

Atlas of the diseases of the skin. [Pt. 1] / by Balmanno Squire.

Contributors

Squire Balmanno -1908.
Royal College of Physicians of Edinburgh

Publication/Creation

London : J. & A. Churchill, 1878.

Persistent URL

<https://wellcomecollection.org/works/h9mmm9f>

Provider

Royal College of Physicians Edinburgh

License and attribution

This material has been provided by This material has been provided by the Royal College of Physicians of Edinburgh. The original may be consulted at the Royal College of Physicians of Edinburgh. where the originals may be consulted.

This work has been identified as being free of known restrictions under copyright law, including all related and neighbouring rights and is being made available under the Creative Commons, Public Domain Mark.

You can copy, modify, distribute and perform the work, even for commercial purposes, without asking permission.



Wellcome Collection
183 Euston Road
London NW1 2BE UK
T +44 (0)20 7611 8722
E library@wellcomecollection.org
<https://wellcomecollection.org>

Ha 9. 32

PART I.

Price 10s. 6d.

ATLAS

OF THE

DISEASES OF THE SKIN.

BY

BALMANNO SQUIRE, M.B.,

SURGEON TO THE BRITISH HOSPITAL FOR DISEASES OF THE SKIN.





ATLAS
OF THE
DISEASES OF THE SKIN.

BY
BALMANNO SQUIRE, M.B.,
SURGEON TO THE BRITISH HOSPITAL FOR DISEASES OF THE SKIN.

London :
J. & A. CHURCHILL, NEW BURLINGTON STREET.

MDCCCLXXVIII.

R37633



R37633

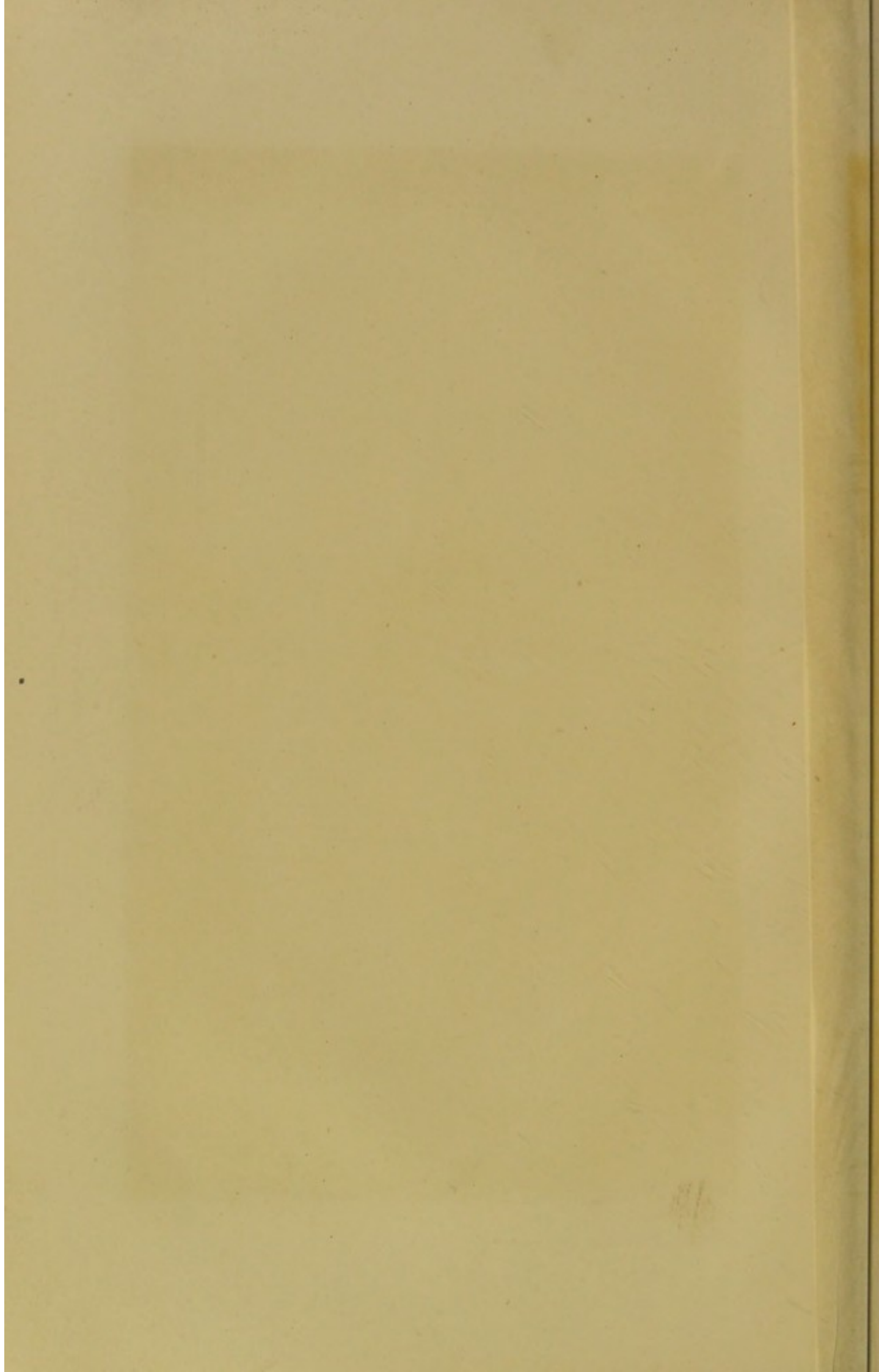


SQUIRE'S

1

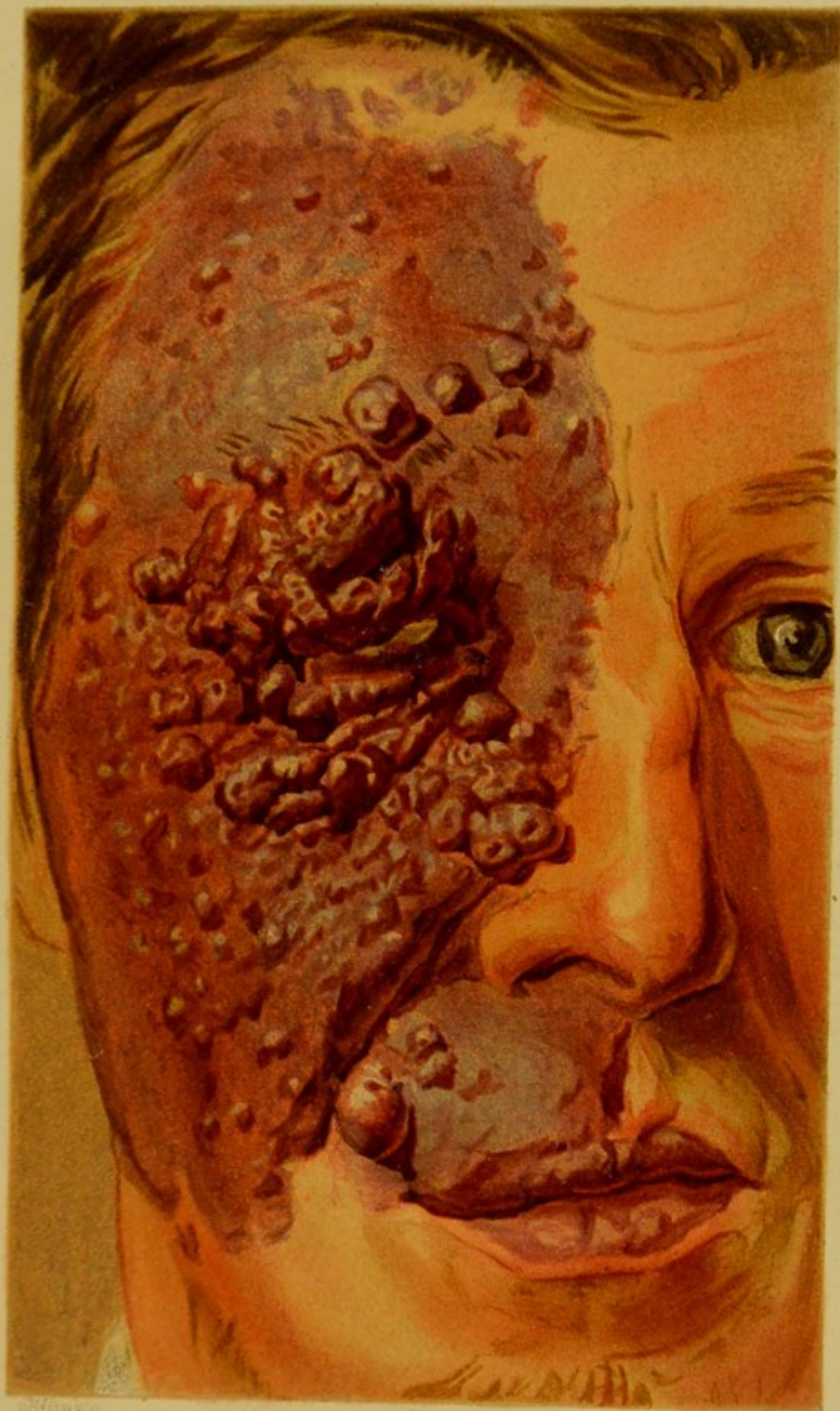
ATLAS

NEVUS VASCULARIS.







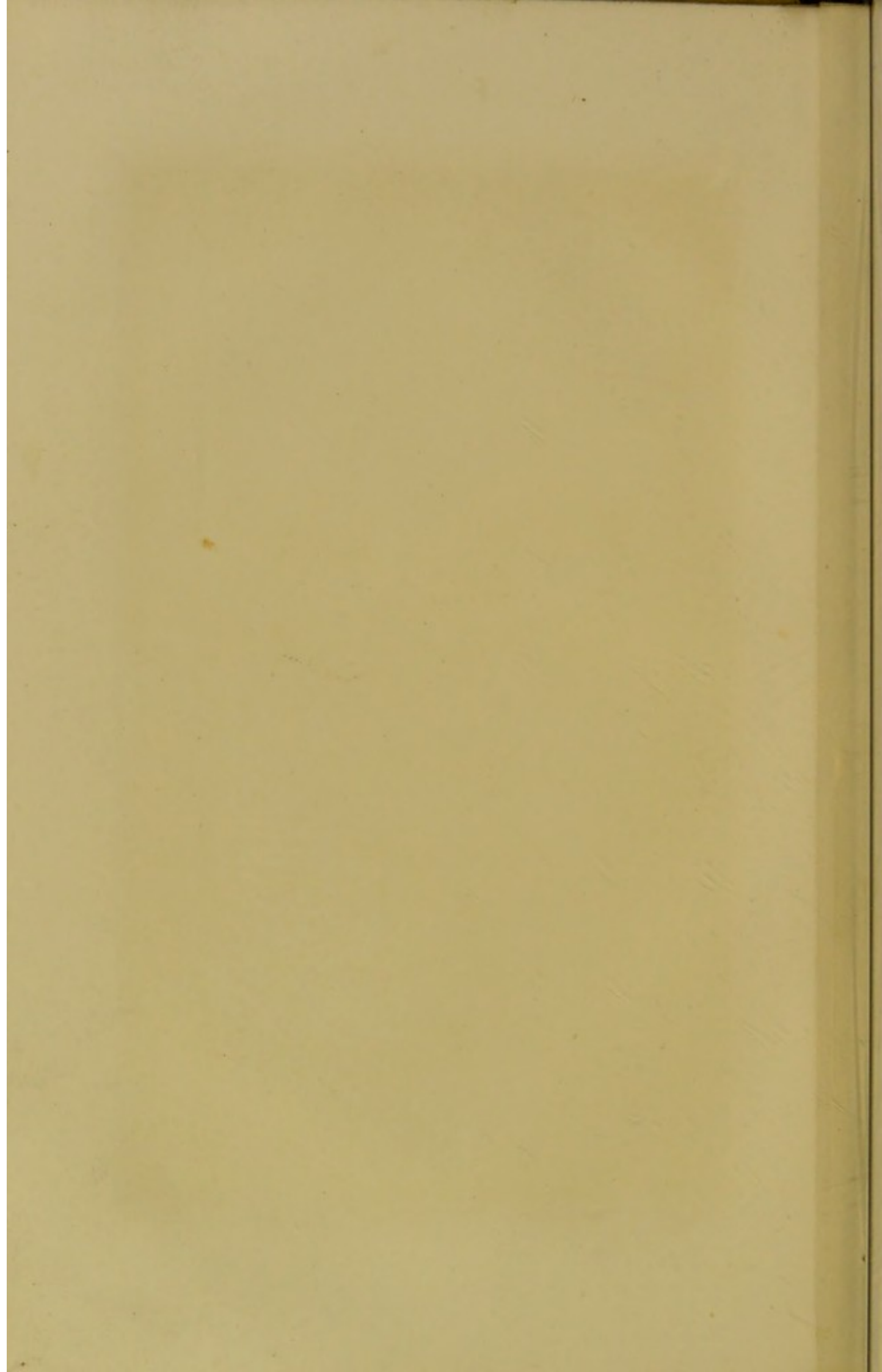


SQUIRE'S

II.

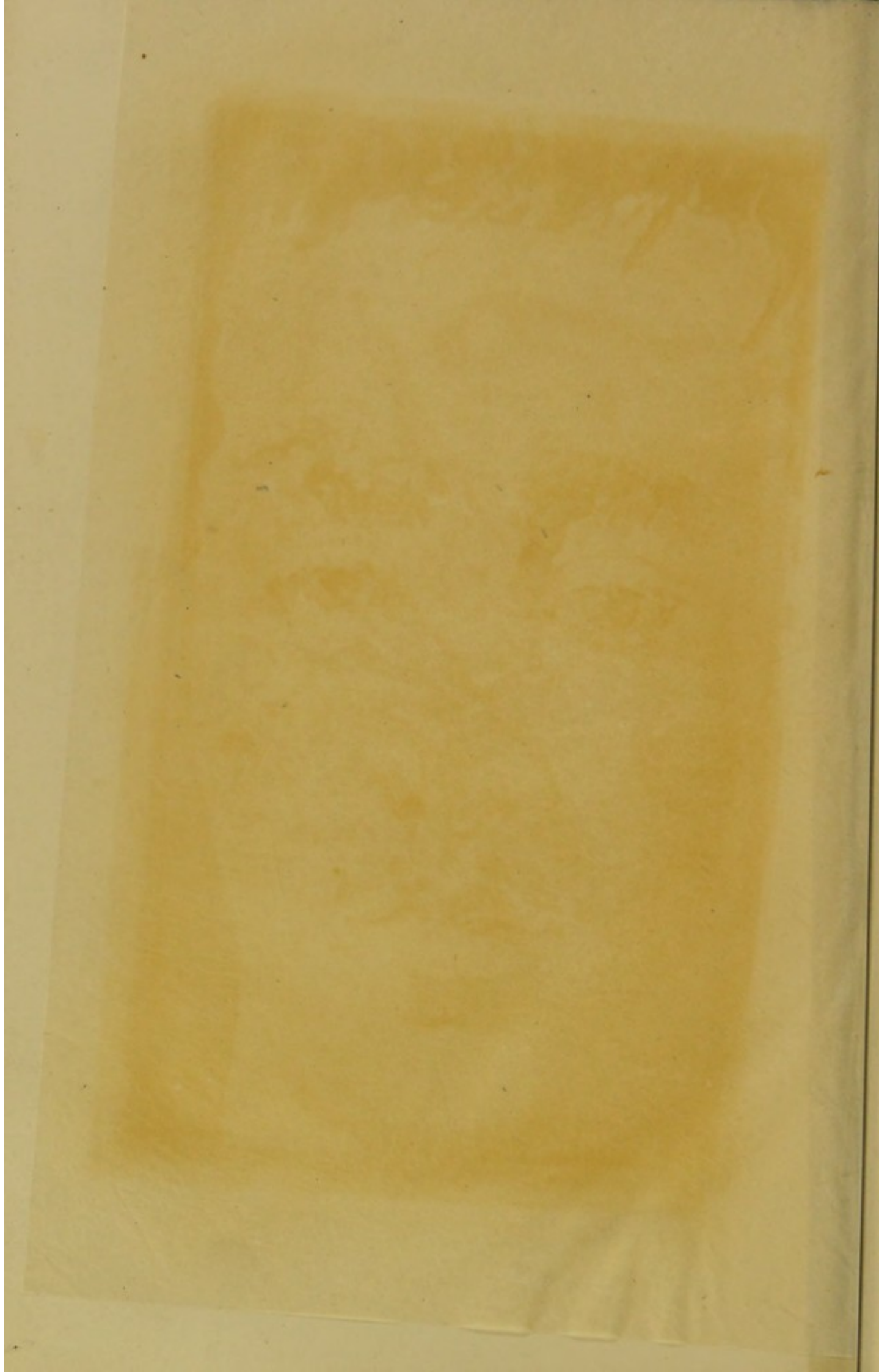
ATLAS

NEVUS VASCULARIS.
(WITH MOLLUSCUM)





PSORIASIS DIFFUSA



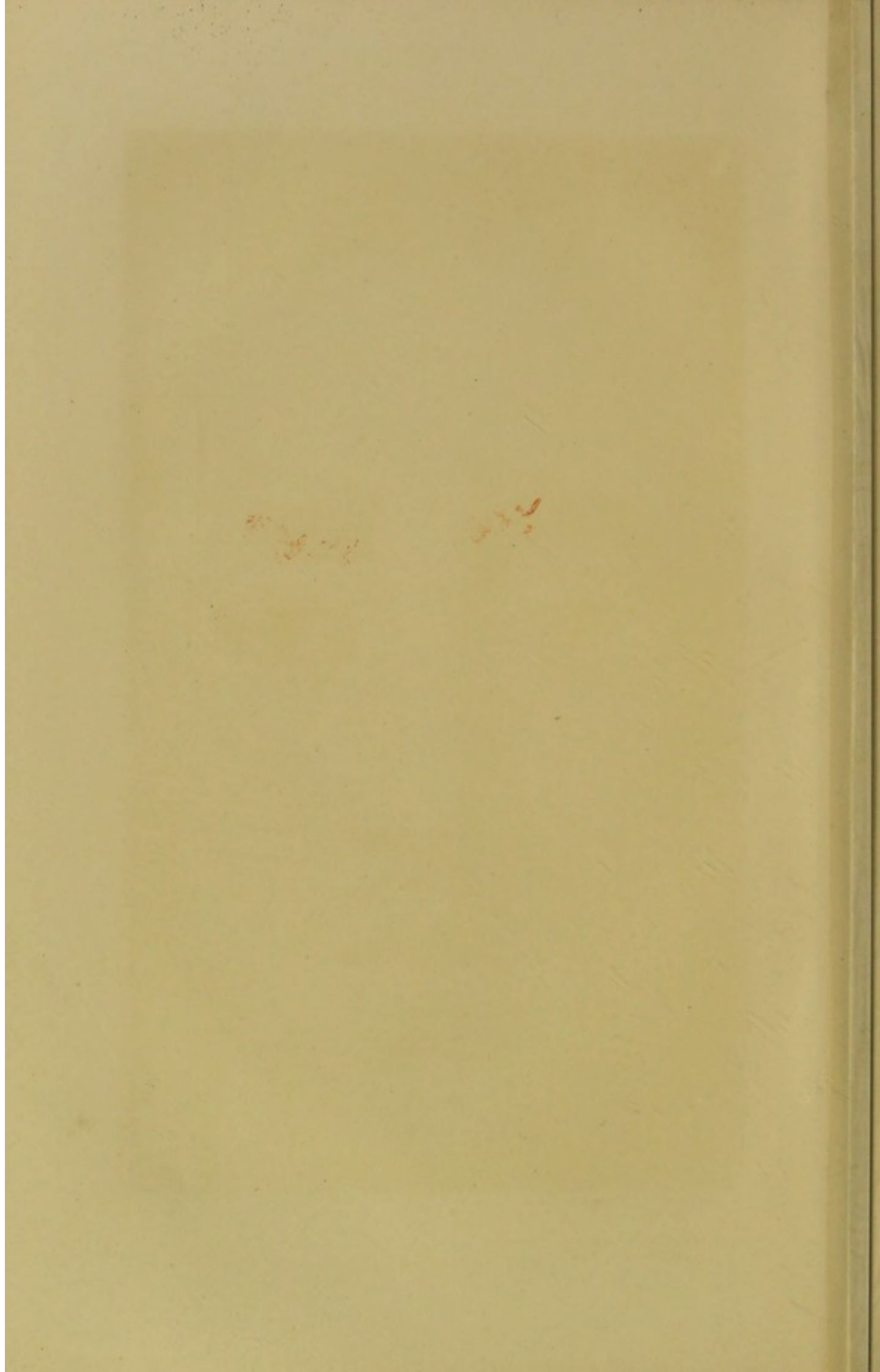


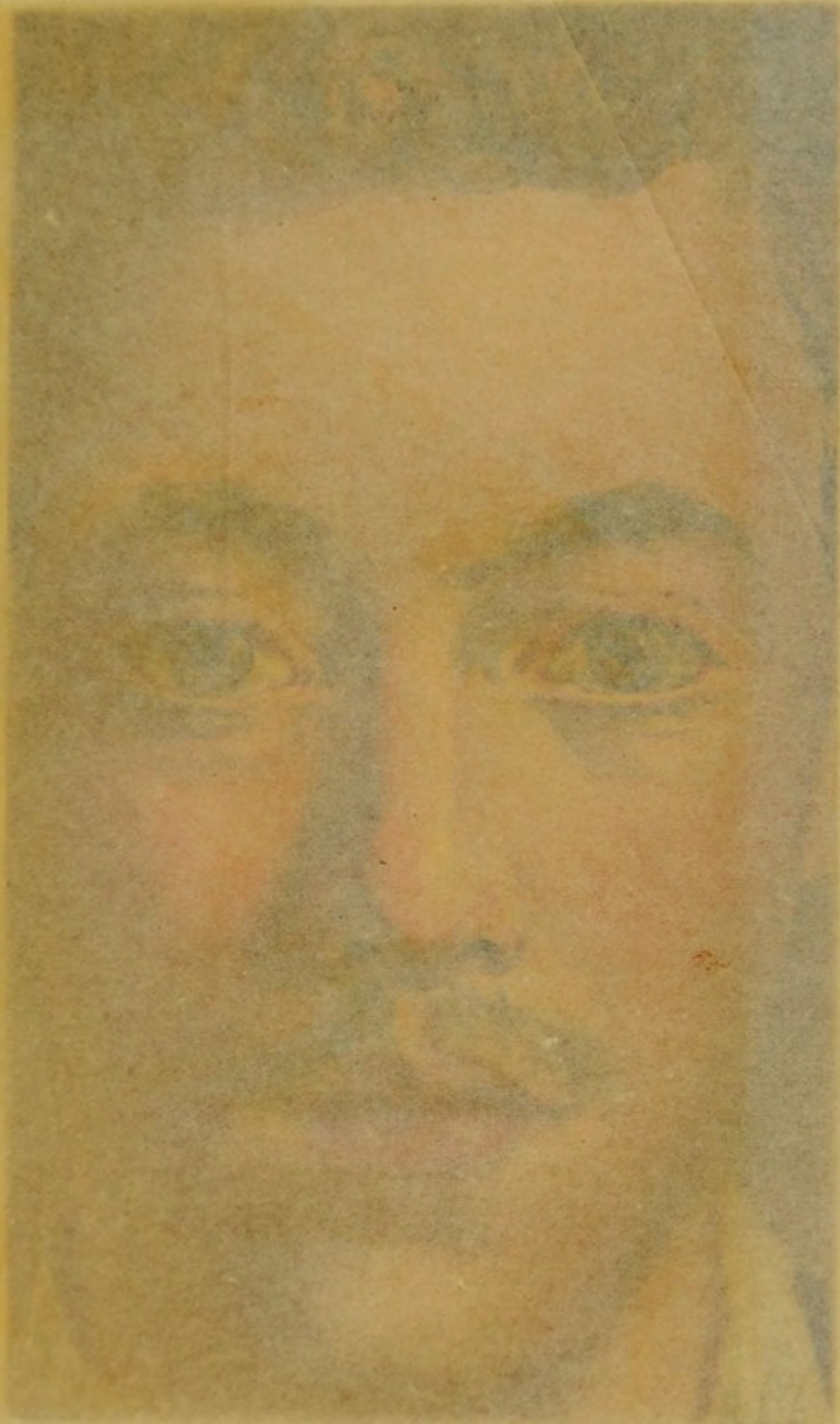
SQUIRE'S

III.

ATLAS

PSORIASIS DIFFUSA.







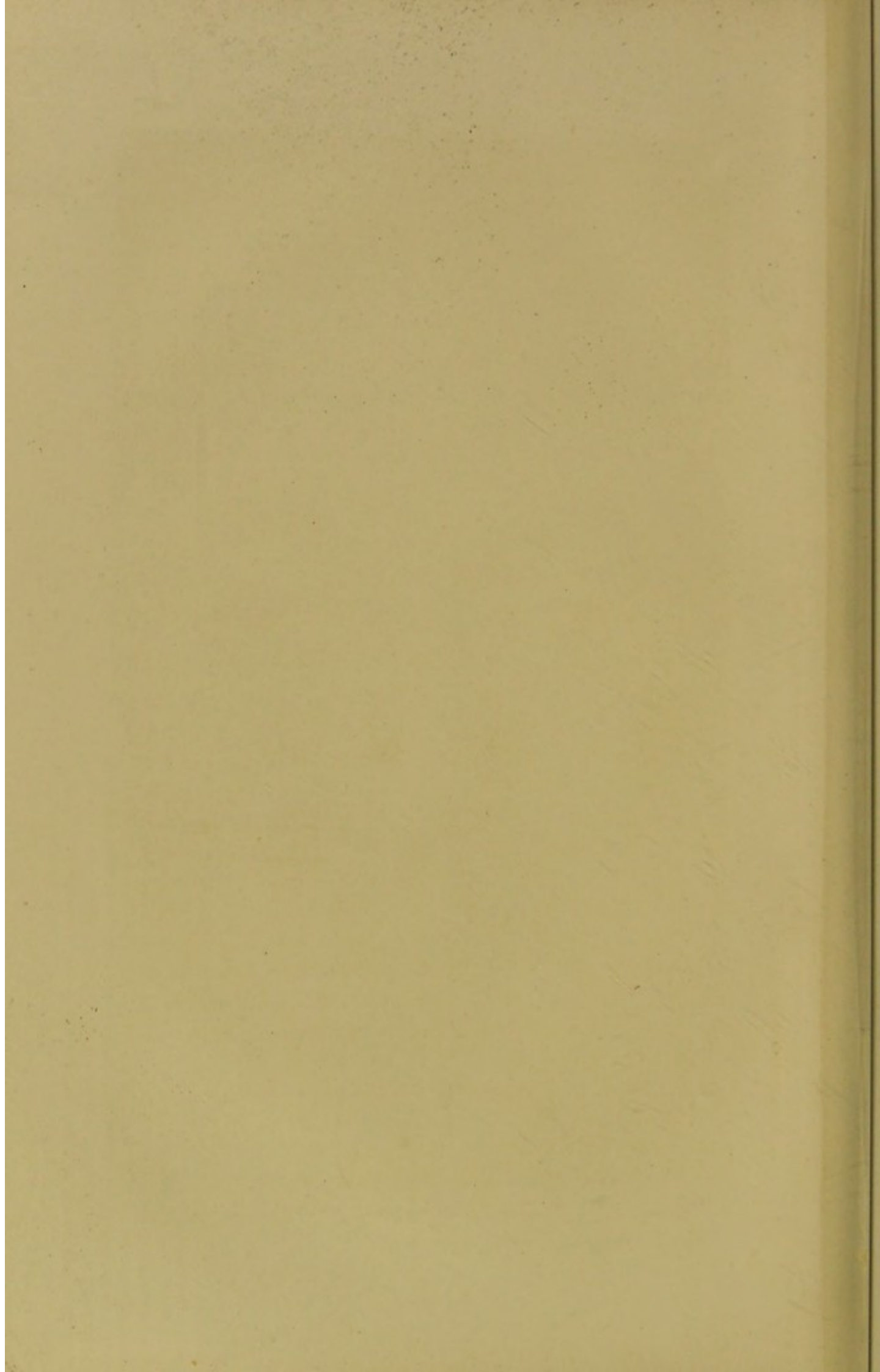


SQUIRE'S

IV

ATLAS

PSORIASIS DIFFUSA
(AFTER TREATMENT)



ADVERTISEMENT.

IN publishing this Atlas, the author has attempted an innovation, which he believes will be found a convenience. He has departed a little from the tradition which has hitherto ruled the production of atlases of cutaneous disease, namely, by depicting the disease of larger size than is usual, while at the same time he has curtailed the dimensions of the paper on which the disease is drawn. It has been said, with a great deal of truth, that an inspection of illustrations of skin disease cannot take the place of clinical observation of the diseases themselves as a means of acquiring a knowledge of them. However, it is obvious that the larger the detail of the drawing, the more possible does it become to depict the disease in a faithful and life-like manner. Then as to the other matter, he believes that the chief reason why many practitioners hesitate to possess themselves of atlases of this kind, which are of unquestionable service in their way, is, that they feel they would scarcely know where to put the atlas when they had got it. Most atlases are of too capacious dimensions to go on a book shelf, and many are even too large to go into any ordinary drawer; they must either be left lying about or else some special receptacle must be constructed for them. They are not portable, so as to be capable of serving for clinical use. This would be a small matter if other considerations were to be found to overbalance it, but the author believes that there are no real reasons why common convenience may not be consulted in the way he has attempted. It is not necessary that a large margin should be provided to each plate, nor is it essential that a considerable portion of the body beyond the area affected by the disease should be included in the drawing. It might perhaps be urged on the other side,

that a tolerably large portion of the body ought necessarily to be included in each drawing, so as to assist in indicating what portion of the surface is represented, but it is hoped that in these illustrations that want will not be felt. Medical practitioners are familiar with the art-anatomy of every region, and by reason of this aptitude can readily recognize the position of any moderately small portion of the body that may be presented to their view. It might still be objected that by contracting the customary size of the drawings it becomes impossible to delineate fairly an eruption which is general, or at all events spread over a large area; but the author is not aware of any attempts which have yet been made to exhibit on one plate the entire area of such a disease, for example, as scabies. He believes that by depicting as nearly to life-size as may be practicable, a limited area of the disease, more advantage is gained by the facility thus afforded in attaining fidelity, than on the whole is gained by depicting, as has usually been done, a considerable area of the disease in dimensions very notably less than the natural ones. However, the drawback which attaches admits of being supplemented in a sufficient degree by supplying, when needed, more than one illustration of the same case of disease. This is an expedient which has often been had recourse to in the larger plates referred to. The author ventures with reference to the many admirable atlases which have preceded this publication, to express an opinion that they would have been more serviceable if in them the diseases had been larger and the paper smaller. He has endeavoured to overcome such disadvantages by increasing the size of the detail wherever practicable to full life-size. While at the same time he has attempted the bold measure of bringing the dimensions of the atlas itself down to the most convenient library-size, namely, to exactly those dimensions of which the majority of books are made, that is to say, the octavo demy page. As regards the price of the work, the author believes that in a publication of

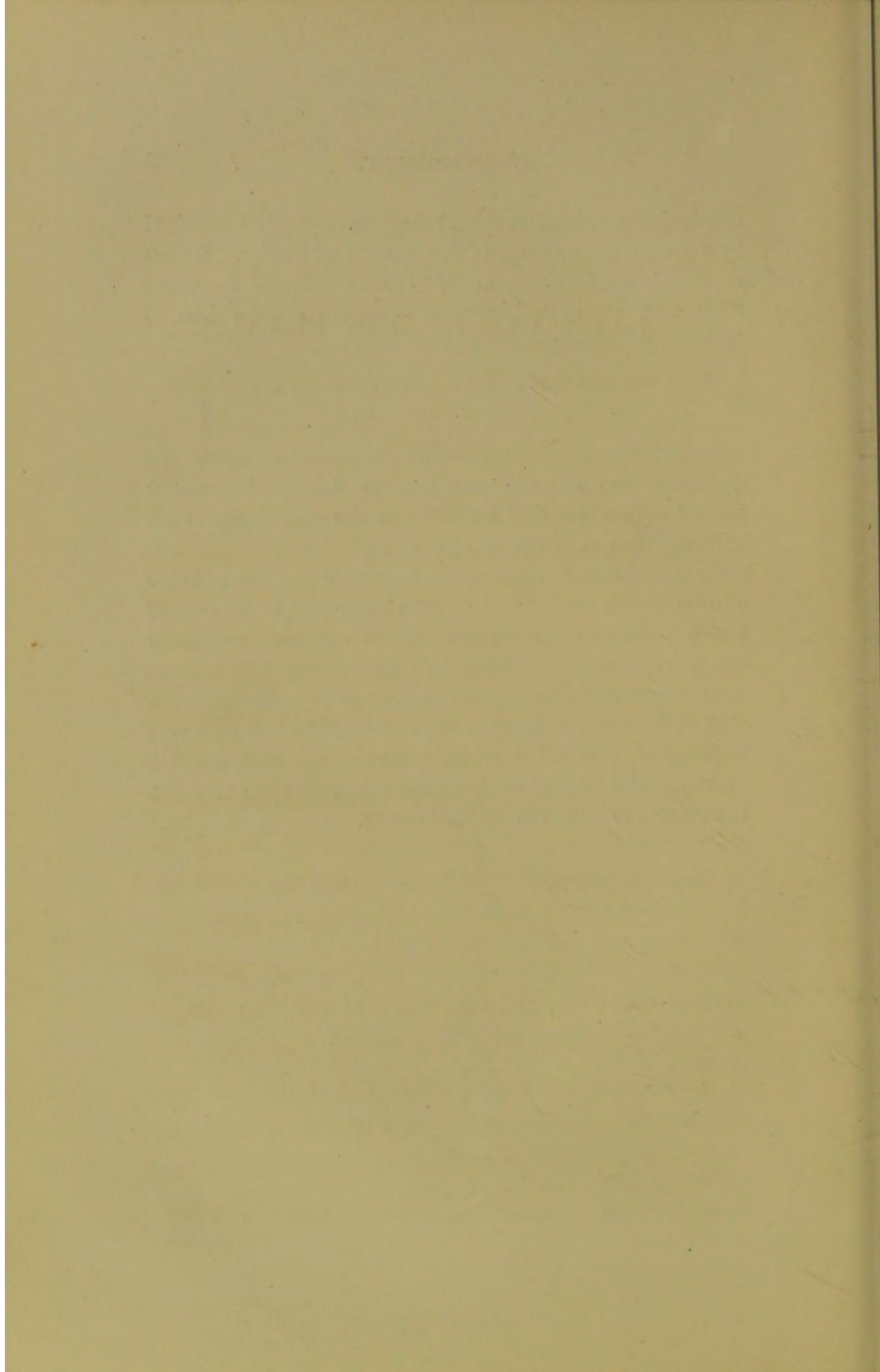
this kind any attempt at special cheapness can only be attained by a greatly disproportionate deterioration of quality. He has accordingly spared no expense as to the execution of the plates themselves. As to the letterpress which accompanies them, so far as it has yet been written, he can only say,

“Dum relego scripsisse pudet quia plurima cerno,
Me quoque qui scripsi iudice, digna lini.”

As to his venturing to produce in any shape an atlas of the diseases of the skin, he may mention that the last wholly original work of the kind published in this country was issued by himself now more than ten years ago.

As to the manner of publication, the author proposes to follow a custom which has before been found expedient in the issue of atlases of this kind. He believes that the interests of purchasers will be best consulted by his refraining from any definite statement, either as to the precise number of parts of which the work shall consist, or as to the exact interval at which each part shall appear. He will, therefore, restrict himself to saying that each successive number will be produced as soon as he may find himself able to issue it in his best manner.

LONDON, *May*, 1878.



NÆVUS VASCULARIS PLANUS.

Eng. *Port-wine-mark.* Fre. *Tache vineuse.* Ger. *Gefässmal.*



NÆVUS (*nævus*, *Lat.*, a natural mark, a blemish) is of two chief kinds, namely, *Nævus vascularis* and *Nævus pigmentarius*. According to the various conceptions of various authors, *nævus* has been made to figure sometimes in one group, sometimes in another. However, *nævus* is a constant unit in all systems of cutaneous classification.

Not to dwell further on this point, I may say at once that the term "*Nævus*," which is merely the scientific representative of the vernacular "*mother-mark*," is never likely to die out. The *mother-mark* or *nævus* then is of two kinds, the dingy-yellowish-brown kind (*pigmentary nævus*), and the bright purplish-red (*vascular nævus*); either sort may alike present this difference, namely, that it may be flat, that is to say, level or nearly so with the surrounding skin, or may be prominent, or, in other words, bulging more or less boldly from the general surface.

Furthermore as regards the pigmentary nævus alone, it may present the peculiarity of exhibiting, if it be of the prominent sort, a thick crop of stout, stiff, dark-coloured bristly hairs, which are in strong contrast to the downy and almost imperceptible hairs of the general surface of the skin. The popular mind has always been more or less fascinated by these unwonted peculiar marks on the surface, and delights in attributing to them a romantic significance. Thus let us suppose that the mark be of the flat pigmentary kind, and can by any ingenuity be likened to the shape of a toad. *Then*, even if its outline should follow that form with only such vague resemblance as the constellation Ursa Major presents to the shape of a bear, such mark is called a toad-mark, and it is believed that the mother of the individual has been frightened during her pregnancy by a toad. One of my relations who is thus affected entertains a hankering impression of this kind. A man of the artisan class, whom I had occasion to employ, presented a very prominent pigmentary nævus on the face, namely, over the cheek; it measured about a couple of inches in length and about one inch in breadth, and was thickly covered with dark bristly hair. This man very seriously told me that the

cause of it was that his mother during her pregnancy had been frightened by a mouse. In the history of the one of the cases represented in the coloured plates, I have related the man's story of his mother being startled by the breaking of a bottle of wine. Such beliefs are doubtless the result of the desire common to humanity, to account for everything that happens in some way or another, and of a readiness, if a logical reason cannot be obtained, to accept a poetical one in its place. It is to be admitted that it is not quite so difficult to follow the ideas that are popularly suggested in the case of mother-marks, as it is in the case of the constellations. However, the popular belief as to the cause of mother-marks may be properly classed with the belief in ghosts or apparitions, that is to say, it is a creation of the fancy. The essential difference between the vascular and the pigmentary nævus is, that the former is constituted by a local excess of blood-vessels in the skin, and the latter by a local excess of pigmentary matter in the skin, with sometimes an excess of hair also, and occasionally indeed an excess of skin generally, but always with special excess of pigmentary matter, and sometimes with special excess of hair. The pigmentary nævus, to

speak more technically, is constituted always by an hypertrophy of the pigment, sometimes by an hypertrophy of the skin altogether, with special hypertrophy of its pigment; sometimes by hypertrophy of the skin, with special hypertrophy of its pigment and of its hair. The vascular nævus, on the other hand, is constituted by hypertrophy of the blood-vessels of the skin, or, if it be preferred, by "new formation" of blood-vessels in its substance.

Hence arises a distinctive difference between the two kinds of nævus. The colour of the vascular nævus can be made to disappear for the moment by pressing on it with the finger. On suddenly removing the finger-pressure, the vascular nævus is seen to be quite pale for a moment before its colour re-establishes itself, which happens almost instantaneously. The pigmentary nævus, on the other hand, fully retains its colour under even the firmest pressure. Again, the vascular, unlike the pigmentary nævus, has a soft elastic feel to the touch.

It is with the vascular nævus that we have here more particularly to deal.

It may, as I have stated, be either of the flat or of the elevated kind.

The flat kind is commonly known as the port-

wine-mark: I have ventured here to describe it as *Nævus vascularis planus*, in contradistinction to the other kind of vascular nævus, which I should distinguish as *Nævus vascularis prominens*.

In both of the accompanying plates of nævus vascularis it is the port-wine-mark, or flat kind of vascular nævus that is illustrated, although in calling it the flat kind it must not be pretended that it is so absolutely level with the surrounding skin as the flat variety of pigmentary nævus; on the contrary, it is always slightly, although only slightly, raised above the general level of the skin.

The port-wine-mark may vary considerably in size; thus I have seen it forming a few scattered dots of the size of millet seeds on the under surface of the chin, or it may occupy, as in both of the examples represented in the plates, a very extensive area. In some cases it presents the appearance of a very minute spot, the size of a lentil seed, with radiating wavy blood-vessels extending from the central spot for a short distance in every direction. It is then called the spider-mark (*nævus araneus*).*

* The *nævus araneus*, however, has, strictly speaking, no real relation with the port-wine-mark. It is not a lesion which as a rule is present at birth or early infancy. It makes its first appearance at a much later period of life, although generally during childhood. It is a "*telangiectasis*."

The port-wine-mark is by no means a symmetrically-disposed lesion of the skin. It generally, although not invariably, is confined to one side of the body. When it is met with on both sides of the body it does not match on the two sides in the manner that is a rule with so many of the diseases of the skin, and is in such cases much more extensive on the one side than on the other. Its commonest situation is on the face, where it is met with as a truly hideous disfigurement, occupying often the greater part of one side of the face, extending sometimes for a considerable distance over the hairy scalp, and, if it should happen to extend over the eye or side of the mouth, it will invade also the contiguous mucous membranes, that is to say, the palpebral conjunctiva and the mucous membrane of the lips and gums. The edge of the lip in such cases becomes markedly swollen and puffy.

The occurrence of port-wine-mark on the scalp or on the hairy part of the face does not give rise to any baldness, or even to thinning of the hair in the situations occupied by the stain. The port-wine-mark does not fade gradually at its circumference to the normal colour of the skin. It is

always abruptly and definitely limited at its margin, and yet its outline is not what artists would term a hard outline; it is softened off. In other words, although it fades at its edge, it fades very suddenly.

Its colour varies in different cases from a light crimson to a deep moreen, or even to a dark purple or violet colour; in some cases it may even present a greyish blue or slate colour, or even a steel-grey tint. The most striking variation in the quality of the port-wine-mark is this variation of colour, and the broadest difference of colour is that which exists between the bright or florid and the sombre or livid examples of the mark. I would, therefore, propose as names for these main varieties the adjectives *floridus* and *lividus*.

As a rule, when the mark is at one part florid, it is so over the whole of its extent; so, again, if a part of it be livid, it is livid throughout. There will be variations in the distinctness or accentuation of the colour of the mark at different portions of its area, but the shade of colour will be the same all over it; that is to say, the difference of colour of the mark at different parts of it will be such as results from a mere dilution of its colour here and there, rather

than from an admixture of various hues at various portions of the mark.

Plate I. illustrates the florid, Plate II. the livid variety of port-wine-mark. However, in the case depicted in our Plate II. the port-wine-mark is complicated by the development on its surface of an altogether different and distinct disease, namely, *molluscum non-contagiosum*, which did not make its appearance until the patient was thirty-three years of age.

The port-wine-mark is a congenital malformation. It may rarely disappear during the first few weeks or months of infant life (Hardy), or in others may increase somewhat (Hebra); the colour of the wine-mark may undergo more or less transitory fluctuations in intensity, just as the general "colour" of the complexion may vary; for instance, it will be heightened during blushing, or by muscular exertion of any kind, but will be rendered less intense by the emotion of anger, or by faintness, and so forth. It may occur either as one or as several distinct patches. The patches are of infinitely varied shapes. The mark affects the upper in preference to the lower half of the body. The great majority of port-wine-marks affect the face or scalp. Port-wine-mark, as a rule, remains

unchanged throughout the patient's life. It may, however (rarely), disappear in part or altogether, either spontaneously with or without scar, or may become affected with gangrene, either occurring spontaneously, or as the effect of injury. The gangrene in either case may destroy either the whole or only a portion of the nævus, a scar, of course, resulting.

As to Treatment.—In undertaking any kind of interference with the port-wine-mark it is necessary to take care that the result of treatment shall not prove to be something which the patient may probably think to be more disfiguring than the original mark. For example, opinions differ on the question as to whether a scar is preferable to a port-wine-mark. Most patients affected with port-wine-mark exhibit a great reluctance to have it interfered with in any way, and those who consent to interference are specially solicitous as to the probable result of treatment. They say, and with reason, that the mark, although disfiguring, is nevertheless obviously a natural mark, and that any artificial disfigurement, even if of a less conspicuous kind, may not so clearly tell its own history, and might, moreover, on the whole, prove more repulsive to the casual observer. Any process, therefore, which involves a seamed or

scarred countenance is unjustifiable, except at the express command of the patient given with a full understanding of the consequence. As regards the port-wine-mark (for it is this alone and not the prominent *nævus* that is here under consideration), it is unlikely that any surgeon would see cause to counsel interference with it unless it occupy some exposed portion of the skin. It is in such situations alone that the production of a superficial scar becomes of any notable importance. I may therefore dismiss (with the proviso I have named) such agents as vaccination, which, although efficient, leaves behind it the well-known vaccine scar, the actual cautery, the galvanic cautery, escharotics of various kinds, and excision. As regards the actual cautery, a fair result of its kind appears to have been achieved by Mr. Jonathan Hutchinson.* As to the galvanic current, it may be employed either as in point of fact an actual cautery (the red-hot platinum wire), or may be made to operate by the application of wet electrodes (electrolysis). However, in employing either the actual cautery or the galvanic current in either of its forms I prefer to operate by

* Drawing of case exhibited by him at the Annual Museum of the British Medical Association, 1876.

stippling rather than in any other way. The patient, of course, in any case must be chloroformed or take laughing gas; a set of needles spaced one-tenth of an inch apart from one another and fixed on a handle may then be heated to a red heat in a spirit-flame and their points thrust to a depth of one-sixteenth of an inch into the skin to be operated on. By having several sets of needles ready heated in a knife-shaped spirit-flame a large mark may be thus stippled over in a few seconds. The operation of course requires to be repeated. By connecting the needles with the pole of a constant battery (instead of heating them) the same effect would be produced, that is to say, a minute tubular eschar would be produced around each needle. By making the needles double, so that they consist each of a narrow pointed loop,* and by passing a powerful constant electric current through them, they become red hot, and so the same result would be obtained, but the best way of using the needles is by heating them in the spirit-lamp. The process of stippling, of course, leaves scars (punctate ones), but the scarring process is thus economized and in part dispensed

* Prof. Neumann shewed me, at Vienna, in 1875, a needle of this kind which he used for the destruction of hair glands after the evulsion of superfluous hairs.

with, and the surface left after the conclusion of the treatment is not so wholly cicatricial as if the actual or the galvanic cautery has been used in such wise as to deal *en masse* with successive portions of the wine-mark.

The instrument I have devised for this purpose (manufactured for me by Messrs. Weiss) consists of a phalanx of parallel needles fixed in a plaster-of-paris handle. The points of the needles occupy a plane of half-an-inch square, and are the tenth of an inch apart from one another; the instrument therefore contains thirty-six needle points in the half inch square. These should only be heated to a black heat on their insertion into the skin, and this insertion of them should only be momentary. I have tried various deviations from the directions I have here laid down. Thus I have tried a phalanx of needles more closely spaced, that is to say, spaced only the one-sixteenth instead of the one-tenth of an inch apart, so that eighty-one instead of thirty-six needle points occupy the half inch square, but used as above. Then I have tried the instrument of *thirty-six* points heated to black heat, but used with a somewhat lingering insertion. And I have also employed it heated to red heat, but with only a momentary insertion;

but either of these deviations produces, as I find, more or less complete sloughing of the entire area of skin operated on, with the consequent production of an extremely disfiguring seamed scar. Mr. J. C. Wordsworth has long employed for the treatment of port-wine-mark a solitary hot needle, bearing a small ball of steel around the needle placed at about three-sixteenths of an inch from the point so as to retain heat (Fig. 1). This hot ball (as he claims) enables a rapid series of punctures to be effected with the needle without the needle losing its heat. He agrees with me in preferring a black-heat to a red-heat in operating by the hot-needle process. His device is an ingenious one, but I venture to think that my phalanx of equally heated needles is in several respects a far preferable instrument. I find, however, that even in the use of the "phalanx" considerable adroitness and nimbleness is requisite, and that in the absence of acquired dexterity in its use on the part of the practitioner a seamed scar is

FIG. 1.



apt here and there to be produced, notwithstanding the observance of the precautions I have named. The results I have obtained by this process are, moreover, not nearly so excellent as those I have gained by the employment of my multiple scarifier, which will be found described further on.

The facts as I take them are that the use of the hot points as compared with that of the cold blades involves the apparently gratuitous superposition of some conditions which are practically uncertain of calculation, such as the regulating the degree of temperature of the points at the time of insertion, and the quick limitation of the period of insertion in addition to the questions of interval of insertion and depth of insertion, which latter questions are common to both methods of procedure. I may say in conclusion, that scarification is, as I find, far more easy of prudent limitation of its effect than the less precisable method of hot puncturation, and that in a matter of this kind a timid caution must constantly be exercised, for here it becomes always possible to advance but never to recede.

Of escharotics, the best unquestionably is fuming nitric acid. The dry, tough character of the eschar produced by this agent, and the long period during

which that eschar continues to adhere with remarkable firmness to the subjacent structures, mark out the "aqua fortis" as especially suited for purposes of this kind. In employing it in cases of port-wine-mark a special precaution is expedient. If the acid be employed in the ordinary way, by simply applying it to the surface of the skin, it is apt to act only on the surface portion of the wine-mark. The considerable volume of blood flowing in the spongy texture of the stained skin protects the deeper portion of the skin from the action of the caustic. If, however, immediately after the application of the acid firm pressure be exercised on that part of the nævus, so as to press out the blood from it, the acid at once effects cohesion of the inner surfaces of the walls of the vessels, so that the blood does not return when the pressure is removed. It will be obvious that when used in this way very little of the acid need be applied, since the stained skin, when thus emptied of blood, is a comparatively thin structure. However, all of these methods leave a scar. I have myself employed recently a method which, as applied to port-wine-mark, is, I believe, entirely new.* Unlike

* 'On Port-wine Mark, and its Obliteration without Scar.' Second edition. London, 1876.

any of the means referred to above, it does not effect the wholesale destruction of the affected skin, but only modifies its structure. Its effect is to destroy the vessels of the skin very efficiently, while a minimum degree of injury is inflicted on the other structures of the skin. The process consists simply in scarifying repeatedly the affected skin with a number of superficial parallel cuts.

The instrument that I at first used for the purpose was an ordinary cataract needle, the spear-shaped end of the needle, however, being made four times the customary minute size. This instrument I preferred, as being less formidable in appearance to a patient on whose face it is about to be used than, for example, a scalpel would seem. But an ordinary scalpel answers equally well, and those who are more accustomed to the handling of a scalpel than of a cataract needle will find it the preferable instrument of the two. The parallel cuts or scarifications should be spaced about one-sixteenth of an inch apart from one another, but a dexterous operator may contrive to execute them as close together as the one thirty-second of an inch.

The process of scarification must be many times repeated, at intervals of a few days, that is to say,

as soon as the last cuts are healed. At each operation the direction of the parallel incisions should be slightly veered, that is to say, the direction of the parallels of the second operation should be oblique to those of the first operation, and so on. The process is a tedious one, but the result of it is highly satisfactory, for the stain is made to disappear without the production of a scar. I know of no other process which gives so excellent a result, but every part of the port-wine-mark requires to be scarified a great many times before the effect aimed at is attained. The number of times required in any particular case will vary with the skill of the operator and the intensity of coloration of the mark, but let me convey an idea of the number by saying that in all cases ten or a dozen repetitions of the scarification will be requisite to produce any considerable alteration of the colour of the stain. This, if the stain be an extensive one, may seem perhaps too laborious a procedure to be worth undertaking, and to involve too great an expenditure of time, but it must be recollected that to recall a face hideously disfigured is a benefit which to some persons is of infinite value.

As to the depth to which the incisions should be carried, this should be about one-sixteenth of an inch.

Some persons (I have operated on several such) are able to bear the process quite firmly without availing themselves of anæsthesia, local or general, but most patients prefer not to feel the cuts. The most convenient course will then be to produce local anæsthesia of the patch about to be operated on by freezing the skin by means of the "æther-spray apparatus," and if a scalpel be preferred for use to the needle the blade of the scalpel must be frozen also. This freezing of the scalpel is readily effected at the same time that the skin is congealed by causing an assistant to hold the scalpel in the spray which is directed on the skin.

The advantages of availing oneself of this method of producing anæsthesia are very great. Not only is the skin rendered insensible, but it becomes (being frozen) firm, resisting, and inelastic, a condition which renders very considerable assistance to the operator in executing with the requisite rapidity and neatness the numerous and closely placed incisions. Moreover, in the frozen condition the skin does not bleed. The least flow of blood during the operation (unless the operator have by some practice acquired dexterity in its performance) is apt to prove very embarrassing to him, and to defeat absolutely any

attempt at accuracy in the draughtsmanship of the incisions.

Where the patient desires to have the whole surface of a fairly extensive nævus operated on at one sitting, this may be accomplished under chloroform, but it is a longer process than would be supposed. The operator working as expeditiously as possible and without stopping, will find that he has occupied an hour or even more than an hour before he has finished his task. I find that a frequent repetition of chloroforming quite upsets for the time the health of at least some patients, nevertheless it permits of considerable expedition in the progress of treatment. When the patient is chloroformed I do not also avail myself of the æther-spray.

The bleeding that results from the scarification of a port-wine-mark is very much less than would be imagined. Indeed, if no measures whatever be taken to arrest it, it will arrest itself after really only quite a trivial loss of blood. However, if a piece of wet blotting-paper be laid over the scarified part (preferably before the skin has thawed), and if this paper be blown upon, for example, by blowing on it with the æther-spray apparatus, after first emptying the æther out of the

bottle of the apparatus, *then* it will be found that the bleeding ceases absolutely almost immediately. When wet blotting-paper is thus used, it should be gently peeled off before it has dried; in short, as soon as "clotting" has had time to take place underneath it. The paper should be peeled off in the direction of the incisions. If it be peeled off transversely to them, they will begin to bleed. On removing the blotting-paper the skin operated on will be found to be covered with a thin clot of blood. This should be lightly and gently and very patiently washed off by means of a large flat camel-hair brush, using plenty of cold water. Thereupon the surface operated on will exhibit but little trace of the operation, presenting to a superficial view little more than a very notable paleness of coloration as compared with its previous condition.

If the little operation be executed cleverly, that is to say, if the skin is well frozen, the instrument exquisitely sharp, the incisions made with perfect regularity of spacing, and with uniform equality of depth, and if special care be taken to avoid any accidental dragging of the strips apart, so that no clot is formed in the incisions: if such details be well cared for, it will be found that the cuts heal

with surprising rapidity, and become within a few days quite invisible. Thus by the exercise of much carefulness in executing the scarification, not only will a much better result be procurable, but the process will permit of repetition at much shorter intervals, and so the final result be more speedily attained.

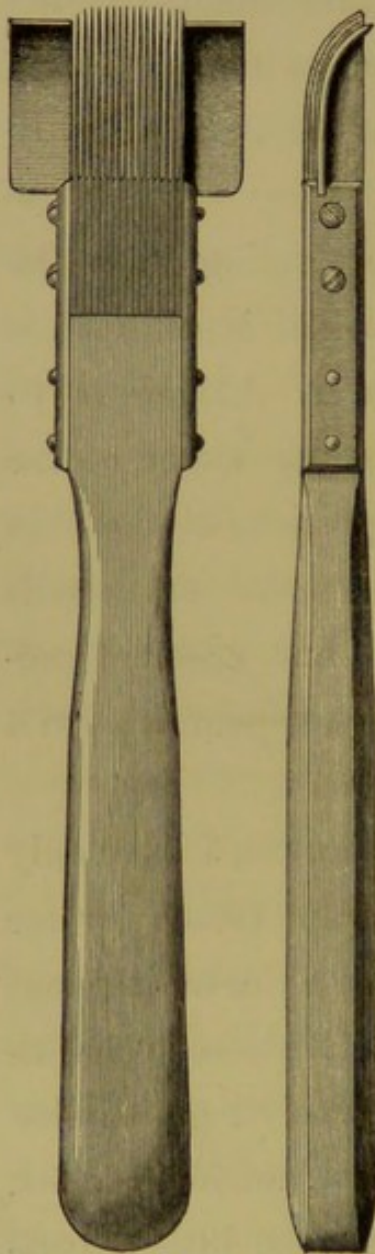
I must not conclude without saying that the "compound anæsthetic æther" which is sold for use with the æther-spray apparatus is dangerous to inhale, and that it apparently produces spasm of the glottis. When, therefore, any portions of the skin in the immediate vicinity of the mouth or nostrils be frozen by the spray, special and effectual precautions should be taken that the vapour shall not be inhaled.

Since writing the rest of this account, I have only quite recently devised an instrument (made for me by Messrs. Weiss) for executing a series of incisions at one stroke * (Figs. 2 and 3). It is a scalpel with sixteen parallel blades placed so closely together that eighteen of them measure only half an inch across. In operating with the *single blade* some little expert-

* Vide my paper read before the Medical Society of London, March 18th, 1878, and published in the 'Medical Times and Gazette' of March 30th, 1878.

ness in the art of pencil or pen-and-ink drawing is a necessary qualification in executing the incisions

FIGS. 2 and 3.



with the requisite nicety, and then again it is necessary to execute them with considerable rapidity in order to finish the operation before the frozen skin has become thawed, an alteration which very rapidly takes place. Moreover, in any case the operation with the single blade is deficient in offering satisfactory expedition. However, the "*multiple scarifier*" which I have devised obviates, at least in great measure, such disadvantages, besides that it enables a very considerable surface or number of surfaces to be expeditiously gone over at one operation.*

HISTORIES OF THE TWO CASES.

—The illustration marked I.

* A full account of the instrument and of the mode of using it is contained in my description of it, published by Messrs. Weiss, of the Strand.

represents a portion of the face of a man aged 30, affected with port-wine-mark in its simple condition. The lesion is restricted absolutely to the right side of the man's face. He presents no port-wine-mark on any other portion of his surface. All of the wine-marked portion of his skin is completely shewn in the illustration. It will be noticed that in this example of the lesion as also in the other example here illustrated (in Plate No. II.), the port-wine-mark, although it actually touches here and there the median line, does not transgress beyond that limit on to the other half of the face. Those who are fond of attributing unilateral phenomena of all kinds to some lesion of the cerebro-spinal nervous system (not indeed without presumptive cause), would refer both of these two cases to some such cause, but as will be seen from the account of another case to which I shall have to refer, nævus is not invariably unilateral. The man states that his disease dated from his birth. He relates that his mother is said to have been frightened during her pregnancy by seeing a girl who had "her head turned the wrong way," and that his mother, turning her head to the left to avoid the sight, put her hand up to the right side of her face in order still further to shut

off her view from the object which had alarmed her, so that the port-wine-mark on his face corresponds to that portion of his mother's face on which her hand had momentarily rested. However, the patient himself disclaims any belief in such a cause. It will be seen, however, by the extent and situation and shape of the patch, that the account is a very ingenious one. The wine-mark in this case, as often happens, is not simply a solidly filled-in patch with regular outline, but is a patch of very irregular outline, and one that not only presents promontories, but also encloses lakes (of unaffected skin), and furthermore is supplemented by adjacent islets. It is an example of the florid variety of flat vascular nævus. It might be fully described by the name *Nævus vascularis planus floridus*.

By slightly everting the eyelids of the right eye of the patient, I ascertained that the palpebral conjunctiva of both lids was partially affected with nævus for an extent corresponding with that portion of the outer surface of the lids which is occupied by the wine-mark. The ocular conjunctiva is, however, quite unaffected. A small portion of the mucous membrane of the lips, corresponding to the right commissure of the lips, is similarly affected.

The treatment adopted in this case was to scarify the affected skin (using a scalpel) with parallel incisions spaced about one-sixteenth of an inch apart and carried about one-sixteenth of an inch deep. The portion of skin to be operated on at each occasion and the scalpel also were previously frozen by means of the æther-spray apparatus. No bleeding took place during the performance of the incisions, and the subsequent bleeding, which was very slight, was speedily arrested by moderately firm pressure applied by the finger tips. The minute clean-cut incisions healed on each occasion within a few days after they had been made, leaving no obvious trace behind them. Several distinct sets of parallel incisions were made at intervals of about a week on each portion of the mark that was operated on: on each separate occasion the direction of the parallel incisions was slightly veered. In this way portions of the mark were eventually obliterated without leaving in their place any obvious trace of the method employed, and other (darker) portions were permanently reduced to a faint pink colour. The case at the time of the publication of this account of it is still under treatment.

The illustration marked II. represents a portion of

the face of a man, aged 42, who had been affected with port-wine-mark from his birth. The illustration exhibits, however, something more than a mere port-wine-mark, namely, a considerable number of little tumours or nodules occupying a large portion but not the whole of the area of the port-wine-mark, and congregated chiefly about the right orbit, so as almost completely to obstruct the vision of the right eye. This nodular growth is, however, something extra and supplementary to the *nævus*, which up till nine years ago had been perfectly flat, so as to exhibit in short the same condition as that shewn in Plate I., only that its area is more extensive and its colour is darker, and moreover differs in quality from the tint exhibited by the other case. The port-wine-mark exhibited here (in Plate II.) is of the livid kind, and may be described in full as *Nævus vascularis planus lividus*, referring in this to the condition in which it remained during the first thirty-three years of the patient's life. It differs in colour from the other example, which presents a crimson or moreen hue, by exhibiting what may be called by way of distinction a purple or livid coloration, which here and there, for example on the temple, and more notably on the upper lip, approaches a steel-grey tint. It will be

noticed that this patch (in Plate II.) is far more compact and regular in its outline than the patch shewn in Plate I. As in the other case, the patch here shewn is strictly confined to the right side of the head. The limit of the anterior margin of the patch (*on the face*) is shewn in the illustration. The posterior margin of the patch (on the face) forms a vertical line just in front of the pinna of the ear. However, the patch extends upwards on the scalp for a considerable distance, namely, as a cone-shaped promontory, the apex of which is as far back as the whorl of hair of the "crown" of the head. Over the stained portion of the scalp the hair grows quite as thickly and is in every respect the same as on the unstained portions of the scalp. The scalp-portion of the patch is much paler than the rest of it, being of a lilac colour. Inferiorly the nævus extends over the margin of the upper lip and again up the inner surface of the lip, and then half-way down the upper gum, where it ceases. The whole of the right half of the upper lip is thus affected. On this account it is about twice the thickness of the left half of the upper lip, and consequently, the line of the mouth slants downwards to the right until just before it reaches the right commissure, when it suddenly

curves upwards. In a much less degree the same kind of distortion of the mouth is observable in the other case also. On compressing the left half of the upper lip forcibly between the thumb and forefinger it presents, momentarily, a shrivelled and withered appearance, but leisurely acquires again in a few moments its original turgid condition.

There were no tubercles of any kind on the patch until nine years ago, the patient being then of the age of 33. The tubercles continued slowly to increase for a few years' time, but for the last five years they have been quite stationary.

The patient attributes their appearance to an "ugly" cut he got across the right eye and the nose, inflicted by a piece of brass which flew off the cylinder of a steam engine he was tending. This cut extended outwards from the bridge of the nose, which got broken, across the upper part of the right cheek, at the level of the lower margin of the orbit. The wound, of course, bled profusely, and the eye was closed for the time by the swelling. A glance at the patient's portrait suffices for proving that he unquestionably has had a broken nose. It was a few months—about three months—after this accident that the tubercles began to be developed. The first ones

were developed a little below, but not *on* the scar of the cut.

The tubercles or elevations on the stain are some of them sessile, but for the most part pedunculated; that is to say, all of them that are at all large are pedunculated. The larger and pedunculated tumours are grouped chiefly around the orbit where they are clustered. One mass, composed of an agglomeration of several such tumours, is attached to, and depends from the eyebrow, and hangs downward from its attachment, concealing the upper lid and the eye. A portion of the "white of the eye" is all that is visible of the right eyeball in the illustration. There are some large scattered tubercles on the lower part of the forehead and on the upper lip, in addition to the main group of larger masses already referred to as arranged around the orbit; and there is a large number of smaller outlying tubercles around the chief mass, and occupying the lower two-thirds of the forehead, the zygomatic region, and the cheek.

On pressing any of the tubercles firmly between the finger and the thumb they become empty and shrivelled, and change from the form of a grape to that of a raisin. On removal of the pressure they at once leisurely fill out again and resume their pristine

colour (a purple colour), whereas immediately after compression they acquire for the moment a dull grey colour, mottled here and there with purple. Most of the lumps have a hilum or pitted depression, such as one can make in a bread-pill with the point of a lead pencil. Some of the lumps have several depressions of that kind. Two very good examples of these hila (or umbilici) may be seen, in the plate, on the twin tubercles that are situate immediately above the right ala of the patient's nose.

The patient illustrated the remarkable superstitions connected with port-wine-mark by gravely explaining the cause of his disfigurement as follows. His mother, while she was pregnant with him, was out with some excursionists; some one accidentally dropped a bottle of port-wine on the ground before her. The neck of the bottle broke off. The mother raised her hand to her face in an attitude of alarm, covering the right side of her face with the palm of her hand. This act imprinted on the corresponding portion of the features of the unborn infant a pictorial record of the catastrophe which had alarmed her, for, according to the patient, the accident is faithfully limned on his features. The promontory which extends back on the scalp is the neck of the bottle; the

broader portion of the patch which occupies the face is the body of the bottle; the terminal portion of the promontory, which, to speak accurately, is divided by a short interval from the rest of the stain, so that it is, in point of fact, an islet, is the broken-off portion of the neck of the bottle.

It will be noticed that in both cases the story of the cause is in one respect the same, only that in the other case the mark is made to represent the shape of the covering hand, whereas in this case it represents the object, the sight of which was shut out by the hand; and here it must be confessed that the mark, taken as a whole, very faithfully corresponds to the shape and size of an ordinary quart wine-bottle. However, in both cases the raising of the hand is the act which is reputed to have determined the *situation* of the mark; and here I may say that I have found the right side of the face to be far more commonly affected with port-wine-mark than the left side. Hence I presume arises the importation of this sensational element of the raising of the hand in stories of the kind; the right hand being preferred to the left in instinctive movements for self protection.

As to the treatment of the case, I had designed to

treat it just in the same way as the other case, but as a preliminary measure I proceeded to cut off with scissors, curved on the flat, all of the tubercles. I had already cleared away all of the larger ones, when the patient got tired of the business, and refused to go on with it. The bleeding from the pedicles of the tubercles was quite easily arrested by firm pressure with the finger tips, interposing a small piece of lint dipped in a strong aqueous solution of Perchloride of Iron (the *Ferri Perchloridi Fortior Liquor*, Ph. Br.).

In describing this case, I may allude briefly to the details of a similar case that I met with a few years ago. The patient, a man, was of about the same age, namely, 40. The port-wine-mark was of a more florid colour than in the present case; but instead of affecting only the right side, it extended also largely over the left half of the face. Below the level of the eyes the face was equally and universally affected with the mark; but above the level of the eyes the mark was limited to the right side only, occupying the right third of the forehead, the central third and left third of the forehead being the only unstained portions of the face. As in the present case, the man continued from birth until past the age of 30

without elevation of any kind appearing on his wine-mark; but at the age of 34, numerous tubercles, having exactly the characters here presented, began to make their appearance. They occupied much the same situations as in the present case, that is to say, the lower portion of the right side of the forehead, with special accumulation of them on the right eyebrow and the right cheek; but in this case the left cheek also was studded with tubercles, quite as numerous and as large as those on the right cheek.

I have repeatedly noticed molluscum as affecting the face in middle-aged or elderly men, without the pre-existence of port-wine-mark as a necessary basis. But it will be noticed in both of these cases that, although not every part of the stained surface has become tubercular, yet there are no tubercles except on the stained surface.

PSORIASIS (DIFFUSA).

(Eng.) *Dry scaly tetter.* (Fre.) *Dartre écailleuse sèche.*

(Ger.) *Schuppenflechte.*



1. PSORIASIS (*ψώρα Gk.* a cutaneous disease) or the "English Leprosy," as it is sometimes called, appears in the shape of dry, white, laminated incrustations, which on scraping off their yellowish-grey superficial layer exhibit a mother-o'-pearl-like, or even silvery lustre, and conceal tawny-red, or even coppery-red,* slightly elevated, and somewhat wrinkled patches of skin. At a little distance, the skin looks, in many cases of this disease, as if it had been splashed with wet mortar, which had been allowed to cake on it. If one of the incrustations be detached by means of the finger-nail, it will be found to adhere pretty firmly to the skin, and to be of about the thickness of cardboard. If the detached crust be broken across, its laminated structure will be displayed; and if the

* It is a common mistake to suppose that if an eruption of psoriasis may happen to present as to the reddened skin (underlying the incrustations) a coppery colour, it must be of a syphilitic nature.

tawny-red patch, laid bare by its removal, be pinched up between the finger and thumb and compared with a similar pinch of the healthy skin, it will be found to be palpably thickened.

The eruption commences as small white spots, of the size of a pin's head (*Psoriasis punctata*); these gradually increase in diameter, so as to form patches of various size and shape.

Psoriasis usually appears first over the elbows and knees; and, when the eruption has spread more extensively, it still remains worst at these places. It next appears on the back, more especially the loins, and afterwards on the chest and belly. It is not uncommon on the hairy scalp, and on the palms of the hands, and the soles of the feet. When it attacks the face, where it is comparatively rare, it affects, chiefly, the upper part of the forehead and the eyebrows.

Its varieties, omitting those names which refer only to its different situations, are designated by the terms "guttata," "nummularis," "gyrata," "diffusa," and "circinata."

The term *P. guttata* is employed when the disease occurs as small rounded patches, from the size of a lentil-seed to that of a split pea, giving the skin the

appearance of having been splashed with mortar. *P. nummularis*, when the disease occurs in rounded patches, varying from the size of a threepenny-piece to that of a two-shilling piece. *P. gyrata*, when it appears in wavy lines of the thickness usually of about half an inch; this is a very rare variety. *P. diffusa* (vide Plate III.), when it forms large irregular patches. These are more commonly found extending from the knee down the front of the leg, or from the elbow along the outer aspect of the forearm. *P. circinata* (or "Lepra vulgaris"), when a spot, by spreading at its circumference and healing at its centre, forms an annular patch of the disease.

Psoriasis, when it affects the palms and soles (*P. palmaris et plantaris*), is characterized by larger, thicker, and less lustrous scales than it produces in other situations, and by deep painful fissures in the skin, which exude a serous or sanguineous fluid. When the nails are affected (*P. unguium*), they become thickened, opaque, sometimes greyish in colour, often deeply grooved transversely, and not unfrequently pitted in a peculiar manner; they may become more or less laminated, and in some cases the nail gets replaced by a scaly incrustation.

Although any one of the above-named varieties

of psoriasis may occur singly, nevertheless more commonly two or more of these varieties are found associated.

In general terms it may be stated that if the eruption be exclusively of the guttate or of the smaller nummular kind, and especially if the area of the eruption be at all widely diffused, the probability is that the history of the case will show that the attack is an acute one, that is to say, acute for psoriasis (an affair of at most two or three months), and this equally whether the attack be the patient's first attack or whether he may have experienced other attacks.

If, on the other hand, patches of psoriasis diffusa are present they indicate *in most cases* a comparatively long-standing duration of the disease.

As a rule psoriasis occupies chiefly what may be termed the dorsal parts of the head, body, and limbs, and, in a much less degree, the ventral surfaces. For example, patches that are the most developed and those that have attained such a size as to merit the term "psoriasis diffusa," are to be met with in such situations as the hairy scalp, the loins, the knees, and the elbows, and not in such situations as the face, the chest, or belly, or the flexures of the limbs.

Very commonly a case of psoriasis will present

comparatively large patches in any one or more, or even in all of the situations just named, and smaller nummular or guttate patches at other parts, with preference as a rule for the limbs rather than the trunk, and occupying the limbs on their "extensor-surfaces" much more copiously than on their "flexor-surfaces." But this is by no means a *standing* rule.

Sometimes, on the contrary (but much less commonly), the belly and chest may be the regions chiefly or even exclusively affected. In such cases the form of the patches is often (but by no means invariably) *ringed* (*P. circinata*).

The occurrence of *P. gyrata*, an extremely rare but certainly a very striking phenomenon, has been accounted for by the coalescence of detached portions of different rings of psoriasis circinata. Opportunities are not rare for observing what happens when two widening circles of psoriasis circinata come at length to touch one another, and so also in the case of many other diseases of the skin when they happen to assume the form of rings. That is to say, where the two circles meet, both of the circles become obliterated. They do not each of them invade the area enclosed by the other, but both of

the circles at the point of contact become obliterated, and so they open into one another more and more widely as the two circles or even as only the one of them may continue to enlarge itself. Accordingly it has been ingeniously supposed that the rare instances which have been recorded of psoriasis gyrata are to be accounted for in this way. Those who hold this view, however, profess themselves unable even by this means fully to account for the phenomenon, and accordingly discredit the pictorial representations that have been published of it; but so gratuitous a breach of faith as an imaginary pathological illustration is scarcely conceivable, and I myself entertain a more possible explanation of the accident. It happens that when a person is affected with psoriasis the application of a sufficient irritant to an as yet unaffected portion of the skin is capable of determining the appearance of a fresh patch, corresponding in shape to the portion of previously sound skin that may thus be irritated. For example, I have had occasion to observe the effect of a mustard poultice acting in this way. A man affected with psoriasis who was an in-patient of one of the large general hospitals of London was so frequently stripped in the winter time, in order that his disease

might be demonstrated to the students, that he contracted a severe bronchitis. For this complication he was treated amongst other remedies by the application of a mustard poultice. The poultice was applied in the evening and he fell asleep with the poultice on him. During the night it slipped down his chest on to his belly. The poultice was of an oval shape and had been applied crossways over the chest, but when it finally came to a rest on his belly its position was a slanting one. Hitherto the man's chest and belly had been completely free from psoriasis, but very speedily two large well-defined patches of the disease developed themselves, the one on his chest and the other on his belly. Each of the two patches corresponded precisely in size and shape to the dimensions of the poultice; the direction of the upper patch was crossways, while that of the lower patch was slanting; and between the two patches joining the one patch with the other was a tract or path of true psoriasis, developed, however, in a decidedly less degree than either of the two terminal patches. In a previous publication* I have recorded the case of a girl who having long been

* 'Coloured Photographs of Skin Diseases, with Descriptive Letterpress.'
London, 1864.

affected on one knee only with a large patch of psoriasis diffusa chanced to stumble on a grating, and falling grazed the other knee, on which forthwith a patch of psoriasis became developed. I have also noticed that an accidental scratch of the skin in persons affected with psoriasis will often be followed at once by a linear patch of the disease corresponding precisely to that scratch, the patch becoming broader in proportion to its duration. I am therefore of opinion that the patches of gyrate psoriasis that have been recorded, the shape of which is at variance with the spontaneous course of the disease, have probably been occasioned in some such way. I refer to these examples not only with a view to accounting for gyrate psoriasis, which has been described and figured by no less reliable an authority than Willan, but to illustrate the effect of certain kinds of irritation as local exciting causes of the disease. For example, I have often enough noticed the effect of a garter in developing a more or less complete but definite ring of the disease around the upper part of the leg or lower part of the thigh, in either case corresponding precisely to the situation of the garter.

As to the ringed form of psoriasis (*P. circinata*), I am of opinion with those who think it should *not*

be regarded as a disease distinct from psoriasis. It is indeed only a more pronounced accentuation in certain individuals of a tendency which is in no case entirely wanting to psoriasis. Thus in most cases of psoriasis even when the disease has in its natural course shewn no obvious or even perceptible tendency to exhibit in any of its patches an annular form, nevertheless, if any of the patches be submitted to efficient local treatment and so compelled by artificial means to disappear, it will be found that quite as a rule the central portion of a hitherto equally filled in patch will undergo improvement before the circumferential part, and so very often by means of measures employed evenly to every part of the patch it will be converted from a disc to a ring before it finally disappears.

As to the *sole and palm forms* of psoriasis (*P. palmaris et plantaris*), they very often, nay even as a rule, exist without manifestation of the disease on any other part, and it has been the fashion amongst well-informed practitioners in every country to arrive at a significant conclusion whenever this happens. They take it, quite generally, to be a conclusive indication of constitutional syphilis, but this is to say the least of it a most unsafe inference, inas-

much as palmar or plantar psoriasis is a decidedly more common event than a syphilitic eruption (of at all events any other kind) of either the palms or soles. The origin of the impression is easy to comprehend; a syphilitic affection of the palms and often also of the soles, resembling to the casual observer psoriasis in some of its chief features, does indeed occur, namely, *that* special form of syphilide which has been minutely described by Professor Hardy, of Paris, under the name of *Syphilide cornée*. I have heard more than one of the leaders of our profession say of a man, "Poor fellow, he had palmar psoriasis, and you know what *that* means." The diagnosis of palmar or plantar *psoriasis* from *squamous syphilide* of the palms or soles (the so-called *syphilitic psoriasis*) is given further on.

However extensively psoriasis may be diffused over the body, it never, in my experience at least, invades the entire surface. In the most extensively spread cases of the disease that have come under my observation I should say that at the most not more than two-thirds of the entire area of the skin have been involved.

When psoriasis affects the scalp, a situation which is more or less affected by the disease in a very large

proportion of cases, it comes within the category of those eruptions which do *not* produce baldness. It is even astonishing to see the hairy scalp covered, as in some cases it is, with a thick layer of scaly incrustation without the hair being apparently in any way affected or injured by so considerable a lesion of the skin on which it grows. Persons who are the subject of psoriasis are however *equally* liable, whether they be the subjects of senile baldness *or not*, to the development of the eruption on the scalp, that is to say, patches of the disease are to be met with on the heads of those whose crowns are already bald as often as on those who have complete heads of hair, and such patches appear to locate themselves indifferently on the bald and on the hair-covered portions of the scalp of bald individuals.

Psoriasis leaves behind it no scar, however long an individual patch may have persisted, nor does it leave behind it even on the lower extremities, where eczema is often apt to produce an indelible brown mark, any *permanent* discoloration of the skin. However, especially on the lower limbs, it is apt to leave a yellow discoloration which in *that* location is *slow* to fade.

Some persons, and amongst them many expert

practitioners, cherish the belief that psoriasis is a mere outlet for some grave disturbance of the system, that it is in short an impurity of the general organism which has gathered on the superficies like dross on the surface of molten lead, and a common creed is that it is in some way a manifestation and at the same time an outlet for gout. I have had under my care many persons who have declared to me that their disease was "better out than in," and very recently a very able practitioner in London, who consulted me for an eczema of his scrotum, incidentally shewed me a psoriasis of his forearms and legs, saying, "Of course I don't intend you to meddle with this, for it's my salvation; if you cured this I should have an attack of gout." Now I have never had anything before me which would lead me to believe that psoriasis, or any other complaint or derangement of any other organ than the skin, is capable of resulting from the cure, however speedily accomplished, of this eruption. I do not find, so far as I may be capable of judging, that the disease has any special connection with gout. Both diseases are tolerably common complaints, and accordingly I have found an occasional, but decidedly rare, coincidence of the two.

I will even go so far as to say that the so-called psoriasis of the tongue, namely, that thickened condition of the epithelium of the tongue which has perhaps served as a reason for such apprehensions, is a condition which is in no way associated with or homologous with psoriasis of the skin. I regard psoriasis as a general disease in one sense and as a local disease in another sense. It is general as being capable of affecting not only a mere portion of the skin, but also of diffusing itself widely over the entire cutaneous envelope. It is a *general* disease *of the skin*, but it cannot be said to be a general disease of the system, in the sense, for example, that small-pox is. It is a disease quite as local as simple diarrhoea, or as bronchitis. Its cure can no more be productive of ill-results to the general system, or to any other part of it, than the cure of a diarrhoea or of a bronchitis, and as a matter of actual fact is attended with no disadvantage whatever, whether immediate or remote.

Psoriasis in short is in no way an advantage, but is simply a disfigurement and a discomfort. The reason why it appears in some persons and not in others, can be stated in no other way than by saying that it is a peculiarity or "idiosyncrasy" of those who

are attacked by it. It is not even an hereditary disease in the majority of instances, although examples occasionally present themselves where more than one member of a family is affected by it. It occurs commonly in both sexes and at all ages, with the exception of infancy. No particular condition of health seems to be incompatible with it. Nevertheless it is commonest at the prime of life, and generally fixes on the robust and healthy. It occurs in every climate, and amongst all races of mankind. It follows in most cases an extremely chronic course, and its tendency is to recur again and again after apparently complete recovery.

In long-standing cases it is usually more developed in the winter than in the summer, although in a certain small proportion of cases the very opposite happens.

In a case that has lasted for some years, the history of it will often be that during the first year or two of its duration the disease was only a winter disease, disappearing spontaneously and completely during the summer, that in the next year or two traces of the disease would persist during the summer, until later on the disease would come to last summer and winter almost alike, only that it would become always somewhat worse every winter.

Of the predisposing causes of psoriasis, little or nothing is known, except that an exceptionally good *physique* and the very best general health seem apparently to favour the occurrence of the disease.

As to the exciting causes of the disease but little more can be said. Winter appears very often to favour its development, and in some cases mental shock, for example, great anxiety or severe mental distress, has seemed to me to serve unquestionably as an immediate determining cause. As I have already stated, local irritation of the skin has been often noticed by me as the direct occasion of the appearance of a fresh patch, and I have observed that in some females the disease always disappears completely during pregnancy and the puerperal state*, while on the contrary it is aggravated during lactation †.

Psoriasis is never occasioned by contagion, it is not a communicable disease. Nor is it even a congenital disease.

As to its relative commonness in comparison with other diseases of the skin (always an important point

* "An Enquiry into the Influence of Pregnancy, the Puerperal State and Lactation, on the Development and Progress of Psoriasis," by B. Squire (March 7th, 1866). 'Proceedings of the Roy. Med. and Chir. Soc. of Lond.,' vol. v., p. 196.

† McCall Anderson, 'Contributions to Dermatology,' No. iii. London, 1865.

in assisting a doubtful diagnosis), psoriasis has been variously stated as constituting from one-sixth* to one-sixtieth† of the total number of cases of disease of the skin.

Cases of psoriasis are about equally distributed between the two sexes. It is to be remembered, however, that skin-disease is more common in the male than in the female.‡

Pathological Anatomy.—The profuse formation of masses of epidermic scales in psoriasis is the result of a chronic inflammatory exudation into the tissue of the cutis (G. Simon§). The papillæ of the skin are considerably enlarged, namely to twelve or fifteen times their normal size, and the vessels of the papillæ are distended (Wertheim).

Neumann||, working with sections treated with acetic acid alone, and with sections treated with carmine, ammonia, and acetic acid, found the epidermic cells and rete Malpighii largely developed and the papillæ (but more especially where the patches

* Devergie, 'Traité pratique des Maladies de la Peau.' Paris, 1857.

† Hebra, 'Lehrbuch der Hautkrankheiten,' Erster Band, Zweiter Auflage, S. 353. Erlangen, 1874.

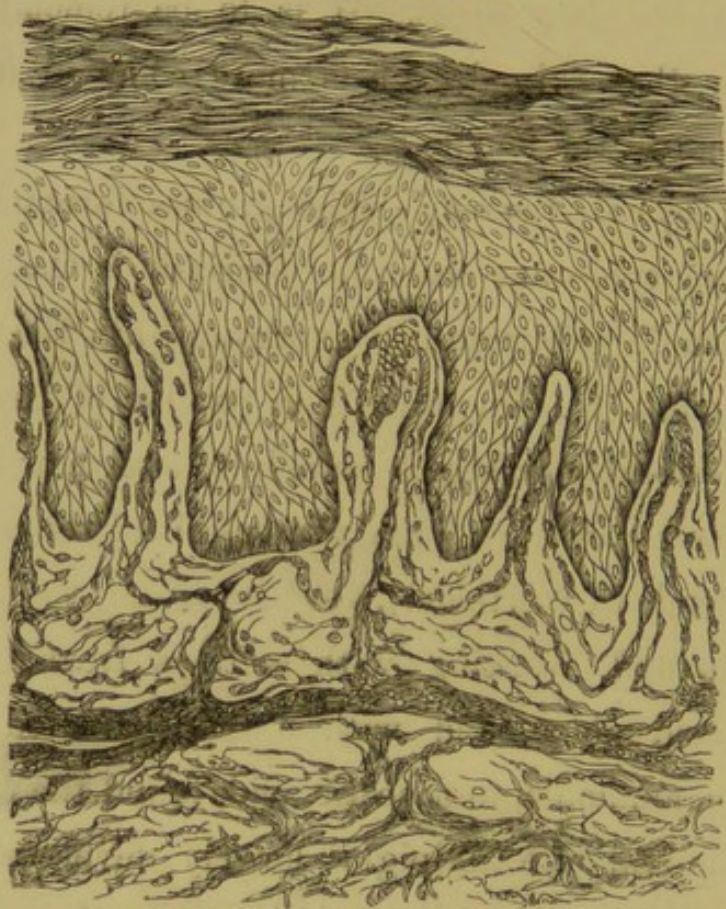
‡ Vide my analysis of 10,000 cases of skin disease in the 'Medical Report of the British Hospital for Diseases of the Skin,' for 1874.

§ 'Die Hautkrankheiten,' p. 112.

|| 'Lehrbuch der Hautkrankheiten Zweiter Auflage,' S. 292. Wien, 1876.

of eruption were old) enlarged. The corium and papillæ he found to be completely occupied by abundant cell-growths, which are chiefly but not exclusively accumulated along the course of the

FIG. 4 (after Neumann).

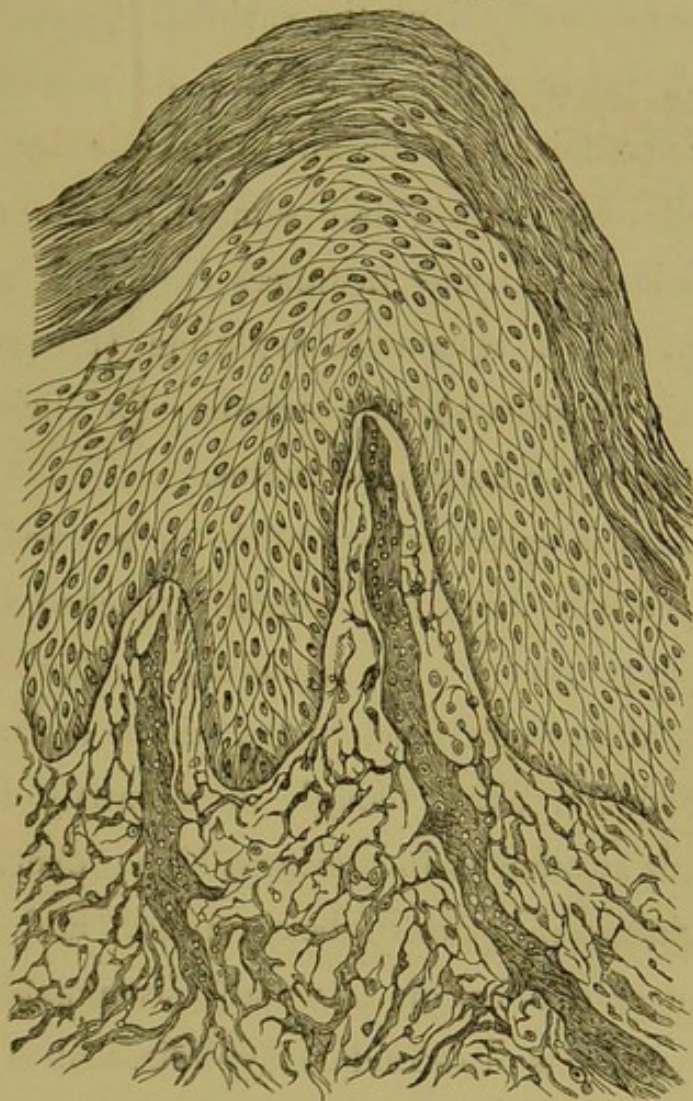


Cell-growth along course of vessels. Transverse arrangement of cells at summits of papillæ.

vessels. This cell-growth he observed chiefly in the superficial layer of the corium and summits of the papillæ. The investing cell-growth around the vessels, which at the bases of the papillæ is arranged

in the long axis of the papillæ, assumes at the summit a horizontal or oblique direction. This hypertrophy of the papillæ is, however, not special

FIG. 5 (after Neumann).



Epidermis and rete Malpighii largely developed; papillæ enlarged.
Cell-growth along vessels and in meshes of corium.

to psoriasis, but occurs also in other chronic skin diseases, as in prurigo and eczema; but while in

psoriasis it is an essential condition and a primary change, it occurs in the other diseases only after long duration of the complaint.

Diagnosis.—Psoriasis is one of the most peculiar in appearance of all of the various diseases of the skin. A fairly well-marked case of psoriasis can scarcely be mistaken for anything else by anyone who has ever seen a fair sample of the disease, nevertheless in some instances psoriasis may be mistaken for a squamous syphilide (the so-called Syphilitic Psoriasis), for eczema, for lichen, for pityriasis, or for herpes circinatus.

But in the *squamous syphilide* the patches do not attain the size that is commonly reached by those of simple psoriasis. The scales are smaller, scantier, thinner, and are confined to the middle of the patch. The reddened skin, though of a tawny hue and somewhat swollen as in psoriasis, is, however, smooth and shining in place of being rough and creased, and the skin affection is usually accompanied with other symptoms of secondary syphilis, that is to say a syphilitic sore throat, and with it enlargement of the posterior cervical glands, the presence of the so-called "syphilitic mucous patches" on the tonsils, uvula, or posterior wall of the pharynx, or on the

tongue or the buccal mucous membrane, or on the lips or on the skin in the immediate neighbourhood of the lips, but more especially about the commissures of the lips, which in such cases are often deeply fissured, or about the anus. Then the squamous syphilide exhibits no preference, such as psoriasis is wont to exhibit, for the dorsal and extensor surfaces of the body and limbs, but affects equally or rather preferably the ventral and flexor surfaces. Then again the age of the patient will often assist the diagnosis. For example, although psoriasis may be met with at all ages excepting only infancy, the squamous syphilide is peculiar to adolescent and early middle age. In my experience the squamous syphilide does not present itself after middle age, that is to say not after the age of 40 at the latest, even when syphilis has for the first time become contracted after that age. Then again inasmuch as the squamous syphilide is wont to appear within a short time after the contraction of the syphilis that has given rise to it, that is to say within the time that a hard chancre takes to disappear, there will probably be present some tangible remains of that chancre, if not as still an open sore, then at least in the shape of that remaining cartilaginous induration which is so slow to disappear,

or failing even this the recent scar of the chancre will at all events in cases of squamous syphilide rarely fail to be present. Concurrently with the remains of induration of the chancre, will be found the remains of induration of the inguinal glands. Then inasmuch as the squamous syphilide has even in its natural course, that is to say untouched by treatment, only a comparatively brief duration, lasting at the most for a period of a few months only, after which time it disappears, or is replaced by some other syphilitic lesion of the skin, in no way resembling psoriasis. *This character* then will often serve to distinguish it from psoriasis, which is wont to have endured for a considerably longer time before it may happen to come under observation. Nevertheless cases occur in adolescent or comparatively young individuals in which an acute and generally diffused eruption of psoriasis disposed in numerous small patches presents itself quite indifferently on the flexor and extensor surfaces of the body; in such cases alone the diagnosis of psoriasis from the squamous syphilide becomes a matter of skill, and even then the differential peculiarities of the patches above referred to, and the presence or absence as the case may be of the usually concomitant lesions

already mentioned of the squamous syphilide, will rarely fail to afford the sufficient materials for a correct conclusion. Syphilitic psoriasis scarcely ever itches, whereas in psoriasis proper itching is *often*, though not invariably, present, and in some cases is even severely distressing.

The effect of treatment is of course a means of diagnosis. A course of mercury pretty soon occasions the disappearance of the squamous syphilide, while it has not that effect on a case of psoriasis proper. But such an aid to diagnosis is in the nature of a last resort.

As regards palmar, or equally plantar, psoriasis, I regret to find myself at variance with some excellent authorities. I do *not* think that the isolated presence of psoriasis in these regions is a strong presumption in favour of its syphilitic nature. Nor do I believe that any kind of syphilitic psoriasis of the palms and soles exists other than the yellow-brown discoid syphilide. If that be so, then psoriasis proper of the palms and soles is a much more common disease than the psoriasis-like syphilide. I base my conclusions on such data as for example the following. The absence (except in the discoid eruption referred to) of any concomitant symptoms of

syphilis. The frequent occurrence of the eruption at a much later age than is proper to the occurrence of any *squamous* syphilide. The extreme chronicity of the disease (lasting for years) as compared with the comparatively short duration (lasting only for months) of any kind of squamous syphilide. With this explanation, then, the diagnosis of palmar and plantar psoriasis from psoriasis-like syphilitic eruption of those regions may thus be put as follows.

In the syphilitic eruption the patches are small, round, tolerably numerous, distinct from one another at first, they are slightly elevated above the rest of the skin, but perfectly flat, of a brownish-yellow colour, and surrounded with a somewhat narrow halo of a decidedly darker coppery-brown colour. The individual patches rarely exceed the size of a sixpenny-piece.

In psoriasis proper of the palms or soles the eruption is scarcely ever nummular in form, but is of a more diffused kind, and of irregular shape, the form of the patches being determined by the well-marked folds or creases of these regions. It gives rise to painful fissures, a condition which is not produced by the syphilitic eruption. Its natural duration is much longer (years) than that of the

syphilitic affection (months). It does not yield to the internal administration of mercury, whereas the syphilitic affection does.

Psoriasis may be readily diagnosed from eczema. In *eczema*, even in its driest and most scaly condition, the scales have in comparison with those of psoriasis a moist, semi-transparent, and thin appearance, and are far more easily detached from the reddened surface that they imperfectly conceal.

The reddened skin of eczema is generally of a fresher, that is to say a more rosy, tint than the tawny red of psoriasis. Itching is commonly a decidedly more urgent symptom in eczema than in psoriasis. Eczema occurs *alike* in the sickly and feeble and in the robust, whereas psoriasis is for the most part confined to the robust and healthy.

In *lichen*, when it assumes the annular form, there may be some resemblance to annular psoriasis, but the scantiness of the scales in lichen, their want of opacity and lustre, and the more rugged appearance of its reddened patches will distinguish it.

In pityriasis there is much less creasing and thickening of the skin, and the scales are thinner, finer, and less abundant than in psoriasis.

In *Herpes circinatus* the patches are more regu-

larly circular than those of psoriasis, the scales are thinner, softer, and less firmly attached to the skin. The circles spread with much greater rapidity. The situations affected by Herpes circinatus are not those chosen by psoriasis. The especial seats of Herpes circinatus are the exposed portions of the body, the face, the neck, the hands. Herpes circinatus is contagious, whereas psoriasis is not so; moreover, by scraping off some of the scales of the Herpes and moistening them with a solution of caustic potash and examining them under the microscope with a quarter-inch power, one can detect the spores and mycelium of the vegetable parasite (*trichophyton tonsurans*), to the presence of which the disease is due.

TREATMENT.—The treatment of psoriasis may be divided into two kinds, the internal and the external, or, as some would say, the general and the local treatment; but I should object in the case of this disease to that way of expressing the difference in effect between remedies that are swallowed and those that are applied directly to the skin. I have already stated my conviction that psoriasis, although in one sense a general disease, is nevertheless a general disease *of the skin only*; if this be so, it is

quite possible to employ general treatment by means of remedies applied directly to the skin itself; and inasmuch as every portion of the skin is readily accessible to this immediate kind of medication, it follows that local treatment is here capable of serving at will as general treatment also. I may at once say I am of opinion that this general treatment by the so-called local means is far more efficacious than general treatment by remedies administered by the mouth, that is to say, the most efficacious of the direct or so-called local remedies that we at present know of will, if employed by themselves, do more towards curing the disease than the most efficacious of the internal remedies that we as yet know of if *these* be employed by themselves. This is unfortunately so, because the prejudice of the public and the feeling of the profession in this and indeed in every other country are in favour of the use of internal medication in preference to "local" measures; I therefore freely confess that although I myself am without bias in either of these two directions, I wish that it were otherwise, that, in short, we knew of some medicine which given by the mouth should be of more avail than the best of our directly applied remedies, or at the least should be equally service-

able. This has not yet happened, but such a remedy is indeed well worth seeking for. Let me illustrate what I have advanced. One of the best reputed modes of treating psoriasis is the employment of arsenic internally and conjointly the use of tar ointment externally. Now I have had repeated occasion to observe in patients thus treated that they will not uncommonly, while taking the arsenic regularly, try to avoid smelling excessively of tar by limiting the use of the ointment to such parts as they more particularly wish to have speedily cured, for example, in the case of housemaids, who have to work with their sleeves tucked up, the use of the ointment has accordingly often been limited to the arms. In such cases, after a month or two of such treatment as I have named, the disease will often be found to remain unaltered or even to have increased on every part where it existed before, excepting only on the arms, which have become perfectly free from all traces of disease. I do not by this mean to say that arsenic of itself never cures psoriasis, for in many cases I find that it is competent *per se* to do so. Nor, on the other hand, do I desire to convey that tar ointment of itself will always suffice, for I have sufficiently often found it to fail absolutely.

But I would say that in my experience tar ointment of itself will cure a very much larger percentage of a given number of cases than arsenic taken internally will prove itself capable of curing. Now arsenic may be justly taken as a type of the more efficient internal remedies, and tar ointment as a fair example of the more efficacious of the external applications in psoriasis. To quote another favourite plan of treating the disease by what may be styled "the double method," for example, the plan of treating it with tar pills internally and at the same time tar ointment externally. I took occasion some time since to analyse this method by treating a considerable number of cases of psoriasis thus. The first case was treated with tar capsules only, the second with tar ointment only, the third was treated as the first, the fourth as the second, and so on, the odd numbers in the order of succession having tar internally only, the even numbers tar externally only. The former were *thoroughly* treated with internal tar, for in every case the remedy was pushed *ad nauseam*. The latter employed throughout tar ointment of the pharmacopœial strength. At the end of a few weeks I found those who had taken tar internally were none of them at all im-

proved, while some had become if anything slightly worse; whereas all those who had used tar ointment exhibited some marked improvement, and a large proportion of them were either quite well or very nearly so.*

Arsenic may be administered in various shapes, for example, in the British Pharmacopœia there is a choice of three modes of prescribing it. Thus there is the *Liquor Arsenicalis* (or solution of Arsenite of Potash, or Fowler's solution), the *Liquor Arsenici Hydrochloricus* (De Valangin's solution), and the *Liquor Sodæ Arseniatis* (Pearson's solution). The strength of these preparations is quite uniform. Each of them contains one part of arsenic in 120 of the solution,† and the dose of each (taken *after* meals three times a day) is from 3 to 10 minims. There are several other preparations of arsenic, for example, the "Asiatic pills," made with seven parts of arsenic and one of black pepper, and there is Donovan's solution (iodide of arsenic and arseniuret of mercury), but I do not for my own part imagine that any one of them is more efficacious than any of the others. My own impression, for what it may be worth, as to

* 'British Medical Journal,' April 10th, 1875.

† Companion to the 'British Pharmacopœia,' by Peter Squire, F.L.S.

the action of arsenic in diseases of the skin is that it acts after all as a local remedy, and this my conclusion is based on the fact that in cases of chronic poisoning by arsenic, the skin amongst some other organs (notably the liver and the lungs) is found on chemical analysis to be especially impregnated with arsenic in (as I understand) the reduced or metallic condition. This supposition is moreover carried out by the grey patchy discoloration of the skin which sometimes occurs, and which I myself have occasionally observed as following on a prolonged course of arsenic. Arsenic, as we know, is an irritant to the gastro-intestinal tract, and psoriasis is benefited mostly by such local applications as have more or less a markedly stimulant effect on the skin. At least no better explanation than this presents itself to me. Some authors are very particular as to the precise form in which arsenic should be prescribed. I confess I am not competent to discuss that question. Dissatisfied with the average effect of arsenic in psoriasis, I have turned my attention more to other remedies.

Quite recently I have made trial of phosphorus as an internal remedy in psoriasis.* It had already been

* 'British Medical Journal,' Nov. 3rd, 1877, and 'Medical Times and Gazette,' Dec. 8th, 1877.

tested by other observers both in this country and abroad. I find that phosphorus is of unquestionable efficacy in psoriasis, and it appears to me to exercise a prompter and more decisive influence over the disease than is commonly evinced by arsenic. I have employed it in the favourite form of "perles" (the little French capsules sold under that name), containing each $\frac{1}{30}$ grain of phosphorus dissolved in oil. Of these perles I give at first one of them three times a day, gradually raising the dose within the course of a week to as many as four perles three times a day (after meals); as a rule I find this dose is tolerated without gastric pain or inconvenience of any kind, except perhaps an occasional "rising" of the taste of phosphorus. Twelve perles a day (which equal $\frac{2}{5}$ grain of phosphorus) are, in my experience, the utmost dose that most patients can tolerate with comfort. Thus administered phosphorus seems to attain its maximum effect on the eruption within a month's course of treatment. I have seen more than the half of an extensive eruption of psoriasis disappear, under the influence of phosphorus alone, within thirty days.

Far more efficacious, however, than any known plan of internal treatment are certain modes of local treatment.

One of the most efficacious of these modes is the employment of india-rubber underclothing.* The effect of this mode of treatment is exemplified in the history of the case represented in the illustration. This mode of treatment, first devised by Dr. Colson, of Beauvais, in France, has been tested and approved by various able observers in different countries, and is an important addition to the therapeutics of the skin.

Quite recently, however, I have devised a still more efficacious mode of locally treating psoriasis, namely, by an ointment of Chrysophanic acid. This acid, which is the active principle and chief component of the Indian remedy known as Goa-powder, exhibits a truly surprising influence over psoriasis. Goa-powder, which had long been employed in India as a remedy for curing and arresting the spread of contagious ringworm, had apparently never been employed for any other purpose until (about a year since) its properties in cases of psoriasis accidentally disclosed themselves to me.† By means of chrysophanic acid ointment alone I have often cured obstinate cases of psoriasis of twenty or thirty years'

* Vide my cases in 'British Medical Journal,' Feb. 1876, and July 8, 1876.

† Vide my cases in 'British Medical Journal,' Dec. 23rd, 1876.

standing, and *that* within the surprisingly short space of from one to two weeks. The strength of the ointment may be from gr. v up to as much as ʒij of the acid to the ounce of lard. The ointment is far more active if prepared by the aid of heat, inasmuch as hot lard dissolves the acid. The remedy has some disadvantages. It stains the underclothing. It is apt, if incautiously used, to inflame unduly the skin, and I must add that special pains must be taken to keep it away from the immediate neighbourhood of the eyes, which otherwise are apt to be affected with smart conjunctivitis. However, my views as to the proper way of employing chrysophanic acid ointment, and my theories as to the manner in which it acts, have quite recently been published at some length.*

Some few years ago my attention was specially directed to the effect of creosote ointment in psoriasis. I had noticed that it appeared to have the property of disintegrating and loosening the scales of psoriasis as well as beneficially stimulating the subjacent reddened skin. But in its ordinary form creosote ointment is of too mild a composition to effect much

* 'On the Treatment of Psoriasis by an Ointment of Chrysophanic Acid.' London, 1878.

good in psoriasis, for example, the ointment of the British Pharmacopœia contains only one ninth part of creosote. I accordingly devised a more active application by melting one part of white wax with two parts of creosote and stirring till "set." This process produces a very potent ointment, of considerable efficacy in many examples of the disease, but such an ointment is too strong for application to the face or the ventral surfaces of the body. It is only applicable for general use to callous patches occurring on the dorsal surfaces, although, if deftly used, it may be employed in almost any situation.

The most favourite of the local applications for psoriasis is tar ointment or tar. Of the two, I prefer tar ointment. The discoloration of the clothes and the smell and the stickiness of the tar and equally of the ointment of tar are qualifying circumstances, but the efficacy of the remedy is considerable. Not that in my opinion it can be compared with the expeditious effect of chrysophanic acid. Different kinds of tar have found favour with different observers, for example, the Juniper tar (*Oleum Cadinum*, from *Juniperus oxycedrus*), the *Oleum Betulæ Albæ* (or *Oleum Rusci* or Birch tar), the *Oleum Fagi* (or Beech tar, from *Fagus sylvatica*), the Coal tar (*Oleum*

ligni fossilis), and so forth; but in my own experience, and I have carefully tried all of those varieties of tar that are in common vogue, none of them is superior to the common (Stockholm) tar (Oleum Pinorum). Indeed, I regard the Unguentum Picis of the British Pharmacopœia, which consists of five parts of tar mixed by aid of heat with two of yellow wax, in the light of as efficient a mode of applying tar as any that I have tried.

Iodine applied in the form of the Linimentum Iodi of the British Pharmacopœia (the Tincture is too weak) is in many cases an efficient application. It may be applied by means of a bristle brush. The liniment contains one part of iodine in nine of rectified spirit. However, I have often found advantage in dealing with the more callous and obstinate patches of an eruption of psoriasis by availing myself of a much stronger solution of iodine, namely, one containing one part of iodine in three of rectified spirit.

Certain mercurial preparations, applied in the form of ointment, are of unquestionable use in cases of psoriasis. One of the more efficient of these is the yellow oxide of mercury, which was first introduced as a therapeutical agent by myself several years

ago.* It has since been adopted into the British Pharmacopœia. Ointment containing from fifteen grains to as much as a drachm of the oxide to the ounce of lard may be employed. But a more stimulant preparation of mercury, namely, the red iodide, has in my hands appeared much more efficacious. From five grains to fifteen grains of the red iodide in the ounce of lard is a proper strength for this ointment, though I have occasionally used a much stronger ointment.

There is another mode of treating psoriasis which I have recently tested with some success; I refer to the treatment by prolonged immersion in water. This plan has been long in use notably at Leukerbad in Switzerland, and also at other continental watering places, and as to some skin-lesions it has been vigorously pursued by Prof. Hebra, of Vienna. But he does not appear to have in any way either employed it or suggested it for psoriasis. His use of it has been confined to the treatment of burns, pemphigus, small-pox, gangrenous bubo, phagedænic chancre, secondary syphilitic ulcers, bedsores, and fistulous

* "On a better mode of preparing Red Oxide of Mercury Ointment for application in certain Cutaneous Diseases," by B. Squire (March 8th, 1865). 'Pharmaceutical Journal and Transactions,' vol. vi., p. 508.

ulcers,* and his results are very excellent. I have succeeded in causing within the space of about six weeks the disappearance of by far the greater part of an extensive eruption of psoriasis by immersion of the patient in water for six hours daily. The temperature at which the bath should be kept is about 90° Fahr.; at this heat the patient neither becomes relaxed or depressed, nor on the other hand at all chilled by his prolonged immersion. However, this mode of treatment makes large demands on the time of the patient.

Whatever application be employed in the treatment of psoriasis, and here I include the prolonged application of water as above, it is expedient that the scales or incrustations of psoriasis should be as thoroughly as possible removed again and again during the progress of treatment. The plan I usually pursue is to wipe the incrustations first with a rag moistened with benzol (so as to remove all grease from them), and then to wash the crusts with warm soap and water, and thereupon to bathe or soak the incrustation thoroughly with warm water until it has become quite soft and "pappy."

* Ueber die Anwendung und Wirkung des kontinuierlichen Wasserbades von Dr. Hans Hebra, Wiener Med. Wochenschrift, Nr. 36 bis 39, 1877.

In this condition the scales are quite easily scraped away; the most convenient implement for the purpose being a dull-edged corn-cutter's knife, the blade of which resembles in miniature that of an ordinary table-knife (vide Figs. 6 and 7).

Fig. 6 represents an instrument of a broader blade and a flatter handle than Fig. 7. The latter is designed rather for elegance and inoffensiveness of appearance, but the former, although a more formidable-looking instrument to the patient, is a more handy one for use, inasmuch as the broad blade and flat handle more readily permit of the angle of inclination of the plane of the blade to that of the skin being deftly adjusted during use.

There are other internal remedies besides those that I have already mentioned, that have been

FIG. 6.



FIG. 7.



praised on good authority for their efficacy in psoriasis. For example, cod-liver oil, or preparations of iron, where the patient is of strumous habit or in a debilitated state. Then again alkalis, colchicum or the iodide of potassium, where a gouty or rheumatic tendency exists; but in my experience it is a rare event for any of such conditions to coincide with psoriasis. In a different capacity, namely, as specifics, Tincture of Cantharides (Rayer, Devergie, Hardy) and Balsam of Copaiba (Hardy, Sims) have been recommended. The tincture in doses of three drops a day, increased by one drop daily up to 30 drops a day; the balsam in doses of a drachm or a drachm and a half in the day, mixed with an equal proportion of magnesia. Carbolic acid administered internally has been advocated by Lemaire, Bazin, Kaposi, and McCall Anderson. I have made careful trial of it, but it has quite failed in my hands. Amongst internal remedies the variation of the patient's diet occupies a strong place in the opinion of some observers. The general public in this, as in other skin diseases, consider the question as of the first importance. The way in which the diet should be varied is not a matter of common consent, although the avoidance

of beer and of salt meat is generally thought to be necessary. Some consider an almost exclusively animal diet advantageous, but especially milk, pork, and other fatty foods (Passavant). Some lay special stress on abstinence from foods of a stimulating character, from spices and from coffee, and interdict not only beer but alcoholic liquors of any kind. For my own part, I do not attach importance to these precautions, for I have seen a great number of persons affected with psoriasis who had carefully observed such regulations for a long time without any obvious benefit, and I have never seen anyone whom I have had reason to judge had become cured, or even half cured, of his psoriasis by such means.

There are various other local means of healing psoriasis which I have not yet referred to. For example, there is the continual bath of Prof. Hebra, of Vienna, a more unflinching measure than the six-hours' daily bath already described. In the continual bath the patient is kept immersed night and day for weeks and even months together. He takes his sleep and he takes his meals in the bath. It is doubtful whether this trying discipline is balanced by sufficient superiority of effect.

The Turkish bath is a favourite conception in the

popular mind for the cure of psoriasis and equally of other chronic eruptions, and it commonly suggests itself as a highly promising expedient to those practitioners who have never tried it. I have often met with patients who had tried it, but my conclusion is that it is of no avail.

Hydropathic "packing" has been tested and approved by Prof. Hebra, but it must be remembered that this is a much more prolonged process than the Turkish bath, and resembles in the kind of influence exerted by it the six-hours' warm bath or the treatment by india-rubber underclothing. In short, it is tantamount to a general fomentation or an immense poultice.

Medicated soaps have for long met with a brisk demand for the treatment of psoriasis and other chronic skin diseases. I myself have every reason to think them perfectly useless. It is a lazy and an elegant way of attempting a cure, but it is too lazy and too elegant a way. The proportion of "medicament" in the soap is always a very moderate one, lest the soap should be made too disagreeable for use. Then when in using it the soap becomes mixed with a very considerable quantity of water, the medicament gets still further diluted, and even thus the

application of it is scarcely more than momentary before it is washed off and the patient's skin wiped dry again with a towel. These soaps as a matter of experience effect no influence whatever on any chronic eruption. It is almost a matter of surprise that any good should ever be expected of them.

Treatment by sulphuret of calcium solution has been tried by Prof. Hebra. His formula is quicklime 1 lb., sulphur 2 lbs., water 20 lbs. Boil down to 12 lbs. and filter when cool. This solution both dissolves off the incrustations and stimulates very considerably the denuded surface of the skin. Its advocate admits that it is a very painful process, but claims great expedition for it.

History of the case.—The patient, a Jew, aged 18 years, was admitted as an in-patient of the British Hospital for Diseases of the Skin under my charge on March 23rd, 1876. He had recently worked his passage to England from New York, where he was born.

He gives the following account of his case. He has been subject to psoriasis since the age of 14, having experienced in all four separate attacks of his disease.

His first attack, which commenced about the age of 14, lasted about five months.

His second attack began at the age of 16, and lasted two months.

His third attack began at the age of 17, and lasted seven weeks. For this attack he was admitted into the Boston Hospital (U.S.A.), and was there treated and speedily cured by frictions with Huile de Cade and Olive oil in equal proportions. After this he remained free from his disease for a few weeks, but it soon reappeared, and has continued ever since, namely:

(His fourth attack) from December, 1875, up to this present date, a period of three months.

His present condition, March 23rd, 1876, is that he is covered pretty generally with patches of psoriasis. His head, forehead, and eyebrows are completely incrustated with thick nacreous incrustations, deeply fissured here and there with painful bleeding cracks. The disease is abundantly distributed in large patches over the trunk at both back and front and on the lower limbs, but is comparatively scanty on the arms.

Seven days after his admission the patient commenced wearing vulcanized india-rubber underclothing, being clothed in a complete suit, consisting of shirt and drawers. These garments he continued to wear next to the skin night and day for six days, at the end of which time he was perfectly well of his

disease over the trunk and limbs. That is to say, the disease had completely disappeared from those portions of the body which had been covered by the underclothing. The disease at this time continued as before unchanged on the head, forehead, and eyebrows, parts which had not as yet been subjected to any treatment.

No internal remedy of any kind was administered to the patient during his stay in the hospital, nor had any medicine recently been taken by him.

On April 20th (four weeks after his admission) he commenced wearing a vulcanized india-rubber cap, which was pulled down over his eyebrows in the evening and at night, and during a part also of the daytime, that is to say whenever the patient was indoors. However, the wearing of this cap was from the first extremely distasteful to the patient, and the probability is that he wore it as little as he could well contrive.

The rubber-cap was in this kind of way worn in all about seven weeks, namely, until the date of his dismissal.

On April 24th, after the cap had been in use for about four days, I found that the patient was in the habit of removing the cap for the greater part of the

day, and that the scalp and brows, although moist, supple, and comfortable while covered with the rubber, became shrivelled, stiff, hide-bound, and irritable during the time the rubber was removed. I accordingly directed him to apply purified gelatinous petroleum to his head and brows whenever the cap was off, that is to say during the daytime. This I ordered with a view to keeping the skin moist and supple during the time the rubber-cap was off, for the patient resolutely refused to wear the cap during the daytime.

From this date also until his dismissal the patient applied to his eyelids, which have been from childhood affected with *Ophthalmia tarsi*, an ointment thus composed: Hydr. Oxid. Flav. gr. vij, Adipis ʒj. By this means the condition of the eyelids was so nearly cured when the patient left as to be quite unnoticeable.

After a few days had elapsed it did not appear that this intermittent wearing of the rubber covering, even when supplemented by the alternation of a layer of paraffin, was conducing much to the cure of the disease; accordingly the petroleum paraffin was mixed with Stockholm tar in the proportion of three parts of paraffin to one of tar. The patient,

however, objected to this application as being too "drying" in effect.

On May 10th the application was consequently changed for an ointment thus composed: creosote $\mathfrak{z}\text{ij}$, white wax $\mathfrak{z}\text{j}$, lard $\mathfrak{z}\text{v}$. After a week's use of this the improvement effected did not seem to be very considerable.

On May 17th he was therefore persuaded to revert to the tar and paraffin, mixed on this occasion in equal proportions, but this soon proved itself to be insufficiently greasy for use. It matted the hair together so that the patient could not apply the ointment easily.

On May 24th the patient was ordered an ointment composed of Hyd. Iod. Rub. gr. xv, Adipis $\mathfrak{z}\text{j}$. He used this for two days only. It excited considerable redness and desquamation, and a good deal of smarting. It seemed, however, to have effected a very decided change for the better.

On May 26th the reaction excited by the Rochard's ointment being too considerable to permit of a continuance of the application, the use of petroleum paraffin was resumed.

On June 7th all trace of eruption had disappeared, excepting only a few patches at the back of the scalp; the patient was therefore dismissed from

being an in-patient and ordered to reapply for a day or two the Rochard's ointment of May 24th to the patches which yet remained.

Two portraits of this case are here presented, the one (Plate III.) taken at the time of the patient's admission into the hospital, the other (Plate IV.) taken at the date of his dismissal.

Plate IV. represents no pathological condition whatever, but its introduction has been deemed necessary in order to elucidate fully the condition exhibited in Plate III. Thus it serves to shew by contrast with its companion plate the complete transformation of the countenance which an eruption such as this is capable of effecting. Each of these two portraits is a remarkably faithful likeness of the patient at the time it was drawn, and yet it would be scarcely possible to recognize in Plate III. the person depicted in Plate IV. In Plate III. besides the alteration of the countenance, produced by the mere supervention of patches of eruption, the eyebrows have disappeared from view, and in great part the eyelashes also; in addition to this the countenance is considerably changed by the pale, thin, worn, and anxious look that has become imprinted on it by the never-ceasing annoyance and

discomfort occasioned by so well-developed an example of the disease occupying so extremely inconvenient a position.

The introduction of Plate IV. serves also to illustrate how grave and deep-seated a lesion of the skin may yet be completely recovered from within a very short time, and that without leaving any trace, although, on the other hand, certain very slight lesions are extremely slow to heal, and are recovered from only to be replaced by an indelible mark.

In Plate III. the countenance of the patient is represented as it was at its worst. The forehead is seen to be over the greater part of its surface covered with the peculiar opaque white incrustations (tinged with a yellowish-grey) that are special to psoriasis. Where the incrustations are of more recent growth, and so have not yet had time to lose their pristine brilliancy, for instance, here and there at the spreading edges of the irregular patches of incrustation, *there* the deposit exhibits a more absolute whiteness. It may be seen that the incrustation is continued upwards over the scalp, losing itself from view under a tolerably thick crop of crisp curly hair, which is in no degree thinned by the presence of the incrustation. On the right side of

the upper margin of the forehead are two well-marked examples of the deep clotted fissures (*rhagades*) which are apt to complicate the disease whenever it occurs on any portion of the skin which is capable of being stretched by movement. These fissures have evidently been produced by a fidgetty exertion of the muscles of the scalp, to which the patient has been impelled by the uneasy stiff and hide-bound sensation occasioned by the morbid condition of his scalp. Over the eyebrows the still greater mobility of the skin by muscular action has by repeated contraction and expansion of the brows split the incrustation up more considerably; the fissures or *rhagades* have become so numerous as *here* to constitute the chief phenomena of the disease, and accordingly the crust has here become fissured in all directions, and is more or less completely blood-stained. The edges of the eyelids are invaded by a condition more or less resembling that which is familiar under the name of Ophthalmia tarsi, but it will be observed that although, as above stated, the patient had been the subject of Ophthalmia tarsi long before he became the subject of psoriasis, nevertheless the edges of his lids now present the characteristic phenomena of psoriasis. In short, it is obvious that the pre-existing inflammation

of the roots of his eyelashes has served as the determining cause of the development of psoriasis in this somewhat unusual situation.

Over the lower part of his face, for example, at one place near the tip of his nose, and in several other places around his mouth, a few minute patches of the eruption have developed themselves.

At the upper part of his forehead, in the middle line and close by the margin of the scalp, the notably reddened skin which always underlies the white incrustations of psoriasis has become laid bare by the detachment of a portion of the crust. This exposed portion of the inflamed skin may be seen to be intersected by two or three comparatively superficial *rhagades* or fissures.

