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We hope that making available the relevant information on Pachyonychia Congenita will be a means of furthering research to find effective therapies and a cure for PC.
Dr. Richard J. Kelly: I believe that lichenplanus should be definitely ruled out by biopsy before the case is accepted as one of psoriasis or parapsoriasis.

Dr. Leslie P. Barker: I really favor lichen planus as a diagnosis in this case. There are numerous shiny, flat-topped, angular and umbilicated lesions which are violaceous, and there are still others which are scaly. It is true that the lack of itching is against the diagnosis of lichen planus. I do not believe that the absence of oral lesions would count against such a diagnosis. I saw no evidence of vesicles. A biopsy would help differentiate between lichen planus and parapsoriasis.

Dr. Thomas N. Graham: I am convinced that this case is one of pityriasis lichenoides et varioliformis acuta. There has been absolutely no pruritus, and there are no lesions on the mucous membrane. One would hardly expect to find extremely extensive lichen planus with neither of these features.

Pachyonychia Congenita. Presented by Dr. Anthony C. Cipollaro.

J. F., a boy aged 12 years, was born with deformed nails. Other changes occurred soon after birth, and they are becoming progressively worse. He now presents changes of all the nails. They are yellowish brown. The surfaces are smooth, and the nails are hard, curved and enlarged, resembling onychogryphosis. There is demedation of skin on the medial surfaces of the great toes and the right external malleolus. The extensor surfaces of both arms show follicular hyperkeratoses, resembling Darier's disease. There are also some lesions resembling filiform and common verrucae. The tongue, as well as the buccal mucosa and roof of the mouth, is covered with white patches (leukokeratoses).

Biopsy of tissue from a denuded area showed eczema. The Wassermann reaction of the blood and the Kahn reaction were negative. Cultures of material from the tongue gave negative results.

DISCUSSION

Dr. Henry D. Niles: There are some features that suggest congenital ectodermal defect; some suggest epidermolysis bullosa. There may have been bullae on the elbows, and the verrucous lesions followed these. There may be avitaminosis A or riboflavin deficiency. Against this possibility is the fact that he has had this condition since birth, and his diet probably has not been inadequate in vitamins A and B since birth, but it would be interesting to make a photometric test and a blood determination for riboflavin. Was there any history of this condition in his family? Some similar cases were shown by Butcherworth at a meeting of the Academy of Dermatology in Philadelphia last November, but his patients did not have perleche or follicular lesions on the arms. Pachyonychia congenita would fit in with the type of nail lesion which this patient has.

Dr. Maurice J. Costello: About two years ago a girl 9 years of age was presented by Dr. Fox (Arch. Dermat. & Syph. 39:367 [Feb.] 1939). She had leukokeratoses on the buccal mucous membranes and conical verrucous lesions on the body. The condition was diagnosed as pachyonychia congenita. Several of the cutaneous lesions looked like those of epidermolysis bullosa, as do the lesions which this patient presents.

Dr. Robert R. M. McLaughlin: I agree with the discussion and the diagnosis. Nevertheless, I should like to see the results of an exhaustive laboratory work-up to see if anything abnormal is found.

Dr. Laird S. van Dyck: This case shows the different manifestations of congenital ectodermal defect: hyperkeratotic lesions on the extensor surfaces of the arms and on the elbows, an epidermolysis bullosa type of eruption around the heels and feet and the greatly thickened, onychogryphotic nails.

Dr. Anthony C. Cipollaro: This patient is presented to show another manifestation of a congenital ectodermal defect.

Blastomyctosis. Presented by Dr. Anthony C. Cipollaro.

F. L., a jeweler aged 28, born in the United States, had an eruption which began about October 1936. He was previously presented at a meeting of the New York & St. Vincent's Hospital. After the patient had been treated with penicillin for 1½ in., the eruption ceased. The lesions in the axilla, supraclavicular, subclavicular and inguinal areas were in great abundance. The chest X-ray showed a shadow about 3.5 cm. at the apex of the left lung.

Now the eruption is present but much reduced. The patient has been treated with Dapsone (3 g. a day). The test for blastomyctosis was negative. He has been treated with three more X-rays to the left shoulder and three more to the inguinal area. He has been treated with 1,000 rads to the inguinal area, and the cervical lymph nodes have decreased in size and the rash has disappeared. He has been treated with several courses of penicillin, and he has also been treated with sulfanilamide. He has had no relapse since he started on Dapsone, and he has been examined by Dr. Thomas N. Graham and Dr. William H. Murphy.

Dr. S. W. Siders: The patient had no relapse while he was on Dapsone. I do not think it is necessary to treat every patient with blastomyctosis with Dapsone. I think it should be treated with other drugs, such as penicillin or sulfa drugs.

Dr. S. W. Siders: The patient has been treated with Dapsone, and the rash has disappeared. The patient has been examined by Dr. Thomas N. Graham and Dr. William H. Murphy.

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