Professor of Helminthology, for the unselfish way in which he, at the expense of much time and patience, initiated me into those special methods of work and thought that in his hands have already so greatly enriched helminthological literature.

THE X-RAY TREATMENT OF RINGWORM OF THE SCALP:

SINGULAR COINCIDENCE OF MEASLES WITH THE DEFLUVIUM OF THE HAIR.

By J. M. H. MAGLEOD, M.D.,

ASSISTANT PHYSICIAN FOR DISEASES OF THE SKIN, CHARING CROSS HOSPITAL; PHYSICIAN TO THE SKIN DEPARTMENT, VICTORIA HOSPITAL FOR CHILDREN.

THE *x*-ray treatment of ringworm of the scalp has now passed through the experimental stage, and become recognized as the most rapidly effective mode of treating the disease, and if properly done by recent methods, it has been shown to be comparatively free from risks. The so-called single exposure method, thanks to the work of Sabouraud and others, has replaced the more uncertain method of repeated exposures and fractional dosage. So certain and well regulated has the dosage become, that the operator now expects the defluvium of the hair from the exposed area to take place on about the sixteenth day without any marked inflammatory disturbance, only occasionally a transient hyperaemia for a few days before the hairs fall out. Consequently, when any marked hyperaemia occurs, it is naturally a source of great anxiety, suggesting the possibility of an overdosage of the rays, or the previous employment of some irritant to the scalp such as tincture of iodine. Recently I had the alarming experience of an erythema occurring on the exposed areas in the scalps of two boys just as the hair was falling out, which was so marked as to cause considerable anxiety, but which turned out to be due to the singular coincidence of an eruption of measles with the defluvium of the hair. This unusual experience seems to be worthy of recording.

Towards the end of last October, two boys, aged respectively 9 and 4 years, suffering from small-spored ringworm of the scalp, were sent up to me from the country for *x*-ray treatment. In both of them an eruption of measles appeared on the exposed areas of the scalp as the hair was falling out. The following are brief notes of the cases:

CASE I.—Aged 9 years. Suffering from tinea tonsurans due to *Microsporon audouinii*. The patches of ringworm were confined to the frontal and occipital regions, and could be included in two exposures with a circular localizer of 7 cm. diameter. The exposures were given on October 27th. On November 14th the hair had begun to fall out from the exposed areas and it was noted that the skin of both areas presented a vivid erythema. This erythema was not of the mild diffuse type usually associated with the falling out of the hair, but was mottled in character and consisted of irregularly-shaped red macules, or slightly raised lesions, somewhat deeper in tint in the centre and varying in size from a pin's head to about $\frac{1}{4}$ in. in diameter. The presence of the eruption was not associated with any itching. At the same time it was noticed that the boy was out of sorts; he complained of headache and coryza, and had a temperature of 101° F. He was sent to bed and next morning a typical measles rash had developed on the forehead, behind the ears, on the sides of the neck, and was rapidly spreading on to the chest and back. I saw the case again on November 28th in consultation with Dr. Owen Lancaster, and found that the measles rash had disappeared and that the hyperaemia had gone from the exposed areas, which were quite bald and the ringworm cured. An interesting point about the case was that the measles eruption was first noticed on the exposed areas where the hair was falling out, and was not present to any extent elsewhere on the scalp. The hair had begun to grow by the middle of January and he was allowed to return to school.

CASE II.—Boy, aged 4 years, younger brother of other case, suffering from extensive tinea tonsurans due to *Microsporon audouinii*. The ringworm was much more widely distributed than in the former case, and it was necessary to give eight single exposures of areas 7 cm. in diameter to include it all. One small patch of ringworm had to be excluded from the *x*-ray exposure, as it had been irritated by previous treatment. The exposures were given on October 25th, 31st, and November 1st. On November 14th the hair had begun to come out of the areas first exposed, and a mottled erythema associated with the same general symptoms as affected the elder brother had developed, but they were more severe in character. Next day the measles eruption had become generalized over the skin. On November 28th the measles rash had disappeared, and the exposed areas were bald. The case was not quite so

satisfactory as the previous one, as the unexposed patch had to be needled on several occasions with croton oil, and also a few stumps which had been left between two contiguous exposed areas. The hair had begun to grow by the middle of January.

These cases were of great interest, on account of the measles eruption appearing on the areas rendered temporarily bald by the *x* rays. When the eruption was first seen in this situation, in spite of the catarrh and temperature associated with it, the possibility of its being measles did not occur to me, and some unusual form of *x*-ray dermatitis suggested itself. This anxiety regarding the cases was, however, dispelled next morning when the eruption had come out fully.

A PLEA FOR THE USE OF TUBERCULIN WITHIN AND WITHOUT SANATORIUMS.

By W. CAMAC WILKINSON, M.D. LOND., F.R.C.P.,

LECTURER IN MEDICINE, UNIVERSITY OF SYDNEY; PHYSICIAN, ROYAL PRINCE ALFRED HOSPITAL.

INFECTIOUS diseases of specific origin are the result of an affinity existing between the specific cause or its product or both and the tissue elements of the man or animal. The result of the disease depends on the action and reaction of these two essential factors. If the specific cause is very virulent or very abundant, it overpowers the vitality of the invaded tissues and destroys the organism. On the other hand, the resisting energy of the tissues may overpower the agents of disease and either destroy them or neutralize their dangerous products. Tubercle bacilli, the specific cause of all forms of tuberculosis, manifest a remarkable affinity for certain parts of the human body, notably the lungs, and the result of tuberculous disease of the lungs depends on the virulence and number of tubercle bacilli and the resisting energy of the invaded tissues.

In the treatment of such an infectious disease there are two rational methods—one directed against the specific cause and therefore called specific, the other aiming rather at strengthening the resisting energy of the invaded tissues. These two distinct methods of specific and general treatment should be combined if we wish to get the best results.

The specific method of treating pulmonary tuberculosis consists essentially in the use of tuberculin in its various forms, which helps to destroy the bacillus and to neutralize its toxic effects. This method is in fact a process of active immunization entirely different to the antitoxic treatment of diphtheria, in which the antitoxin is supplied ready made. In principle there is no difference between the tuberculin treatment for the purpose of curing tuberculosis and the use of Haffkine's fluid or similar agents for the purpose of preventing for a short time such diseases as plague, cholera or typhoid fever. If, then, the method is advocated in order to protect a healthy person against a disease, which in a mathematical sense he has a very small chance of contracting, it is not unreasonable to urge the use of the method if it offers even a small chance of cure to one who has already fallen a victim to the disease. Those who have used and advocated the use of specific prophylactic fluids containing germ products for the prevention of plague cannot with any show of consistency oppose the use of tuberculin, which is, after all, merely a vegetable product of the living tubercle bacillus. Many are, in their ignorance, guilty of this strange inconsistency. On the other hand, I may disarm some opposition by saying at the outset that the extraneous use of tuberculin is not the one only indispensable means of curing tuberculosis, even in an anatomical sense. We know of no disease in which death is inevitable. Always some individuals are ordained by Nature or strong enough to survive an attack of the most virulent disease. Plague does not kill all its victims; nor yet tetanus or anthrax. This power to resist lies in the tissues. Let us go a little further. This power to resist depends upon the ability of the tissues to produce a sufficiency of antibodies which either kill the specific agency or render their products harmless. It is too often forgotten that the very and only cause of the production of these antibodies in the tissues is the specific cause of the disease. *The disease works out its own cure by means of its own cause.* Not only the disease but even the mechanism of immunity

that cures it, are both the results of the living germ through its specific products. Except in this way no infectious disease cures itself or protects against itself. Even when we seek to strengthen the energy of tissue so that the disease may be resisted, we are blindly assisting Nature to work a cure in Nature's own way. In pulmonary tuberculosis sanatorium treatment, open-air treatment, the rest cure, and other methods act by stimulating the system to evolve the mechanism of immunity in response to the action of the products of the tubercle bacilli in the tissues, the most important of which is tuberculin. It may be a shock to some of the advocates of sanatorium treatment to hear that they themselves, without knowing it, have been innocently vaunting the efficacy of tuberculin in the treatment of tuberculosis. On the other hand, those who advocate the artificial supplementing of Nature's own direct weapon of defence are quite consistent in upholding the value of other methods, especially sanatorium treatment. Daily experience tells us that pulmonary tuberculosis is a disease that too often fails to work out its own cure. Some fault in the mechanism of immunity allows the germ to continue its work of destruction or, maybe, to lie in ambush for months and years. The whole purpose of treatment is to stimulate the tissues to build up and finish the mechanism of immunity, so that the tissues shall no longer be at the mercy of the tubercle bacillus. *A priori* it seems logical to stimulate the mechanism by means of the specific products, called tuberculin. *A posteriori* other methods evolved through empiricism are vaunted as the *me plus ultra*, and specific methods are held to be superfluous.

Unfortunately, there is no royal road to an accurate estimate of the value of treatment in a disease so irregular in its onset, so complicated in its nature, and so variable in its course as pulmonary tuberculosis, and the best of us may hardly avoid the pitfalls of inconsequent and circuitous reasoning. Least of all can we judge of the effects of treatment if we report and exhibit our immediate successes. Those who have had a large field for observation are at times staggered at the vagaries of this disease. The science of recent years, especially through the labours of Vagades and Kossel, working under the inspiration of Koch, tells us in unmistakable language that one of the chief causes of variation has been largely ignored—the variable virulence of the essential factor, the tubercle bacillus. In the old days the natural explanation of the variable course of pulmonary tuberculosis was found in the overrated element of predisposition. The tendency of the old school is still to labour the question of predisposition. The tendency of the new school of heretics is rather to give due weight to the definite, tangible, and measurable factor—the infective agent in all its variations and vicissitudes. Naegeli's statistics would seem to show that we are all predisposed. "*Jedermann ist ein bisschen tuberculös.*" The strongest athlete in the heyday of health and youth may be just as little immune as the slender, weakly factory girl with the flat chest and the so-called phthisical habit. The former may succumb to rapid and acute phthisis; the latter may show only an inert localized lesion. Predisposition at least is a quality that cannot be estimated, nor yet eliminated.

It is difficult beyond ordinary comprehension to give a right value to the effect of any method of treatment in a disease that runs such a variable course as pulmonary tuberculosis. The disease may exist for months and years without arresting the attention of patient or physician. It may become quiescent at any time; it may relapse after months or years; it may reach a serious stage involving the greater part of a lobe, and then end in perfect restoration of health. In spite of treatment of any and every kind, the disease may never relent; the victim knows no respite till death. Without any treatment, the disease may come to a standstill and never again disturb the health. The most affectionate regard for logic may not restrain us from attributing success to our own small efforts and failures to the vagaries of the disease. Our memories seize fast hold of successes; we leave others to record our failures, or leave them unrecorded. Let us adopt what measures we may, more or less failure is the rule, and yet we place a high value on many of our methods. In no other disease is it so difficult to estimate fairly the effect of treatment upon the course of the disease as it is in pulmonary tuberculosis. One sees cases of

pulmonary tuberculosis, even complicated with tuberculous ulceration of the larynx or epiglottis, get well of themselves without any special treatment, without sanatorium treatment, without injections of any sort, without local application.

In the first place, early diagnosis is the key to successful treatment. In the early stages the lesion of active or latent tuberculosis may produce physical signs like those of obsolete foci, and tubercle bacilli may not yet have escaped from the tissues. Obsolete lesions are not tuberculous, but post-tuberculous. How can the physician attempt to unravel the mystery of these various lesions? If the tubercle bacilli have disappeared there can be no tuberculosis, and if there is no active tuberculosis there is no reaction to tuberculin. That is a vital point. Tuberculin alone gives the clue whether the lesion is active or inert. If the focus is inert it may harbour tubercle bacilli that will become active at some future time. Yet, if the tuberculin reaction fails, it is likely that the tubercle bacilli are so surrounded that the tissues can themselves destroy the bacilli. On the other hand, a reaction to tuberculin proves that the lesion is not inert. This reaction is a danger signal of the first importance. It warns the physician of a danger hidden from sight, like the fog signal warns the sailor of a danger in a mist which the eye cannot penetrate. By the systematic use of tuberculin we may learn the true nature of many of those lesions which Naegeli too readily assumed to be tuberculous. Many of these lesions may be merely passive—quiescent, but still ready to be kindled into activity by inflammations or other infections. Sad to say, these closed lesions thus neglected may become the source of the acute and rapidly-progressing forms that develop in early adolescence. Now, if these terrible disasters may happen, there has been no cure, even though the lesion is for a time closed and inert. By no other way than by the systematic use of tuberculin can we distinguish these latent cases from absolute cures; and if tuberculin is not used, no one has a right to use the term *cure*. If the tuberculin test is negative, and again after an interval of three months or six months again negative, there is some certainty that a cure has been accomplished. When the prejudice against tuberculin has died its natural and inevitable death, one of the most valuable uses of tuberculin will be found in determining the effect of treatment of any and every sort. Meanwhile, except by those who use the test, the term *cure* must be avoided.

It is satisfactory to note that the Tuberculosis Congress in London, 1901, deliberately adopted the opinion that tuberculin was an invaluable agent in diagnosis. The education of English opinion needed ten years before the truth of Koch's original statement was recognized.

Sanatoriums cannot dispense with tuberculin as a diagnostic agent, and gradually tuberculin is taking its right place in all the sanatoriums of Germany. If tuberculin is not used, mistakes must occur. True cases of tuberculosis are overlooked, and, on the other hand, there is the risk of condemning a man to an expensive and irksome course of treatment for a disease which he has not got. In one year Weicker rejected 48 spurious cases already diagnosed by good examiners as early cases. In the eager chase after early cases, otherwise trustworthy examiners may condemn to sanatorium treatment many cases in which the diagnosis rests not upon trustworthy evidence, such as tubercle bacilli in the sputum or a definite reaction to tuberculin, but rather upon the subjective impressions of the observer as to the character of respiratory movement or auscultatory signs. The tuberculin test alone can save the profession from the Yes-No diagnosis. But for the tuberculin test Weicker might have greatly improved his statistics by including the rejected cases, and ultimately recorded them as cases of cured tuberculosis! Christian Science can do as much for these cases as the best sanatoriums. Let us take care we give no such chances to the Christian Scientists to show their skill. It is an easy offhand criticism to offer that tuberculin in diagnosis may lead to the inclusion of cases of latent tuberculosis that may never further develop. The same may be said of many of the cases upon which the statistics of sanatoriums are based. Who will dare to say that it will not develop if a reaction to tuberculin occurs? On the other hand, by the use of tuberculin I have saved many persons the expense and inconvenience of exile to the country, to which they had been sentenced by various

medical men. Further, when one uses tuberculin for treatment also, if perchance tuberculin has given a doubtful or false indication, the mistake is soon remedied. Thus, if the reaction be no greater than 99.5° to 100° F., and tuberculin is given for treatment, a constant absence of reactions with larger doses rapidly increased arouses suspicion. In my experience, with proper doses a temperature of 100° is positive. A rise of temperature to 99.5° to 100° is doubtful. *Tuberculin is quite harmless, if there is no tuberculosis.* Why, then, should we fear to use it in the cause of sanatorium or other methods of treatment, when it surely reveals the presence of tuberculous lesions? I have no hesitation in saying that tuberculin is an invaluable agent in the selection of suitable cases for sanatoriums, and also a ready means of gauging the success or failure of treatment. A more open question is the value of tuberculin as a curative agent. It is extremely difficult to measure the value of different methods of treatment in a disease that runs such a variable course. For any and every method of treatment successes will be claimed. The only test is the relation of successes to failures. If we investigate the statistics of sanatoriums, we find that the successes of to-day are the failures of to-morrow. Every medical man has had successes, but far more failures. Moreover, records are practically worthless, *unless they show that after an interval of time, say two years, the patient is the better for treatment.* It is the tradition of sanatoriums to publish results as soon as patients leave the institution. This pernicious practice must give rise to misconceptions and disappointments.

Dr. Sinclair, Superintendent of the Wentworth Falls Sanatorium, New South Wales, is an expert in sanatorium methods, and I fully recognize the humane and unostentatious labour of the last two years of his busy life. He knows too well the vagaries of the disease he has to deal with to raise hopes that may not be realized. He knows as well as I do that the immediate results of sanatorium methods, as of other methods, are satisfactory in every point but the most important—they do not last. The sequel to the chapter of improvements that stand recorded when the patient leaves the sanatorium must be stated with equal truth, and, sad to say, is a long wearisome chapter of relapses terminating in death after one or several years in the majority of cases—even though at the outset special care is exercised in selecting cases favourable for treatment.

Any one who has studied the analysis of 30,000 cases or thereabouts treated in German sanatoriums (Engelmann and Hameld, *Tuberculose-Arbeiten*) will hardly find occasion to boast of brilliant success. The fruit of the English sanatoriums and of our own sanatorium in New South Wales is not yet ripe for analysis—I said so in 1903. Ransome says the same in 1905. What is true in 1905 was doubly true in 1903, though I was laughed to scorn when I made the statement. Engelmann's statistics show that of the cases in Stage 1, 7.6 per cent. were disabled or dead in 1 to $1\frac{1}{2}$ years, 19.7 per cent. in 2 to $2\frac{1}{2}$ years, 33.3 per cent. in 3 to $3\frac{1}{2}$ years, 55.6 were disabled or dead in 4 years. In all stages the records were infinitely worse. In 1 to $1\frac{1}{2}$ years 25 per cent. were dead, in 2 to $2\frac{1}{2}$ years 38.4 per cent., in 3 to $3\frac{1}{2}$ years 55.0 per cent., in 4 years the deaths amounted to 66.7 per cent. Moreover, the failure of present methods is written large in the black letters of the statistics of every country.

The after-history of 20,878 cases treated in 1897 showed the following permanent results:

In 1898	...	...	66 per cent. permanent results.
In 1899	...	...	48 " " "
In 1900	...	...	39 " " "
In 1901	...	...	30 " " "

In Weicker's statistics—2,469 cases:

In following year	...	...	55 per cent. permanent results.
In second year	...	...	50.7 " " "
In third year	...	...	41.4 " " "
In fourth year	...	...	35 " " "

Two years after treatment 25 per cent. are dead, four years after treatment 50 per cent., and six years after treatment 63 per cent. are dead.

Even Dr. Sinclair has been premature with his records. When I published my results in 1902 my work extended back five years and more; Dr. Sinclair's extend back hardly more than two years and most of his successes have been reported within a year of treatment. The condition of time has not been fulfilled, and his records can at most

form a starting point for further observations. Many of the apparent successes of to-day may prove the certain failures of to-morrow. Still the after-history of these recorded cases year by year will show the truth about the results of sanatorium treatment.

We learn already from Dr. Sinclair, as I insisted years ago, that a three months' residence in a sanatorium may be well enough from an insurance point of view, since it may restore the industrial competency of a workman for one or more years, but in three months one cannot expect to arrest the disease, and it is arrest of the disease which the workman is led to expect and desires. The workman wishes not only to be able to work but to recover his health. In most cases the work of sanatoriums is patchy and unfinished. Patients are discharged—improved no doubt—but with the disease still potential, if not active, and merely awaiting a favourable opportunity to reassert itself. My purpose at this congress is to bring forward reasons for advocating the use of tuberculin as a remedy so as to bring the work of the sanatorium to a higher level of efficiency and completeness, for the benefit of the unfortunate victim of pulmonary tuberculosis, and even of the whole community. The better the work of the sanatorium the better for the community, and at the present time the inmates of our sanatoriums are denied the advantages of tuberculin treatment that are enjoyed by patients in some of the best German sanatoriums. The ideal treatment is specific treatment combined with those general methods adopted in the sanatorium that are of undoubted value in increasing that tissue energy upon which the success of tuberculin treatment depends. Weicker lost hope after a careful experience of the ordinary and best sanatorium methods of Brehmer; he weighed sanatorium treatment in the scales and found it wanting. He tried tuberculin, and, combining both methods he has taken heart again. Another very great authority, Moeller, has become a convert to our side, but he states that he uses tuberculin especially when sanatorium methods absolutely fail (see *Zeitschrift*), and in such cases he has been astounded at the splendid effects of tuberculin. My simple criticism of this somewhat half-hearted advocacy is that surely if tuberculin has been proved by him to be of enormous value as a curative agent, when *sanatorium methods have failed*, there is no *a priori* reason why it should not be far more successful in those cases in which sanatorium methods do good.

Years ago, when I was making my early observations with tuberculin, I studiously avoided the introduction of factors that might vitiate my conclusions. Accordingly I instructed patients to live under the conditions to which they had been accustomed. Having thus proved that the uniform improvement could be only due to the new factor—the tuberculin—I lost no time in adopting all measures that might reasonably be supposed to help in the arrest of the disease and the cure of the patient.

Strange as it may seem, I am the only specialist in diseases of the lungs in Sydney who has gone to the trouble of providing sanatorium treatment for private patients, even though I consider the sanatorium methods of subordinate importance. Other medical men who openly proclaim that sanatorium treatment is of primary importance, have taken no steps to secure for their private patients that method of treatment which they tell the world is the best and indeed the only treatment. It is idle to pretend that the haphazard exile of patients to the country constitutes sanatorium treatment. I leave it to the over-zealous advocates of sanatorium treatment for the poor to explain why it should not be equally successful in their well-to-do and rich patients. Let those who wish to be enlightened upon the great virtues of sanatorium methods read Dr. Ransome's article in the *BRITISH MEDICAL JOURNAL*. He quotes Walther of Nordrach to this effect, that, if by cure we mean that all subjective and objective signs of disease have disappeared, no more than 11.20 per cent. can be so classed, although improvement occurs in 70.80 per cent. of the cases. Ransome writes himself, "I think it may fairly be said, as the result of a large mass of Continental statistics, that only about 30 per cent. of patients discharged from sanatoriums for the poor maintain the capacity for work more than four years." He also writes, "In England sanatoriums for the poor have existed too short a time (writing himself in 1905) to allow of statistics of much value being collected from them." I said the very same thing quite two years before—in 1903.

Later Ransome says, "Exactly half the patients discharged have maintained the improvement gained for over a year, while half have got worse or are dead."

Professor Moeller, of the Belzig Sanatorium near Berlin and a recognized authority on tuberculosis, six years ago an utter sceptic upon tuberculin treatment, is now one of its most earnest advocates. He tells us that in cases in which sanatorium methods have entirely failed, tuberculin has been proved to possess undoubted curative properties, and that while sanatorium treatment never cures in three months, permanent cures are often obtained with tuberculin.

In his first record Moeller showed that

Sanatorium methods alone cured	10.9 per cent.
Sanatorium methods and tuberculin cured	36.3 "

Arranged according to stages the results were:

Stage I.—Sanatorium methods alone cured	31.8 per cent.
Sanatorium methods and tuberculin cured	75.0 "
Stage II.—Sanatorium methods alone cured	1.9 "
Sanatorium methods and tuberculin cured	20.0 "
Stage III.—No cures possible except as curiosities.	

According to Moeller's later experiences, sanatorium methods alone may cure 25.30 per cent. of the cases of pulmonary tuberculosis in the first stage (German Board of Health classification), while tuberculin in his hands has secured the same result in 84.6 per cent. of the cases. I venture to say that when Professor Moeller uses larger doses or repeats the course of treatment, he will find that tuberculin will cure 90 to 100 per cent. of these early cases. In fact, Professor Moeller will agree, as I do, with our great teacher, Professor Koch, that "*tuberculosis of the lungs in the first stage can be cured with certainty by tuberculin.*" In the second stage, which Moeller maintains is never cured by sanatorium treatment alone, tuberculin gives permanent results in 40 per cent. to 60 per cent. of the cases. Even in the third stage tuberculin sometimes yields remarkable results that cannot be approached by sanatorium methods. When these splendid results are claimed for tuberculin by those who have had an extensive and prolonged experience with it, are we going to be so foolish as to pay any heed to the carping, surreptitious criticism of those sterile authorities who have the hardihood to express adverse opinions on a matter concerning which they have no personal knowledge?

In medicine, as in surgery, pioneers have often had to bear much unfair criticism. Experience is our great teacher. I do not know any great authority who has used tuberculin with the conditions and limitations laid down by Koch and found tuberculin wanting. On the other hand, I have seen no carefully compiled records that prove tuberculin to be either harmful or useless. We do not condemn operations because novices and those who have not learned their art make mistakes and fail. There have been terrible tragedies arising from various operations in their early history, but the operations have survived. The failures and tragedies associated with tuberculin are not the fault of tuberculin, but the fault of those "fools who rush in where angels fear to tread."

Failures may be the stepping-stones to high success; and the failures of to-day are converted by increasing knowledge and experience into the successes of to-morrow.

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INTERNATIONAL BALNEOLOGICAL EXPOSITION.—An international balneological exposition will be held at Spa this year from July 20th to August 30th. Among the objects exhibited will not only be such as show the present condition of balneology in the strict sense, but any others that may seem to be of importance for the development of modern watering-places. Among these are especially objects relating to hygiene, architecture, the betterment of dwellings, the improvement of baths, and the provision of amusements. Communications relative to the exhibition should be sent not later than June 3rd to the General Secretary, 43, Avenue de Marteau, Spa, Belgium.

UNDER the will of the late Miss Margaret Harrison, of Bayswater, the London Hospital receives a bequest of £200.

MEMORANDA: MEDICAL, SURGICAL, OBSTETRICAL.

A CASE OF URTICARIA PIGMENTOSA TREATED BY X RAYS.

In July, 1906, a male child, aged 13 months, was brought to me on account of a rash which proved to be a very typical example of urticaria pigmentosa. The child had fair hair and blue eyes. The rash first appeared on the abdomen, eight days after vaccination, at the age of 4 months. The distribution of the rash over the front of the body is well seen in the photograph; on the back

its distribution and extent was similar; it involved the neck. The face, hands, and feet were free. Upon the trunk the lesions ran in oblique lines in its girdle axis. The individual lesions were macules, and although a number could be felt with the eyes shut, I believe that this was due to temporary turgescence. In colour they were a deepish brown with a tint of yellow, in shape oval. Turgescence of the old lesions on irritation and factitious urticaria were very marked. Itching was slight. The child was in all other respects healthy, and gave a normal blood count.

For treatment the child had three exposures to the x rays at intervals of a week, the total dose being insufficient to produce any visible reaction. For six months from this date both factitious urticaria and turgescence of the old lesions on irritation ceased, and no new lesions appeared. At the end of this period the old symptoms returned, but were again removed by three doses of x rays, and remain absent after three months. The mother holds that the old macules are lighter in colour, but I am not convinced of this.

F. H. JACOB, M.D., M.R.C.P.,
Physician to the Nottingham General Hospital.

URTICARIA AND INFLUENZA.

A GIRL of about 8 years, with normal temperature, had an inflamed throat and consolidation of the base of the right lung. These gave no appreciable symptoms. I was asked to see large urticarial patches—boggy in nature—of irregular outline. One in front of the neck was 5 in. long and 2 in. wide (vertically) and was surrounded by skin somewhat red and swollen. Another circular patch about 1½ in. in diameter was at the back of the neck, while a large patch 5 in. by 2 in. was placed over the left shoulder, extending down the limb; another