The blood Wassermann reaction was found to be positive (confirmed), and the quantitive Kahn test 10 Kahn units. The cerebrospinal fluid was clear and not under pressure. Laboratory examination of the cerebrospinal fluid showed: Cells 1 per c.mm. Protein 40 mg. per 100 c.c. Globulin slightly increased. Lange normal. W.R. positive.

In view of the possibility of a Herxheimer reaction, the patient was first given weekly intramuscular injections of 0.2 gramme bismuth before commencing penicillin, and the cutaneous lesions of the face, right shoulder and arm at once began to heal rapidly. During the early part of treatment he had an exacerbation of the urinary symptoms previously described, and B. coli were cultured from the urine. The infection responded to sulphonamides.

**Comment.**

This case shows two interesting features. The patient when first seen was found to be suffering from an annular cutaneous syphilide, an aneurism of the ascending aorta, and tabes dorsalis. Judging from the history, it would appear to be possible that the tabetic symptoms and the symptoms referable to the aneurism appeared almost simultaneously, and the cutaneous lesions appeared about twelve months later.

While it is impossible to be certain that this is not a case of acquired lues, the family history, the absence of any previous lesions, the slender but suggestive evidence of facial appearance, and the fact that the disease was not transmitted to the patient's wife and children would all suggest that the infection might possibly be congenital in origin. Unfortunately, the other members of the family could not be examined, and so further confirmatory evidence is lacking.

**Acknowledgment.**

I am indebted to Colonel C. O. Shackleton, O.B.E., Officer Commanding, Royal Herbert Hospital, Woolwich, for permission to publish the case report.

**References.**


**Lichen Planus Linearis.**

**By**

Major R. J. McGill, M.B.

Indian Medical Service.

[Received September 9, 1947.]

The following case of lichen planus linearis in an African soldier had some unusual features.

**Case-histroy.**—Private K., aged 23, of normal physique and temperament, stated that at the end of March, 1943, he developed fever with malaise and nausea but no vomiting, and accompanied by generalized pruritus, day and night. After one week, the fever subsided, but coincidentally a rash with linear distribution appeared on the left of the
thorax and a fortnight later it extended to the left arm and forearm. One week after that, discrete lesions appeared on the penis, and one week later still on both legs, left thigh, and right forearm. With the appearance of the rash, pruritus disappeared during the day, but it recurred regularly at night (when he was in bed).

For one month from the time of onset of the fever there was a generalized soreness in his mouth.

On June 30 the rash was still fully developed. It was distributed in two groups as follows:

(a) As a curved narrow line extending first from a point one fingerbreadth to the left of the left sternal border at the level of the second left intercostal space up to a point 1 inch below the middle of the left clavicle, then across the anterior fold of the axilla to the middle of the anterior border of the deltoid, and then down the middle of the anterior aspect of the arm and forearm to within two inches of the wrist. It consisted essentially of two lichen manifestations, discrete irregularly-shaped papules, 1/16 to 1/8 inch in diameter, and plaques half an inch wide and of variable length, forming small discrete squares or oblongs or large irregularly shaped areas of roughly oblong shape, with their longer axis in the general direction of the band. The larger confluent areas were confined to the arm and forearm.

(b) As scattered papules on the distal 2 inches of the left forearm, including the
wrist, and on the left palm, on all the anterior aspect of the right forearm and on the dorsum of the right hand. There were a few papules on the shaft of the penis, more on the anterior aspect of the thighs, on the medial aspect and dorsum of the knees and a few on the calves.

Some areas on the left arm and forearm were macules only, not rising above the level of the surrounding skin. The colour was throughout burnished dense black, except for the smallest papules, which were white. (The black lesions, due to their sheen or burnish, appear white in the photograph.)

There were a few white papules on the inner surface of the cheeks opposite the third molars and on the soft palate.

Wickham’s striae were not seen.

The lesions were tender on firm pressure; they were not indurated.

He was afebrile throughout his stay in hospital. The circulatory system, lungs, alimentary tract, and C.N.S. were normal. The spleen and liver were not palpable, and there were no abnormal glands. B.P. 120/66. The urine was normal; reaction alkaline. Stool, ova of *Ascaris lumbricoides* seen. Blood Kahn negative. C.S.F. (1.7.43) normal. W.B.C. (30.6.43) 8,200. P. 42 per cent, E. 13 per cent, B. 1 per cent, L. 41 per cent, M. 3 per cent (300 cells counted). Santonin gr. iii was given on 22.7.43, and two roundworms were passed on the following day. The differential count on 29.7.43 (220 cells counted) was P. 45 per cent, E. 7 per cent, L. 44 per cent, M. 4 per cent. On 4.8.43 the stools were negative for ova.

A course of sulphostab was initiated, but at the end of August when he was transferred to another hospital his condition was unchanged.

**Differential Diagnosis.—Linear naevus** (ichthyosis hystrix), whose distribution may resemble that of lichen planus linearis, is readily distinguished by its being a congenital and permanent malformation, appearing as a rule soon after birth and evolving slowly, whereas lichen planus linearis occurs usually in adult life, the whole extent of the lesions developing simultaneously (Macleod, 1933).

*Morphæa* (circumscribed sclerodermia) in the rare raised form (Barber, 1936), whose distribution may also resemble that of lichen planus linearis, is distinguished by its slow progress, and in the band type of the disease, the lesions adhere to the underlying structures.

**COMMENT.**

No improvement followed lumbar puncture, and no aetiological factor could be discovered. The patient was not unduly concerned and was in no way an anxious type; nor was he phlegmatic.

The long linear distribution did not follow the course of any one peripheral nerve. It resembled a case reported by Hallum (1931) where the condition was also linear and commenced at the mid-line over the sacrum, extended to its lateral border, and then down the dorsum of the thigh and leg to the ankle. No theory involving adherence to lines of embryonic fissures and clefts, Head’s zones, the course of a peripheral nerve, blood supply or lymph drainage can be evoked to explain the distribution in either case. It is extremely improbable that the linear lesion here followed the course of a scratch mark. It is of interest that, according to MacCormac (1937), lichen planus linearis is seldom associated with other and more characteristic lesions.

The various theories which attempt to account for the distribution of the linear dermatoses are reviewed by Piers (1945), but none as yet explains this particular arrangement.
Obituary

SUMMARY.

A case of lichen planus linearis with an unusual onset and subsequent features is described and its aetiology briefly discussed.

I am indebted to the D.M.S., India Command, for his permission to forward this case for publication.

REFERENCES.


Obituary.

Lieutenant-General Sir Harold Ben Fawcus.

In Hillingdon on October 24, 1947, Lieutenant-General Sir Harold Ben Fawcus, K.C.B., C.M.G., D.S.O., D.C.L., M.B., Director-General, Army Medical Services, 1929 to 1934, and Director-General, British Red Cross Society, 1934 to 1938. Son of Mr. John Fawcus of South Charlton, Northumberland, he was born there May 20, 1876, and educated at Durham School and Durham University, where he graduated M.B. in 1899. He played both cricket and football for the University for five years, and he was also in Durham County XV and the Northumberland XV. Joining at Netley on probation on March 1, 1900, he was commissioned Lieutenant R.A.M.C. April 25, 1900. Promoted Captain April 25, 1903. At the examination for promotion to Major, he obtained a first class certificate entitling him to a year's acceleration of promotion. He was promoted Major April 27, 1911. He was Assistant Professor of Hygiene, R.A.M. College January 1, 1912, to February 28, 1914, and Instructor Army School of Sanitation March 1, 1914, till August 4, 1914. Promoted Lieutenant-Colonel March 1, 1915, Brevet-Colonel June 3, 1919, Colonel June 1, 1926, Major-General October 27, 1926, and Lieutenant-General on his being appointed Director-General September 16, 1929, he retired March 1, 1934, when he was appointed Director-General, British Red Cross Society, which appointment he held till 1938. He was an A.D.G. at the War Office July 1, 1922, till June 2, 1926. He was appointed V.H.S. March 1, 1920, and K.H.P. January 1, 1923. Created C.B. June 3, 1928, and K.C.B. 1931. He was Colonel Commandant R.A.M.C. August 9, 1937, till August 7, 1941. He was a Commissioner of the Royal Hospital, Chelsea. In South Africa 1900-1902, he took part in the operations in Natal, Cape Colony, Orange Free State and Transvaal, receiving the Queen's Medal with four Clasps and the King's Medal with two Clasps. He served in France from August 9, 1914, till April 1, 1919. Six times mentioned in despatches, he was created C.M.G., and awarded the D.S.O., French War Cross, 1914 Star and Clasp, British War and Victory Medals.