DISCUSSION.

Dr. F. Parkes Weber alluded to the occurrence of xanthomyelomata ("myeloid tumours of tendon-sheaths") and xanthomyelosarcomata in the absence of any cutaneous xanthoma. He likewise referred to the relationship of arterial atheroma with cutaneous xanthoma. At the old Dermatological Society of London, in 1902, Mr. Willmott H. Evans showed a well-developed man, aged 41, with a nodular patch of xanthoma at each elbow (British Journal of Dermatology, 1902, xiv, p. 465). These xanthoma patches were successfully removed by Roentgen-ray treatment. But, about seven years later, the patient commenced to suffer from "intermittent claudication of the lower extremities." The symptoms were at first slight, but gradually increased in severity, so that in January, 1911, when Dr. Weber with others saw him, he could not walk much more than 200 yards without having to rest temporarily on account of a sensation of pain or severe fatigue in the calf-muscles of one or both legs. The pain or discomfort rapidly passed off on resting, and he could then proceed another short distance, and so on. No pulsation could be felt in any of the arteries of either foot, and this classical symptom-complex was obviously due to deficient arterial blood-supply to both legs. The intermittent claudication continued till the patient's death (from cancer of the large intestine) in 1913. The abdominal aorta and iliac arteries (No. 1492b amongst the pathological specimens in the Museum of St. Bartholomew's Hospital, London) showed that the cause of the arterial obstruction was "nodular sclerosis with atheromatous ulceration." Syphilis could be excluded as a cause. Arterial atheroma was histologically a kind of "nodular xanthoma of the arteries," and to some extent pathologically and etiologically analogous to cutaneous xanthoma. Dr. Weber suggested that patients with nodular xanthoma of the skin—if not being specially treated for diabetes mellitus—should be dieted so as to diminish excess of cholesterol in the blood (limitation of fatty meat, eggs, &c.). In that way, perhaps, a xanthomatous eruption on the skin, serving as a danger-signal, might enable the doctor to ward off or delay the onset of grave atheroma of the arteries and cardiac valves.

Dr. J. M. H. MacLeod directed attention to an article on xanthoma tuberosum multiplex in the American Archives for February. There was in it a careful record of the post-mortem findings.

An Unusual Case of Unilateral Sclerodactylyia and Lupus Erythematous, with Raynaud Phenomena, in a Syphilitic Woman.

By George Pernet, M.D.

The patient is a housewife, aged 58. According to her, the trouble started six years ago with "chilblains" about the fingers of the right hand, accompanied by some symptoms of local asphyxia, during the winter time, but the condition went on all through last summer and became permanent. There is a marked difference between the appearances of the two hands, the left one being normal. The right one shows atrophy and tightening of the skin, and also atrophy about the terminal phalanges, especially of the little and ring fingers. A skiagraph demonstrates rarefaction of bone. There is lupus erythematous about the flexor surfaces of the right fingers. She complains of tenderness and pain in the right hand. There are also similar changes to a less degree about the lower end of right forearm. Eight years ago she noticed changes in the skin of the left thigh and on examination I found a serpiginous infiltrating syphilide leaving behind atrophic scarring of the skin over which it had travelled. There is marked glossitis. On iodide of potassium administration the syphilide has involuted and the condition of the tongue has improved. I am indebted to Dr. Grainger Stewart for the following notes from the neurological
point of view: "No sign of syringomyelia. Condition of hand peripheral. Left ankle-jerk absent." I am keeping the patient under observation; she is very thin and in poor health, though she has improved in a general way as a result of the pot. iod. combined with tartrate of iron treatment.

Last year I showed a woman with bilateral symmetrical sclerodactyilia of the same type, with Raynaud phenomena; and disseminated lupus erythematosus: upper limbs, back, scalp, palms. That patient presented irregularity of the pupils, and Argyll-Robertson. Her Bordet-Wassermann reaction was found to be ++ (cerebro-spinal fluid): no lymphocytosis; Wassermann negative. She was quite deaf, but Mr. Banks-Davis, who kindly saw her for me, did not consider the deafness was of a syphilitic nature.

The question arises as to the syphilitic origin of the Raynaud phenomena and sclerodactyilia in these two cases.

Case of Acneform Syphilide: Type determined by Camphorated Oil Inunctions to the Skin.

By W. J. O'DONOVAN, M.D.

A. B., a single female, aged 24, gives a history of exposure to infection with a sailor now at sea.

Six weeks ago she had an acute attack of bronchitis, for which she was well rubbed with camphorated oil. Three days after this rubbing there was an outcrop of spots on the back and front of the chest. When seen first, a fortnight before this meeting, her back and front of chest were freely peppered with small comedones in irregular groups, interspersed with a few red papules. On the bend of the elbows there were red discrete macules. During the last fortnight she has developed a copious coppery maculo-papular eruption, falling hair, adenitis, pallor, condylomata and copious minute blackheads on the forehead. The Wassermann reaction is positive. Treatment has been suspended owing to the interesting point worth demonstrating, that the type of syphilitic eruption has been determined by inunction of oil known to produce grouped comedones. The patient is positive as to her previous complete freedom from blackheads or pityriasis of the scalp.

Psoriasis with a Chronic Ulcer of the Lower Lip.

By H. C. SEMON, M.D.

The patient, a man aged 72, also has severe psoriasis of many years' standing, but I do not suggest that there is any connexion between the two diseases. The ulcer, which is situated in the middle line on the mucous surface, and does not involve the skin, is the size of a sixpence. It has been present for two years, and for the eighteen months during which I have observed it, has not altered its appearance in the least. The base is soft, the edges quite flat, and there is very little discomfort and practically no discharge. The microscopic section is exhibited here. The pathologist at my hospital reported it to be a septic papilloma, but as the clinical aspect and the history and results of simple treatment do not accord with this view, I am submitting the case, which of course is highly suspicious of malignancy. Dr. MacCormac, who has seen