and my colleagues at the German Hospital and their correspondents for being able to use this material.

November, 1936.—The patient was queer in the head and very forgetful (out-patient department). Complete achylia even after histamine.

February, 1937.—Out-patient at Maudsley Hospital.

Summer, 1942.—Still had unreality feelings (face); tongue protruded slightly to right; right plantar reflexes doubtful; spleen moderately enlarged; question of "splenic anaemia"; sternal puncture said to show a typical megaloblastic picture; C.I. usually against Addisonian anaemia.

October, 1942.—Dr. Wyburn-Mason, at the National Hospital, Queen Square, found no definitely abnormal physical signs in the central nervous system. The right plantar reflex was not so definitely flexor as the left, but there was no doubt that it was flexor. The only other finding was a left supinator jerk which was perhaps brisker than the right. Dr. Wyburn-Mason thought that at that time there were no definite signs of neurological disease and suggested that the mental symptoms were either connected with the anaemia or were hysterical.

1942 to June, 1946.—The patient was treated as an out-patient and on several occasions as an in-patient for his anaemia, but on many occasions he complained of heaviness, etc., in his head.

June to August, 1946.—In-patient at Roffey Park Rehabilitation Centre. On his discharge the medical officer reported to the German Hospital that it had become apparent, during the patient's stay there, that he was suffering from a paranoid schizophrenic illness. He had undergone a course of electrical treatment which had improved the depressive symptoms.

1946 to April, 1952.—The patient continued to attend the medical out-patient department. His anaemia appeared to remain controlled on "anahaemin" injections, 2 ml., which towards the end of this period were given once a month. *Blood count* (June 1, 1950): haemoglobin, 80%; erythrocytes, 5,280,000; C.I., 0.77; P.C.V., 42%; M.C.V., 80.8 cubic microns; M.C.H.C., 21.5%.

March 1950.—Bassini's operation for right inguinal hernia was performed at the German Hospital. Post-operative progress was uneventful.

July, 1952.—At the request of his local doctor the patient was seen by Dr. E. R. W. Mons, psychiatrist to the German Hospital. He complained of his "head getting hot all over" and also of "pins and needles," dyspnoea, nervous dyspepsia, and occasional blurring of vision when reading. He has not attended the psychiatric out-patient department since then.

Recent Blood Counts.—January 8, 1952: haemoglobin, 70%. March 13: haemoglobin, 82%; leucocytes, 6,200 per c.mm. April 24: haemoglobin, 84%; erythrocytes, 5,430,000; C.I., 0.8; differential count—neutrophils 67%, lymphocytes 24%, eosinophils 9%; erythrocytes appear hypochromic with slight polychromasia.

May 18, 1953.—Returned from Brentwood Mental Hospital. Attended medical out-patient department of the German Hospital (Dr. Mills Hall), but was referred to the psychiatrist (Dr. Mons).

June 11, 1953.—Seen by Dr. Mons in the out-patient department. Patient feels quite well now. Has been back to business for two weeks, is taking things slowly, and says he can manage. In Brentwood on arrival he had had electric convulsion treatment, and eight treatments after seven months. He was told to report to Whipps Cross Hospital (Dr. Copeland) if a relapse occurred. He was discharged from Dr. Mons's psychiatric out-patient clinic.

In this short summary it has been impossible to include all the diagnostic and therapeutic tests and trials that have been made or suggested, but the account suggests that amongst the symptoms complicating cases of achlorhydric anaemia in males must be reckoned symptoms resembling those of so-called temporal lobe epilepsy and various schizoid manifestations.

Medical Memoranda

Fatal Rupture of Retro-pharyngo-oesophageal Abscess

We have been unable to trace any record of a case resembling the one reported below, which may therefore be found of interest.

CASE REPORT

A previously healthy girl aged 10 was admitted to Neasden Hospital at 3.15 p.m. on June 11, 1952, with a history of a sore throat on June 4 and subsequent swelling of the glands. She had been treated with sulphonamides and chloramphenicol.

On admission the temperature was 100.6° F. (38.7° C.), pulse 110, and respiration rate 28. There was mild stridor, nasal speech, marked cervical adenitis and periadenitis in the anterior and posterior triangles. The post-pharyngeal wall was inflamed and oedematous, with no evidence of abscess formation. She swallowed fluids without difficulty. Further physical examination was negative. The blood showed a leucocytosis of 19,800 cells (79% polymorphs).

Intensive penicillin and sulphonamide therapy, with anti-histamines, was instituted immediately and a kaolin poultice applied to the neck. At 11.55 p.m. the girl suddenly became cyanosed and rigid, and stopped breathing. Tracheotomy was at once performed and a tube inserted, through which a large amount of thin brownish fluid exuded from the trachea. Despite postural drainage, continued artificial respiration, and intracardial nikethamide, she died immediately.

Bacteriological investigation of the pus revealed large numbers of yeasts and non-haemolytic streptococci—no tubercle bacilli or anaerobes.

Post-mortem Examination (Dr. R. Donald Teare).—"An extensive abscess occupied the posterior pharyngeal region from the uvula and tonsillar region down to the arch of the aorta. It had recently ruptured into the pharynx and flooded the trachea and bronchi with pus, which was very offensive. No foreign body or mark of a foreign body was found."

COMMENT

There was no history of injury from foreign body or food. Chemotherapy localized the pus. It would appear that, had there been a pointer, a barium swallow x-ray examination or oesophagoscopy might have led to diagnosis.

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Fixed Sulphonamide Eruption Simulating Early Syphilis

Sulphonamides are a rare cause of "fixed drug eruption." Robson and Keele (1950) define a fixed eruption as being "characterized by the rapid development of one or more sharply circumscribed lesions on the skin or mucous membranes as an invariable response to the administration of the offending drug." A case presenting this phenomenon in which the eruption closely resembled early syphilis is worth recording.

CASE REPORT

A married tile-fireplace maker aged 28 was referred to the department of venereology, Doncaster Royal Infirmary, with a penile sore and "mucous patches" on the tongue of about eight days' duration. He denied extramarital intercourse. It transpired that ten days previously he had consulted his family doctor, who prescribed sulphydryl tablets for a mild attack of erysipelas affecting the left ear. Two days later an irritating rash appeared on the scrotum. The following day a similar rash appeared on the penis and left side of the neck, and slightly painful ulcers appeared on the tongue. He reported back to his doctor, who prescribed promethazine hydrochloride tablets with little relief

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 $\frac{1}{2}$ 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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REFERENCES

- Campbell, D. J., and Doyle, J. O. (1953). *Brit. J. ven. Dis.*, **29**, 32.
Cole, L. M. (1946). *Arch. Derm. Syph. (Chicago)*, **54**, 675.
Ghosh, M. N. (1952). *British Medical Journal*, **2**, 26.
Meltzer, L. (1949). *J. invest. Derm.*, **13**, 213.
Philpott, J. A. (1951). *Arch. Derm. Syph. (Chicago)*, **63**, 776.
Robson, J. M., and Keele, C. A. (1950). *Recent Advances in Pharmacology*. Churchill, London.

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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REFERENCES

- Bruce, J. M., and Dilling, W. J. (1918). *Materia Medica and Therapeutics*, 11th ed. London.
Dilling, W. J. (1940). *Pharmacology and Therapeutics*, 17th ed. London.