REPORT OF AFFILIATED SOCIETY.

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

Meetings of the St. John's Hospital Dermatological Society (incorporating The London Dermatological Society) will be held at St. John's Hospital, 49, Leicester Square, at 4.15 p.m. on:—

Wednesday, 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, February 27th, at 4.15 p.m. Dr. J. E. M. Wigley, the President, was in the Chair.

Clinical cases were shown as follow:—

Case 1, Dr. Corsi.—A case of Chondrodermatitis helicis chronica in a man aged 36. It was situated as is almost invariable on the margin of the external surface of the pinna. It had been present for nearly a year, and except that it was sometimes more painful it had altered very little since first noticed by the patient.

Dr. MacLeod said that this condition had been described in the American literature under the title of "Painful nodule of the ears," which he thought was a more suitable one than that put forward. With regard to treatment, he had used X-rays, radium, cautery and CO_2, but the results in all cases so treated were disappointing, and he found the method of choice was excision. He did not think the condition was essentially one of old people, as he had seen it in adults of all ages. He had made histological preparations of the condition and was unable to find any association with the cartilage of the ear, its general appearance resembling that of a corn. Although he had seen bilateral lesions, he had not come across one with more than one lesion on the one ear.

Dr. Wigley mentioned a case that had come under his care, and which had been treated by excision. After healing, however, he noticed a recurrence appear in the scar.

Case 2, Dr. Corsi.—A case of sebaceous adenoma in a woman aged 50. There were a number of tumours on the face, mostly in the central part, which the patient said had been coming on for years. The three largest were four millimetres in diameter; the remainder were of all sizes smaller than this. They had a somewhat translucent appearance, were yellowish in colour, and had a tendency towards umbilication. The patient appeared to have normal mentality.

Dr. Muende reported on the section, which he said was that of a sebaceous adenoma: in other words a true hyperplasia of the sebaceous glands. This condition should be distinguished from Pringle's adenoma sebaceum, which was really of a mixed nævoid character with little sebaceous change, but more marked angiomatous and fibrous proliferation. Mental changes, therefore, should in this particular case not be expected.

Dr. Goldsmith agreed with the previous speaker in that this condition should be distinguished from Pringle's adenoma sebaceum, which gave a typical clinical picture of small reddish symmetrical lesions of a mixed nævoid type. He thought that the particular case under discussion was even more rare than Pringle's disease.

Dr. Brain thought that this condition must be very rare, and was of considerable

interest as some lesions closely resembled molluscum contagiosa, and others rodent ulcer even more closely.

Dr. MacLeod said that he had met such cases, and that Unna had distinguished them from adenoma sebaceum of Pringle. Selhorst had given a very good account of it in the American Archives. In answer to the previous speaker, he said that he did not think they could undergo a rodent change. They certainly resembled rodent ulcers, and even had fine teliangectases coursing over their margins, but on palpation they did not possess a cartilaginous feel.

Case 3, Dr. Corsi.—Female, age 34. A case of atrophy with some destruction of the skin occurring in nummular areas about the elbows, wrists and fingers. On the fingers there was a resemblance to chilblains or tuberculids, but about the elbows there was no such appearance, and there were no symptoms of pain or irritation. The diagnosis seemed to be between lichen planus atrophicans or morphœa and the anetodermia described by Jadassohn.

Dr. Goldsmith thought it was a case of Acrodermatitis atrophicans rather than anetodermia of Jadassohn. It was certainly not typical of this condition, being thicker and less translucent and more demarcated. It was interesting to find in this case that the initial stage was a little lump which could be felt as a definite thickening. This did not correspond to what was found in anetodermia, where there were frequently little indentations similar to those associated with von Recklinghausen's disease.

Dr. Griffith thought that the lesions on the fingers were of a tubercular nature, and suggested the diagnosis of folliclis.

Dr. Brain was inclined to regard the case as atrophic lichen planus.

Dr. MacLeod said that although he agreed that the lesions on the fingers resembled a necrotic tubercular condition, he had never seen anything quite so extensive as the eruption on the elbows.

Dr. Grace Griffith asked if the poor circulation in the patient's hands was related in any way to the condition under discussion.

Dr. Wigley said that he thought the lesions on the fingers were tubercular, and those on the arms white spot disease. He saw no lesions in the mouth to support the diagnosis of lichen planus.

Case 4, Dr. Wigley.—A case of epidermolysis bullosa in a child age 4, in which the condition appeared at birth. There had been mild injuries to the right elbow, knuckles and interphalangeal joints, to both hands and knees, which was followed by blistering. When the blister subsided little white specks (epidermal cysts) were left. The condition was getting less severe. The family history was negative. The condition at the present time was that on the right elbow, over practically all the joints of both hands, there are pink atrophic areas in which the numerous pearly-white nodules of the epidermal cysts are scattered. On the left elbow there was a minute atrophic area. On both knees there were erythematous atrophic patches studded with similar cysts, and a lax blister on the right knee.

Dr. MacLeod said he had seen a good many cases of epidermolysis bullosa, and had examined biopsies of several of them, but he had never seen so many closely packed milia as there were in this case. He felt that the condition did undergo improvement with years. He reminded the members that the condition need not necessarily appear at birth, and was frequently delayed until the age of 10 or 12.

Dr. Griffith said that he was not aware of the fact that these cases improved, and in his experience he had met patients who had definitely shown no improvement whatsoever. He felt that the prognosis was, therefore, very bad.

Dr. Sibley expressed the opinion that they nearly always got better.

Dr. Brain remarked upon a case of a girl aged 12 who had had the condition since a few days after birth, and whom he had watched over a period of 5 years. The girl was very sensitive to any trauma, and although she was improving slowly, she still presented lesions at rare intervals. He also recalled a case of a girl age 13 who had a condition on her leg but not on any other part of the body.

Case 5, Dr. Sibley.—A case for diagnosis in a woman age 60, who for two years has had an intensive irritable scattered papular rash, especially on the shoulders, chest and limbs, which kept her awake at night, and was at first labelled scabies. However, the usual sulphur treatment had no effect, and the papules continued to appear. She was given arsenic internally, and calamine lotion externally, without benefit. The rash consisted of small circular hard papules, generally scattered, rather than grouped. Some intramuscular injections of collosol mercuric sulphide had apparently given relief, and would be continued.

Dr. Griffith admitted that there were some excoriations, and suggested that the sulphur ointment was probably the cause of the excessive irritation and subsequent excoriations.

Dr. Goldsmith thought that the striking thing about the case was that the excoriations were all quite round. He thought that if the eruption was merely due to scratching, they would be more irregular. He felt that originally they were small papules, the tops of which had become scratched. He suggested that the eruption may have been purely neurogenous. He was of opinion, too, that intestinal toxæmia may be a possible cause.

Dr. Corsi was in favour of the diagnosis of dermatitis herpetiformis, and suggested that as arsenic appears to have failed to alleviate the condition, germanin should be tried.

Dr. Wigley had seen a case which had started with an eruption similar to the one in the case presented, which eventually showed evidence of Hodgkin's disease. He could not agree with the diagnosis of dermatitis herpetiformis.

Dr. MacLeod agreed that Hodgkin's disease and leukæmia should be taken into consideration, but he did not think that the case resembled dermatitis herpetiformis.

Case 6, Dr. Sibley.—A case of squamous-celled carcinoma supervening on Lupus vulgaris. Man, age 28, had Lupus vulgaris on the back of the left hand since he was 5 years of age. He was treated at various hospitals, and had had X-ray therapy some years ago. He now presented a very large offensive fungating mass of his hand. Dr. Sibley did not think that the malignant change was due solely to the X-ray treatment.

Dr. Griffith said he thought this was a good example of squamous-celled carcinoma supervening on X-ray treatment of lupus, a practice which, he maintained, was ill advised.

Dr. Muende said that the histology showed a rapidly growing squamous-celled carcinoma, and as the axillary glands were involved, amputation at the shoulder was advisable.

Case 7, Dr. Sibley.—Erythema scarlatiniforme in a man of 30, with a complete shedding of the epidermis of the palms. He had had a similar attack a few months ago.

Dr. Goldsmith said that he had frequently seen such cases in people who had recurrent attacks of sore throat.

Case 8, Dr. Goldsmith.—A case of Lichen ruber verrucosus linearis in a male, aged 64. Above the right clavicle, there was a series of parallel mauve-brown, raised, hyperkeratotic streaks, surrounded by a narrow red halo. Just below them was an apparently quiescent brown pigmented mole. On the left buccal mucosa there was an isolated white stellate spot. The eruption had been noticed for 12 months, and was still extending, and gave rise to itching. The patient's general health was good. Dr. Goldsmith said that a clinical diagnosis of lichen ruber verrucosus linearis was made, but the distribution was so unusual that he thought it might conceivably be a linear nævus. The biopsy confirmed the diagnosis of lichen ruber. Dr. Goldsmith said that occasionally one meets with lichen ruber in a long line, stretching down one leg in a position exactly corresponding to that sometimes assumed by a linear nævus. This cannot be mere chance. Moreover, such nævi can develop late in life. He suggested the probability that such cases of lichen planus develop on the site of a potential nævus. The latter cannot be easily excluded histologically, as linear hyperkeratotic nævi, more often than not, reveal no pathogenic islands of nævus cells in the corium.