Discussion.—Dr. J. T. INGRAM suggested that the condition was simple telangiectasia. He did not know why Dr. Thomson should describe it as a new formation of capillaries; why not a dilatation of pre-existing capillaries? He thought that angioma serpiginosum had punctate lesions, red and brown spots, not seen in this case.

Dr. F. PARKES WEBER said he thought that the condition in the skin of the legs in this patient was an idiopathic result of frequent and long-continued dilatation of the small blood-vessels of the part, the dilatation becoming, after a time, permanent, i.e. there was a permanent ectasis of the superficial small blood-vessels and capillaries. That dilatation might be due to different causes, such as cold, which he thought might be the exciting cause in the present case, acting in a congenitally predisposed individual. A permanently telangiectatic skin was not rarely seen over the nose and face of elderly people who had had frequently recurring flushing of that part, excited by drinking too much tea, &c. The final reactive result in all such cases was different from that of ordinary people. The capillaries yielded to the recurrent reaction and ultimately refused to return to the normal size.

Dr. THOMSON (in reply) said that if this was an ordinary simple dilatation of the capillaries usually present in the skin, he did not see why there should be the very marked tree-like branching. In the second place there were punctæ on the upper thigh, where one could see pin-point vessels, and the eruption had spread the whole way by that means. Angioma serpiginosum has been very much confused with Majocchi's disease and, in spite of the question of purpura occurring and the suggestion of ring formation and clearing in the centre, identical cases have been described under both titles. He regarded this case as one of definite angioma, from the shape of the vessels and the way in which they were leashing. Because it did not quite fit in with the classical description it did not mean it was not angioma serpiginosum.

Leuconychia.—M. SYDNEY THOMSON, M.D.

This man, aged 23, shows complete leuconychia of most of the nails. On the hands all the nails are affected, whilst on the feet the right fifth and left third, fourth, and fifth nails do not show this change. At present the right thumb-nail is not completely white. Until nine months ago it was so, but a ridge then present formed the point from which the superficial layer of the nail-plate was torn off. Some plate was left and this thin sheet looked normal in colour. About one month ago a white patch appeared in the centre of this regrown nail, since when it has spread centrifugally with great rapidity. This occurred without any apparent exciting cause. The patient also suffers from hyperidrosis, but the skin, hair, eyes, teeth, mentality, &c., all appear to be normal. The nails are all known to have been white since the age of one month, and it is therefore probable that the patient was born with them in this condition. His mother was severely ill after parturition and so cannot confirm this assumption.

Family history.—The parents are first cousins, i.e. his grandmothers were sisters. His mother has disliked cats intensely since childhood. During this, her only pregnancy, a neighbour's large white cat with green eyes was frequently seen and frightened her, particularly on one occasion during the third month. It is also interesting to note that this man has severe varix of the veins of both legs. These have been present "as long as he can remember," and attempted treatment by injections has failed. Both his father and his mother suffer from severe varix.

J. G. and W. D. Stubenbord reviewed this condition in the *Archives of Dermatology and Syphilology*[1] last year. There is usually some association with rheumatism, malnutrition, trauma, trophic disorders, vitiligo, alopecia, &c. The disease may begin in childhood, but I believe this case may prove to be unique in that the condition is known to have been present so early in life. In the recorded cases the colour is reported as bluish-white, chalky, ivory, &c., Stubenbord's suggestion

[1] 1935, **32**, 761.

that this variation may be due to differences in the thickness of the nail-plate and of the affected patches themselves is supported by the bluish-white colour of the new patch on this man's thumb, which contrasts markedly with the chalky colour of the thicker nails.

Discussion.—Dr. J. T. INGRAM asked what was the mechanism of leuconychia.

Dr. THOMSON (in reply) said that this case was certainly one of the earliest in onset to be recorded. The hypothesis of "air" in the nail seemed to have been disproved. Becher had proved that such air spaces could not be found microscopically. On the other hand, large nucleated cells were present. It would seem that there was a hyperactivity of the germinal layer with parakeratosis and that refraction from these large cells caused the whiteness. In this case the thicker nails were more opaque and chalk-like in colour than their fellows.

Parakeratosis Variegata.—H. W. BARBER, M.B., and F. F. HELLIER, M.D.

The patient, a middle-aged man, noticed the eruption about nine weeks ago. The onset was apparently sudden, and the extension rapid. He gives a history of having had a rash some years ago, the nature of which is unknown. The present eruption is characteristic of the variety of parapsoriasis which was labelled by Unna, Santi, and Pollitzer, "parakeratosis variegata." The livedo-like reticular markings are well seen, particularly on the upper arms. The elementary lesions are lichen-like papules, which, for the most part, are closely set or confluent; many have a central depression and appear to be perifollicular. On the parts where the reticulation is marked, the papules, though more evident on the darker reticular areas, are also present in the paler central portions. Here and there, for example on the thighs, are redder papules covered by scales that recall the mica-like appearance of those that characterize parapsoriasis en gouttes.

We are showing the case partly on account of the rarity of this variety of parapsoriasis, and partly in the hope that it may evoke a profitable discussion on the interrelationship of the eruptions which are now included in the group of parapsoriasis (resistant maculopapular scaly erythrodermias of Fox and Macleod).

The following classification is, I think, generally accepted and will serve as a basis for discussion :—

(1) *Guttate parapsoriasis.* Synonyms: Parapsoriasis en gouttes (Brocq); dermatitis psoriasiformis nodularis (Jadassohn); pityriasis lichenoides chronica (Juliusberg).

The interest of this variety is that, in spite of having been labelled "pityriasis lichenoides *chronica*" by Juliusberg, we now know that it has an acute onset, like pityriasis rosea, and that, although it may persist for several months, it tends to clear up spontaneously; in some cases, as in a few observed personally, its course may, like that of pityriasis rosea, be a matter of weeks. Several acute cases were shown by Dr. MacCormac and others, including myself, some years ago. I think we are now agreed that the "*pityriasis lichenoides et varioliformis acuta*" of Habermann and Mucha is a variety of the same disease. Dr. A. M. H. Gray was the first to show a case of it before the Section, and afterwards it became the fashionable exhibit. Now it seems almost to have died out.

It is clear that both in the varioliform (I prefer varicelliform) and simple forms, the disease must, like pityriasis rosea, be due to a specific infective organism.

(2) *Parapsoriasis en plaques.*—Brocq's original term for this was erythrodermia pityriasique en plaques disséminées, and it is the xanthoerythrodermia perstans of Crocker. On clinical grounds it is difficult to believe that this eruption has any connexion ætiologically with the guttate form. It is essentially chronic, and shows little tendency to clear up spontaneously, although occasionally it may do so.