Clinical and other Notes.

THREE CASES OF GONORRHOEAL KERATOSIS.

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Gonorrhœal keratosis is such a rare complication of Gonorrhœa that we feel justified in bringing to notice three cases which developed simultaneously in a hospital. The first record in British literature of this condition was made by Sequeira in 1910, though the first description was by Vidal in 1893. In December 1916, Graham Little gave a summary of all recorded cases—thirty-eight in number. Since then four cases have been published by one of us (W. H. B.) with other officers: three other cases have been brought to notice by officers of this unit—bringing the total observed in this hospital up to ten, out of a total number of about 40,000 cases of gonorrhœa. Two cases have recently been described by Captain C. Lundie, R.A.M.C., who mentions two more recorded in Les Annales des Maladies Vénériennes, 1917. This brings the total number of cases that we have been able to trace to fifty-two.

The three cases now described correspond very closely in all respects with most of those already recorded. The patients had severe toxæmia, marked emaciation, multiple arthritis and iritis.

In none of our cases was there much fever in spite of the severe general symptoms, the morning temperature being rarely over normal, and the evening temperature varying from 90°F to 101°F. The three patients were suffering from a first and recent attack of gonorrhœa in contradistinction to many of the recorded cases, in which the patients were suffering from second or subsequent attacks.

All three cases suffered from prostatitis, none had epididymitis, knee-jerks were normal. In Case 1, the cerebrospinal fluid was examined after the keratosis had developed and was found to be quite normal as regards cells and albumin, and the Wassermann test was negative.

A point of interest is that these cases developed the keratosis although they were at the time under vaccine treatment (a mixed vaccine of gonococcus and staphylococcus) for the other complications.

Case 1.—M. D., soldier, aged 22. Admitted to hospital October 16, 1918, with acute gonorrhœa, double conjunctivitis and iritis—marked in the right eye. Two days later arthritis developed in the left knee and both ankles. About five weeks after admission he developed a keratosis on the glans penis, in the form of a thick crust surrounding the glans, and a few days later the first evidence of keratosis on the feet appeared, developing fully in about eight to ten days.

Case 2.—F., soldier, aged 25. Admitted September 24, 1918, with acute gonorrhœa. About two months after admission, when still suffering from a gleet,
he developed arthritis of the right knee, and a few days later in both ankles and in the right temporo-maxillary joint. Next, iritis of the right eye appeared. Fully developed keratosis on both feet was first observed on January 6, 1919, three and a half months after admission.

Case 3.—Fl., soldier, aged 38. Admitted October 29, 1918, with acute gonorrhoea, first attack. One month after admission iritis developed in the right eye and five days later arthritis of left knee and right ankle appeared. On January 17, 1919, keratosis was first noticed on both feet.

**Description of Skin Lesions.**

The changes in the skin were quite characteristic in the three cases, and corresponded in every way with the description in the cases already published. Both feet were affected in each case, though not quite to the same degree, and on the areas of pressure the changes were most manifest. Isolated crusted nodules were also present quite apart from the points of pressure—on the ankles and knees.

In Case 1 (see illustration) the picture was very striking. A well-marked crop of hard cone-shaped nodules was present on the outer half of the ball of the left foot, and where these had become confluent an irregular ridge was formed. Between the third, fourth and fifth toes there was a good deal of desquamation and maceration of the skin, but projecting between the toes, beyond the points of contact, were present the same hard, ridge-like crusts sweeping from the dorsal surface, round the interspace, to the plantar surface. On the great toe there were...
no nodules. Over the heel there was a diffuse hyperkeratosis, with one or two hard limpet-shaped crusts breaking through the skin. Below the internal malleolus a large, isolated, flat-topped crust was present. On the knee also there were two similar nodules.

The toes had a dusky cyanosed appearance. On the right foot very similar conditions prevailed. General hyperkeratosis on the sole of the foot, but mainly on the areas of pressure. Similarly the crusted condition was present on the outer half of the ball of the foot and around the fourth and fifth toes.

Case 2 presented very much the same features as in Case 1, but in a less marked degree—generalized keratosis on the soles, with isolated hard, cone-shaped nodules embedded in the epidermis. In the early stages the thick cornal layer of the epidermis could be separated from the underlying hard, brown, cone-shaped crust, which could then be picked out, leaving a raw, somewhat warty, base. This feature has already been described in the case recorded by Brown and Davidson.

In Case 3, the eruption was very sparse and consisted of three or four small typical, hard, cone-shaped nodules on the balls of both feet. On removal of the cornal layer of the nodules, a hard lenticular mass was found which on maceration was seen to consist of squamous epithelial cells.

In the three cases the hands were not affected and the finger-nails showed no changes.

The three cases had to be transferred soon after diagnosis and we were unable to make further observations on them except in Case 1, where there was great improvement after a few days’ massage with castor oil, masses of the hardened tissue being then readily picked off.

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A CASE OF PRIMARY SARCOMA OF THE LIVER.

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The following case is interesting on account of its rarity.

The patient, a man aged 42, was admitted to the hospital in a condition of advanced emaciation. He stated that his health had been good until about a year previous, when he began to feel pain in the stomach about half an hour after food, and had a constant sense of discomfort during the intervals between meals. Flatulence was a prominent feature, but there had never been any vomiting. There was no noteworthy constipation. There had been a steady progressive loss of weight.

On examination, the abdomen was found to be distended by a large smooth solid tumour, extending from the costal margin to the brim of the pelvis; at its lower edge a distinct fissure could be felt in the middle line. There was some bronchial catarrh, with a persistent irritating cough. The urine was normal