

no reason to suppose that the cause of the epistaxis in the instance before us, and the bleeding from the gums, may not have been a sudden hypertrophy of blood-vessels, such as we just described as appearing on the skin. And it appears to us that to the well-known hæmorrhagic diathesis as a cause of hæmorrhage there must be also added a sudden hypertrophy of the blood-vessels and rupture of their coats, as exemplified in the case before us."

Conclusion.—I find it difficult to classify the case I have recorded. Notwithstanding the history of epistaxis in childhood and the subsequent rectal bleeding I hesitate to include the case in the fourth group. The rectal bleeding is exceptional but occurred in Anderson's case, and the epistaxis has not been recurrent over years. There is no family history of bleeding or epistaxis. And lastly, the site and picture of the telangiectases is peculiar. A prolonged observation probably will alone determine the nature of the case.

CLINICAL NOTE.

CASE OF LUPUS ERYTHEMATOSUS ASSOCIATED WITH NEPHRITIS.

By J. M. H. MACLEOD.

THE following case is of interest, as it adds another to the list of acute cases of Lupus erythematosus associated with nephritis, and having a fatal issue.

The patient, a young woman, aged 17 years, was sent up to Charing Cross Hospital, to be under my care, by Dr. C. F. Clarke, of Plumstead, on August 2nd, 1907, suffering from Lupus erythematosus of the face and hands. She was a delicate-looking girl, tall and thin, but who had enjoyed fairly good health with the exception of an attack of scarlet fever at the age of nine years. No serious sequelæ, such as rheumatism or cardiac disease, appeared to have followed the scarlet fever. About three months before she came to the hospital she had had what she regarded as a severe bilious or gastric attack associated with vomiting, and on account of which she was confined to bed for

a few days.* It was at this time that the skin-affection first appeared on the face. This illness, the exact nature of which was uncertain, had markedly affected her general health since then, and had caused menstruation to cease. When she was first examined at the hospital she seemed to be in fairly good health. A physical examination was made for any sign of tuberculosis but with negative results, and no history of that disease was obtained in the family. Her heart and lungs appeared to be healthy. Her peripheral circulation was fairly good, and she had not suffered to any extent from chilblains, though she had had them occasionally. Her urine was clear, pale in colour, 1008 in specific gravity, and contained neither sugar nor albumen. On the face and hands there was an extensive eruption of *Lupus erythematosus*, the outbreak on the face being the most classical example of the disease—involving the whole of the bat's-wing area—which I have seen. It extended from ear to ear, spreading out symmetrically over both cheeks, and forming a narrow band across the bridge of the nose.

Isolated patches were present on both eyebrows, on the forehead, just above the nose, and a few small lesions occurred on the chin. The tip of the nose and the skin around the mouth were not involved, and the greater part of the forehead and the eyelids were also free from the disease. The affected skin was bright pink in tinge and covered with typical adherent scales, especially at the margins of the larger patches, which were well-demarcated from the surrounding skin. The hands, especially the backs of the index and fifth fingers of the right hand, presented several small red patches with adherent scales in the centre, and in one or two instances, where the patches had involuted, an appreciable degree of atrophy had resulted.

The mucous membrane of the mouth was examined, but no lesions were detected upon it.

The whole appearance of the skin was that of an acutely spreading *Lupus erythematosus*, the duration when I first saw it being only between two and three months.

* Dr. Clarke, who attended her at this time, kindly informed me that the attack was of the nature of an acute gastro-enteritis, with vomiting, pain in the lower part of the abdomen, and that the stools were offensive and contained mucus and blood. There was no pyrexia, and after a few days in bed with morphia and bismuth medicine and a restricted diet the patient recovered. It was on this occasion that the *Lupus erythematosus* was first noticed, and it had progressed gradually since then.

I prescribed salicin internally, gr. xv twice daily, and locally Hebra's soap spirit lotion to remove the scales, and zinc paste to try and reduce the hyperæmia. Under this treatment a distinct improvement set in, and when she was seen on October 3rd the scaliness had disappeared and the hyperæmia was less marked. On that occasion calamine lotion was substituted for the zinc paste, with instructions to apply the lotion on a mask for half an hour twice daily.

On October 17th the improvement was much more marked and the redness had entirely faded away from certain of the patches, leaving slight atrophy of the skin. But at this time the patient began to look ill. She complained of headache affecting the forehead and the back of the neck, and she appeared to be anæmic and was constipated. On this account the salicin was stopped, and a mixture of iron and sulphate of magnesia was prescribed. By November 7th the Lupus erythematosus had practically disappeared, and only a slight pinkness and atrophy of the skin could be detected in the affected areas, the rapidity and completeness with which the affection of the skin had disappeared being remarkable. Her general condition, however, was worse than on the previous occasion, and she complained of morning sickness and swelling of the legs. On examination it was found that her legs were swollen from the knees downwards, the swelling being most marked about the ankles and dorsum of the feet. On this account I asked my colleague, Dr. Fenton, to see her. Her urine was examined again, and it was found that it contained a large quantity of albumen.

The next I heard of the patient was a note I had from Dr. Clarke announcing her death on December 3rd, and he kindly furnishing the following details: "At the time of her death she had profound anæmia. Marked œdema was present about the ankles and purpuric spots were noted on the feet. For some days before her death there was an increasing languor. On the morning of her death she was found to be in a condition of collapse. Just before her death her pulse was rapid and full, and her body was warm and her skin moist." Unfortunately a post-mortem examination was not obtained.

This case presents several points of interest which may be briefly noted. In the first place there was no evidence of tuberculosis in the patient or history of it in the family. Then there were the interest-

ing facts that the disease developed rapidly, and followed immediately a short acute general illness of toxic origin; that marked amelioration took place under local treatment, and salicin internally, with almost complete disappearance of the lesions in four months; and that while the eruption was fading her general health was also rapidly declining, till she suddenly died with acute nephritis. The decline in general health and the profound anæmia with which it was associated were probably to some extent responsible for the rapid amelioration apparently produced by the treatment. The whole history of the case pointed to a toxic condition, the result of an auto-intoxication from toxins eliminated owing to the defective state of the kidneys.

CURRENT LITERATURE.

LICHEN OBTUSUS CORNEUS; AN UNUSUAL TYPE OF LICHENIFICATION. CHARLES. J. WHITE. (*Journ. of Cut. Dis.*, September, 1907.)

C. J. WHITE describes and figures a cutaneous eruption of about eight years' duration in a widow (housewife), aged 63 years. It commenced when exhausted by long nursing of her husband in his fatal illness, and she had been subject previously to nervous headaches, and about six years before had "muscular rheumatism," sciatica, and some abdominal trouble confining her to bed for twelve weeks. She had one child; no miscarriage. The menopause occurred at age of forty-seven years.

The eruption consisted of numerous discrete, disseminated, reddish-brown, dry, hard, round, dome-shaped nodules, fairly uniform in size, averaging $\frac{1}{2}$ to $\frac{3}{4}$ in. in diameter, and raised $\frac{1}{4}$ in. above the surface, with grey, rough, uneven tops, some displaying horny plugs. The nodules could be moved about in the skin. Some scratched lesions exhibited crateriform depressions, sometimes filled with hæmorrhagic crusts. The eruption was distributed mostly on the extensor aspects of arms and legs, but many were on flexor sides also. Recent lesions under observation simulated wheals, and were unlike the old elements. Rubbing excited a halo of erythema. Later on fresh lesions were strongly suggestive of wheals on account of central raised papulation and surrounding halo. The eruption induced fierce scratching.

Histologically the papillary layer was accentuated, the epidermis was acanthotic, and there was a mononuclear cell infiltration round dilated vessels. The histology approached rather closely to Lichen planus hypertrophicus.

The patient was dieted with the idea of increasing the coagulability of the blood, and protective gelatine dressings were applied and the patient improved. Later the eruption was disappearing under use of chrysarobin and lactic acid.

White associated his case with those described by Hardaway as "Multiple