Clinical and other Notes.

A CASE OF EPIDERMOLYSIS BULLOSA COMPLICATING MALARIA.

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Mr. B., the subject of this note, is a man, aged 40, well developed mentally and physically, of abstemious habits, and by profession a rubber planter.

I was asked to see him in the early summer of 1928, as he was in ill-health, and described as suffering from: (1) malaria; (2) diarrhoea of uncertain origin; and (3) some undiagnosed skin affection.

Although we are mainly concerned with the last-named ailment, the first must be mentioned because of its effect on his general health, while the intestinal complaint is not without a peculiar interest of its own.

(1) Mr. B.'s attacks of malaria had been severe and persistent, and had left him in a debilitated state, also contributed to by overwork and worry in connexion with the opening up of jungle for new plantations. Otherwise the malaria in itself showed nothing of interest.

(2) He complained of long-continued looseness of the bowels accompanied by "indigestion" and flatulence; he passed several unformed motions daily, he said, but had never suffered from dysentery so far as he knew, nor noticed blood in the stools. He was asked to pass a motion for cultural and other tests, and I was surprised to see that the matter consisted mainly of lumps of food still identifiable, obviously bolted without chewing. The patient was told that before laboratory examinations were undertaken, his ability to digest properly masticated food must be tested, and he was directed to chew each mouthful of food a set number of times until thorough mastication had become a habit. These admonitions were reinforced by an ocular demonstration of the impossible task he had been expecting his digestive apparatus to perform. He carried out his instructions faithfully, with the result that the indigestion and diarrhoea ceased absolutely without other treatment, and did not return.

(3) The patient's skin generally had a thinned and atrophic appearance, and showed the presence of many blisters both serous and haemorrhagic. These varied in diameter from about one-sixth of an inch up to about two inches, and affected in particular the parts more liable to injury—the hands, elbows, knees and ankles. Those on the hands numbered over twenty, in various stages. I had the interesting experience of seeing one in process of formation. In making a movement one of the patient's fingers brushed lightly against my table. So gentle was the impact that I should have
Figs. 1 and 2.—"Mr. B.'s hands before treatment was commenced. The lesions with ill-defined margins (in the photographs) are serous blisters."
been unaware of it had not the motion of his hand caught my eye. Almost immediately a blood-blister formed at the point of contact.

Needless to say, Mr. B. found this abnormal sensitiveness of the skin a most serious handicap both in work and play, and a simple procedure like tying up a parcel, or changing gear in a car, left his hands badly blistered, while exercises like golf and riding were out of the question. He found it difficult to enter or leave a bus or taxicab without some reminder of his journey in the form of skin injuries. In short, pressure on the skin to a degree quite inappreciable to a normal person sufficed to cause painful and even crippling blisters. Sometimes these lesions healed up without giving rise to further trouble, but often they became infected, and resulted in painful sores. Altogether the patient was in a pitiable state.

He had noticed the condition commencing, he said, about three years before. At first it was not troublesome, but slowly got worse, and with the onset of severe and long-continued malaria the skin complaint advanced rapidly, seemingly keeping pace with the deterioration in his health. I inquired carefully for a history of other cases in the patient's family; he knew of none in the past, nor on questioning various elderly relatives could he hear of any such. Most suggestively, however, his brother, also a rubber planter in the same country, has developed a similar skin affection while suffering from severe malaria, so that some familial predisposition is evident. (This second gentleman, I have just been informed, has been invalided home because of his skin condition, and is now on his way to England.)

Naturally Mr. B. was most concerned regarding prognosis, and one explained that there was some congenital deficiency of elastic tissue in the skin, obviously not of an extreme degree, else some evidence would have been noticed before, that probably this hereditary weakness had been aggravated by persistent malaria, and that the greater the responsibility of the second factor, the greater the hope of amelioration.

The patient was put on a well-balanced diet, arranged so as to include all the known essential elements, and, in addition, Promonta daily was prescribed. Medicinal treatment consisted of three-day courses of calcium lactate (thirty grains daily) and parathyroid extract (½ grain daily), alternating with three free days. He was instructed to massage the hands and more exposed parts daily with olive oil in the hope of thickening the epidermis.

There was a steady improvement, and each time that I saw the patient during the summer, or heard from him, he reported continued progress. His last visit was in November, 1928, just before he embarked for his return abroad, and his skin was then free from any lesions. In April, 1929, he writes that "after four months of our hottest and very trying weather, coupled with quite a lot of work," he is fit and well, and that there has been no return of his trouble. He still takes an occasional course of calcium and parathyroid, and also adds certain prescribed salts to the
Clinical and other Notes

drinking water, for the reason that in his district this is so deficient in saline constituents as to be practically equivalent to distilled water. It seems a sound precaution to raise the salt content to that of an ordinary drinking water, a measure, moreover, that is most gratifying to the patient.

THE TREATMENT OF RINGWORM OF THE SCALP OCCURRING IN THE CHILDREN OF MILITARY FAMILIES.

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Tinea tonsurans is a disease which is very prevalent amongst school children throughout the world; it is not surprising, therefore, that cases are frequently occurring amongst the children of military families. Treatment of the condition is costly and not without danger, and when it occurs in the Army presents a problem which, up to now, has not been satisfactorily solved.

In all cases the hairs are infected right down to the roots, consequently no treatment which does not epilate is of any avail. Epilation may be accomplished by any of three main methods: (a) X-rays, (b) local applications, (c) internal administration of certain drugs.

(a) X-RAYS.

This method is by far the most satisfactory in skilled hands, but it has certain disadvantages:—

(1) A costly apparatus is required.
(2) It cannot conveniently be employed for children under 3 years of age, because such small infants will not keep still long enough.
(3) Markedly inflamed ringworm cannot be treated with X-rays for fear of severe reaction and possible permanent scarring.
(4) The operator must have a great deal of experience of this method; the dose must be exact, as too small a dose fails to epilate completely and a small over-dose may result in permanent alopecia. Even under ideal conditions it is impossible to guarantee complete freedom from accident.

(b) LOCAL APPLICATIONS.

In certain types of ringworm—notably those due to a trichophyton—kerion is apt to form; this is, in effect, a localized inflammatory reaction. As a result of this reaction the hairs are loosened and may fall out, spontaneous cure resulting.

This fact is made use of in treatment of cases which cannot for various reasons be treated by other means.

The hair is cut short and is shampooed with spirit soap daily. After shampoo Adamson's ointment (composed of equal parts of common salt and vaseline) is vigorously rubbed into the whole scalp. When properly applied, the application causes an acute inflammatory reaction of the infected area, leaving the rest of the scalp untouched.