Clinical notes on psoriasis : with especial reference to its prognosis and treatment / by L. Duncan Bulkley.

CLINICAL NOTES

ON

PSORIASIS,

WITH ESPECIAL REFERENCE TO

ITS PROGNOSIS AND TREATMENT.

BY

L. DUNCAN BULKLEY, A.M., M.D.

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CLINICAL NOTES ON PSORIASIS, WITH ESPECIAL REFERENCE TO ITS PROGNOSIS AND TREATMENT.[1]

By L. DUNCAN BULKLEY, A.M., M.D.,
NEW YORK.

In his recent work upon the treatment of syphilis Professor Fournier makes the remark, that too little attention is often paid to the real treatment and cure of the disease, and that too many physicians and patients are content with only the removal of the symptoms as they arise; it thus happens that in relatively few instances is the treatment of syphilis carried out in a patient and thorough manner to a cure. It is within the memory of quite young men when that disease was regarded as incurable, and it is only within the last decade that definite rules have been established (largely through the work of Fournier) which, if accurately carried out, will commonly result in the radical cure of syphilis.

Much the same may be said in regard to psoriasis; for, thus far, physicians and patients have been far too often satisfied with attempting to remove the eruption as its recurs, again and again, and commonly far too little study and attention have been given to the underlying cause and its removal.

And yet I believe that the time has come when the treatment of psoriasis should be placed on a much more certain and definite basis than is now commonly accepted, and the influence of diet and hygiene in its production recognized, and when, consequently, we can offer to our patients much more encouragement as to the real cure of the trouble.

To the end of understanding better the clinical relations of psoriasis, and, therefore, its treatment and prognosis, I have made a study of my recorded notes of 366 cases in private practice, which have been under my personal observation and care. These cases occurred among 9483 miscellaneous cases of skin diseases, making it to form almost 4 per cent.; it thus comes fourth on the list as to frequency,

[1] Read before the Medical Society of the State of New York, February 7, 1895.

after eczema, acne, and syphilis. The ages of these 366 patients at the time of applying for treatment is shown in the following table:

TABLE I.—AGES OF 366 PATIENTS WITH PSORIASIS.

	Male.	Female.	Total.
5 years and under	1	0	1
5 years to 10 years	2	4	6
10 " 15 "	3	12	15
15 " 20 "	17	29	46
20 " 25 "	28	30	58
25 " 30 "	35	28	63
30 " 35 "	43	19	62
35 " 40 "	27	9	36
40 " 45 "	23	4	27
45 " 50 "	16	2	18
50 " 55 "	7	5	12
55 " 60 "	3	4	7
60 " 65 "	2	5	7
65 " 70 "	3	2	5
70 " 75 "	1	1	2
Unknown age	1	0	1
Total	212	154	366

In a recent clinical study of 1000 cases of psoriasis[1] occurring among 25,443 cases of miscellaneous skin diseases in my public and private practice together, the proportion in public practice was found to be 3.69 per cent.

It is seen from the above table that males are affected with psoriasis more frequently than females, there being 212 males to 154 females, respectively 57.92 and 42.07 per cent.

The youngest patient seen with the disease was a male nearly five years of age; the oldest, also a male, just seventy-five years old. The largest number of patients applied for treatment between the ages of twenty-five and thirty, when there were sixty-three patients, or nearly 18 per cent. of all the cases; but there were also almost as many cases during the five years of life before and after this period. Thus, during the fifteen years between twenty and thirty-five years of age there were 183 cases, or exactly one-half of the entire number.

It is impossible, however, to draw from this table any exact conclusion in regard to the age of the patient at which psoriasis is most likely to develop for the first time, for in many instances the disease had lasted for many years before coming under treatment, as will be seen in a later table. In the next Table, II., is given the

[1] Trans. Congr. Internat. de Dermat., etc., Paris, 1889, p. 878; also, Maryland Medical Journ., September and October, 1891.

age at which the eruption first appeared, according to the statements recorded in the notes of the cases:

TABLE II.—AGES OF 366 PRIVATE PATIENTS WITH PSORIASIS AT WHICH THE ERUPTION FIRST APPEARED.

	Male.	Female.	Total.
"During infancy"	5	0	5
1 year to 2 years	1	1	2
2 years to 3 years	2	2	4
3 " 4 "	2	3	5
4 " 5 "	2	4	6
5 years and under	12	10	22
"During childhood"	4	3	7
5 years to 10 years	14	18	32
10 " 15 "	22	41	63
15 " 20 "	48	28	76
20 " 25 "	42	16	58
25 " 30 "	19	14	33
30 " 35 "	23	5	28
35 " 40 "	10	5	15
40 " 45 "	7	1	8
45 " 50 "	5	4	9
50 " 55 "	2	4	6
55 " 60 "	1	2	3
60 " 65 "	1	2	3
Not stated	2	1	3
Total	212	154	366

These cases are, perhaps, too few to permit any very definite conclusions to be drawn from them as to the first development of the disease, but a little study of the table develops many items of interest.

The disease belongs principally to the early, formative period of life. Thus, it is seen that in the largest number of instances, namely, 76, or over 20 per cent., the eruption was first observed in the period between fifteen and twenty years of age, and in a very large number, 63, between the ages of ten and fifteen, while the eruption first appeared in 197 cases, or almost 55 per cent. of the whole, between ten and twenty-five years of age; after this period the number of cases diminishes very rapidly, there being only 12 patients in whom the eruption first appeared after fifty years of age. It is seen, however, that there are relatively few cases during very early life, there being only 22 instances in which it appeared before the age of five years. These facts appear quite opposed to the statement of Neumann,[1] who asserts that the

[1] Neumann: Lehrbuch der Hautkrankheiten, Wien, 1873, p. 259.

eruption generally appears about the sixth year of life. It is a little curious to note that while the females are very largely in excess between the ages of ten and fifteen, in the next period of five years the number of the males is nearly double that of the females; while between twenty and twenty-five the males present nearly three times the number of cases found in females. The question arises, whether the great difference relates in any way to the effect of the later development of the sexual function in males than in females.

Psoriasis is known to be one of the most rebellious of all skin diseases; beginning often quite early in life, it may persist indefinitely, even in spite of active treatment, and often wears out the patience both of the physician and patient. In a certain small proportion of cases it will seem to disappear, even without treatment, and to remain absent for varying periods, perhaps entirely. Such cases are, however, very rare, and the disappearance of the eruption seems to depend on some radical change in the mode of life, or sometimes follows a change of abode. A prolonged residence in a warm climate will occasionally arrest the disease, but it is liable to recur on return to a colder or more changeable climate. In some cases it becomes less pronounced after middle life, and may become confined to a few lesions, giving little annoyance.

The duration of the eruption at the time of applying for treatment is shown in the next Table, III.:

TABLE III.—DURATION OF PSORIASIS IN 366 CASES AT THE TIME OF APPLYING FOR TREATMENT.

	Male.	Female.	Total.
Under 1 month	7	5	12
1 month to 3 months	0	0	0
3 months to 6 months	7	5	12
6 months to 1 year	20	15	35
1 year to 2 years	10	14	24
2 years to 3 years	9	8	17
3 " 4 "	15	9	24
4 " 5 "	12	9	21
5 " 10 "	42	42	84
10 " 15 "	25	22	47
15 " 20 "	23	15	38
20 " 25 "	19	3	22
25 " 30 "	10	2	12
30 " 40 "	8	2	10
40 " 50 "	2	1	3
50 " 60 "	0	1	1
Not stated	3	1	4
Total	212	154	366

This table fully bears out the chronic character of the disease, for there appear cases in it which had lasted thirty years or more at the time of first observation; in a very large number of instances (84, or nearly one-quarter of the entire number) the eruption had existed from five to ten years previous to the first visit.

The natural history of psoriasis is, therefore, to be reckoned by years rather than by days and months. Thus, of these 366 cases, no less than 221, or over 60 per cent., had lasted for five years or over.

Comparatively few cases were observed at or soon after the first appearance of the eruption, only 12 cases during the first three months, and only 24 cases in all during the first six months of the existence of the eruption. It will be seen later that this is a fact of no little importance in connection with the proper treatment of the disease, and its prognosis.

Something more can be learned in regard to the obstinacy of the complaint by a consideration of the periods of time during which these patients were under observation. These are shown in the following Table, IV.:

TABLE IV.—DURATION OF OBSERVATION OF 366 PATIENTS WITH PSORIASIS.

	Male.	Female.	Total.
1 month or less (74 seen but once)	95	45	140
1 month to 3 months	6	15	21
3 months to 6 months	14	16	30
6 months to 1 year	32	28	60
1 year to 2 years	18	12	30
2 years to 3 years	7	8	15
3 " 4 "	8	3	11
4 " 5 "	5	4	9
5 " 10 "	16	13	29
10 " 15 "	6	7	13
15 " 20 "	4	2	6
20 " 30 "	1	1	2
Total	212	154	366

Here it will be seen that a large number of the cases were seen but for a short time; 191, or over one-half, for a period less than six months, and of these 74 were seen but once, and many others but two or three times. In looking over the notes of these cases we find that some of them yielded to treatment and were apparently cured even in a short time, while many were lost sight of before any conclusions could be reached as to the value of treatment. In

many of the cases which were for a long while under observation, the notes show that it was often for recurrences of the eruption, for these patients are commonly satisfied with its disappearance, and are seldom willing to undergo prolonged medical supervision with a view to the cure of the disease. In studying the records of these cases we find that in proportion to the length of time the disease has already continued, either before or while under observation, in about the same degree will the eruption resist treatment; in other words, as the disease becomes engrafted on the individual the results of treatment are less satisfactory, much as is observed in connection with gout, with which, as we shall see, this eruption is frequently closely allied, and, indeed, often intimately connected.

This brings us to a brief consideration of the *nature* of psoriasis. Anyone who has followed out cases of the disease during a period of years must be convinced that it is not a local affection, in the sense in which we speak of epithelioma, verruca, the parasitic eruptions, etc., and it is certain that it is not due to any specific poison introduced from without, as in the case of syphilis and leprosy, nor is there any definite indication that it is of malarial origin.

Every evidence points to the fact that it must depend upon some internal cause, which at one time or another produces the changes in the skin. Unless, therefore, measures are taken looking toward the alteration or removal of the internal or general condition underlying the disease, we cannot hope for a permanent cure. All have been disappointed again and again by the recurrence of the eruption, even after its complete disappearance under local treatment, and all acknowledge the futility of local measures to prevent its appearance or development.

What the exact underlying cause of psoriasis is we are not yet prepared to say, but advances are being slowly made in this direction.

Heredity has been commonly supposed to have a very great influence in its production, and many writers state this with considerable positiveness. But, as far as I can learn by a study of the cases here analyzed, as well as also from the much larger number seen in public practice, this element is of relatively little importance. Notes have been taken of all my private cases, and in most instances the patients have been carefully interrogated, both as to the positive and negative aspects of this question; the results are tabulated in the following Table, V.:

TABLE V.—HEREDITY OF PSORIASIS.

	Male.	Female.	Total.
Cases with anterior heredity	28	16	44
Cases with posterior heredity	6	6	12
Cases with no history of heredity	131	111	242
Unknown or unrecorded	47	21	68
Total	212	154	366
Anterior heredity:			
Parents affected	22	15	37
Grandparents affected	3	0	3
Parents and grandparents affected	3	1	4
Total	28	16	44
Posterior heredity:			
Children affected	6	6	12
Grandchildren affected	0	0	0
Total	6	6	12
Collateral heredity:			
Cases with brothers affected	23	13	36
Cases with sisters affected	25	12	37
Cases with collateral relatives affected	3	6	9
Total	51	31	82

Here we see that of 366 cases only 56 showed any anterior or posterior heredity; in 68 cases there was no definite record; while in 242 cases, or over 66 per cent., there was no history of heredity, either in immediate ancestors or in children, and in only 15 per cent. was there any assurance that this had occurred. This certainly is not any greater proportion of concurrence than could be traced in many diseases, and bears no comparison with that found in eczema. In regard to collateral heredity we find 82 cases in which this was recognized, a no larger proportion than might be expected among brothers and sisters brought up under similar conditions as to diet, hygiene, etc.

As remarked before, it is often very difficult to determine with certainty the underlying causes which operate to produce the eruption, for it is observed in those presenting widely diverse conditions of life, and under the greatest variety of circumstances. It develops with about equal frequency among the poor and the rich. Not only will it appear after exhaustive diseases, after pregnancy, and in those debilitated by various excesses, but it comes also in subjects who are apparently in the best of health and enjoying the surroundings of a healthy and apparently proper life. No

single cause or element, or any combination of causes or elements, can be traced in every case.

The evidence increases, however, that it is more or less closely allied to the blood-states which are known as the gouty and rheumatic; and we can often clinically identify the cases belonging to one or the other of these classes. Upon our recognition of the base upon which the disease rests will depend necessarily our success in treatment, and consequently our prognosis.

Undoubtedly, the most common systemic condition found is that associated with the still little understood sub-oxidation process which underlies or is akin to that found in *gout*.

Sir Henry Holland[1] says: "I cannot doubt from my own observations that certain of these (skin) disorders often occur as the result of the habit in question (gout). I have so often seen psoriasis, for example, occurring in gouty families—sometimes alternating with acute attacks of that disease, sometimes suspended by them, sometimes seeming to prevent them in persons thus disposed—that it is difficult not to assign the same morbid cause to these results."

Dr. Garrod[2] believes that psoriasis is, perhaps, the most frequent form in which the cutaneous (gouty) disease manifests itself, and that there are many cases in which the skin and joint affections are alternated.

Sir Thomas Watson,[3] speaking of psoriasis and lepra, says: "I believe that they sometimes depend upon the presence or the generation of an excess of acid in the system; and that they are often cured by alkaline remedies, I am sure."

Prout[4] mentions the alternation of leprous and scaly skin diseases, with deposits of phosphate of lime in the urine, in patients who have been subject to gout and rheumatism, the urinary affection becoming better as the cutaneous affection has become worse, and *vice versa*.

I have purposely quoted from these older writers, rather than from those of recent date, better known in connection with diseases of the skin, because the tendency of modern specialism has been rather in the direction of the minute study of local lesions and of

[1] Holland: Medical Notes and Reflexions, Philad'a, 1857, p. 212.
[2] Garrod: Reynolds's System of Medicine, Philad'a, 1868, vol. i. p. 824.
[3] Watson: Practice of Physic, Philad'a, 1858, p. 1295.
[4] Prout: Stomach and Renal Diseases, Philad'a, 1843, p. 221.

the local causes of diseases of the skin, and away from constitutional conditions; and the so-called humoral views of older writers have been rather overlooked of late.

These who have been quoted (and the number could be greatly increased, if desired) were general practitioners and teachers of prominence, and all were experienced, accurate observers, and their opinions should have weight in this, as they have in other matters.

These observations, and others made by equally careful and acute observers, I can to a good measure indorse by my own experience, and many cases in my own practice abundantly confirm their truth. As yet, however, no perfectly well-defined statements can be made as to the precise condition which may be looked for in all cases, even in those which present symptoms which may be looked upon as gouty; but I believe that real advances will be made in proportion as they are recognized and treated.

The urine is often a most valuable guide in the recognition and treatment of the acid state which underlies many cases of psoriasis, and should receive more attention than is commonly the case in the management of this disease. In my recorded observations of the urine of patients with psoriasis this excretion was seldom such as could be regarded as that of health, and although an analysis of the data does not show any very great uniformity in the deviations from the normal, the changes found were such as one should expect in those functional derangements of the liver and other organs which have to do with the metabolic processes in the system.

The specific gravity in them varied greatly, ranging from 1008 to 1040; in relatively few instances was it below normal, and very generally it was much above the normal point, a gravity from 1030 to 1035 being not infrequent; it was common to find a very great difference between various specimens from the same patient. Albumin was found but once; sugar was not found at all, even in specimens with the highest specific gravities, the increased weight being due to urea and organic salts.

In most of the examinations I have found very decided hyperacidity, with crystalline deposits of uric acid, urates, oxalate of lime, and occasionally stellar phosphates.

The cases which present this acid state of the system well marked are commonly characterized by a congested state of the eruption, often attended with burning or itching, and will generally show a marked contrast to the sluggish and indolent eruption presented by

those exhibiting simple debility, or the strumous state. It is not possible, as yet, to determine and express the differences presented by those in whom the acidity takes the rheumatic form ; clinically, they resemble the gouty cases, but often the rheumatic element will be manifested more or less acutely in the joints or otherwise, of which I have known some striking examples.

Whether there is really any difference in psoriasis found in these three commonly recognized states is difficult to determine. I, myself, am inclined to think that there is but one cause for the eruption, the acid blood-state belonging or leading up to gout, which may be developed, more or less, in the rheumatic and strumous, as well as in those where its fuller development ends in gouty deposit in or inflammation of the small joints.

As may be supposed, the *treatment* of psoriasis will depend very largely upon the recognition of the blood-state or condition upon which the disease depends. While most persons with this eruption will appear to be in perfect health, I believe that there is always some departure from the normal which can and should be discovered and reached if the disease is really to be cured. In many instances the eruption depends wholly upon pure debility, and a prolonged and most careful tonic course will ultimately overcome the difficulty. In the gouty and rheumatic class of cases undoubted benefit results from a prolonged and faithful alkaline course of treatment, with such remedies as meet the underlying blood-state.

In many cases a strumous habit will be at the bottom of the trouble, the faulty metabolism being dependent on this, and cod-liver oil, phosphates, etc., will be needed, alternated occasionally with alterative doses of mercury. I do not, of course, allude to cases of syphilitic skin-lesions, which often closely resemble the eruption in question, for these have nothing to do with it, and it should never be spoken of as syphilitic psoriasis. A number of writers have reported the cure of psoriasis with full and prolonged doses of iodide of potassium, others have praised antimony, while the number and variety of remedies which have been advocated in this disease are so great that the mere enumeration of them would occupy and waste much time and space; their very number and variety indicate the difficulties attending the treatment of psoriasis, and that there must be causes which are not yet fully understood.

There is certainly no single specific for psoriasis, although arsenic seems to come nearer to this than any one remedy ; when given in

full and persistent doses it often serves to remove the eruption and to keep it in abeyance. Arsenic is a very safe remedy, as the drug is eliminated almost immediately from the system, largely by the urine, and, as far as I can learn, no ultimately toxic effects occur even from its free and prolonged use. In one instance a patient of mine, a gentleman in whom the eruption began at twenty-two years of age, took nearly eight ounces of the pure Fowler's solution in a single year; and some time ago he calculated that he had taken over half a gallon of pure Fowler's solution in the course of fourteen years.

But arsenic constantly fails either to remove the eruption or to prevent relapses, nor could we expect otherwise, for the most that arsenic can do is so to control the nerve-elements that they shall not be irritated by the acid condition of the blood; when its use is suspended, or when it loses its controlling effect, the same condition returns as before. In cases where arsenic has seemed to cure the eruption, the blood-state which called forth the skin-lesions had probably been of but brief duration, and the arsenic had aided the tissue in returning to the normal.

In psoriasis, therefore, the patient should be studied rather than the eruption; his diet, habits of life, the state of the emunctories, the condition of the nutrition, and many features which a careful physician notes and takes into consideration in connection with other complaints. My plea is, that one who approaches a case of psoriasis should by no means be content with alone recognizing the local conditions on the skin, and prescribing local measures to benefit them, but that, with broad medical knowledge, he should study the patient, and seek to rectify the causes back of the local manifestations on the skin.

Time and space fail to develop here fully the details of this interesting and most important part of our subject, but a few of the most practical matters may be considered.

As may be judged from what has preceded, alkalies should never be neglected in psoriasis. They should not be used sparingly; but, taking the urine as a guide, they should be pushed with judgment, and be continued long enough to effect the desired result. Potash, lithia, and soda, in various forms and combinations, are remedies of incalculable value in this disease.

But it would hardly be expected that any one remedy or group of remedies would cure a disease which has been such a *bête noire*

to the profession; alkalies alone will not accomplish this, but their free use is only urged in connection with other measures. While we know that alkalies are of benefit in gout and rheumatism, all know also that their simple exhibition, without due reference to other remedies, and dietetic and hygienic regulations, will never permanently cure either of these complaints.

In psoriasis, therefore, they must also be given in combination with and alternated with other remedies. Colchicum is often a great aid, and in sthenic cases aconite often assists greatly; prolonged alkaline treatment will often result in more or less anæmia, and iron and manganese will also come in as adjuvants, while strychnia, phosphates, cod-liver oil, and many tonics and reconstructives may be needed in fully overcoming the disease.

The proper use of water will also aid in the treatment. The acidity of the urine, as is known, is modified by free dilution, and the changes of assimilation and dissimilation, which are at fault in psoriasis, are hastened and improved by the free passage of water through the system.

Treatment by means of mineral springs has long been a favorite one in psoriasis, and undoubtedly many cases have been greatly benefited by the use of medicinal waters of many and various kinds.

One objection to the treatment of psoriasis by means of visits to mineral springs is that, as a rule, these visits must necessarily be short, and while they may possibly be of service at the time, it is impossible in this brief period so to modify the system that the eruption shall not return when the active treatment is omitted; the patient is often thus misled into a neglect of the proper, protracted course of treatment which can alone be of permanent benefit.

After many visits to many mineral springs, in this country and Europe, I have become more and more convinced that the single element which is of value is the water common to them all. I, therefore, advocate the free use of common water to psoriasis patients, taken, as at the springs, hot and on an empty stomach, half to one hour before meals. When very convenient to the patient, I also advise visits to mineral springs, as an adjuvant, during the summer months, when the regular treatment is apt to be neglected, owing to absence from personal supervision.

But as in pronounced gout simple medication will not remove and keep away the disease without aid from diet and hygiene, so in

psoriasis these aids are necessary. The effect of a full and stimulating diet is often shown in psoriasis by a rapid increase in the eruption, in its congested and irritable character, and in the freer production of scales; whereas a light and unstimulating diet, with total abstinence from alcohol, will often be followed by an improvement in the eruption. Everything which contributes to the production of an acid state of the system also tends to increase the skin difficulty, and every indulgence in sweets, pastry, fermented wines and beer, or spirits may precipitate an attack, and will always aggravate the existing eruption.

Excessive meat-eating will also increase the disease, which, however, will frequently improve with much greater rapidity, under the same treatment as before, when the quantity of meat taken is greatly lessened, or when it is entirely cut off. I have a considerable number of psoriatic patients who have taken no meat, or only a very little fish and white meat of poultry, with the result of being free from the eruption for a long period of time. Fatty matter, however, if properly digested, will aid in removing the diseased state.

Hygiene is also often of importance in psoriasis. This includes proper attention to the clothing worn, to exercise, and to the mode of life. Pure wool should be worn next to the skin, to prevent all chilling of the surface and check of perspiration, which I have repeatedly seen followed by outbreaks of the eruption. Exercise should be moderate, but sufficient to keep the circulation active, and this will often need to be inquired into and directed by the physician, as also the general mode of life, hours of eating and sleeping, etc., for few patients fully understand or carry out the rules conducive to a perfectly healthy life. A warm and equable climate undoubtedly contributes to the cure of the disease, and raw and damp cold climates, and sudden changes of season, tend to develop and perpetuate the disease. I have known patients to remain quite free from the eruption as long as they resided in the tropics.

The *local treatment* of psoriasis is undoubtedly very important, and very much can be done by it in the way of more rapid removal of the eruption present, and its use should never be neglected. Many remedies, including chrysarobin, pyrogallic acid, salicylic acid, naphthalin, gallaceto-phenon, aristol, and others, all are of great value, and by means of one or the other of them the eruption

may often be promptly removed. Bathing of various kinds, including sea-bathing, is also of much assistance. But it would lead beyond the limits intended to consider these in this paper, which is intended to show the importance of constitutional rather than local measures in obtaining the really best results in psoriasis.

The *prognosis* of psoriasis has always been most unsatisfactory. While all recognize that the eruption may be removed again and again by local treatment, the majority of writers imply, if they do not assert, that the disease is very uncertain of cure; and I find that this view of the case is taken more or less decidedly in proportion as the writer emphasizes more or less strongly the value of local treatment.

But to return to the remarks made at the opening of this paper: as in the case of syphilis, the ultimate cure depends largely upon the intelligence, faithfulness, and persistence put into the treatment, by both physician and patient, so in the case of psoriasis, its cure depends upon the same elements.

I believe that psoriasis can and should be cured; but as in the case of syphilis relatively few cases are commonly cured so as never to give further manifestations, so in psoriasis it is often extremely hard for the patient and physician to persist patiently in the plan of treatment which will end in a permanent cure.

It is very difficult, indeed next to impossible, to give any statistical presentation in regard to the cure of the cases which have been here analyzed, for in a consultation practice drawn from many quarters the patients are commonly lost sight of, and therefore rarely seen when freed from this trouble, even as in olden time only one of the ten lepers returned to give thanks for his cure; but from a considerable number of cases with whose later history I am acquainted I feel positive that sufficient knowledge, care, and patience on the part of the physician and patient will result in the real cure of this complaint, which has too often been relegated to the now lessening category of incurable diseases.

4 East Thirty-seventh St.

SYPHILIS IN THE INNOCENT

(SYPHILIS INSONTIUM),

CLINICALLY AND HISTORICALLY CONSIDERED,

WITH

A PLAN FOR THE LEGAL CONTROL OF THE DISEASE.

BY

L. DUNCAN BULKLEY, A.M., M.D.

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Internat. Jour. of Surgery, Sept., 1894.—"This work is the most important contribution to the literature of syphilis which has appeared within recent years."

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