our patients complained, not of pain, but of a feeling of stiffness and tightness in the affected part, which had a mottled appearance—some areas purple and others dark red—with a poorly demarcated edge. Without treatment the condition is self-limiting and lasts 6–8 weeks. In the cases I have seen there has been little or no general toxaemia, though in several cases the whole of the dorsum of the hand and even lower forearms were involved.

Like Dr. Cyril Boroda (December 17, p. 1411), I found sulphonamides useless. Penicillin I have since used, though with varying success, as although the disease is usually cured in 4–7 days a minority linger on for several weeks despite adequate dosage. In answer to Dr. Boroda's query, the casualty officer here tells me he has seen six cases in the past six months, and I myself have seen a similar number in private and hospital practice in the Black Country.—I am, etc.,

Wolverhampton. E. G. DOLTON.

REFERENCES

1 *Lancet*, 1946, **1**, 125.
2 Ibid., 1946, **1**, 327.

Anaphylactoid Purpura in Pulmonary Tuberculosis

SIR,—I was very interested in the article on "Anaphylactoid Purpura in Pulmonary Tuberculosis" by Drs. P. G. Dalgleish and B. M. Ansell (January 28, p. 225), as we admitted a similar case to hospital recently.

A young man aged 19 was admitted on October 1, 1949, with a 3-weeks history of pyrexia, loss of appetite, and loss of weight. There was no family history of tuberculosis or history of contact. He was said to have suffered from recurrent attacks of eczema of the hands from the age of 3 years. On examination, he had obviously lost a great deal of weight, was slightly anaemic, and his abdomen felt tumid, but there were no other abnormal physical signs. He had a remittent pyrexia, with evening temperatures of 102°–103° F. (38.9°–39.4° C.).

Chest radiograph, blood culture, culture of the stools, Widal reaction, and Mantoux test (1/10,000 and 1/1,000) were negative. Blood count on admission: red cells, 4,400,000; haemoglobin 12.8 g. per 100 ml.; white cells 3,500 (polymorphs 76%, lymphocytes 16%, monocytes 8%).

He continued to run a temperature and ten days later developed a pain in the right side of the chest on breathing—accompanied by a definite pleural rub. He developed signs of a small right pleural effusion, which was confirmed by a chest radiograph—10 ml. of clear straw-coloured fluid were removed by aspiration (lymphocytes 98%, polymorphs 2%, culture sterile). The specimen was cultured for tubercle bacilli and two guinea-pigs were inoculated and killed at three and five weeks. All results were negative. Soon afterwards he developed a small left-sided effusion.

Eight weeks after admission he suddenly developed a generalized purpuric eruption, most profuse on the arms and legs. There were fairly large bullae on the lips and the buccal mucous membrane. Two days later he had a severe epistaxis from the left nostril, and this persisted in spite of packing and transfusion with 2 pints (1.1 litres) of group O blood. The foot of the bed was put on blocks and ¼ gr. (16 mg.) of morphine was given and the bleeding stopped.

The Hess test was positive at the time of the eruption, but the bleeding time and coagulation time were normal. Unfortunately a platelet count was not done at the time of the eruption, but a marked diminution in the number of platelets was noted on a Leishman film. A platelet count one week later was normal. Although the purpura was thought to be of the allergic type, it was decided to carry out further investigations. The patient was referred to Dr. J. F. Wilkinson's haematological out-patient department at the Manchester Royal Infirmary, where full investigations were carried out. The Hess test was then negative, the bleeding and clotting times normal, and the platelet count normal. A full blood count and sternal marrow count were also normal.

A radiograph of the chest on December 15, 1949, showed that the right pleural effusion had absorbed but that there was now some infiltration of the right lower lobe. "The appearances are of a bronchopneumonic inflammatory process. Tuberculosis must be considered." The onset of the purpura coincided with a distinct deterioration in the patient's general condition, but once over the acute attack he has slowly improved.

In view of the previous history of eczema in this case it would be interesting to know if there was any previous history of allergy in the other cases reported.—I am, etc.,

Manchester, 10. J. W. FLETCHER.

Idiosyncrasy to Aspirin

SIR,—Idiosyncrasy to aspirin shown by haematemesis is a well-recognized entity, but of sufficient rarity to justify the following report.

An officer aged 34 serving in Malaya was found to be suffering from right-sided renal colic. He was shocked, cold, sweating profusely, and restless, and had twice vomited normal stomach contents in the previous hour. Rigidity and tenderness were elicited over the right loin and in the course of the right ureter. He was given morphine ¼ gr. (16 mg.) (no atropine was available), which had to be repeated in an hour. He was next given mist. sod. cit. and aspirin 15 gr. (1 g.), to be repeated in four hours, when the aspirin was reduced to 10 gr. (0.65 g.).

Eight hours later he was free of pain, asleep, and had taken sod. cit. and aspirin 10 gr. He began taking tinct. belladonnae four-hourly—after being warned of possible toxic effects. He felt quite well except for very slight nausea. Four hours later he was again examined. One hour previously he had taken tea and toast and vomited it immediately. As he then felt better he took aspirin 10 gr., mist. sod. cit., and tinct. belladonnae 10 minims (10.6 ml.). Five minutes later he vomited three-quarters of a pint (425 ml.) of fresh and slightly altered blood. He was shocked, but in an hour again felt well except for slight nausea and tenderness over the duodenal cap. All medicaments were discontinued. No facilities existed for laboratory examinations owing to the geographical position.

The next day he felt well, apart from slight nausea and epigastric tenderness. In the evening he passed a melaena stool, which left him weak for an hour. Three days later he passed a small renal calculus without discomfort, and shortly afterwards was evacuated to the nearest military hospital. A barium meal and follow-through were negative.

As it seemed impossible to correlate renal colic with haematemesis in the absence of any blood dyscrasia, the haematemesis was assumed to be due to aspirin idiosyncrasy. It was of interest to discover that the patient had never previously taken aspirin or other oral medicament. In the present case he had taken aspirin 35 gr. (2.32 g.) in 12 hours.

I am indebted to D.M.S., FARELF (Brigadier T. Young, O.B.E.), and the consulting physician (Brigadier Bennett) for permission to publish this report.

—I am, etc.,

Coatbridge, Lanark. HENRY A. N. RICHMOND.

Fate of the Foreskin

SIR,—I am grateful to the many correspondents who have commented on my article (December 24, 1949, p. 1433), particularly to those who have added further facts to a subject the discussion of which in the past has too often engendered heat rather than light. A number of pertinent questions have been asked.

Phimosis. Dr. C. A. Royde (January 21, p. 181) doubts my contention that true phimosis causing urinary obstruction virtually never occurs and so cannot be responsible for many of the child deaths registered as due to "circumcision or phimosis." The facts are: (1) I have long searched for such a case without finding one; (2) two experienced paediatric surgeons, Mr. Twistington Higgins and Mr. Denis Browne, both interested in urology, inform me that they have never met such a case; and (3) the only reference I know is that of Campbell,[1] who writes, "I know of four infant deaths in New York City from this cause," without giving further details—but this author's account of the anatomy of the prepuce is so at variance with my own that I feel bound to question his explanation of these deaths.

Drs. H. M. Rose and A. M. Gould (January 28, p. 247) find "true phimosis" present in one-sixth of the infants referred for circumcision. I am well aware of the appearances they describe, and if they will try the effect of simply completing the separation of prepuce from glans they will be surprised to see that the preputial constriction is an illusion. In this context Dr. B. Webber's experience (January 28, p. 247) is valuable: in circumcising some 200 infants he found none in which the prepuce was not easily retractable after separation.

Venereal disease. Limitation of space caused me to deal summarily with the evidence, but my conclusion that it "seems scarcely to warrant universal circumcision as a prophylactic