OBSERVATIONS ON SENSITISATION OR "IDE" ERUPTIONS FOLLOWING VARICOSE ULCERATION, VARICOSE ECZEMA AND INFECTIOUS ECZEMATOID DERMATITIS.

by

O.A. Finn.

From The Department of Dermatology, Stobhill Hospital, Glasgow.

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Introduction and Purpose of Thesis.

A comprehensive review of the literature appertaining to the condition described by Engman (1902) as infectious eczematoid dermatitis has revealed a general consensus of opinion as regards the traumatic and/or infective origin of this comparatively common cutaneous disorder. But there would appear to be a definite difference of opinion with regard to the causation of the "sensitisation" or "ide" eruptions which commonly supervene in such cases and little real attempt has been made to classify these very varied pictures on a clinical or histopathological basis. It has, therefore, appeared of interest to conduct a further investigation, supported by clinical and pathological studies in a representative group of cases, into the aetiological factors governing the production of the sensitisation phenomena associated with primary infectious eczematoid dermatitis. This is the purpose of the thesis which follows.

II. HISTORICAL SUMMARY.

Historical Summary of Infectious Eczematoid Dermatitis and its concomitant sensitisation eruptions.

In 1902, Engman[14] isolated from the eczema group an entity which he designated infectious eczematoid dermatitis. This was characterised by areas of dry scaling dermatitis, or large weeping patches or a combination of moist and crusted lesions. The initial lesion was a vesicle, pustule or erythematous scaly plaque which appeared to have followed local skin trauma or infection. The lesions rapidly coalesced and formed circumscribed eczematous patches with sharply defined borders, the eruption increasing by peripheral extension of the patches and formation of new ones by auto-inoculation. Engman described a typical patch as "eczematoid dermatitis because in its course we have papules, vesicles, pustules and a reddened scaly surface from which oozes a sticky liquid that stiffens linen and forms crusts." He illustrated the infectious element by the reproduction of the disease in another person by close contact. Furthermore, he stated his opinion that the conditions respectively designated "varicose eczema" and "varicose ulceration" were merely examples of this disease process occurring on skin devitalised,/

devitalised, and thus rendered prone to abnormal reaction as a result of trauma or infection, by underlying venous varicosity. Fordyce[15] (1911) stressed the importance of antecedent injury or sepsis but pointed out that fresh lesions were not always the result of auto-contagion. Because of the abrupt and generalised dissemination of the disease process he suggested a blood borne infection. In 1920, Sutton[41] noted that many cases of infectious eczematoid dermatitis were accompanied by a concurrent urticarial eruption. He stated that the association of the two conditions (viz. 19 out of 75 cases, i.e. 25%) was too frequent to be coincidental and regarded this secondary eruption as an anaphylactic phenomenon. Barber[4] (1926) expressed the current view that the condition was an entity probably due to epidermal sensitisation to staphylococcal infection.

In this connection it should be noted that Darier[9] (1896) had introduced the term "tuberculide" to describe a group of differing cutaneous syndromes which were recognised to be associated with tuberculosis. A tuberculide was thus regarded as an allergic cutaneous manifestation of systemic tuberculosis. The "ide" suffix/

suffix was adopted by Audry[3] (1902) who applied it to the cutaneous lesions of leukaemia. He called attention to a group of non-specific, pruriginous, urticarial, exudative and exfoliative lesions of the skin often associated with leukaemia.

The "ide" concept was still further developed when Guth[17] (1914) used the term to denote an exanthem occurring in children with kerion ringworm. He showed that his patients reacted positively to intracutaneous injections of extracts of trichophytes. Later, Barber[5] (1929) proposed the term "streptococcides" to designate eruptions that were apparently due to an allergic state of the skin to the streptococcus and, in the same year, Dennie et al[11] described generalised exfoliation of the skin following local dermatitis around burned areas; the latter workers expressed the opinion that the generalised dermal reaction was due to a sensitisation to "protein picrinate" produced at the site of the burn and carried by the blood stream to remote areas of the skin. Peck[32] (1930) showed the allergic relationship of certain cutaneous manifestations, particularly the so-called dyshidrotic vesicular eruptions of the hands, to the presence of fungous infection of the feet.

Later/

Later, Andrews, Birkman & Kelly [2] (1934) described a curious persistent eruption which was bilaterally symmetrical and affected the soles and palms and to which they gave the name "pustular bacteride." Patients with the disease reacted positively to intracutaneous injections of extracts made from staphylococci and some completely recovered after removal of foci of infection in the teeth or tonsils. Whitfield [46] (1921) reported two cases in whom generalised toxic eruptions occurred 10 days after they had sustained large haematomata due to trauma, while a third patient developed a red-streaked urticarial wheal whenever serum from an eczema of the legs came in contact with normal skin. Whitfield's observations on sensitisation of the skin by antigenic or toxic substances formed in situ were confirmed by Perutz [33] (1927) who, by transferring the blister fluid from a patient with turpentine eczema, produced an eczematous reaction in a test-subject. Later, Whitfield [47] (1930) demonstrated that the skin can become sensitised to the products of its own damaged cells, and showed that if the fluid from an eczematous vesicle was allowed to flow over an area of apparently healthy skin that there appeared "first, a red/

red streak, secondly, after a few minutes, a well marked urticarial wheal and, lastly, a row of vesicles at first minute and clinically indistinguishable from the primitive vesicles of the eczema but subsequently coalescing to form a linear bulla." On Whitfield's own skin, the fluid produced no reactions, thus providing experimental proof that the patient was sensitive to the fluid containing his own tissue products and that it was innocuous to another person. This phenomenon was called by him "autosensitisation eczema." Dowling[13] (1936) was unable to confirm this reaction and found that intradermal injections of the fluid from a bulla on the eczematous skin into the normal skin of the same subject failed to produce any abnormal change. He further noted that intradermal injection, and application to both sound and scarified skin of a filtrate of eczema scales ground up with sand produced similarly negative results in eczematous and normal subjects. Another opinion was advanced by MacLeod and Muende[27] (1936) when they discussed the aetiology of eczematous reactions and attempted to draw an analogy to wheal formation. They postulated the theory that the primary lesion released a diffusible substance from the epidermal cells which/

which they called the X substance, and that this hypothetical substance was absorbed into the general circulation eventually producing eczematous patches on remote areas of the skin. Hallam[19] (1938) supported this view and added that the cause of the onset of the primary lesion was often a degree of trauma or infection which was inoffensive to a normal individual. He also pointed out that, given low-grade physical or mental resistance, scratching or rubbing due to lack of self-control, often changed a trivial localised patch of inflammation into a generalised eruption. Further evidence of an X-substance was provided by Smith[38] (1945) who incriminated a locally formed "dermolysin" which was probably a protein of bacterial or tissue break-down origin or perhaps a combination of both. Templeton[42] (1945) thought the sequence of events was that the patient's epidermis first became sensitised to his own altered tissue products and that, in due course, enough of these autogenous products were absorbed to sensitise the whole skin. Experiments by Rostenberg[37] (1947), Kalkoff[21] (1948) and Landsteiner & Chase[23] (1941) seemed to confirm this theory of blood or lymph borne allergens.

This review of the literature thus clearly shows that all observers are agreed that a definite relationship exists between the initial lesion and the secondary eruption, while the majority adduce experimental evidence pointing to the fact that the latter is a cutaneous manifestation due to an allergen produced and absorbed at the site of the original lesion. If this allergic theory is true, it seems difficult to understand the series of negative results obtained by Whitfield (vide supra). Furthermore, the auto-infective contention of Engman has by no means been disproved.

III. CLINICAL MATERIAL.

CLINICAL MATERIAL.

One hundred patients, 62 males and 38 females, were considered suitable for inclusion in the present study and a detailed history and thorough clinical examination was carried out in each case. The primary eruption which was present in 85% of the cases on the legs and, in the remainder, on the upper limbs, was composed of infectious eczematoid dermatitis in 71 cases, varicose eczema in 11 and varicose ulceration with eczema in 18. There was an indeterminate interval between the initial lesion and the appearance of the secondary or sensitisation eruption but usually an exacerbation of the original condition preceded the generalised exanthem. The "ide" eruptions varied in character and particular attention was paid to their clinical features. The individual records are available in Appendix A. giving a detailed description of the cutaneous manifestations encountered and, unless otherwise stated, it can be understood that no abnormal symptoms or signs were elicited in the examination of other systems. The various types of "ide" eruptions are further illustrated by photographs in Appendix B.

IV. INVESTIGATIONS.

I N V E S T I G A T I O N S.

Investigations were conducted on the following lines -

a) Detailed examination of the blood.

b) Urine analysis.

c) X-rays of chest, sinuses and teeth.

d) Vaccination with serous exudate from the primary lesion into the patient's forearm in an attempt to reproduce the sensitisation eruption.

a) Detailed examination of the blood.

The haemoglobin levels were determined by the acid haematin method of Sahli and the standard employed was calibrated so that 100 per cent was equivalent to 13.8 grams haemoglobin per 100 ml blood. The total leucocyte and corpuscle counts were obtained by using standard pipettes and a Neubauer haematocytometer. The blood films were made on cover slips and stained with Leishman's stain, they were examined systematically with an oil immersion lens and in each case a total of

200/

200 polymorphonuclear cells were enumerated from which a differential leucocyte count was recorded. On the same film the red blood corpuscles were inspected for shape, size and staining. The erythrocyte sedimentation rates were estimated by the Westergren method. The exact findings in each case are shown in Table No. 1.

The serum proteins were estimated by the routine "biuret" method while the blood urea, blood cholesterol and serum calcium levels were calculated by the technique explained by King[22] (1946). The results are shown in Table No. 2.

b) Urine analysis.

For investigation purposes, the early morning specimen of urine was used and the acidity was tested with litmus paper. The usual chemical tests were performed to detect the presence of albumin, blood, bile and sugar. In females, catheter specimens and in males midstream specimens of urine were used for microscopic and bacteriological examinations. (Table No. 3).

c) X-rays of chest, sinuses and teeth.

In search for foci of infection skiagrams of chest, sinuses and teeth were examined but where the patient was edentulous, no x-ray of jaw was considered necessary. The radiological findings are demonstrated in Table No. 4.

d) Vaccination of the patient's forearm with serous exudate from the primary lesion.

The Wassermann reactions in all cases of this series were negative and thus the following technique was employed in 40 cases in an attempt to reproduce the "ide" eruption. The primary lesion, viz - infectious eczematoid dermatitis was dressed for 24 hours with hypertonic saline dressings. A drop of serous exudate from this area was collected by means of a glass capillary tube and placed on the patient's forearm. A drop of normal saline was used as a control and two linear scratches ($\frac{1}{4}$" in length) were made with a Hagedorn needle and the reactions read in 12, 24 and 48 hours. A similar procedure was carried out in a normal control subject.

The/

The experiment was then repeated on the control's forearm on a site which, 24 hours previously, had been injected intracutaneously with 0.05 c.cs of the patient's blood serum and the immediate response was noted. The various reactions are shown in Table No. 5.

TABLE NO. 1.

Case No.	Hb% Sahli	R.B.C's per cu.mm.	W.B.C's per cu.mm.	Differential Blood Count				Sedimentation Rate	
				Neutrophils	Eosinophils	Lymphocytes	Monocytes	1st hour	2nd hour
								mm.	mm.
1	105%	5,540,000	11,600	62%	-	38%	-	21	45
2	105%	5,380,000	11,200	76%	1%	23%	-	4	10
3	98%	5,380,000	10,800	65%	-	35%	-	2	8
4	100%	5,460,000	7,600	65%	2%	32%	1%	25	53
5	96%	4,330,000	8,000	66%	1%	32%	1%	8	22
6	106%	5,160,000	7,400	63%	5%	32%	-	5	20
7	101%	4,900,000	5,000	65%	1%	34%	-	3	7
8	104%	5,200,000	8,200	63%	1%	36%	-	6	16
9	100%	4,750,000	5,400	60%	4%	34%	2%	6	18
10	98%	4,760,000	4,400	51%	-	39%	-	13	27
11	106%	5,460,000	6,800	51%	-	35%	4%	6	18
12	102%	4,900,000	8,600	64%	-	34%	2%	2	3
13	88%	4,280,000	6,800	61%	1%	35%	3%	4	9
14	110%	5,300,000	8,200	63%	3%	34%	-	1	5
15	92%	4,600,000	12,600	64%	2%	32%	2%	2	6
16	108%	5,800,000	10,400	68%	-	32%	-	5	12
17	104%	5,050,000	12,000	70%	-	30%	-	4	8
18	96%	4,890,000	9,600	57%	-	39%	4%	4	12
19	110%	5,450,000	11,000	62%	1%	37%	-	22	30
20	104%	5,400,000	14,000	65%	2%	30%	3%	4	12

TABLE NO. 1. (Contd.)

Case No.	Hb% Sahli	R.B.C's per cu.mm.	W.B.C's per cu.mm.	Differential Blood Count				Sedimentation Rate	
				Neutrophils	Eosinophils	Lymphocytes	Monocytes	1st hour	2nd hour
								mm.	mm.
21	88%	4,550,000	7,000	63%	1%	34%	2%	2	6
22	92%	5,120,000	6,200	55%	3%	40%	2%	8	27
23	96%	4,500,000	8,000	60%	9%	30%	1%	17	45
24	110%	5,360,000	10,600	65%	3%	28%	4%	1	4
25	97%	4,090,000	7,000	60%	-	35%	5%	6	20
26	82%	5,040,000	6,600	55%	-	42%	3%	17	40
27	105%	5,310,000	13,000	67%	6%	25%	2%	3	8
28	92%	4,360,000	9,600	66%	-	31%	3%	8	17
29	94%	4,490,000	9,400	72%	2%	24%	2%	10	21
30	104%	4,970,000	8,000	68%	1%	31%	-	2	4
31	102%	5,420,000	9,000	58%	-	41%	1%	12	20
32	94%	4,900,000	6,600	62%	-	38%	-	13	30
33	82%	4,330,000	5,200	59%	-	41%	-	8	18
34	104%	5,100,000	6,000	64%	1%	34%	1%	22	52
35	106%	5,200,000	8,600	66%	-	31%	3%	4	10
36	102%	4,920,000	4,600	62%	-	34%	4%	2	7
37	110%	5,420,000	10,200	73%	-	27%	-	4	18
38	105%	4,640,000	7,000	62%	2%	34%	2%	6	10
39	100%	5,500,000	9,000	59%	2%	37%	4%	6	12
40	78%	4,130,000	10,200	63%	1%	34%	2%	50	96

TABLE NO. 1. (Contd.)

Case No.	Hb% Sahli	R.B.C's per cu.mm.	W.B.C's per cu.mm.	Differential Blood Count				Sedimentation Rate	
				Neutrophils	Eosinophils	Lymphocytes	Monocytes	1st hour	2nd hour
								mm.	mm.
41	95%	4,650,000	10,200	60%	2%	34%	4%	10	27
42	98%	4,650,000	8,200	67%	-	32%	1%	2	5
43	96%	4,930,000	10,000	74%	-	26%	-	7	16
44	102%	4,540,000	7,000	64%	3%	31%	2%	26	54
45	98%	4,730,000	8,800	63%	-	35%	2%	2	4
46	110%	5,450,000	8,000	58%	2%	38%	2%	7	17
47	104%	5,080,000	7,400	70%	-	28%	2%	11	21
48	98%	4,810,000	9,600	66%	1%	33%	-	24	45
49	108%	5,180,000	6,600	60%	1%	35%	4%	16	30
50	90%	4,550,000	9,200	70%	-	30%	-	6	12
51	108%	4,920,000	7,200	57%	3%	38%	2%	7	20
52	84%	4,380,000	4,400	65%	1%	32%	2%	20	40
53	100%	3,920,000	6,800	73%	-	27%	-	6	10
54	98%	4,910,000	10,800	65%	-	35%	-	15	25
55	114%	5,330,000	8,800	60%	-	40%	2%	5	10
56	88%	4,380,000	6,000	65%	-	33%	2%	10	18
57	104%	4,670,000	6,600	60%	-	38%	2%	10	30
58	95%	4,460,000	10,400	66%	3%	27%	4%	18	32
59	110%	5,290,000	6,800	65%	-	34%	1%	4	7
60	94%	5,190,000	9,000	61%	-	36%	3%	8	17

TABLE NO. 1. (Contd.)

Case No.	Hb% Sahli	R.B.C's per cu.mm.	W.B.C's per cu.mm.	Differential Blood Count				Sedimentation Rate	
				Neutrophils	Eosinophils	Lymphocytes	Monocytes	1st hour	2nd hour
								mm.	mm.
61	92%	3,800,000	7,200	64%	3%	31%	2%	10	20
62	78%	3,680,000	10,800	60%	2%	36%	2%	10	18
63	104%	5,030,000	6,800	60%	-	39%	1%	8	12
64	102%	5,210,000	7,400	67%	-	30%	3%	4	10
65	104%	5,640,000	8,600	64%	-	32%	4%	6	14
66	92%	3,850,000	6,000	51%	4%	43%	2%	6	10
67	84%	4,200,000	7,600	66%	-	31%	3%	12	18
68	88%	4,700,000	5,600	69%	3%	24%	4%	16	22
69	100%	4,960,000	8,000	64%	2%	34%	-	3	7
70	92%	4,420,000	6,400	60%	2%	35%	3%	8	14
71	108%	5,180,000	6,000	63%	1%	36%	-	4	10
72	96%	5,290,000	8,400	56%	5%	36%	3%	8	20
73	104%	4,670,000	6,000	66%	-	31%	3%	1	5
74	98%	4,730,000	10,200	71%	1%	26%	2%	2	5
75	96%	4,400,000	9,000	67%	1%	29%	3%	7	22
76	100%	4,870,000	6,400	59%	-	38%	3%	8	23
77	110%	5,140,000	8,400	64%	1%	33%	2%	3	12
78	94%	4,960,000	10,600	66%	-	31%	3%	16	48
79	90%	4,600,000	8,000	71%	1%	25%	3%	19	46
80	90%	4,810,000	8,800	61%	-	38%	1%	4	8

TABLE NO. 1. (Contd.)

Case No.	Hb% Sahli	R.B.C's per cu.mm.	W.B.C's per cu.mm.	Differential Blood Count				Sedimentation Rate	
				Neutrophils	Eosinophils	Lymphocytes	Monocytes	1st hour	2nd hour
								mm.	mm.
81	95%	5,090,000	8,200	66%	-	32%	2%	10	29
82	94%	4,530,000	9,000	58%	-	39%	3%	10	23
83	104%	4,550,000	5,600	71%	1%	24%	4%	2	4
84	94%	5,490,000	13,000	72%	1%	27%	-	14	26
85	115%	5,700,000	7,000	60%	2%	37%	1%	14	32
86	110%	5,530,000	9,400	70%	1%	29%	-	10	18
87	104%	5,320,000	12,400	59%	-	40%	1%	3	6
88	105%	5,060,000	8,600	67%	1%	29%	3%	7	16
89	92%	4,690,000	6,400	57%	2%	39%	2%	9	20
90	96%	5,140,000	7,200	67%	-	32%	1%	4	8
91	90%	5,310,000	7,000	68%	1%	29%	2%	1	2
92	95%	4,820,000	6,400	72%	-	28%	-	7	14
93	105%	5,480,000	9,600	62%	-	36%	2%	15	27
94	88%	4,790,000	6,200	65%	-	35%	-	26	50
95	102%	5,000,000	6,600	70%	2%	26%	2%	6	11
96	90%	4,500,000	12,200	76%	-	24%	-	8	25
97	94%	4,390,000	7,600	73%	1%	25%	1%	4	6
98	98%	5,090,000	7,400	55%	2%	42%	1%	4	10
99	98%	4,790,000	5,000	59%	3%	35%	3%	2	5
100	90%	4,760,000	8,600	73%	2%	23%	2%	15	36

TABLE NO. 2.

Case No.	Serum Proteins			Blood Urea mgms%	Blood Cholesterol mgms%	Serum Calcium mgms%
	Total gms%	Albumen gms%	Glooulin gms%			
1	7.09	4.40	2.69	33	127	10.5
2	7.42	4.40	3.02	28	161	11.5
3	7.52	5.20	2.32	27	173	12.0
4	7.20	3.80	3.40	58	142	12.0
5	7.36	4.32	3.04	46	142	10.5
6	5.90	4.40	1.50	52	157	9.5
7	7.31	4.80	2.51	64	153	10.0
8	7.63	4.40	3.23	34	152	10.0
9	6.98	3.60	3.38	24	170	11.0
10	8.28	5.20	3.08	26	213	11.5
11	8.49	6.00	2.49	46	137	11.0
12	7.63	5.00	2.63	23	154	10.5
13	8.49	5.40	3.09	34	162	9.5
14	7.42	5.40	2.02	20	156	11.0
15	7.85	5.20	2.65	22	132	10.0
16	7.20	4.40	2.8	48	175	10.0
17	8.49	5.40	3.09	22	210	10.5
18	6.77	4.20	2.57	25	189	10.0
19	8.71	5.40	3.31	42	170	11.5
20	8.06	4.60	3.46	26	243	10.5

TABLE NO. 2. (Contd.)

Case No.	Serum Proteins			Blood Urea mgms%	Blood Cholesterol mgms%	Serum Calcium mgms%
	Total gms%	Albumen gms%	Globulin gms%			
21	6.87	4.80	2.07	20	187	11.5
22	6.87	5.20	1.67	33	117	10.0
23	7.42	5.22	2.20	36	158	11.0
24	8.38	5.20	3.18	22	133	10.0
25	6.77	4.60	2.17	37	228	10.5
26	7.95	4.80	3.15	36	175	10.0
27	7.30	4.30	3.00	30	152	10.5
28	6.40	4.20	2.20	63	150	9.7
29	6.54	4.20	2.34	32	152	11.0
30	6.44	5.20	1.24	41	152	11.0
31	7.68	5.64	2.02	48	178	10.5
32	7.20	5.60	1.60	30	150	12.5
33	6.34	4.40	1.94	30	178	10.5
34	8.71	5.20	3.51	38	225	11.5
35	7.40	4.60	2.80	48	162	10.5
36	6.55	4.40	2.15	20	138	10.5
37	6.55	4.40	2.15	22	131	10.5
38	6.34	4.60	1.74	30	154	10.0
39	7.20	4.80	2.40	17	134	10.5
40	6.77	4.40	2.37	46	158	9.5

TABLE NO. 2. (Contd.)

Case No.	Serum Proteins			Blood Urea mgms%	Blood Cholesterol mgms%	Serum Calcium mgms%
	Total gms%	Albumen gms%	Globulin gms%			
41	7.20	4.60	2.60	27	142	10.5
42	5.47	4.20	1.27	26	109	8.0
43	7.42	4.80	2.62	27	147	12.0
44	8.71	5.20	3.51	36	167	10.5
45	7.20	5.20	2.00	22	146	9.0
46	6.98	4.80	2.18	48	142	11.0
47	6.77	4.80	1.97	33	136	10.0
48	8.71	4.40	4.31	24	156	13.0
49	5.68	3.60	1.08	26	142	11.5
50	6.77	4.00	2.77	31	155	10.0
51	8.06	4.80	3.26	30	183	10.0
52	6.55	4.60	1.95	33	190	10.5
53	7.24	4.84	2.40	36	182	11.0
54	7.42	4.40	3.02	46	176	11.0
55	6.32	4.20	2.12	40	164	10.5
56	6.77	4.20	2.57	36	186	10.5
57	6.55	4.40	2.15	27	184	10.5
58	8.92	4.80	4.12	42	186	10.5
59	7.85	4.80	3.05	29	179	10.0
60	6.98	4.60	2.38	39	176	11.5

TABLE NO. 2. (Contd.)

Case No.	Serum Proteins			Blood Urea mgms%	Blood Cholesterol mgms%	Serum Calcium mgms%
	Total gms%	Albumen gms%	Globulin gms%			
61	7.20	4.80	2.40	40	150	11.0
62	6.12	4.20	1.92	22	206	10.0
63	6.25	4.00	2.25	26	164	10.0
64	6.50	5.00	1.50	30	146	10.5
65	6.84	3.60	3.24	34	142	10.5
66	7.75	5.60	2.15	24	148	12.0
67	Not done					
68	Not done					
69	7.00	4.60	2.40	14	125	8.0
70	7.24	4.40	2.84	30	136	10.5
71	7.00	4.40	2.60	16	128	10.0
72	7.50	4.40	3.10	22	136	11.5
73	7.75	4.40	3.35	33	189	10.0
74	7.50	4.60	2.90	27	164	12.5
75	7.50	4.80	2.70	34	154	12.5
76	8.25	4.80	3.45	27	163	11.5
77	7.00	4.40	2.60	22	142	11.0
78	7.50	4.80	2.70	24	170	11.5
79	7.00	4.80	2.20	22	153	10.0
80	7.50	4.80	2.70	35	182	11.0

TABLE NO. 2. (Contd.)

Case No.	Serum Proteins			Blood Urea	Blood Cholesterol	Serum Calcium
	Total gms%	Albumen gms%	Globulin gms%	mgms%	mgms%	mgms%
81	7.00	4.40	2.60	24	164	11.0
82	6.00	4.20	1.80	31	184	10.5
83	7.00	4.80	2.80	33	172	10.5
84	6.50	4.40	2.10	30	162	11.0
85	6.50	4.00	2.50	25	178	10.5
86	6.50	4.80	1.70	22	148	11.0
87	6.25	4.20	2.05	26	186	10.0
88	6.50	4.40	2.10	23	176	10.5
89	5.50	4.00	1.50	27	179	10.0
90	6.00	4.40	1.60	22	184	11.0
91	6.50	4.20	2.30	28	136	10.5
92	6.50	4.00	2.50	34	192	10.0
93	7.00	3.40	3.60	29	146	10.5
94	6.80	4.20	2.60	32	146	10.0
95	6.50	4.20	2.30	36	127	10.6
96	6.90	4.40	2.50	26	150	10.0
97	6.50	4.00	2.50	39	175	10.5
98	8.50	5.60	2.90	17	206	11.6
99	7.25	5.60	1.65	20	208	12.5
100	6.00	4.60	1.40	24	186	11.5

TABLE NO. 3.

(- denotes normal)

U R I N A L Y S I S				
Case No.	Reaction	Chemically	Microscopically	Culture
1	Acid	-	-	No growth
2	Acid	-	-	No growth
3	Acid	-	-	No growth
4	Acid	-	-	No growth
5	Acid			No growth
6	Acid	-	-	No growth
7	Acid	-	-	No growth
8	Acid	-	-	No growth
9	Acid	-	-	No growth
10	Acid	-	-	No growth
11	Acid	-	-	No growth
12	Acid	-	Epithelial cells	No growth
13	Acid	-	-	No growth
14	Acid	-	-	No growth
15	Acid	-	-	No growth
16	Acid	-	-	No growth
17	Acid	-	-	No growth
18	Acid	-	-	No growth
19	Acid	-	-	No growth
20	Acid	-	-	No growth

TABLE NO. 3. (Contd.)

(- denotes normal)

Case No.	URINALYSIS			
	Reaction	Chemically	Microscopically	Culture
21	Acid	-	-	Not done
22	Acid	-	-	No growth
23	Acid	-	-	Not done
24	Acid	-	-	No growth
25	Acid	-	Epithelial cells	Not done
26	Acid	-	Epithelial cells	No growth
27	Acid	-	-	No growth
28	Acid	-	-	No growth
29	Acid	-	-	No growth
30	Acid	-	-	No growth
31	Acid	-	Pus cells	Coliform Bacilli
32	Acid	-	-	No growth
33	Acid	-	-	No growth
34	Acid	-	-	No growth
35	Acid	-	-	No growth
36	Acid	-	-	No growth
37	Acid	-	-	No growth
38	Acid	-	-	No growth
39	Acid	-	-	No growth
40	Acid	-	Gram negative bacilli Pus cells	Coliform Bacilli

TABLE NO. 3. (Contd.)

(- denotes normal)

U R I N A L Y S I S				
Case No.	Reaction	Chemically	Microscopically	Culture
41	Acid	-	Pus cells Epithelial cells	Mixed growth of coliform bacilli and diphtheroids
42	Acid	-	-	No growth
43	Acid	-	-	No growth
44	Acid	-	R.B.C's Pus cells	Coliform bacilli
45	Acid	-	-	No growth
46	Acid	-	-	No growth
47	Acid	-	-	No growth
48	Acid	-	-	No growth
49	Acid	-	-	No growth
50	Acid	-	-	No growth
51	Acid	-	-	No growth
52	Acid	-	-	No growth
53	Acid	-	-	No growth
54	Acid	-	-	No growth
55	Acid	-	-	No growth
56	Acid	-	-	No growth
57	Acid	-	-	No growth
58	Acid	-	-	No growth
59	? Alk.	-	Gram negative bacilli	Growth coliform bacilli
60	Acid	-	-	No growth

TABLE NO. 3. (Contd.)

(- denotes normal)

U R I N A L Y S I S.				
Case No.	Reaction	Chemically	Microscopically	Culture
61	Acid	-	-	No growth
62	Acid	-	-	No growth
63	Acid	-	-	No growth
64	Acid	-	-	No growth
65	Acid	-	-	No growth
66	Acid	-	-	No growth
67	Acid	-	-	No growth
68	Alkaline	Albumen, blood	Pus cells R.B.C's.	Caliform bacilli
69	Acid	-	-	No growth
70	Acid	-	-	No growth
71	Acid	-	-	No growth
72	Acid	-	Pus cells	Coliform bacilli
73	Acid	-	Pus cells	Coliform bacilli
74	Acid	-	-	No growth
75	Acid	-	-	Coliform bacilli
76	Acid	-	-	No growth
77	Acid	-	-	No growth
78	Acid	-	-	No growth
79	Acid	-	-	No growth
80	Acid	-	-	No growth

TABLE NO. 3. (Contd.)

(- denotes normal)

U R I N A L Y S I S.				
Case No.	Reaction	Chemically	Microscopically	Culture
81	Acid	-	Pus cells	Coliform bacilli
82	Acid	-	-	No growth
83	Acid	-	-	No growth
84	Acid	Albumen	Epithelial cells	No growth
85	Acid	-	-	No growth
86	Acid	-	-	No growth
87	Acid	-	-	No growth
88	Acid	-	Epithelial cells	No growth
89	Acid	-	-	Streptococcus faecalis
90	Acid	-	-	No growth
91	Acid	-	-	No growth
92	Acid	-	-	No growth
93	Acid	-	-	No growth
94	Acid	-	-	No growth
95	Acid	-	-	Streptococcus faecalis
96	Acid	-	-	No growth
97	Acid	-	Pus cells	No growth
98	Acid	-	Pus cells	Coliform bacilli
99	Acid	-	-	No growth
100	Acid	-	Pus cells	Coliform bacilli

TABLE NO. 4.

(+ denotes infection)
(- denotes normality)

RADIOLOGICAL FINDINGS.			
Case No.	Sinuses	Teeth	Chest
1	-	Dentures	-
2	+	Carious teeth	-
3	-	Dentures	-
4	-	-	-
5	-	Dentures	-
6	-	Edentulous	There is fibrosis consistent with chronic bronchitis.
7	-	+	-
8	-	Dentures	-
9	-	-	-
10	+	Dentures	There is congestion at left base.
11	-	-	-
12	-	-	-
13	+	Dentures	-
14	-	-	-
15	-	Dentures	-
16	-	-	There is fibrosis due to chronic bronchitis and there is considerable emphysema in upper right zone and in left mid zone.
17	-	-	-
18	-	Dentures	-
19	+	Dentures	-
20	+	+	-

TABLE NO. 4. (Contd.)

(+ denotes infection)
(- denotes normality)

RADIOLOGICAL FINDINGS.			
Case No.	Sinuses	Teeth	Chest
21	-	Carious teeth	-
22	-	-	-
23	-	Edentulous	-
24	-	-	-
25	-	Dentures	-
26	-	-	Bronchiectasis in left base.
27	-	-	-
28	- Polyp	Dentures	-
29	-	+	-
30	+	-	-
31	-	Dentures	-
32	-	-	-
33	-	Dentures	-
34	-	-	-
35	-	-	-
36	-	-	-
37	-	-	-
38	-	Dentures	-
39	-	Dentures	-
40	-	Dentures	-

TABLE NO. 4. (Contd.)

(+ denotes infection)
(- denotes normality)

RADIOLOGICAL FINDINGS			
Case No.	Sinuses	Teeth	Chest
41	-	-	-
42	-	-	-
43	+	-	-
44	-	Carious teeth	-
45	-	-	-
46	-	-	-
47	-	-	-
48	-	Dentures	-
49	-	-	-
50	-	-	-
51	-	Dentures	-
52	+	-	-
53	-	-	-
54	+	-	-
55	-	Dentures	-
56	+	Dentures	-
57	-	-	-
58	-	Dentures	-
59	-	-	-
60	-	Dentures	-

TABLE NO. 4. (Contd.)

(+ denotes infection)
(- denotes normality)

RADIOLOGICAL FINDINGS.			
Case No.	Sinuses	Teeth	Chest
61	-	-	-
62	-	-	-
63	-	-	-
64	-	-	-
65	-	-	-
66	-	-	-
67	-	-	-
68	X-ray examination not carried out.		
69	-	Carious teeth	-
70	-	Dentures	-
71	-	-	-
72	-	-	-
73	-	Dentures	-
74	-	Dentures	-
75	-	-	-
76	+	Dentures	-
77	-	-	-
78	+	Dentures	-
79	-	-	-
80	-	-	-

TABLE NO. 4. (Contd.)

(+ denotes infection)
(- denotes normality)

RADIOLOGICAL FINDINGS.			
Case No.	Sinuses	Teeth	Chest
81	-	-	-
82	-	-	-
83	-	Dentures	-
84	+	Dentures	-
85	-	Carious teeth	-
86	-	Dentures	-
87	+	-	-
88	-	-	-
89	-	Carious teeth	-
90	-	-	-
91	-	-	-
92	-	Dentures	-
93	-	-	-
94	-	Dentures	There are chronic bronchitic changes in both lungs.
95	-	-	-
96	+	-	-
97	-	Dentures	-
98	-	Dentures	-
99	-	Dentures	-
100	+	-	-

Allerg.Hist. = Allergic History
L/eryth. = Linear erythema
Imm. R. = Immediate Response
Pr. = Primary
c = with

TABLE NO. 5.

Patient			Patient and Test-subject vaccination with		Test - subject		
					Passive transfer c 0.05 cc patient's blood serum	24 hours after passive transfer vaccination with	
Case No.	Allerg. Hist.	Duration between Pr.lesion & "ide" eruption	serous exudate 24 hrs.	normal saline 24 hrs.	Imm. R.	serous exudate Imm.R.	normal saline Imm.R.
1	Nil	11 mths	L/eryth	L/eryth	0	0	0
2	Nil	1 mth.	L/eryth	L/eryth	0	0	0
3	Nil	8 yrs.	L/eryth	L/eryth	0	0	0
4	Nil	12 yrs.	L/eryth	L/eryth	0	0	0
5	Nil	8 mths	L/eryth	L/eryth	0	0	0
6	Nil	10 yrs.	L/eryth	L/eryth	0	0	0
7	Nil	5 mths	L/eryth	L/eryth	0	0	0
8	Nil	1 mth.	L/eryth	L/eryth	transient erythema	0	0
9	Nil	2 mths	L/eryth	L/eryth	0	0	0
10	Nil	2 mths	L/eryth	L/eryth	0	0	0
11	Nil	14 mths	L/eryth	L/eryth	0	0	0
12	Nil	2 yrs.	L/eryth	L/eryth	0	0	0
13	Nil	3 yrs.	L/eryth	L/eryth	0	0	0
14	Nil	5 yrs.	L/eryth	L/eryth	0	0	0
15	Nil	2 mths	L/eryth	L/eryth	0	0	0
16	Asthma	8 yrs.	L/eryth	L/eryth	erythema-tous + wheal	0	0
17	Nil	8 yrs.	L/eryth	L/eryth	0	0	0
18	Nil	6 mths	L/eryth	L/eryth	0	0	0
19	Nil	2 mths	L/eryth	L/eryth	0	0	0
20	Nil	5 mths	L/eryth	L/eryth	0	0	0

Allerg.Hist. = Allergic History
L/eryth. = Linear erythema
Imm. R. = Immediate Response
Pr. = Primary
$\overline{c}$ = with

TABLE NO. 5. (Contd.)

Patient			Patient and Test-subject vaccination with		Test - subject		
					Passive transfer $\overline{c}$ 0.05 cc patient's blood serum	24 hours after passive transfer vaccination with	
Case No.	Allerg. Hist.	Duration between Pr.lesion & "ide" eruption	serous exudate 24 hrs.	normal saline 24 hrs.	Imm. R.	serous exudate Imm. R.	normal saline Imm.R.
21	Nil	22 yrs.	L/eryth	L/eryth	0	0	0
22	Nil	6 yrs.	L/eryth	L/eryth	0	0	0
23	Nil	2 mths	L/eryth	L/eryth	0	0	0
24	Asthma	1 yr.	L/eryth	L/eryth	0	0	0
27	Nil	2 yrs.	L/eryth	L/eryth	transient erythema	0	0
30	Nil	1 mth.	L/eryth	L/eryth	0	0	0
37	Nil	2 mths	L/eryth	L/eryth	0	0	0
39	Nil	6 mths	L/eryth	L/eryth	0	0	0
44	Nil	4 mths	L/eryth	L/eryth	0	0	0
46	Nil	6 mths	L/eryth	L/eryth	0	0	0
49	Nil	2 mths	L/eryth	L/eryth	0	0	0
50	Nil	4 mths	L/eryth	L/eryth	0	0	0
63	Nil	1 week	L/eryth	L/eryth	0	0	0
68	Nil	9 yrs.	L/eryth	L/eryth	0	0	0
73	Nil	3½ yrs.	L/eryth	L/eryth	0	0	0
76	Nil	10 yrs.	L/eryth	L/eryth	0	0	0
80	Nil	4 mths	L/eryth	L/eryth	transient erythema	0	0
81	Nil	1 mth.	L/eryth	L/eryth	0	0	0
92	Nil	3 wks.	L/eryth	L/eryth	0	0	0
94	Nil	1 mth.	L/eryth	L/eryth	0	0	0

V. DISCUSSION.

D I S C U S S I O N.

The involved and elusive nature of the "ide" eruptions, both in regard to their causation and classification, presents a problem which is fraught with many difficulties and pitfalls. The efforts which have been made to find a satisfactory and convincing explanation have proved for the most part disappointing and have left this perplexing question largely unsolved. In the discussion which follows the opinions and views expressed must therefore remain largely conjectural but, at the same time, they serve on the one hand to corroborate some of the accepted findings and, on the other, to disprove certain views which are misleading and untenable. It is proposed to discuss the subject mainly along general lines under two headings -

1) The clinical aspect

2) Observations on investigations.

1. Clinical aspects.

The possibility of a definite time factor existing between the appearance of the initial lesion and the "ide" eruption was considered but no evidence could/

could be found to support this view. The sequence of events in this series showed that the sensitisation eruptions developed in 31% of the cases within two months of the appearance of the original lesion; in 34% within two months and in 19% within six months of an efflorescence, whilst in the remaining 16% no history of any exacerbation was elicited. The "ide" eruptions were not constant in character or distribution and bore no resemblance to the primary lesions. But their predominant clinical features provided a basis for the following classification into ten different groups, three of which (Groups I, II and IV) accounted for 76% of the cases.

I. The erythematous and papulo-vesicular group.

II. The combined nummular eczematous and papulo-vesicular group.

III. The nummular eczematous group.

IV. The extensive exudative group.

V. The seborrhoeic group.

VI. The erythema-multiforme group.

VII. The urticarial group.

VIII. The psoriasiform group.

IX. The pityriasis rosea-like group.

X. The cheiropompholoid group.

I. The erythematous and papulo-vesicular group.

This type of "ide" eruption was present in 24% of the cases, 9% of which followed infectious eczematoid dermatitis whilst the remaining 15% occurred subsequent to varicose eczema or ulceration. The main features were the numerous erythematous papules and papulo-vesicles which were scattered more or less symmetrically over the trunk and limbs. The papules varied in size from a pin head to a pea; they remained discrete, often surmounted by loosely attached greyish white scales, occasionally eroded by scratching, but, as a rule, showed no tendency to grouping, eczematisation or impetiginisation. There was no residual scarring or pigmentation and the mucous membranes were not involved. The sites of election were the extensor aspects of forearms and the lumbo-sacral region of the trunk. There was no associated inguinal or axillary adenitis.

II. The combined nummular eczematous and papulo-vesicular group.

The eruption in this group consisted of numerous coin-shaped or nummular patches showing marked exudation with intervening papules and papulo-vesicles. These nummular areas were well/

well demarcated, they varied in size from ¼" to 2" in diameter and were composed of groups of papulo-vesicles which had coalesced. The majority of the lesions showed a pronounced eczematous reaction, and a few of the older lesions were heavily crusted and superficially resembled impetigo circinata but did not show the central involution of the latter. At the periphery of the patches there were often a number of papulo-vesicles while elsewhere scattered irregularly over the trunk and limbs were numerous papules and papulo-vesicles which showed a tendency to grouping, coalescence and subsequent formation of fresh circinate lesions. There was often an associated lymphadenopathy related to the crusted lesions. The eruption healed leaving no scars but there was some residual bluish red staining which persisted for three to four weeks. There were 28 cases in this group and 26 of them were secondary to a primary lesion of the infectious eczematoid dermatitic type.

III/

III. The nummular eczematous group.

This "ide" eruption closely resembled group No. II but, although the exudative coin-shaped patches were similar in appearance, there were no outlying papules or papulo-vesicles. There were 4 cases in this group which were all secondary to infectious eczematoid dermatitis. Thus, if these two groups (II and III) were considered together, they would comprise 32% of all cases and would appear to be predominantly associated with infectious eczematoid dermatitis as only 2% were were secondary to varicose eczema. This apparent disproportion is partly explained by the fact that there are only 29 cases of the latter condition as compared with 71 of infectious eczematoid dermatitis.

IV. The extensive exudative group.

In this group the epidermis was denuded from large areas of the trunk and limbs, particularly at the flexures. The exposed underlying surfaces were moist and raw with numerous blebs of serous exudate. Accompanying this desquamation of the skin/

skin was a generalised vivid erythema with numerous erythematous papules and papulo-vesicles. Pruritus was a marked feature and several long linear excoriations were present. The axillary and inguinal glands were invariably enlarged. There was no Nikolsky's sign and no case developed a generalised exfoliation. There was no scarring or pigmentation although there was a transient residual dusky reddish blue staining which persisted for approximately 4 to 6 weeks. The buccal mucosa was occasionally affected with an associated oedema of the lips, whilst several cases presented massive desquamation of the palmar skin. There were 24 cases in this group, 19 following infectious eczematoid dermatitis and 5 varicose eczema and ulceration.

V. The seborrhoeic group.

In 7 cases the initial lesion, viz - infectious eczematoid dermatitis appeared to be the "trigger action" in the production of an eruption resembling seborrhoeic eczema. The main features were greasy, scaly brownish red patches and outlying follicular papules/

papules involving the sternal and interscapular areas of the trunk. The axillae, groins and inframammary regions were involved in an exudative reaction and there was often a marked retro-auricular intertrigo but there was no evidence of marginal blepharitis. The mucous membranes were not affected and no scarring or pigmentation was observed. Several of the lesions became crusted and impetiginised and there was an associated regional lymphadenopathy.

VI. The erythema-multiforme group.

The polymorphic character of the "ide" eruptions was further illustrated by this group in which 5 cases showed erythema-multiforme-like features. The eruption was sudden in onset and consisted of circular or irregular erythematous blotches, often symmetrically distributed on the dorsal aspects of the hands and forearms. There were a few lesions on the buccal mucosa and, invariably, there was some oedema of the lips. The "target" macules of erythema iris, although

not/

not a marked or constant feature, were occasionally present on the forearms. There was no history of preceding sore throats, diarrhoea, joint pains, ingestion of drugs or pyrexial state. There was no associated adenitis or scarring but a violaceous staining persisted for some weeks over the sites of the lesions.

VII. The urticarial group.

There were 5 cases in this group and all were secondary to varicose eczema or ulceration. The eruption was characterised by an abrupt onset with an initial intense irritation followed by erythematous blotches and wheals. The lesions were irregular and asymmetrical in distribution, although the face was affected in all cases by a vivid erythema and a pronounced oedema of the lips and eyelids. The blotches and wheals were transient and rapidly disappeared following successful treatment of the primary cutaneous condition. No previous history of urticarial or other/

other allergic manifestation was elicited. In addition to this urticarial reaction, there was usually an accompanying papular erythema on the forearms and, in one case, an associated cheiropompholyx.

VIII. The psoriasiform group.

In Case No. 53, an elderly woman with a primary lesion of infectious eczematoid dermatitis, there developed an "ide" eruption which was characterised by scaling and erythematous plaques on the elbows and knees. The scales lacked the silvery appearance of those of psoriasis and on grattage no bleeding points were produced. There was no involvement of the nails or scalp and no previous psoriatic or rheumatoid arthritic history was elicited.

IX. The pityriasis rosea-like group.

This eruption developed one week after the occurrence on the right forearms of a patch of infectious eczematoid dermatitis. The lesions were not confined to the bathing trunk area but were/

were present on the face, trunk and limbs. They consisted of oval shaped, scaling pink macules, several of which showed peripheral attachment of the scales thus producing the marginal collarette appearance. The long axis of several of the oval lesions on the trunk was parallel to the ribs. There was no "herald patch," no history of sulphonamide ingestion or sore throat and, in view of the antecedent injury with a supervening eczematoid dermatitis, this exanthem was regarded as an "ide" eruption and not a coincidental pityriasis rosea.

X. The cheiropompholoid group.

Case No. 27 exhibited the typical features of cheiropompholyx, viz - small, discrete, deeply embedded vesicles which resembled boiled sago grains in the skin of the palms, the interdigital spaces and along the sides of the fingers. No other evidence of cutaneous sensitisation to the initial lesion of infectious eczematoid dermatitis was observed in this patient.

But/

But in addition to this case there was a further 20 patients in whom a pompholoid eruption of the hands and feet occurred in association with other types of sensitisation rashes.

It is interesting to note that Fox[16] (1873) who first described cheiropompholyx expressed the opinion that the condition was wholly attributable to dysfunction of the sweat glands. Later investigations by Whitfield & Sabourad[48] (1911) isolated epidermophyton from vesicular and scaly eruptions of the hands and feet. Darier[10] (1919) held that, if exogenous dermatitis were excluded, pompholyx was probably always due to a direct fungus infection, while Bloch[6] (1929) and Jadassohn[20] (1930) considered cheiropompholyx to be an epidermophytide and that the majority of cases were of fungous origin. In 1930, Williams & Dowling[44] [12] stated that most cases were produced by ringworm infections. Sulzberger & Wise[40] (1930) expressed the view that cheiropompholyx was a dermatophytide secondary to foot-ringworm. In 100 cases Rageb[36] (1934) found trichophyton in 53 and monilia in 15 cases, but McLachlan and Brown[26] in the same year commented that all Rageb's illustrations resembled typical primary ringworm rather than pompholyx.

From/

From their experience they concluded that cases of pompholyx due to fungus were uncommon as compared with those due to other causes such as foci of bacterial infection in teeth, tonsils or elsewhere, and to auto-sensitisation from trauma. Muende[29] (1934) considered that true pompholyx was never due to direct fungus infection because it was unlikely that the organism could grow so rapidly as to give rise within a few hours to a bilateral vesicular eruption. But more than 50% of his cases were associated with fungus infection elsewhere, particularly the feet.

In this series of 100 cases, there was no clinical or microscopical evidence of ringworm infection, yet 21% showed cheiropompholyx which confirms the view expressed by McLachlan & Brown[26] that cheiropompholyx is not solely due to a sweat dysfunction or essentially connected with fungus infection. Further, the association of injury with a secondary sensitisation eczema of the cheiropompholyx type supports their contention that the latter is a cutaneous reaction of the eczema group and that it may be due to auto-sensitisation following trauma.

The/

The classification of the various types of "ide" eruptions and their relation to the primary lesions are clearly shown in Table No. 6, whilst the number with associated cheiropompholyx are illustrated in Table No. 7.

TABLE NO. 6.

I.E.D. = Infectious eczematoid dermatitis
V.U.& V.E. = Varicose ulceration with eczema
V.E. = Varicose eczema
N.E. = Nummular eczema

Group No.	Type of "ide" eruption	Number of Cases	Primary Lesion		
			I.E.D.	V.U.& V.E.	V.E.
I	Papulo-vesicular	24	9	8	7
II	Combined N.E. & papulo-vesicular	28	26	2	-
III	Nummular eczematous	4	4	-	-
IV	Extensive exudative	24	19	4	1
V	Seborrhoeic	7	6	1	-
VI	Erythema multiforme	5	4	1	-
VII	Urticarial	5	-	2	3
VIII	Psoriasiform	1	1	-	-
IX	Pityriasis rosea	1	1	-	-
X	Cheiropompholyx	1	1	-	-
	TOTAL	100	71	18	11

TABLE NO. 7.

Group No.	Type of "ide" eruption	Number of Cases	Number with associated pompholyx
I	Papulo-vesicular	24	4
II	Combined N.E. & papulo-vesicular	28	1
III	Nummular eczematous	4	1
IV	Extensive exudative	24	5
V	Seborrhoeic	7	3
VI	Erythema multiforme	5	5
VII	Urticarial	5	-
VIII	Psoriasiform	1	1
IX	Pityriasis rosea	1	-
X	Cheiropompholyx	1	1
	TOTAL	100	21

In the majority of the above cases the condition commenced as a localised dermatitis or ulceration of the lower limbs. A typical history revealed evidence of an injury and within a few days or months of the appearance or exacerbation of the primary focus a secondary eruption developed on the forearms, trunk and occasionally the face. In Engman's[14] original article (1902) he attributed the fresh lesions to auto-contagion and applied the diagnosis of infectious eczematoid dermatitis to the entire eruption. Later Fordyce[15] (1911) and Sutton[41] (1920) pointed out that auto-contagion although possible in a few cases was on the whole unlikely and suggested that the secondary exanthem might be due to an anaphylactic phenomenon. Reports by Whitfield[46 & 47] (1921 & 1930), Dennie[11] (1929), Brown[7] (1939) and Smith[38] (1945) described the secondary eruptions as sensitisation reactions; they produced experimental evidence in support of this theory. It is here postulated that the abrupt onset and uneven bilateral symmetry of the secondary lesions on the covered parts disprove any suggestion of auto-contagion, while the subsidence of the generalised process concurrently with an improvement of/

of the local eruption implies a sensitisation reaction due to absorption from the original site. Despite the evidence of the above workers, however, the diagnosis of infectious eczematoid dermatitis is still applied by many to cover the entire eruption and this probably accounted for the difficulties encountered by Costello[8] (1943) in distinguishing seborrhoeic eczema from infectious eczematoid dermatitis. It appears likely that the latter condition was the primary focus with an accompanying "ide" eruption of a seborrhoeic character.

Although an attempt has been made to describe a clear cut picture for each type of "ide" eruption, it must be remembered that the clinical findings were often mixed in character and that the above classification is based on the predominant features. The closest approach noticed in the literature to the above classification is that by Brown[7] (1939) in an article entitled "Some clinical manifestations of endogenous sensitisation eruptions following local infection or injury." The following is a summarised version of the types of eruptions he encountered -

a) /

a) Sensitisation eruptions in scabies.

i) Vesicular

ii) Papular

b) Eruptions following treatment of varicose veins and ulcers.

i) Erythematous, eczematous or follicular

c) Eruptions following a primary local sensitisation dermatitis.

i) Papulo-vesicular

ii) Lichen simplex chronicus

d) Eruptions following burns.

i) Erythemato-papular

ii) Vesicular

iii) Eczematous

iv) Cheiropompholyx

e) Sensitisation eruptions in association with local bacterial infection.

i) Urticaria

ii) Erythema multiforme

iii) Psoriasiform.

Since/

Since detailed descriptions of the various sensitisation eruptions are not recorded a closer comparison between the two classifications is impossible and it is open to conjecture whether Brown's eczematous reactions are similar to those in groups II, III & IV of the present classification. It is also interesting to note that pityriasis rosea and seborrhoeic-like "ide" eruptions are not included in Brown's series.

The possibility that a particular type of primary lesion could provoke a specific "ide" eruption has been considered but the clinical evidence in this series of cases largely confirmed by Brown's, more or less disproved this theory. There is some suggestion of specificity in Table No. 6 which is difficult to explain where all urticarial cases occur following varicose eczema or ulceration. However, it is well recognised that urticaria, cheiropompholyx and erythema multiforme are caused by various endogenous and exogenous stimuli and it is considered that their presence amongst the sensitisation eruptions paradoxically suggests that the "ide" reactions are non-specific. On the other hand, the character of the secondary eruption,/

eruption, although not dependent on the type of primary lesion may be influenced by the patient's basic reaction and the therapy employed towards the original condition. But enquiry into the family and personal histories of the cases in this series has failed to reveal any supporting evidence of Koebner's isomorphic response. It is reasonable to assume, however, that a subject need not have an active cutaneous lesion to comply with Koebner's phenomenon, but that there is a latent individual diathesis, perhaps psoriasis, seborrhoea or eczema, which will appear as the dominant feature in an acquired cutaneous manifestation. A few of the cases showed that the type of reaction was influenced by treatment administered to the primary or secondary eruption. In Case No. 41, a morbilliform exanthem due to luminal therapy, was superimposed upon an already existing papulo-vesicular "ide" eruption. The sensitisation eruption in Case No. 45 was complicated by the presence of an intense erythema with a slate-like desquamation due to sulphonamide therapy, whilst in Case No. 54 there was an accompanying vesicular eruption due to Clarke's blood mixture. In Case No. 67, the predominant urticarial feature/

feature of the sensitisation eruption was almost certainly due to the application of penicillin cream to the varicose ulcer of the left leg. These were the cases in which the patient's history combined with our knowledge of a drug's characteristic sensitisation reaction supplied the key to the explanation for part of the clinical picture. It is more difficult to assess the importance of the role played by topical applications but, in view of the examples mentioned above, it is suggested that ill-timed application and ingestion of drugs, although perhaps not primary causes are contributary factors in the aetiology of many of the sensitisation eruptions.

2. Observations on investigations.

a) Haematological examination.

b) Biochemical findings.

c) Urine analysis.

d) Radiological findings of chest, sinuses and teeth.

e) Experimental vaccination with serous exudate from the primary lesion.

f) Histopathology.

a) Haematological examination.

It is interesting to note that, despite the extent and severity of the sensitisation eruption and the superadded infection as denoted by the presence of impetiginous crusts, there was a poor leucocytic response. Leucocytes are generally regarded as the mobile defences of the body, yet in this series of cases only 10% showed leucocytosis, i.e. 11,000 w.b.c. per c.m.m. or over, while on the other hand there was no case of leucopenia and thus no depression of the haemopoietic centres. The total red cell counts showed 5 males and 4 females with under 4,500,000 and 4,000,000/

4,000,000 r.b.c's per c.m.m. respectively and with corresponding low colour indices. There was no particular type of "ide" eruption associated with this microcytic anaemia which was regarded as coincidental and not as the result or cause of the secondary exanthem. The stained blood films showed no abnormal cells and the differential counts revealed no pathological disproportion between polymorphonuclears and lymphocytes. The majority of studies on the subject of pruritic dermatoses usually speak of an associated eosinophilia. Thus MacLeod & Muende[28] (1946) stated that "an increase in eosinophils is found in wide spread chronic eczematous eruptions" and Whitby & Britton[45] (1950) that "the amount of eosinophilia appears to bear some direct relation to the intensity of the infection and the extent of the skin affected." The highest eosinophil count (viz. 9%) was obtained in Case No. 27 of this series where the "ide" eruption presented as cheiropompholyx. The intensity and extent of the skin involvement in this patient was minimal compared to the other cases. There is, therefore, here no evidence to support the views of the above workers.

Generally/

Generally speaking the erythrocyte sedimentation rate is increased in all conditions where there is infection, tissue break-down or where foreign protein enters the blood stream. As the majority of the "ide" eruptions show epidermal tissue break-down and presumably some absorption of products of inflammation, it is interesting to note that 54% of the cases (31 males and 23 females) had increased sedimentation rates. These results are based on the accepted normal values -

Men	:-:	3-5 m.m. at end of first hour.
		7-15 m.m. at end of second hour.
Women and Children	:-:	4-7 m.m. at end of first hour.
		12-15 m.m. at end of second hour.

The possibility that focal infection might have influenced the sedimentation rate has been considered and investigation showed that 19 of the 54 cases had an associated dental, urinary or pulmonary infection. There was no apparent relationship between raised sedimentation rates and a particular type of sensitisation eruption, while the presence of focal infection did not appear to be a contributory factor. Table No. 8 shows the number of cases with raised sedimentation rates and foci of infection and correlates them to the various "ide" eruptions.

TABLE NO. 8.

E.S.R. = Erythrocyte sedimentation rate
N.E. = Nummular eczematous

Type of "ide" eruption	Total No. of Cases	No. with Raised E.S.R.	No. of Raised E.S.R. with associated focus of infection	Total No. with Focus of Infection
Papulo-vesicular	24	13	5	11
Combined N.E. & papulo-vesicular	28	13	8	16
Nummular eczematous	4	2	-	1
Extensive exudative	24	15	4	13
Seborrhoeic	7	5	1	1
Erythema multiforme	5	2	-	-
Urticarial	5	3	-	1
Psoriasiform	1	-	-	-
Pityriasis rosea	1	1	1	1
Cheiropompholyx	1	-	-	-
TOTAL	100	54	19	44

2. b) Biochemical findings

In eczema there is an inter and intracellular oedema of the prickle-cell layer and it is thought that any condition which leads to oedema of the skin predisposes to eczema. This view is partly confirmed by clinical evidence that oedema of the legs may be followed by eczema irrespective of whether the oedema is due to cardiac failure or varicosity of the veins. The serum proteins were estimated, therefore, in each case because it is well recognised that a reduction of their level causes oedema of the skin due to a disturbance of the balance between the osmotic and hydrostatic pressure in the blood and tissue fluids. However, perusal of Table No. 2 reveals no evidence of hypoproteinemia in this series which would indicate that protein deficiency is not a factor in the production of the "ide" eruption. It also shows that, since the majority of the cases exhibited moist weeping surfaces, the loss of tissue fluids was not sufficient to influence the serum protein concentration. These results confirm the investigations of Muleville [30] (1944) who reported no significant change in the values of the serum proteins in 15 different dermatoses/

dermatoses with the exception of pemphigus vulgaris. Previously Mulholland[31] (1943) investigated 35 cases with decubitus ulcers and showed them to be associated with hypoproteinemia, and added that the extent and depth of the ulcer seemed related to the level of the concentration of serum proteins. Again Guy[18] (1950) showed that varicose ulcers are associated with hypo-proteinemia but these findings were not substantiated by the 18 cases with varicose ulceration in this study. Other causes of oedema to be considered were cardio-vascular and renal diseases but there was no clinical evidence of the former whilst blood urea levels and urinary findings excluded the latter condition. There were 14 cases with blood urea levels above 40 mgms.%, the highest two recorded were 52 mgms.% and 63 mgms.% but there was no relationship between raised blood urea level and the accompanying type of sensitisation eruption. Finally, the calcium and cholesterol blood levels were within normal limits and obviously played no part in sensitisation eczema.

c) Urine analysis

d) Radiological/

c) Urine analysis

d) Radiological findings of chest, sinuses and teeth.

These two sub-sections are considered together because both deal with the search for foci of infection. The association between focal infection and cutaneous lesions has been recognised since 1911 when Pringle[35] recorded the development of angio-neurotic oedema due to a carious tooth. Later, Lang[24] (1913) drew attention to the presence of pyorrhoea in certain cases of acne rosacea. Although many belittle the significance of the focal infection theory, the majority accept it as a primary or contributing cause of certain cutaneous eruptions. Andrews[1] (1946) stated that "most patients with varicose eczema have infected teeth, and in patients over 50 with chronic eczema of the legs, or eczema which starts on the legs and spreads to the arms and trunk, the cause is nearly always dental infection." MacCormac[25] (1946) demonstrated a patient who was rendered pathologically sensitive to sunlight by circulating products derived from a focus of bacterial infection. When the source was eliminated by extraction of the offending carious teeth, the acquired pronounced sensitivity to sunlight ceased. These views have led to a consideration as to whether the sensitisation eruptions/

eruptions might be related to the presence of foci of infection. As distinct from the findings of Andrews[1], only 9% of the total number of cases in this series and 14% of the varicose eczema group showed dental sepsis, whilst it is interesting to note that 34% of the cases with varicose eczema had an accompanying urinary infection. A study of Tables Nos. 3 and 4 reveals that 44% of the cases had foci of infection, 14% had urinary infection and 30% had pulmonary, dental or antral sepsis, but it has not been demonstrated that their presence influenced the type of "ide" eruption. The exact relationship between the secondary exanthem and foci of infection is shown in Table No. 9. (see overleaf).

e) Experimental vaccination with serous exudate from the primary lesion.

A total of 40 cases was investigated by the vaccination technique already explained and the individual results are shown in Table No. 5. The average response appeared 12-24 hours after vaccination with serum or normal saline and consists of a linear erythema which persisted for 3 to 5 days. A similar reaction was obtained in the test-subject and, although there were occasional/

TABLE NO. 9.

N.E. - Nummular eczematous

Type of "ide" eruption	Total No.of Cases	Total No. with focus of infection	Location of focus of infection			
			Urinary	Sinus	Dental	Pulmonary
Papulo-vesicular	24	11	5	2	2	2
Combined N.E. with papulo-vesicular	28	16	4	6	3	3
Nummular eczematous	4	1	-	-	1	-
Extensive exudative	24	13	4	6	3	-
Seborrhoeic	7	1	-	1	-	-
Erythema multiforme	5	-	-	-	-	-
Urticarial	5	1	1	-	-	-
Psoriasis	1	-	-	-	-	-
Pityriasis rosea	1	1	-	1	-	-
Cheiropompholyx	1	-	-	-	-	-
TOTAL	100	44	14	16	9	5

occasional variations in the intensity of the reaction, no apparent significance could be attached to such differences. It is interesting to note in certain cases, e.g. Nos. 3, 14, 15, 19, 37, 49, 52, 60, 97 & 98 that no cutaneous irritation was provoked by the serum which trickled on to the normal skin, whilst on the other hand in Case No. 91 there was a linear arrangement of vesicles in an excoriation. It is not clear for what reason the present experiments failed to produce eczematous reactions except that the contact with the irritant or antigen should be more intimate than a mere single scratch and that many such vaccinations may be required. The linear erythema obtained from all scratch tests are probably due to the trauma inflicted by the needle. Several other workers including Dowling[13], Templeton, Lunsford and Allington[43] have also failed to corroborate Whitfield's[47] findings, but most are in agreement with his auto-sensitisation theory which seems a satisfactory ex - planation for a clinical entity which is familiar to all dermatologists.

The exacerbation of the primary focus followed by the secondary exanthem suggested absorption into the blood stream and the possibility of circulating anti-bodies. The/

The Prausnitz-Kuestner[34] (1921) test has been used as the basis of experiments in the study of the antigen-antibody reaction. The same 40 cases were subjected to the following experiment - 0.05 c.c. of the patient's blood serum was injected intracutaneously into a test-subject and the immediate response noted, whilst 24 hours later a drop of serous exudate from the primary lesion and a drop of normal saline as a control were introduced to the injection site by the scratch technique. The individual results are shown in Table No. 5. and the immediate reactions were observed to be negative except in cases Nos. 8, 16, 27 and 80. About 12-24 hours after vaccination a linear erythema surrounded the scratch mark and persisted for 3 to 5 days depending on the trauma inflicted by the needle. Thus the absence of any positive reactions to these tests tended to rule out the possibility of circulating antibodies in sensitisation eczema. These results are in agreement with those of Sulzberger[39] (1933) who stated that in his experience no patients with only eczematous reactions possessed anti-bodies, unless they also gave the immediate wheal type of reaction to intracutaneous tests. He believed that probably/

probably all of the reported cases of positive transmission of sensitivity in eczema-patients were due to the accompanying presence of the urticarial type of reactivity. In case No. 16 the asthmatic background probably explained the wheal obtained in the Prausnitz-Kuestner test but there was no apparent explanation for the transient erythematous blush recorded in cases Nos. 8, 27 and 80.

Thus this series of results did not confirm Engman's[14] theory of auto-contagion or that of Whitfield's[47] auto-sensitisation whilst the negative Prausnitz-Kuestner reactions suggested the absence of circulating antibodies. Engman's[14] designation of infectious eczematoid dermatitis appears to be a misnomer because in addition to the failure of the present vaccination experiments, not one of the 100 patients gave evidence of contagion to a third party, which rules out the infectious part of the title. It is agreed that superficial infection accompanies the primary lesion and in the presence of a secondary eruption it is suggested that the term infective dermatitis with an "ide" or sensitisation eruption would be more correct. This title could be further qualified by stating the site of the initial lesion and the type of sensitisation, e.g. infective/

infective dermatitis of the right leg with a nummular "ide" eruption. The basis of such a nomenclature agrees with Whitfield's[47] hypothesis and although the present experiments failed to corroborate his theory, the opinion is advanced that the auto-sensitisation phenomenon is a satisfactory explanation for the above sequence of events.

f) Histopathology.

Seventeen patients granted me permission to perform biopsies of the primary lesion and of the accompanying "ide" eruption. The sections, thirty of which are available in appendix B were stained with haematoxylin and eosin; they are representative of five different sensitisation groups, viz. 3 from erythematous papulo-vesicular, 4 from the combined nummular eczematous erythematous papulo-vesicular, 3 from the nummular eczematous, 2 from cheiropompholyx and 5 from the extensive exudative groups.

The usual histological picture of the initial lesion showed the epidermis to be moderately acanthotic with a slight degree of parakeratosis. The epidermis was/

was infiltrated with polymorphonuclears and lymphocytes whilst there were small areas of oedema amounting to vesiculation. The papillary layer of the corium was slightly oedematous and there was usually an accompanying vascular dilatation with perivascular round cell infiltration. The sections from the secondary eruptions showed a somewhat similar eczematous picture but variations occasionally occurred depending on the type of sensitisation, e.g. the extensive exudative group showed denudation of the superficial epithelial layer. The dermis showed vascular dilatation with round cell infiltration although to a lesser degree than in the initial lesion, but in cases Nos. 2 and 12, the reaction was more marked in the corium of the secondary eruption than in the original lesion. The reaction in these two cases suggested a dermal sensitivity whereas in case No. 14 the corium was apparently normal which indicates an epidermal sensitivity. Recently Kalkoff (1948)[21] fashioned islands of the skin in guinea pigs by deep incisions and demonstrated that a spreading eczema was not halted by the complete divisions. This view that the spread of eczema is not entirely intradermal is supported by the changes/

changes noted in the corium of the majority of the sections.

From a general study of the material available, no more specific diagnosis than acute or sub-acute dermatitis could be made since the various types of sensitisation eruptions did not appear to present a histological picture sufficiently diagnostic to allow of their further differentiation.

VI. SUMMARY.

S U M M A R Y.

One hundred cases of sensitisation eruptions following infectious eczematoid dermatitis, varicose eczema and ulceration are described and classified according to their clinical features into one of ten different groups.

The literature on the subject is reviewed and only one previous attempt (Brown[7], 1939) to record a classification is noticed. The majority of observers are agreed that the sensitisation eruption is due to an absorbed allergen from the original lesion.

The associated haematological and bio-chemical findings are within normal limits except that in 54% of cases there is an increased erythrocyte sedimentation rate. A total of 44% show an accompanying focus of infection which does not appear to influence the type of sensitisation eruption.

Vaccination with serous exudate from the primary eruption fails to produce a specific reaction and the failure to demonstrate antibodies agrees with many previous workers. Whitfield's auto-sensitisation phenomenon/

phenomenon, although not corroborated, is accepted as a satisfactory explanation for the appearance of the secondary eruption.

Finally, the clinical classification is not confirmed by the histopathology which reveals a non-specific picture of acute or sub-acute dermatitis.

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The investigations of this thesis were conducted in the wards of Dr. A.D. McLachlan at Stobhill Hospital, Glasgow. The research owes its initiation to Drs. A.D. McLachlan and A. Girdwood Fergusson and I should like to express my thanks for their encouragement and helpful suggestions which have been greatly appreciated.

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APPENDIX A.

CASE RECORDS.

CASE RECORDS.

The sensitisation or "ide" eruptions which are described in the following case records were classified by the writer into the various groups as shown below in Table No. 10.

N.E. = Nummular eczema.

Type of "ide" eruption	Case Numbers.
Papulo-vesicular	12; 18; 20; 21; 25; 26; 36; 39; 40; 42; 45; 58; 66; 68; 70; 72: 73; 74; 75; 76; 77; 79; 80; 82.
Combined N.E. & papulo-vesicular	2; 10; 13; 14; 15; 16; 17; 24; 38; 41; 46; 47; 49; 50; 52; 54; 55; 62; 69; 71; 81; 86; 87; 89; 91; 93; 94; 95.
Nummular eczematous	3; 7; 11; 60.
Extensive exudative	1; 4; 5; 6; 8; 19; 23; 29; 30; 31; 37; 43; 44; 48; 78; 83; 84; 85; 90; 92; 97; 98; 99; 100.
Seborrhoeic	9; 22; 35; 51; 56; 61; 88.
Erythema multiforme	28; 32; 63; 64; 65.
Urticaria	33; 34; 57; 59; 67.
Psoriasiform	53.
Pityriasis rosea	96.
Cheiropompholyx	27.

CASE NO. 1.

J.C. a married man, aged 48 years, was admitted to Stobhill Hospital on 30.4.48 with a diagnosis of infectious eczematoid dermatitis of the right leg and a sensitisation eruption on the trunk and arms.

General History.

1. Previous illnesses: Measles in childhood.
2. Family history: Nothing relevant.
3. Personal history: Employed as a labourer.
4. Allergic history: No family or personal history of allergic manifestations.

Immediate History.

The patient was fit and well until May 1947 when he developed furunculosis of his arms, legs and nape of the neck. There was no associated glycosuria and the condition responded to local therapy except for some residual erythema over the right medial malleolus. This patch remained localised until January 1948 when it gradually extended to involve the lower half of his right leg. Pruritus of the part became marked and as a result of scratching, the lesion became exudative/

exudative and later crusted. About two months later, numerous eczematous pruritic patches appeared on the arms and, within a week, the thighs and trunk were similarly affected. With the onset of this secondary eruption he was admitted on 30.4.48 to Stobhill Hospital.

Examination on admission.

The patient was a well nourished, middle-aged man. On the antero-medial aspect of the right leg there was a well demarcated area of infectious eczematoid dermatitis.

The sensitisation eruption was exudative in character on the limbs and papulo-vesicular on the trunk. The predominant lesions were numerous, ill-defined, moist eczematous patches (1" x $\frac{3}{4}$") on the extensor surfaces of his forearms and the anterior aspects of the thighs, whilst the epidermis was denuded from the flexures particularly at the popliteal and antecubital fossae. There were a few discrete vesicles and numerous papulo-vesicles scattered asymmetrically on the trunk and volar aspects of the forearms. There was a well marked folliculitis of the medial aspects of the thighs accompanied by a painful inguinal adenitis.

CASE NO. 2.

H.C. a married man, aged 48 years, was admitted to Stobhill Hospital on 14.5.48 with a diagnosis of infectious eczematoid dermatitis of the right leg and a sensitisation eruption on the trunk and limbs.

General History.

1. Previous illnesses: Measles, whooping cough in childhood. Left sided nephrectomy following an injury 1923. Appendicectomy 1936.
2. Family history: Nothing relevant.
3. Personal history: Employed as a docker.
4. Allergic history: No family or personal history of allergic manifestations.

Immediate History.

The patient was fit and well until February 1948 when an injury caused a laceration of his right mid-leg. Before the wound had completely healed another injury reopened it and, within a few days, the skin surrounding the lesion became eczematised. A week later, numerous pruritic papules appeared on the legs and forearms. Subsequent scratching produced moist eczematous patches which varied in size from $\frac{3}{4}$" to 2" in/

in diameter. The eruption did not respond to topical treatment and he was admitted to Stobhill Hospital.

Examination on admission.

The patient was a well nourished, middle-aged man. On the anterior aspect of the right mid-leg there was a well defined area of infectious eczematoid dermatitis.

The sensitisation eruption consisted of numerous, nummular moist eczematous patches on the forearms, thighs and left leg. A few discrete erythematous papules were present on the periphery of the patches which were composed of aggregations of small papules and papulo-vesicles, whilst a few of the older lesions were covered with yellowish brown adherent crusts. Across the lumbar region and extending up the posterior-axillary lines, there was a horse-shoe shaped pattern of minute erythematous papules. The inguinal and axillary glands were not enlarged.

CASE NO. 3.

R.M. a married man, aged 45 years, was admitted to Stobhill Hospital on 1.5.48 with a diagnosis of infectious eczematoid dermatitis of the legs and a sensitisation eruption on the forearms.

General History.

1. Previous illnesses: Scarlet fever in childhood.
2. Family history: Father had varicose eczema for many years.
3. Personal history: Employed as a steel-marker in an engineering shop.
4. Allergic history: No family or personal history of allergic manifestations.

Immediate History.

The patient was fit and well until April 1940, when he developed an erythematous pruritic patch on the lateral aspect of his left knee. No history of trauma or local irritant was elicited. Within a few weeks numerous similar lesions appeared on both legs which rapidly became eczematised, probably as a result of scratching. The lesions coalesced and soon this exudative eruption had encircled both legs. He was referred to the out-patient department of the Glasgow Royal Infirmary where he received local treatment.

The/

The condition cleared completely except for some residual erythema of the left lateral malleolus. In October 1947, this erythematous area became eczematised and by peripheral extension involved the lower third of the left leg. The eruption remained localised to the left leg until April 1948 when eczematous lesions occurred on the forearms and he was admitted to Stobhill Hospital.

Examination on admission.

The patient was a well nourished, middle-aged man. There was an area of infectious eczematoid dermatitis on the stocking distribution of the left leg and a similar smaller patch on the anterior aspect of the right leg.

The sensitisation eruption was present on the extensor aspects of the forearms and consisted of nummular eczematous patches which were well demarcated and varied in size from a sixpence to a florin. The lesions were composed of aggregations of papules and papulo-vesicles, and several of them were covered with honey coloured crusts which appeared "stuck-on" as in impetigo/

impetigo contagiosa. The skin between the exudative patches was normal and showed no evidence of irritation despite a purulent discharge which escaped from a few of the lesions. There was an associated axillary adenitis.

CASE NO. 4.

D.K. a married man, aged 74 years, was admitted to Stobhill Hospital on 17.5.48 with a diagnosis of infectious eczematoid dermatitis of the legs and a sensitisation eruption on the body and arms.

General History.

1. Previous illnesses: Operation 1925 for perforated duodenal ulcer.
2. Family history: Nothing relevant.
3. Personal history: Employed as labourer.
4. Allergic history: No family or personal history of allergic manifestations.

Immediate History.

The patient was fit and well until May 1936, when he sustained a slight laceration of the left medial malleolus./

malleolus. The wound healed slowly leaving an erythematous patch which remained quiescent for two years. But, in June 1938, following a trivial injury, an eczematous reaction developed on the lower third of his left leg. The condition responded to treatment but, a few months later, there was a recurrence of the eczema on both legs which again improved with local therapy. These remissions and exacerbations continued periodically until May '48 when, following an acute exacerbation of eczema on the legs, the trunk and forearms were affected and he was admitted to Stobhill Hospital.

Examination on admission.

The patient was a well nourished old man. There were areas of infectious eczematoid dermatitis encircling both legs from the knees to the ankle regions. Oedema of the ankles was very pronounced.

The sensitisation eruption was mixed in character; the forearms, thighs and scrotal regions were markedly eczematous, while a dry, scaling vivid erythema was present on the face, neck and trunk. The epidermis was denuded from the forearms, thighs and scrotum leaving a moist, raw surface from which oozed a yellowish coloured/

coloured serous exudate. A diffuse, brick-red erythema covered the face and trunk, whilst the palms and soles of the feet exhibited a glove-like desquamation. A painful inguinal axillary adenitis was present.

CASE NO. 5.

J.S. a married man, aged 49 years, was admitted to Stobhill Hospital on 28.5.48 with a diagnosis of infectious eczematoid dermatitis of the legs and a sensitisation eruption on the trunk and arms.

General History.

1. Previous illnesses: Measles in childhood.

1921 ... Notified as pulmonary tuberculosis - treated in Knightswood Hospital.

1933 ... Pulmonary tuberculosis - Stobhill Hospital.

1938 ... Deafness - as a result of chronic otitis media.

1947 ... Eczema of the trunk and legs - Glasgow Royal Infirmary.

2. Family history: Nothing relevant.

3./

3. Personal history: Employed as a storeman in the Royal Navy Depot.

4. Allergic history: No family or personal history of allergic manifestations.

Immediate History.

The patient remained well, dermatologically, until March 1947, when he noticed a small scratch on the dorsum of the left foot which rapidly became erythematous and pruritic. No definite history of injury to the foot was elicited. As a result of applying various forms of ointments, the condition deteriorated and spread to involve the lower one third of his leg. This patch of eczematisation remained relatively quiescent until December 1947 when, following an acute exacerbation with generalised sensitisation of the trunk, forearms and legs, he was admitted to The Royal Infirmary, Glasgow. The condition responded to treatment and he was discharged on 7.3.48. One month later, numerous small erythematous papules appeared on the shoulders and, within a few days, numerous ill-defined erythematous lesions appeared on both the thighs, legs and arms, the latter rapidly became exudative. About forty-eight hours before admission to Stobhill Hospital/

Hospital, many closely set superficial vesicles suddenly appeared on the palms and soles of his feet.

He has been troubled with a cough for many years and recently has noticed increasing breathlessness on exertion.

Examination on admission.

The patient was a middle-aged man of average build and nutrition. On the antero-lateral aspects of both lower legs there were extensive, well demarcated areas of infectious eczematoid dermatitis.

The sensitisation eruption was mixed in character; the predominant features were irregularly-shaped, ill-defined, moist eczematous patches on the arms and thighs, whereas on the trunk the lesions were mainly vesicular and closely resembled those of varicella. There was a typical pompholyx affecting the hands and feet.

Respiratory System.

The chest moved freely and equally on each side. The percussion note was resonant throughout, the R.M. was vesicular with a few sibilant rhonci and sticky rales at both bases.

CASE NO. 6.

R.S. a married man, aged 65 years, was admitted to Stobhill Hospital on 12.7.48 with a diagnosis of infectious eczematoid dermatitis of the legs and a sensitisation eruption on the trunk and arms.

General History.

1. Previous illnesses: Measles in childhood.
   1922 ... Pneumonia.
   1946 ... Herpes Zoster.
2. Family history: Nothing relevant.
3. Personal history: Employed as a boiler fireman.
4. Allergic history: No family or personal history of allergic manifestations.

Intermediate History.

The patient was fit and well until the winter of 1938 when a vivid erythema appeared on the front of both legs. The patient attributed the erythema to his employment as a boiler fireman and volunteered the information that occasionally, for no apparent cause, the legs became moist and raw but readily healed with local applications of calamine lotion. For a period of years there were repeated exacerbations and remissions of the/

the eczematous reaction of the legs. In July 1947, an acute exacerbation was attributed to the heat from the fires and when he stopped work a transient improvement was noticed, but soon the pruritic eczematisation reappeared on his legs. Despite frequent topical treatment, the condition persisted and, about three weeks before admission to Stobhill Hospital in July 1948, numerous erythematous pruritic papules developed on the face, arms and trunk.

Examination on admission.

The patient was an elderly, thinly-built man of sallow complexion. There were well defined areas of infectious eczematoid dermatitis on both legs extending from the knees to his toes. A painful inguinal adenitis was also present.

The sensitisation eruption was mixed in character; the predominant lesions were the scaly erythematous papules on the face, trunk and extensor surfaces of arms, whilst the flexures of the limbs were moist and raw. On the face and trunk the lesions were discrete except at the peri-umbilical region where the papules/

papules were grouped together and formed an erythematous plaque. The extensor aspects of the forearms were completely covered with numerous, closely-set, scaly papules. The epidermis was denuded from the scrotum, neck and flexures of the limbs leaving moist raw areas. A typical well marked cheiropompholyx was also present.

CASE NO. 7.

M.W. a married man, aged 39 years, was admitted to Stobhill Hospital on 13.7.48 with a diagnosis of infectious eczematoid dermatitis of the right leg and a sensitisation eruption on the arms.

General History.

1. Previous illnesses: Measles and mumps in childhood. Multiple injuries to legs and jaw following a motor cycle accident.
2. Family history: Nothing relevant.
3. Personal history: Employed as a boiler fireman.
4. Allergic history: No family or personal history of allergic manifestations.

Immediate History./

Immediate History.

The patient was fit and well until February 1948 when new footwear produced an erythema of the dorsum of the right foot. He applied various proprietary ointments and, within a few weeks, marked eczematisation occurred. A few days later, a pruritic patch of eczema appeared on the lower third of the left leg. After treatment by his doctor, a dry scaling erythema developed on both legs. This condition persisted until July '48 when the lower third of legs suddenly became eczematised and, within one week, erythematous papules appeared on the back, forearms and hands.

Examination on admission.

The patient was a well developed, young man, with marked pityriasis capitis and a seborrhoeide eruption on the sternum and interscapular region. On the anterior aspect of the lower third of both legs there were well demarcated areas of infectious eczematoid dermatitis.

The sensitisation eruption consisted of nummular patches of eczema on the forearms and dorsal aspects/

aspects of the hands. These lesions were the size of a shilling, well defined, and the majority of them were exudative in character while the remainder were heavily crusted. The crusts were brownish yellow in colour and so adherent that, on their removal, moist bleeding surfaces were exposed. The circinate patches were composed of closely set papules and papulo-vesicles and there was no evidence of any intervening, discretely scattered, individual lesions. There was no involvement of the inguinal and axillary glands.

CASE NO. 8.

T.M. a married man, aged 64 years, was admitted to Stobhill Hospital on 16.7.48 with a diagnosis of infectious eczematoid dermatitis of the legs and a sensitisation eruption on the trunk, neck and arms.

General History.

1. Previous illnesses: Diphtheria in childhood.
2. Family history: Nothing relevant.
3. Personal history: Employed as a bricklayer's labourer.

4./

4. Allergic history: No family or personal history of allergic manifestations.

Immediate History.

The patient was fit and well until March '47, when in the course of his employment, he sustained a laceration of the dorsum of his right hand. Injudicious scrubbing with soap and water produced an erythematous pruritic patch which rapidly became moist and raw. The eczematous process quickly spread to involve the hands, wrists and forearms, and he was admitted to the Glasgow Southern General Hospital on 24.4.47. He was discharged well on 1.7.47 but further exacerbations on arms and legs required hospitalisation from 29.7.47 to 30.8.47, and again from 22.9.47 to 20.12.47. The condition remained quiescent and he continued at work until June '48 when, subsequent to a slight injury of his right leg, an erythematous area appeared on the anterior aspect of lower mid-leg. Within a week eczematous patches had appeared on his forearms, legs, trunk and face, and he was admitted to Stobhill Hospital on 16.7.48.

Examination on admission./

Examination on admission.

The patient was an elderly, thick-set, well nourished man with a vivid erythema of body, limbs and face; the redness of the latter was accentuated by his silvery white hair.

On the anterior and posterior aspect of both legs there were areas of infectious eczematoid dermatitis. There was also a painless inguinal adenitis.

The sensitisation eruption was predominantly exudative in character and occurred as a widespread eczematous reaction on the trunk, neck and forearms. On the trunk there was a diffuse denudement of the epidermis, particularly at the axillae and groins. Nikolsky's sign was not elicited and the intervening skin between the exudative areas appeared normal. The neck and flexures of the upper limbs were markedly eczematous and appeared bathed in serous exudate, while on the forearms there were numerous erythematous papulo-vesicles. The ankles and, to a lesser degree, the dorsa of his hands exhibited pitting oedema. There was a massive desquamation of the palmar skin.

CASE NO. 9./

CASE NO. 9.

J.S. a married man, aged 22 years, was admitted to Stobhill Hospital on 28.7.48 with a diagnosis of infectious eczematoid dermatitis of the legs and a sensitisation eruption of the face and forearms.

General History.

1. Previous illnesses: Measles and tonsillectomy in childhood. Repeated attacks of seborrhoeic dermatitis.
2. Family history: Nothing relevant.
3. Personal history: Released from Army in February '48 and employed as a labourer.
4. Allergic history: No family or personal history of allergic manifestations.

Immediate History.

The patient was well until May '48 when hyperhidrosis of the feet became marked and, a few days later, a number of vesicles appeared on the soles. He remained ambulant and friction ruptured the vesicles producing ill defined, moist, eczematous areas on the soles of the feet. He was referred to the out-patient department/

department of Glasgow Victoria Infirmary, where local treatment soon cleared the condition. In the hot weather of July '48, the perspiration of his feet became more pronounced and with the friction of new footwear, a further relapse occurred. The soles of his feet rapidly became eczematised and peripheral extension of the lesions involved the dorsal aspects of the feet and the lower half of both legs. A week later, the face became erythematous with marked periorbital oedema and numerous pruritic papules appeared on the extensor aspects of the forearms, while deep seated vesicles developed on the palms. The condition did not respond to treatment and he was admitted to Stobhill Hospital.

Examination on admission.

The patient was a well nourished, young man with pityriasis capitis and a greasy, scaling erythema of the nasolabial folds and seborrhoeide patches on the sternum and interscapular area. His eyes were closed due to the oedema of the periorbital tissues.

There were areas of infectious eczematoid dermatitis encircling the lower half of both legs.

The/

The sensitisation reaction consisted mainly of an erythematous papulo-vesicular eruption on the face, forearms and trunk. Several discrete follicular papules were scattered over the trunk, while in the axillae there were discoid macules of a reddish-yellow colour. Cheiropompholyx was a prominent feature with a few large, superficial thin-walled pustular bullae on the thenar eminces.

CASE NO. 10.

J.G. a widower, aged 67 years, was admitted to Stobhill Hospital on 30.7.48 with infectious eczematoid dermatitis of the left leg and a sensitisation eruption on the right leg, forearms and trunk.

General History./

General History.

1. Previous illnesses: Measles, mumps in childhood.

   1915 Appendicectomy - Royal Infirmary, Manchester.

2. Family history: Nothing relevant.

3. Personal history: A retired sea-man.

4. Allergic history: No family or personal history of allergic manifestations.

Immediate History.

The patient remained well until May '48 when, for no apparent reason, he developed an erythematous patch on the left medial malleolus. Pruritus of the part became unbearable and scratching resulted in eczematisation of the lesion. Despite local treatment, the condition extended on to the dorsum of his left foot and in July '48 numerous small patches of eczema appeared on his right leg. Later, erythematous papules appeared on the forearms, while vesicles developed on the palms and fingers and he was admitted to Stobhill Hospital.

Examination on admission.

The patient was a well nourished, old man.

On/

On the dorsum of the right foot there was a well demarcated area of infectious eczematoid dermatitis.

The sensitisation eruption consisted of vesicles, papules and pustules scattered all over the forearms. On the trunk, particularly the buttocks and lumbo-sacral regions, there were numerous erythematous papules. Patches of nummular eczema ($\frac{1}{2}$" diameter) were present on the front of his right leg and on the dorsal aspects of both forearms. Cheiropompholyx was a prominent feature. There was no associated inguinal or axillary adenitis.

Cardio-Vascular System:

The pulse was regular in rhythm and of average rate. The vessel walls were palpable. B.P. 162/116. The apex beat was visible in the 6th interspace, five inches from mid-sternal line. Heart sounds were distant with a soft systolic murmur at apex.

CASE NO. 11./

CASE NO. 11.

J. McK. a married man, aged 60 years, was admitted to Stobhill Hospital on 30.7.48 with a diagnosis of infectious eczematoid dermatitis of the legs and a sensitisation eruption on the forearms.

General History.

1. Previous illnesses: 1943 .. Pleurisy. Stobhill Hospital.
2. Family history: Nothing relevant.
3. Personal history: Retired, recently employed as a "sweeper" in a furnace room.
4. Allergic history: No family or personal history of allergic manifestations.

Immediate History.

The patient was well until May '47 when he sustained a slight injury to the front of both legs. The lacerations failed to heal and pruritic eczematous patches appeared on his lower legs. The condition responded quickly to treatment and he remained well until January '48 when the eczematous process reappeared over both malleoli. No definite history of injury was associated with this recurrence. Local treatment healed/

healed the eruption but further exacerbations on the same site occurred with increasing frequency. In July '48 an acute exacerbation of the eczematous lesions on his legs was accompanied with pruritic patches on forearms and he was admitted on 30.7.48 to Stobhill Hospital.

Examination on admission.

The patient was a well nourished elderly man.

On the lower third of the left leg and lower two-thirds of his right leg, there were well defined areas of infectious eczematoid dermatitis.

The sensitisation eruption was present on the extensor aspects of the forearms and characterised by patches of nummular eczema. A few of the lesions were crusted, whilst the majority showed aggregations of eroded papules and papulo-vesicles. The skin between the patches was normal except for a number of excoriations but there was no evidence of any linear arrangement of the individual lesions. The axillary glands were not enlarged.

CASE NO. 12.

M.S. a married man, aged 39 years, was admitted to Stobhill Hospital on 8.10.48 with a diagnosis of infectious eczematoid dermatitis of the left leg and a sensitisation eruption on the forearms.

General History.

1. Previous illnesses: Measles in childhood.
2. Family history: Nothing relevant.
3. Personal history: Employed as a radio-engineer.
4. Allergic history: No family or personal history of allergic manifestations.

Immediate History.

The patient was fit and well until June 1946 when he developed a thin-walled vesicle on the sole of the left foot. Friction ruptured the blister and a raw moist area was produced which gradually extended to involve the entire sole of his foot, but local treatment with an aqueous solution of gentian violet cleared the condition. An exacerbation in June '47 was successfully treated by/

by the same therapy. In May '48, a group of vesicles appeared over the head of first metatarsal and soon the sole of his left foot became eczematous. Despite treatment the condition deteriorated and gradually extended to involve the dorsum of his foot and lower half of his leg. In August '48, a number of erythematous pruritic papules appeared on the forearms and, later, deep seated vesicles developed on the palms. The eruption did not respond to treatment and on 8.10.48 he was admitted to Stobhill Hospital.

Examination on admission.

The patient was a thin young man with marked pityriasis capitis and an associated seborrhoeide on the front of the sternum.

There was a well demarcated area of infectious eczematoid dermatitis involving the dorsum of the left foot and lower half of the leg. There was slight oedema of the ankles.

The sensitisation eruption consisted of numerous erythematous papules which were more or less symmetrically distributed on the forearms. The/

The papules varied in size from a pin head to a pea; they remained discrete and were often surmounted by loosely attached, greyish white scales. The extensor aspects were more extensively involved than the volar surfaces of his forearms. A few discrete pustules were studded over the upper limbs and on the palms there was a well marked cheiropompholyx. There was no axillary adenitis.

CASE NO. 13.

J.M. a married man, aged 57 years, was admitted to Stobhill Hospital on 29.10.48 with a diagnosis of infectious eczematoid dermatitis of the left leg and a sensitisation eruption on the forearms and right leg.

General History.

1. Previous illnesses: Measles, mumps, whooping cough, chicken pox in childhood.
2. Family history: Nothing relevant.
3. Personal history: Employed as a gardener's labourer.

4./

4. Allergic history: No family or personal history of allergic manifestations.

Immediate History.

The patient remained well until September '45 when he sustained a laceration on the middle third of the left leg. The wound failed to heal and the surrounding area became eczematous in character and the eruption gradually extended downwards to encircle the lower half of his leg. After six months local treatment, the leg healed completely and he remained well for three years. In June '48, a trivial accident resulted in an abrasion of the left medial malleolus and this area soon became eczematous. The lower half of his leg was rapidly involved by peripheral extension of the exudative process, and he was referred to the out-patient department of Stobhill Hospital. The condition did not respond to treatment and, as fresh lesions were now appearing on the right leg, he was admitted to Stobhill Hospital.

Examination on admission.

The patient was a well nourished man who looked much younger than his 57 years.

There/

There was a well defined area of infectious eczematoid dermatitis of the left leg extending from the knee to the dorsum of his foot. There was oedema of the left ankle.

The sensitisation eruption was exudative in character on the right leg and predominantly papular on the forearms. On the antero-medial aspect of the lower third of the right leg there were well demarcated nummular eczematous patches (1" diameter). The majority of them revealed moist, raw, weeping surfaces whilst a few were covered with "pancake" crusts of a yellowish brown colour. At the periphery of the lesions and on the extensor aspects of the forearms, there were numerous erythematous papules and papulo-vesicles. A few of the papules were crowned with loosely-attached greyish white scales. The inguinal glands were enlarged but not painful.

CASE NO. 14./

CASE NO. 14.

J.M. a married man, aged 24 years, was admitted to Stobhill Hospital on 22.10.48 with a diagnosis of infectious eczematoid dermatitis of the left leg and a sensitisation eruption of the forearms and right leg.

General History.

1. Previous illnesses: Measles, mumps, chicken pox and scarlet fever in childhood.
2. Family history: Nothing relevant.
3. Personal history: Employed as a labourer.
4. Allergic history: No family or personal history of allergic manifestations.

Immediate History.

In October '43, the patient was serving in the Royal Navy when an eczematous patch appeared on the medial aspect of the left calf, which was attributed to the chafing of his trousers. An occlusive dressing was applied and the eruption disappeared. However, during the next few years exacerbations and remissions occurred frequently. In February '48, an unusually acute exacerbation of/

of the eczematous process on his left leg was accompanied by inguinal adenitis and he was referred to the out-patient department of the Royal Infirmary, Glasgow. He received a week's course of 25 gms of sulphanilamide and the adenitis subsided. For the next few months the eczematous patch on the leg was most resistant to treatment and the patient finally resumed work against medical advice. In the course of his employment, the friction of rubber boots produced a severe exudative reaction of the lesion which rapidly extended to involve the whole of his left leg. Within a few days, fresh eczematous patches appeared on his right leg and a pruritic erythema occurred on the forearms. The involvement of the forearms forced him to stop work and he was admitted to Stobhill Hospital.

Examination on admission.

The patient was a well nourished young man with a few crusted impetiginous lesions on the chin.

On the medial aspect of the lower two thirds of the left leg there was an area of infectious eczematoid dermatitis.

The sensitisation eruption on the right leg consisted of shilling-sized patches of nummular eczema composed of numerous closely-set papules and papulo-vesicles. A number of the lesions were heavily crusted and, from some, a purulent discharge trickled on to the normal skin and produced no local irritation. On both forearms there were numerous erythematous papules and papulo-vesicles, several of which showed a tendency to coalescence with the ultimate formation of circinate patches. There was a mild folliculitis of the forearms and thighs with an associated axillary and inguinal adenitis.

CASE NO. 15.

D.W. a married man, aged 50 years, was admitted to Stobhill Hospital on 22.10.48 with a diagnosis of infectious eczematoid dermatitis of the left leg and a sensitisation eruption on the right arm, face and right leg.

General History./

General History.

1. Previous illnesses:

1918 ... Gunshot wound resulted in amputation of left forearm.

1940 ... Cholecystectomy, Glasgow Western Infirmary.

2. Family history: Nothing relevant.

3. Personal history: Employed as a telephonist.

4. Allergic history: No family or personal history of allergic manifestations.

Immediate History.

The patient was well until July '48, when he sustained a second degree burn of the dorsum of his left foot which rapidly became eczematised. The condition slowly healed and he resumed work in September '48. A few weeks later the left foot became itchy and the exudative reaction recurred and, within a few days, the face and ears were similarly involved. The facial eruption cleared rapidly under local treatment but his leg and ears proved resistant to therapy. One week before admission to Stobhill Hospital, numerous patches of nummular eczema/

eczema appeared on the legs and right forearm.

Examination on admission.

The patient was a thin man who appeared older than his fifty years.

On the dorsum of the left foot there was a well demarcated patch of infectious eczematoid dermatitis.

The sensitisation eruption consisted mainly of patches of nummular eczema on the legs and right forearm. A few of the lesions were crusted with beads of pus-like exudate escaping from under the crusts but there was no evidence of cutaneous irritation due to this exudate. On the face, right forearm and between the circinate lesions, there were a few erythematous papules whilst on the ears a few crusted impetiginous lesions were present. The inguinal and right axillary glands were enlarged but not painful.

CASE NO. 16./

CASE NO. 16.

W. McH. a married man, aged 59 years, was admitted to Stobhill Hospital on 23.10.48 with a diagnosis of infectious eczematoid dermatitis of the legs and a sensitisation eruption on the forearms.

General History.

1. Previous illnesses: Scarlet fever in childhood.
   1926 ... Pneumonia.
   1926 - 32 Frequent attacks of asthma.
2. Family history: Mother suffered from asthma.
3. Personal history: Employed as a joiner.
4. Allergic history: After pneumonia in 1926, the patient suffered from frequent attacks of asthma. In 1932 he went to sea as a ship's joiner and has never had a further asthmatic attack.

Immediate History.

The patient was fit and well until 1940, when he developed an unexplained pruritus of the anterior aspects of both legs. Subsequent scratching caused moist raw patches on the legs which he treated successfully/

successfully with various proprietary ointments. In September '48, the pruritus recurred and the patient in an attempt to alleviate the condition scrubbed the legs vigorously with soap and water. Again the lower legs became raw and moist and, a few days later, a number of nummular patches appeared on the forearms. The eruption did not respond to local therapy and he was referred for admission on 23.10.48 to Stobhill Hospital.

Examination on admission.

The patient was a well nourished man who appeared younger than his 59 years.

There was a large well defined area of infectious eczematoid dermatitis encircling the lower half of each leg. Both ankles were oedematous and there was a painless inguinal adenitis.

The sensitisation eruption was confined to the forearms; on the extensor surfaces it consisted of numerous nummular shilling sized areas of moist raw eczema. Between the exudative patches and on the volar aspects there were numerous erythematous papules, papulo-vesicles and linear excoriations. The axillary glands/

glands were not enlarged.

Respiratory System.

The chest moved freely and equally on each side. The percussion note was resonant. On auscultation, the expiratory phase was prolonged and almost equalled inspiration, while the R.M. was vesicular with a few sibilant rhonci at the right base.

CASE NO. 17.

W.F. a married man, aged 44 years, was admitted to Stobhill Hospital on 16.11.48 with a diagnosis of infectious eczematoid dermatitis of the left leg and a sensitisation eruption on the forearms and face.

General History.

1. Previous illnesses: Repeated ulceration of left leg.
2. Family history: Nothing relevant.
3. Personal history: Employed as an engineer.
4. Allergic history: No family or personal history of allergic manifestations.

Immediate History. /

Immediate History.

The patient was well until 1940 when, subsequent to a slight injury, an ulcer appeared on the left medial malleolus and the surrounding skin became raw and moist. The condition responded to local treatment and he remained well until October '48, except for exacerbations of the eczematous process during April '46, November '47 and January '48. In October '48, after a trivial trauma the skin again became eczematous over the left medial malleolus and, despite local therapy, the condition extended to the lower third of his leg. A few weeks later, an intense pruritus of his forearms and face was followed by a papular eruption and he sought admission to Stobhill Hospital.

Examination on admission.

The patient was a well built young man.

There was an area of infectious eczematoid dermatitis on the antero-medial aspect of the lower half of his left leg. The foot was grossly oedematous and there was a painful inguinal adenitis. There was marked varicosity of veins of the legs while on the antero-medial/

antero-medial surface of the lower third of his right leg there was a typical area of Schamberg's disease.

The sensitisation eruption was predominantly exudative in character and occurred on the forearms, face and neck. On the extensor aspects of his forearms, there were several, well-defined, nummular patches ($\frac{1}{2}$" diameter) of raw moist eczema. Between these lesions and on the volar aspects of the forearms there were numerous, discrete, erythematous papulo-vesicles. There was a generalised erythema of his face with slight peri-orbital swelling and a few erythematous papules on both cheeks. On the nape of his neck there was an erythematous plaque of grouped papules.

CASE NO. 18.

J.D. a married woman, aged 64 years, was admitted to Stobhill Hospital on 26.11.48 with a diagnosis of infectious eczematoid dermatitis of the legs and a sensitisation eruption on the forearms.

General History.

1. Previous illnesses: Measles in childhood.
   1919 ... Erysipelas of face.
2. Family history: Nothing relevant.
3. Personal history: Housewife. Menopause at 44 years.
4. Allergic history: No family or personal history of allergic manifestations.

Immediate History.

In April '48, the patient developed a phlebitis of the right leg and in the course of treatment her leg and thigh were strapped with elastoplast. On removal of the elastoplast the skin desquamated leaving a moist raw surface extending from the groin to her toes. The thigh healed quickly but the lesion on her leg persisted and about three weeks before admission to Stobhill Hospital, numerous, erythematous, pruritic papules appeared on the back and forearms.

Examination on admission.

The patient was a well nourished elderly woman.

There/

There was an area of infectious eczematoid dermatitis on the stocking distribution of the right leg. Oedema of the ankle was very marked but there was no inguinal adenitis.

The sensitisation eruption consisted of small, erythematous papules crowned with frilly white scales and a few scattered papulo-vesicles. The scales were loosely attached and on removal left a red glazed surface. The lesions were present on the interscapular area, the V-shaped area on front of the chest and on the extensor aspects of forearms. The papules were scattered more or less symmetrically on the forearms and varied in size from a pin head to a pea; they remained discrete and showed no tendency to grouping.

CASE NO. 19.

J.F. a married woman, aged 68 years, was admitted to Stobhill Hospital on 15.10.49 with a diagnosis/

diagnosis of infectious eczematoid dermatitis of the legs and a sensitisation eruption on the chest.

General History.

1. Previous illnesses: Nil.
2. Family history: Nothing relevant.
3. Personal history: Housewife.
4. Allergic history: No family or personal history of allergic manifestations.

Immediate History.

The patient remained well until May '48 when she sustained lacerations to the front of both legs. The lesions failed to heal and soon eczematous patches (2" x 1") made their appearance and, despite local therapy, they extended peripherally to involve the middle third of each leg. About July '48, the patient experienced an intense pruritus of the anterior chest wall, followed in a few days by the appearance of numerous erythematous papules. Several of the papules coalesced, particularly around the nipples and subsequent scratching produced exudative areas. Later, a few of the lesions became crusted and when a number of erythematous papules appeared/

appeared on her neck, she sought admission to Stobhill Hospital.

Examination on admission.

The patient was a well nourished elderly woman.

There were areas of infectious eczematoid dermatitis covering the middle-third of the anterior surfaces of both legs. A well marked oedema of the ankles was also present.

The sensitisation eruption was predominantly exudative in character and was confined to the anterior chest wall. Over both breasts and mid-sternum were several patches (3" x 2") of raw moist eczema, several of these were heavily crusted with a pustular exudate escaping from under the yellow brown crusts. This exudate did not appear to cause any local cutaneous irritation. The epidermis was denuded from the inframammary regions and a moist intertriginous surface was exposed. On a V-shaped area on the front of her neck and between the exudative patches were numerous, tiny, erythematous papules and papulo-vesicles.

CASE NO. 20.

J.F. a married woman, aged 59 years, was admitted to Stobhill Hospital on 27.11.48 with a diagnosis of varicose ulcer of the right leg and a sensitisation eruption of the forearms.

General History.

1. Previous illnesses: June '45 ... varicose ulcers on both medial malleoli.
2. Family history: Nothing relevant.
3. Personal history: Housewife.
4. Allergic history: No family or personal history of allergic manifestations.

Immediate History.

In May '48, following a slight trauma, the patient noticed a small ulcer on the medial aspect of the right leg. Despite local treatment with Eusol soaks and calamine lotion the ulcer gradually extended and oedema of the foot became very marked. The patient remained ambulant for some months and refused to rest but when numerous pruritic papules appeared on the forearms, she sought admission to Stobhill Hospital.

Examination on admission./

Examination on admission.

The patient was an elderly obese woman. Over the right medial malleolus there was a small circinate shallow ulcer the size of a shilling. The edge was indurated and the base of warty granulation tissue was covered with a foetid, thin, sero-sanguineous discharge. The skin surrounding the ulcer for an area of two or three inches was of a moist eczematous nature.

The sensitisation eruption was limited to the extensor surfaces of the forearms and consisted of numerous, small, discrete, erythematous papules. The papules varied in size from a pin-head to a pea and showed no tendency to grouping; several of them were crowned with loosely attached, whitish grey scales which, on grattage, exposed glazed red surfaces. The axillary glands were not enlarged.

CASE NO. 21.

S.L. a married man, aged 48 years, was admitted to Stobhill Hospital on 19.11.48 with a diagnosis of varicose ulcer of the right leg and a sensitisation eruption on the forearms.

General History.

1. Previous illnesses: Repeated ulceration of the right leg over a period of 22 years. Iritis left eye.
2. Family history: Nothing relevant.
3. Personal history: Employed as an electric welder.
4. Allergic history: No family or personal history of allergic manifestations.

Immediate History.

For the past 22 years, the patient has had recurrent ulceration of his right leg caused by repeated slight trauma. In October '48, he received an injury to his right leg which resulted in the appearance of a small ulcer which, despite treatment, increased in size and the surrounding skin became eczematous. A few weeks later, he developed a pruritic, papular eruption on the forearms and trunk. When these lesions appeared he consulted his doctor who arranged admission to Stobhill Hospital.

Examination on admission.

The patient was a well nourished, middle-aged man. On the anterior aspect of the right mid leg, there was/

was an ulcer (diameter 2"), the base of which was partially covered with a dirty brown crust. On the lower half of the leg and surrounding the ulcer was a typical patch of varicose eczema.

The sensitisation reaction consisted of a papular eruption on the dorsal aspect of the forearms, medial aspects of thighs and on the lumbo-sacral region. The papules varied in size from a pin-head to a pea and the angry red colour of the exanthem was accentuated by the loosely attached greyish white scales which crowned several of the lesions. There was no associated inguinal adenitis.

CASE NO. 22.

W.F. a widower, aged 76 years, was admitted to Stobhill Hospital on 11.1.49 with a diagnosis of infectious eczematoid dermatitis of the right leg and a sensitisation eruption on the forearms.

General History./

General History.

1. Previous illnesses: Nil.
2. Family history: Nothing relevant.
3. Personal history: Retired baker.
4. Allergic history: No family or personal history of allergic manifestations.

Immediate History.

The patient was fit and well until six years ago when after an injury, a small ulcer appeared on the right medial malleolus. The ulcer healed fairly quickly but slight trauma caused frequent recurrences and the skin over the right medial malleolus became erythematous, hard and fixed to the underlying bone. In July '48, an injury to the part produced an eczematous reaction which extended to involve the dorsum of the foot and the lower half of his right leg. Oedema of the foot became a very marked feature and he was advised to stop work. The patient was treated by his doctor for three months at home and was almost ready to resume work, when a minor trauma caused a recurrence of the eczema of the right leg. About two weeks later, a number of erythematous papules appeared on the forearms and a scaling erythema became evident/

evident on his face and chest. He was admitted on 11.1.49 to Stobhill Hospital.

Examination on admission.

The patient was a well nourished, elderly man. There was an area of infectious eczematoid dermatitis on the "stocking" distribution of the right leg and a moderate degree of pitting oedema of the right ankle.

The sensitisation eruption was characterised by numerous, follicular, erythematous papules on the flexor aspects of the forearms. There were several linear excoriations, no vesiculation and across the forehead and both cheeks there was a diffuse, maculo-papular erythema. The eyelids were slightly oedematous but there was no evidence of blepharitis. There were typical seborrhoeic manifestations on the glabrous skin, viz. - retro-auricular intertrigo with seborrhoeide patches on the sternum and interscapular region and on the trunk there were several, greasy, scaling, brownish-red, discoid patches, between which there were a number of small follicular papules.

CASE NO. 23.

G.J. a married man, aged 59 years, was admitted to Stobhill Hospital on 25.2.49 with a diagnosis of infectious eczematoid dermatitis of the legs and a sensitisation eruption on the forearms.

General History.

1. Previous illnesses: Measles, scarlet fever in childhood.
2. Family history: Nothing relevant.
3. Personal history: Employed as a labourer.
4. Allergic history: No family or personal history of allergic manifestations.

Immediate History.

The patient was fit and well until December '48 when he developed a pruritus of the right medial malleolus and subsequent scratching produced an eroded exudative patch (2" x 2"). Other than by excoriations, no definite history of injury was elicited, although as a labourer he was subject to minor trauma. Patient applied a "sulphur ointment" for one week; the pruritus was relieved and the eruption cleared leaving a residual erythema. In February '49, there was a recurrence of the exudative process which rapidly extended and involved the/

the whole of the right leg. About a week later, several patches of nummular eczema appeared on the left leg and when, a few days later, an acute eczematous reaction developed on the forearms, he sought admission to Stobhill Hospital.

Examination on admission.

The patient was a thin grey-haired, elderly man. There was an area of infectious eczematoid dermatitis on the lower one third of the antero-medial aspect of the right.

The sensitisation eruption was predominantly exudative in character and consisted of numerous, penny-sized, nummular eczematous patches on the dorsa of the feet, left leg and antero-medial aspects of both knees. The intervening skin between these patches was normal. On the left calf and medial surfaces of the thighs there were many tiny erythematous papules and papulo-vesicles, several of which had coalesced to form circinate patches. There was a generalised erythema of both forearms, the extensor surfaces were moist and raw and denuded of superficial epidermis. The palms exhibited a punctate frilly desquamation resembling/

resembling a healing cheiropompholyx. A painless inguinal and axillary adenitis was also present.

Alimentary System.

His tongue was moist and furred, gums were edentulous. Abdomen moved freely on respiration, the liver was two-finger breadths palpable, no abnormal masses or tenderness elicited on palpation.

CASE NO. 24.

P.T. a married man, aged 36 years, was admitted to Stobhill Hospital on 21.1.49 with a diagnosis of infectious eczematoid dermatitis of the right leg and a sensitisation eruption on the left leg and forearms.

General History.

1. Previous illnesses: Asthma. Left sided pleurisy 1945.
2. Family history: His father suffered from asthma.
3. Personal history: Employed as a plumber's labourer.
4. Allergic history: The patient has had asthma since his childhood. For a period of years/

years the attacks were very frequent and were controlled by ephedrine sulphate. About five years ago the asthmatic attacks became infrequent and for the six months prior to admission he has been free of symptoms.

Immediate History.

In January '48, the patient developed a boil on the front of his right leg. He applied various ointments, viz. "Zambuk" and "Germoline" but the surrounding skin became pruritic and later moist and eczematous. His general practitioner prescribed calamine lotion and the condition healed leaving a residual erythema. Occasionally minor trauma on this erythematous area caused a recurrence of the eczema which would heal quickly with local applications. In December '48, an injury provoked an exacerbation of the exudative process and, by the beginning of January '49, the whole of the right leg was moist and raw whilst fresh circinate patches of eczema were present on the forearms and left leg. He was admitted to Stobhill Hospital on 21.1.49.

Examination on admission./

Examination on admission.

The patient was a well nourished young man. There was a well demarcated area of infectious eczematoid dermatitis extending over the entire right leg excluding the posterior surface of the calf and the dorsum of his right foot.

The sensitisation eruption was characterised by nummular eczematous patches (1" diameter) on the antero-medial aspect of the left leg, medial surfaces of the thighs and on the dorsal aspects of the fore-arms. The skin between the lesions on the lower limbs was normal while on the forearms there were several papules and papulo-vesicles.

Respiratory System.

The chest moved freely and symmetrically on respiration. The percussion note was resonant throughout, the R.M. was vesicular with a prolongation of the expiratory phase. No adventitiae were detected.

CASE NO. 25./

CASE NO. 25.

E.E. a spinster, aged 66 years, was admitted to Stobhill Hospital on 11.3.49 with a diagnosis of varicose eczema of the legs and a sensitisation eruption on the forearms.

General History.

1. Previous illnesses: Pleurisy 30 years ago.
2. Family history: Nothing relevant.
3. Personal history: Spinster - menopause at the age of 46 years.
4. Allergic history: No personal or family history of any allergic manifestations.

Immediate History.

The patient was well until November '48 when her legs became pruritic and erythematous which she attributed to her frequent habit of sitting before coal fires. Subsequent scratching produced an eczematous reaction on the front of both legs. Local applications rapidly healed the lesions but a pruritic, scaling, erythema persisted and, in January '49, a recurrence of the eczema of the legs was accompanied by the appearance of numerous, small, papules on both forearms. Despite treatment/

treatment with calamine lotion, no improvement was noticed and she reported to her doctor who arranged admission to Stobhill Hospital on 11.2.49.

Examination on admission.

The patient was a well nourished, elderly woman. There was oedema of both ankles and a mild degree of varicosity of the leg veins. There was an ill-defined eczema of the lower third of the antero-medial aspects of the legs.

The sensitisation eruption consisted of small erythematous papules on the forearms. There were no vesicles and no signs of exudation; the papules remained discrete and several of them were covered with small greyish white scales. The majority of the lesions were present on the dorsal surfaces of the forearms. The axillary glands were not enlarged.

CASE NO. 26.

A.P. a married woman, aged 64 years, was admitted to Stobhill Hospital on 9.2.49 with a diagnosis of varicose ulcers of the legs and a sensitisation eruption on the forearms.

General History.

1. Previous illnesses: Lung abscess 1913.
   Pneumonia 1917 and 1946.
2. Family history: Nothing relevant.
3. Personal history: Housewife, menopause at 44 years.
4. Allergic history: No family or personal history of allergic manifestations.

Immediate History.

For the past fourteen years the patient has had repeated ulceration of both legs. About February '47 an injury caused a recurrence of an ulcer on the left medial malleolus. Despite local therapy, this ulcer failed to heal and gradually became bigger and, by January '49, the ulcer was about three inches long with marked oedema of the ankle. About this period a pruritic erythema developed on her forearms and she was admitted on 9.2.49 to Stobhill Hospital.

The patient has been troubled with a cough and an offensive foul smelling sputum for ten or twelve years.

Examination on admission.

The patient was a well nourished elderly woman, with marked clubbing of the fingers.

On the medial malleolus there was a superficial rectangular shaped ulcer (4" x 1½"), from which oozed a sero-sanguineous exudate. The skin surrounding the ulcer was moist and eczematous while a marked oedema of the foot was also present. Over the lateral aspect of the leg there was a typical patch of dermatitis vegetans. On the right leg there were areas of brownish pigmentation and scars of healed ulcers. The varicosity of veins of both legs was a marked feature.

The sensitisation eruption was papular in character and confined to the extensor aspects of both forearms. The papules varied in size from a pin-head to a pea, showed no tendency to grouping and the intervening skin was normal. Several of the lesions were eroded and others were crowned by loosely attached, greyish white scales.

Respiratory System.

The chest moved freely but there was a diminution of movement on right side. The percussion note was resonant while the R.M. was vesicular throughout, although there was a poor air entry into the right base. A few rales were heard at the right base.

CASE NO. 27.

D.D. a married man, aged 35 years, was admitted to Stobhill Hospital on 18.2.49 with a diagnosis of infectious eczematoid dermatitis of the left leg and a sensitisation eruption on the palms.

General History.

1. Previous illnesses: Tonsillectomy in childhood.
2. Family history: Nothing relevant.
3. Personal history: Employed as a painter.
4. Allergic history: No personal or family history of allergic manifestations.

Immediate History.

About two years ago the patient developed a pruritic erythema on the medial aspect of the left leg. There was no history of injury and no apparent cause for the lesion. Pruritus of the part was intense and subsequent scratching produced a moist raw patch (3" x 2") which showed a transient response to local therapy. There were, however, frequent exacerbations and remissions of the eczematous process and, in February '49, an unusually acute exudative reaction developed on the left leg. A few days later a severe palmar pruritus was succeeded by numerous, deep-seated, closely-set vesicles and he was admitted on 18.2.49 to Stobhill Hospital.

Examination on admission.

The patient was a well built young man. On the medial aspect of the left leg there was a well-defined patch of infectious eczematoid dermatitis extending from the mid-leg to the medial malleolus.

The sensitisation eruption was vesicular in character and confined to the palms of the hands. On the palms and fingers there were numerous deep seated vesicles embedded in the skin and resembling boiled sago grains, while on the thenar eminences and front of wrists there were several thin-walled bullae. There was an associated oedema of the dorsal aspects of the hands. The axillary glands were not enlarged.

CASE NO. 28.

A. McL. a married woman, aged 69 years, was admitted to The Western Infirmary, Glasgow, on 8.3.49 with a diagnosis of infectious eczematoid dermatitis of the left leg and a sensitisation eruption on the trunk and forearms.

General History./

General History.

1. Previous illnesses: Gastro-enterostomy 1940.
2. Family history: Nothing relevant.
3. Personal history: Housewife. Menopause at 48 years.
4. Allergic history: No family history of allergic manifestations.

Immediate History.

The patient remained well until June '45 when an erythema appeared on the dorsum of the left foot. No history of injury was elicited and later this erythematous patch became pruritic and gradually extended to involve the lower third of her leg. Subsequent scratching produced eczematisation which rapidly responded to local applications leaving a persistent scaly erythema. For the past four years, despite an occasional exacerbation of the exudative phase, the lesion remained localised to the left leg until February 1949 when, following an acute efflorescence, pruritic papules appeared suddenly on the trunk and forearms. Later, raw moist lesions developed on the thighs and she was admitted to the Western Infirmary on 8.3.49.

Examination on admission. /

Examination on admission.

The patient was an elderly obese woman. There was an area of infectious eczematoid dermatitis affecting the dorsum of her foot and the lower one third of the medial aspect of her left leg.

The sensitisation eruption was mixed in character; some lesions presented as erythema multiforme and others as nummular eczematous patches. On the wrists, particularly the dorsal aspects, there were several symmetrically distributed, discrete, concentric erythematous rings resembling erythema iris. On the extensor surfaces of the forearms, lumbo-sacral regions and the medial aspects of thighs there were numerous erythematous blotches and papulo-vesicles, some of the latter lesions were grouped together and eroded to form nummular patches ($\frac{1}{2}$" diameter) of eczema. There was also a typical cheiropompholyx.

CASE NO. 29.

J.M. a married man, aged 38 years, was admitted to Stobhill Hospital on 11.3.49 with a diagnosis of infectious eczematoid dermatitis of the right forearm and a sensitisation eruption on the face and palms.

General History.

1. Previous illnesses: Measles and mumps in childhood.
2. Family history: Nothing relevant.
3. Personal history: Employed as an engineer.
4. Allergic history: No family or personal history of allergic manifestations.

Immediate History.

The patient was perfectly fit and well until March '49, when he sustained a second degree burn of his right forearm. An elastoplast dressing was applied and left in situ for two weeks; on its removal there was a well demarcated raw moist patch (3" x 2") on the extensor surface of the forearm. His general practitioner applied calamine lotion but there was no improvement and, a few days later, the face and neck became eczematous with marked peri-orbital oedema. A few days before admission to Stobhill Hospital, several nummular exudative patches ($\frac{1}{2}$" diameter) developed on the left forearm and both legs, while deep-seated vesicles appeared on the palms.

Examination on admission./

Examination on admission.

The patient was a well nourished young man. On the dorsal aspect of the right forearm there was a well demarcated patch (3" x 2") of infectious eczematoid dermatitis.

The sensitisation eruption was exudative in character and was present on the face, neck, limbs and palms of the hands. The face was erythematous and the oedema of the eye-lids closed the eyes; on the forehead, cheeks and neck there was an acute moist eczematous reaction. On the left forearm and front of both legs there were several well defined patches of nummular eczema. A typical cheiropompholyx was also present while the cervical and axillary glands were enlarged and painful on palpation.

CASE NO. 30.

J.P. an unmarried man, aged 22 years, was admitted to Stobhill Hospital on 7.3.49 with a diagnosis of infectious eczematoid dermatitis of the face and a sensitisation eruption on the forearms.

General History./

General History.

1. Previous illnesses: Bronchitis. Left sided pleurisy 1944.
2. Family history: Nothing relevant.
3. Personal history: Employed as a lorry driver.
4. Allergic history: No family or personal history of allergic manifestations.

Immediate History.

The patient was perfectly fit until January 1949, when the acid from a car battery which he was carrying on his shoulder, leaked into his right ear. He mopped the part dry and several hours later a pruritic erythema developed on the ear and he applied calamine lotion. No vesiculation was noticed but, within 48 hours, the ear was moist, raw and oedematous. Later, the eyebrows and right cheek were affected in this exudative process. He reported to his general practitioner who prescribed calamine liniment soaks; the condition improved and he remained at his work. However, about three weeks after the injury a pruritus of forearms developed, followed later by a moist eczema in the cubital fossae and he was admitted to Stobhill Hospital on 7.3.49.

Examination on admission./

Examination on admission.

The patient was a well nourished young man. Over the right ear, neck and right cheek there was a patch of infectious eczematous dermatitis. The peri-orbital tissues were oedematous and the eyes were almost completely closed. The cervical glands were enlarged and painful.

The sensitisation eruption was exudative in character and was confined to the forearms. The superficial epidermis was denuded from the ante-cubital fossae and moist eczematous surfaces were exposed. There were a few brownish adherent crusts present at the periphery of these eczematous patches, and on the ventral surfaces of the forearms there were a few discrete erythematous papules. Nikolsky's sign was not elicited. There was no enlargement of the axillary glands.

CASE NO. 31. /

CASE NO. 31.

W.L. a married woman, aged 60 years, was admitted to Stobhill Hospital on 11.3.49 with a diagnosis of varicose ulcer of the left leg and a sensitisation eruption on the forearms and face.

General History.

1. Previous illnesses: Fracture left leg ... 1943.
2. Family history: Nothing relevant.
3. Personal history: Housewife.
4. Allergic history: No family or personal history of allergic manifestations.

Immediate History.

The patient has had marked varicosity of the leg veins for years and after a minor trauma in October 1948, she noticed a small ulcer on the medial aspect of her left leg. Despite local treatment the ulcer gradually extended and, by March '49, it was the size of a penny while the surrounding skin for an area of three inches was markedly eczematous. About a week before admission, a pruritic erythema suddenly appeared on the face associated with swelling of the eyelids. A few days later, moist, raw, shilling-sized patches occurred on the forearms and thighs.

Examination on admission.

The patient was an obese, elderly woman. On the left malleolus there was an oval-shaped ulcer (2" x 1"), the edges of which were undermined while its base showed exuberant warty granulations. The surrounding skin which was eczematous, was thickened and fixed to the underlying bone. There was marked pitting oedema of both ankles with an associated varicosity of the superficial veins of the legs.

The sensitisation eruption was exudative in character and involved the face, forearms and thighs. The face exhibited a moist, raw surface and appeared to be denuded of superficial epidermis, while another prominent feature was the oedema of the peri-orbital tissues. On the forearms and medial aspects of the thighs, there were several, irregularly shaped, eczematous patches with numerous, intervening papules and papulo-vesicles. A few of the exudative areas were heavily crusted, particularly on the forearms and there was an accompanying regional lymphadenopathy. A typical cheiropompholyx was also present.

CASE NO. 32.

A.B. a married woman, aged 53 years, was admitted to Stobhill Hospital on 22.3.49 with a diagnosis of varicose ulcer of the right leg and a sensitisation eruption on the forearms.

General History.

1. Previous illnesses: Measles, mumps and scarlet fever in childhood.
2. Family history: Nothing relevant.
3. Personal history: Housewife. Menopause induced by radium therapy ... 1944.
4. Allergic history: No family or personal history of allergic manifestations.

Immediate History.

The patient was well until one year ago when she sustained an injury resulting in an ulcer on the front of her right leg. The ulcer healed quickly with local treatment but a minor trauma in August '48 caused a recurrence of the ulceration. The wound healed over fairly quickly but was reopened in February '49. The skin surrounding the ulcer became moist and raw; she reported to her general practitioner who prescribed various lotions with no success. In March '49 an intense/

intense pruritus suddenly developed on the forearms and, within a few hours, a blotchy erythema and a few blisters appeared on the volar aspects. Later, numerous vesicles occurred on the palms while the face became covered with erythematous blotches, and admission was arranged on 22.3.49 to Stobhill Hospital.

Examination on admission.

The patient was an obese middle-aged woman.

There was a circular ulcer ($1\frac{1}{2}$" diameter) situated at the mid-point on the antero-lateral aspect of the right leg. The base was dirty with several greyish verrucose granulations, the edges were rolled and indurated. A dry scaly erythema surrounded the ulcer.

The sensitisation eruption was present on the face and forearms and closely resembled erythema multiforme in character. The lips were swollen and oedematous and on the cheeks there were several erythematous macules but no lesions on the buccal mucosa. On the volar aspects of the forearms there were several, thin-walled bullae on erythematous bases, while on the dorsal surfaces there were numerous typical lesions of erythema iris. A well marked cheiropompholyx was also present.

CASE NO. 33.

R.K. a married woman, aged 45 years, was admitted to Stobhill Hospital on 27.3.49 with a diagnosis of varicose ulcer of the left leg and a sensitisation eruption on the face and forearms.

General History.

1. Previous illnesses: Recurrent varicose ulceration of both legs. Injection for varicose veins ... 1942.
2. Family history: Nothing relevant.
3. Personal history: Housewife.
4. Allergic history: No family or personal history of allergic manifestations.

Immediate History.

In March '48, the patient was admitted to Stobhill Hospital where a small ulcer on the medial aspect of her left leg was treated with local applications of 20% triturate of zinc peroxide in water. The ulcer healed rapidly but recurred eight months later following a trivial injury, and failed to heal, despite the same local treatment. In March '49, it was noticed that both forearms were covered/

covered with erythematous papules. One week before admission to Stobhill Hospital on 27.3.49, the face became pruritic and erythematous and suddenly, within a few hours, marked blotchy swellings appeared on the cheeks, trunk and limbs. Later, oedema of the eyelids occurred closing both eyes.

Examination on admission.

The patient was a well nourished young woman.

On the medial aspect of her left lower leg there was an ulcer (2" x 1") with irregular edges and a red clean base. There was pronounced varicosity of the veins.

The sensitisation eruption was mixed in character and was present on the face, trunk and forearms. There was a vivid erythema of the face with marked peri-orbital oedema, and scattered asymmetrically over the face, trunk and forearms were several ill-defined, irregular, erythematous blotches and a few well-formed wheals. Dermographism was a marked feature. On both forearms there were numerous tiny erythematous papules and papulo-vesicles, several of which were eroded and covered with yellowish brown crusts. The axillary glands were not enlarged.

CASE NO. 34.

R.M. a married woman, aged 62 years, was admitted to Stobhill Hospital on 14.4.49 with a diagnosis of varicose ulcer of the left leg and a sensitisation eruption on the face and forearms.

General History.

1. Previous illnesses: Pneumonia ... 1939.
2. Family history: Nothing relevant.
3. Personal history: Housewife.
4. Allergic history: No family or personal history of allergic manifestations.

Immediate History.

The patient was well until March '49 when she fell and injured her left leg, producing an ulcer. Various local applications were applied with no improvement; she then consulted her doctor who prescribed calamine lotion locally and sulphatriad orally (4 gm. daily for ten days). Three days after completion of the chemotherapy an intense pruritus developed on the face and forearms and, within forty-eight hours, a vivid erythema of the face appeared with marked oedema of the eyelids. On the forearms numerous tiny pruritic papules became evident and arrangements were made for her admission to Stobhill Hospital.

Examination on admission.

The patient was an elderly well nourished woman.

On the medial aspect of the left leg there was an oval-shaped ulcer ($1\frac{3}{4}$" x 1"). The base was dirty with a sero-sanguineous discharge oozing from underneath a greyish brown crust. The edges were irregular and undermined, while the surrounding skin was erythematous.

The sensitisation eruption was mixed in character, the forearms showed a papular condition while the predominant feature was the urticarial reaction on the face. There was a marked peri-orbital oedema completely closing both eyes. On the cheeks, face and V-area of the neck there were a few wheals and several erythematous blotches. The trunk was clear but demonstrated factitious urticaria. There was a slight oedema of the lips and a few ruptured vesicles on the buccal mucosa. On the forearms, there were numerous discrete erythematous papules with a few minute purpuric macules.

CASE NO. 35.

P.M. an unmarried man, aged 65 years, was admitted to Stobhill Hospital on 4.4.49 with a diagnosis of infectious eczematoid dermatitis of the left leg and a sensitisation eruption on the trunk and limbs.

General History.

1. Previous illnesses: Repeated varicose ulceration of legs. Occasional rash on anterior chest wall.
2. Family history: Nothing relevant.
3. Personal history: Employed as a bricklayer.
4. Allergic history: No family or personal history of allergic manifestations.

Immediate History.

For a period of years the patient has been troubled with recurrent eczema of the legs which he attributed to the varicosity of the leg veins. In December '48, he sustained an injury to his left leg resulting in a wound which did not heal and gradually the skin surrounding it became moist and raw. This eczematous process extended and involved the whole of his left leg. In March '49, numerous erythematous papules and blotches appeared on his trunk and forearms while/

while eczematous lesions developed on his ears, axillae and thighs. He was admitted on 4.4.49 to Stobhill Hospital.

Examination on admission.

The patient was a well-nourished, elderly man. There was an area of infectious eczematoid dermatitis on the stocking distribution of the left leg.

The sensitisation eruption was mainly seborrhoeic in character and involved the abdomen, lumbo-sacral region and the dorsal aspects of the forearms. There were a number of greasy, brownish-red maculo-papular lesions on the trunk with typical seborrhoeide patches on the sternum and interscapular regions. There was a marked axillary, inguinal and retro-auricular intertrigo while scattered asymmetrically on the forearms and trunk there were numerous, discrete, follicular papules. There was no marginal blepharitis and no involvement of the scalp.

CASE NO. 36./

CASE NO. 36.

J.M. a married man, aged 40 years was admitted on 26.4.49 to Stobhill Hospital with a diagnosis of infectious eczematoid dermatitis of the right leg and a sensitisation eruption on the thighs, forearms and left leg.

General History.

1. Previous illnesses: Measles. Scrotal injury in childhood.
2. Family history: Nothing relevant.
3. Personal history: Employed as slater's labourer.
4. Allergic history: No family or personal history of allergic manifestations.

Immediate History.

The patient was well until February '48 when he sustained an injury to the lateral malleolus producing a raw moist patch. This condition healed slowly leaving a persistent residual erythema which was subject to periodic exacerbations and remissions of an exudative type. In April '49, a minor trauma precipitated an acute exacerbation and, within one week, numerous pruritic papules appeared on his left leg, thighs and forearms. The condition showed no improvement/

improvement with local treatment and he was admitted on 26.4.49 to Stobhill Hospital.

Examination on admission.

The patient was a well nourished, thinly built young man.

Over the lateral malleolus there was a well demarcated patch (3" x 2") of infectious eczematoid dermatitis. There was marked varicosity of the veins.

The sensitisation eruption was papular in character and was present on the thighs and forearms. On the extensors of forearms, anterior aspects of the thighs and left leg, there were numerous small, discrete erythematous papules. There was no grouping of the lesions and no suggestion of vesiculation. A few of the papules were eroded and a number of linear excoriations were present.

CASE NO. 37.

R. McN. an unmarried man, aged 32 years, was admitted to Stobhill Hospital on 5.4.49 with a diagnosis of infectious eczematoid dermatitis of the right leg and a/

a sensitisation eruption on the face, ears and forearms.

General History.

1. Previous illnesses: Measles in childhood.
   Tonsillectomy 1928.
   Tinea pedis 1942.
2. Family history: Nothing relevant.
3. Personal history: Employed as an engineer.
4. Allergic history: No family or personal history of allergic manifestations.

Immediate History.

The patient was fit and well until 21.1.49 when he sustained a burn with molten metal to the dorsum of the right foot. A few days later the affected area became moist and raw but local treatment improved the condition and on 7.2.49 he resumed work, although the lesion was not completely healed over. Within a few days, the exudation had recurred on the right foot and, despite local treatment, the condition spread to involve the lower one third of the leg. Later, a pruritic erythema appeared on the face, ears and forearms and, within a few days, these sites were involved in a wide-spread eczema. The patient was reluctant to attend hospital/

hospital and his doctor applied calamine lotion but no improvement was noticed and he was finally admitted to Stobhill Hospital on 5.4.49.

Examination on admission.

The patient was a well-nourished young man with marked pityriasis capitis. There was an area (3" x 2") of infectious eczematoid dermatitis on the dorsum of the right foot and anterior aspect of the leg.

The sensitisation eruption was predominantly exudative in character and involved the ears, neck and forearms. Exfoliation of the superficial epidermis from the ears and neck was a marked feature and from the exposed surfaces oozed a yellowish exudate which trickled on to the normal skin but produced no local cutaneous irritation. There was no otitis media and the drum heads were normal. There were several oval-shaped areas ($\frac{1}{2}$" x $\frac{1}{4}$") of moist eczema on the cheeks, while on the forearms there were numerous papulo-vesicles scattered between large, irregularly shaped, exudative patches.

CASE NO. 38.

J.G. a married man, aged 69 years, was admitted to Stobhill Hospital on 31.3.49 with a diagnosis of infectious eczematoid dermatitis of the right foot and a sensitisation eruption on the forearms.

General History.

1. Previous illnesses: Chronic bronchitis.
   1943 ... Jaundice.
2. Family history: Nothing relevant.
3. Personal history: Employed as a general labourer.
4. Allergic history: No family or personal history of allergic manifestations.

Immediate History.

The patient was well until December '48, when he developed a pruritic erythematous patch on the dorsum of the right foot which he attributed to the wearing of new foot-wear. He applied a proprietary ointment for a few days, but the condition became moist and raw and he consulted his general practitioner who prescribed calamine lotion. The lesion soon healed, leaving a residual scaly erythema which remained quiescent until January '49 when an exudative exacerbation occurred on the dorsum of the right foot. A few days later the forearms/

forearms became pruritic and oval-shaped areas of erythema appeared on them to be followed by eczematous patches. The pruritus was intense and subsequent scratching made the lesions very much worse and he was admitted on 31.3.49 to Stobhill Hospital.

Examination on admission.

The patient was an elderly well-nourished man with a sallow complexion. There was a well demarcated patch (3" x 2") of infectious eczematoid dermatitis on the dorsum of the right foot.

The sensitisation eruption was exudative in character and was present on the dorsal surfaces of the forearms. There were several nummular eczematous patches ($\frac{1}{2}$" diameter), the majority of which were covered with a thin yellowish exudate, while the others were heavily crusted. On the intervening skin there were a few discrete papules, papulo-vesicles and several linear excoriations. There was an associated axillary adenitis.

CASE NO. 39./

CASE NO. 39.

J.B. a married man, aged 50 years, was admitted to Stobhill Hospital on 14.5.49 with a diagnosis of infectious eczematoid dermatitis of the right leg and a sensitisation eruption on the forearms and thighs.

General History.

1. Previous illnesses: Measles, whooping cough in childhood. Enteric fever ... 1917. Haematemesis ... 1942.
2. Family history: Nothing relevant.
3. Personal history: Employed as a joiner.
4. Allergic history: No family or personal history of allergic manifestations.

Immediate History.

The patient was fit until December '48 when he sustained a laceration of his right medial malleolus. Local treatment with calamine liniment was applied for ten days and he resumed work. He remained well until February '49 when a trivial injury to the same part resulted in the appearance of an eczematous patch which, despite topical treatment, extended rapidly and involved the lower one third of the right leg. In April '49, a number/

number of pruritic papules appeared on the forearms and thighs; the pruritus was intense and he was admitted on 14.5.49 to Stobhill Hospital.

For the past ten years the patient has had typical symptoms of a duodenal ulcer and, since 1942 following a haematemesis, he has been able to control the pains by alkalis and dietary measures.

Examination on admission.

The patient was a well-nourished, middle-aged man. On the stocking distribution of the right leg there was an area of infectious eczematoid dermatitis.

The sensitisation eruption was predominantly papular in character and was present on the forearms, thighs and lumbo-sacral region. On the dorsal aspects of the forearms and the antero-medial aspects of the thighs, there were numerous, discrete, erythematous papules and also a few papulo-vesicles with several linear excoriations. There was a plague (3" x 2") of closely-set erythematous papules on the lumbo-sacral region. A number of the papules were crowned with loosely attached greyish white scales.

Alimentary System./

Alimentary System.

The tongue was moist and clean; a complete set of dentures was worn. The abdomen moved freely on respiration and no muscular guarding or tenderness was elicited on palpation.

CASE NO. 40.

J.G. a widow, aged 60 years, was admitted on 18.5.49 to Stobhill Hospital with a diagnosis of varicose ulceration of the left leg and a sensitisation eruption on the thighs and forearms.

General History.

1. Previous illnesses: Whooping cough ... 1916.
   Cholecystectomy .. 1927.
   Recurrent varicose ulceration.
2. Family history: Nothing relevant.
3. Personal history: Housewife.
4. Allergic history: No family or personal history of allergic manifestations.

Immediate History./

Immediate History.

Since 1914 the patient has been troubled with repeated varicose ulceration of both legs which she attributed to minor trauma and the presence of varicose veins. In 1942, an extensive ulceration of the left leg required twelve weeks treatment in The Victoria Infirmary, Glasgow. She remained well until 1945 when a recurrence of the ulceration on the left leg was accompanied by an erythema of the face, peri-orbital oedema and numerous pruritic papules on the forearms. This generalised eruption responded to treatment but the ulcer remained static. In May '49, an increase in the size of the ulcer was followed by numerous pruritic papules on the forearms and the patient sought admission to Stobhill Hospital.

Examination on admission.

The patient was a thin, poorly nourished, elderly woman. On the left leg there was a large, irregular ulcer (5" x 3") involving the whole of the medial malleolus and inner aspect of the lower leg. The base showed numerous warty exuberant granulations and the surrounding skin was hard and fixed to the underlying/

underlying bone. There was a marked varicosity of the veins with an associated oedema of both ankles.

The sensitisation eruption was papular in character and was confined to the anterior aspects of the thighs and the dorsal aspects of the forearms. The papules which varied in size from a pin-head to a pea showed no tendency to grouping or crusting. There was no associated regional lymphadenopathy.

CASE NO. 41.

J. McK. a married woman, aged 52 years, was admitted on 12.5.49 to Stobhill Hospital with a diagnosis of varicose ulceration of the right leg and a sensitisation eruption on the forearms and trunk.

General History.

1. Previous illnesses: Nephrectomy at the age of 9 years. White leg complicating puerperium.
2. Family history: Nothing relevant.
3. Personal history: Housewife.
4. Allergic history: No family or personal history of allergic manifestations.

Immediate History.

The patient was well until November '48, when a minor injury caused ulceration of the right lateral malleolus. Despite local treatment the ulcer failed to heal and after a few months it gradually enlarged and oedema of the foot became more marked. In April '49, numerous pruritic papules appeared on the forearms and thighs. The pruritus was intense and as the patient was unable to sleep, her doctor prescribed one grain of phenobarbitone at night. This sedation was continued for two weeks when suddenly a pruritic exanthem developed on the trunk and she was admitted to Stobhill Hospital.

Examination on admission.

The patient was an elderly obese woman. On the right leg about one inch above the lateral malleolus there was a superficial ulcer (2" x ¾"). A dirty brown crust covered the base from which a sero-sanguineous discharge escaped. The skin surrounding the ulcer was moist and raw and there was marked oedema of the right foot and ankle.

The/

The sensitisation eruption was mixed in character; on the trunk there was a morbilliform exanthem while an eczematous reaction was present on the limbs. The trunk was covered with a maculo-papular erythema closely resembling measles but there was no photophobia and no lesions on the buccal mucosa. On the antero-medial aspects of the thighs and extensors of the forearms there were several, shilling-sized, nummular patches of eczema with numerous intervening papules and papulo-vesicles.

CASE NO. 42.

D.S. a married woman, aged 34 years, was admitted on 10.5.49 to Stobhill Hospital with a diagnosis of infectious eczematoid dermatitis of the right thigh and a sensitisation eruption on the forearms and neck.

General History.

1. Previous illnesses: Appendicectomy ... 1925.
2. Family history: Nothing relevant.
3. Personal history: Housewife.
4. Allergic history: No family or personal history of allergic manifestations.

Immediate History.

The patient was fit and well until April '49, when she developed a boil on the antero-medial aspect of the right thigh. The lesion burst and the surrounding skin became eczematous and she reported to her doctor who applied calamine lotion. The condition showed a transient improvement but, two weeks later, a spasm of scratching caused an exudative reaction and within a few days of this exacerbation, numerous pruritic papules appeared on the forearms. Later, a few oval-shaped scaly erythematous patches appeared on the neck and she was admitted on 10.5.49 to Stobhill Hospital.

Examination on admission.

The patient was a thin, poorly nourished woman with marked pityriasis capitis. On the antero-medial aspect of the upper half of the right thigh there was an area (3" x 2") of infectious eczematoid dermatitis.

The sensitisation eruption was mixed in character with a papular element on the forearms and seborrhoeide patches on the neck. The forearms, particularly the extensor surfaces, were studded more or less symmetrically with numerous papules; the intervening skin was normal and a few linear excoriations were present.

On/

On the neck and the interscapular area were typical seborrhoeide patches, while a prominent feature was the marked inguinal, axillary and retro-auricular intertrigo.

CASE NO. 43.

C.W. a widow, aged 75 years, was admitted to Stobhill Hospital on 13.5.49 with a diagnosis of infectious eczematoid dermatitis of the right leg and a sensitisation eruption on the forearms and thighs.

General History.

1. Previous illnesses: Enteric fever at the age of 7 years.
2. Family history: Nothing relevant.
3. Personal history: Housewife. Menopause at 46 years.
4. Allergic history: No family or personal history of allergic manifestations.

Immediate History.

The patient remained well until 1939, when she sustained an injury to the calf of the right leg and the resultant lesion became moist and raw and rapidly spread/

spread to involve the whole of the lower half of the leg. The forearms became pruritic, erythematous and, later, moist eczematous patches appeared on them. Local treatment cleared the condition and she was fit and well until a trivial injury in January '49 to the front of the right leg resulted in the appearance of an exudative patch. The condition gradually extended to cover the whole of the right leg while several eczematous patches developed on the thighs and forearms. Despite local treatment no improvement was noticed and she was admitted to Stobhill Hospital on 13.5.49.

Examination on admission.

The patient was an elderly, poorly nourished woman. On the front of the right leg there was an area of infectious eczematoid dermatitis extending from the knee to the ankle.

The sensitisation eruption was exudative in character and was present on the forearms and thighs. There was a single well demarcated moist raw patch (4" x 3") on the extensor of each arm close to the elbow. There were several similar patches (2" x 1") on the anterior surfaces of the thighs, while at the periphery of these patches were several discrete erythematous papules.

CASE NO. 44.

M.B. a married woman, aged 73 years, was admitted to Stobhill Hospital on 7.12.48 with a diagnosis of varicose ulcer of the right leg and a sensitisation eruption on the face and forearms.

General History.

1. Previous illnesses: Recurrent ulceration of both legs for the past ten years.
2. Family history: Nothing relevant.
3. Personal history: Housewife.
4. Allergic history: No family or personal history of allergic manifestations.

Immediate History.

In July '48, the patient sustained a fracture of the right leg which healed fairly quickly but, after the removal of the plaster of Paris, a small ulcer was noticed on the medial malleolus. Later, around the ulcer, an eczematous reaction developed which gradually extended and involved the whole of the right leg. The condition persisted and in November '48, numerous pruritic papules appeared on the forearms to be followed by nummular patches of eczema. Later a pruritic erythema developed on/

on the face and, within a few hours, was accompanied by a marked oedema of the lips and eyelids which caused the patient to seek admission to Stobhill Hospital.

Examination on admission.

The patient was an obese, elderly woman. On the right medial malleolus there was an oval-shaped superficial ulcer (1" x ½"), the edges of which were irregular while the base showed several warty granulations. On the stocking distribution of the right leg there was a typical patch of varicose eczema with an associated varicosity of the superficial veins of both legs.

The sensitisation eruption was mixed in character but the prominent feature was an urticarial reaction. There was a diffuse erythema of the face with marked oedema of the lips and peri-orbital tissues. There were several wheals and erythematous blotches on the neck and trunk, while factitious urticaria was easily provoked. The forearms showed a patchy exfoliation of the superficial epidermis which resulted in large exudative areas, particularly at the ante-cubital fossae. Several of the eczematous lesions on the dorsal aspects of the forearms were covered with yellowish-brown crusts and there was an associated axillary adenitis.

CASE NO. 45.

W.F. a married man, aged 37 years, was admitted to Stobhill Hospital on 21.5.49 with a diagnosis of varicose ulcer of the right leg and a sensitisation eruption on the face, forearms and the trunk.

General History.

1. Previous illnesses: Measles, mumps in childhood.
2. Family history: Nothing relevant.
3. Personal history: Employed as a butcher.
4. Allergic history: No family or personal history of allergic manifestations.

Immediate History.

For the past ten years the patient has had recurrent ulceration of both legs. In January '49, a small ulcer was noticed on the right medial malleolus; a dry dressing was applied and the patient continued at his employment. A few weeks later a pruritic papular erythema appeared on the forearms, particularly on the volar surfaces. The patient consulted his doctor who prescribed sulphanilamide powder to the ulcer and calamine lotion to the forearms. After eight weeks on this treatment, the patient developed an erythema on the face and the trunk while the forearms became

became eczematous. He was admitted on 21.5.49 to Stobhill Hospital.

Examination on admission.

The patient was a well nourished young man.

On the right medial malleolus, there was a small shilling sized superficial ulcer. The edges were irregular and indurated and there was brownish pigmentation of a stocking distribution on both legs. There were several healed scars and the varicosity of the veins was pronounced.

The sensitisation eruption was mixed in character; the predominant feature was the scaling erythema of the face and trunk while the upper limbs presented a papular erythema. There was a vivid brick-red facial erythema with a number of small loosely attached frilly white scales. From the trunk a diffuse desquamation of the skin gave a slate-like appearance of greyish scales, removal of which revealed a dry, red, glazed surface. The forearms were studded with numerous discrete erythematous papules and papulo-vesicles, friction and scratching of which caused moist eczematous patches at the ante-cubital fossae.

CASE NO. 46.

P.G. a married man, aged 72 years, was admitted to Stobhill Hospital on 3.6.49 with a diagnosis of infectious eczematoid dermatitis of the right leg and a sensitisation eruption on the forearms.

General History.

1. Previous illnesses: Measles in childhood.
2. Family history: Nothing relevant.
3. Personal history: Employed as a labourer.
4. Allergic history: No family or personal history of allergic manifestations.

Immediate History.

The patient was well until October '48, when as a result of an injury he sustained a laceration of the medial aspect of the right leg. The wound was neglected and, within a few days, a moist raw patch (2" x 1") developed over the site of the trauma. The eruption remained localised to the right leg although gradually by peripheral extension the postero-medial aspect of the calf was involved. The patient applied calamine lotion but no improvement was noticed and in March '49 the forearms became pruritic and numerous erythematous papules made their appearance. The involvement/

involvement of the forearms caused him to stop work and for a few days a slight improvement was apparent. However, the pruritic papular erythema on the forearms progressed to form circinate exudative areas. The eruption was most resistant to treatment and he was admitted on 3.6.49 to Stobhill Hospital.

Examination on admission.

The patient was an obese, elderly man. There was an area (4" x 2") of infectious eczematoid dermatitis on the postero-medial aspect of the right calf.

The sensitisation eruption was predominantly exudative in character and consisted of circinate patches (1" diameter) of moist eczema on the forearms. The lesions were composed of grouped papules and papulo-vesicles. A number of the lesions were covered with adherent brownish crusts, removal of which left bleeding raw surfaces. On the intervening skin there were numerous papules and papulo-vesicles. There was an associated axillary adenitis.

CASE NO. 47.

R.W. a married man, aged 36 years, was admitted to Stobhill Hospital on 16.6.49 with a diagnosis of infectious eczematoid dermatitis of the legs and a sensitisation eruption on the forearms.

General History.

1. Previous illnesses: Fracture femur ... 1943.
2. Family history: Nothing relevant.
3. Personal history: Employed as a textile worker.
4. Allergic history: No family or personal history of allergic manifestations.

Immediate History.

The patient was fit and well until April '49 when a pruritic erythema appeared on both ankles. There was no history of injury but he volunteered that the heat from the furnace fires irritated his legs. The pruritus of the ankles became so severe that spasms of uncontrolled scratching resulted in linear excoriations and later exudative patches developed on the lower third of the legs. Despite local treatment with simple zinc cream and complete rest in bed, the legs remained eczematous and in June '49, when pruritic exudative patches appeared on the forearms he was admitted to Stobhill Hospital.

Examination on admission.

The patient was a pale, thin, young man. On the lower half of the legs there were patches of infectious eczematoid dermatitis encircling both limbs.

The sensitisation eruption was predominantly exudative in character; the forearms and medial aspects of the thighs were covered with numerous oval-shaped patches (1" x ½") of eczema. The lesions on the forearms and thighs were well demarcated, the majority of which were moist and raw and covered with a serous exudate while a few were heavily crusted. The crusts were brown in colour and removal of one exposed a moist raw bleeding surface. There was an associated inguinal and axillary adenitis. A number of discrete erythematous papules were studded over the arms and shoulders and several deep linear excoriations were present on the legs and forearms.

CASE NO. 48./

CASE NO. 48.

C. O'D. an unmarried man, aged 41 years, was admitted to Stobhill Hospital on 12.7.49 with a diagnosis of infectious eczematoid dermatitis of the right leg and a sensitisation eruption on the forearms.

General History.

1. Previous illnesses: Measles in childhood.
2. Family history: Nothing relevant.
3. Personal history: Employed as a plasterer's labourer.
4. Allergic history: No family or personal history of allergic manifestations.

Immediate History.

The patient was fit and well until June '49, when an injury resulted in a laceration on the front of the right leg. He immediately reported to the first aid post where the wound was dressed, but he was infrequent in subsequent attendances for treatment and after about ten days a large moist eczematous patch developed on the middle third of the right leg. He consulted his general practitioner who painted the affected part with an aqueous solution of gentian violet. An improvement was noticed but this was only transient and soon several moist raw patches appeared on the thighs, forearms and scrotum./

scrotum. Later, numerous pruritic papules occurred on the arms, shoulders and trunk, and he sought admission to Stobhill Hospital.

Examination on admission.

The patient was a well-nourished, young man. There was an area of infectious eczematoid dermatitis on the stocking distribution of the right leg. There was gross oedema of the right leg with an associated varicosity of the superficial veins.

The sensitisation eruption was exudative in character and affected the forearms, thighs and scrotum. There was a diffuse exfoliation of the superficial epidermis of the forearms and the underlying exposed surfaces showed marked exudation. The intertrigo of the groins extended on to the scrotum and medial aspects of the thighs and from these areas oozed a thin yellowish exudate which dried to form yellowish-brown impetiginous crusts. There were also numerous papules and papulo-vesicles on the arms, shoulders, trunk and anterior aspects of the thighs. Nikolsky's sign was not elicited. There was an associated inguinal and axillary adenitis.

CASE NO. 49.

T.A. a married man, aged 64 years, was admitted to Stobhill Hospital on 14.6.49 with a diagnosis of infectious eczematoid dermatitis of the right ankle and a sensitisation eruption on the forearms.

General History.

1. Previous illnesses: Measles, chickenpox in childhood.
2. Family history: Nothing relevant.
3. Personal history: Employed as labourer in gas works.
4. Allergic history: No family or personal history of allergic manifestations.

Immediate History.

The patient was fit and well until April '49, when as a result of an injury he sustained an abrasion over the right medial malleolus. He neglected the wound which soon assumed the character of a well defined patch (2" x 1") of moist weeping eczema. The lesion gradually extended and involved the medial aspect of the lower half of the right leg. About two months later the forearms and thighs became pruritic and shilling-sized circinate exudative patches made their appearance, particularly/

particularly on the medial aspects of the thighs. The patient consulted his doctor who arranged admission to Stobhill Hospital on 14.6.49.

Examination on admission.

The patient was a well nourished, elderly man. On the antero-medial aspect of the lower half of the right leg there was a well demarcated area (5" x 3") of infectious eczematoid dermatitis.

The sensitisation eruption was exudative in character and consisted of numerous, nummular, moist, raw patches ($\frac{1}{2}$" diameter) on the extensors of the forearms and medial aspects of the thighs. A few of the circinate lesions were heavily crusted and a yellowish exudate which oozed from them produced no cutaneous irritation. On the intervening skin and particularly at the periphery of the nummular lesions, there were a few, discrete papules and papulo-vesicles.

CASE NO. 50.

J.Q. a married man, aged 63 years, was admitted to Stobhill Hospital on 26.7.49 with a diagnosis of infectious eczematoid dermatitis of the left foot and a sensitisation eruption on the forearms.

General History.

1. Previous illnesses: Pneumonia 1949.
2. Family history: Nothing relevant.
3. Personal history: Employed as a railway porter.
4. Allergic history: No family or personal history of allergic manifestations.

Immediate History.

The patient was fit and well until March '49 when he sustained an injury to the dorsum of his left foot. He continued at work until the wound became infected and later an abscess formed, which required an incision and evacuation of pus. He resumed work before the wound had completely healed and the friction of his boot produced a moist eczematous patch over the dorsum of the left foot. Despite local therapy with calamine lotion, fresh exudative lesions appeared on both legs while numerous pruritic papules developed on the upper limbs. Later, eczematous patches appeared on the forearms and when a papular reaction occurred on the trunk, he sought admission to Stobhill Hospital on 26.7.49.

Examination on admission./

Examination on admission.

The patient was a thin, poorly nourished, old man. On the dorsum of the left foot and anterior aspect of the lower one third of the left leg there was a well defined area of infectious eczematoid dermatitis.

The sensitisation eruption was mixed in character with exudative lesions on the limbs and a papular reaction on the trunk. On the forearms and thighs there were several, florin-sized, nummular patches of eczema, several of which were covered with adherent yellowish brown crusts. The circinate lesions were composed of aggregations of papules and papulo-vesicles. A few discrete papules were asymmetrically studded over the forearms and trunk, particularly on the lumbo-sacral region.

CASE NO. 51.

S. McF. a married man, aged 50 years, was admitted to Stobhill Hospital on 2.8.49 with a diagnosis of an infectious eczematoid dermatitis of the left forearm and a sensitisation eruption on the face, trunk and limbs.

General History:

1. Previous illnesses: Measles, mumps whooping cough in childhood.
2. Family history: Nothing relevant.
3. Personal history: Employed as a pneumatic riveter.
4. Allergic history: No family or personal history of allergic manifestations.

Immediate History.

The patient was fit and well until January '49 when he sustained a laceration of the left forearm which failed to heal and, a few weeks later, a moist eczema surrounded the wound. The patient applied various lotions and the condition improved leaving a dry scaling erythema; however, in July '49, a trivial injury to the same forearm was soon followed by a recurrence of the exudative process. Despite local applications of calamine lotion, the eruption spread and involved the whole of the left forearm and dorsum of the left hand. A few days later , an intense pruritus of the face and trunk was followed by a well marked flexural eczema and he was admitted to Stobhill Hospital.

Examination on admission./

Examination on admission.

The patient was a well nourished, middle-aged man. There was an area of infectious eczematoid dermatitis which encircled the left forearm from the elbow to the wrist.

The sensitisation eruption resembled in appearance and distribution the features of seborrhoeic dermatitis. The ears were erythematous and oedematous with a pronounced retro-auricular intertrigo, while numerous, eroded papules were present on the scalp. There was a maculo-papular erythema of the face with greyish, greasy scales in the naso-labial folds. There was no marginal blepharitis but a marked exudative phase was present on the axillae, groins, popliteal and the cubital fossae. Over the trunk and legs there were numerous discrete, scaling, follicular papules, while on the palms there was a typical cheiropompholyx.

CASE NO. 52. /

CASE NO. 52.

J.T. a married man, aged 81 years, was admitted on 2.8.49 to Stobhill Hospital with a diagnosis of infectious eczematoid dermatitis of the right leg and a sensitisation eruption on the forearms.

General History.

1. Previous illnesses: Measles, mumps, whooping cough, chicken pox in childhood.
   Facial erysipelas ... 1940.
   Pneumonia ... ... 1947.
2. Family history: Nothing relevant.
3. Personal history: Employed as night watchman.
4. Allergic history: No family or personal history of allergic manifestations.

Immediate History.

The patient was fit and well until June '49, when he noticed a patch of moist eczema on the front of his right leg. He was not aware of any injury but, for some weeks prior to the onset of the eczematous reaction, there had been an intense pruritus of the leg and he attributed the exudation to scratching. He reported to his practitioner who prescribed calamine liniment, but/

but a few weeks later circinate patches of eczema appeared on the forearms and on 2.8.49 he sought admission to Stobhill Hospital.

Examination on admission.

The patient was an obese, elderly man. On the anterior aspect of the lower two thirds of the right leg there was an area of infectious eczematoid dermatitis.

The sensitisation eruption was exudative in character and was confined to the forearms. On both forearms, particularly the extensor surfaces, there were several penny-sized patches of moist eczema. The patches, which were composed of aggregations of eroded papulo-vesicles, were well demarcated and showed no evidence of crusting. An exudate which trickled on to the intervening skin produced no evidence of cutaneous irritation although, at the periphery of the lesions, there were a few discrete papules and papulo-vesicles.

CASE NO. 53./

CASE NO. 53.

D.A. a widow, aged 63 years, was admitted to Stobhill Hospital on 11.7.49 with a diagnosis of infectious eczematoid dermatitis of the left leg and a sensitisation eruption on the trunk and forearms.

General History.

1. Previous illnesses: Periodic ulceration of the left leg for 30 years.
2. Family history: Nothing relevant.
3. Personal history: Housewife.
4. Allergic history: No family or personal history of allergic manifestations.

Immediate History.

In July '48, the patient sustained an injury to her left leg which caused a small, superficial, penny-sized ulcer which healed leaving a scaling erythema on the antero-medial aspect of the lower third of the leg. For the next year there were frequent recurrences of the eczematous process and, in May '49, an unusually acute exudative exacerbation was accompanied by the appearance of numerous pruritic scaly patches on the trunk and forearms. The condition did not respond to topical treatment with calamine lotion and she was admitted to Stobhill Hospital.

Examination on admission.

The patient was a well nourished, elderly woman. On the antero-medial aspect of the lower one third of the left leg there was a large patch of infectious eczematoid dermatitis.

The sensitisation eruption was psoriasiform in character and appeared on the trunk and limbs. On the elbows, knees and lumbo-sacral region there were large erythematous scaling plaques. The scales were a greyish colour and lacked the silvery appearance of psoriasis and grattage revealed no pin-point bleeding points. On the trunk and forearms there were several guttate scaling lesions and a few small eroded papules. There was no evidence of psoriasis on the scalp or finger nails.

CASE NO. 54.

M. McC. a widow, aged 63 years, was admitted to Stobhill Hospital on 29.7.49 with a diagnosis of infectious/

infectious eczematoid dermatitis of the left forearm and a sensitisation eruption on the face, hands and right forearm.

General History.

1. Previous illnesses: Measles, mumps, whooping cough in childhood. Glaucoma both eyes 1941.
2. Family history: Father died aged 65 years with cerebral haemorrhage.
3. Personal history: No family or personal history of allergic manifestations.

Immediate History.

The patient was fit and well until May '49 when she received a scald of the left forearm which produced a marked erythema but no vesiculation. She neglected the burn and, within one week, a raw moist eczematous patch appeared on her forearm. Later, the right forearm and dorsal aspects of the hands became pruritic and erythematous and subsequent scratching resulted in the appearance of patches of moist eczema. She reported to her practitioner who applied calamine liniment. The patient, however, treated herself with large doses of "Clarke's" blood mixture and, within two weeks,/

weeks, several thin-walled bullae appeared on the face, and she was admitted to Stobhill Hospital.

Examination on admission.

The patient was a well nourished, elderly, blind woman. On the extensor surface of the left forearm there was a rectangular-shaped (3" x 2") patch of infectious eczematoid dermatitis.

The sensitisation eruption was mixed in character; the predominant feature was the exudation on the forearms, while a vesicular element was present on the face, trunk, thighs and fingers. On the forearms there were several, florin-sized areas of moist raw eczema with tiny, discrete papules studded on the intervening skin but particularly at the periphery of the lesions. On the malar prominences, the forehead and hands, there were numerous vesicles, several of which had coalesced to form large flaccid bullae and, on the trunk and thighs, there were several eroded vesicles and a few linear excoriations.

CASE NO. 55./

CASE NO. 55.

W.S. a married woman, aged 70 years, was admitted to Stobhill Hospital on 2.8.49 with a diagnosis of infectious eczematoid dermatitis of the right leg and a sensitisation eruption on the chest and forearms.

General History.

1. Previous illnesses: Measles, whooping cough in childhood.
   Rheumatic Fever 1914 and 1918.
   Pneumonia 1940.
2. Family history: Nothing relevant.
3. Personal history: Housewife.
4. Allergic history: No family or personal history of allergic manifestations.

Immediate History.

The patient was fit and well until July '49, when she sustained a bruise on the front of her right leg and, a few days later, the part became pruritic and subsequent scratching produced an area of moist eczema. The patient scrubbed the part with soap and water and the lesion spread to involve the anterior aspect of the middle third of the right leg. Despite repeated applications/

applications of calamine lotion, the condition failed to heal and, one week later, pruritic papules appeared on the chest and forearms and arrangements were made for her admission to Stobhill Hospital.

Examination on admission.

The patient was a thin, elderly woman. On the front of the middle third of the right leg there was a well defined patch of infectious eczematoid dermatitis.

The sensitisation eruption was predominantly papular in character and was present on the trunk and upper limbs. There were numerous, erythematous papules and papulo-vesicles on the forearms, anterior chest wall, shoulders and lumbo-sacral region. The papules varied in size from a pin-head to a pea; the majority remained discrete while several of them showed a tendency to grouping. On the dorsal aspects of the forearms, there were a few sixpenced-sized areas of nummular eczema composed of aggregations of papules and papulo-vesicles. The axillary glands were not enlarged.

CASE NO. 56./

CASE NO. 56.

A.F. a widow, aged 70 years, was admitted to Stobhill Hospital on 2.8.49 with a diagnosis of varicose ulceration of the left leg and a sensitisation eruption on the trunk, thighs and forearms.

General History.

1. Previous illnesses: Periodic ulceration of left leg. Enteric fever at 20 years.
2. Family history: Nothing relevant.
3. Personal history: Housewife.
4. Allergic history: No family or personal history of allergic manifestations.

Immediate History.

The patient has been troubled with recurrent ulceration of the left medial malleolus for forty years. The ulcerations invariably followed upon minor injuries and usually healed fairly quickly with complete rest in bed. However, four years ago, an ulcer on the left medial malleolus recurred and remained quiescent until May '49 when, suddenly, within one week, numerous erythematous papules appeared on the forearms and trunk. This fresh eruption was intensely pruritic and subsequent scratching produced eczematisation and she was admitted to Stobhill Hospital.

Examination on admission.

The patient was a well nourished, elderly woman, with seborrhoeide patches on the chest and interscapular region.

On the medial aspect of the left leg, there was a large ulcer ($6\frac{1}{2}$" x 2") with irregular scraggy edges and exuberant, warty granulations on the base. On the right medial malleolus there was a similar small ulcer ($2\frac{1}{4}$" x $\frac{3}{4}$").

The sensitisation eruption was mixed in character; the predominant feature was the marked flexural exudation. There were large eczematous areas affecting the groins, axillae, popliteal and the cubital fossae, the intertrigo of the groins extended on to the thighs and pubic region. On the trunk, antero-medial aspects of the thighs and dorsal surfaces of the forearms, there were numerous, small, discrete papules and papulo-vesicles. The palms exhibited a well marked cheiropompholyx.

CASE NO. 57./

CASE NO. 57.

M.B. a widow, aged 57 years, was admitted to Stobhill Hospital on 19.8.49 with a diagnosis of varicose eczema of the left leg and a sensitisation eruption on the face and forearms.

General History.

1. Previous illnesses: 1934 ... injection therapy for varicose veins.
2. Family history: Nothing relevant.
3. Personal history: Housewife.
4. Allergic history: No family or personal history of allergic manifestations.

Immediate History.

Since April '49, the patient has had recurrent attacks of moist eczema on the legs which was attributed to the varicosity of the superficial veins. In August '49, an unusually acute exacerbation of the exudation on the legs was accompanied by numerous, pruritic, papules on the forearms. A few days later, an intense pruritus developed in the face and was followed, within a few hours, by a blotchy erythema and a pronounced oedema of the peri-orbital tissues. About forty-eight hours before admission to Stobhill Hospital, numerous vesicles appeared on the hands and feet.

Examination on admission.

The patient was an obese, elderly woman. On the antero-medial aspect of the left leg, there was a well marked area of varicose eczema (6" x 3"). There was a mild degree of oedema of the ankles with a pronounced varicosity of the veins.

The sensitisation eruption was mixed in character; the striking feature was the peri-orbital oedema and the intense, brick-red erythema of the face. There were no lesions on the buccal mucosa, the lips were slightly swollen and the oedema of the eyelids closed the eyes. There were a few wheals and blotches on the neck and trunk while on the fore-arms and V-shaped area of the neck and chest, there were numerous, erythematous papules. The hands and feet exhibited typical lesions of cheiro and podopompholy.

CASE NO. 58./

CASE NO. 58.

J.M. a married woman, aged 71 years, was admitted to Stobhill Hospital on 18.8.49 with a diagnosis of bilateral varicose ulceration of the legs and a sensitisation eruption on the trunk and forearms.

General History.

1. Previous illnesses: 1947 ... treated in The Victoria Infirmary, Glasgow, for haemorrhage from a ruptured varicose vein.
2. Family history: Nothing relevant.
3. Personal history: Housewife.
4. Allergic history: For the past number of years the patient has had infrequent attacks of asthma which were controlled by gr. i ephedrine sulphate twice daily. During her sojourn of five weeks in hospital, despite the absence of ephedrine sulphate, she remained free from asthma.

Immediate History.

The patient has been troubled with varicosity of the leg veins for several years and, in February 1948, she noticed a small, sixpence-sized ulcer on the left leg. No history of trauma was elicited and, despite local applications, the ulcer gradually became bigger.

In/

In June 1948, another ulcer appeared on the right leg and, for the next few months, the patient was very conscientious in carrying out the prescribed local treatment, but when she noticed no improvement she became discouraged and stopped all local therapy. In July 1949, numerous pruritic papules developed on the trunk and forearms, and she was admitted to Stobhill Hospital.

Examination on admission.

The patient was a thin, wizened, old woman with a marked kyphosis. On the lateral malleolus of the left leg there was an ulcer (2" x 1") with a dirty, yellowish crusted base and irregular steep edges. On the right malleolus there was a small, florin-sized ulcer with warty granulations on the base. An ill-defined moist eczema surrounded the ulcers and there was an associated varicosity of the superficial veins.

The sensitisation eruption was papulo-vesicular in character and confined to the trunk and upper limbs. On the extensor surfaces of the forearms, anterior chest wall and lumbo-sacral region there were numerous erythematous, scaling papules and papulo-vesicles which varied in size from a pin-head to a pea.

The/

The lesions remained discrete and showed no tendency to grouping or eczematisation.

Respiratory System.

The chest moved freely on respiration, the percussion note was resonant. The R.M. was vesicular with a prolongation of the expiratory phase and numerous sibilant rhonci were heard at both bases.

CASE NO. 59.

G.L. a married woman, aged 56 years, was admitted to Stobhill Hospital on 21.8.49 with a diagnosis of varicose eczema of the left leg and a sensitisation eruption on the face, forearms and trunk.

General History.

1. Previous illnesses: 1922 ... Pleurisy.
   1930 ... Rheumatic fever.
   1941 ... Appendicectomy.
   1943 ... Injection therapy for varicose veins.
2. Family history: Nothing relevant.
3. Personal history: Housewife.
4. Allergic history: No family or personal history of allergic manifestations.

Immediate History.

About five years ago, the patient was severely scratched by a cat and, as a result, she developed a patch of eczema on her left leg. The condition responded to topical treatment but exacerbations were frequent until an elastic stocking was worn which provided longer quiescent periods. Recently, she neglected to wear a supporting stocking and a trivial injury caused a recurrence of the eczema. In August 1949, a number of pruritic papules appeared on the forearms and trunk and, three weeks later, the face suddenly became pruritic, erythematous and markedly swollen, which necessitated her admission to hospital.

Examination on admission.

The patient was an obese, middle-aged woman. On the antero-medial aspect of the lower one third of the left leg there was an area of varicose eczema which surrounded a small, shilling-sized ulcer.

The sensitisation eruption was mixed in character; the predominant feature was an urticarial reaction. There was a diffuse, brick-red, facial erythema with swollen lips and a marked peri-orbital oedema which almost closed the eyes. On the trunk, particularly/

particularly at the clothing pressure points, were several, erythematous blotches and wheals while factitious urticaria was easily provoked. On the forearms and trunk, especially the lumbo-sacral region, there were numerous discrete, slightly scaling papules and a few eroded papulo-vesicles.

CASE NO. 60.

J.McN. a widower, aged 76 years, was admitted to Stobhill Hospital on 5.8.49 with a diagnosis of infectious eczematoid dermatitis of the left forearm and a sensitisation eruption on the forearms and legs.

General History.

1. Previous illnesses: Facial erysipelas ... 1946.
2. Family history: Nothing relevant.
3. Personal history: Retired gardener.
4. Allergic history: No family or personal history of allergic manifestations.

Immediate History.

The patient was well until June 1947, when he fell and grazed his left elbow. The laceration was neglected/

neglected and a moist eczema rapidly developed around the wound. Local treatment with calamine lotion cleared the eruption but the patient complained of a residual pruritus and subsequent scratching produced a recurrence of the exudative phase. For the next two years, exacerbations and remissions were frequent but, during an acute exacerbation in June 1949, the patient developed oval-shaped eczematous lesions on the buttocks, thighs, legs and forearms.

Examination on admission.

The patient was a well nourished, old man. On the left elbow region there was a patch (4" x 3") of infectious eczematoid dermatitis.

The sensitisation eruption was exudative in character and comprised several, nummular shaped areas of eczema on the forearms, buttocks and legs. The lesions were about the size of a shilling; the majority of which showed marked exudation, whilst others were heavily crusted. The intervening skin was normal and a serous exudate, which trickled from the eczematous patches, produced no cutaneous irritation. On the extensor surface of the left forearm and on the dorsal aspects of both wrists, there were patches of infiltrated, thickened skin with lichenification.

CASE NO. 61.

J.H. a married woman, aged 40 years, was admitted to Stobhill Hospital on 11.7.49 with a diagnosis of infectious eczematoid dermatitis of the forearms and a sensitisation eruption on the face, axillae and legs.

General History.

1. Previous illnesses: Scarlet fever and whooping cough in childhood.
2. Family history: Nothing relevant.
3. Personal history: Housewife.
4. Allergic history: Repeated attacks of hay-fever.

Immediate History.

The patient remained well until June 1949, when a superficial laceration of the right forearm became pruritic and a vivid erythema appeared on the surrounding skin. After a few days on local treatment, the condition settled; however, the patient injudiciously scrubbed the part with soap and water and an acute exacerbation of the pruritic erythema resulted. The prutitus was so severe that spasms of uncontrolled scratching produced a patch of moist eczema on the right forearm/

forearm. Later, a flexural intertrigo developed with associated eczematous patches on the left forearm and she was admitted to Stobhill Hospital.

Examination on admission.

The patient was a poorly-nourished, middle-aged woman. There was a rectangular-shaped patch of infectious eczematoid dermatitis on the right forearm.

The sensitisation eruption was predominantly seborrhoeic in character and confined to the ears, axillae, groins and thighs. There was a marked intertrigo of the axillae, groins and the retro-auricular areas. On the trunk and anterior aspect of the thighs there were a few, greasy, scaling, brownish-red patches and several, small, scaling, follicular papules, while on the left forearm and medial surfaces of the thighs there were a few, moist, eczematous patches.

CASE NO. 62.

M.M. a married woman, aged 20 years, was admitted to Stobhill Hospital on 29.8.49 with a diagnosis of infectious eczematoid dermatitis of the left hand and a sensitisation eruption on the forearms and legs.

General History.

1. Previous illnesses: 1939 ..... pneumonia.
2. Family history: Nothing relevant.
3. Personal history: Housewife.
4. Allergic history: No family or personal history of allergic manifestations.

Immediate History.

In July 1949, the patient sustained a laceration of the dorsum of her left hand which was neglected and, a few days later, an intense pruritus developed around the wound and subsequent scratching produced an area (3" x 2") of moist, raw, eczema. The condition did not respond to local treatment with calamine lotion and, within a few weeks, fresh eczematous patches appeared on the forearms and legs and she was admitted to Stobhill Hospital.

Examination on admission.

The patient was a well-nourished, young woman. On the dorsum of the left hand there was an area of infectious eczematoid dermatitis.

The sensitisation eruption was exudative in character and comprised nummular lesions of moist eczema. On the forearms and legs there were several, penny-sized eczematous/

eczematous areas which were composed of aggregations of papules and papulo-vesicles. A few of the older lesions were covered with impetiginous crusts. The intervening skin was normal except for a few, discrete papulo-vesicles and a few linear excoriations.

CASE NO. 63.

E.F. a married man, aged 41 years, was admitted to Stobhill Hospital on 30.9.49 with a diagnosis of infectious eczematoid dermatitis of the legs and a sensitisation eruption on the forearms and hands.

General History.

1. Previous illnesses: Measles.
2. Family history: Nothing relevant.
3. Personal history: Employed as a joiner.
4. Allergic history: No family or personal history of allergic manifestations.

Immediate History.

The patient was fit and well until September 1949 when the friction of his rubber boots produced a papular reaction on the dorsal aspects of his feet. Later,/

Later, with subsequent scratching, a moist eczema appeared and despite applications of calamine lotion this exudative eruption extended peripherally and involved the lower one third of the legs. About one week later, preceded by an intense pruritus, numerous vesicles and bullae made their appearance on the palms, wrists and fingers, and he was admitted on 30.9.49 to Stobhill Hospital.

Examination on admission.

The patient was a well-nourished, young man. On the anterior aspect of the lower half of each leg there was a well demarcated area of infectious eczematoid dermatitis.

The sensitisation eruption was primarily vesicular in character and was present on the forearms and hands. There was a mixture of circular and irregularly-shaped, erythematous blotches with a more or less symmetrical distribution of vesicles and bullae on the hands and forearms. There were a few target lesions of erythema iris on the extensor surfaces of his wrists but on the palms, there were several thick-walled bullae, a few of which had ruptured and exposed raw bleeding surfaces. There were no lesions on the buccal mucosa.

CASE NO. 64.

J. McG. a married man, aged 43 years, was admitted to Stobhill Hospital on 11.10.49 with a diagnosis of infectious eczematoid dermatitis of the left foot and a sensitisation eruption on the forearms.

General History.

1. Previous illnesses: Measles in childhood.
2. Family history: Nothing relevant.
3. Personal history: Employed as a labourer.
4. Allergic history: No family or personal history of allergic manifestations.

Immediate History.

The patient was fit and well until June 1949, when a blister developed on the dorsum of his left foot. He attributed this lesion to irritation by footwear and further friction caused rupture of the blister, producing a raw, moist surface which extended peripherally and involved the base of his toes and the distal half of the dorsum of his foot. In September 1949, several papules developed on the forearms and, a few weeks later, numerous vesicles appeared around the wrists and hands. He reported to his doctor who advised him to stop working and prescribed calamine liniment locally, but the condition did/

did not improve and with the appearance of a lymphangitis of the left forearm and axillary adenitis, he was admitted to Stobhill Hospital.

Examination on admission.

The patient was a well-nourished, young man. On the dorsum of the left foot there was a rectangular patch of infectious eczematoid dermatitis.

The sensitisation eruption resembled erythema multiforme and consisted of discrete papules and well-defined bluish-red, circinate macules on the forearms. Scattered between the lesions there were numerous vesicles and a few bullae, a number of which were ruptured, particularly on the left wrist where impetiginous crusting was a marked feature. On the wrists there were a few pustules while the hands exhibited a typical picture of cheiropompholyx. There was an associated lymphangitis of the left forearm and an accompanying axillary adenitis. There were no lesions on the buccal mucosa.

CASE NO. 65.

A.D. a married man, aged 32 years, was admitted to Stobhill Hospital on 14.10.49 with a diagnosis of infectious eczematoid dermatitis of the left hand and a sensitisation eruption on the trunk, forearms and legs.

General History.

1. Previous illnesses: In 1944, while serving in the Royal Navy the patient developed a vesicular eruption on the hands and feet. The eruption persisted for almost one year and was diagnosed as "tropical dermatitis."
2. Family history: Nothing relevant.
3. Personal history: Employed as a "dresser" in a carpet factory.
4. Allergic history: No family or personal history of allergic manifestations.

Immediate History.

In October 1949, while at his work the patient sustained a scratch on the dorsum of his left hand. This failed to heal and the surrounding skin became eczematous and, a few days later, vesicles appeared on the fingers, palms and feet. Suddenly, within forty-eight/

eight hours, the trunk became covered with erythematous papules, while on the limbs erythematous blotches made their appearance. About two days before admission, a pruritus developed in the scalp which was soon covered with crusted impetiginous lesions and he was admitted to Stobhill Hospital.

Examination on admission.

The patient was a thick-set, muscular, young man. On the dorsum of the left hand there was an area (2" x 1") of infectious eczematoid dermatitis.

The sensitisation eruption presented a mixed picture of papular, vesicular, bullous and impetiginous features. There were numerous closely-set papules and papulo-vesicles on the trunk, particularly in the lumbo-sacral region. The scalp was covered with impetiginous crusted lesions with an associated post-cervical adenitis. There were a few ruptured lesions on the buccal mucosa while on the forearms and thighs the eruption closely resembled erythema multiforme bullosa. The lesions on his feet and podgy hands were typical of podo-cheiropompholyx.

CASE NO. 66.

D. McG. a married man, aged 48 years, was admitted to Stobhill Hospital on 27.10.49 with a diagnosis of infectious eczematoid dermatitis of the right leg and a sensitisation eruption on the forearms.

General History.

1. Previous illnesses: Accident in childhood which resulted in the loss of sight in the right eye.
   1923 ... Rheumatic fever.
   1944 ... Oil folliculitis of the forearms.
2. Family history: Nothing relevant.
3. Personal history: Employed as an engineer.
4. Allergic history: No family or personal history of allergic manifestations.

Immediate History.

In 1923, the patient received a kick on the front of his right leg; the resultant laceration did not heal completely and an erythematous, scaling patch remained. During the last twenty-five years, there have been periodic exacerbation of a moist eczema on this site, usually associated with a minor trauma. In October 1949, when the patient was working in bad conditions/

conditions, the friction of the footwear on his wet feet caused an efflorescence of the exudation on the right leg and foot. About one month later, numerous pruritic papules appeared on the forearms and dorsal aspects of the hands and he was admitted to Stobhill Hospital.

Examination on admission.

The patient was a well-nourished, middle-aged man. On the dorsum of the right foot and lower one third of his right leg, there was a large patch of infectious eczematoid dermatitis.

The sensitisation eruption was present on the forearms and consisted of numerous, closely-set papules, particularly on the extensor surfaces. The papules, a few of which were crowned with loosely attached scales, varied in size from a pin-head to a pea. They remained discrete except on the dorsal aspect of the right wrist where there was a rectangular-shaped eczematous patch composed of aggregations of eroded papules and papulo-vesicles. About three or four large thin-walled bullae were present on the thenar eminences while on the fingers, there were a few superficial thin-walled pustules and vesicles.

CASE NO. 67.

W.K. a married woman, aged 36 years, was admitted to Stobhill Hospital on 31.10.49 with a diagnosis of varicose eczema of the left leg and a sensitisation eruption on the face and forearms.

General History.

1. Previous illnesses: Appendicectomy ... 1938.
2. Family history: Nothing relevant.
3. Personal history: Housewife.
4. Allergic history: No family or personal history of allergic manifestations.

Immediate History.

For the past twelve years the patient has had repeated attacks of varicose eczema of her left leg and, one year ago, an unusually acute exacerbation was followed by a slight trauma which resulted in the appearance of a small ulcer. The patient tried various topical measures but no improvement was noticed and, in October '49, after several pruritic papules appeared on her forearms, she applied penicillin cream to the ulcer. Within a week of this application the face suddenly became pruritic and, a few hours later, erythematous and finally oedematous. She was admitted to Stobhill Hospital on 31.10.49.

Examination on admission.

The patient was an obese, young woman. There was a large area of moist eczema on the stocking distribution of the left leg with a superficial ulcer on the medial malleolus. There was an obvious varicosity of the superficial veins of both legs with an associated oedema of the feet.

The sensitisation eruption was urticarial in character; the predominant feature was a diffuse brick-red erythema of the face with marked oedema of the lips and peri-orbital tissues. On the right malar prominence there was an eczematous reaction, while across the forehead there were several, yellowish-brown crusts and on the neck and trunk there were wheals, blotches and erythematous macules. The papules which were present on the forearms and the lumbo-sacral region remained discrete, varied in size from a pin-head to a pea and were occasionally crowned with loosely attached greyish white scales. Dermographism was a marked feature.

CASE NO. 68.

J.A. a married woman, aged 59 years, was admitted to Stobhill Hospital on 16.11.49 with a diagnosis of varicose eczema of the legs and a sensitisation eruption on the forearms.

1. Previous illnesses: Measles and mumps in childhood.
2. Family history: Nothing relevant.
3. Personal history: Housewife.
4. Allergic history: No family or personal history of allergic manifestations.

Immediate History.

In 1940, following a trivial injury an ulcer appeared on the medial aspect of the right leg. The ulcer gradually increased in size to about 2" x 1" and later, a smaller ulcer the size of a shilling, occurred on the left medial malleolus. She reported to her general practitioner who ordered complete rest in bed, and the ulcers healed. The patient remained well until 1948 when an eczema appeared on both legs which she attributed to prolonged standing and walking entailed by nursing her sick husband. The exudative phase spread peripherally and encircled the legs from the knees to the ankles. In September 1949, the forearms became pruritic and later numerous erythematous papules made their appearance and she/

she was admitted to Stobhill Hospital.

Examination on admission.

The patient was an obese, elderly woman. There was varicose eczema of the stocking distribution of both legs with marked varicosity of the veins.

The sensitisation eruption was papular in character and was present on the upper limbs and lumbo-sacral region. On the forearms and lateral aspects of the arms, there were numerous, discrete, erythematous papules, a few of which were crowned by loosely attached greyish, white scales. On the lumbo-sacral region there was an erythematous plaque composed of coalesced papules with a few outlying, discrete papules.

Central Nervous System.

The pupils were circular and unequal, the right was larger than the left, and there was no reaction to light or accommodation. The tendon reflexes were present and normal except the knee jerks which were not elicited. The plantar reflexes were flexor. The condition was probably one of myotonic pupil (Adie's Syndrome).

CASE NO. 69.

J.M. a married man, aged 27 years, was admitted to Stobhill Hospital on 18.11.49 with a diagnosis of infectious eczematoid dermatitis of the right leg and a sensitisation eruption on the forearms.

General History.

1. Previous illnesses: Chicken pox in childhood.
2. Family history: Nothing relevant.
3. Personal history: Employed as joiner.
4. Allergic history: No family or personal history of allergic manifestations.

Immediate History.

The patient was fit and well until September 1949 when he developed a boil on his right medial malleolus. He neglected the lesion for a few days, then applied hot boracic fomentations. The boil burst and the discharge caused an area of pruritic erythema, and subsequent scratching produced an eczematous reaction. About three weeks later, the forearms became pruritic and several nummular patches of moist eczema appeared on the upper limbs, and he was admitted to Stobhill Hospital.

Examination on admission./

Examination on admission.

The patient was a well-nourished, young man with a few carious teeth. On the right medial malleolus there was an area (2" x 1") of infectious eczematoid dermatitis.

The sensitisation eruption was characterised by sixpence-sized patches of nummular eczema on the upper limbs. The lesions were composed of aggregations of small papules and papulo-vesicles, while between the patches, there were numerous, discrete, individual lesions, several of which showed a tendency to grouping with formation of fresh, circinate, eczematous areas. There was no crusting or impetiginisation and the axillary glands were not enlarged.

CASE NO. 70.

I.P. a spinster, aged 53 years, was admitted to Stobhill Hospital on 22.11.49 with a diagnosis of varicose eczema of the right leg and a sensitisation eruption on the forearms.

General History./

General History.

1. Previous illnesses: 1916 .. Appendicectomy.
   1935 .. Bowel obstruction due to adhesions.
   1938 .. Incisional hernia repaired.
2. Family history: Nothing relevant.
3. Personal history: Employed as a clerkess.
4. Allergic history: No family or personal history of allergic manifestations.

Intermediate History.

About September 1949, a pruritic erythema developed on the lower half of the right leg and, a few weeks later, was followed by a patch of varicose eczema. She applied various local applications including penicillin cream and pragmatar ointment. After the latter, there was an acute exacerbation of the eczematous reaction which was treated with calamine lotion. She continued at her work but, about six weeks later, numerous, small, pruritic papules appeared on the forearms and she sought admission to Stobhill Hospital.

Examination on admission./

Examination on admission.

The patient was a well-nourished, middle-aged woman. There was a well defined area of varicose eczema on the lower half of the right leg, with an associated prominent varicosity of the veins of both legs.

The sensitisation eruption was papular in character and confined to the forearms, where there were a few, small, discrete, erythematous scaling papules, particularly on the dorsal surfaces. The lesions showed no tendency to grouping, crusting or impetiginisation and there was no associated lymphadenitis.

CASE NO. 71.

J. McG. a youth, aged 16 years, was admitted to Stobhill Hospital on 22.12.49 with a diagnosis of infectious eczematoid dermatitis of the left wrist and a sensitisation eruption on the thighs and forearms.

General History./

General History.

1. Previous illnesses: Measles, scarlet fever in childhood.
2. Family history: Nothing relevant.
3. Personal history: Employed as an apprentice printer.
4. Allergic history: No family or personal history of allergic manifestations.

Immediate History.

The patient was fit and well until January 1949 when he noticed an erythematous patch on the ulnar aspect of the left wrist. He attributed this to the repeated irritation of resting his wrist on the edge of a "type-case" when holding the "setting-stick." Various local applications were employed and finally occlusive dressings were applied but no improvement was apparent and, a few months later, several nummular patches of eczema appeared on the forearms. In December '49, a pruritus developed on the medial aspects of the thighs and was followed by the appearance of shilling-sized eczematous areas, and he was admitted to Stobhill Hospital.

Examination on admission./

Examination on admission.

The patient was a well-nourished youth. There was a patch of infectious eczematoid dermatitis on the ulnar aspect of the left wrist.

The sensitisation eruption was exudative in character and consisted of several, nummular patches of eczema on both forearms and medial aspects of the thighs. At the periphery of the lesions and across the lumbo-sacral region, there were a few erythematous papules and papulo-vesicles. There were also a few linear excoriations on the forearms.

CASE NO. 72.

W.McC. a married woman, aged 47 years, was admitted to Stobhill Hospital on 8.2.50 with a diagnosis of varicose ulceration of the right leg and a sensitisation eruption on the trunk and forearms.

General History./

General History.

1. Previous illnesses: Measles, chicken pox in childhood. Recurrent varicose ulceration of both legs.
2. Family history: Nothing relevant.
3. Personal history: Housewife.
4. Allergic history: No family or personal history of allergic manifestations.

Immediate History.

In July 1942, following a minor injury, a small ulcer appeared on the front of the right leg. Despite the following applications, viz. - ungt. scarlet red 4%, zinc peroxide (20% triturate) in water, and Hey's wash, no improvement was noticed and the patient thus became discouraged and neglected her leg for some months. By February 1950, the ulcer was much larger and the surrounding skin was eczematous. She reported to Stobhill Hospital where ichthyol-calamine liniment dressings were applied but, a few days later she returned for admission, with several pruritic papules on the forearms and numerous vesicles on her hands.

Examination on admission./

Examination on admission.

The patient was a very obese woman with several penny-sized, shallow ulcers on the antero-lateral aspect of the right leg. Surrounding the ulcers there was an area of moist, weeping eczema which merged into a brownish staining of the lower half of the leg. Varicosity of the veins was marked and there was pronounced oedema of the whole leg. On the left leg there was a single superficial ulcer with an associated varicose eczema.

The sensitisation eruption was papular in character and was present on the trunk, neck and fore-arms. Across the abdomen, nape of neck and lumbo-sacral region there were several eroded papules and a few linear excoriations. On the forearms there was a macular erythema with a number of small, discrete papules and, on the volar aspects of the wrists, there were a few superficial vesicles. Both hands, particularly the thenar eminences and lateral surfaces of the fingers, exhibited typical features of cheiropompholyx.

CASE NO. 73./

CASE NO. 73.

A.Y. a married man, aged 63 years, was admitted to Stobhill Hospital on 10.2.50 with a diagnosis of infectious eczematoid dermatitis of the left leg and a sensitisation eruption on the face, forearms and legs.

General History.

1. Previous illnesses: Measles, chicken pox in childhood.
2. Family history: Nothing relevant.
3. Personal history: Employed as foreman on road repairs.
4. Allergic history: No family or personal history of allergic manifestations.

Immediate History.

The patient was fit and well until July 1946 when he sustained a fracture of the left leg. On removal of the plaster, a circular ulcer was noticed on the posterior aspect of the mid-leg. This ulcer proved most difficult to heal and required hospitalisation on four occasions. On discharge from hospital in June 1949, he remained well but, in December 1949, the ulcer recurred and he reported to Stobhill out-patient department where zinc peroxide (20% triturate) in equal parts of water was applied. The ulcer improved but the surrounding area

of/

of the skin became moist and eczematous, and ichthyol-calamine liniment was prescribed. This exudative phase cleared quickly only to recur again in February 1950 and was followed by the appearance of pruritic papules on the forearms, face and legs, and he was admitted to Stobhill Hospital.

Examination on admission.

The patient was a well-nourished, elderly man. On the posterior aspect of the left calf there was a well demarcated area of infectious eczematoid dermatitis.

The sensitisation eruption was mixed in character with a purpuric element on the legs and a papular eruption on the forearms and face. On the face, thighs, legs and extensor aspect of the forearms there were several papules and papulo-vesicles. The individual lesions remained discrete and varied in size from a pin-head to a pea, whilst a few of the papules were crowned by loosely attached greyish white scales. On the medial aspect of the upper third of the legs and lower third of the thighs, there were several, punctate, purpuric lesions.

CASE NO. 74.

G.D. a married man, aged 58 years, was admitted to Stobhill Hospital on 3.12.49 with a diagnosis of varicose eczema of the left leg and a sensitisation eruption on the forearms and thighs.

General History.

1. Previous illnesses: 1914 ... Pneumonia.
2. Family history: Nothing relevant.
3. Personal history: Employed in a brewery.
4. Allergic history: No family or personal history of allergic manifestations.

Immediate History.

The patient was fit and well until November 1949, when he noticed several papules on the medial aspect of his left leg. An intense pruritus developed and subsequent scratching produced an eruption, which his doctor called varicose eczema and for which he prescribed zinc paste. A few days later, a number of pruritic papules appeared on the forearms and thighs and he sought admission to Stobhill Hospital.

Examination on admission.

The patient was a well-nourished, obese, middle-aged man. On the antero-medial aspect of the left/

left leg there was a large patch of varicose eczema which merged into an area of brownish pigmentation. A similar staining was present on the right leg but with no evidence of eczematisation. There was a mild degree of varicosity of the veins.

The sensitisation eruption was mainly papular in character and was present on the forearms and the antero-medial aspects of the thighs. Over the forearms, particularly the extensor surfaces, and on the thighs there were numerous erythematous, scaling papules and several linear excoriations. A few of the papules coalesced to form erythematous scaly patches; the scales were small, greyish white in colour and loosely attached so that on removal a glazed, red surface was exposed. The majority of the papules remained discrete and were more or less symmetrically distributed on the forearms and thighs. There was no inguinal or axillary adenitis.

CASE NO. 75.

J. McN. a married man, aged 30 years, was admitted to Stobhill Hospital on 2.3.50 with a diagnosis of phlebitis of the right thigh, a varicose eczema of his right leg and a sensitisation eruption on the forearms.

General History.

1. Previous illnesses: Varicose eczema of the right leg ... 1946.
2. Family history: Nothing relevant.
3. Personal history: Employed as a crane driver.
4. Allergic history: No family or personal history of allergic manifestations.

Immediate History.

About two months ago, the patient noticed a few pruritic papules on the medial aspect of the right leg and, later, the part became eczematous. The patient reported to his practitioner who diagnosed varicose eczema and prescribed simple zinc cream and calamine lotion. The condition improved but, following a slight trauma, there was a recurrence of the exudative phase. On the 2.3.50, the patient developed a pain in the medial/

medial aspect of the right thigh, which was diagnosed as phlebitis, and he was admitted to Stobhill Hospital on 2.3.50. A few days after admission, the forearms became pruritic and a number of erythematous papules made their appearance.

Examination on 5.3.50.

The patient was a thin, poorly-nourished, young man. On the right leg there was a well demarcated patch of varicose eczema with an associated varicosity of the veins of both legs. On the right thigh there was a linear streak of erythema which, on palpation, was cord-like and extremely tender and which was accompanied by a regional lymphadenitis.

The sensitisation reaction was papular in character and confined to the extensor aspects of the forearms. The eruption consisted of papules and papulo-vesicles which varied in size from a pin-head to a pea. A few of the older lesions were crusted while a number were eroded but there was no evidence of linear arrangement or grouping of the papules.

CASE NO. 76.

P.L. a widower, aged 67 years, was admitted to Stobhill Hospital on 11.3.50 with a diagnosis of varicose eczema of both legs and a sensitisation eruption on the forearms, scalp and shoulders.

General History.

1. Previous illnesses: Measles, whooping cough in childhood.
   1910 .. Ligation of femoral veins.
   1943 .. Varicose eczema treated for five months in The Royal Infirmary, Glasgow.
2. Family history: Nothing relevant.
3. Personal history: Retired railway signalman.
4. Allergic history: No family or personal history of allergic manifestations.

Immediate History.

For the past ten years the patient has had repeated attacks of varicose eczema but there has been no previous sensitisation eruption on other parts of the body. The present exacerbation commenced in December 1949, when a moist raw eczema developed on both legs. Despite local applications of calamine lotion/

lotion no improvement was noticed and, when fresh vesicular lesions appeared on the trunk, he was admitted to hospital.

Examination on admission.

The patient was a well-nourished, elderly man. On both legs there were patches of varicose eczema with oedema of the ankles. There was a marked degree of varicosity of the leg veins. On the lower one third of the right leg there was a typical patch of dermatitis vegetans.

The sensitisation eruption was mixed in character; the predominant feature was the papular and papulo-vesicular element on the shoulders, chest and forearms. The eruption was more or less symmetrically distributed with the greatest profusion of papules on the extensor aspects of the forearms. The lesions varied in size from a pin-head to a pea, remained discrete and showed no tendency towards grouping. On the interscapular area there was a cluster of thin-walled vesicles which closely resembled herpes simplex. Several of the vesicles were ruptured and a few excoriations were present but there was no evidence of any linear arrangement of the lesions.

CASE NO. 77.

G.T. a married man, aged 31 years, was admitted to Stobhill Hospital on 14.3.50 with a diagnosis of varicose eczema of the left leg and a sensitisation eruption on the face and forearms.

General History.

1. Previous illnesses: Measles in childhood.
2. Personal history: Employed as an engineer.
3. Family history: Nothing relevant.
4. Allergic history: No family or personal history of allergic manifestations.

Immediate History.

The patient was fit and well until November 1949 when, as a result of an injury, he developed an ulcer of the medial malleolus. For several years prior to this accident, he had been aware of varicosity of the leg veins with patches of brownish pigmentation. The ulcer healed with complete rest in bed but periodically a moist eczema appeared around the ankle. In February 1950, an unusually acute exacerbation of the moist eczema was accompanied, a few days later, by the appearance of pruritic papules on the face and forearms. The patient was extremely worried about the facial eruption and/

and he was admitted to Stobhill Hospital.

Examination on admission.

The patient was a well-nourished, young man. On the left medial malleolus there was a well demarcated patch (2" x 1") of varicose eczema with an associated varicosity of the leg veins. On both legs there were several patches of brownish staining with discrete, cayenne-pepper coloured papules which closely resembled Schamberg's disease.

The sensitisation eruption was mainly papular in character and was confined to the face and forearms. On the cheeks and forearms there were a few, discrete, slightly scaling erythematous papules. There was no evidence of vesiculation and no associated lymph adenitis.

CASE NO. 78.

W.H. a married man, aged 68 years, was admitted to Stobhill Hospital on 22.3.50 with a diagnosis of varicose eczema of the left leg and a sensitisation eruption on the thighs and forearms.

General History./

General History.

1. Previous illnesses: 1900 .. Enteric fever.
   1920 .. Pneumonia.
2. Family history: Nothing relevant.
3. Personal history: Retired gardener.
4. Allergic history: No family or personal history of allergic manifestations.

Immediate History.

The patient was fit and well until about June 1946, when he developed a patch of varicose eczema on both legs. The eruption healed with local dressings of calamine lotion and for the next six months he wore elastic stockings and had no further trouble until February 1947, when he developed an eczematous patch on the left leg. The condition responded to treatment but he experienced frequent exacerbations and remissions. On February 1950, during an efflorescence of the exudation on the left leg, the patient noticed the appearance of numerous papules on the forearms and, later, several boils developed on the right arm, and he was admitted to Stobhill Hospital.

Examination on admission.

The patient was a well-nourished, obese, elderly man. On the left leg there was a large patch of varicose eczema./

eczema.

The sensitisation eruption was mixed in character with marked eczematisation on the right forearm and a papular reaction on the thighs and left forearm. There was a large exudative patch on the dorsum of the right hand and wrist, as if the epidermis had been degloved from the hand. On the right shoulder, right forearm and left thigh there were several, shilling-sized patches of moist eczema, while studded at the periphery of these lesions and on the left forearm, there were numerous erythematous papules and papulo-vesicles. At the right ante-cubital fossa and the right axilla were two large boils with an associated right axillary adenitis.

CASE NO. 79.

P.B. a married woman, aged 30 years, was admitted to Stobhill Hospital on 28.3.50 with a diagnosis of infectious eczematoid dermatitis of the right hand and a sensitisation eruption of the face and left forearm.

General History./

General History.

1. Previous illnesses: Measles, mumps, whooping cough and chicken pox in childhood.
2. Family history: Nothing relevant.
3. Personal history: Housewife employed as a hospital domestic help.
4. Allergic history: No family or personal history of allergic manifestations.

Immediate History.

The patient was fit and well until 18.3.50 when she noticed a few pimples on the dorsum of her right hand and, within a few days, the part became eczematous. A lymphangitis developed with pain in the right axilla and her doctor immobilised the arm in a sling and prescribed paintings of aqueous gentian violet. A few days later, numerous, pruritic papules appeared on the face and forearms and she was admitted to Stobhill Hospital.

Examination on admission.

The patient was a well-nourished, young man. There was a patch of infectious eczematoid dermatitis on the dorsum of the right hand and wrist. A lymphangitis and axillary adenitis was also present.

The sensitisation eruption was predominantly papular in character and was present on the face and upper limbs. The papules varied in size from a pin-head to a pea and were scattered asymmetrically over the cheeks and forearms. On the right cheek there were a few crusted impetiginous lesions with an associated cervical adenitis.

CASE NO. 80.

B.K. a spinster, aged 66 years, was admitted to Stobhill Hospital on 4.4.50 with a diagnosis of varicose eczema of the legs and a sensitisation eruption of the forearms.

General History.

1. Previous illnesses: Measles, mumps, whooping cough in childhood.
   1930 ... Cholecystectomy.
2. Family history: Nothing relevant.
3. Personal history: Reitred book-keeper.
4. Allergic history: No family or personal history of allergic manifestations.

Immediate History./

Immediate History.

The patient was fit and well until August '49, when following a trivial injury she developed patches of varicose eczema on the legs. By peripheral extension of the patches the lower two thirds of the legs were gradually involved. In January '50, numerous, pruritic papules appeared on the forearms and she was referred to the out-patient department at Stobhill Hospital where calamine liniment was prescribed. The lesions on the legs improved a great deal and the papular eruption on the forearms quickly disappeared. However, in April '50, an exacerbation of the eczema of her legs provoked a recurrence of the eruption on the forearms and she was admitted to Stobhill Hospital.

Examination on admission.

The patient was a well-nourished, elderly woman. On both legs extending from the knees to the ankles there was an exudative varicose eczema with marked oedema of the feet and ankles.

The sensitisation eruption was papular in character and confined to the upper limbs. On the forearms, particularly the extensor surfaces, there were numerous,/

numerous, discrete, erythematous papules, several of which were eroded while a few of them were covered with loosely attached greyish scales. There was no axillary adenitis.

CASE NO. 81.

J.E. a widower, aged 75 years, was admitted to Stobhill Hospital on 5.4.50 with a diagnosis of paralysis of the right forearm and infectious eczematoid dermatitis of the right leg and a sensitisation eruption on the forearms.

General History.

1. Previous illnesses: 1943 .. Scurvy treated in Southern General Hospital, Glasgow.
2. Family history: Nothing relevant.
3. Personal history: Employed as a motor mechanic.
4. Allergic history: No family or personal history of allergic manifestations.

Immediate History. /

Immediate History.

The patient was fit and well until March 1950 when he noticed a crusted sore on the right leg. He was unable to explain its appearance although he admitted that in the course of his employment he was exposed to minor injuries. He removed the crust and exposed a red raw surface which gradually extended in size and involved the lower one third of the right leg. The patient applied "lint dressings" but when pruritic patches of eczema developed on the forearms, he sought the advice of his doctor who prescribed zinc ointment. A few days later, he felt a slight numbness of the right wrist and fingers and when he woke up next morning, viz. 1.4.50, he discovered his right arm was paralysed. There was also some disturbance of his speech and arrangements were made for his admission to hospital.

Examination on admission.

The patient was a well-nourished, old man. On the right leg there was a large patch (4" x 2") of infectious eczematoid dermatitis.

The/

The sensitisation eruption was mixed in character and was present on the upper limbs. On the extensor surfaces of the forearms there were several nummular patches of moist eczema. These shilling-sized patches appeared as well-defined islets on the normal skin and were composed of aggregations of papules and papulo-vesicles. Between the circinate lesions there were a few irregularly distributed erythematous papules. The axillary glands were not enlarged.

Central Nervous System.

The pupils were circular and equal; they reacted to light and accommodation. The tendon reflexes of the limbs of the right side were exaggerated while the plantar reflexors were flexor. There was loss of motor power from the elbow to the right hand and some sensory loss from his finger-tips to the wrist, but the muscle joint sense in his right hand was present.

CASE NO. 82.

J. McD. a married woman, aged 50 years, was admitted to Stobhill Hospital on 12.4.50 with a diagnosis of varicose ulcer of the left leg.

General History.

1. Previous illnesses: Scarlet fever, whooping cough in childhood.
2. Family history: One sister with varicose eczema.
3. Personal history: Housewife.
4. Allergic history: No family or personal history of allergic manifestations.

Immediate History.

For the past ten years the patient has been troubled with a pruritic, red patch over the left medial malleolus. Periodically, the part became eczematous but local treatment with calamine lotion cleared the exudation and left a dry scaling erythema. In December '49, an acute eczematous exacerbation was followed by ulceration of the leg and, as no improvement to topical measures was observed, she sought the advice of a dermatologist who arranged admission to Stobhill Hospital. Three days after admission, she complained of a pruritic rash on the lumbo-sacral region which was regarded/

regarded as a sensitisation eruption to the varicose ulceration and eczema of her left leg.

Examination on 15.4.50.

The patient was a well-nourished, obese, woman. Over the medial malleolus was a shallow penny-sized ulcer with clean, red, granulating base and irregular shelving edges. Surrounding the ulcer was an area of varicose eczema with an associated varicosity of the veins.

The sensitisation eruption was purely papular in character and confined to the "bathing-shorts" distribution. Across the lumbo-sacral region, buttocks and lateral upper surfaces of the thighs, there were numerous, discrete, erythematous papules. The papules which varied in size from a pin-head to a pea showed no evidence of vesiculation and a few of them were surmounted by loosely attached, greyish-white scales.

CASE NO. 83.

A.W. a married woman, aged 53 years, was admitted to Stobhill Hospital on 14.4.50 with a diagnosis of varicose ulcer of the left leg and a sensitisation eruption on the forearms.

General History.

1. Previous illnesses: Measles in childhood.
   1943 ... Ligation of Saphenous veins.
2. Family history: Father and brother .. varicose eczema.
3. Personal history: Housewife.
4. Allergic history: No family or personal history of allergic manifestations.

Immediate History.

The patient was fairly well until February '50 when she noticed a pruritic red patch over the left medial malleolus. She bathed the part with a weak solution of dettol which appeared to help it but, in March '50, she sustained an injury which produced a small ulcer. Despite local treatment the ulcer increased in size and the surrounding skin became moist and eczematous. About the beginning of April '50, she developed a pruritus of the forearms and later erythematous/

erythematous patches appeared which were soon followed by a widespread eczematisation of the upper limbs, particularly on the extensor surfaces. The condition showed no response to topical treatment and she was admitted on 14.4.50 to Stobhill Hospital.

Examination on admission.

The patient was a well-nourished, middle-aged woman. On the left malleolus there was a superficial, shilling-sized ulcer with exuberant, warty granulations and surrounded by a patch (4" x 3") of varicose eczema.

The sensitisation eruption was predominantly exudative in character and confined to the upper limbs. There was a massive exfoliation of the superficial epidermis of the forearms and the exposed eczematous surfaces were bathed with a serous exudate. On the volar aspects of the forearms there were several, penny-sized, dermatitic patches and at the periphery of which, there were a few discrete papules and papulo-vesicles. Nikolsky's sign was not elicited and there was no associated regional lymphadenitis.

CASE NO. 84.

W.C. a widower, aged 71 years, was admitted to Stobhill Hospital on 15.4.50 with a diagnosis of infectious eczematoid dermatitis of the left forearm and a sensitisation eruption on the trunk and limbs.

General History.

1. Previous illnesses: Measles in childhood. 1949 ... Prostatectomy.
2. Family history: Nothing relevant.
3. Personal history: Employed as engineer's machine-man.
4. Allergic history: No family or personal history of allergic manifestations.

Immediate History.

The patient was fit and well until March '49 when he developed a moist, raw eczema over the dorsum of the left forearm. No history of injury was elicited and the patient attributed the eruption to contact with oil. Despite local applications of calamine lotion, the condition spread and affected his whole forearm and dorsal aspect of his left hand. A few weeks later, erythematous pruritic patches appeared on the right forearm, trunk, thighs and legs while a few pruritic papules made their appearance on both cheeks, and he was admitted to Stobhill Hospital.

Examination on admission.

The patient was a well-nourished, old man. There was a large patch of infectious eczematoid dermatitis encircling the left forearm and involving the dorsum of the hand.

The sensitisation eruption was mixed in character and involved the face, trunk and limbs. There were a few crusted, impetiginous lesions on the cheeks and scalp, while on the trunk and legs there were numerous papules, papulo-vesicles and patches of nummular eczema. The skin was denuded from the thighs and right forearm, and the underlying surfaces showed marked exudation. On the palms and soles of the feet there was a patchy, frilly desquamation of the skin with a few deeply embedded vesicles.

CASE NO. 85.

H.A. a widower, aged 70 years, was admitted to Stobhill Hospital on 19.4.50 with a diagnosis of infectious eczematoid dermatitis of the right leg and a sensitisation eruption on the forearms and left leg.

General History.

1. Previous illnesses: 1920 .. Compound fracture of the right leg.
2. Family history: Nothing relevant.
3. Personal history: Retired: recently employed as a groomsman.
4. Allergic history: No personal or family history of allergic manifestations.

Immediate History.

The patient was fit and well until April '49, when he developed an eczematous patch over the old fracture scar on his right leg. The condition responded to local treatment but, in March '50, for no apparent reason, there was a recurrence of the exudation. The patient was living alone and he neglected the eruption which rapidly extended and encircled the entire right leg. About ten days later, when eczematous patches appeared on the forearms and thighs, he reported to his doctor who prescribed calamine lotion. The condition steadily deteriorated and he was referred to Ballochmyle Hospital from where he was transferred to Stobhill Hospital.

Examination on admission.

The patient was a well-nourished, elderly man. There was an area of infectious eczematoid dermatitis on the stocking distribution of the right leg. There was a/

a large, linear scar over the anterior surface of the leg.

The sensitisation eruption was exudative in character and was present on the trunk and limbs. The superficial epidermis was partially exfoliated from the thighs and forearms, and the exposed, underlying surfaces showed marked exudation. A thin serous exudate which trickled on to the adjacent normal skin produced no obvious local reaction. On the legs, forearms and trunk there were several, asymmetrically scattered, discrete erythematous papules and papulo-vesicles while the palms presented a punctate frilly desquamation of the skin. There was an associated axillary and inguinal lymphadenitis.

CASE NO. 86.

A.C. a married man, aged 50 years, was admitted to Stobhill Hospital on 13.5.50 with a diagnosis of infectious eczematoid dermatitis of the right forearm and a sensitisation eruption on the left forearm, legs and trunk.

General History:/

General History.

1. Previous illnesses: Chicken pox in childhood.
2. Family history: Nothing relevant.
3. Personal history: Employed as a "steel-cupola charger."
4. Allergic history: No family or personal history of allergic manifestations.

Immediate History.

The patient was fit and well until the end of February '50, when he sustained an injury to his forearm which was dressed at the works' first aid room with "triple-dye." The patient continued at his work but he neglected to apply further dressings and about two weeks after the accident, he noticed a patch of eczema over the site of the injury. He reported to his doctor who prescribed zinc paste but, despite this treatment, the eruption gradually spread and involved the whole of the right forearm. Later, when fresh eczematous patches appeared on the dorsal aspect of the hands, legs and left forearm he stopped work, and attended tht out-patient department at The Western Infirmary, Glasgow, where ichthyol-calamine liniment soaks were applied. Although the condition improved slightly,/

slightly, progress was slow and on 13.5.50 he was admitted to Stobhill Hospital.

Examination on admission.

The patient was a thick-set, middle-aged man. On the dorsum of the right forearm there was a patch (4" x 2") of infectious eczematoid dermatitis.

The sensitisation eruption was exudative in character and consisted of several, nummular patches of eczema on the dorsal aspects of the hands, wrists, left forearm, legs and lumbo-sacral region. The majority of the lesions showed marked exudation, while a few were covered with yellowish-brown crusts and, scattered between the patches, were numerous, small, eroded papules and papulo-vesicles.

CASE NO. 87.

J.M. an unmarried man, aged 50 years, was admitted to Stobhill Hospital on 22.5.50 with a diagnosis of infectious eczematoid dermatitis of the right leg and a sensitisation eruption on the trunk and forearms.

General History. /

General History.

1. Previous illnesses: No previous illnesses.
2. Family history: One sister has asthma.
3. Personal history: Employed as a joiner's labourer.
4. Allergic history: The patient's sister suffers from periodic attacks of asthma which are controlled by ephedrine sulphate.

Immediate History.

The patient was fit and well until April '50, when he noticed a small crusted sore on the right calf. No history of injury was elicited. He reported to his doctor who prescribed zinc cream but, despite this treatment, a moist eczematous patch appeared on the leg and, about two weeks later, numerous pruritic papules developed on the forearms and thighs. The papular reaction was quickly followed by eczematisation of the affected parts and, on 22.5.50, he was admitted to Stobhill Hospital.

Examination on admission.

The patient was a well-nourished, middle-aged man. There was a patch of infectious eczematoid dermatitis on the lateral aspect of the right calf.

The sensitisation eruption was exudative in character and consisted of numerous, sixpence-sized patches of eczema on the forehead, forearms and antero-medial aspects/

aspects of the thighs. The eruption was most marked on the forearms, particularly at the ante-cubital fossae, where several of the patches had coalesced and produced large, irregularly-shaped eczematous areas. Scattered between the patches there were numerous, erythematous papules and papulo-vesicles, a few of which showed a tendency to grouping with ultimate formation of fresh, circinate eczematous areas.

CASE NO. 88.

J.S. a married man, aged 46 years, was admitted to Stobhill Hospital on 26.5.50 with a diagnosis of infectious eczematoid dermatitis of the left leg and a sensitisation eruption on the forearms, thighs and trunk.

General History.

1. Previous illnesses: Whooping cough and measles in childhood.
2. Family history: Nothing relevant.
3. Personal history: Employed as a railway engineer.
4. Allergic history: No family or personal history of allergic manifestations.

Immediate History.

The patient was fit and well until the summer of 1947 when he noticed a patch of eczema on the left leg. He was unable to account for its appearance and was not aware of any injury. His doctor applied calamine lotion which cleared the condition but, during the next three years, there were repeated exacerbations and remissions. In April '50, an unusually acute efflorescence of the eczema occurred on the left leg and, two weeks later, numerous erythematous papules developed on the forearms and thighs. Despite local treatment, the eruption extended and involved the scalp, axillae and trunk, and on 23.5.50 he was forced to stop work and, three days later, he was admitted to Stobhill Hospital.

Examination on admission.

The patient was a well-nourished, middle-aged man. On the left leg, particularly on the lateral surface, there was a large patch of infectious eczematoid dermatitis.

The sensitisation eruption was predominantly seborrhoeic in character and was present on the scalp, axillæ, trunk and thighs. On the scalp, which showed alopecia on the vertex and frontal areas, there were numerous,/

numerous, greasy, scaling, erythematous patches. There was a marked inguinal, axillary and retro-auricular intertrigo with an associated folliculitis of the nape of the neck and pubic areas. On the trunk, forearms, thighs and buttocks there were several brownish-red, scaling patches of a slightly greasy nature, and scattered irregularly between these areas were small, follicular papules.

CASE NO. 89.

A. McD. a widow, aged 47 years, was admitted to Stobhill Hospital on 12.5.50 with a diagnosis of varicose ulcer of the right leg and a sensitisation eruption on the forearms.

General History.

1. Previous illnesses: Whooping cough, chicken pox and measles in childhood.
   1940 .. Varicose ulcer treated in The Royal Infirmary, Glasgow.
2. Family history: Nothing relevant.
3. Personal history: Housewife.
4. Allergic history:/

4. Allergic history: No family or personal history of allergic manifestations.

Immediate History.

The patient remained well until July '49, when following a trivial injury an ulcer developed on the right leg. Various local treatments - calamine lotion, zinc paste and, finally, occlusive dressings, were applied but no improvement was noticed and, a few weeks later, a number of vesicles, papules and papulo-vesicles appeared on the forearms. The affected parts were extremely pruritic and scratching caused an acute eczematous reaction, and the patient sought admission to Stobhill Hospital.

Examination on admission.

The patient was a middle-aged, obese, woman. On the lateral aspect of the right leg there was a small ulcer with a surrounding area of moist eczema and an associated varicosity of the superficial veins of the legs.

The sensitisation eruption was mixed in character and was present on the limbs. The predominant features were the grouped vesicles on the dorsal aspects of the forearms which resembled herpes simplex. On the anterior/

anterior surfaces of the thighs and forearms there were numerous, sixpence-sized patches of moist eczema. Between the exudative areas and scattered irregularly on the limbs there were several, discrete papules and papulo-vesicles.

CASE NO. 90.

W.D. a married woman, aged 48 years, was admitted to Stobhill Hospital on 27.5.50 with a diagnosis of infectious eczematoid dermatitis of the right hand and a sensitisation eruption on the face, forearms, trunk and legs.

General History.

1. Previous illnesses: Measles, whooping cough, chicken pox and mumps in childhood.

2./

2. Family history: Nothing relevant.

3. Personal history: Housewife.

4. Allergic history: No family or personal history of allergic manifestations.

Immediate History.

The patient was fit and well until December '49, when she noticed a cluster of small pimples on the dorsum of her right hand. Later, an eczematous reaction developed on the affected part which showed a transient improvement with local treatment of calamine lotion. For the next few months there were periodic exacerbations and remissions but, on the 22.5.50, during one of the exacerbations an intense pruritus of the forearms was followed by the appearance of several eczematous patches. Within a few hours, the face became hot, pruritic, and subsequently, erythematous blotches appeared on the forehead and both cheeks. The next day, the face became eczematous while oedema of the peri-orbital tissues almost closed the eyes and several erythematous papules developed on the trunk and legs. The condition showed no response to frequent applications of calamine lotion and admission was arranged to Stobhill Hospital.

Examination on admission.

The patient was a well-nourished, middle-aged woman. On the dorsum of the right hand there was a well demarcated patch of infectious eczematoid dermatitis.

The sensitisation eruption was mixed in character and was present on the face, trunk and limbs. On the forearms, trunk and legs, there were numerous, large eczematous patches, particularly at the flexures where exfoliation of the skin exposed moist, raw surfaces. There were several thin-walled vesicles on the wrists and the dorsum of the left hand, while scattered asymmetrically on the limbs and trunk, were numerous papules and papulo-vesicles. A vivid, bright red, blotchy erythema was present on the face with impetiginous crusts on the malar regions and an associated cervical adenitis. The lips were slightly swollen while the eyes were closed due to a gross oedema of the peri-orbital tissues.

CASE NO. 91. /

CASE NO. 91.

A.C. a married woman, aged 40 years, was admitted to Stobhill Hospital on 30.5.50 with a diagnosis of infectious eczematoid dermatitis of the left wrist and a sensitisation eruption on the forearms, trunk and legs.

General History.

1. Previous illnesses: Diphtheria, whooping cough in childhood.
   1926 .. Tonsillectomy.
   1935 .. Nasal polypus removed.
   1947 .. Industrial dermatitis of forearms.
2. Family history: Nothing relevant.
3. Personal history: Housewife, employed as a tramcar conductress.
4. Allergic history: No family or personal history of allergic manifestations.

Immediate History.

The patient was fit and well until May '50, when she noticed an eczematous patch on the left wrist which she attributed to a scald caused by a steaming kettle. She reported to her doctor who prescribed calamine/

calamine lotion but, despite this therapy, fresh eczematous patches appeared on the forearms, legs and trunk. A few days before admission to Stobhill Hospital she developed several pruritic papules on the face.

Examination on admission.

The patient was a well-nourished, young woman. On the antero-medial aspect of the left wrist there was a well demarcated patch of infectious eczematoid dermatitis.

The sensitisation eruption was predominantly exudative in character and was present on the face, trunk, legs and forearms. On both cheeks there were several, discrete, erythematous papules and on the limbs there were numerous shilling-sized patches of moist eczema, between which there were numerous, eroded papules and papulo-vesicles. On the lateral aspect of the left arm there were three linear excoriations and on these scratch marks there were a few vesicles. On the trunk the papular reaction was confined to the lumbo-sacral region.

CASE NO. 92.

D. McA. a married man, aged 49 years, was admitted to Stobhill Hospital on 6.6.50 with a diagnosis of infectious eczematoid dermatitis of the left leg and a sensitisation eruption on the forearms and face.

General History.

1. Previous illnesses: Chicken pox in childhood.
   1946 .. Infectious eczematoid dermatitis of the face - treated for ten days in The Western Infirmary, Glasgow.
2. Family history: Nothing relevant.
3. Personal history: Employed as a ship's wright.
4. Allergic history: No family or personal history of allergic manifestations.

Immediate History.

The patient was fit and well until the beginning of May '50, when the irritation of a new pair of boots produced a moist, raw eczema on the dorsum of the left foot. He applied talcum powder and continued to wear the boots but, within a few days, the eruption extended and involved the lower one third of the left leg. The patient then applied calamine lotion for about ten days and a transient improvement was noticed. However, during/

during the night of 27.5.50 he experienced an intense pruritus and heat in the face and forearms. The next morning, there were erythematous blotches on the face with patches of moist eczema on the forearms. He was referred to the out-patient department at The Western Infirmary, Glasgow, where he received an alkaline mixture internally and locally ichthyol-calamine liniment soaks. At the end of one week on this treatment there was no appreciable difference and on 6.6.50 he was admitted to Stobhill Hospital.

Examination on admission.

The patient was a well-nourished, middle-aged man. On the lower one third of the left leg and the dorsal aspect of the foot there was a well demarcated patch of infectious eczematoid dermatitis.

The sensitisation eruption was exudative in character and involved the face, neck and forearms. The epidermis was denuded from the face, neck and dorsal aspects of the forearms and the exposed moist surfaces were bathed with a straw-coloured serous exudate. On the volar aspects of the forearms there were numerous florin-sized patches of eczema between which there were several erythematous papules and papulo-vesicles.

CASE NO. 93.

J.S. a married man, aged 56 years, was admitted to Stobhill Hospital on 5.6.50 with a diagnosis of infectious eczematoid dermatitis of the left leg and a sensitisation eruption on the face and forearms.

General History.

1. Previous illnesses: Scarlet fever in childhood.
   1930 .. Pneumonia.
   1946 .. Contact dermatitis of hands (tomato plants).
2. Family history: Nothing relevant.
3. Personal history: Employed in a brewery.
4. Allergic history: No family or personal history of allergic manifestations.

Immediate History.

The patient was fit and well until 31.3.50 when, in the course of his employment, he sustained a fracture of the left tibia. The leg was encased in plaster of Paris for five weeks and then strapped with elastoplast for one week. On removal of the elastoplast, the skin was eczematous and, one week later, pruritic moist patches appeared on the forearms and face and he was admitted to Stobhill Hospital on 5.6.50.

Examination on admission.

The patient was a well-nourished man. On the stocking distribution of the left leg there was a patch of infectious eczematoid dermatitis.

The sensitisation eruption was mixed in character, with numerous erythematous papules on the cheeks, forearms and right leg, while several sixpence-sized areas of moist eczema were present on the extensor surfaces of the forearms. In the centre of each palm there was a shilling-sized patch of frilly desquamation of the skin but there was no clinical or microscopical evidence of associated ringworm infection.

CASE NO. 94.

B.S. a widower, aged 70 years, was admitted to Stobhill Hospital on 2.6.50 with a diagnosis of infectious eczematoid dermatitis of the legs and a sensitisation eruption on the thighs and forearms.

General History.

1. Previous illnesses: Measles, mumps in childhood.
1900 .. Pneumonia.
Repeated attacks of bronchitis.

2. Family history: Nothing relevant.

3. Personal history: Retired railway clerk.

4. Allergic history: No family or personal history of allergic manifestations.

Immediate History.

The patient was well until May '50 when he developed an eczema of the right leg and, later, the left leg became similarly affected. He was unable to account for the appearance of this eruption and no history of injury was elicited. His doctor applied various lotions and ointments but no improvement was noticed and, when fresh eczematous patches appeared on his thighs and forearms, he was admitted to Stobhill Hospital.

Examination on admission.

The patient was a well-nourished, elderly man. On the stocking distribution of both legs, there were patches of infectious eczematoid dermatitis accompanied by marked oedema of the ankles. There was no obvious varicosity of the superficial veins of the legs.

The sensitisation eruption was mixed in character; the predominant features were the numerous, nummular patches of moist eczema on the forearms and medial/

medial aspects of the thighs. There were also several, small, eroded papules between the circinate patches, particularly on the thighs where there were a number of small petechial haemorrhages. There was no sign of crusting or impetiginisation and no associated enlargement of the axillary and inguinal glands.

CASE NO. 95.

J.D. a widower, aged 59 years, was admitted to Stobhill Hospital on 23.6.50 with a diagnosis of infectious eczematoid dermatitis of the left forearm and a sensitisation eruption on the legs.

General History.

1. Previous illnesses: 1927 .. Appendicectomy.
   1944 .. Rheumatoid Arthritis.
2. Family history: Nothing relevant.
3. Personal history: Employed as a railway-engine driver.
4. Allergic history: No family or personal history of allergic manifestations.

Immediate History. /

Immediate History.

The patient was fit and well until 1944 when he sustained a laceration of the left forearm. He neglected the lesion and soon the surrounding skin became eczematous and he then attended his local practitioner who prescrived calamine liniment. A few weeks later, owing to an attack of rheumatoid arthritis, he had to stop work and rest in bed, and it was noticed that the skin eruption almost cleared completely. On resumption of work, the eczema remained quiescent until January '50 when it became much worse and some months later, a few fresh exudative patches appeared on the right forearm. In June '50, numerous eczematous areas developed on the legs and he was admitted to Stobhill Hospital.

Examination on admission.

The patient was a well-nourished, elderly man. On the left forearm there was a well demarcated patch of infectious eczematoid dermatitis.

The sensitisation eruption was exudative in character and consisted of several circinate and rectangular -shaped patches of moist eczema on the legs and medial/

medial aspects of the thighs. At the periphery of these patches and scattered over the limbs, there were numerous, small, eroded papules and papulo-vesicles.

CASE NO. 96.

S. McD. an unmarried girl, aged 18 years, was admitted to Stobhill Hospital on 25.7.50 with a diagnosis of infectious eczematoid dermatitis of the right forearm and a sensitisation eruption on the trunk and limbs.

General History.

1. Previous illnesses: Measles in childhood.
2. Family history: Nothing relevant.
3. Personal history: Employed as a "finisher" in a carpet factory.
4. Allergic history: No family or personal history of allergic manifestations.

Immediate History.

The patient was fit and well until July '50, when she noticed a boil on the right forearm. The surrounding skin became pruritic and, as a result of subsequent/

subsequent scratching, the part became eczematous. Penicillin cream was applied for 3 days but no improvement was noticed and, a few days later, fresh eczematoid patches appeared on the left forearm and legs, while patches of scaling, brownish erythema appeared on the trunk. She reported to her doctor with this generalised eruption and he arranged admission to Stobhill Hospital.

Examination on admission.

The patient was a well-nourished, young girl. Over the right forearm there was a patch (4" x 2") of infectious eczematoid dermatitis.

The sensitisation eruption was mixed in character with a few, moist, eczematous irregularly-shaped areas on the forearms and legs. On the trunk and thighs there were numerous oval-shaped, scaling, pinkish-coloured lesions which closely resembled pityriasis rosea. The long axis of several of the trunk lesions were parallel to the ribs and a few of them showed peripheral attachment of the scales.

CASE NO. 97. /

CASE NO. 97.

T.C. a married man, aged 63 years, was admitted to Stobhill Hospital on 19.7.50 with a diagnosis of infectious eczematoid dermatitis of the left leg and a sensitisation eruption on the limbs.

General History.

1. Previous illnesses: Scarlet fever in childhood.
   1927 ... Appendicectomy.
2. Family history: Nothing relevant.
3. Personal history: Employed as petrol pump maintenance-man.
4. Allergic history: No family or personal history of allergic manifestations.

Immediate History.

The patient was fit and well until the beginning of July '50 when he sustained a laceration on the front of his left leg. A few days after the injury, he reported to the first aid room where an aqueous solution of gentian violet was applied. The lesion gradually became eczematous and his doctor prescribed zinc cream but, within twelve days of the initial lesion, numerous, fresh exudative patches appeared on the legs and forearms and he was admitted on 19.7.50 to Stobhill Hospital.

Examination on admission./

Examination on admission.

The patient was a thin, poorly-nourished, elderly man. On the stocking distribution of the left leg there was a well defined area of infectious eczematoid dermatitis.

The sensitisation eruption was exudative in character and was present on the limbs and lumbo-sacral region. The epidermis was exfoliated in patches from the forearms and, from the exposed moist, raw surfaces, oozed a thin yellowish exudate which trickled on to the adjacent normal skin and produced no local cutaneous irritation. On the thighs, right leg and lumbo-sacral region there were large, ill-defined, eczematous patches between which were scattered numerous, eroded papules and papulo-vesicles. Nikolsky's sign was not elicited. There was an inguinal and axillary adenitis.

CASE NO. 98.

D.B. a married woman, aged 55 years, was admitted to Stobhill Hospital on 4.8.50 with a diagnosis of varicose ulcer of the right leg and a sensitisation eruption on the forearms and chest.

General History.

1. Previous illnesses: Measles and mumps in childhood. Recurrent varicose ulceration of both legs.
2. Family history: Nothing relevant.
3. Personal history: Housewife.
4. Allergic history: No family or personal history of allergic manifestations.

Immediate History.

The patient has been troubled with repeated ulceration of both legs for the past twenty years. Recently, owing to nursing her invalid husband, she was unable to treat an ulcer on her left leg which gradually became much larger. Finally, an eczematous reaction developed around the ulcer and, within a few weeks, numerous pruritic papules appeared on the forearms. A few days before her admission to Stobhill Hospital an eczema developed on the chest.

Examination on admission.

The patient was an obese, elderly woman. There was an ulcer ($3\frac{1}{2}$" x $1\frac{1}{2}$") on the right medial malleolus with steep irregular edges. Surrounding the ulcer was an area of moist eczema and an associated varicosity of the superficial veins of the legs. There was/

was a brownish coloured staining on the lower half of the legs with a marked oedema of the ankles.

The sensitisation eruption was mixed in character with large exudative patches and numerous eroded papules on the chest and anterior aspects of the forearms. There was a marked intertrigo and fissuring of the inframammary regions with an associated axillary adenitis. A thin serous exudate from the eczematous areas trickled on to the normal skin but produced no local reaction.

CASE NO. 99.

J.S. a married woman, aged 59 years, was admitted to Stobhill Hospital on 10.8.50 with a diagnosis of infectious eczematoid dermatitis of the right leg and a sensitisation eruption on the forearms and chest.

General History.

1. Previous illnesses: 1938 ... Pneumonia.
2. Family history: Nothing relevant.
3. Personal history: Housewife.
4. Allergic history: No family or personal history of allergic manifestations.

Immediate History.

The patient was fit and well until June '48, when she sustained an injury to the front of her right leg and, within a few days, the skin surrounding the laceration became eczematous. The condition responded to treatment with zinc cream and she remained well for several months until another slight trauma provoked a recurrence of the eczematous process. Local treatment improved the eruption but exacerbations and remissions continued until July '50, when an unusually acute efflorescence was accompanied by pruritic papules on the forearms and the development of a widespread eczema on the anterior chest wall. Several local treatments (calamine lotion, aqueous solution of gentian violet and finally zinc cream) were applied but no improvement was noticed and she was admitted to Stobhill Hospital.

Examination on admission.

The patient was an elderly, obese woman. There was an area of infectious eczematoid dermatitis on the stocking distribution of the right leg.

The sensitisation eruption was mainly exudative in character and was present on the trunk and limbs. The inframammary/

inframammary regions were moist and raw and the eczematous reaction involved the axillae and anterior chest wall. On the anterior surfaces of the thighs and forearms there were several, large exudative patches from which oozed a thin serous exudate. On the forearms, thighs and lumbo-sacral region there were numerous, closely-set, eroded papules and papulo-vesicles. Nikolsky's sign was not elicited.

CASE NO. 100.

M.T. a married man, aged 46 years, was admitted to Stobhill Hospital on 28.8.50 with a diagnosis of infectious eczematoid dermatitis of the right leg and a sensitisation eruption on the face, trunk and forearms.

General History.

1. Previous illnesses: Compound fracture of the right femur in 1945.
2. Family history: Nothing relevant.
3. Personal history: Employed as works' "gateman."
4. Allergic history: No family or personal history of allergic manifestations.

Immediate History.

The patient was fit and well until 4th August, 1945, when he sustained a compound fracture of the right femur with severe lacerations of the right leg. He made an uneventful recovery but, in June '46, a moist eczema developed around the scars on the right leg. He attended The Royal Infirmary, Glasgow, where local applications healed the eruption but, during the next few years, there were frequent recurrences of the eczematous process. In August '50, an exacerbation of the eczema, caused by the friction of a new surgical boot, failed to respond to the usual local treatment. About ten days after this efflorescence, an intense pruritus developed in the face and forearms which was later followed by numerous papules and papulo-vesicles, and he was admitted on 28.8.50 to Stobhill Hospital.

Examination on admission.

The patient was a well-nourished, middle-aged man. There was a well demarcated patch of infectious eczematoid dermatitis on the lower half of the right leg. A long linear scar was present and extended from the mid-thigh/

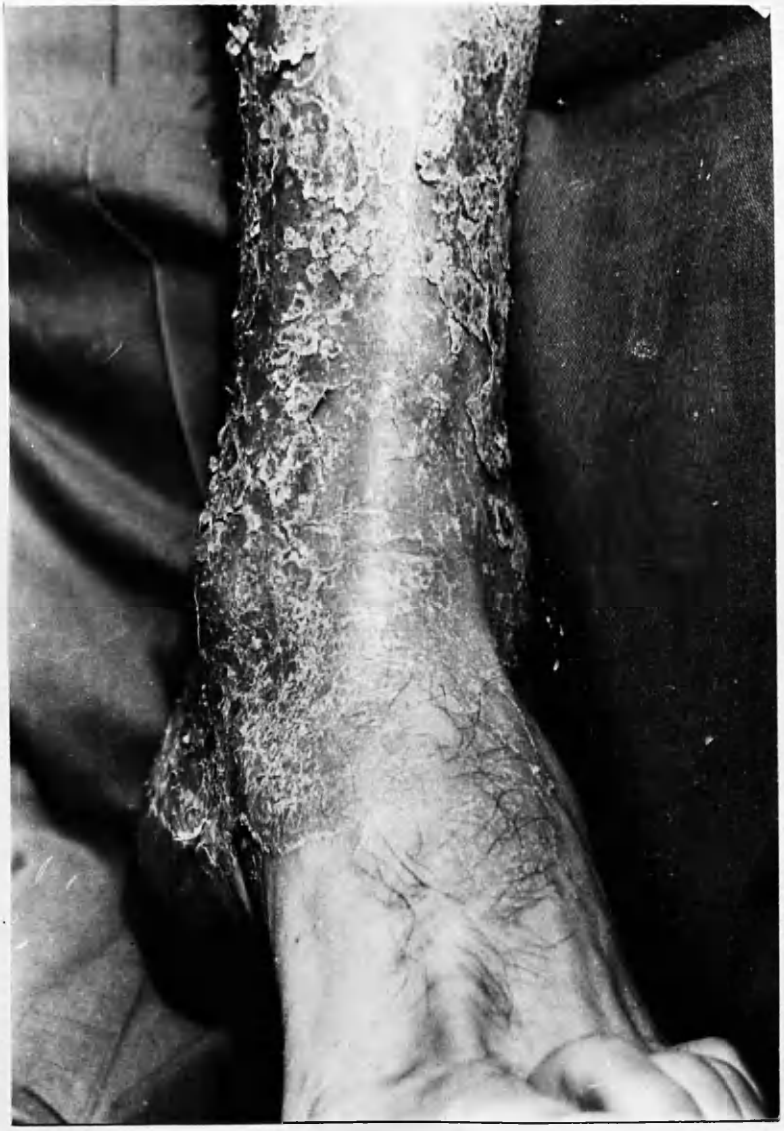
mid-thigh to the ankle; there was atrophy of the quadricep muscles with an associated ankylosis of the right knee.

The sensitisation eruption was exudative in character and affected the face and forearms. The predominant lesions were ill-defined, moist eczematous patches on the face and forearms, several of which, particularly those on the chin and neck, were covered with adherent, impetiginous crusts. At the periphery of these patches and on the chest, lumbo-sacral region and the neck, there were numerous eroded papules and papulo-vesicles. There was also a typical well-marked cheiropompholyx and an associated axillary adenitis.

APPENDIX B.

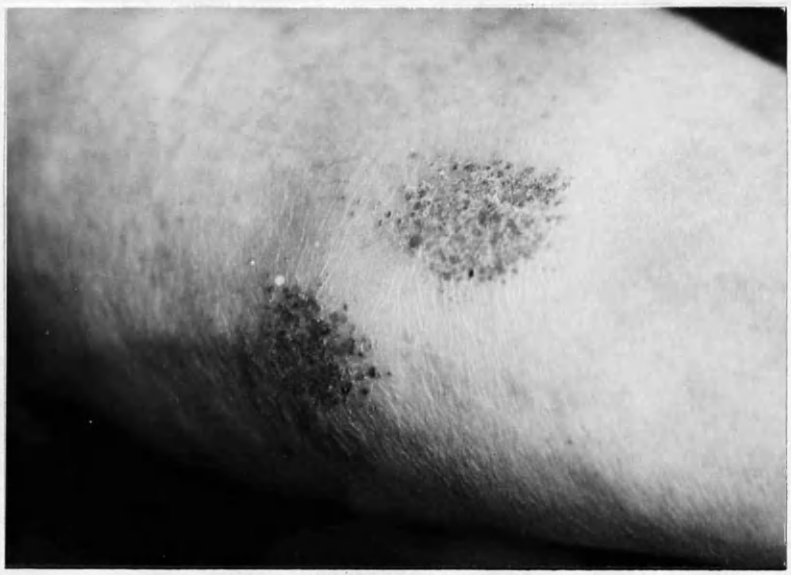
PHOTOGRAPHS.

CASE NO. 5.



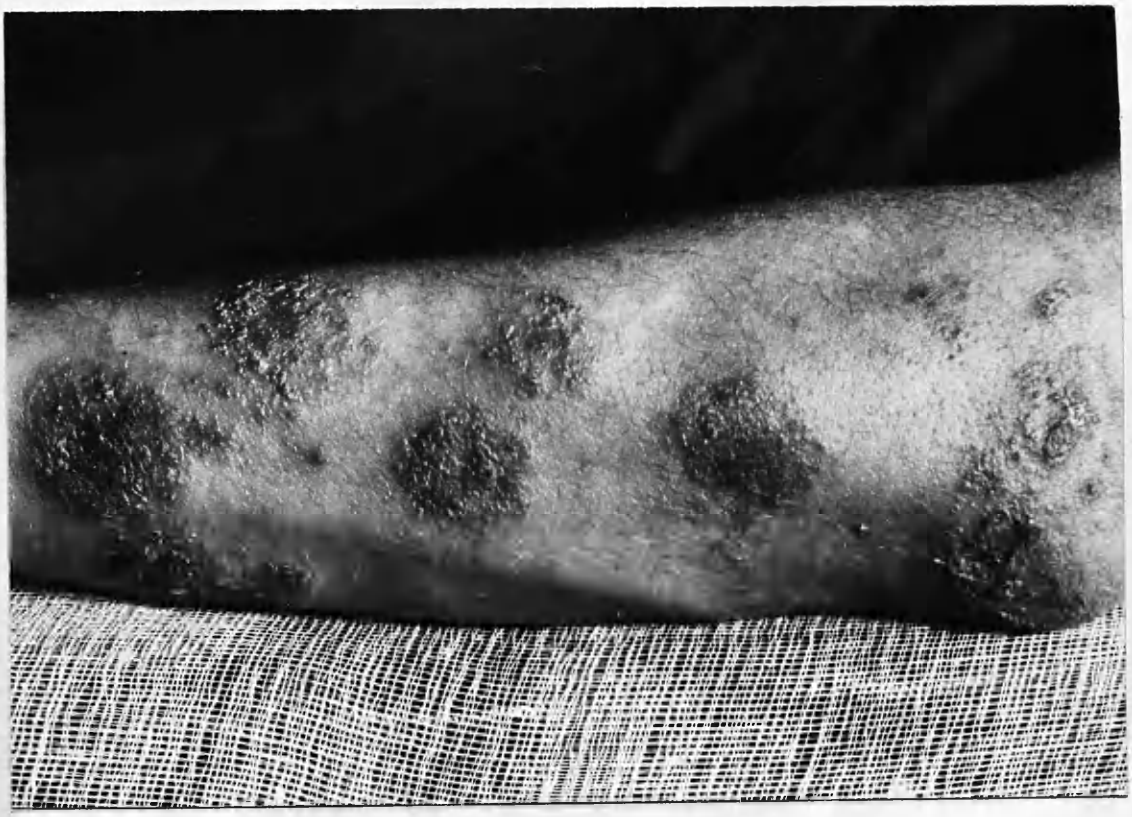
Infectious eczematoid dermatitis.

CASE NO. 11.



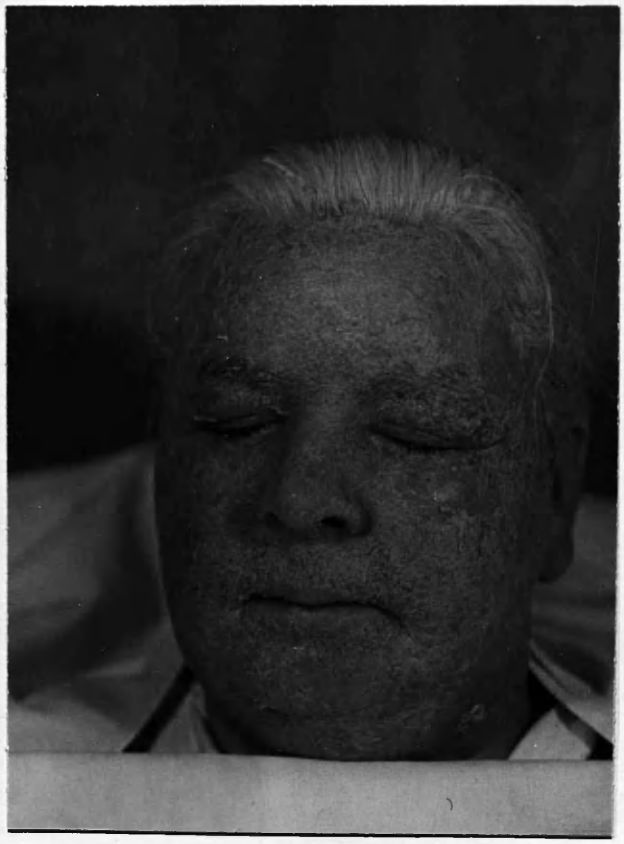
Extensor aspect of right forearm showing nummular patches of eczema. Each patch is composed of aggregations of papules and papulo-vesicles.

CASE NO. 24.



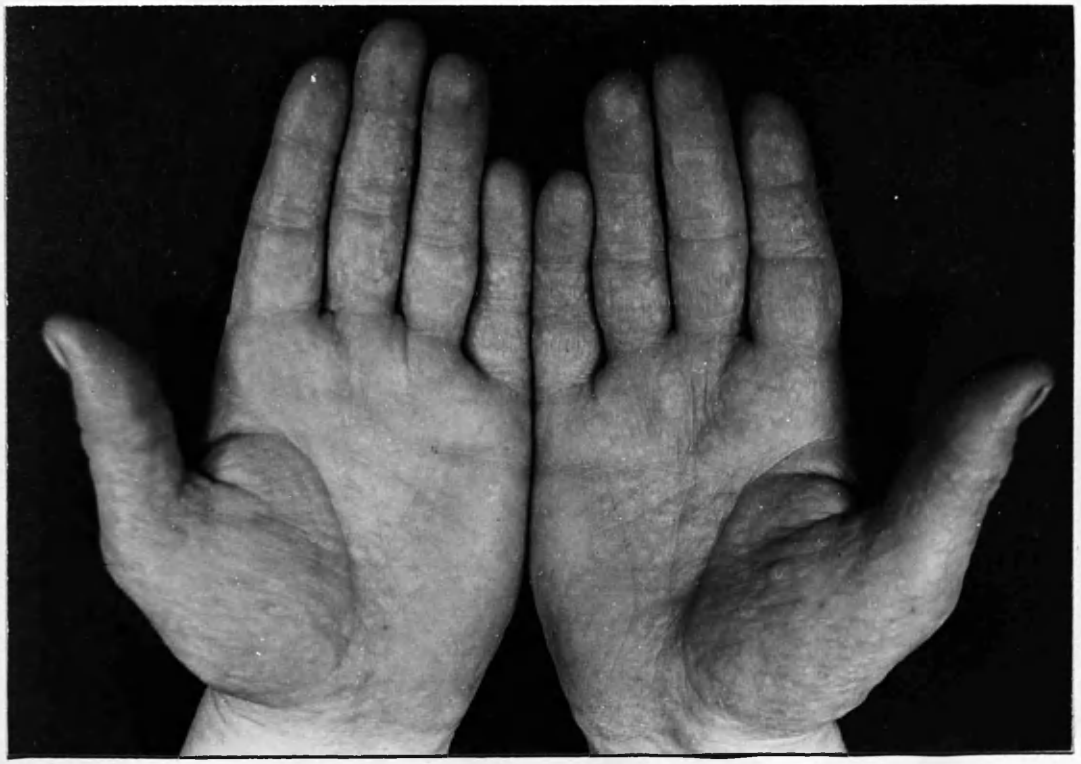
Nummular eczema on the left forearm.

CASE NO. 31.



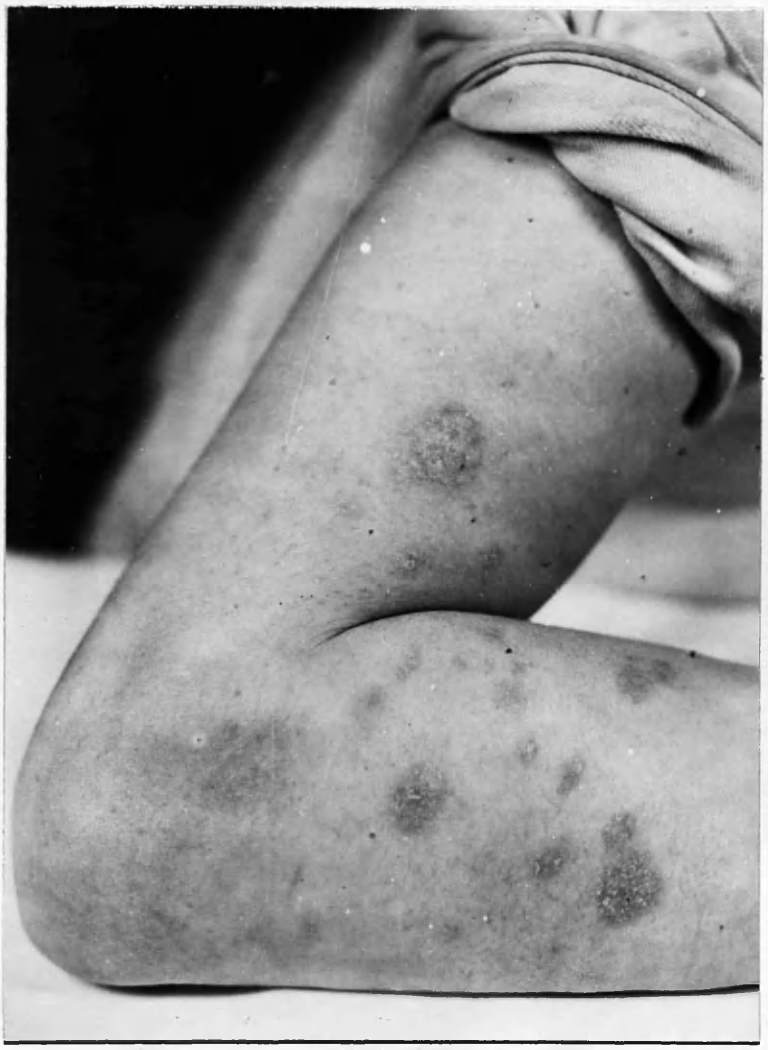
Facial involvement showing marked eczematisation and peri-orbital oedema. The scaly crusted appearance is the result of topical treatment.

CASE NO. 63.



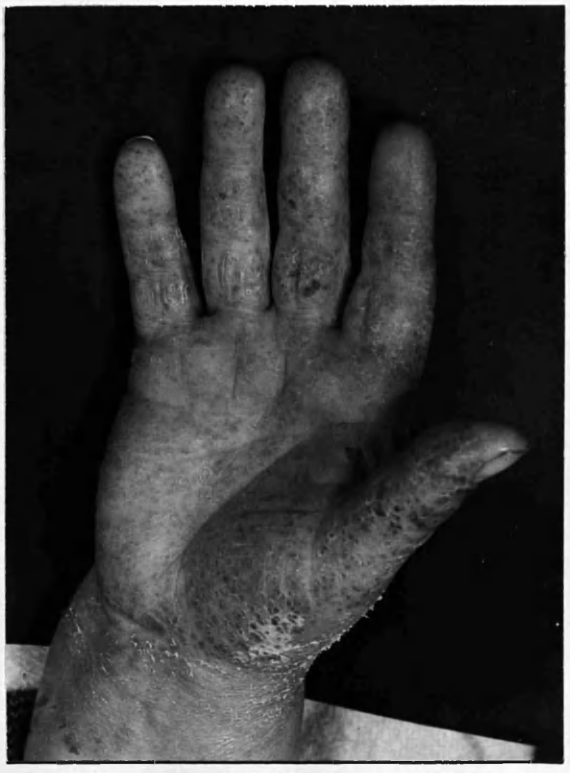
Palms showing deep-seated vesicles of cheiropompholyx.

CASE NO. 69.



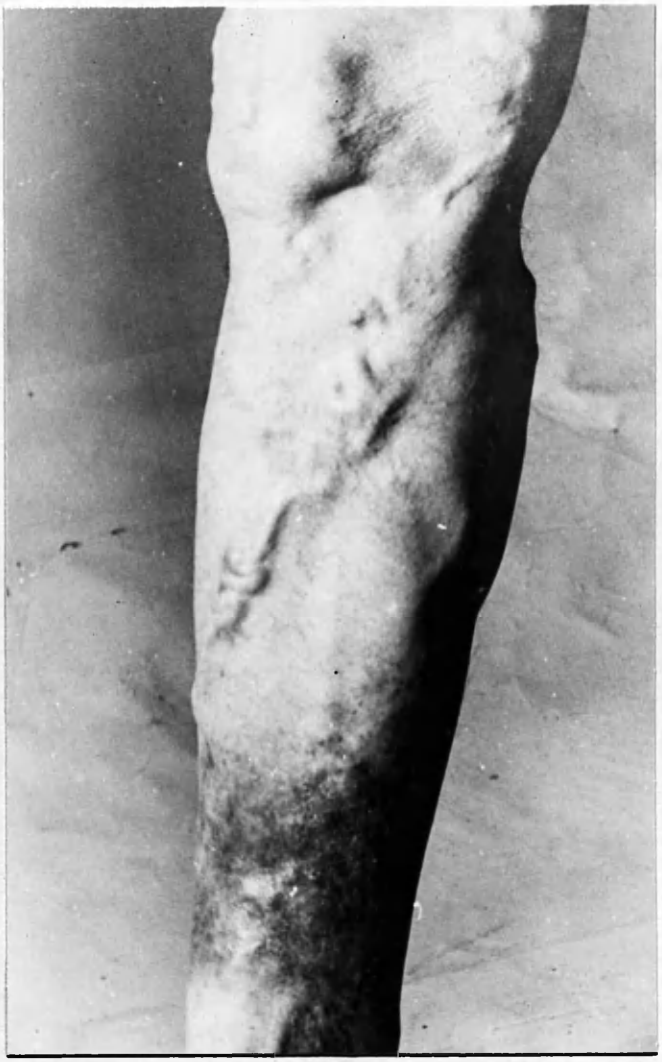
Right forearm showing nummular patches of eczema with intervening papules and papulo-vesicles.

CASE NO. 72.



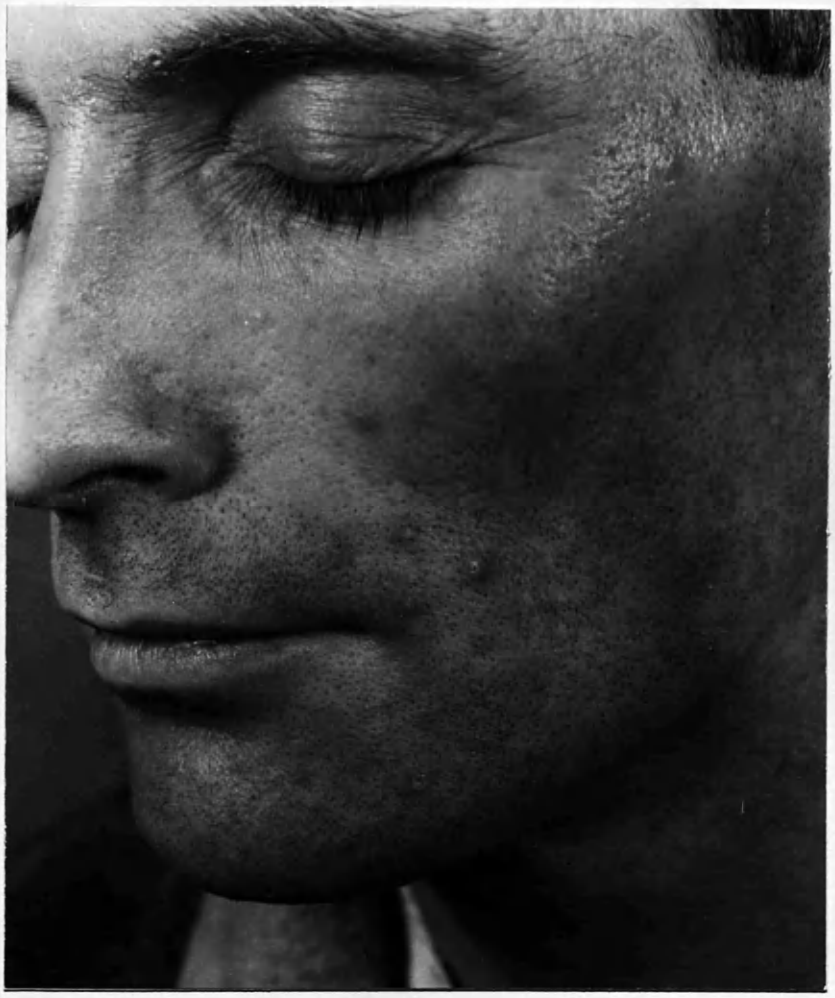
Right palm illustrating
cheiropompholyx.

CASE NO. 76.



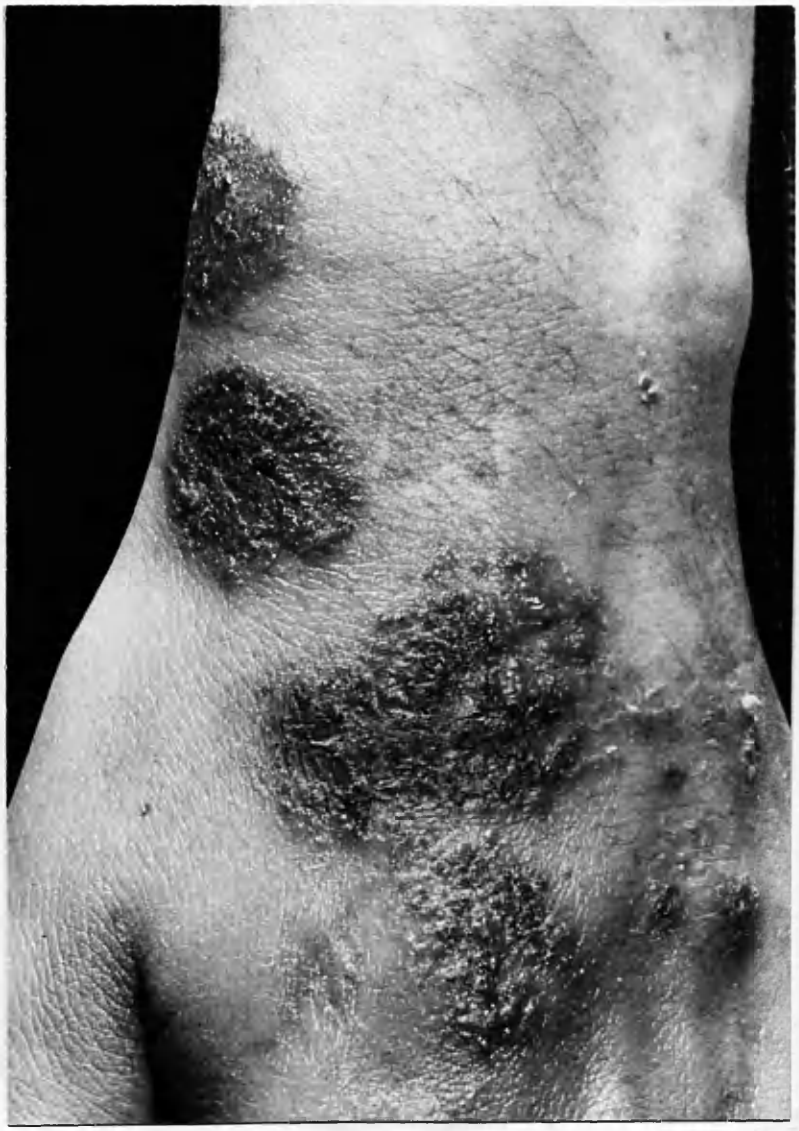
Varicose Eczema.

CASE NO. 77.



Discretely scattered papules on left cheek.

CASE NO. 86.

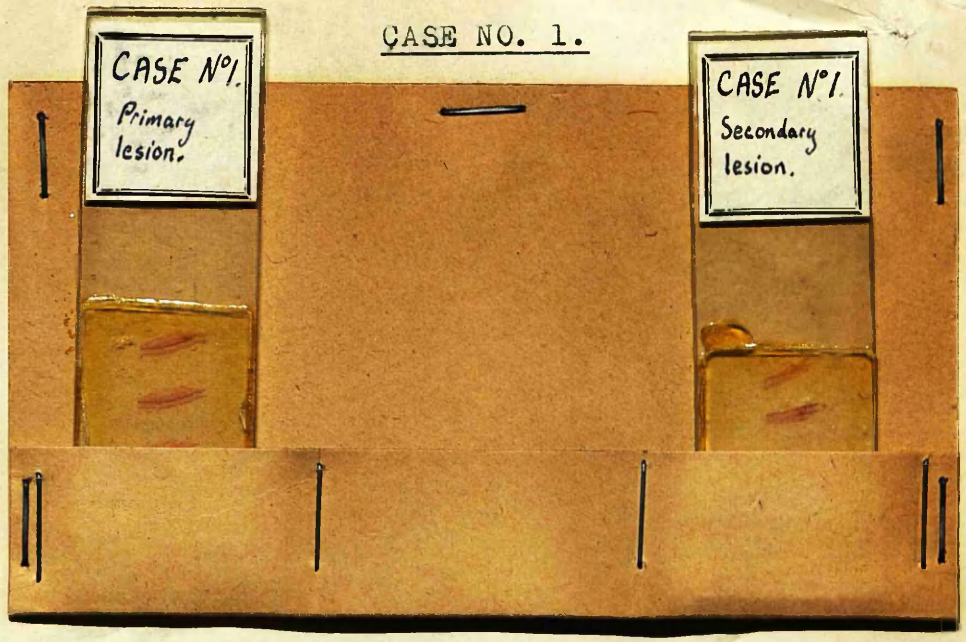


Nummular eczema on dorsal aspect of the right hand.

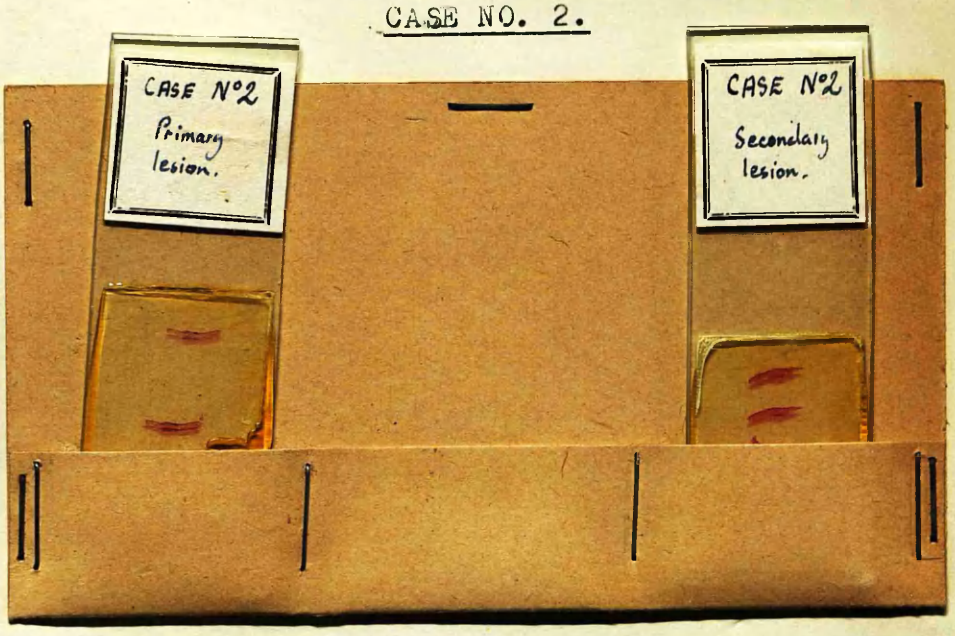
APPENDIX C.

PATHOLOGICAL SECTIONS.

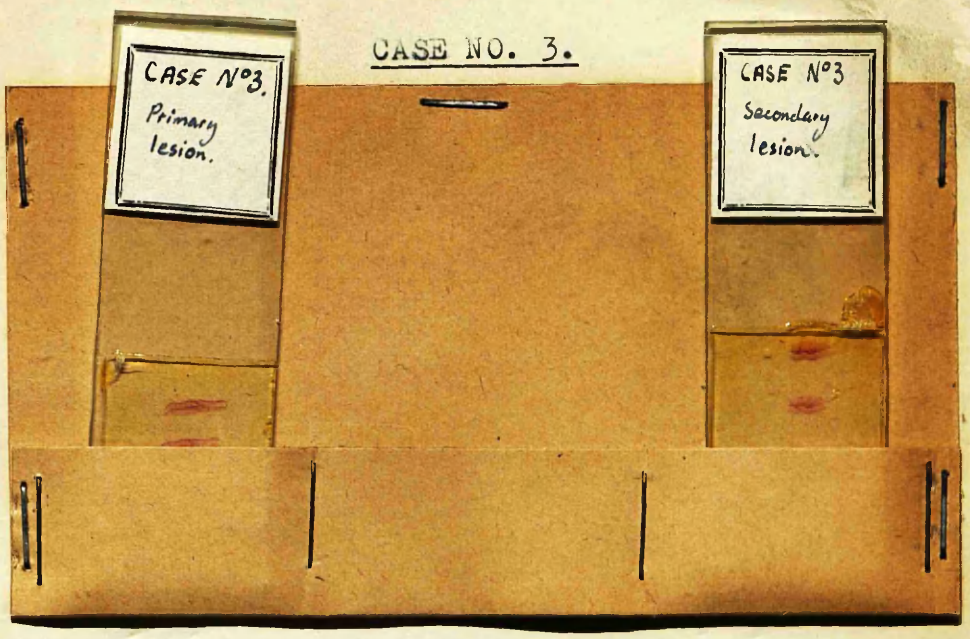
CASE NO. 1.



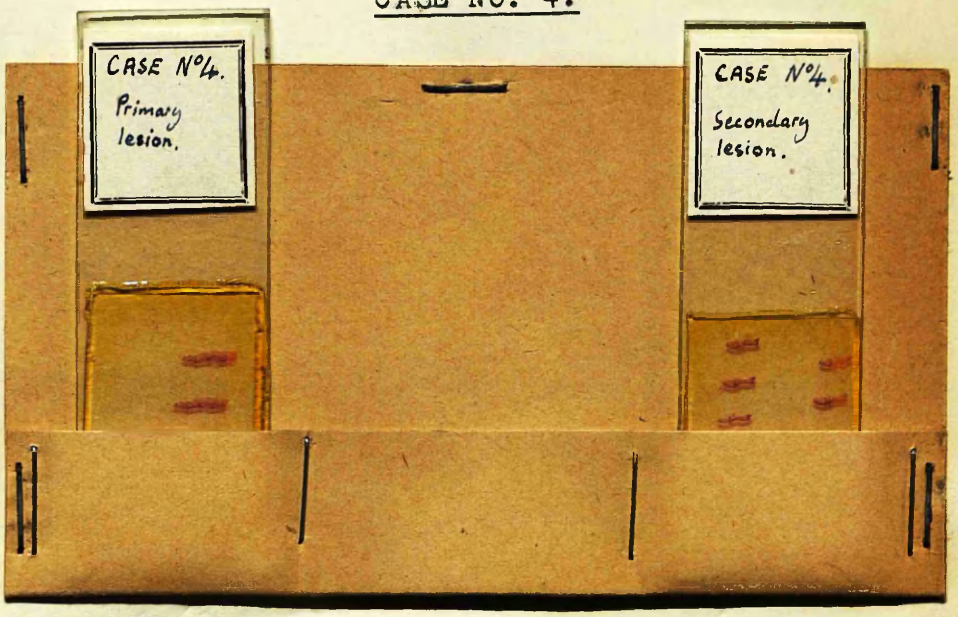
CASE NO. 2.



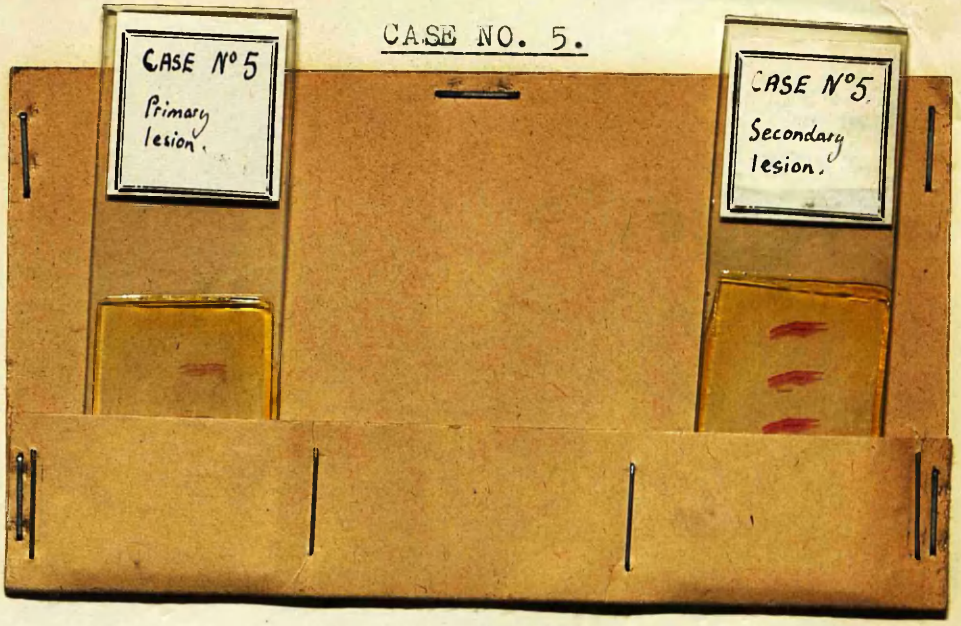
CASE NO. 3.



CASE NO. 4.



CASE NO. 5.



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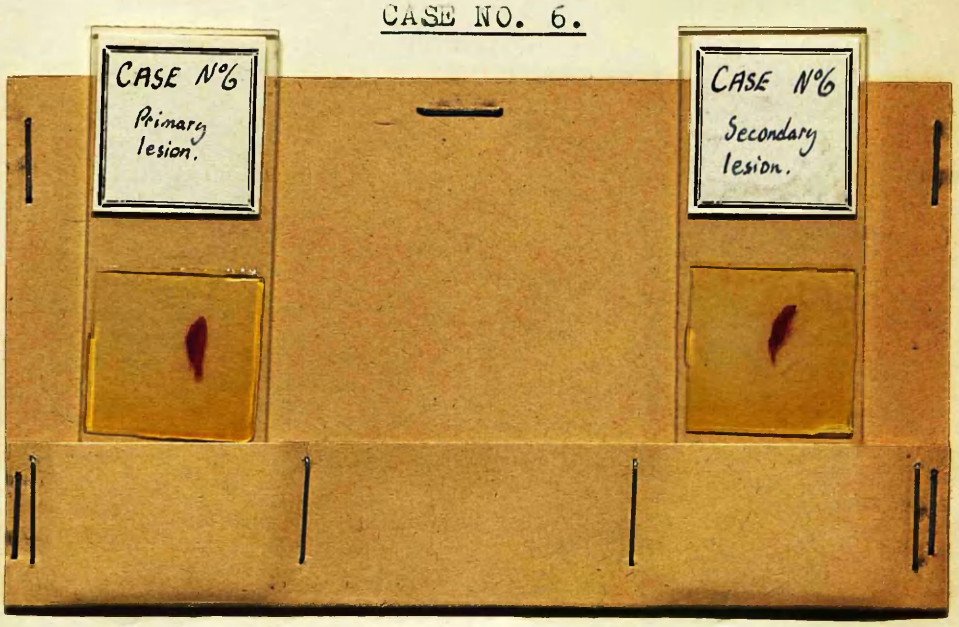

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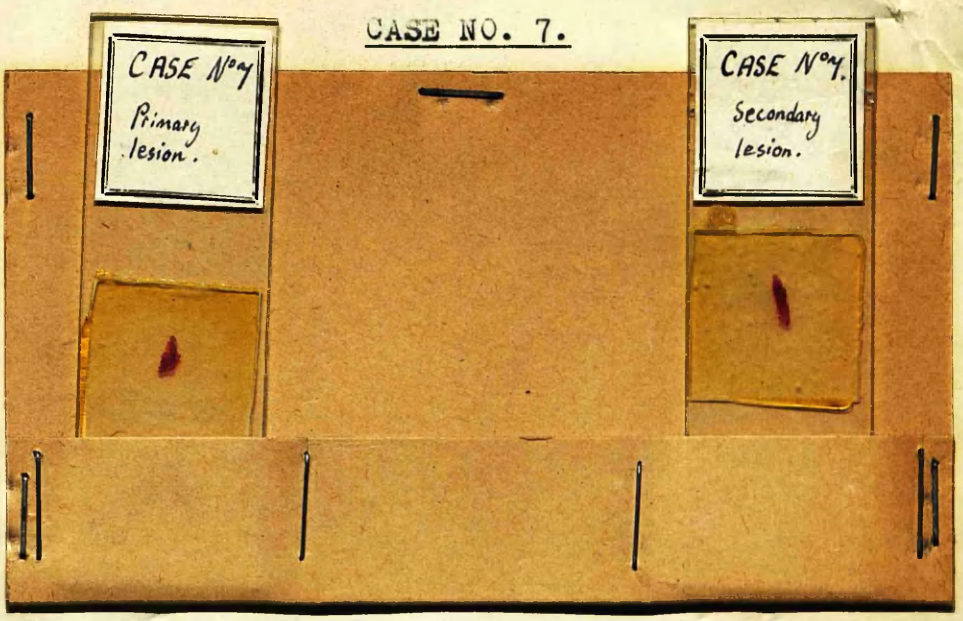
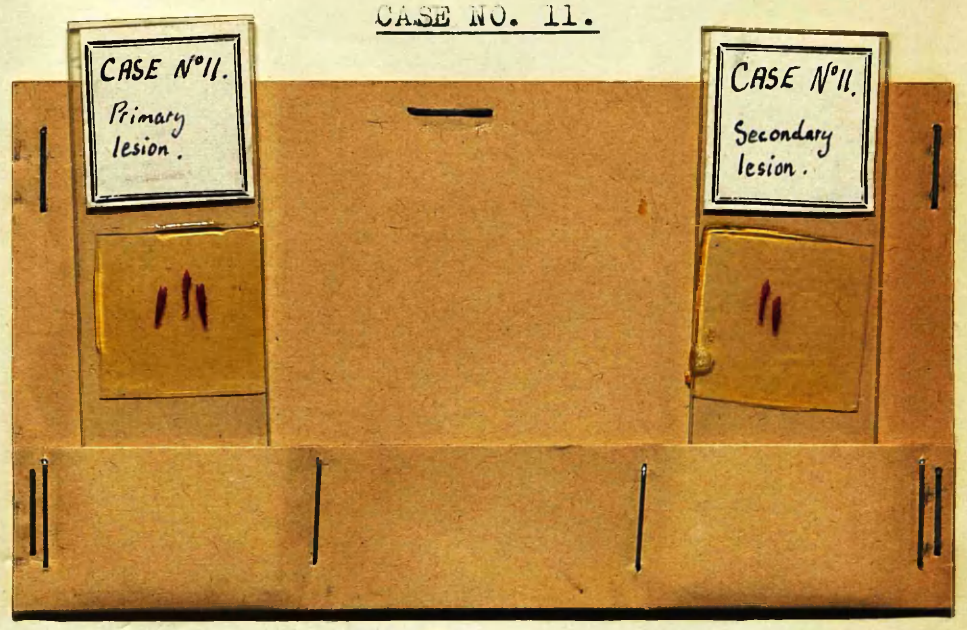


CASE NO. 11.



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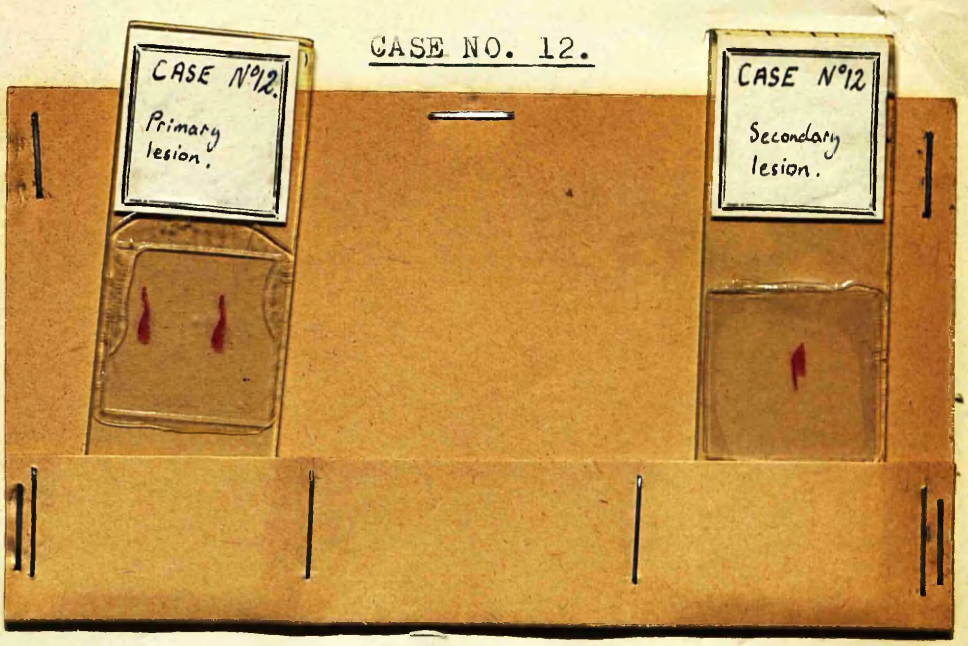
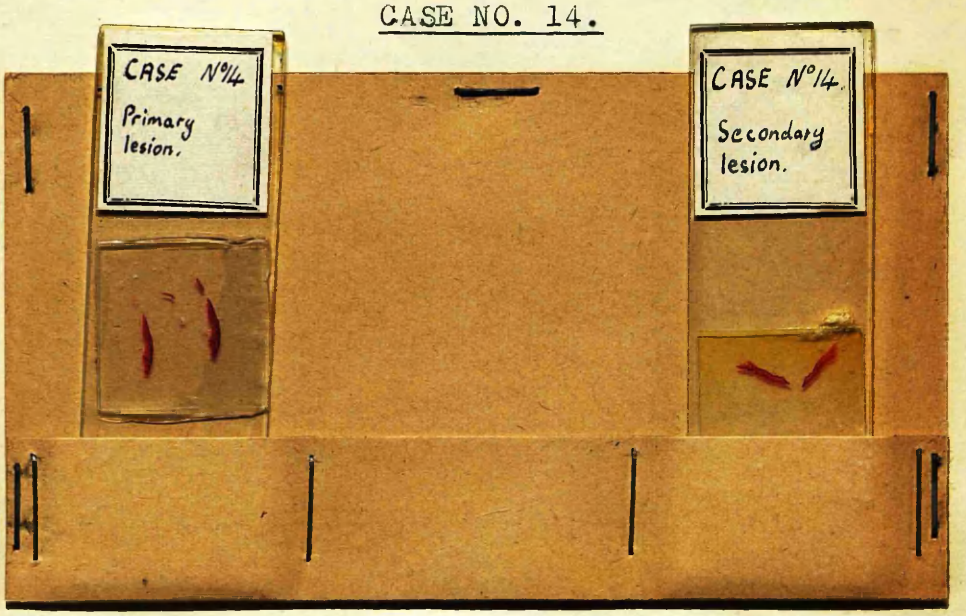


CASE NO. 14.



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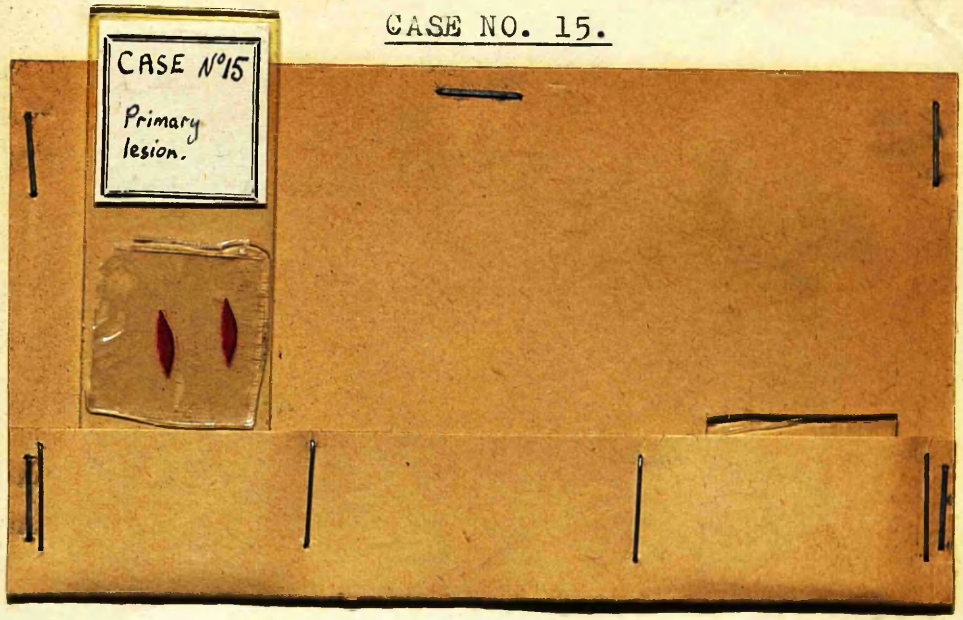

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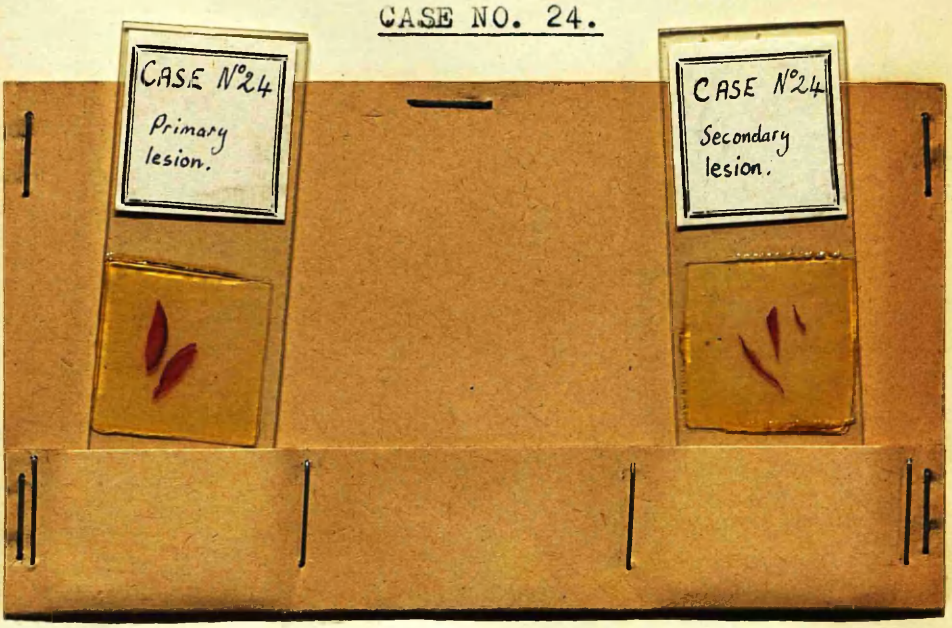
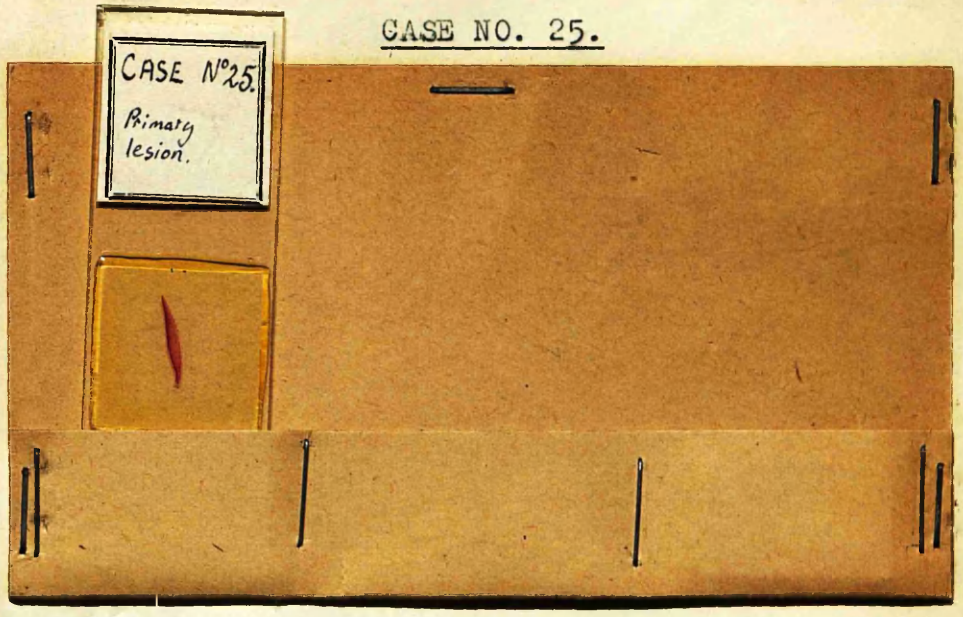
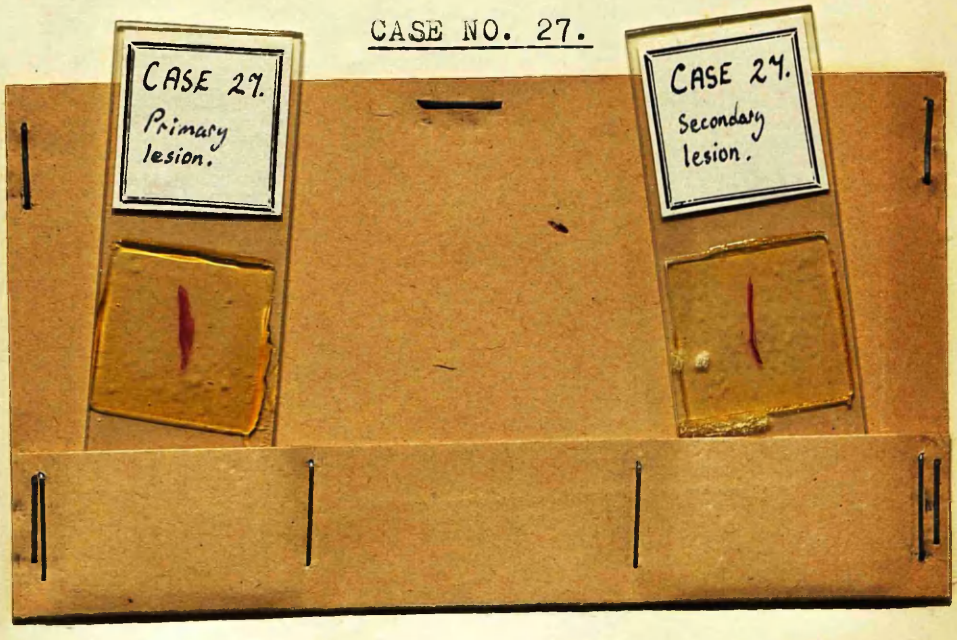


CASE NO. 25.



CASE NO. 27.



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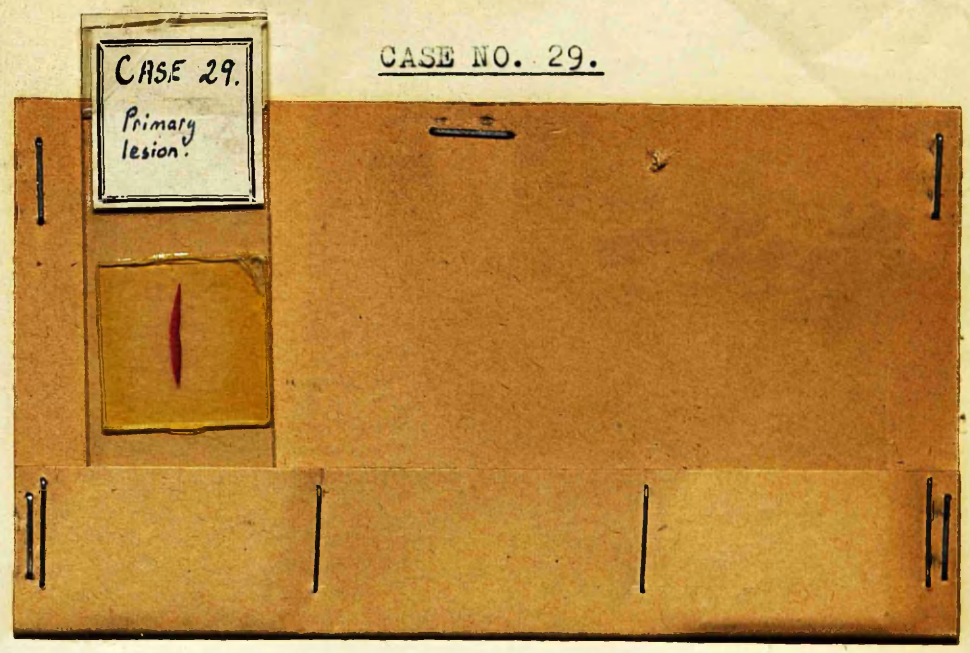

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