In assessing the prognosis in any case of eczema or other functional itching skin disorder a large number of factors require consideration. Factors prejudicial to recovery might be grouped thus:

1. *Psychological*.—Domestic disharmony, frustration, or unhappiness at work. Overcrowded housing conditions and friction with "in-laws." Overwork, worry, insomnia, compensation disputes.

2. *General*.—Hypertension, anaemia, dyspnoea from chronic bronchitis, emphysema, or other cause. Alcoholism. Poor renal function as in prostatic obstruction and other states of sub-health. Faulty nutrition. Bad heredity.

3. *Endocrine State*.—Unfavourable influence of puberty and menopause.

4. *Chronicity of the Lesions*.—A dermatosis of many years' duration is likely to be more intractable than one of months or weeks.

5. *Local Factors* (e.g., xeroderma or hyperidrosis).—Haemorrhoids or fistula in pruritus ani, ankle oedema due to varicose veins, deep thrombosis or other cause in leg eczema. Perniosis. Impossibility of avoiding local allergic contacts.

6. Unwillingness or inability to carry out exact treatment.

In attempting to estimate the worth or otherwise of any therapy in these conditions much reliance must be placed on clinical judgment, since cases exactly comparable in every respect with regard to such factors as those mentioned above are not available.

Summary and Conclusion

Although antihistamine ointments can be absorbed when massaged into areas of dermatitis the friction and trauma of the rubbing may make the dermatitis worse. Their use is therefore likely to be limited, and any beneficial effect is probably due to their gentle application as a surface analgesic. Since they are also potent sensitizers they should be used, for short periods only, on localized areas of skin. They are seldom used in the Sunderland Skin Clinic, and several cases of dermatitis due to them have been encountered.

The introduction of antihistamines into the skin by iontophoresis can be brought about without the trauma and friction necessary to introduce the ointment. The method is free from toxic reactions, and for localized areas of chronic dermatitis or pruritus may have a useful though limited role.

REFERENCES

- Aaron, T. H., Peck, S. M., and Abramson, H. A. (1948). *J. invest. Derm.*, **10**, 85.
 Baldridge, G. D. (1951). *Arch. Derm. Syph., Chicago*, **63**, 260.
 Brain, R. T. (1950). *British Medical Journal*, **1**, 719.
 Dale, Sir Henry H. (1950). *Brit. J. Derm. Syph.*, **62**, 158.
 Ellis, F. A., and Bundick, W. R. (1949). *J. invest. Derm.*, **13**, 25.
 McCavack, T. H., Schulman, P., Schutzer, R., and Elias, H. (1948). *Arch. Derm. Syph., Chicago*, **57**, 308.
 Madden, J. F. (1950). *Ibid.*, **61**, 673.
 Peck, S. M., et al. (1950). *J. invest. Derm.*, **14**, 177.
 Perry, D. J. (1947). *Ibid.*, **9**, 95.
 Rasmussen, K. A. (1949). *Acta derm.-venereol., Stockh.*, **29**, 564.
 Shelley, W. B., McConahy, J. C., and Hesbacher, E. N. (1950). *J. invest. Derm.*, **15**, 343.
 Warin, R. P. (1950). *Brit. J. Derm. Syph.*, **62**, 166.
 Wooldridge, W. E., and Joseph, H. L. (1949). *Arch. Derm. Syph., Chicago*, **60**, 390.

Two hundred years ago on May 19 Antonio Scarpa, the Italian anatomist and surgeon, was born. He studied under Morgagni and others at Padua, and became an expert anatomist. Soon after obtaining his degree in medicine he published an important work on the ear, in which he recorded his discovery of the membranous labyrinth. During a visit to London he worked with Pott and the Hunters. As professor of anatomy and surgery at Pavia he built his reputation as the greatest Italian anatomist and surgeon of his century. His *Tabulae Neurologicae*, 1794, with beautiful drawings by Scarpa himself, showed him to be one of the best of those medical men who have illustrated their own works. He was the first to tie the femoral artery for popliteal aneurysm. Scarpa was blind for the last few years of his life and died on October 31, 1832.

A CASE OF CONFLUENT CHICKEN-POX WITH HAEMORRHAGIC SYMPTOMS

BY

J. PICKFORD MARSDEN, M.D., D.P.H.

AND

W. J. COUGHLAN, M.B.

(From the Infectious Diseases Unit, River Hospitals, Dartford, Kent)

The following is a record of a case of chicken-pox of exceptional severity which exhibited a confluent haemorrhagic eruption and a severe leucopenia. Recovery followed treatment with "aureomycin."

Case Report

The patient was a man aged 40, hitherto in good health. On July 21 a small boy arrived to stay in the patient's house, but was found to be suffering from chicken-pox and returned to his own home on July 25. So far as is known there were no unusual features about this attack. Two children of our patient, aged 10 and 4 years, developed chicken-pox about August 3. We are informed that each experienced a mild attack and made a rapid recovery. The patient felt unwell on August 4 and a rash began to appear next day. When first seen by his doctor, on August 7, "he had a very extensive varicella rash and what looked like a follicular tonsillitis": he was febrile, and was sent home to bed and put on sulphonamides. On August 9, as he was vomiting after a restless night, the drug was omitted. The temperature then was 101° F. (38.3° C.). At night he was kept awake by persistent hiccup. On August 10 his temperature had risen still further and the rash began to show a purpuric element: 400,000 units of penicillin was given. Hiccup returned at night. On August 11 aureomycin therapy was started (0.5 g. six-hourly) and admission to hospital was sought because of the severity of the illness and the need for investigation of the haemorrhagic symptoms. Attempts to obtain suitable hospital accommodation nearer his home having failed, we agreed, on his doctor's advice, to admit him to our unit, although this entailed a journey of some 50 miles (80 km.) up from the country.

On arrival the patient was found to have an extremely profuse eruption (Figs. 1 and 2), confluent over the face and on parts of the trunk, quite generalized, and exhibiting no selectivity except that the profusion was greatest on the trunk and face. The rash generally showed purpuric staining, but there was, at this stage, no free bleeding into any of the many large superficial vesicles. The rash was mixed as regards age and size of its elements: it was pustular on the face, of which there was pronounced swelling. A profuse enanthem was present in the mouth and fauces, and there were lesions also on the conjunctivae. The patient felt weak and tired, the pulse was running, some rhonchi were

FIG. 1.

FIG. 2.

audible at the bases and his temperature was 101° F. (38.3° C.). The dosage of aureomycin was increased to 0.5 g. four-hourly. He remained toxic, breathless, and exhausted on any exertion; the temperature rose to 103° F. (39.4° C.) and the pulse to 125. Hiccup was especially persistent at night, when sleep could be obtained only by the use of morphine. The rash progressed irregularly. No free bleeding occurred into the skin or from mucous surfaces, but there was widespread purpuric staining of the elements of the rash and more obvious haemorrhage at the base of and into some vesicles. Gradual improvement followed: the fever had subsided by August 17, when the aureomycin treatment was stopped. On August 21, when many of the crusts were separating and all anxiety regarding his recovery had disappeared, the patient returned, at his own wish, to his home environment. Styes and boils caused some trouble in convalescence.

Investigations.—On August 13 the vesicle fluid was negative to the complement fixation test for the vaccinia-variola group; egg culture was negative for vaccinia and variola. A throat swab showed no Vincent's organisms present in film. *Strep. viridans* and yeast were found on culture. The blood picture on August 13 was: Hb, 104%; red cells appear normal; platelets moderately diminished; white cells, 1,500 per c.mm. (polymorphs 57%, lymphocytes 39%, monocytes 2%, plasma cells 2%). On August 14: white cells 4,200 per c.mm. (polymorphs 54%, lymphocytes 43%, monocytes 3%). On August 16: white cells, 5,500 per c.mm. (polymorphs 61%, lymphocytes 33%, monocytes 5%, plasma cells 1%).

Discussion

An attack of varicella of the severity shown in this case must be extremely rare. During the past 23 years we have personally examined some 400 chicken-pox patients in whom, often because of the profusion of the rash or of the amount of constitutional disturbance, a diagnosis of smallpox has been considered. Yet among these severe cases we can recall only two, one of which proved fatal, which were comparable to the one here described. That the type of attack in this instance was not determined by an especially virulent strain of virus is suggested by the mildness of the disease in the three children who were known to be infected in the same series.

We have hesitated to apply the term "haemorrhagic" to this case as, following the teaching of Ricketts (1908) in respect of smallpox, we would reserve its use, in any acute infection, to describe the type of case in which initial toxæmia is extreme, and usually rapidly fatal, and in which considerable skin and mucous membrane bleeding may be prominent. In spite of the fact that the present patient's condition gave rise to some anxiety, we do not consider that his case falls into this category.

It has been suggested by M. Mitman (1951, personal communication) that in some instances haemorrhagic symptoms in chicken-pox may be determined by the occurrence of this

disease in a subject already afflicted with some disorder of the blood. In the above case a marked leucopenia at the first blood examination, combined with the severe faucial angina, pointed to an agranulocytosis, possibly determined by idiosyncrasy to sulphonamides. However, in spite of the low total white count, the polymorphonuclear cells never fell below 54%, and in the course of a few days the blood picture resumed a more normal appearance, in keeping with the general clinical improvement of the patient. Consequently we regarded the leucopenia as a symptom and not as a cause of the unexplained lack of resistance to the virus which determined the severity of the attack.

The enanthem formed a serious feature. The mouth and the fauces, for as far as they could be inspected, were profusely involved. The cause of the hiccup may well have come from lesions more remotely situated. But for antibiotic therapy the risk of pulmonary complications must have been considerable.

We wish to thank Dr. J. A. J. Hammond, who referred the case to our unit, for details of the patient's illness before his admission to hospital.

REFERENCE

Ricketts, T. F. (1908). *The Diagnosis of Smallpox*. London.

A CASE OF ACCIDENTAL GENERALIZED VACCINIA

BY

O. A. FINN, M.D.

(From the Department of Dermatology, Stobhill Hospital)

JOHN C. DICK, M.D.

AND

JOHN S. STEVENSON, M.D.

(From the Department of Pathology, Stobhill Hospital)

The following case of accidental generalized vaccinia demonstrates the source of infection and presents unusually extensive pathological lesions.

Case Report

A male child aged 6 months and weighing 16 lb. (7.3 kg.) was admitted on June 23, 1948, with exudative infantile eczema affecting the face, buttocks, and outer aspects of the thighs. Next day it was discovered that a female child who had been admitted 13 hours previously to a cot adjacent to the patient's had an active vaccination sore. This child was immediately isolated and made an uneventful recovery.

The patient responded satisfactorily to treatment, but 12 days later a number of papulo-vesicles appeared on the buttocks and thighs. The lesions, which rapidly became pustular, were discrete, umbilicated, roughly circular, of similar size, and at the same stage of evolution. With this exanthem the child became febrile and penicillin therapy was instituted. Two days later further crops of vesicles appeared on the face, trunk, and limbs, but no pulmonary lesion was detected clinically or on x-ray examination. By July 11 most of the pustular lesions had become small ulcers, several of which had coalesced, producing large ulcerated areas (Fig. 1) associated with inguinal and axillary adenitis. Sulphadiazine therapy was started. On July 14, for the first time, there was reluctance to feed and facial grimacing became a marked feature: signs of bronchopneumonia were now present. Death occurred on July 15.

Post-mortem Findings

The necropsy (four hours after death) showed lesions only in the skin (see above), lungs, and stomach.