of his blood count elsewhere had given no signs of hyper-eosinophilia, I had it re-examined in October, when a "hyper-eosinophil phase" of 11% was found.

F. R. Rugeley published a paper on allergic causes of pruritus ani recently (*Annals of Allergy*, 1946, 4, 374 and 396) and reported about 14 cases of pruritus ani in which a connexion with allergic causes was revealed and rapid improvement achieved by treatment on these lines, whereas the conventional treatment, tried before, had proved to be unsuccessful. He holds the opinion that excoriations, oedema of the skin, thickening, or exudation vary in intensity, and that papillitis, fissures, and other changes thought to be causative factors are often secondary and not primary changes. He recommends strongly that allergic causes of pruritus ani should be investigated before radical procedures are suggested, such as surgical interference, x-ray treatment, local injections, divisions of nerves, or tattooing of the anal margins with anaesthetics.—I am, etc.,

London, W.1.

E. M. FRAENKEL.

Congenital Hepatic-duct Malformation

SIR,—Length of survival may warrant recording the following case. A female child 10 months old had been jaundiced since her normal birth. Weight records were: 7 lb. (3.1 kg.) at birth, 9 lb. (4 kg.) at 6 months, 12 lb. (5.4 kg.) at 10 months. Absence of breast milk had resulted in cows' milk feedings. Three older children were healthy.

The child was lively and profoundly jaundiced. Her spleen extended three fingerbreadths below the ribs, and the nodular liver extended below the umbilicus. The urine was dark, contained bile, and the stools were light. Her haemoglobin was 65%, red blood count 3,000,000, white blood count 5,100, and the Wassermann was negative in mother and child.

On Dec. 12, 1946, the abdomen was opened in the hope of finding a gall-bladder for anastomosis. A small amount of bile-stained fluid appeared. The enlarged liver was hobnailed and had rounded borders. No gall-bladder and no extra-hepatic ducts were present. The spleen surface was granular. Prof. J. H. Fisher examined a biopsy specimen and reported "obstructive biliary cirrhosis." Post-operative condition was good until Dec. 18, when hepatic failure developed. On Dec. 23 the wound disrupted, with bowel prolapse. The child was unconscious, and the wound was closed with through-and-through silkworm sutures without anaesthesia. The child died eight hours later, having lived ten months and eight days.—I am, etc.,

Arkansas, U.S.A.

FRANK RIGGALL.

De Morgan's Spots

SIR,—I was much interested to read the paper by Capt. A. R. Murison, Lieut. J. W. Sutherland, and Flying Officer A. M. Williamson on De Morgan's spots (May 10, p. 634). Their observations on a very large number of patients are a valuable addition to the literature on the subject and incidentally a confirmation of earlier findings by other authors. I would however like to point out that the literature on the "ruby spots" is by no means "extremely meagre" and the erroneous impression that "there is an entire absence of precise information on their significance" is obviously due to some confusion in the terminology.

"De Morgan's spots" is an obsolete term almost wholly unknown outside this country and rarely met with even in the British literature. The more or less generally accepted name for this type of telangiectatic skin lesion is angioma senile. This term is generally used in the international literature, but also by English authors (e.g., Colcott Fox, *Brit. J. Derm.*, 1908, 20, 145) and in English textbooks of dermatology (McLeod, Sequeira). Less common synonyms are angioma eruptivum, angioma tuberosum, angioma nodulare cutis, senile ectasia, *perles sanguines*. The pathology of angioma senile, including its relationship to malignant disease, has been the subject of comprehensive investigations, mainly by French and German authors. In my monograph on "Haemangiomata and Telangiectasias of the Skin" (Jadassohn, J., *Handbuch der Haut- und Geschlechtskrankheiten*, Vol. 12, Pt. 2, Berlin, Julius Springer, 1932) I dealt exhaustively with angioma senile (pp. 379,

398, 404). May I be allowed to quote just a few passages from what I said then.

"These tiny multiple angiomata are of interest also, because, under the name of Leser-Trélat's symptom, their presence has occasionally been regarded as indicative of internal carcinoma. Trélat, de Boucaud, and subsequently Leser believed that their incidence was higher in patients with internal carcinoma. These authors" (not De Morgan) "suggested therefore that senile angiomata had a certain diagnostic significance, especially when present in early adult life and in great number. This concept has, however, been disproved by Gebele, Raff, Reitzenstein, Rosenbaum, A. Symmers, and Wolff." Summing up I said: "There is little evidence to support the view that they [i.e., senile angiomata] are of pathognomonic significance in the diagnosis of malignant tumours."

As for the histological structure of angioma senile, it seems not quite correct to say that the lesions have the character of simple haemangioma. More aptly they may be described as telangiectasias, because—I am quoting again from the above monograph—"there is no evidence of a formation of new blood vessels. Development and enlargement of the minute tumours are entirely due to dilatation of (pre-existent) capillaries or small veins. In addition, pathological changes of the cutaneous tissue, such as destruction of the elastic fibres and degeneration of the collagen, are often, though not in all specimens, found to be present in the neighbourhood of the dilated vessels."—I am, etc.,

Manchester.

L. WERTHEIM.

Prognosis of Primary Pleural Effusions

SIR,—I read with great interest Dr. Brian C. Thompson's article (April 12, p. 487) on the prognosis of primary pleural effusions. I would like to suggest a fourth factor which seems of equal importance to the three that he describes as being necessary in the correct assessment of the development of tuberculosis over a period of five years. This is the nature and duration of the initial treatment of the pleural effusion. Figures quoted by Coope suggest that a period of several months' treatment under sanatorium regime when the pleural effusion is first manifested greatly reduces the incidence of tuberculosis subsequently. He states that, in cases thus treated, there is less than a 10% incidence of tuberculosis, whereas in untreated cases figures up to 60% are quoted.

It would be very interesting to learn whether Dr. Thompson's cases underwent any sanatorium treatment when the pleurisy with effusion first developed, and, if so, how this group compared with those who had no initial treatment with regard to the development of tuberculosis subsequently.—I am, etc.,

London, N.6.

J. D. L. REINHOLD.

REFERENCE

Coope, Robert (1945). *Diseases of the Chest*, Edinburgh.

Acute Non-specific Diarrhoea and Dysentery

SIR,—I was surprised to read Dr. G. R. Kershaw's article (May 24, p. 717) because I had not heard such views expressed by anyone of the present generation. I can only say that some of us slept for two months in a troopship to the Far East with at most a pair of short pants for cover, with a louvre directed at our naked forms without ill-effect. In India many of my acquaintance slept almost nude under fans through very hot weather and they reputedly were less frequently troubled with epidemic diarrhoea than others who slept in a more temperate way.

Any epidemics of local "tummy rot" could well be ascribed to the lack of hygiene in Indian cooks and cookhouses. In fact one was persuaded that the less covering to which one could accustom one's body, the more resistance one achieved to local minor diseases—a view which received the approval of Army authorities.—I am, etc.,

Bournemouth.

G. DALLEY.

SIR,—I read Dr. G. R. Kershaw's article on acute non-specific diarrhoea (May 24, p. 717) with interest. From my own experience I am convinced that chilling of the abdomen is a common cause not only of acute diarrhoea but of chronic loose motions. During six years in South China I was able to study the effects of chilling on the abdomen, often after violent