antiseptic solutions and dressings. I have found that these must always be mild, for there is no pain sense to act as a danger signal. I have gotten the best results with solutions of copper sulphate, varying in strength from 0.5 to 2 percent, according to the ulcer to be treated. The patients are given a plentiful supply of this solution and are instructed to change the dressings several times a day. It would be ideal to have a nurse to do that, but my clinic has never been able to afford such a luxury. However, it is only a small minority of patients who cannot be inspired with sufficient enthusiasm to take a fair amount of care of their own lesions. They are rewarded and encouraged by rapid improvement.

But all of the above avails little without treatment of the disease which in the first place was the cause of the lesions. The treatment must be both local and general. For the local treatment I have found that intramuscular injections of the iodized ethyl ester of chaulmoogra oil around the ulcers give the best results. These injections never exceed 0.5 cc., but they are repeated as often as is possible without damaging the tissues. If there is any sign of redness, or if the patient complains of pain, there must be a delay of a few days before giving another injection. The parts some inches removed from the site of the ulcer itself, if anesthetic, must be treated with intradermal injections of the same preparation. The intramuscular injections not only combat the disease but induce a hyperemia which promotes healing.

Because in advanced cases every tissue of the body may be invaded by the organisms, treatment must always be systemic as well as local. In the mildest cases intradermal injections are to be given wherever there are anesthetic areas of skin, the dosage being as great as the patient will welcome without uncomfortable reaction. No less essential is the raising of his resistance by plenty of good food, supplemented by as much cod-liver oil as he is willing to take.

FILARIAL MANIFESTATIONS SIMULATING LEPROSY

BY S. N. CHATTERJI, M.B., D.T.M., (CAL.)

Filarial manifestations is rarely confused with edema of the feet and legs due to reacting leprous lesions. Occasionally an en-
larget epitrochlear gland may be mistaken for localized thickening of the ulnar nerve. The following two cases of filariasis very closely simulated leprosy.

Case 1 (S.C.D.).—The patient, aged 26 years, received treatment in the filariasis department of the Calcutta School of Tropical Medicine for some time and was then sent to the skin department for attention to a patch on his right thigh. He was at last sent to our clinic on suspicion of leprosy.

The center of the patch, which was of 15 days duration, was pale and flat, the margin narrow, raised and erythematous, with a sharp, well-defined edge. To all external appearances it looked like a typical tuberculoid lesion of leprosy, but to our astonishment we could not find any superficial anaesthesia or anaesthesia to pin prick, even in the center of the patch. A slit smear from the margin was negative for acid-fast bacilli.

On palpation it was found that the raised erythematous border was due to inflamed and thickened lymphatics. These had not appeared on the same day, but one after the other. These lymphatics encircled an area on the thigh and gave the appearance of a patch (Plate 6, fig. 1 and Text-fig. 1). On examination of the inner side of the right thigh we found that there was a thick cord which might have been the enlarged internal femoral cutaneous nerve. The thickened lymphatics of the patch were connected with this structure, which was not a nerve but a larger lymphatic vessel.

Previous history: There was no previous history of lymphangitis or orchitis, and there had been no frank chill or fever. About fifteen days previously the patient had been slightly indisposed, the indisposition lasting for two or three days. Soon after that he noticed that a part of the right thigh was erythematous. The inguinal glands were palpable but not definitely enlarged or tender.
CASE 2 (K.P.B.).—This case was rather a puzzle to a doctor in charge of a leprosy clinic and the patient was sent to us for opinion. There was a thick, elongated cord on the inner side of right arm, and in one part of that there was a round and soft swelling. At first sight it looked like the thickened ulnar nerve with an abscess (Plate 6, fig. 2).

History: About five months previously the patient noticed a swelling at the inner side of right arm, which gradually became bigger. There was no history of fever or lymphangitis. Lymphatic glands were not enlarged.

Examination: There was no superficial anesthesia in the distribution of the right ulnar nerve. That nerve, quite normal, could be palpated by the side of the cord described. The case was diagnosed as one of filariasis and was referred to Dr. Sundar Rao, research worker in filaria, who reported: "A case of filarial cyst of the lymphatic vessel. The lymph shows microfilaria."

Discussion.—Of the three diagnostic signs of leprosy, superficial anesthesia, acid-fast bacilli and thickened cutaneous nerves, the first two were absent in the first of the cases here recorded. In a case of leprosy in which the first two signs are absent but the cutaneous nerve in connection with the patch is definitely thickened, a positive diagnosis is made. In the first case discussed we fortunately could make out that the thick cord at the inner side of the right thigh was not a nerve, otherwise we would have been led to a wrong diagnosis. The history of the case also was unlike that of leprosy, and was typical of lymphangitis.

The second case presented what looked like a typical abscess of the ulnar nerve, having a slightly abnormal course. But as there was no jaundice, and no anesthesia in the distribution of the ulnar nerve, we were cautious about the diagnosis. Careful examination revealed that the ulnar nerve was not thickened and that the cord which was present was a lymphatic vessel.

DESCRIPTION OF PLATE
PLATE 6

FIG. 1. Marginate filarial lesion of thigh, simulating a tuberculous leprotic patch; Case 1. (See Text-fig. 1.)

FIG. 2. Filarial swelling on the inner side of right arm, associated with an elongated cord, simulating an abscessed leprotic ulnar nerve. (Photograph taken with arm horizontal on table.)