

Sycosis Barbae

Five patients with sycosis barbae were treated by this method. They had suffered from the disease for periods of five years, two years, two years, a few weeks, and ten days respectively. All yielded cultures of penicillin-sensitive staphylococci and streptococci, and all improved very greatly after two weeks' treatment. Over a number of months the improvement was found to fluctuate and reach a stage in which a few pustular follicles persisted in appearing. In spite of this the patients found the treatment more satisfactory than any they had had before: by the daily use of the cream after shaving they were able to keep the sycosis very well in check.

Superimposed Infection

This term is used to cover all cases of pyogenic infection following other disease or trauma. Ten such cases have been investigated. They occurred after (1) tinea pedis; (2) chronic eczema (2 cases) (E.A.H.-F. syndrome); (3) varicose eczema (2 cases); (4) self-inflicted excoriations (2 cases); (5) a diathermy burn; (6) traumatic ulcers on the fingers; and (7) unknown superficial trauma.

(1) This case frequently relapsed, developed a lymphadenitis followed by bacteraemia, which responded to intramuscular penicillin, and eventually recovered from the dermatitis after seven weeks, the tinea remaining as before.

(2) Both patients were clear of the infection in two weeks, and neither complained of any increased irritation from the use of the preparation.

(3) Both cases were healed in three weeks.

(4) One of these excoriations had been present for six years, except for a brief period; the other was a more generalized and recent crop of spots. With adequate watching and restraint they were healed in four and in two weeks.

(5) This was a burn which had been treated with sulphathiazole ointment and subsequently flavine. The sensitization rash was followed by a large patch of skin infection around the burn. After two weeks the skin was clear and the burn had healed; the rash subsided without further incident.

(6, 7) These patients were clear of infection in a week.

From all these cases penicillin-sensitive *Staph. aureus* was isolated; apart from this fact they are not comparable, but serve to illustrate the effectiveness of a low-concentration penicillin cream in the treatment of fairly superficial infection.

Otitis Externa and Retro-aural Intertrigo

From all four of these very chronic cases we had excellent results. The shortest history was 10 years, the longest 25; but, notwithstanding the consequent fibrosis and the presence of *B. coli* in one ear as a secondary invader, infection disappeared in each case within six weeks, and the cracks were then healed, slowly, with the help of silver nitrate. No untoward reactions were observed in this, admittedly small, series of cases. The application of the cream was usually followed by a stinging sensation, but it soon passed off and no visible effects were left.

Conclusions

It is wise to treat all cases without waiting for bacteriological findings (perhaps the phenoxetol, and certainly the washing, help).

When impetigo is caused by a penicillin-sensitive organism, and has not been present for more than five weeks, it will heal in from three days to two weeks—usually nearer a week.

To avoid recurrences treatment should be continued in all cases, regardless of the length of the history, until no mark remains on the skin.

In chronic cases, in sycosis barbae, and in those few caused by resistant strains, this cream may fail to clear up the disease.

No evidence of a sensitive strain becoming resistant during treatment was found.

Finally, in view of what I believe to be a general lack of faith on the part of civilian doctors in penicillin cream of low concentration, I would emphasize the effectiveness of this very low concentration cream.

I wish to thank Dr. J. E. M. Wigley, head of the Skin Department, Charing Cross Hospital, for the original and many other valuable suggestions, as well as for permission to carry out this work; and to express my appreciation of the service of the pathological laboratory and also of the nursing staff in the Skin Department.

Medical Memoranda

Intestinal Hernia between Folds of Broad Ligament

The following case may be of sufficient rarity to be put on record.

CASE HISTORY

Miss A., an A.T.S. private, was admitted to Old Windsor Emergency Hospital from a camp reception station on July 11, 1943, with the following history. Twenty-four hours previously she had developed acute abdominal pain of a colicky type, and had had three bouts of vomiting. She also complained of frequency of micturition and headache. The temperature was 100.8°, pulse 98, respirations 20. The tongue was furred. The abdomen was tender and rigid, especially to the right of the umbilicus. The urine was free from acid and albumin. A soap enema had been given, but had yielded a very scanty result.

On admission to hospital the temperature was 100°, pulse 98, respirations 25. There were low abdominal tenderness and rigidity, and a right-sided paramedian scar resulting from removal of the appendix, with drainage, eighteen months previously. On vaginal examination she was tender over the right and posterior fornices, especially on palpation of an elastic mass which appeared to lie in the pouch of Douglas. This mass was also felt on rectal examination. Menstruation was normally at monthly intervals, but the last period had occurred only a week after the previous one had finished. Risk of pregnancy was admitted. During the 48 hours after admission the bowels were opened twice—once spontaneously—both motions being small in amount.

In view of the history and findings, a tentative diagnosis of ectopic pregnancy was made, and laparotomy was performed through the original incision. A little free fluid was present in the peritoneal cavity, and the inferior part of the right broad ligament was distended by what proved on investigation to be rather more than a foot of ileum which had passed through a ragged hole in the posterior fold. The hernia was reduced without much difficulty, and the bowel, though very congested, was viable. The rent in the broad ligament was repaired with catgut, and the abdomen closed without drainage. Recovery was uneventful.

It appears that the perforation in the broad ligament may have resulted from the use of a drain after the appendix operation, but the exact time when the hernia occurred is problematical.

My thanks are due to Col. Owen-Prichard, superintendent of Old Windsor Emergency Hospital, for permission to publish this case.

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A Case of Penicillin Dermatitis

It is not yet known whether the minor toxic reactions (urticaria, unpleasant taste, headaches, etc.) occasionally occurring after the clinical administration of penicillin are due to the penicillin or to its impurities. Dermatitis following the application of penicillin creams has been thought to be due to the vehicle (lanette wax, etc.). A case of extensive and severe dermatitis after penicillin administration was recently reported in a British officer (Michie and Bailie, 1945). The case described below demonstrates that penicillin itself and not its impurities can be indicted as a cause.

CASE HISTORY

A Royal Air Force medical officer, aged 31, was experimentally treated with penicillin pastilles (300 units per lozenge) and a throat spray (250 units per c.cm.) for a febrile nasopharyngitis and tracheitis. Both spray and lozenges were administered hourly, during the waking hours, for two days, after which all signs and symptoms had subsided.

One week later, T.A.B.C. vaccine, which contains 25% of alcohol, was accidentally splashed into both eyes, the acute resulting symptoms being rapidly relieved by copious normal saline irrigation. Fourteen days later there were still signs and symptoms of a mild conjunctivitis, and treatment consisting of zinc sulphate 0.25% drops was instituted after seeking the advice of an ophthalmologist. No improvement occurring after four days, the treatment was changed to penicillin eye-drops (250 units per c.cm.) hourly. Considerable improvement took place within 24 hours, when the patient began to complain of intense itching of the skin over the inferior orbital margins. The next day, penicillin drops having now been instilled for 48 hours, the conjunctivitis had largely subsided, but the intense irritation continued and a vesico-papular rash was noticed. The rash was present over the inferior orbital margins, in a "butterfly" distribution, where the surplus eye-drops had been wiped away by the patient. All treatment was immediately discontinued. The penicillin solution was found to be still active (more than 200 units per c.cm.), and was left at room temperature for subsequent experiment.

The rash subsided without treatment in eight days. It progressed to vesiculation, the vesicles being pin-point in size on a papulovesiculosis base. A fine desquamation occurred, the skin finally returning to normal in 14 days. There was no previous history of dermatitis, other rashes, or exposure to the sun. A dermatologist

agreed that the rash may have been a contact dermatitis due to the penicillin solution.

To determine the aetiology of the rash the patient was patch-tested with the original penicillin solution (now found to be completely inactive), a freshly prepared solution of penicillin, and the 0.25% zinc sulphate solution, on the flexor surface of the forearm. This test proved negative. After the rash had completely subsided the patch tests were repeated on the site of the lesions—i.e., immediately below both eyes. In 24 hours the active penicillin solution produced a patch of itching vesico-papular lesions on an erythematous base exactly similar to the original rash; the inactive solution and the zinc sulphate patches were negative.

COMMENT

The inactive penicillin solution can have contained only manufacturing impurities and the breakdown products of penicillin. The fresh solution which produced the positive patch differed only in that penicillin was present. It can legitimately be concluded, therefore, that the aetiological agent in the production of the dermatitis was penicillin and not its impurities. It is probable that sensitivity had been induced in the patient by the course of penicillin 25 days previously. A curious feature is that the conjunctivitis was not aggravated by the dermatitis-producing agent. Winthrop's penicillin, supplied in 100,000-unit ampoules, was used throughout.

The haphazard use of penicillin-containing face powders and toilet applications envisaged in the popular press would appear to be not devoid of risk.

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REFERENCE

Michie, W., and Bailie, H. W. C. (1945). *British Medical Journal*, 1, 554.

Dermatitis due to Sulphaguanidine

The patient is a private in the R.A.M.C., a member of the hospital staff, aged 41. Before dealing with his present condition it is relevant to consider past events.

He was admitted to hospital on April 11, 1945, suffering from dermatitis of uncertain origin but probably solar, affecting the lower part of the left leg, which ulcerated, this being to some extent due to varicose veins, from which he suffers. Sulphanilamide powder was applied to the ulcer for three successive days, but in view of the lack of response this was stopped and the ulcer eventually healed with simple lotions. There was no generalized eruption at that time. On May 23 the ulcer broke down again, and he was admitted to hospital. He was treated by local saline dressings and parenteral sulphathiazole, of which he received in all 12 g. in three days. On the second day he complained of itching, and on the third day a typical papular eruption was observed on the legs and trunk. The ulcer subsequently healed, and has remained healed.

On July 31, 1945, he was again admitted to hospital, this time suffering from bacillary dysentery. In view of the past history I was chary of giving sulphaguanidine, but as a test I gave him 0.5 g. of the drug in the afternoon of July 31. There was no sign of eruption on the next day and I therefore started him on the normal course of sulphaguanidine—7 g. immediately and 3.5 g. four-hourly. He received 17.5 g. on Aug. 1, and 21 g. on the following day. Towards the end of the second day he noticed a slight erythema of the left leg, and the next morning he presented an almost identical picture to that of the previous sulphathiazole dermatitis. There was a papular eruption covering the anterior and posterior aspects of the trunk, especially the chest, and a similar eruption on the legs, more severe on the left. A serous discharge later exuded from the rash on this leg. The eruption on the back showed a straight line of demarcation from normal skin corresponding to the boundary line of the sunburned area, the untanned area below the belt being free from rash. Similarly the thighs showed few papules, while the legs were severely affected on flexor and extensor surfaces. The face and hands were unaffected, and the arms showed only a small eruption in the flexures of the elbows. The axillae were free. Apart from the serous discharge from the lesion on the left leg, the remainder of the eruption followed a normal course to recovery, using simple lotions. No other drugs were being taken by the patient at the time, nor was there any history of dermatitis following administration of any other drug.

The connexion between the origin and distribution of the dermatitis and the action of sunlight is interesting. Patch tests with sulphanilamide and sulphaguanidine on non-sunburned areas were negative.

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Five organizations concerned with chiropody and all recognized by the Board of Registration of Medical Auxiliaries—British Association of Chiropodists, Chelsea Chiropodists' Association, Chiropody Practitioners (N.I.Ch.) Ltd., Incorporated Society of Chiropodists, and Northern Chiropodists' Association—have amalgamated to form the Society of Chiropodists Limited. The new organization will also take over the functions of the Chiropody Group Council in relation to the Board of Registration of Medical Auxiliaries, on which body it is directly represented.

Reviews

ALLERGY

Essentials of Allergy. By Leo H. Criepp, M.D. With foreword by Robert A. Cooke, M.D. (Pp. 381 + 43 illustrations. \$5.00 or 30s.) Philadelphia and London: J. B. Lippincott Company.

This book is one of a series designed to provide concise and effective working manuals for the busy practising physician. It is prefaced by the chairman of the Committee on Education of the American Academy of Allergy, and the author is, among other things, consultant in allergy to the medical service of the U.S. Veterans Administration. The hopes raised by these auspices are not disappointed, for Dr. Criepp has written a compact, well-balanced, and useful account of allergy as it concerns the clinician. In driving a way through the thicket of data and terms which has grown up around anaphylaxis and allergy Criepp has used a bulldozer technique, and it is certain that other pathologists and allergists will not agree with all his definitions and interpretations. Nevertheless, the student will find an extremely clear presentation of the meaning of such words and ideas as atopy, idiosyncrasy, intolerance, and anergy. If he is an intelligent student he will also realize that there are many gaps in our understanding of the allergic diseases. As R. A. Cooke writes in the preface, relatively little is known of the fundamentals of the allergic reactions or the nature of the protective response to present-day methods of immunological treatment, which rests largely on empiricism. It is, perhaps, the only defect of Criepp's book that it gives no explanation of the mechanism of the pollen treatment of hay-fever or the desensitization to liver extract of a patient under treatment for pernicious anaemia. After discussing the fundamental aspects and morbid physiology of allergy Dr. Criepp gives a general account of diagnosis and treatment, and then proceeds to describe the individual manifestations of allergy—hay-fever, bronchial asthma, nasal allergy, skin allergy, serum allergy, bacterial allergy, fungus allergy, physical allergy, and a miscellaneous group. Each chapter has a helpful summary, and there are short case-histories followed by lists of teaching points. The book is indeed a most successful teaching manual. Looking at it from a broader scientific aspect, however, the general physician or pathologist may wonder whether the specialist in allergy is perhaps not too preoccupied with the handling of the familial allergies or atopy, as he calls them. These are characterized by two features. The first is an abnormal tendency to produce *reagins*—that is, to become sensitive—to common substances in the environment. The second is the possession of a shock organ, usually the respiratory tract or the skin. The detection of the substances which may provoke asthma or rhinorrhoea in susceptible people has perhaps precluded us from thinking hard enough about the acquired or intrinsic asthmas and about the reason for the localization of symptoms. The identification and listing of allergens must obviously continue, and we are only just realizing the allergic potentialities of sulphonamides, thiouracil, penicillin, and a host of other non-protein compounds used in medicine and industry. However, just because the number and variety of allergens are almost unlimited it will be profitable now to think a little harder about what makes a shock organ such, and why the reaction is sometimes so exquisitely particularized, as in the response of the platelets in the drug purpuras. There are, indeed, few fields of clinical science in which a greater harvest of useful knowledge waits to be gathered than in the allergic diseases.

BLUE-PRINT FOR THE NATION

Post-War Britain. Edited by Sir James Marchant, K.B.E., LL.D. (Pp. 255. 12s. 6d. net.) London: Eyre and Spottiswoode.

Sir James Marchant has assembled eleven leading authorities, each of whom discusses the phase of post-war reconstruction in which he is an expert. Lord Horder writes about the future health of the nation. It is difficult to avoid platitudes in writing about health, but Lord Horder's style is always refreshing and he salts his essay with epigrams. Thus he suggests that one way of attaining health is to be "really convinced that it is better being well than ill"—a precept which needs to be placed in front of a good many people. He also touches on the contribution to health which is to be made by the State. Evidently