and called, "E.C.C.O." He had injected 1/20th of a c.c. vertically intradermally at intervals of one centimetre, and it caused a very sharp pain, which the patient complained about at the time. The results were not at all bad. Some places improved, but in each plaque a few nodules remained unaffected by the treatment, and the speaker eventually gave up this form of treatment because of the pain.

Dr. Cochrane said that he saw the case some months ago at the London Skin Hospital with Dr. Muende, and suggested that as the intradermal method of treatment in leprosy was in certain cases promising, such methods should be tried for lupus vulgaris. Sir Leonard Rogers published an article on the treatment of lupus by the chaulmoogra oil derivatives in the British Medical Journal of January 1933, page 47. The speaker had not seen the case for 3 months, and now noted a very considerable improvement in the patient's condition. The remedy that had been used was the proprietary remedy of Burroughs Wellcome & Co. of creosoted moogrol. This consists of the esters of hydnocarpus wightiana oil with 4 per cent. creosote. It was practically non-irritating, the only pain complained of being a slight stinging on injection. This was probably due to the creosote, and possibly would be less if the percentage of creosote were reduced to 2 per cent. The method of injection was similar to the method used for leprosy, that is, intradermally into the lesions, not more than 2 mm. being injected at each puncture. This preparation was probably the most effective. There were, however, other preparations on the market. There was one that goes under the term of "E.C.C.O." This, having camphor in it, was considerably more irritating than the one just mentioned. Owing to the very promising nature of these results and to favourable reports having been published by Sir Leonard Rogers, he felt that this method of treatment should have a wider trial in the treatment of lupus vulgaris.

Case 4, Dr. Wigley.—A woman aged 30 who had a "cyst" removed from the left side of her lower jaw about three years ago. Shortly after the operation radon seeds were inserted, and the wound has never healed since. She now presented a raised serpiginous spreading granuloma, enclosing an area of about 3½-in. × 1½-in. Part of this area is shiny and shows numerous telangiectases, and a small more or less central ulcer. There are a few minute yellow points in the granulomatous border, but very little induration beyond it. The lymphatic glands are not palpable, and the lesion does not appear tender or painful. Otherwise she is healthy; the W.R. is negative, and moderate doses of mercury and potassium iodide have had no visible effect on the lesion. Smears and cultures—negative.

Dr. Roxburgh thought that one should endeavour to exclude actino-mycosis, and advised the therapeutic use of large doses of potassium iodide.

Dr. Goldsmith said that he thought clinically the granulomatous margin was too soft for it to be actino-mycosis.

Dr. Muende said that both histological and bacteriological examinations were being made, and he hoped to report on the findings at the next Meeting.