Dr F F Hellier: I think it is an important point that there may be disturbance of function before there are any anatomical changes which can be shown on simple X-ray. We had a patient in Leeds with minimal scleroderma in whom the X-ray of the chest was normal. She was seen by the chest physiologist in the thoracic unit and her respiratory exchange rate was markedly reduced. Thus there was gross functional abnormality before any evidence on X-ray. The same may apply to abdominal cases. Straight X-ray without special techniques will not show a functional bowel disturbance. This may be of wider application in scleroderma and functional tests may be needed before anatomical ones.

Dr G B Dowling: It is perhaps worth while having an œsophageal swallow examination done.

Dr P F Borrie: That has been done in the supine position and was negative.

Dr G B Dowling: That suggests the other abdominal symptoms were not genuine. The œsophagus is the most commonly disturbed before the mobility of the gut, &c. I think œsophageal peristalsis is disordered first, and abdominal changes follow later according to the literature. By the time you get diarrhœa it is pretty late.

Dr B C Tate: I am not happy about the diagnosis of scleroderma. I could find no signs of sclerosis of the face, mouth or fingers and I should have thought that these would have been apparent in true scleroderma, as the functional disturbance had been going on for twenty years.

Dr G B Dowling: Scleroderma of the fingers is not invariably present with Raynaud's symptoms and other manifestations of the 'systemic sclerosis' syndrome. One such patient had Raynaud's symptoms with absorption of terminal phalanges, calcinosis, a severe swallowing defect and the characteristic facies. The fingers were rather thick but perfectly mobile.

Dr S C Gold: If, as Dr Dowling says, sclerosis of the fingers or face are not necessary and it seems also that telangiectasia need not be present, then what are the minimal requirements for making such a diagnosis?

Dr H R Vickers: I agree with the diagnosis of systemic sclerosis. She has telangiectases on the face. I removed her face powder and counted five. In these difficult cases with few definite symptoms I feel that it is always worth while considering doing a renal biopsy, since if the kidney is involved, the diagnosis will then be established with certainty. I have had renal biopsies done in several of my patients and it is a procedure with very little risk which in this type of case is justifiable.

Pemphigoid with Malignant Melanoma

J M Marks MRCP (for S C Gold MD)

F T, female, aged 61. Housewife.

History: First seen in October 1956 on account of blisters in mouth which had been present for four months. Recent onset of sparse blisters on shoulder, face and scalp. Biopsy of blister showed histology consistent with a diagnosis of pemphigoid. Tzanck test for acantholytic cells negative.

November 1956: mentioned a mole on her back which had been present for years. This was originally flat, but for some time had been raised and for a year had been bleeding intermittently. It was excised and found to be a malignant melanoma.

Skin lesions settled without treatment, but buccal blisters continued.

December 1956: started on prednisone 10 mg/day. Maintained on a small dose of steroid with very little skin involvement, but with mouth lesions that fluctuated. In January 1960 blisters became much more troublesome and in May 1960 patient was admitted to hospital. On examination then there were blisters in the mouth and blisters and gyrate erythema of the trunk and limbs (Fig 1). In the right axilla was an enlarged lymph node,

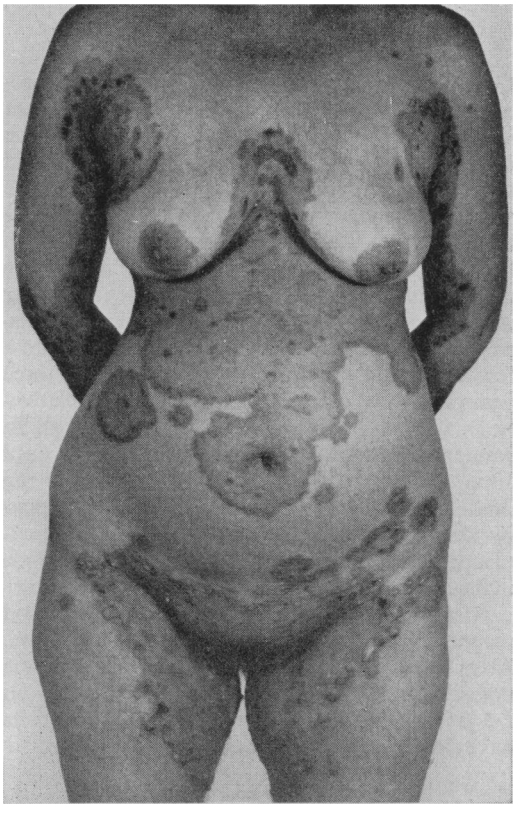

Fig 1 *Pemphigoid with malignant melanoma, May 31, 1960*

said to have been present for two months. Treatment with prednisone, adrenocorticotrophic hormone (ACTH) and sulphapyridine produced improvement of the skin and mucosæ. The patient was about to be discharged when she developed a

temperature of 101°F and further enlargement and tenderness of the lymph node in the axilla. There was no skin sepsis and no abnormality in other systems. Chest X-ray was then normal.

Temperature returned to normal and lymph node became smaller and less tender after a course of penicillin. Lymph node excised October 1960. Histology showed deposits from melanoma. Maintained with clear skin on 5–10 mg prednisone/day.

November 1960 admitted for excision of skin nodule. Hæmoptysis while in hospital.

Clinical findings: Scars of lymph node and skin nodules. No blisters on skin or in mouth.

Investigations: Chest X-ray taken 1.11.60 after hæmoptysis showed widespread metastases throughout both lung fields.

Comment: This patient with pemphigoid presented with blisters in her mouth. Minor skin involvement appeared within four months of the onset of the disease but serious skin lesions did not occur until much later, the major episode starting in January 1960. Because of the predominance of mouth blisters and sparse, fixed skin lesions a diagnosis of benign mucous membrane pemphigus was considered, but the eyes and other mucous membranes never showed signs of disease. A malignant melanoma was excised within a few months of the onset of the illness. For three years after the blisters were controlled by relatively small doses of prednisone (5–20 mg/day). In January 1960 the dose had to be increased until June 1960 when the patient was taking 60 mg prednisone/day as well as ACTH and sulphapyridine. While on her maximum dose of prednisone, she developed a large, tender lymph node in the right axilla.

Histological examination showed necrosis and secondary deposits from the malignant melanoma. After excision of the lymph node it became possible to keep the blisters under control on 2·5–5 mg prednisone/day. Secondary deposits have since developed in the lungs and skin.

Dr S C Gold: It took me some time before I realized that the pemphigoid could be related to the development of malignant melanoma but in retrospect the timing does coincide well. What the febrile upset which occurred with increased swelling and tenderness of the axillary gland could have been due to is most uncertain. The section from this gland shows extensive necrosis in the secondary deposit and one wonders if the high dosage of steroids being given at that time could be connected with this inflammatory process.

Dr F F Hellier: In a recent article, Cooke (1960) has suggested that one can distinguish pemphigus from pemphigoid because the latter affects chiefly the palate and gums, whilst pemphigus occurs more marked on the red borders of the lips and the mucus membrane of the cheeks. Do members agree with this?

REFERENCE
Cooke B E D (1960) *Brit. Dent. J.* **109**, 131

Dr S C Gold: I have seen two other patients with pemphigoid occurring with carcinoma of the bronchus. Both had severe buccal involvement and I wonder if such an association is common in those related to cancer.

Dr H T H Wilson: I had a similar case, a lady with an inoperable carcinoma of the breast and pemphigoid. She had several lesions in the mouth which bled freely. It is certainly well worth considering the possibility that lesions in the mouth are more common in cases associated with carcinoma.

The following cases were also shown:

Urticaria Pigmentosa
Dr R M B McKenna

(1) **Keratosis Pilaris with Cicatricial Alopecia and Bilateral Congenital Cataract**
(2) **Acne Conglobata**
Dr P F Borrie

A Case for Diagnosis? Sub-corneal Pustular Dermatosis? Psoriasis
Dr M Smith

(1) **Reticulosis**
(2) **Dermatitis Herpetiformis**
Dr A Scott

Scleredema Adultorum (Buschke)
Dr Harold Wilson

Lichen Planus Atrophicus; Pseudo-pelade
Dr C M Ridley (for Dr Brian Russell)