Dr. JAMES GALLOWAY remarked that the term "frambœsiform syphilide" seemed to be more aptly applied to the multiple, definitely papillomatous lesions which made their appearance in the early periods of the disease. These lesions produced very little ulceration. They seemed to be of rare occurrence, but he remembered bringing forward a case some years ago of this type of syphilide. The patient was a young woman who was admitted to the hospital with a doubtful diagnosis of lymphadenoma, on account of the great enlargement of the lymphatic glands in the neck. On examination she was found to present the remains of a primary infection of the lower lip; the great glandular enlargement was the consequence of this and was accompanied by a considerable degree of fever and constitutional disturbance. While in this condition she developed a papillomatous frambœsiform syphilide. It occurred, therefore, in an early stage of the malady. The treatment adopted was by means of mercurial inunctions. The eruption rapidly disappeared, leaving practically no ulceration; the glands diminished in size, and the patient, though remaining under observation for some time, had no further manifestations. Ulcerating granulomatous lesions of the palms of the hands, as in the case presented by Mr. McDonagh, were almost always difficult to heal. The position of the lesions and the peculiar characteristics of the epithelium of the palms were probably the chief factors in preventing rapid healing, and it might be well worthy of consideration whether local methods of treatment would be of greater value than too long persistence in general antisyphilitic medication.

Dr. GRAHAM LITTLE had noted a remarkable improvement in a very chronic tertiary syphilitic lesion, resembling somewhat this case, after two applications of freezing with carbon dioxide snow.

Mr. MCDONAGH, in reply, said that he did not mean to suggest that all palmar syphilides did not disappear under treatment; on the contrary, most did so, and quickly, and only to those types which remained uninfluenced did he intend to refer. The reasons why he gave the name of frambœsiform syphilide to the lesions of the case presented were: (1) Because they were indistinguishable from the true lesions of yaws affecting the palms; (2) because they resembled almost exactly the more common type of syphilitic lesion affecting the scalp, which went by the name of "frambœsiform"; (3) because, like all frambœsiform syphilides, they appeared very early in the disease.

Case of Dermatitis following Large Dose of Arsenic.

By J. M. H. MACLEOD, M.D.

THE patient was a little girl, aged 7. She was a patient of Mr. Devereux Marshall, at the Moorfields Eye Hospital, for sympathetic ophthalmia, and the exhibitor was indebted to him for kind permission to show the case. She was seen first by the exhibitor at Charing

Cross Hospital in December, 1912, when she presented a profuse eruption, most marked on the trunk and face. Previous to that for two months she had been under treatment at Moorfields Hospital with intravenous injections of salvarsan, and had had 0·4 grm. on October 5, 0·6 grm. on October 22, and 0·6 grm. on November 6. A week after the last injection the eruption appeared. It came out first on the chest, and gradually involved the arms, face, scalp, upper parts of the thigh, and dorsum of the feet, being most profuse on the face and over the abdomen. It consisted of brownish-red macules, circular or irregular in outline, about the size of a pin's head, and tending to coalesce to form small irregular patches. Some of the smaller lesions were follicular in origin. The macules were covered with small, greyish, adherent scales or horny crusts, which did not extend to the periphery of the macule. It was associated with slight itching. Some days after the eruption appeared the skin of the palms and soles became diffusely red, then definitely thickened from hyperkeratosis. This was associated with changes in the nails, consisting of inflammation about the posterior nail wall, hyperkeratosis of the nail-beds, and a raising up of the free border of the nail.

The symptoms gradually subsided under a soothing calamine cream. At the end of January another injection of salvarsan was given *per rectum*, and a fortnight later an eruption similar to the first attack appeared. When exhibited, the second outbreak had almost completely subsided, except a few indefinite scaly macules and pitting of the nails.

It was difficult to make a firm diagnosis from the condition presented at the time of exhibition. It was suggested that the eruption might be psoriasis, which was improbable, as the original outbreak only superficially resembled that disease and differed from it in the brownish tinge of the lesions, the adherent, horny scales, and the diffuse keratosis of the palms and soles.

DISCUSSION.

Dr. GRAHAM LITTLE recalled an example of an acute very extensive vesicular eruption, coming out almost like an exanthem, but without rise of temperature, in a lad, aged 15, who had been given arsenic for about a week previously to the appearance of the eruption.

Dr. H. G. ADAMSON thought the eruption now present was psoriasis of the punctate type not uncommon in children. He called attention to pitting of the nails, which, he thought, supported the diagnosis of psoriasis.

Dr. F. PARKES WEBER said that, of general exanthems resulting from the internal administration of arsenic the vesicular forms were probably severer, or else more acute, than the dry ones.

Dr. ARTHUR WHITFIELD said that he did not agree with Dr. Adamson with regard to the diagnosis of psoriasis. He considered that the whole eruption might be due to salvarsan, and he did not regard the nails as characteristic of psoriasis. The nail plate was pitted like the peel of an orange, and this was a frequent concomitant of eczematous dermatitis.

The PRESIDENT said that he thought this was a case of psoriasis. Psoriasis in a very young child was always very difficult to diagnose. He had seen a very large number of cases of arsenical poisoning, but had never seen one like this.

Three Cases of Tinea Tonsurans cured by X-rays.

By J. M. H. MACLEOD, M.D.

THESE cases were brought forward to illustrate a difficulty in connexion with the technique. In two of them the defluvium of the hair had taken place, the exposure having been given a month previously; in the third case, which was only X-rayed ten days ago, the hair had not yet fallen out. The technique employed was the usual Kienböck-Adamson method, the Sabouraud pastille being used to estimate the dosage, and the exposures being given at Charing Cross Hospital by Dr. Maurice Hannay, assistant in the Skin Department. In two of the cases a marked erythema appeared about a week after the exposure, while in the third there was scarcely any perceptible erythema. In the two cases in which the erythema was marked the same tube had been used, in the other case another tube. It has been found that the tube which caused the erythema was capable of doing so with an exposure under a pastille dose, and was, in consequence, a "dangerous tube." Some months ago a tube in use in the department behaved in a similar way and led to imperfect re-growth of the hair.

What it was in the tube that made it dangerous the exhibitor had been unable, so far, to ascertain. It did not seem to be any defect in the position of the anticathode, or difference in the thickness of the glass, and the tube appeared to be identical with one made about the same time, which was safe. It was not a question of peculiar susceptibility on the part of the patient, as whenever a "dangerous tube" is used and a pastille dose given marked erythema and impaired re-growth result.