a condition in which the results of Menghini percutaneous biopsies are also often unsatisfactory. Specimens may be improved by incorporating a stylette within the needle to prevent possible aspiration and fragmentation of the specimen in the syringe.

In summary, while this technique should be attempted only by those experienced in catheterisation and cannulation of the internal jugular vein, transjugular liver biopsy is valuable when percutaneous biopsy is hazardous, or when pressure measurements or venography are also required.

We are grateful to Miss V Arnold for her technical help. ITG is in receipt of a Medical Research Council Training Fellowship.

¹ Rösch, J, *et al*, *New England Journal of Medicine*, 1973, **289**, 227.

² Rösch, J, Antonovic, R, and Dotter, C T, *American Journal of Roentgenology, Radium Therapy, and Nuclear Medicine*, 1975, **125**, 602.

³ Branthwaite, M A, and Bradley, R D, *Journal of Applied Physiology*, 1968, **24**, 434.

⁴ Menghini, G, *Gastroenterology*, 1958, **35**, 190.

(Accepted 23 March 1977)

St Thomas's Hospital, London SE1 7EH

I T GILMORE, MRCP, research fellow, gastrointestinal laboratory, Rayne Institute, and honorary senior registrar in medicine

R D BRADLEY, BSC, MB, consultant physician, department of clinical physiology

R P H THOMPSON, DM, MRCP, consultant physician

Crohn's disease: an unusual cause of dyspareunia

The commonest dermatological manifestation of Crohn's disease is direct extension of the disease from the affected bowel, such as perianal lesions or extension on to the anterior abdominal wall after surgical treatment. A much rarer and only recently recognised complication is metastatic Crohn's disease, in which skin lesions occur in a site distant from the gastrointestinal disease. Disease of the groins, male genitalia, submammary region, and postauricular area have been reported.¹⁻³ The present case describes vulval lesions and resulted in gynaecological referral.

Case report

A 45-year-old woman was referred from another hospital for further investigation of diarrhoea. Her major complaints, however, were of persistent vulval soreness and dyspareunia, for which she had attended gynaecological outpatients for three years, having had dilatation and curettage twice and treatment for one proved monilial infection without any improvement. Her gastrointestinal complaints had lasted four years, being diarrhoea with the passage of 3-4 loose explosive stools daily. She had a 15-year history of recurrent iritis and a 2-year one of recurrent oral ulceration and arthropathy of the knees, hips, and elbows. She was a fit woman in whom the only abnormal physical finding was an area of small reddened nodules with surrounding erythema on the right labia majoras with no other perianal or perineal lesions.

Although the result of a barium enema was normal, a diagnosis of Crohn's disease with total disease of the large bowel was established by sigmoidoscopy and colonoscopy with histological evidence from rectal biopsy specimens. A barium follow-through showed ileal narrowing consistent with Crohn's disease and x-ray films of the sacroiliac joints confirmed the presence of

Giant-cell granulomas and mononuclear inflammation beneath vulval epidermis. (Haematoxylin and eosin. $\times 100$.)

sacroileitis. A biopsy specimen of the vulva showed very similar changes to the rectal biopsy specimen with numerous granulomata (figure).

Her gastrointestinal symptoms failed to improve with simple symptomatic measures but responded rapidly to oral steroid treatment. Nevertheless, there was no change in her vulval symptoms or lesion after treatment with oral, local, or intradermal steroids.

Discussion

Parks, Morson, and Pegum⁴ first drew attention to metastatic Crohn's disease and described it as cutaneous disease occurring remote from the gastrointestinal tract and separated from it by normal skin. Only six subsequent cases have been reported and, although there is no explanation for this cutaneous lesion, Mountain² noted that it occurred where skin surfaces were in close apposition and tended to be moist. Vulval disease, which has not been described, would also fit this association.

Although her gastrointestinal symptoms resolved completely with oral steroids, she still complained bitterly of dyspareunia. As cutaneous sarcoid lesions occasionally respond to intradermal steroids, we tried these in this patient, but there has been no symptomatic or objective improvement.

¹ McCallum, D I, and Kinmont, P D C, *British Journal of Dermatology*, 1968, **80**, 1.

² Mountain, J C, *Gut*, 1970, **11**, 18.

³ McCallum, D I, and Gray, W M, *British Journal of Dermatology*, 1976, **95**, 551.

⁴ Parks, A G, Morson, B C, and Pegum, J S, in *Proceedings of the Royal Society of Medicine*, 1965, **58**, 241.

(Accepted 23 March 1977)

University Departments of Medicine and Histopathology, Bristol Royal Infirmary, Bristol BS2 8HW

P A HAMILTON, BSC, MB, house physician

P BROWN, MB, MRCP, lecturer in medicine

J D DAVIES, MD, MRCPATH, consultant and senior lecturer in pathology

P R SALMON, MB, MRCP, consultant senior lecturer in medicine

Princess Margaret Hospital, Swindon

K D CROW, FRCP, consultant dermatologist