of his symptoms. Three days later he was referred to the dermatologist, Dr. J. Savage, who sent him to the department of venereology, as he deemed it wise to exclude specific disease first.

On examination a sharply circumscribed tender non-indurated squamous erythematous eruption $\frac{1}{2}$ in. by $\frac{1}{2}$ in. (1.9 by 1.3 cm.) was present on the left side of the glans penis. A similar eruption was present on the scrotum and on the left side of the neck. Sharply demarcated circular,

FIG. 1.—Sulphonamide eruption on the penis and scrotum.

slightly tender, superficial ulcers $\frac{1}{4}$ in. (3 mm.) in diameter were present on the dorsum of the tongue. There was no significant adenopathy. No condylomata were detected.

Repeated dark-ground examination failed to reveal *Treponema pallidum* in the penile lesion. Blood was taken for Wassermann and Kahn tests. A tentative diagnosis of sulphonamide sensitivity was made, no treatment was prescribed, and the patient was requested to return in seven days' time. When he reattended on the specified date the eruption on the

FIG. 2.—Sulphonamide eruption on the tongue.

penis, scrotum, neck, and tongue had cleared up, leaving no sequelae. The blood Wassermann reaction and Kahn test were negative.

He was given a test dose of four tablets of "sulphatriad," and within 30 minutes of ingestion he experienced irritation of the penis and scrotum at the site of the previous lesions. Within two hours his tongue and roof of mouth

felt very warm. The following morning an eruption similar to the original one appeared (Figs. 1 and 2). No treatment was given, and six days later the eruption had completely cleared up.

COMMENT

This case is of interest in that the eruption somewhat resembled lesions seen in early syphilis. The ulcers on the tongue were reminiscent of the classical mucous patches seen in secondary lues. Cole (1946) recorded three cases of fixed eruption of the buccal mucosa and penis due to sulphadiazine. Meltzer (1949) reported a fixed eruption on the right thumb and penis following the ingestion of various sulphonamides. Philpott (1951) described a fixed eruption on the chest and glans penis due to sulphadiazine. Ghosh

(1952) described repeated attacks of swelling of the lips, anus, and external urethral meatus accompanied by the appearance of erythematous plaques on the left hypochondrium and medial border of the right foot as a manifestation of fixed drug eruption due to sulphonamides. Campbell and Doyle (1953) reported recurrent balanitis as a manifestation of fixed sulphonamide eruption.

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Poisoning Due to Belladonna Plasters

A woman aged 67 was admitted to the Grove Hospital, S.W.17, at 4.15 a.m. on April 11, as a possible case of meningitis or cerebral haemorrhage. She had a history of occasional occipital headaches for the previous few months, but had not complained of headache during the course of the illness for which she was admitted. At 6 p.m. on the day before admission she developed a queer sensation in the eyes with a "muzzy" feeling in the head, and during the course of the evening, while watching television, she was mystified to find that she could not see clearly, and kept wiping her glasses, thinking that they were smeared.

At 10.30 p.m., when she went to bed, she felt she could not keep her legs still, and thereafter remembered no more until her return to consciousness. At 2 a.m. she disturbed her husband by becoming delirious and excitable and making writhing movements with her hands. When the doctor arrived he found her delirious, flushed, with pupils dilated and equal, and non-reactive to light. She was muttering and sitting up in bed, and resisted attempts at restraint. There was marked tachycardia. Morphine, 1/6th gr. (11 mg.), was given, and penicillin, 500,000 units, at 3.30 a.m.

On arrival in hospital she was flushed and semi-comatose. There was no meningism. The pupils were dilated and equal and non-reactive, and the optic fundi were normal. The arms were held rigidly in flexion and the biceps reflexes were brisk. The abdominal reflexes were absent. The legs were held stiffly with no detectable difference in tone. All the leg reflexes were exaggerated and the plantar responses were extensor.

On further examination a large belladonna plaster was found adhering to the skin on each side of the back. On removal of these the skin was found to be excoriated. The plasters were replaced by tulle gras. It appeared that the patient had been suffering from backache for some weeks and had been applying the belladonna plasters on her own initiative for a month, replacing them weekly without an interval. Her husband had assisted her to the bath at 4 p.m. on the night before admission and had observed that the skin was very raw before the application of the new plaster.

Within 12 hours of admission the patient was back to her normal state of consciousness, but the pupils remained somewhat dilated for more than 36 hours. The back healed up in about ten days. Before going home she was given tincture of belladonna, 7 minims (0.42 ml.) t.d.s., for two days, to see if there was undue sensitivity, but no symptoms resulted.

It is of interest that Bruce and Dilling (1918) mentioned the possibility of this complication of the topical use of belladonna, but Dilling (1940) makes no reference to the danger, no doubt because of the infrequency with which these plasters are now prescribed. But they can be readily obtained by the lay public.

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