ASSOCIATION NOTES

Bombay Branch :—

The following cases were presented by Dr. M.P. Vakil, House Physician, St. Georges Hospital, at a clinical meeting held at the Skin Department (Chief Dr. L. Marquis) on 11th May 1961:—

A CASE OF PEMPHIGUS VULGARIS

Patient: D.D., Male 70 years.

History: Prior to the onset of the present complaints the patient was in normal health. One month prior to admission he developed a non pruritic rash on the face, chest, abdomen and back, in that order. The initial lesions consisted of blisters which on rupturing discharged clear fluid and subsequently became crusted. A few days after the onset of the skin eruption the patient developed painful lesions in the mouth.

There was no history of ingestion of drugs prior to onset of the complaints.

Examination : At the time of admission the patient had flaccid bullae and crusted lesions on the face, abdomen, chest, back and proximal aspect of the extremities. There was no erythema or edema at the base of the lesions. The bullous fluid had a serosanguinous appearance. The mouth showed irregular superficial ulcers.

Systematic examination was normal.

Treatment : On a clinical diagnosis of Pemphigus Vulgaris the patient was treated with 15 mgm of Prednisolone per day for 10 days. As there was no response to this the dose of prednisolone was stepped up to 50 mgm per day with rapid clearing of skin lesions. The mucosal lesions however have not healed.

Comments :

Dr. L. Marquis : The presence of lesions of Pemphigus in the mouth indicates a severe type of disease with a correspondingly poor prognosis, and high mortality.

Dr. V.R. Mehta : In the mucosal or ocular form of Pemphigus the lesions often remain confined to the mucous membranes, without skin lesion developing. The disorder here follows a chronic course.

Dr. T.K. Mehta : The dose given is rather small. It should be remembered that most of the skin diseases require a rather high dose to begin with and this is particularly so in case of Pemphigus Vulgaris. it should have been between 40 to 60 mg. per day for Pemphigus Vulgaris to bring the disease under control. It goes without saying that maintenance dose should be esablished in each case by trial and error.

A CASE OF PYOGENIC GRANULOMA

Patient: S.U., Male, 14 years.

History: Six months prior to admission the patient had a "minor head injury" involving the left fronto parietal region. One month later he noticed a swelling ½"×½" in size over this area. The swelling gradually increased in size, ulcerated and has been discharging pus and blood.

Examination: A pedunculated tumor 4"×3"×1½" size was located over the left frontoparietal region. The lesion was non-tender firm to feel bled easily on touch and could be moved freely over the underlying bone. Pressure over certain areas of the tumour resulted in exudation of pus, pulsation and an impulse on coughing could not be elicited.

Firm, freely movable non tender and discrete enlarged lymph nodes were present in the pasterior triangle of the neck on both sides, but were more marked on the left side.

Comments:

Dr. V. R. Mehta: A categorical diagnosis is not possible without subjecting the tumour to histopathologic examination, however, the possibility of cylindroma should be kept in mind.

A CASE OF DERMATITIS HERPETIFORMIS

Patient: G.H., Male 22 years.

History: The patient was in normal health prior to the onset of the present complaints, 15 years ago. For the last 15 years he has been getting recurrent attacks of a generalized rash accompanied by severe pruritus and a burning sensation over the lesions. Till the last 5 years there used to be spontaneous exacerbation and remissions of the disease. Since this time, however, the lesion have been present at some place or the other constantly. The lesions have always appeared in groups, have healed with hyper or hypopigmentation and several new lesions have developed at or round the sites of healed eruption. The mucous membranes have always been free from lesions.

Examination: The patient was of poor built and showed marked wasting. The mucous membraness of the mouth and conjunctivae were pale.

The skin showed groups of vesicle and bullae arising mostly over an erythematous and mildly edematous base. Some lesions however arose from normal appearing skin. Some lesions were seen at the sites of healed eruption. The bullae were tense and varied between 3 mm in diameter to 1 cm. some lesions were crusted while others had healed with hypo and hyperpigmentation.

The lesions were distributed over the distal part of the extremities, in the axillae, groins and a few on the trunk and face. The mucous membranes wre free from the eruption.

Investigations :

R.B.C. Count	—	2.25 Mil/cmm.
Haemoglobin	—	25%
W.B.C. Count	—	Total 6300/smm.

Differential P 42%, L 18%, M 8%, E 32.

Stools: Normal, Urine: Normal, Screening of the chest: Normal. Smear from the base of the lesion showed plenty of eosinophils.

Treatment : Carbarsone 12 grs. per day for 23 days, liquor arsenicals 12 mins per day for 115 days, diamino-diphenyl sulphones 300 mgm per day for 30 days, sulpha pyridine 1.5 gms per day for 26 days, prednisolone 15 mg per day for 45 days, largactil 50 mgms per day for 28 days, chloramphenicol 750 mgs per day for 7 days, 3 sulphanilamido, 6 methoxypyridazine 1.5 gms daily for 15 days, and a blood transfusion of 250 mls were all without effect.

Comments :

Dr. T. K. Mehta : The dose of sulphapyridine used appear to be too low. It should have been given in a dose of 3 gms. per day.

Dr. M.W. Dhurandhar: The dose of liquor arsenicals should be still higher if it is to be effective.

Dr. H.A. Choksey: Autohaemo therapy should be given a trial in this case.

Dr. V.R. Mehta: A diagnosis of Dermatitis herpetiformis can hardly be doubted, but a histopathologic examinataion should be carried out all the same.

A CASE OF ACTINOMYCOSIS NOCARDIOSIS OF THE FOOT

Patient: A., Male, 30 years. Occupation: Farmer and Cattle breeder.

History: Four months prior to admission the patient noticed a nodular eruption on the dorsal surface of the base of the 4th and 5th toes of the letf foot. One month later these nodules broke down discharging yellowish pus. Subsequently the lesions have spread proximally to involve the whole foot and have been accompanied by swelling of the feet and limitation of its movements.

Examinations: The left foot was markedly swollen and showed the presence of multiple nodules, and sinuses discharging pus. The skin over the foot was pigmented and could not be lifted up from the

underlying tissues some of the nodules were tender to pressure. There was marked limitation of movements of the toes and ankle. The inguinal glands were normal.

Investigations :

X-Ray of the foot showed erosion of several bones and periosteal reaction.

Treatment: The patient was treated with Tetracycline phosphate 250 mgs and Nystatin 250,000 units, orally 4 times a day for 15 days and subsequently with sulphadiazine 4 gms per day. He is still on sulphonamides.

Comments :

Dr. V.R. Mehta: The clinical picture may best be described as Madura foot. As several fungi could cause this clinical appearance, the patient should be adequately investigated mycologically.

Dr. T.K. Mehta: I am sure we could investigate the case for Dr. Marquis and send him back to him for traetment and follow up.

A CASE OF XERODERMA PIGMENTOSUM

Patient: P.A. Male, 12 years.

History: The symptoms have been present since birth. At the time of delivery it was noticed that the skin over the legs peeled off with minimal trauma. Subsequently the patient has been getting large blisters at the sites of injury particularly the hands, feet and knees. The symptoms have been more marked during the summer season than during the winter.

In addition the patient gets redness of the face and exposed parts on exposure to sunlight. For the last 4 years dark spots are appearing over the exposed areas.

The younger brother has a similar disorder but the mother and father are free from symptoms. No H/O consanguinous marriages could be obtained.

Examinations: The face showed marked erythema and a large number of dark brown macular lesions. The latter were discrete as well as confluent and some were also present on the extensor aspect of the upper extremities.

2. There were bullous and crusted lesions on the extensor aspect of the extremities. The lesions had healed in several places with loss of elasticity of the skin and hyper and hypopigmentation. These changes were most marked over the hands and feet Most of the digits showed loss of nails.

Comments :

Dr. V.R. Mehta: The peeling of the skin at the time of birth and the subsequent development of bullae at the sites of trauma and their mode of healing all suggest epidermolysis bullosa as the diagnosis. The presence of photosensitivity suggest the possibiltiy of coexisting Porphyria. The urine should be examined for porphyrins. That one more member of the family suffers from a similar disorder further acts as a pointer to the genetic origin of the condition.

Dr. T.K. Mehta: Porphyrinuria may occur in cases of Epidermotysis bullosa. He also cited a similar case recently seen by him.

IVTH ALL INDIA CONFERENCE

A preliminary meeting of the Conference Committee was held on the September 16, 1961, when the members of the Conference Committee recommended the following resolutions :

1. Reception Committee should be enrolled to include other prominent members of the profession in addition to those on the Conference Committee.

2. The Reception Committe fees were fixed at Rs. 20/- unanimously.

3. The Committee authorised unanimuosly

(a) To open the bank account in the name of the Fourth All India Conference of Dermatologists and Venercologists under the aegis of Indian Association of Dermatologists and Venereologists, Head Office: 1, Nagindas Mansion Bombay-4.

(b) Bank account may be operated by any two of the following office bearers of the Conference Committee.

i. Dr. V.R. Mehta, Organising Secretary, Fourth All India Conference of Indian Association of Dermatologists and Venercologists.

ii. Dr. James C. Fernandez - Treasurer, Fourth All India Conference of Indian Association of Dermatologists and Veneriologists.

iii. Dr. S.C. Desai, Hon. Secretary, Indian Association of Dermatologists and Venercologists.

(c) Any surplus accruing after meeting the Conference Accounts may be credited to the Accounts of the All India Association of Dermatologists and Venereologists.

4. The following office bearers were proposed for the organisation of the Conference :

Dr. A.C. Rebello,
Chairman, Rec. Com.

Directors:

Dr. H.A. Maniar,
Dr. H.A. Choksey.

Dr. M.W. Dhurandhar,
Dr. V.R. Mehta,
Dr. S.J. Yawalkar,
Organising Secretaries.

Dr. James Fernandez,
Treasurer.

Executive Committee:

Dr. B.A. Daruwala,
Dr. (Mrs.) C.R. DaCosta,
Dr. S.C. Desai,
Dr. M.W. Dhurandhar,
Dr. James Fernandez,
Dr. L. Marquis,
Dr. T.K. Mehta,
Dr. V.R. Mehta,
Dr. J.C. Shroff,
Dr. M.S. Trasi.

Entertainment Committee:

Dr. R.K. Menda, (Chairman)
Dr. J.C. Shroff, (Organiser)

Exhibition Committee:

Dr. Suresh Sheth, (Chairman)
Dr. V.R. Mehta, (Organiser).

Souvenir Committee:

Dr. V.D. Arora, (Chairman)
Dr. T.K. Mehta,
Dr. S.J. Yawalkar, (Organisers)

Reception Committee:

Dr. N.N. Shah, (Chairman)
Dr. (Mrs.) C.R. DaCosta,
(Organiser)

Accommodation Committee:

Dr. A.D. Daftary, (Chairman)
Dr. L. Marquis, (Organiser)

Registration and Enquiry Committee:

Dr. Kotwal, (Chairman)
Dr. M.S. Trasi, (Organiser)

Scientific Committee.

Dr. P.M. Udani, (Chairman)
Dr. S.C. Desai, (Organiser).

Volunteer Committee:

Dr. M.A. Panwala, (Chairman)
Dr. M.W. Dhurandhar,
(Organiser).