Although the details of each case naturally differed, there were certain similarities between them. In each case pruritus, rather than any particular skin reaction, was the main feature, and this was associated with agitation. The skin reaction appeared secondary to the pruritus and could be shown to be due to scratching. Thus relief of the depression obtained by use of E.C.T. was accompanied by a cessation of pruritus and an immediate improvement in the skin condition. In those cases in which a relapse of the depression occurred it was noticed that pruritus, with scratching, returned before the skin condition reappeared.

All cases showed evidence of the endogenous type of depression. Disturbed sleep, with early waking, loss of weight and appetite, and low spirits, with diurnal variation, were common. The favourable response to E.C.T. was also confirmatory evidence of the affective nature of the illness. Apart from ideas of hopelessness, however, none of the patients showed psychotic thought content. This fact is interesting and perhaps explains why the depressive nature of the illness remained unrecognized in some cases for months or years.

It is well known that anxiety and obsessional states may be symptoms of an underlying depression, and the neurotic picture so presented may be misleading. That somatic symptoms are also common is equally well known, but it does not appear to be generally recognized that pruritus, with skin reaction, may be the main presenting symptom of melancholia.

In some instances the response to E.C.T. was dramatic, in others less so, but in every case the skin condition closely followed the mental state of the patient. No claim is made that E.C.T. benefits skin conditions as such, except when they are secondary to a disorder that itself responds to E.C.T.

Summary

Six cases of melancholia complicated by pruritus and skin reactions are described. All cases benefited from E.C.T., although in one case neither the depression nor the skin condition was cured until leucotomy was performed.

Evidence has been brought to show that the pruritus was secondary to melancholia and could rightly be regarded as a symptom of it. This fact does not seem to be generally appreciated.

I would like to thank Dr. J. H. O. Roberts, medical superintendent of the North Wales Hospital, for permission to publish these cases.

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An article in the December issue of the *NAPT Bulletin* discusses what the doctor should tell the patient with suspected tuberculosis. "There is an art in these things," it says, "an art not always taught in medical schools. It is not what the doctor says, or leaves unsaid, but the way he does it. The greatest clinicians have practised this art to perfection upon patients and relatives. To watch them at work, or even to read their clinical letters, is an education. They don't necessarily 'tell.' It is not a question of facts at all. But they can generally relieve the tension in the patient's mind. The greatest clinicians have the power to communicate a real dilemma in a way that causes least distress. They can confess ignorance without losing face. They express a danger in such a way that it braces the patient to put forth his best effort. It is not humbug. On the contrary it is the finest expression of medical skill."

CASE OF ACHLORHYDRIC ANAEMIA IN A MALE FOLLOWED UP FOR 20 YEARS

BY

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In 1933 I wrote a paper with my then house-physician, Dr. W. Weisswange, on "Simple Achlorhydic Anaemia in Adult Males."* It is well known that typical achlorhydic or hypochlorhydic anaemia is very much rarer in males than in females and that the history of male cases, if followed up for a number of years, often discloses peculiar features or associations. The following history is that of Case 4 in the above-mentioned paper.

Case Report

A commercial traveller and collector aged 32 came under observation in December, 1932, with the history that he had looked pale for a long while and had had dyspeptic troubles for the previous four months. For some time he had had a sore tongue, which the dentist told him was not due to his teeth. In 1931 he had had double pneumonia, and (at another hospital) was given two blood transfusions. Blood count (December, 1932): haemoglobin, 38%; erythrocytes, 2,400,000; C.I., 0.8; leucocytes, 5,750 per c.mm. (polymorphs 77%, lymphocytes 20%, monocytes 3%); anisocytosis, poikilocytosis, and a little basophilia punctata. Fractional examination of the gastric contents showed complete achlorhydria, even after the subcutaneous injection of histamine; pepsin present after the histamine. Brachial systolic blood pressure: 115/45 mm. Hg. Negative Wassermann reaction. Vitiligo. In February, 1933, the spleen could be felt during inspiration.

The presence of achlorhydria was confirmed in January and July, 1933. In July no enlargement of the spleen could be detected, and the blood count gave: haemoglobin, 75%; erythrocytes, 5,000,000; C.I., 0.75; leucocytes, 6,950 per c.mm. (eosinophils 2%, polymorphs 62%, lymphocytes 29%, monocytes 7%); very slight anisocytosis and poikilocytosis. The out-patient treatment, doubtless somewhat irregularly taken, had been ferrum reductum and an acid pepsin mixture with meals. Dr. Price-Jones, who examined blood films of December, 1932, and February, 1933, wrote that the extreme degree of poikilocytosis did not suggest simple microcytic anaemia.

The patient was readmitted to the German Hospital on September 18, 1936, in a more anaemic condition: haemoglobin, 60%; erythrocytes, 3,660,000; C.I., 0.82; sedimentation rate, 14 hours (Linsensmeyer). A complete gastric achylia, even after subcutaneous injection of histamine. X-ray examination of the stomach showed nothing abnormal. After four weeks at the German Hospital he left very much improved. In the out-patient department on November 12 his erythrocytes were 5,400,000; haemoglobin, 82%; C.I., 0.75. At this period he sometimes seemed queer in his head. He would complain of various peculiar subjective feelings, notably as if part of his face was absent (unreality feelings). He was given a letter for the out-patient department of the Maudsley Hospital, which communicated with the German Hospital, the patient being under the care of both hospitals jointly.

Mrs. S. Brock, of the German Hospital, has kindly looked up the scattered notes relating to the patient and the correspondence about him with other doctors until 1952. I myself last saw the patient some time before 1952, and I am indebted to Mrs. Brock for a summary of the notes and correspondence about him, and also to Dr. H. C. Lauber

*F. Parkes Weber and W. Weisswange, *British Medical Journal*, 1933, 2, 1066.

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 sulphapyridine 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