cyst was derived from a congenital duplication of the large intestine.

The cyst described in this paper and the retroperitoneal cyst of Hughes and Greene bear a close resemblance histologically, the endothelial foam cells and giant cells found in both suggesting a breaking down of fat cells following infection; but, whereas theirs was unilocular and lay on the antimesenteric border of the gut, the one now reported was multilocular and invaded the appendices epiploicae. It is possible that the two cysts may have a similar origin, which may be explained in the way suggested by Hughes and Greene.

The importance of this type of cyst is its clinical resemblance to carcinoma of the colon.

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Leprosy Diagnosed as Syringomyelia

Leprosy is one of the oldest diseases of mankind, and its heaviest incidence is in tropical and subtropical zones. Indigenous cases do not occur in Great Britain (*Memoranda on Medical Diseases in Tropical and Sub-tropical Areas*, 1946), although they are recorded in Scandinavia, the Baltic States, and Mediterranean countries. Thus its recognition may be delayed when it does occur in immigrants to this country, more especially if its manifestations are unusual—for example, neurological. It may therefore be worth while reporting two cases which have been recently seen in this hospital, to which they were referred as cases of syringomyelia.

CASE REPORTS

Case 1.—An Anglo-Indian aged 20 was first seen in the out-patients department in November, 1948, when he complained of numbness of the right hand for two years and weakness of that hand for one year. He had previously lived in India, and first noticed these symptoms after a painful whitlow which took a month to heal. His index finger and thumb at that time began to feel numb and clumsy, and a cigarette burn of the finger was quite painless. Subsequently the whole hand became similarly affected and he noticed impairment of touch sensation in addition to insensitivity to pain. These symptoms lasted a year before he was aware of any weakness. His past history was not relevant and there was no family history of leprosy.

He was an apparently healthy man without abnormalities other than those in the right arm. The skin of the hand was thickened and showed the scars of many wounds. There was global wasting of the intrinsic hand muscles as well as impairment of all forms of sensitivity below the middle forearm. The reflexes in the arms and legs were normal. There was no palpable thickening of any peripheral nerve and the skin was completely normal. Radiological examination of the cervical spine and examination of the cerebrospinal fluid revealed no abnormality. Although the possibility of leprosy was considered at that time, nasal scrapings were negative, and, despite the atypical nature of the sensory loss, a diagnosis of syringomyelia was made, for which he was given a course of deep x-ray therapy.

Five months after his discharge he noticed numbness of the ulnar border and little finger of his left hand and a reddened area on his left thigh. A month later the right foot became numb, and soon afterwards he experienced shooting pains in the right forearm and foot. Meanwhile the sensory loss had been gradually extending up his right arm. He was readmitted in November, 1949, by which time the wasting of the right hand had produced a well-marked claw deformity. The sensory loss extended higher up the

forearm, and there was wasting of the left hand with slight loss of all forms of sensitivity along its ulnar border. There was a reddened area of skin 2 in. (5 cm.) across on the front of the left thigh, also two small areas on the back, over which sensitivity to all forms of stimulus was impaired. The cranial nerves and reflexes were unchanged. Acid-fast bacilli were found in scrapings from the left thigh and a diagnosis of leprosy was made.

Case 2.—An Anglo-Indian aged 26 came to England in 1950 and subsequently joined the Army, from which he was discharged in January, 1955, with a diagnosis of syringomyelia. A month later he was referred to the out-patients department. Weakness and wasting of the right hand had first been noticed four months previously. These symptoms rapidly became worse, and he soon noticed loss of appreciation of touch, heat, and cold. For two months he had a patch of similar sensory loss over the right knee. Ten years earlier he had noticed a small patch of anaesthesia over his right elbow; this had remained unchanged. There was a family history of leprosy, his father suffering from the disease.

The patient was a healthy-looking man. Neurological examination showed the cranial nerves to be normal; a thickened posterior auricular nerve was palpable in the left side of the neck. There was severe weakness of the right hand, with global wasting and some wasting of the flexors and extensors of the forearm. All forms of sensitivity were impaired in the arm up to midway between the elbow and the shoulder. The reflexes were brisk and symmetrical. The right ulnar nerve was thickened to the size of a pencil at the elbow, and could thence be traced continuously up to the axilla. The left ulnar nerve was also thickened, but to a less extent. There was anaesthesia to touch and pin-prick over the right knee and upper third of the leg, but no other abnormality. On these clinical grounds leprosy was diagnosed, and skin biopsy at the Hospital for Tropical Diseases confirmed this diagnosis.

DISCUSSION

Although in leprosy early diagnosis is important (Manson-Bahr, 1950), in this country the disease is liable to be overlooked owing to its rarity. The occasional resemblance of neural leprosy to syringomyelia is of interest, and it is noteworthy that, whereas accounts of syringomyelia rarely include leprosy in discussing differential diagnosis, almost all accounts of leprosy refer to syringomyelia. Since the neurological changes of leprosy are due to involvement of peripheral nerves alone, there is no evidence of a spinal-cord lesion, such as is provided by long-tract disturbances or by a Horner's syndrome, and which is almost invariably present in syringomyelia by the time wasting of the hand is pronounced. In leprosy the sensory loss usually includes all forms of sensitivity, although, as discrimination between heat and cold is lost first, at an early stage the anaesthesia may appear to be dissociated (*Memoranda on Medical Diseases in Tropical and Sub-tropical Areas*, 1946). It is often of "glove" distribution, but in syringomyelia this type of distribution of sensory loss is uncommon (Brain, 1951). A further significant point is that in syringomyelia there is almost invariably depression of one or more of the reflexes in the upper limbs by the time wasting is pronounced, but in leprosy the reflexes are preserved and may even be exaggerated (Cochrane, 1947). The most valuable confirmatory sign of neural leprosy is palpable thickening of peripheral nerves.

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