Unfortunately the colours have undergone some change, and it is not so clear as could be wished. Author's diagnosis: Syphilide pigmentaire.

2. A chromo-lithograph from Chotzen's *Atlas*. The neck of a young woman exhibiting in the most definite manner large areas of dull white arranged dapple-wise on a brown skin.

3. From Chotzen's *Atlas* we have one designated "Lues: Leucoderma coli." It shows the back of the neck and shoulders of a dark-haired young woman dappled over with white patches which cover almost the entire surface. The pigmented network is not very dark and by no means conspicuous.

4. In one of Neumann's two portraits the front of the neck and upper part of the bust are shown, and the condition of dapping is very definite. "Leucoderma syphiliticum."

5. Copied from the St. Louis Hospital collection and published in the *Atlas* edited by Dr. Pringle, we have shown the side of the neck of a young woman of a dark, swarthy skin. The skin of the neck is darker than that of the shoulder, and is dappled over with white ill-margined patches about the size of fourpennies. In several instances these have become confluent. The ground network is very dark.

6. Mr. Shillitoe's portrait represents the side of the neck of a young woman with brown or auburn hair. It is dappled with white patches, which cover the greater part of the surface.

7.—Tafel 157 of Kaposi's *Atlas* represents the back of the neck of a woman with brown hair. Numerous small spots are scattered over the neck, not larger than split peas, and all of them consisting of a white ring, which in some instances encloses a dark centre like the nucleus within a cell. The enclosed nucleus is about the same tint as the ground colour. The patches are in some places confluent, and they cover the greater part of the surface. The diagnosis is "Leucoderma syphiliticum. Pigment syphilis." It can scarcely be considered to be either pigmented or leucodermic, but only congested. It resembles the following:

8. Number 210 in the supplement to Jacobi's *Atlas* has the diagnosis "syphilis maculosa confluens; leucoderma syphilitica." It represents the front of the bust, shoulder, and neck of a young woman, which is dappled all over with a pink eruption, which encloses lighter coloured spots. On the front of the neck these spots are white. It is tolerably clear that a diffuse erythematous condition has brought out the dappled pattern of the skin. Only on the neck is there evidence of pigmentation.

9. Tafel 158 from the same *Atlas* and with the same nominal diagnosis represents the front of the trunk from the nipples to the upper part of the thigh, marbled or dappled all over by a pigmented network. The contrast in colour is not very great. The neck and shoulders are not shown. A man.

10. A second portrait of Neumann's represents the back of the neck and almost the entire trunk. The groundwork of the entire skin is very dark, swarthy rather than black, and it is spotted over with darker patches the arrangement of which it is difficult to interpret. On the back of the neck, however, there occur definite areas of white skin enclosing darker spots, as in Kaposi's portrait mentioned above. Across the loins the condition of mapped-out dapping is definite, and the paler spots have dark centres. The contrast in colour is nowhere very marked.

11. The portrait published by Dr. Taylor of New York. The side of a man's neck is shown. The patches are very dark, and Taylor distinctly recognizes three forms.

12. A portrait given by Dr. MacLaren's valuable *Atlas of Venereal Diseases* (Plate 12). This was published in 1887, but I have only recently found it.

It will be seen that these portraits present us with some interesting problems. They are not all alike. Two of them show the dappled condition occurring over the whole trunk, and in one of them, perhaps both, the patient was a male. Two of them showed a condition which has possibly hitherto escaped notice in England—I desire to speak with the utmost caution—the presence of a dark nucleus in the centre of the white patch.

Now, if we observe the arrangements of colour on the skins of animals to which I have already adverted, we have at least three distinct types as regards the relation of patches to ground.

In the leopard black patches occur on a yellow ground, and many of the patches have yellow centres.* In a few of the latter black nuclei occur, which are thus surrounded by yellow, which again is margined with black. This is exactly what occurs, but in reverse order, in the portraits of leucoderma syphiliticum given by Neumann and Kaposi respectively.

In the giraffe dark patches are mapped out on a yellow ground. The ground in one variety is so scanty as to be little more than lines, but in another it may increase so as to comprise the greater part of surface and to reduce the patches to comparatively small areas.

Thirdly, we have the pattern shown on a deer or dappled horse, in which light-coloured patches, mostly round and

of very various dimensions, occur on a darker ground. This is the condition usually realized in syphilitic leucoderma. It may be further noted that on some regions (see loins and neck of Neumann's portrait) the pigmented areas are squared rather than round, in exact imitation of what occurs in the giraffe, and in some of the regions of skins of leopards and other animals.†

Fournier, who devotes one of his admirable clinical lectures‡ to "*Syphilide Pigmentaire ou Ephelique*," is emphatic in declaring that this condition stands apart from other syphilitic conditions, and should be studied by itself: "Accident très bizarre, très curieux, qui s'éloigne à tous égards des autres déterminations cutanées de la vérole." He does not admit that the white "taches" are in any degree decolorized, but regards them as normal skin. He had seen but one case in a male. He thought the condition incurable by specifics and that it never lasted less than one or two years and often longer.

He distinguished it from Addison's disease by stating that in the latter the pigmentation is general and uniform, "non-tachetée." If, however, we deny, with him, that the white patches are other than of normal tint, then this condition is "non-tachetée" also, for it is the pigmentation of the ground which is excessive, and this is not tachetée. Thus we reject altogether such terms as "macular lesion" as inapplicable, and come to the conclusion that the condition is one of diffuse melanoderma plus the peculiarity of a normally pale skin in patches. This brings us very near to the suggestion of a functional temporary and minimized type of Addison's disease, due, possibly, to derangement of the suprarenal capsules. Fournier denies, and I cannot but think with good reason, that it can be regarded as in any way secondary to preceding syphilitic eruptions.

We may, I think, safely assume that the peculiar patterns evolved in cases of this affection are physiological, and due to original organization and not to disease. Building on this assumption, I would further suggest that in secondary syphilis, disordered function of the suprarenal and other organs favours the accumulation of melanin in the cells, and that, finally, exposure to light brings about its deposition in unprotected parts. Thus we explain the preference of the malady for the female sex, and for the neck and bust, and its tendency to persist.

We may conjecture that the affection is far more common in non-syphilitic subjects than has yet been suspected. If some observer, as zealous and keen-sighted as Mr. Shillitoe, would conduct a series of control observations on healthy individuals—brunettes by preference, but not excluding those of the male sex—we should probably obtain some very interesting facts. In the meantime I would invite those interested in the matter to pay an observation-visit to the Zoo, and afterwards to devote half an hour to our Chenies Street Museum.

A CASE OF VINCENT'S ANGINA.

By J. T. C. NASH, M.D., D.P.H.,

COUNTY MEDICAL OFFICER OF HEALTH FOR NORFOLK.

THE following case appears to suggest that the organisms associated with the name of Vincent might after all be merely ordinary oral parasites which happen to find a suitable nidus for multiplication in certain throat conditions, especially where there is a tendency to the formation of a false membrane through the action of streptococci or pneumococci, or even the *Bacillus diphtheriae*; but it is only just to state that a previous case of Vincent's angina had occurred in the same house in an adult female in the preceding August. In this case, also, Vincent's organisms and streptococci were found bacterioscopically.

Mlle. P., aged 20, complained of severe headache on October 16th, 1906. On the 18th she noticed a pricking pain in the throat on the right side, accompanied by some dysphagia. Appetite good, and no constitutional signs of any moment beyond headache, which persisted for some days.

† No one will, I hope, suppose I am suggesting any sort of "reversion" towards the peculiarities of any particular animal. My meaning is simply that the potential endowments of the human integument are the same as those of animals, and may favour the production of various resemblances which are based upon its structure. The growth of the nails, the arrangement of the surviving hair, etc., are familiar illustrations of what is intended.

‡ It is worth noting that these lectures are on syphilis as observed chiefly in females.

* The jaguar is the leopard on whose skin these conditions are best observed. See page 394 of Lydekker's *Royal Natural History*, or, still better, the specimen in the South Kensington Museum.

Clinical Signs.

On examination the tongue was normal, and there were no enlarged glands; a white membranous patch was visible between the pillars of the right fauces, and there was slight nasal discharge.

Bacteriological Examination.

A swab taken from the white patch of deposit was first rubbed on blood serum for incubation at 37° C., and then on a clean slide for immediate examination. After standing with Loeffler's methylene blue, the immediate examination revealed numerous fusiform bacilli and spirilla, the organisms described by Professor Vincent. These failed to grow on the inoculated serum, which after twenty-four hours' incubation at 37° C. revealed the presence of streptococci.

Treatment.

The treatment adopted was that which is recommended for *angine de Vincent*—namely, tincture of iodine locally, and potassium chlorate internally.

Result.

The organisms of Vincent disappeared rapidly, the streptococci more slowly, but recovery took place in a week.

The data in this and other cases mentioned are too meagre to permit any reliable conclusion to be drawn, but in each of my cases it seemed probable that street dust inhaled accounted for the sore throat and streptococci, and that Vincent's organisms were merely accidental, but in view of Vincent's own experience and descriptions further study of similar cases is required.

I am strongly of opinion that if more throat swabs were subjected to immediate examination than at present obtains, and Vincent's organisms looked for, it would be found that these organisms are not so rare as is thought.

The question of their pathogenicity also requires further investigation, and appears to be worth the attention of the clinical pathologist.

The point to be decided is this: Is Vincent's angina a sufficiently distinct disorder to deserve a specific designation? The symbiosis of spirilla and fusiform bacilli point in this direction, as also the fact that the particular spirilla are difficult of cultivation. They really seem to be more of the nature of spirochaetes.

The above notes were written nearly two years ago. There appeared in the issue, November, 1908, of the *Journal of the Royal Institute of Public Health* a contribution by Dr. M. A. Arnold on Vincent's organisms which corroborates the views I have expressed. Dr. Arnold's contribution is well worth attention. The clinical appearance of the membrane seen on the fauces in the cases, in which I have examined for and found Vincent's organisms, is very suggestive of diphtheritic membrane. I am afraid my own opportunities of further study of these organisms are now likely to be few, but I venture to hope others will follow the matter up.

Memoranda:**MEDICAL, SURGICAL, OBSTETRICAL.****MENDELIAN HEREDITY IN ASTHMA.**

As I think the enclosed chart, showing, in black, the members of a family who have been afflicted with

spasmodic asthma, will be of interest to Mendelians, I shall be glad if you will publish it.

The numbers—10 normal and 10 abnormal descendants—are in accord with Mendel's theoretical 50 per cent. of each class in such cases, for there was almost certainly a heterozygous abnormal parent of those shown in the first line.

Wrexham.

H. DRINKWATER.

DIPTEROUS LARVAE INFECTION.

It must be an uncommon experience to have two cases of infection by dipterous larvae under one's care at the same time. The method of infection in the one case and the consequence of the infection in the other may warrant their being reported.

CASE I.—Mrs. B., aged 55, an asthmatic, while sitting sewing, felt a fly under her right nostril. She at once tried to expel it by blowing the nose, but without success. An attack of asthma coming on at once, she had recourse to the fumes of a powder which she habitually used at such times. The fly, not quite dead, fell out, but could not be found. This was on a Wednesday afternoon. Severe attacks of sneezing troubled her the same night, and the next morning there was a bloody nasal discharge. The nose began to swell, and the discharge became more bloody and the sneezing more annoying. By Friday she could not leave her bed; by Saturday night the bleeding was sharp and the swelling had spread to the cheeks and eyelids. Such was her condition on my seeing her on Sunday morning. In addition there was a foul, sanious discharge, the lining membrane was much swollen and cracked, the pain and distress severe. The septum nasi showed an old-standing perforation centrally. The nose was washed out with a saturated solution of boric acid and an antiseptic inhalation given. By next day the patient's distress was so serious that Dr. Marry was asked to see her with me. The nose was douched several times a day with potassium permanganate, which kept down the fetid smell, but gave no other relief. By Wednesday morning the discharge of maggots began and kept up for about ten days. A perforation occurred through the right nostril just below the nasal bone. As the right ala became very much swollen and blocked the passage it was incised, and a small nest of maggots was revealed. They spread into the right cheek up to the lower eyelid; they burrowed into the gums and appeared in the mouth. In spite of douches of hydrogen peroxide, mercury perchloride, and per-

manganate, they kept on appearing up to the number of about a dozen and a half each day. Between 100 and 150 maggots must have been passed in all. They left the nasal cavity disorganized, and bone exposed in many directions. I secured one of the maggots, which were evidently too large for those of the house fly, and put it in a bottle. It hatched out a blue-bottle. The accompanying photograph shows the fly and its case.

CASE II.—While attending the last case I saw an elderly lady who had an epithelial tumour the size of a small hen's egg growing in front of the left ear. It had begun to bleed. On examining its base, which was about 1½ in. by ¾ in., I saw a few maggots. Evidently the bleeding was due to their destruction of the tissue where the vessels entered. In spite of strong applications for their destruction the maggots, which proved far more numerous than I thought, succeeded in riddling the tumour in twenty-four hours, causing pretty severe loss of blood. By next day the tumour was fetid, the bleeding continuous, and the face as far as the eye oedematous. Dr. Marry saw the case with me, and we decided to remove the growth with the cautery. The whole centre was a mass of maggots. When the tumour was removed down to the level of the skin a large nest of maggots was found in the cheek, and had to be destroyed with the cautery. They had evidently developed from ova of the housefly, being much smaller than those of the previous case. Promptly the bleeding stopped and the swelling disappeared, leaving only the scar resulting from the use of the cautery.—I am, etc.,

Trinidad, B.W.I.

STEPHEN M. LAURENCE, M.B., C.M.

OEDEMA OF THE EYELIDS WITH PYREXIA.

My attention has been drawn to an article in your issue of December 12th, 1908, by Dr. Spriggs, under the title of