erythema had cleared up, but he continued to run a temperature and grow paler. He had headache at the onset of his illness. He improved, but although he said he felt all right he was very easily fatigued. He was advised to have sanatorium treatment, and was admitted to the Derbyshire County Sanatorium on October 24th. Dr. Niven Robertson, physician superintendent, reports his condition as follows:

"Cheeks flushed, pale waxy skin round the mouth, thyroid slightly enlarged, phlyctenule on the right eye at 9 o'clock on the limbus. Right Kronig's area $1\frac{1}{4}$ inches, left Kronig $1\frac{1}{2}$ inch. Marked loss of resonance upper part of left lung, no adventitious sounds. X-ray examination shows well marked hilus shadows on both sides and dense triangular shadow at the left apex resembling 'pneumonic triangle.'

"Quantitative von Pirquet Test, November 8th, 1923: 64, 16, 4, 1 per cent., all well marked positive. Latterly the scarified areas closely resembled erythema nodosum patches.

"Arneeth Count, November 22nd, 1923: 23, 41, 32, 4, 0; left-hand drift: positive.

"Spengler's Precipitation Test:

Specific precipitation	...	1 in 100,000, positive.
Bovine precipitation	...	1 in 100,000, positive.
Auto-precipitation	...	1 in 100,000, positive."

REFERENCE.

¹ *Tubercle*, June, 1922.

A CASE OF ERYTHROEDEMA POLYNEURITICA.

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ACCORDING to Drs. Donald Paterson and Greenfield,¹ who have recently published an account of five cases of this uncommon disease, the chief characteristics of the malady are: (1) the age incidence—it occurs in young children from 4 months to 3 years of age; (2) erythroedema—coldness, redness, swelling, and irritation of the extremities; (3) sweating, associated with a mouse-like odour; (4) alopecia; (5) insomnia and mental depression; (6) muscular hypotonia; (7) partial loss of sensation. Two of these cases died, and *post-mortem* examination revealed marked degeneration of the peripheral nerves with evidence of inflammatory changes in the spinal cord.

Diphtherial neuritis, avitaminosis, and infection have been suggested as causes; Paterson and Greenfield incline to the last view. There is some evidence that the cases follow influenzal epidemics.

When the paper referred to above was published the following case was under observation in the Children's Hospital of the Leicester Royal Infirmary.

M., aged 3, was sent to the out-patient department by Dr. Garrett of Earl Shilton, Leicestershire, on August 22nd, 1923, suffering from sleeplessness, sweating, and weakness. She was a full-time infant, and the labour had been normal. There were four other children, all well, and the parents were healthy. The patient had had no previous illnesses. She had walked and talked at 12 months; teething had commenced at 10 months. The present symptoms had come on gradually during the preceding eight weeks. In addition to the sweating, sleeplessness, and weakness, she had "gone off her legs," and her hands had been cold and red. There had been much crying. The appetite had considerably decreased. Just before the symptoms commenced the patient had suffered from a severe "cold on the chest." The child had been breast-fed until 18 months; she was then weaned and put on to cow's milk, various foods being added until she was having 1 pint of milk, milk puddings, egg, fish, bread, butter, jam, potatoes, and gravy.

FIG. 1.

The patient was quite well nourished, and walked fairly well (Fig. 1). The arms and legs were red, swollen, and cold, but although they looked oedematous they did not pit on pressure. There was extreme muscular atony, and the limbs could be placed in all sorts of bizarre positions as is shown in the photographs (Figs. 2, 3), which remind one of amyotonia congenita. No abdominal reflexes or knee-jerks could be obtained, but the ankle-jerks were present. There was marked alopecia in the temporal regions. The urine showed no gross abnormality.

The patient was admitted for further investigation. While in the ward she was placid, but abnormally quiet and still, and her hands seemed painful. No definite sensory loss was ascertained. A fort-

FIG. 2.

night after admission she had for a week irregular pyrexia, for which no cause could be found; the highest temperature was 100° F., otherwise the temperature was subnormal but irregular. The systolic blood pressure was 110 mm. Hg, diastolic 80. The vasomotor paralysis and amyotonia suggested that the chromaffin tissue was affected, but 10 grams of glucose by the mouth produced no glycosuria, and 20 grams only a trace of sugar in the urine. (The weight of the child was 23 lb.) The blood sugar was 0.1 per cent. Swabs from the nose and fauces showed on culture the presence of Hoffmann's bacillus in large numbers; there were no true diphtheria bacilli. The redness and coldness of the extremities was apparently uninfluenced by the temperature of the air.

The treatment given was general massage, under which the patient slowly but surely improved. By October 23rd both knee-jerks were obtainable, and the limbs could not be placed in

FIG. 3.

abnormal positions. The child's mental attitude was much brighter, and the erythroedema was markedly less. She was discharged on October 30th very much improved.

It will be seen that this case corresponds very closely to those described by Paterson and Greenfield. The only differences were the absence of any demonstrable sensory loss and of any distinctive odour.

REFERENCE.

¹ *Quart. Journ. of Med.*, October, 1923.

Memoranda:

MEDICAL, SURGICAL, OBSTETRICAL.

DIATHERMY IN LUPUS OF SOFT PALATE AND FAUCES.

THE treatment of lupus by diathermy appears to be more frequently employed in France than in England. I have used it in intranasal lupus with very satisfactory results, and the following case shows the effects in lupus of the throat.

A. L., a woman aged 26, was first seen in March, 1923. She gave a history of stiffness and soreness of the throat for six months, with some pain when swallowing. She also had a cough. The whole of the soft palate and fauces were affected by lupus, which spread from there over the pharynx and involved it for 1 to $1\frac{1}{4}$ inches from above downwards. Ulceration had taken place on and in the region of the uvula. The posterior surface of the soft palate was free from disease, and there were no signs of any mischief in the lungs.

On March 27th, under a general anaesthetic, the greater part of the diseased area was treated with the small button electrode. A fairly strong current was employed, and the electrode moved somewhat rapidly over the diseased parts so that superficial coagulation was obtained with little injury to the deeper tissues. Throughout the application the fact that it was better to do too little than too much was kept in mind. On April 17th a further application was made, and on healing being completed only one or two small points of disease remained.

She was prevented by her work from attending hospital again till November, when it was found that the diseased patches which were seen after healing in May had enlarged considerably, but no fresh infection had occurred in the healed area. On November 20th she was again treated, and all the affected area appeared perfectly healthy after healing was completed, except one minute patch, consisting of five or six apple-jelly nodules, on the left posterior faucial pillar. These were treated under local anaesthesia.