Section of Dermatology

President—A. C. ROXBURGH, M.D.

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? Eosinophilic Granuloma. ? Sarcoid of Boeck.—J. E. M. WIGLEY, M.B.

Mrs. E. C., aged 46. Two years ago a lesion was excised from her forehead at Kingston Hospital. She says the present lesions appear to her the same, and have developed since. On the forehead and nose are some three to four discrete, greyish-brown, infiltrated lesions, varying in size up to that of a silver threepenny piece. (*See* fig.) They are slightly raised above the surface, smooth to the touch, and on diascopy leave a greyish-brown staining. Otherwise physical examination is negative.

W.R. negative. Mantoux test: 1:10,000 strongly positive. Control negative.

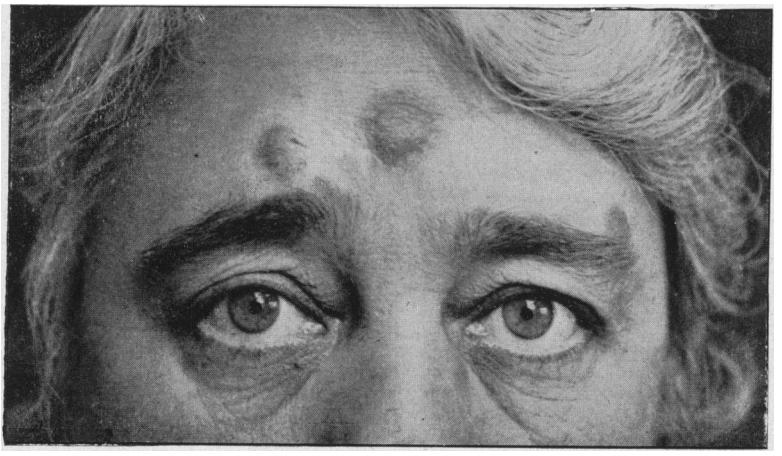
Blood-count: Total W.B.C. 7,200 per c.mm.; polys. 68%; eosinos. 4·5%; basos. 1·5%; lymphos. 21%; monos. 5%.

X-ray examination: Chest, hands and feet negative.

Histology (Dr. I. Muende).—The corium contains numerous coalescing foci of closely packed cells, among which there are numerous endothelial cells, some binucleate, very numerous eosinophils, polymorphs and a few plasma cells.

No acid-fast bacilli seen in Ziehl-Neelsen preparations. *Chronic infective granuloma of the skin.* Not suggestive of sarcoid (Boeck).

The clinical appearances of these lesions seem to me almost typical of sarcoid of Boeck, which the histology can hardly be said to be.



? Eosinophilic granuloma. (*Photograph by Dr. A. C. Roxburgh.*)

Dr. W. Freudenthal: Dr. Wigley's section shows a very unusual picture. Chief features are reticulo-endothelial cells (histiocytes) and large numbers of eosinophilic cells, some of which show phagocytic activity (Burkhart and Montgomery, 1944). The eosinophilic

cells are arranged in foci or are diffusely scattered amongst the reticulo-endothelial cells. The picture reminds me of that found in "Eosinophilic Granuloma (Eosinophilic Reticulo-endotheliosis) of Skin" (Martinotti, Nanta, Pasini, Cerutti). It may be that this case is an instance of this very rare disease (or body reaction?), about the clinical manifestations and pathogenesis of which we still know very little.

In 1940, both Otani and Ehrlich, and Lichtenstein and Jaffe, independently, described a condition with an identical histology in the bone. Farber (1941) suggested that this "Eosinophilic Granuloma of Bone" was a variant of Schüller-Christian's disease, a view accepted by T. B. Mallory (1942) in a critical review on this subject. These authors were unaware of the "Eosinophilic Granuloma of Skin".

It might be worth while to search in Dr. Wigley's case for any symptoms of Schüller-Christian's disease (X-ray of bones, sections stained for fat, &c.).

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Dr. I. Muende: The sections were not stained for fat, for nowhere could one see anything suggestive of a foam-cell, or an endothelial cell with any obvious vacuolation.

The diagnosis of eosinophilic granuloma came to my mind, but the eosinophils were not as numerous in the section, nor was there the high degree of eosinophilia associated with the latter disease. I could not accept the diagnosis of sarcoid, and considered it much more likely that we were dealing with a case of Hodgkin's disease with skin lesions.

Dr. H. C. Semon: It occurs to me to comment on the strongly positive Mantoux test in this case.

The President: The patient had no tuberculous lesion?

Dr. I. Muende: No.

Dr. A. Burrows: If this granuloma is similar in type to the tumours in the Christian-Schüller syndrome it should be radiosensitive and this fact might be helpful in diagnosis.

Dr. J. E. M. Wigley: The X-ray of the chest showed a certain amount of most of the ribs; there was no obvious change in the bones.

The President: I understand skiagrams of the hands and feet were normal?

Dr. W. N. Goldsmith: Were the earlier lesions more lumpy?

Dr. Wigley: They are now, if anything, a little more lumpy than when I first saw them.

Dr. Goldsmith: The flatness is more like xanthoma than Hodgkin's disease, and perhaps the colour also.

Pityriasis Lichenoides Chronica (Parapsoriasis Guttata).—THERESA KINDLER, M.D. (for A. BURROWS, M.D.).

N. L., 8-year-old boy, has had a non-irritating, slowly spreading rash on his trunk, buttocks and the proximal parts of his extremities for five years. The eruption consists of pin-head to pea-sized maculo-papules with very little infiltration; they are pink or reddish at first, some are covered with a thin scale. Later they become greyish-brown; the scale can be detached as a whole and has a lid-like, mat appearance. When removed, it leaves a moist surface or may show some bleeding but not of the papillary type. Finally, the subsiding lesion leaves only a grey easily removable scale. New lesions crop up continuously as some of the old ones subside. In some places coalescence of the lesions forms larger, superficial scaling patches. The eruption has been completely unresponsive to treatment, including ultraviolet irradiation.

Dr. Forman: Could we have an opinion as to the natural course of this disease? How long does the rash take to disappear?

Dr. T. Kindler: Cases have been known to last twenty years.

The President: I remember a boy who had the more necrotic type, the so-called varioliformis type, which cleared up after a year or two. I have seen during most of the war period a soldier who goes on more or less continually with the eruption. It is reduced by ultraviolet light but does not get well.

Dr. G. B. Dowling: I recall a case of what we are nowadays accustomed to calling pityriasis lichenoides acuta upon whom during the course of at least a year, every variety of treatment which has been said to influence the condition was tried in turn. Ultimately the patient and I agreed to give it up. Several months after the cessation of treatment the rash disappeared.