of the general population have levels of urinary calcium excretion higher than the normal range suggested by Hodgkinson and Pyrah (1958)—100–300 mg./24 hours for males, and 100–250 mg./24 hours for females (on a normal diet)—and the relation between high urinary excretions of calcium and the formation of calcium-containing stones is not definitely established. Whether the risks of stone formation are higher in normocalcaemic hypercalciuric patients with sarcoidosis is also unknown. However, Sharma *et al.* (1967) concluded that the natural history of the calcium derangement is dependent on the type of sarcoidosis. In the patients presenting with erythema nodosum or bilateral hilar lymphadenopathy the calcium metabolism always reverted to normal. In the group with pulmonary fibrosis the calcium abnormalities persisted. Hypercalciuria occurring in this latter group might therefore require treatment even in the absence of hypercalcaemia or urinary calculi in order to prevent stone formation.

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Perforation of the Nasal Septum in Systemic Lupus Erythematosus

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Perforation of the nasal septum may be caused by various infections including syphilis, tuberculosis, and leprosy. Other causes are industrial exposure to certain dusts, such as those containing chromium, phosphorus, iodine, and cement. It may also be the result of congenital anomalies, trauma, malignant disease, granulomatous states, and diseases of the blood. But we could find no reports of systemic lupus erythematosus (S.L.E.) as a cause. No reference to it appears in the studies by Dubois and Tuffanelli (1964), Larson (1961), and Shulman and Harvey (1960). We report a case here.

CASE REPORT

A 36-year-old housewife presented in 1957 with a raised temperature, dyspnoea, tiredness, malaise, and weakness. The family history and her previous history contained nothing relevant. Enlarged lymph nodes and pleural effusion on both sides later appeared. The erythrocyte sedimentation rate was 62–92 mm. in one hour. On electrophoresis the amount of gammaglobulins was always above 30%; the rheumatoid factor was negative. The patient had already been examined twice for the L.E. phenomenon, with negative results. But as the disease was believed to be systemic lupus erythematosus treatment with antimalarial drugs was started. In 1959 arthritis of the rheumatoid type appeared. There was myalgia, and tests for the rheumatoid factor were now positive. One further test for the L.E. phenomenon was negative. In 1960 the L.E. phenomenon was found to be positive for the first time, with hypergammaglobulinaemia 47.7% and a butterfly rash. Laboratory tests now showed the disease to be highly active. The thymol turbidity reaction was positive and there was thrombocytopenia (80,000/cu. mm.). There was a false-positive Wassermann reaction.

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From 1958 to 1964 the patient had received steroids three times, but never for longer than three months. Treatment with anti-malarial drugs was continuous, and salicylates were given when needed.

In 1965 hemiparesis, diplopia, and psychotic symptoms were noted, all probably caused by arteritis. Five tests for the L.E. phenomenon were still positive. The thymol turbidity reaction was sometimes positive and also the latex-fixation test, but with a low titre. The leucocyte counts were repeatedly lower than 5,000/cu. mm. Signs of right heart failure were evident from the end of 1966. In 1967 leg ulcers appeared on both sides. There was livedo reticularis, more breathlessness, clubbing of the fingers, and sometimes nose bleeding. When the leg ulcers appeared she also complained of pain in her nose.

She was examined by Dr. S. Sadecky, otolaryngologist, who reported: "The septum of the nose is lightly deviated to the right, and the mucous membrane is red and dry; in the centre part of the septum there is a defect of about 10 mm. surrounded by crusts, a perforating ulcer of the nasal septum." As the mucous membrane was fragile and infected, histological examination was not undertaken. This state remained unchanged up to September 1968.

Comment.—We believe that our record is the first to be described of perforation of the nasal septum in S.L.E. Even so we doubt whether it is a rare manifestation of S.L.E., but suspect that it has been overlooked.

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