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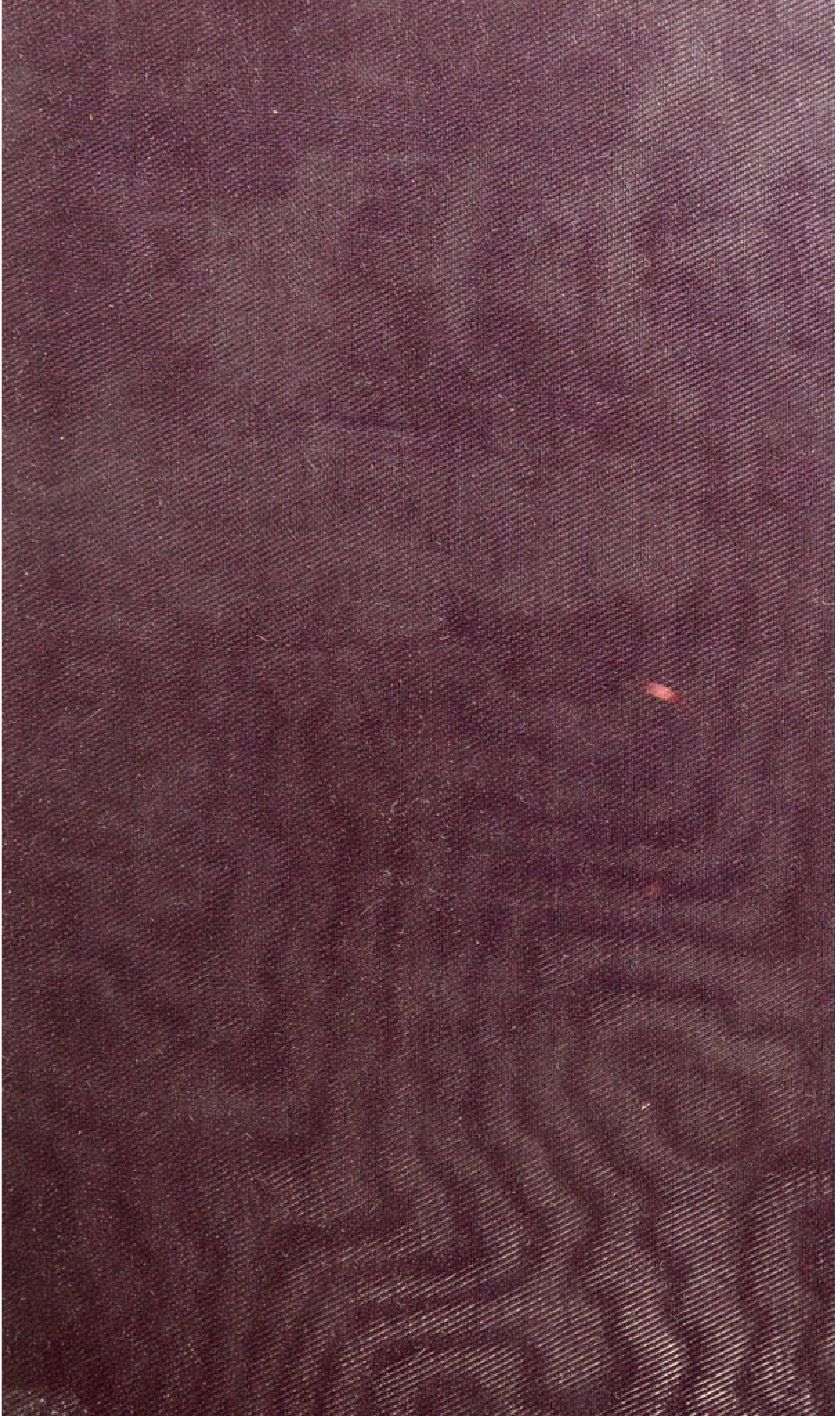

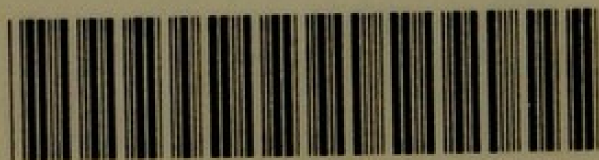
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OBSERVATIONS

ON THE

VARIOUS FORMS OF SUPERFICIAL DERMATITIS,

PARTICULARLY

ERYTHEMA, ECZEMA, PSORIASIS, LICHEN, AND PITYRIASIS RUBRA.

WITH CASES.

By P. H. PYE-SMITH, M.D.

The inflammatory affections of the skin are by far the most numerous and the most common, and it is here that all systematic writers have found the greatest difficulty. The classification now most generally accepted, that of the late Professor Hebra, was based upon the pathological doctrines of Rokitansky. Accordingly, we find a class Exudations, which takes up just half of the closely-printed pages of the 'Hautkrankheiten,' and yet does not include lupus, nor ulcers, nor inflammations due to syphilis. The subdivisions of this unwieldy class rest for the most part, not on *pathological* distinctions, but on the *anatomical* basis of Willan's system, while scabies is only separated from eczema by its *ætiology*, and pityriasis rubra is defined by its *clinical* features.

I have, in a former volume of these reports,[1] given reasons against this and the many other less successful attempts to classify diseases. These must always be attempts to classify objects which are not homogeneous, sometimes not even definable. If, however, we recognise the different aspects in which "diseases" may be regarded, we may usefully recognise the points in which they agree under each head, whether regarded as anatomical conditions, as physiological processes, as constant clinical combinations of symptoms, as results of antecedent causes, or, lastly, as amenable to curative agents. The first or histological method is useful for definition, the second or pathological for prognosis, the third or clinical for diagnosis, the fourth or ætiological for prevention, and the last or therapeutical for treatment.

Applying this principle to Dermatitis, we may first draw a marked distinction between the *superficial inflammations*, which affect the Malpighian layer of the epidermis and papillary layer of the cutis only, which never destroy the papillæ, and are therefore never followed by a scar, and the *deep inflammations*, which affect the subpapillary layer of the cutis and the subcutaneous connective tissue, which destroy the papillæ, and always leave cicatrices behind. To the former group belong all the common superficial inflammations of the skin of which eczema is the type, to the latter the deeper and more formidable lesions like lupus and tertiary syphilis. In both groups we distinguish *traumatic* inflammations, due to a known external irritant or injury, from those which are *symptomatic* of a more general pathological process, or which are independent and of unknown cause, *i.e. idiopathic*. Thus, among superficial inflammations, we distinguish Scabies and Eczema solare, and Prurigo pedicularis, as traumatic, from the symptomatic eruptions due to Scarlatina or to Syphilis, and from those which depend on some unknown condition of skin itself. And in like manner we distinguish the deep inflammation caused by a burn from that due to the formation of gummata or of tubercle beneath the papillæ of the cutis, and from the autochthonous processes of Leprosy or of Lupus.

Confining our attention to the more numerous and difficult

[1] Third series, vol. xxii, p. 151.

group of superficial inflammations of the skin, we have no difficulty in separating from the rest so well-marked and peculiar a disease as Zona, the inflammations due to Syphilis, the usually slight inflammations caused by the presence of a parasitic fungus, and the special effects due to vermin, Scabies and Prurigo pedicularis. The remainder, regarded clinically as well as physiologically, appear to fall into the following large divisions :

1. Symptomatic Eruptions, including the Exanthemata and Syphilodermia. These scarcely need treatment as eruptions, but are of value for recognition of the disease of which they are parts.

2. Allied to these as not being traumatic are the Erythematous rashes, which also agree with most of the first class (as measles, scarlatina, enterica) in their anatomical characters, but differ by being not certainly associated with any other morbid conditions. They resemble each other in their slight degree of severity, their fugitive course, their wide and capricious distribution, and their greater frequency among the young.

3. Common superficial dermatitis, *i.e.* such as can be produced in the great majority of skins by an appropriate irritant. Usually traumatic in origin, but probably always combined with a certain vulnerability which responds readily to irritants, which keeps up the dermatitis when the exciting cause has passed, and which sometimes seems sufficient alone to produce a spontaneous or idiopathic dermatitis. This group includes all varieties of Eczema.

4. A group of which Psoriasis is the type and almost the sole representative, peculiar in histology and in form, incapable of being produced by any known irritant, slow in progress, apt to recur, definite in distribution, unconnected with internal as with external causes, and with its inflammatory character but slightly marked.

5. Lastly, there are the rare, but most interesting, cases of superficial dermatitis, which are universal, which differ from other diseases in their form, which are often accompanied with pyrexia, albuminuria, and other signs of general disturbance, and which not unfrequently end fatally.[1]

[1] Of pemphigus, the most important of the idiopathic superficial inflammations

In the following pages I propose to record cases and offer observations on *Erythema* and its allies, on *Eczema* and traumatic dermatitis, on *Psoriasis* and the interesting disease known as *Lichen planus*, and, lastly, on the *Pityriasis rubra* of Hebra and exfoliative dermatitis of Wilson.

I. Erythema.

If we define erythema anatomically as a superficial dermatitis which does not go beyond the stage of papules, it is impossible to recognise it as a disease. For the term will then include scarlatina and measles, syphilis and enterica, many cases of scabies, and most of prurigo. If, however, we fix our attention on clinical and not only on anatomical features, we shall, I think, admit a natural family of affections of the skin—for the most part obscure in origin, and chiefly important for their resemblance to more serious maladies—which may be fairly called the erythematous group.

We must, however, separate off such slight local dermatitis, set up by external irritants, as intertrigo and the so-called *Erythema leve* of anasarca. These bear the same relation to idiopathic eruptions of the same kind, as *Eczema solare* to true idiopathic Eczema, as pustular inflammation from pediculi capitis to ordinary impetigo of the scalp, or as wheals caused by a stick or a nettle or a caterpillar, to idiopathic urticaria.

Next must be separated cases of abortive or papular eczema, which may be identified by their recurrence, their localisation, and by their being preceded or followed by ordinary "moist tetter."

Thirdly, we exclude erythema where it is merely a concomitant of another primary external lesion, as in prurigo, where the erythema or urticaria so often seen is the result of the patient's scratching.

Fourthly, we put in a separate group erythema which is merely a symptom of an internal primary disease, as in measles.

Is the remaining group of idiopathic non-contagious Erythemata natural and homogeneous?

not mentioned in the above list, I hope to offer some observations in a future volume of these Reports.

If we turn to Willan's species of Roseola and Erythema, we shall find no real pathological distinction between them, except in the case of *Erythema nodosum*. Nor do I think that Hebra made a valid distinction between mere hyperæmia (under which he includes several unimportant forms of roseola and erythema) and inflammatory Erythema (*E. exudativum*).

"Roseola," if the term is to be kept at all, should mean a rose-rash without papules, due to whatever cause. Hebra includes two varieties of "Erythema," *E. multiforme* and *E. nodosum*. To these may, as clinical allies, be added *Urticaria*, and two erythematous inflammations of the skin, which go beyond the stage of papules: *Erythema* (or *Herpes*) *iris* and *Erythema bullosum*.

The erythematous group of diseases thus formed agree in the following points:—In their acute or at least subacute course; in not spreading; in frequent return under similar conditions; in causing considerable local irritation; and in leaving no trace behind. They resemble the rashes of measles and early syphilis by a patchy and irregular distribution. They rarely affect the scalp or the flexures of the joints. They are more often seen in children and young adults than in those who have past their prime. The anatomical condition is one of active hyperæmia, often accompanied with acute œdema so as to form wheals, and occasionally producing pimples, vesicles, or blebs. When the congestion is chronic and venous, the œdema may be accompanied with hæmorrhage, as in *Erythema nodosum*.

We know little of the causes of these diseases and less of their rational treatment. They are seldom or never due to an external irritant, but some cases of general erythema and of urticaria are undoubtedly connected with gastric irritation from certain articles of food or from drugs; and this fact makes it probable that other apparently similar cases (especially in children) are also due to slight gastric disturbance. Again, some cases of urticaria, of ordinary erythema (peliosis), and of erythema nodosum, are coincident with attacks of rheumatic fever.

All dermatologists of experience admit the close clinical connection between ordinary erythema and urticaria. I need, therefore, give no cases in illustration of it; but will here

record a few examples of the rarer erythematous affections which are attended with vesicles or blebs.

Vesicular or herpetic erythema.—The outbreak of a little group of clear vesicles on an inflamed patch of skin is not enough to constitute a disease, and there is nothing but an anatomical likeness between the several "species" of Herpes which have been admitted by authors. Willan recognised the distinctive characters of a herpetic eruption and rightly defined it from the anatomical point of view. The species of the genus given by Willan and Bateman are *H. phlyctænodes, H. zoster, H. circinatus, H. labialis, H. præputialis,* and *H. iris.* The first of these, preceded by two or three days' fever, irregular in locality, and appearing in successive clusters for nearly the space of a week, may probably refer to zona occurring in other regions than the chest. The third is ringworm of the body. Hebra admits the remaining four species, *H. labialis* vel *facialis, H. præputialis* vel *progenitalis, H. zoster* vel *zona,* and *H. iris,* including non-parasitic circinate forms. The pathological characters which he gives as common to these varieties are their acute, typical course, their spontaneous involution, and their recurrence at regular intervals. That they are all rapid in their course and curable without interference, is no doubt true, but this is surely not enough to outweigh the marked clinical differences between *H. labialis* and *H. zoster.* Herpes of the face and Herpes of the genitals agree in sometimes recurring, but recurrence of zona is at least as rare as that of scarlatina. Most modern dermatologists therefore separate Zoster (or zona) altogether, in name as in nature, from Herpes. The rare and curious affection called Herpes iris is best grouped with Erythema, as Rayer taught long ago. It may be called *Erythema iris* with Neumann, or simply Iris. One word is better than two, it is distinctive and does not at all events mislead.

The two remaining species of Willan and Bateman may be well united under the name Herpes, the locality affected being indicated by an adjective. This has been done already by Dr. Liveing and other good observers, who have called them febrile, catarrhal, or symptomatic Herpes. Beside the well-known anatomical appearance of the lesion, this disease is characterised

by its acute course, by its spontaneous cure, by its localisation in the neighbourhood of one of the orifices of the body—the nostrils, mouth, urethra or ear—by its not being accompanied by neuralgia, by its frequent recurrence, and by its association with irritation of the cavities near which it appears. I am not aware that it has ever been observed in the neighbourhood of the rectum, but from its painless and rapid course it would be apt, if it did occur here, to be overlooked.

Erythema iris.—CASE.—One of our students, a young man in vigorous health, came to me with a perfect example of the classical "Herpes iris" upon the back of his hand. It measured an inch in diameter and consisted of a bulla in the centre, a circle of vesicles, then a well marked injected circle, and lastly, an imperfect vesicular circle at the circumference of the patch. It was unattended with pain or notable irritation, and disappeared in a week. There was no ground for connecting it with indigestion or with any local irritant, and there was no rheumatic history, direct or indirect.

Another case of typical Iris occurred in the practice of Mr. Waren Tay, which he was kind enough to send for me to see. The patient was a boy of thirteen very subject to chilblains. Beside bullous erythema of the feet and ears he had two Iris circles on the back of one hand.

I have now under my care a similar case of *E. bullosum* and iris in a lad of seventeen.[1]

E. bullosum is often a mere variety of *E. congestivum* or *pernio*. One sees occasionally cases which resemble a broken chilblain in appearance, but which differ from it by their localization, or their occurrence apart from cold, or their more rapid course.

CASE.—A well-nourished, healthy shop-girl came to me on the 13th of May, 1879, with livid, swollen, pernio-like patches on the fingers, the back of the hands, and the palms. Several had small bullæ upon them. She said that she had never suffered from chilblains of the hands or feet.

I have seen several other cases, both of ordinary chilblain

[1] Dr. Frederick Taylor and Dr. Crocker have lately brought several cases of vesicular and bullous Erythema, Hydroa, or Herpes iris before the Clinical Society (Feb. 25, 1881).

and of bullous erythema not apparently connected with cold, affecting the palms of the hands and the soles of the feet. In one child of five years both soles were severely affected, a bubo had formed in the thigh, and it looked at first sight not unlike a bullous syphilide.

CASE.—In June, 1879, a girl of 18, came to me on account of a distressing "flushing" of both cheeks. There was a permanent erythematous patch on the left cheek, livid in colour, with slightly enlarged veins. I was assured that occasionally little bladders formed on such a red patch on the cheek or nose, and exuded a little clear watery liquid. Three weeks later she came again to prove the correctness of the statement, by showing me four or five vesicles on an injected patch on the right cheek. These were as big as split peas, and one had already burst, exuding a drop of transparent yellow serum. The skin was not thickened. There was an erythematous patch on the other cheek also. I could find no connection of this troublesome disorder with the menstrual function, but the patient was subject to flatulent dyspepsia, and also to chilblains (of the feet only) in winter. I advised strict diet and horse exercise, and prescribed alkalies and laxatives, with the local application of collodion. The latter application, she told me afterwards, often stopped it when she was sure it was going to appear by the premonitory flushing and tingling of the face.

A curious erythematous affection has been recorded by Mr. Morrant Baker, the late Dr. Tilbury Fox, Dr. Sangster, and Dr. Cavafy, under the name *Urticaria pigmentosa.*

CASE.—Dr. Goodhart was kind enough to send me a case of this disease from the Evelina hospital. Solomon G—, a child of two years old, has, from the age of three months, been affected with an eruption of rather large, discrete, yellowish-brown papules. They cover the greater part of the back, chest, abdomen, and adjacent parts of the arms and thighs. The hands and feet and the head and neck are free. The rash was not affected by the process of teething. There were two or three fresh wheals of urticaria with erythematous injection around.

I have seen two very similar cases under the care of Drs. Barlow and Sangster. The following case in an adult may, perhaps, be classed as an allied form of Erythema. It also

throws light on the origin of certain forms of Melanodermia and Leucodermia.

Case.—Eliza B—, æt. 32, lady's maid, of somewhat dark complexion, was sent up to me by Dr. Thos. Fagge, of Ascot, at the end of November, 1880. There was no history of affections of the joints or the skin in the family. She herself had suffered from rheumatic fever at twelve years of age, and had since been liable to palpitation of the heart.

Four years before I saw her, brownish red patches appeared on the abdomen. They itched, though not severely, and they have never entirely left her. Lately she has had a similar rash upon her back. On admission to the hospital she presented a nearly uniform reddish eruption over the back, made up of more or less circular patches, very slightly elevated, smooth, and of a yellowish tinge, which does not disappear on pressure. There are no papules, no scales, and no well-formed wheals. On the abdomen the patches are more separate and gyrate in form, the inside being pale and the edge strongly pigmented. The eruption extends to the flanks, nates, thighs and shoulders, but the head, chest and limbs are free. She says it itches, but there are no scratch marks. I had a watercolour drawing taken by Mr. Hurst, and after other means had been tried, found belladonna liniment successful in relieving the irritation. After eight weeks there was no other improvement. She was soon after attacked with rheumatism, recovered well under salicylate of soda,[1] but had a relapse, which detained her until the end of April, 1881. At that time the redness and irritation had disappeared, but the pigmentation remained.

II. Eczema.

Definition and varieties.—Excluding traumatic dermatitis, *i.e.* cases of eczematous eruption in which the lesion corresponds in extent and in duration to the operation of an external irritant, we may perhaps usefully recognise the following as the most important clinical varieties of "eczema," *i.e.* of common, idiopathic,

[1] In this patient, as in many others taking salicylates, I have found the urine reduce copper.

superficial dermatitis, which has reached or will reach the stage of exudation.

1. The most numerous and characteristic group of cases, those which may be called *typical eczema.* The patients may be of either sex and of any age, but are more often young or middle aged adults than children or aged persons. The eruption begins as a papular erythema, but the papules rapidly become small, thin walled, superficial vesicles, which so readily burst under friction that (although almost always present if looked for at the right time) they are in most cases practically absent. A weeping surface thus forms, over which the traces of vesicles may often be discerned (*état ponctué*). As the profuse secretion subsides, thin yellowish crusts appear, the dry surface becomes covered with small dingy scales, the redness and infiltration gradually subside, and the skin returns to its normal condition. Only rarely is accumulation of pigment observed, and never formation of scars. The course of the disease is more or less acute at the outset, but soon becomes chronic, and is apt to return after cure. The distribution is characteristically limited to the thin skin of the flexor surfaces, the favourite places being the bend of the elbows, the hams, and the back of the ears; next, the face, neck, arms and hands, axillæ and groins, abdomen and genitals, thighs and legs; while this form of eczema is rare on the scalp, buttocks and feet. Always more or less symmetrical, it is often as exactly so as psoriasis. Lastly, it is almost always accompanied with itching as well as smarting.

With respect to the pathology of this commonest and most characteristic form of eczema, I confess that I am quite unable to recognise its association with any other disease, or with any supposed diathesis, constitution, dyscrasia, or temperament. It has, I believe, nothing to do either with rheumatism (*i.e.* multiple synovitis with pyrexia) or with gout (arthritis with deposits of urates of soda), or with scrofula (caseous infiltration of lymph glands), or with rickets, or with anæmia, or with gastric or uterine disturbance. No doubt we see cases of eczema in conjunction with each of these conditions; if this never happened, we should have to investigate the reason of such mutual exclusion; but I believe that it is essentially a disease of the skin and nothing else. As to the blood espe-

cially, we have not, so far as I know, the least reason to suppose that its condition in eczema differs from that of health.

2. *Universal eczema.*—This is a rare form of disease, and many of the supposed cases of it are probably better described as exfoliative dermatitis or pityriasis rubra. But a universal, common superficial dermatitis may occur, which by its localization (when it first appears or after it has become chronic), by its return as a less general affection, or by other characters, claims the title of genuine eczema.

Case.—Alexander B—, æt. 14, came among my out-patients towards the end of 1877 with inveterate and universal eczema. It was clear that he could not have the necessary attention at home, and I therefore took him into the hospital. He was a thin, miserable lad, of naturally dark complexion; and his whole body had acquired the colour of a mulatto by the gradual increase of pigment. His father and mother and their other children were of ordinary colour and had healthy skins. It appears that he was a healthy baby, but at five years old began to suffer from "scald head." This gradually spread over his body, and though often better and worse has never left him for nine years. On admission, there was dry scaly eczema of the head, face and neck; the ears were fissured and blood-stained, as was the right axilla. The eruption on the arms and back was papular; on the abdomen, genitals, perinæum, nates, and thighs, red and profusely weeping. Except the palms, soles, and part of one shoulder, there was no part of the body free from the disease. The viscera were normal, the urine free from albumen, and the appetite good. Under ordinary local treatment and steadily increased doses of arsenic, in spite of occasional interruption from sickness, the disease rapidly improved, and after five weeks the lad went out with an almost healthy skin. He has several times shown himself again when there has been a slight return of eczema of the scalp or ears, but in other respects he continues well, and has grown into a stout healthy lad; the whole skin continues remarkably dark, but is smooth, soft, and in every other respect normal.

3. *Impetigo.*—The pustular form of common superficial dermatitis as it affects the scalp or face of children is very characteristic and well known. It includes the "scald head," *achor* or

Crusta lactea of older writers, Willan's *Porrigo larvalis* and also *P. favosa*, the *Impetigo larvalis* of Bateman, *Teigne muqueuse*, *Eczema impetigo*.

It rarely affects infants before the scalp is well covered with hair, and still more rarely adults, although we have lately had several cases of typical impetigo of the scalp in both men and women. The exudation is not the characteristic albuminous secretion of eczema, but is purulent, forming thick massive crusts. The eruption is in patches; it is accompanied by comparatively little itching; instead of affecting the ears, limbs, and bend of the joints, it is at first confined to the scalp or face, especially the lips and nose, and when it spreads elsewhere appears to do so by direct inoculation. The three conditions to be distinguished from this true idiopathic pustular dermatitis, are, (1) the pustular inflammation of the occiput caused by pediculi, almost exclusively confined to children, and readily cured by removing the irritant; (2) scabies, which may be little developed on the feet or hands or nates, or may even have been cured and yet has by inoculation of its pus produced "impetigo" of the face or scalp of the child; (3) true ringworm, either obscured by the inflammation it produces, or more often concealed or even supplanted by the severity of the applications which have been used to destroy the fungus.

That impetigo of the scalp and face in children is really a pustular form of eczema is proved, by an ordinary eczema of the scalp or face in an infant becoming pustular and crusted as the patient grows older, by impetigo in a child assuming the characters of common eczema when it recurs, and by impetigo of the scalp being associated in the same patient with vesicular or weeping eczema of other parts. We may connect its pecularities, first, with the age of the patient. The skin of children appears to be more prone to suppurate than that of adults. Not only eczema but scabies is more often pustular with them; and the scattered pustules of doubtful origin which go by the names of ecthyma and impetigo sparsa are almost confined to children. Secondly, the presence of large and numerous sebaceous glands seems to lead to suppuration, when the surface is inflamed. We know how readily pustules form within the nostrils and in the eyelids (hordeolum), over the shoulders, on the face (acne), and in the beard (sycosis). When eczema spreads to the head in adults

we occasionally see a true impetigo result, but I have never seen pustular eczema on a bald head; here it produces its ordinary clear secretion. Moreover, impetigo is seldom seen on the downy scalp of an infant.

4. *Eczema of the lips.*—This is a curious and somewhat rare form of superficial dermatitis, which used to be called psoriasis labiorum. Its true nature is shown by sero-purulent secretion being present, though in small quantity and forming very thin scabs, and by its association with eczema elsewhere, especially with impetigo of the face. Thus, a little boy with this affection in its most marked form, had also a few pustules on the scalp and ordinary eczema of one ham. Its peculiar appearance is due to the thinness of the skin of the prolabium leading to hæmorrhage, so that the crusts are brown or black and massive. It sometimes affects the lower lip alone. All the cases I have seen have been in children or young girls. The treatment I have found successful is removal of the crusts with bread poultices and application of our Unguentum metallorum.[1] The patients are often pale and are benefited by steel.

5. Eczema rimosum, rubrum, squamosum, of the hands, including the so-called grocer's and baker's itch, and most cases of what has been called psoriasis palmaris. I have seen two or three cases of true psoriasis of the palms associated with ordinary unmistakable psoriasis, but I believe it never occurs independently. Such cases are either *syphilis squamosa* of the palms and soles, with its small, scanty, dirty scales, its dry surface, its symmetry, and its predilection for the inner side of the sole; or else they are true eczema in its squamous stage.

6. Eczema of the anus, perinæum, vulva, or male genitals, extremely irritable, weeping, very rarely pustular.

7. Eczema of the outside of the forearm and legs. A form not uncommon in adults, usually rather acute in its onset, appearing in separate round patches, sometimes vesicular, more often presenting the appearance due to broken vesicles, which was described by Devergie as *état ponctué*. Sometimes spreading to the thigh and upper arm, but rarely to the hand or foot; and rather avoiding the usual position of eczema at the elbow and ham.

[1] Containing equal parts of Ung. Zinci, Ung. Plumbi Acet.; and Ung. Hydr. Nit.

8. Eczema or dermatitis intertrigo, always weeping and painful, characteristically affecting the folds of the neck in infants, the mammæ in women, the nates, the thigh and scrotum, the groins, and occasionally the toes. I have never seen it on the eyelids or between the fingers.

9. Eczema or dermatitis of one or both legs above the ankle, depending on venous delay, weeping and confluent, œdematous, very chronic, rarely seen before middle age, and often combined with varicose ulcers.

10. The very chronic pruriginous eczema seen in old persons; the lesions usually papular or scaly, with little moisture. To this group belong the worst cases of eczema genitalium and eczema podicis.

11. Chronic, dry, "single-patch" eczema, not itching and lasting for years unaltered. In a patient now under my care, a man of sixty-five, such a patch appeared at forty on the inside of the left thigh, lasted upwards of twenty years without any change, then disappeared, and has for the last eighteen months been succeeded by a similar dry non-irritable patch, as large as a crown piece, on the inside of the right forearm. The old place was called psoriasis, probably incorrectly; this one, which he tells me is just like it, is undoubted eczema, with abortive vesicles. The patient is a hearty man, who has lived freely, but never suffered from gout or anything like gout or rheumatism.

12. *Lichen tropicus,* the acute, intensely irritable, papular, and almost universal "prickly heat" of the tropics. I have lately had two well-marked examples of this curious affection under treatment.

Case.—The patient is a remarkably tall, well built man of thirty. He was for several years a soldier in the East Indies and was then attacked by this disease. He drank freely, but could not connect the outbreak with a particular debauch nor with any other exciting cause. He has been home some months, and is still much troubled with what is now a very irritable papular eczema. The parts affected are the abdomen, groins, and buttocks; the perinæum and genitals are free. There are also a few scattered papules on the forearms and on both thighs. The irritation continues great, as is testified by numerous scratch marks, but it does not give rise to urticaria. Under

abstinence from drink, free diluents and laxative medicine, he soon improved. The local treatment we found best was an ointment of one drachm of boracic acid made up with equal weights of white wax and lard, softened with oil of almonds. It happened that one of the gentlemen present when this patient appeared had been in Bombay, and another in Australia, and both recognised this affection as the prickly heat with which they were familiar.

Case.—A soldier, æt. 27, came to me with a papular and pustular eruption distributed over the trunk and limbs; most severe on the abdomen, buttocks, and thighs. The head, face and neck, the hands and feet, and the genitals are quite free. It is very irritable and there are numerous scratch marks. The general aspect is more like prurigo than ordinary eczema. There are some erythematous patches with small wheals from scratching. He says that he had the eruption when he first went to Bengal in 1878. It disappeared in the cold season but returned with the heats. He got rid of it during his voyage home in December, 1880, but it has reappeared this spring.

These are the clinical varieties of eczema which seem to me to be most worth recognising for the practical purposes of diagnosis and treatment. They are varieties, not separate diseases, each of the local kinds being liable to spread into the more common and generalised eruption, and each of the pathological species being liable to assume one of the allied forms. They are all *common* inflammations, *i. e.* such as can be produced at will by an irritant; all *superficial,* not deeper than the papillæ, and therefore, however severe, never followed by scars; all "*moist tetters,*" *i.e.* the inflammation is severe enough to cause at one period or other a visible exudation, presenting according to the stage and locality an injected surface, papules, vesicles, raw weeping surfaces, cracks or fissures, pustules, scabs or crusts, a dry, red surface, or branny desquamation. But we never see produced the imbricated scales of psoriasis, nor the large grouped vesicles of zona, nor the rings of tinea, nor the bullæ of pemphigus, nor the large, thin, adherent plaques of exfoliative dermatitis, nor the polymorphic lesions of syphilis. Lastly, all these varieties of eczema are more or less accurately symmetrical, more or less irritable, and run a chronic course, with great liability to relapse.

Ætiology.—On the one hand, we must never lose sight of the fact that eczema is anatomically a "common" superficial dermatitis. For convenience we restrict the name to one which has reached the stage of visible liquid exudation. The exudation may be plasma with but few leucocytes and little fibrinogen, the non-coagulable lymph or "serum" of the older writers, consisting almost entirely of the water, salts, and albumen of the blood: we then have the typical vesicular or weeping eczema; the discharge is abundant, watery, irritating from its saline character, and characteristically stiffening linen from its albumen—*instar seminis,* like white of egg, *comme les sirops.* Or the exudation may be richer in leucocytes than the liquor sanguinis, and these rapidly dying and undergoing fatty degeneration form the opaque, yellowish, milk-like lymph known as pus. But essentially the inflammation is the same, and we see it in all its forms and stages, not only in the various kinds of eczema enumerated above, but also in scabies, which, though rightly distinguished clinically, is nothing but a common dermatitis set up by a special irritant, the eczema of the acarus, or, as Hebra called it, "Scabies eczema."

On the other hand, we must recognise something besides an irritant, namely, an irritable skin. Often none but the ordinary conditions of the skin as to heat, moisture, cold, and friction can be discovered. Even when we can recognise an exciting cause, as in eczema solare, or in scabies itself, we see that the *quidquid irritabile,* as well as the *quidquid irritans,* is necessary; for two men may be equally exposed to the sun yet only one will be sunburnt; two women may be washing at the same tub, but only one has chapped hands; two children are infested by itch-mites, yet one has only the burrows to show and slight local irritation to complain of, while the other is covered with pustules, scabs, and blisters, over regions which the acarus never visits.[1]

Now, what is this *quidquid irritabile* which makes an eczema of a traumatic dermatitis? It is not the normal skin, or we

[1] As in a case of severe bullous scabies, affecting the face as well as the trunk and limbs of a little boy. 'Guy's Hospital Reports,' Series III, Vol. xxii, p. 164, plate I.

should all have eczema from the friction of our clothes and the irritation of soap and water.

It is not "dyscrasia" of the blood or any other "humour," for there is not even a pretence to prove that the blood of eczematous persons differs from that of others.

It is not a poison, an "acridity" circulating in the blood, for why should it affect the skin, and certain parts of the skin only, while the more tender conjunctiva and the more vascular mucous membranes escape? Moreover, in syphilis, where really an infective something is conveyed by the lymph and blood-stream to the skin, the lesions there produced are anything except eczema. When other irritants are carried to the skin —iodides, bromides, belladonna, copaiba, &c.—they produce rashes which simulate, we may almost say which are, acne, erythema, ecthyma, but never what could be mistaken for eczema.

It is not "defective innervation," for if the central nervous system is at fault, why have we no evidence of the brain or spinal cord being affected? If a reflex paresis is set up, what is the seat of the primary irritation? If the fault is in the peripheral nerves, then it is after all a mere local affection of the skin. Besides, we know that in the cases best established of lesions due to injuries of trophic nerves, sloughing of the cornea after division of the fifth, wasting of muscles in amyotrophic lesions of the anterior cornua of the cord, Mr. Hilton's case of ulcer of the finger from pressure on the ulnar nerve,[1] the glossy skin after injury to nerve trunks,[2] in all these and other more doubtful instances we find either gangrene or atrophy, not eczema, as the result of "defective innervation." But, more important still, we have in zona an affection of the skin which is inflammatory, and which is also clearly connected, by its distribution, by the neuralgia which accompanies or follows or occasionally precedes it, and by direct anatomical post-mortem evidence, with a lesion of the ganglia of cutaneous nerves. Yet zona is not eczema.

It is not a general "constitution" of the body nor a "diathesis" or disposition of the organism; for we see eczema

[1] See Mr. Jacobson's Edition of 'Hilton on Rest and Pain,' 3rd edition, p. 200.

[2] In cases of gunshot wounds in the American Civil War reported by Surgeon Mitchell.

in persons of all ages, of both sexes, of all races, weak and strong, thin and fat, pale and rosy, dyspeptic and robust, gouty and free from gout.

As to the existence of a herpetic diathesis I shall have to speak presently, when discussing the ætiology of psoriasis. But even granting that there is such a thing, we find no practical agreement among its most eminent supporters as to its limits or its signs. While Prof. Hardy and most of his disciples regard eczema as "l'expression type de l'herpétisme," and only admit in addition lichen, psoriasis, and pityriasis, others, like M. Gigot-Suard, of Cauterets, include under "manifestations primordiales de l'herpétisme" (beside all forms of eczema and impetigo, psoriasis, lichen and pemphigus) acne rosacea, prurigo, urticaria, pityriasis, furunculus, and many more; under *Herpétides muqueuses,* most internal diseases; and as "manifestations ultimes de l'herpétisme," consumption and cancer.

M. Bazin, again, distinguishes between herpétisme (the dartrous diathesis) and arthritisme (the gouty and rheumatic diathesis), and classifies the varieties of eczema according to their ætiology as traumatic, scrofulous, herpetic or arthritic. "*L'eczéme n'existe pas comme entité morbide. C'est une affection générique appartenant à l'ordre des vésicules que l'on retrouve dans plusieurs maladies dont elle ne doit être considérée que comme la manifestation.*[1] The following are the characters by which herpetic may, according to M. Bazin, be distinguished from arthritic eczema:

Eczéma herpétique.	*Eczéma arthritique.*
Spreads.	Circumscribed patches.
Limbs chiefly affected.	Uncovered parts or mucous orifices.
Symmetry.	No symmetry.
Free secretion.	Dry, or scanty secretion.
Bright red.	Deep venous red.
Frequent recurrence.	Persistent.
Itching.	Smarting.
Frequent metastases.	No metastases, but previous affections of the joints.

[1] Bazin, 'Examen Critique,' p. 76.

Now, the second column seems to describe the local chronic pruriginous eczema of the anus and vulva, the first common eczema; but I venture to think that itching is more severe in local circumscribed eczema than in ordinary weeping eczema of the face or limbs. As to "metastases" I suppose few pathologists believe in them, but if ever they occur it is rather in the chronic dry eczema of the aged than in the acute moist tetter of the young.

Instead of saying dry eczema means *arthrite,* wet eczema means *dartre,* and pustular eczema means *scrofulide,* when each of these words is so vague and elastic that the assertion is almost as hard to disprove as to prove, surely what facts warrant us in saying is that pustular dermatitis is more frequent on the face and scalp, and profuse secretion on the thin skin of the flexures; that impetigo is commoner with children, and dry chronic eczema with persons past their prime.

When eczema occurs in a thin, pale child, whether with caseous lymph glands or no, we all agree in giving steel and cod-liver oil; when it occurs in a person who has had gout we prescribe colchicum; and when it occurs in a person who bears traces of malaria we add quinine to local treatment, but beyond these limits I do not think that an unprejudiced judgment can at present go. Most cases of eczema are idiopathic, neither traumatic or "diathetic," and we cure them best by local treatment.

Though believing that the true line of progress in dermatology was from Willan to Hebra, and that the fancies of Alibert have been purely mischievous, I do not deny the services of his successors at St. Louis, and especially of M. Hardy. The advance which we owe Biett in recognising the group of *syphilides* is most important and the ætiological classification which we are now discussing is the ultimate one and the most practically useful of all. But we must follow only proved facts and distrust the guidance of ill-defined terms which are themselves the survivals of systems long proved false.

I admit that the question is much altered in the hands of one who is not a specialist, but a sound pathologist as well as an eminent surgeon. Mr. Hutchinson would associate together as "dartres," diseases which are characterised by relapsing, by symmetry, by chronic and obstinate course, and by distribution

on circumscribed patches rather than diffusely. We are asked to believe that these diseases are due to some unknown constitutional condition which may be called the dartrous diathesis. The diseases so classed by Mr. Hutchinson are psoriasis, pemphigus, many cases of eczema, and a few of lichen, with certain forms of lupus. This list differs from M. Bazin's and from M. Hardy's. If such a clinical group is to be made I should be inclined to add prurigo and pityriasis rubra. But, while recognising certain likenesses between each, each also differs from the rest, and resembles some other affection. I should prefer to admit that all these diseases approach more or less near to psoriasis, but of this I shall presently have to add a few words. With regard to eczema I will only say, that while some chronic dry forms come near to lichen, prurigo, and psoriasis, and some acute and generalised forms approach exfoliative dermatitis and pemphigus foliaceus, the ordinary moist tetter shows rather contrast than likeness to psoriasis, the pustular form differs in almost every point from the "dartres," and some chronic cases of eczema simulate lupus, or elephantiasis, as closely as others do its supposed herpetic allies.

Treatment.—With respect to treatment of the various forms of eczema I have enumerated, the first condition of success is I believe to recognise that the condition is one of ordinary inflammation of the Malpighian and papillary layers of the skin, not "constitutional" or "diathetic," any more than inflammation of the kidneys or of the stomach.

Next, we must look carefully for sources of irritation. It is remarkable that ordinary squalor and neglect produce pustular eruptions, but seldom true eczema; and vermin lead to prurigo or to urticaria, but seldom to eczema. Nor is eczema produced by animal poisons, as are the pustular and erythematous eruptions which we see in the hide workers of Bermondsey, and in butchers. Eczema is the result of the irritation of sweat or of friction, or of exposure to fire, to hot sun, or cold wind. Still more frequently it is produced by the mechanical or chemical irritants used in various trades; as the water in which the washerwoman's hands are kept half wet and half dried, and the coarser kinds of sugar handled by grocers. Eczema of the anus and genitals again may sometimes be

traced to want of scrupulous cleanliness in adults as well as in children.

We must also, in all cases of pustular dermatitis, remember the contagious property of pus, varying greatly in degree, but never to be lost sight of. Many cases of impetigo which seem at first sight to be idiopathic, can be traced, especially in children, to inoculation by the nails from a few pustules produced by scratching an occiput infected with pediculi, or to similar inoculation from a whitlow, from an inflamed phimosis, or from the sores produced by accidental injuries. The spread of scabies itself is not only due to the direct irritation of the acarus and the secondary irritation of the patient's nails, but also to the contagion of the pus. So, again, we see furunculi and ecthyma appear in crops from a single primary source of suppuration.

In most cases, however, and particularly those of the most typical kinds of eczema, we find no traumatic or infective origin. They are strictly idiopathic. Between the purely accidental dermatitis, to which all skins are liable under irritation, and the purely idiopathic eczema where no irritating condition can be found, there is every gradation. As in catarrhal pneumonia, as in dyspepsia, it commonly takes two to make a quarrel. Some persons are exposed to cold yet do not cough, others eat too much and too fast yet suffer no remorse. All I venture to maintain is that the difference between one person and another is not in the "constitution" or "diathesis," but in the anatomical structure (hereditary or otherwise acquired) of the lungs, or of the stomach, or of the skin.

We must then, regarding eczema as dermatitis, treat it like other inflammations, and first and most important is *local* treatment.

We relieve the inflamed skin from the friction of the clothes and as much as possible from that of movement. We protect it from air by rags soaked in lotion, or by smearing it with unguent, or by dusting it with an indifferent powder. And thirdly, we must protect it from water, or rather from the change from moist to dry by evaporation, which is the result of washing.

The late Professor Hebra published not long before his death a characteristic and amusing lecture on the deleterious effects

of water upon the skin.[1] Few of us can be convinced that the daily tub will do healthy English skins anything but good. But there is no doubt that not only soap and water but water alone may be an irritant to an inflamed skin, just as food which is suitable to the stomach in health may be an irritant in gastritis. If we keep an eczematous surface under water, it is soothing so long as the temperature is the same: a continuous bath is sometimes excellent treatment, and there is no objection to the water dressing except from the heat it maintains. But we shall do wisely to forbid washing in the ordinary way in most cases of eczema. Oatmeal, or gruel, or size baths are soothing as well as cleansing if of proper temperature (about 90° F.), and if continued for at least a quarter of an hour; but they are more useful in cases of prurigo, especially infantile prurigo, than in eczema, and should only be used in this disease when the surface affected is large and the secretion free. In eczema, and especially in impetigo of the scalp, the hair must of course be cut short, or in severe cases shaved, the crusts softened with poultices and prevented from re-forming by oil, and the scalp kept clean with equal parts of strained white of egg and water; even this should be sparingly applied and scrupulously dried.

What we want to procure is uniformity of condition. All irritants to living tissues, mechanical, chemical, or what not, are more or less sudden changes. It is possible to heat a frog's muscle until the myosin is coagulated without producing a twitch, or to introduce a constant voltaic current into a nerve, gradually to increase its strength until it much exceeds that of an efficient stimulus, and gradually to diminish it until it can be withdrawn altogether, yet without a negative variation being produced. It is the rapidity of a change, not its amount which acts as an irritant, whether in the normal or the morbid department of physiology.

Poultices or water dressing with gutta percha or india rubber or goldbeater's skin are almost always hurtful from the heat which is produced, whether first applied cold or hot. Nor do I think that we gain by using alkaline water, as used to be the custom at St. Louis. Theoretically, one would recommend "the normal salt solution" of the laboratory with enough

[1] Translated in the 'London Medical Record' for March 15, 1877.

carbonate of soda to make it faintly alkaline. But, practically, it is difficult to prevent even half per cent. alkaline solutions from causing irritation to a raw eczematous surface. Except as prolonged baths or in exceptional circumstances, it is better, I believe, to use moist applications in eczema only as medicated lotions.

Before leaving the subject of water in eczema I may remind the less experienced reader that the cases of general, irritable, weeping eczema are, in old persons, and occasionally in infants, fatal. In these cases continuous luke-warm baths seem to be indicated, but whether really "exhausting" or not, they are supposed to be so, and must therefore be administered with caution. One of my first cases of eczema was in a stout, handsome, healthy old gentleman, with pink skin and silvery hair, whom I saw with Mr. L—. It was widely distributed and excessively irritable. Fresh from Vienna, I ordered a continuous bath, as I had seen it used by Hebra. Great relief followed; but an older and more sagacious physician, who was afterwards called in, while not attempting to cure the eczema, predicted a speedy and fatal result, which soon after happened, and I have not met Mr. L— since.

A short time afterwards, when medical registrar in this hospital, I found, just admitted under Dr. Wilks's care, a patient with extensive and irritable and weeping eczema, also a man above seventy, with clear pink complexion and abundant white hair, and also with a history of gout, though, as in the other case, without evidence of renal disease. I made an unfavorable prognosis of the case. But the patient recovered. I have at the present time an old gentleman of eighty under treatment with extremely obstinate pruriginous eczema, and he appears at present to be equally unlikely to part with his eczema or with his life.

The drugs which we find most useful in controlling local inflammation are those which belong to the group of astringents—zinc, borax, alum, chalk, tannic acid, silver, lead. Of these lead is the most generally and deservedly employed in the treatment of eczema. Zinc and borax appear to have the special additional merit of diminishing irritation. Nitrate of silver is only suited to circumscribed and chronic patches of inflammation.

We have three modes of applying these drugs, as dry powders, in solution, and in suspension or chemical combination as unguents, oleates, or plasters. The general rule I learned from the late Dr. Hughes Bennett is an excellent one: lotions to wet and ointments to dry eruptions. If greasy applications are made to a profusely secreting *Eczema madidans* the discharge washes away the ointment, so that the lead or chalk or zinc never reaches the diseased surface any more than if it were applied over the thick crusts of *Impetigo larvalis.* On the other hand, if lotions are placed in contact with intact epidermis, the horny scales, rendered more water tight by the sebum which covers the surface of the healthy skin, form an almost impenetrable barrier to the action of the drug in solution.

There are, however, exceptions to the rule. Lead lotion is often found to be the best application in the early stages of eczema while still erythematous and in some of its most pruriginous dry forms. Lotions are indicated in hot weather when the skin sweats freely, and ointments in winter when there is no fear of their turning rancid. Lotions are easily applied to infants by the nurse, and to the face and upper extremities by the patient himself; but to be efficient they must be constantly renewed and the surface as lightly covered as possible. Hence they are less applicable to parts of the body which cannot readily be exposed and handled. For the same reason one more often prescribes ointments as a vehicle with hospital out-patients, and those who are about all day, and lotions with in-patients, and those who can or must lie up at home and devote themselves to their cure. Lastly, we meet with certain cases in which our patients assure us that either lotions or ointments always disagree with them, and I have too often verified this assertion to neglect it.

When there is much clear serous effusion, and especially in eczema of the folds of the limbs, powders are often better than either lotions or unguents. Finely powdered chalk, oxide of zinc, or zinc and starch, dry up such weeping surfaces and form a false scab under which the healing process goes rapidly on. The intertrigo of infants and of the breasts in women is often quickly relieved by first cleansing with white of egg, carefully drying, and then powdering with oxide of zinc. This plan is,

however, ill adapted when the affected parts are allowed to be in motion, as with intertrigo of the nates. In such cases the ordinary benzoated zinc ointment, with double the officinal quantity of zinc oxide so as to make it drier and firmer, or vaseline with zinc, are better applications: they should be spread upon thin rags and kept in place with a suspensory bandage between the thighs. When a similar condition arises from riding or rowing, the interval between the periods of irritation are longer, and it is possible, by scrupulous cleanliness and diligent powdering, to procure healing without altogether stopping the cause.

There are, however, some cases of eczema, especially, I think, in the young, and of the moister kinds, which resent every kind of medication, and can only be treated by the sedulous employment of the most soothing and indifferent applications. Among these, as I have already pointed out, water cannot be reckoned; it almost always does harm, and alkaline washes are worse. Thin size, cold cream or vaseline, I think, are the most likely to succeed in such cases. Glycerine of starch occasionally succeeds when everything else seems to fail, but it often proves extremely irritating, and on the whole is I believe less used than it was some years ago. Glycerine has the advantage of mixing freely with water and may thus be used as a vehicle of tannin or of borax to moist surfaces and mucous membranes; but the withdrawal of water from the surface appears in itself to be sometimes an irritant.

I am convinced that for the common "eczema solare" of Switzerland and of the sea glycerine is with most persons of little or no use, and is far better replaced by vaseline, which should be gently rubbed in before the face begins to sweat, and renewed from time to time while the exposure continues.

After the acute stage of an eczema has passed, and it is as a chronic inflammation that it usually comes before us, astringents are still indicated, but instead of soothing and protection some stimulation is necessary. This we obtain by adding a mercurial salt, and the *Ung. Metallorum* of our Guy's Pharmacopœia is one of the best combinations for treating impetigo and chronic eczema. The red oxide ointment, either alone or added to *Ung. Zinci*, is also very valuable, especially in the most chronic and indolent forms which approach ulceration.

In obstinate eczema, especially where of small extent and moist, the application of Liquor Potassæ, as advised by Dr. McCall Anderson, is often an efficient and rapid means of cure. Acid nitrate of mercury is the best application for local deep fissures of inveterate eczema rimosum. In the very chronic eczema, which is dry and scaly without much active inflammation and itching, tar ointment, or our *Ung. Liq. Carbonis detergentis* are indicated. For single patch eczema, if wet, *Liq. Potassæ*, if dry, *Ung. Picis liquidæ* is best.

Meantime we must prevent the irritation of scratching and rubbing by relieving its cause. Oxide of zinc, calamine, or borax, as ointments, weak corrosive sublimate wash or *Ung. Hydrargyri ammoniati*, hydrocyanic acid lotion (ʒiv—ʒvj to a pint), cyanide of potassium ointment (gr. ij to the ounce), and mere protection from the air by such indifferent applications as cold cream and vaseline :—these are all useful for the purpose indicated, the poisonous sedative being used with caution when the moist surface is extensive. One advantage of the continuous bath is the relief from itching it affords. But beside external remedies it is important, especially with children, to add sedatives to secure rest for the inflamed skin at night. Opiates are undesirable not only on general grounds for children, but also because they occasionally aggravate pruritus. Henbane is better, and combined with camphor as a pill or a draught often seems to suit old men better than any other hypnotic. Chloral hydrate is particularly adapted to children, and is best given to infants alone. With older children and adults, bromide of potassium and chloral hydrate make the best combination.

In obstinate cases of eczema of the hands the following method is almost always successful. Wash them thoroughly, removing all crusts, secretion, and dead epidermis, and cutting the nails short. Then rub vaseline gently in all over, put on a well fitting pair of kid gloves and keep them on night and day, only removing them for applying fresh vaseline.

But with all our care we find local remedies inadequate to the cure of perhaps half our cases of eczema. Even at Vienna medicines are taken internally in this disease.

Impetigo rarely needs physic, but when the child is pale steel certainly hastens the cure, beside doing good otherwise. Steel wine for infants, the saccharine carbonate of iron for older

children, and the citrate of iron and quinine are all useful in the treatment of children's eczema; but when they fail, and steel is still indicated, it is worth giving the tincture of the perchloride in glycerine and water before trying arsenic. In the severe form of chronic eczema in children, especially when not pustular and when widely distributed, arsenic is almost always necessary, and rarely fails of success. It must, of course, be begun in small doses, and must always be given with food, and then it scarcely ever disagrees. Children bear it very well even in full doses, and grow fat and rosy while taking it. I have given as much as fifteen drops of Fowler's solution three times a day to a child of seven years old without any but good effects. Sometimes the soda agrees better than the potash salt and it should always be well diluted with water. Except a little syrup to sweeten it no adjuvant is needed. Perseverance in this treatment is rewarded in the most inveterate cases. I have given the above in a case of universal eczema which existed from infancy till near puberty in a boy, and was cured at last in a few weeks by sedulous local treatment and persistent exhibition of arsenic notwithstanding sickness. I had equal success with a girl of sixteen, who had been subject to eczema from early childhood, and suffered terribly from its excessive irritability and its deformity. She could never go out without a thick veil, and every evening was obliged to retire to her bedroom on account of the itching, which then became intolerable. Under arsenical treatment the disease completely disappeared, and she is now able to go into society. This case was one of those which were once explained by the theory of "metastasis," for when the eczema was least troublesome the patient was subject to asthma, and this disappeared in spring and autumn, when the eczema became most severe. Since, however, the skin has become normal the cough and dyspnœa have also improved.

In some children with more or less obvious signs of tubercle in the lymph glands or elsewhere, the exhibition of cod-liver oil certainly appears to hasten the cure of eczema, as well as to improve their general health.

I have already referred to the importance of hypnotics in the treatment of irritable eczema in children.

In the acute weeping eczema of adults experience confirms

the practice of giving saline laxatives along with local treatment. Friedrichshall or Carlsbad water, Epsom salts, and the "white mixture" of magnesia and sulphate of magnesia, or carbonate of soda with sulphate of soda and sulphate of magnesia, are the best kinds of purgatives. Occasionally soda and rhubarb succeed better. In the eczema of children few internal remedies are so useful as Gregory's powder. The value of mercury internally administered is almost confined to the disease in young children, and in some cases we cannot doubt its benefit. The carbonate of soda three parts with Hyd. c. Cretâ one part of our pharmacopœia is the best form in which to give it.

Iron is seldom needed unless obvious anæmia is present. But with women, especially towards the menopause, sulphate of iron with sulphate of magnesia forms an excellent combination, especially if a few drops of dilute sulphuric acid be added.

In the irritable and obstinate eczema of elderly persons arsenic often appears to aggravate the malady. Local treatment assisted by internal sedatives is in these cases most useful, but occasionally purges appear to be of service, and certainly add to the physical and mental comfort of the patient. I believe that eczema occurs more often in connection with gout than does psoriasis or any other disease of the skin. In such cases colchicum is undoubtedly indicated.

The local persistent forms of eczema rarely benefit except by careful and persevering local treatment; but in the ordinary chronic dermatitis of the legs in elderly persons laxatives are no doubt a valuable adjunct to elevation of the limb, and artificial support of the enfeebled veins by flannel rollers, elastic stockings, or, best of all, by Martin's india-rubber bandage.

As to diet, we are for the most part content to follow the traditional warnings against salted food, spices, and preserves. I am sure that most children suffering from eczema benefit by a meat diet and some of them by the addition of stimulants. This also applies to anæmic adults, and especially to the case of women suffering from over-lactation or from menorrhagia. On the other hand, adults in general appear to benefit by taking less meat, no malt liquors, abundant diluents, and plenty of fruit and vegetables. In cases of the pruriginous

eczema of the aged abstinence from fermented liquors is sometimes successful, though I have more than once known it fail.

The regulation of the diet of infants suffering from eczema is of paramount importance. We often find that before they are fully weaned infants are fed upon potatoes and other food containing indigestible cellulose or excess of starch. It is easy to see the mischief of this. But even when milk alone is given it often causes irritation, as shown by diarrhœa and vomiting; and if our local remedies are to succeed we must dilute it or mix it with lime water. Infants suffering from dermatitis, with consequent pyrexia, often "crave" for the breast or the bottle, not from hunger, but from thirst, and thus complete a vicious circle by overloading their stomachs with food, when, if they could express their wants, they would ask for water.

On the whole, internal treatment is most likely to be of value when used to help careful and energetical local treatment.

III. Psoriasis.

Frequency.—Next to eczema, scabies, and syphilitic eruptions, psoriasis is the commonest disease of the skin among London out-patients.

Of 180 consecutive cases noted for the purpose in January and February, 1879, I found the numbers to be of eczema 45, scabies 29, psoriasis 19, syphilis 18, impetigo capitis 11; of 179 consecutive cases in the same months this year (1880) there were of eczema 32, scabies 27, psoriasis 16, syphilis 10, and impetigo capitis 32. In three summer months (June, July, and August) of 266 consecutive cases 37 were impetigo, 59 other forms of eczema, 23 scabies, 21 syphilis, and 18 psoriasis. Uniting the three lists the proportion is of eczema 22 per cent.; of scabies, 12·5; of impetigo, 13; of psoriasis, 8·5; and of syphilis, 8.

Comparing these figures with those of other observers we find that of the enormous total of 10,000 consecutive cases observed in hospital practice in Glasgow by Dr. McCall Anderson, 2527 were eczema, exactly the same number scabies, 725

psoriasis, 567 ringworm and other *tineæ*, 517 syphilodermia, and 327 phthiriasis. The same physician found among 1000 consecutive cases in private practice 348 of eczema, 106 of psoriasis, 101 of erythema, 57 of syphilis, 36 of ringworm (beside four of favus, which is less rare in Scotland than elsewhere), 44 of scabies, and 54 of acne, and 21 of rosacea (*i.e.* gutta rosea or acne rosacea).

Of Mr. E. Wilson's 1000 consecutive cases observed in private practice, 298 were eczema, 112 acne (or gutta) rosacea, 73 psoriasis (alphos), 55 acne, 39 ringworm, 37 scabies, and 30 syphilis.

At the Bellevue Hospital of New York, Dr. Bulkley found among 1000 consecutive cases, 302 of eczema, 111 of acne, 98 of syphilis, 57 of phthiriasis, 50 of psoriasis, 48 of *tineæ*, and 36 of scabies.

Of 11,000 cases collected by the American Dermatological Association, from private and hospital practice throughout the States, more than 3000 were eczema, 1414 syphilis, 685 acne (excluding gutta rosea); and next came psoriasis with 402 cases, followed by ringworm with 356, and urticaria with 333 ('Tr. Amer. Derm. Assoc. Philadelphia,' 1881).

Terminology.—The name psoriasis is, like most others in dermatology, of purely conventional significance; it is not a "condition of psora," for it has nothing to do with scabies, and in most cases is attended with less itching than prurigo or than chronic eczema. But the name is distinctive and universally recognised, so that there is fortunately no chance of "alphos" or any other displacing it.[1] Happily also the artificial and misleading use of lepra as a synonym of certain supposed forms of psoriasis is now almost forgotten. One can only wonder that such an acute observer as Willan should have admitted the distinction between lepra and psoriasis against the evidence of his senses, in order to follow the confused and sometimes misinterpreted descriptions of Greek and Latin authors.

Hippocrates ('Aphor.,' iii, 20) speaks of *leprae* together with

[1] "Pour citer un exemple, le psoriasis d'Erasmus Wilson n'a rien de commun avec l'affection ainsi nommée en France," writes Dr. Vérité, and quotes from Mr. Wilson: "Psoriasis is a mitigated and chronic form of psora or ekzema."

lichen and *alphos* as diseases which occur in the spring of the year. Galen ('De tumoribus,' xiii) makes *psora* and *lepra* "melancholic diseases of the skin alone; if they affect the veins and flesh they are called *cancer.*" Paulus Ægineta (lib. v, cap. 89) also puts *psora* and *lepra* together, as roughness and itching of the skin, "proceeding from black bile," *i.e.* melancholic; but he distinguishes lepra thus: διὰ βάθους ἐπινέμεται τὸ δέρμα κυκλοτέρως, μετὰ τοῦ φολιδοειδεῖς ἀφεῖναι λεπίδας. This does not so well apply to psoriasis but rather to the squamous and ulcerative stages of cutaneous syphilis. Actuarius (lib. ii, cap. 20) describes *lepra* as less formidable than *elephantiasis* (a term not used before Celsus and Aretæus), the next in severity being *psora* (scabies), and then *lichenes* (impetigines). Lepra goes deeper than the latter and wastes away the skin (τίνας συντήξεις σαρκὸς ποιεῖ) and gives off scales—a mere repetition of the statement of Ægineta.[1] Herodotus speaks of persons suffering from λέπρα or λέυκη being compelled to live separately in Persia (i, 138). The terms here are no doubt synonymous with what would still be called scaly and white leprosy respectively.

The Septuagint translators used λέπρα as the equivalent of the Hebrew ZAARATH, and λεπρός is the word for a leper in the New Testament. Thence the word passed into all European languages, with the adjective *leprosus,* from which our form 'leprosy' is derived.

After the word elephantiasis[2] was introduced, it was supposed to denote the most malignant kind of leprosy. Thus in the passage quoted above, Actuarius says: "*Lepra* is a less evil than *elephas;* after it again comes *psora,* and then *lichenes.*"

After the revival of learning, Gregory Horst, of Nuremburg, in his 'Epistola de Hymene et Lepra' (17—), distinguishes Elephantiasis Arabum as "a disease of the feet with great swelling and distended veins," and correctly describes the

[1] This and the two preceding citations I came upon in the exposition of Greek words used by Hippocrates, Aretæus, and other medical writers, published by Henry Stephen, in 1564.

[2] "Elephantiasis Græcorum" is a clumsy expression, which has produced endless confusion of leprosy with Pachydermia. "Leprosy" and "Barbadoes leg" have each a definite meaning, Elephantiasis has none.

elephantiasis of the Greeks as the same with the lepra of the Latins and Arabians; *i.e.* as leprosy (*Aussatz*); and he describes the lazar houses of Germany at that time.

In the eighteenth century the learned Dr. Mead, in his 'Medica Sacra,' heads the chapter on the leprosy of the Bible with the title *Lepra morbus.* He says that lepra is a kind of scabies, and speaks of elephantiasis as *leprae congener morbus.* After quoting the well-known accounts of Celsus and Aretæus he concludes: *"Ex his igitur omnibus manifestum fit, lepram in Syriâ non naturâ sed gradu tantum ab illâ in Greciâ quæ* λεύκη *ibi vocabatur diversam fuisse; et ipsum hunc morbum interdum apud Græcos, maximè verò inter Arabas elephantiæ affinem fuisse.*

Dr. Daniel Turner, in his 'Treatise of Diseases incident to the Skin,' 1723, describes Barbadoes leg as leprosy of the Arabians, and elephantiasis as leprosy of the Greeks.

Blancard's 'Lexicon Medicum' (Lugd. Batav. 1702), which correctly distinguishes Elephantiasis Arabum, *de quo morbo ne verbum quidem fecerunt Græci,* from Elephantiasis Graecorum *quam Arabes lepram vocant,* describes true leprosy as "Elephantiasis, sive lepra et leprosis;" and translates it "Aussatz, Lèpre, the Leprosie."

Heberden and Cullen both affirm that they had never seen lepra, but the former describes psoriasis clearly enough as "a branny scurf observed in patches all over the body, and very apt to begin at the point of the elbow." So that the difficulty of which Bateman speaks[1] arises only from his refusing to recognise lepra as a term for leprosy.

Diagnosis.—The discrimination of psoriasis from scaly syphilis is occasionally difficult, but in most cases the large, glistening scales, the colour, the characteristic distribution, the uniformity of lesion, the irritability, and the recurrence of the attacks in precisely the same form, distinguish the former from the latter disease, apart from the absence of other signs of syphilis.

[1] "It is difficult, therefore, to account for the opinion expressed by the late Dr. Heberden respecting the extreme rarity of Lepra in this country. And still more difficult to explain the statement of Dr. Cullen . . . that he had never seen the disease."—'Practical Synopsis,' p. 28, *note* (ed. 1824).

Most of the cases which were formerly described as *psoriasis palmaris* were no doubt squamous syphilides, and others seem to have been chronic *Eczema rimosum ;* but I have certainly seen true psoriasis affecting the palm, once in Vienna and twice at least in my own practice. In each of these cases the occurrence of psoriasis in the usual situations made its recognition easy. The distinction of true psoriasis from eczema squamosum (*i.e.* of alphos from psoriasis, according to Mr. Wilson) is easy enough in practice; the confusion is only one of words. The distribution, the size and colour of the scales, and the previous condition of the skin, are amply sufficient to distinguish them.

Ætiology.—With respect to the origin of psoriasis, I am entirely incredulous of its connection with gout or with scrofula, or with any imaginary diathesis, dyscrasia or temperament. It is a disease of the skin and nothing else. I do not deny that psoriasis may occur in a patient who has urate of soda in his joints, or in a child who has caseous cervical lymph glands. If we never met with such cases, it would follow that gout or scrofula protected from psoriasis. But one may certainly see marked and inveterate psoriasis in the most varied conditions of health, in the most robust and ruddy, as often as in the thin and pale. It is not a disease of the blood, nor of the humours, nor of the nerves, but of the skin; and is as independent of other lesions as any other histologically local disease.

Bazin, Hardy, and French pathologists generally, supported by some authorities in this country, have assigned to psoriasis a leading place in the group of dartrous diseases, which has already been criticised under eczema. The hypothesis of a dartrous diathesis and the entire order of ideas to which it belongs, appear to me to be baseless in fact, unscientific in principle, and useless or harmful in practice.

Willan wisely discarded the imaginary *virus dartreux*, which was in fact nothing else than the psoric humour of Hahnemann (*la gale partout*) a humour now (I believe) given up even by his own followers. The disciples of the English school of dermatology in France—Biett, Cazenave and Gibert, and Devergie maintained the same scientific and practical attitude, not framing hypotheses but observing facts. But the dartres were

again brought into notoriety by the presumptuous and hasty dogmatism of Alibert, and have since, under various modifications, been recognised by his successors at St. Louis, by Bazin, Hardy, Caillaut, Guibout, and many others.

If any one wishes to judge of the lengths to which this doctrine has been carried, I would recommend the perusal of the bulky volume on "Herpétisme" by M. Gigot-Suard.

Taking with all respect the statements of the eminent French physician, M. Hardy, we find that the characters of the dartres are: 1, They are not contagious; 2, they are often hereditary; 3, they recur; 4, they itch; 5, they spread; 6, they are chronic; and 7, they do not leave scars.[1] By these characters "we are led logically to believe" that these dartres are due to *un vice dartreux, virus dartreux*, or, as M. Hardy prefers to call it, *diathèse dartreuse.* The diseases, which are not local, but true dartres, are beside psoriasis, eczema, including impetigo, lichen, and pityriasis, including pityriasis rubra. To these other authorities add pemphigus, erythema, and many other kinds of disease, so that, excepting syphilis, herpes and cancer, few affections of the skin have not been brought more or less under the comprehensive dartrous hypothesis.

We are told that it is possible to distinguish a dartrous diathesis apart from its manifestation in actual disease of the skin. "Les personnes dartreuses, bien qu'ayant en apparence tous les attributs de la bonne santé, sont cependant dans un état particulier qui n'est pas la santé parfaite." Their skin is dry, and they do not easily sweat. Their skin readily itches, and is inflamed by slight causes, such as eating shell-fish (which makes *urticaria ab ingestis* a "dartre," contrary to M. Hardy's classification elsewhere), and they have a good appetite even when they are ill. These characters (excepting the last) appear to me to apply to eczema and to eczema only. When the skin is irritable and readily inflamed we may say, if we please, that it is "disposed" to common superficial dermatitis, *i.e.* to eczema;

[1] "Nous appellerons *dartres* des affections de la peau à lésions élémentaires différentes, non contagieuses, se transmettant souvent par voie d'hérédité, se reproduisant d'une manière presque constante, présentant pour symptôme principal des démangeaisons, toujours disposées à envahir de nouvelles régions, à marche habituellment chronique, et dont la guérison a lieu sans cicatrices, bien qu'elles s'accompagnent souvent d'ulcérations."—'Leçons sur les Maladies de la Peau,' p. 19.

or that the skin (not the person) is of an eczematous construction or "constitution," of an eczematous disposition or "diathesis." But patients who often suffer from eczema are not particularly liable to psoriasis, nor to acute erythema; and there is no reason to suppose that their blood (any more than their nerves or brains) is different from other people's.

Looking to the signs given above, which are to justify one in assigning an actual eruption on the skin to a dartrous origin, we find none of them sufficient. (1) Lupus is not contagious yet it is not a dartre; pustular eczema is often contagious yet it is a dartre. (2) Hereditary transmission proves only that a disease is not accidental or traumatic, not contagious and not parasitic. What is hereditary is a certain structure of the skin, as of other organs, as stature, as malformations, as shape of limbs and head and nails, as colour of skin and hair and eyes; or again, functional peculiarities, as early or late baldness and greyness, early or late atheroma. Every one admits that eczema is often hereditary and that psoriasis is so also; but what wants proof is that any common state is transmitted which may turn to one or the other. Moreover, other diseases of the skin not considered dartrous are often hereditary, as cancer, leprosy, and even erythema nodosum. (4) Itching is less characteristic of psoriasis than of prurigo, urticaria, and scabies. (7) Not leaving scars shows only that the papillæ are not destroyed and applies to all other superficial affections of the skin. The remaining characters, chronic course, gradual spreading, and aptness to recur, are no doubt points of agreement between eczema and psoriasis.

That there is a pathological relationship between them may be admitted, but it is chiefly one of contrast. Eczema is often acute or subacute, psoriasis is chronic; eczema is at one time or other moist, psoriasis never; eczema affects the flexures and the thinnest parts of the skin, psoriasis the most exposed and thickest regions: eczema is the most varied of diseases in its outward form, psoriasis the most constant; eczema can be and often is produced by direct irritants, psoriasis is always idiopathic.

Apart from the special question of the origin and nature of psoriasis, I may here be allowed to repeat that the whole order of notions expressed by such terms as "constitution," "dia-

thesis," "temperament," appears to me to be a survival of exploded physiological systems and only obstructive of investigation. Constitution means a certain structure of the solids of the body. Temperament means a certain tempering or mixture of the humours of the body;[1] dyscrasia an ill mixing of the same humours. But the humoral pathology is dead. There is no mixture of blood, bile, phlegm, and black bile. The spleen is not a gland, and melancholic patients are not, by the testimony of the deadhouse, "splenetick." If there was any accidental truth in the doctrines of the humoral pathology, it must be proved anew by careful investigations into the prevalence of certain diseases in the lower races of mankind. Certainly so mixed a population as that of England is ill fitted for such inquiries.

It was once believed that the skin was a chart on which the humours of the body displayed their signs for the scrutiny of the physician, just as we now look on the tongue chiefly as an index to the state of the stomach. There was foundation for such a theory in the case of jaundice, of syphilodermia and of febrile rashes. But we now know that most affections of the skin are strictly local and structural. If it can be proved that psoriasis occurs more often than the doctrine of chances would explain in persons subject to gout or to scrofula, and if we thereby learn how better to treat our patients, the proof will be a welcome addition to science and to practical therapeutics. But gout must mean not an arbitrary assumption, but the existence of urate of soda in the tissues; and scrofula

[1] "If the Element of Fire be Chieftain, the Body is said to be Cholerick; if Air bear rule, to be Sanguine; if Water be in his Vigour, the Body is said to be Phlegmatick; if Earth have his Dominion, to be Melancholick. For Choler is hot and dry, Bloud, hot and moist, Water, cold and moist, Earth, cold and dry. These four complexions (or temperaments) are compared to the four Elements, secondly to the four Planets, Mars, Jupiter, Saturn, Luna, then to the four Winds, then to the four Seasons of the year, fifthly unto the twelve Zodiacal Signs, in whom are four Triplicities, lastly to the four Ages of Man; all of which are here deciphered and limned out in their proper orbs, thus: I. *Cholerick*, Aries, Leo, Sagittarius; Mars, Ignis, Favonius, Aestas, Juventus. II. *Sanguine*, Gemini, Libra, Aquarius; Jupiter, Aer, Auster, Ver, Adolescentia. III. *Phlegmatick*, Taurus, Virgo, Capricornus; Luna, Aqua, Autumnus, Vergens, Aetas. IV. *Melancholick*, Cancer, Scorpio, Pisces; Saturnus, Terra, Aquilo, Hyems, Senectus."—'The Optick Glasse of Humours,' 1664.

must not mean vaguely ill-health, but caseous degeneration of lymph glands.

Until, therefore, we learn better, we must consider that psoriasis is not due to a supposed arthritic, herpetic, or dartrous diathesis, that it is not a manifestation of gout, and that it has no more to do with scrofula than with syphilis.

Again, we cannot trace psoriasis, as we so often can eczema, to a local irritant. It cannot be excited at will, it is not produced by sun or cold, or sweat or friction, or mustard, or venous congestion. It is scarcely an inflammation, certainly not an exudation in the sense of Rokitansky and Hughes Bennett.

But the histological appearances are decisive of its being a true chronic inflammation of the Malpighian layer and subjacent papillæ, with hypertrophy of the latter and subsequent atrophy of the former.[1] And occasionally we see the early stages of psoriasis, like those of syphilodermia, showing the ordinary signs of inflammation.

Case.—A young man came to me with a bright rose rash, which had appeared the day before in minute patches over his chest. It looked like early syphilitic roseola, but there were no other secondary symptoms and no evidence of infection. There was slight local heat and general malaise. Two days later he came again, perfectly well in himself, with the rash changed into a papular form and several of the papules covered with small white scales. In a week or ten days an ordinary *Psoriasis guttata* had developed, which soon yielded to remedies and has not returned.

The early origin of psoriasis, its almost constant distribution, its frequent repetitions, and its appearance in different members of the same family, point to its being an inherent and not an accidental vice of the skin.

Though most cases of psoriasis appear to be free from hereditary influence, we sometimes meet with such marked instances that we must admit it among hereditary diseases. In this respect it resembles carcinoma and rheumatism.

I need scarcely refer to a lately propounded hypothesis that psoriasis depends upon the presence of a fungus, for it is

[1] See the figures by Neumann, and an interesting paper by Dr. Thin, in the 'British Medical Journal' for July, 1881.

contradicted by all we know of its course and origin, as well as by microscopical investigation of the scales and of the skin in section. Dr. Yandell, of St. Louis, recognised several of my cases as malarial in origin, but the evidence did not convince me.

Form and distribution.—The form of psoriasis is remarkably constant, and its distribution scarcely less so. It is always the dry, scaly tetter, always bilateral, and often exactly symmetrical, but never, I believe, universal. Symmetry has been said to prove that a disease is "constitutional." If this means only that it is not traumatic, it is true enough, but if it means that the symmetrical disease is due to some anomaly of the blood like leuchæmia, or to some generalised condition like carcinoma, I can see no justification for the dictum. The lesions of the skin in purpura, an affection of the blood and blood-vessels, and in syphilis, a generalised disease, are far less symmetrical than in psoriasis and idiopathic eczema, which are both strictly confined to a single organ. The two elbows are not covered with scales because they are both supplied with the same blood, for no part of the skin (or mucous membrane either) has its private supply of nourishment. The two elbows are affected with psoriasis because their skin is more alike than that of any other part of the body. Next in likeness is the skin over the knee caps, and least so the skin of the axillæ.

The varieties described as *Psoriasis punctata, guttata, nummulata, annulata, gyrata,* &c., depend chiefly on the period at which the disease is observed, and are of no scientific, that is, of no practical importance. There is, however, one form of this affection which seems to me to be distinct enough in more than mere accidents of appearance to deserve notice as a variety.[1] (1) It is guttate in figure, the separate spots not coalescing as usual into larger patches; (2) there is little redness around the scales; (3) the distribution is much less regular than usual, the whole trunk being often spotted over and the elbows and knees free; (4) it scarcely itches at all; (5)

[1] Since writing the above I have noticed in Dr. Liveing's excellent 'Handbook of the Diagnosis of Skin Diseases,' p. 120, a very similar account of what he called Scrofulous Psoriasis.

it occurs almost invariably in children; (6) it often does not require arsenic, but is successfully treated with cod-liver oil, or sometimes with steel.

This want of conformity to the typical geography of the disease is what may be observed in other cases of children's pathology, in pneumonia, for instance, and in tubercular disease of the abdomen, in affections of the joints, and of the eye. In the case of the skin we may perhaps say that the distribution of morbid processes is less precise than in the adult, because the several regions of the skin are less differentiated, because the skin of the elbow, the hand, the back, the chin, is much more alike in the child than in the man.

Psoriasis of the nails and of the tongue.—The nails are seldom affected except in the most severe and extensive forms of the disease; yet malformations of the nails are more frequently due to psoriasis than to eczema, ringworm, syphilis, or any other general disease of the skin.

Beside the well-known patches of thickened epidermis on the dorsum of the tongue, which go with fissures, nodes, and other undoubted syphilitic lesions of the part, and beside the chronic indolent patches of "psoriasis" or *ichthyosis linguæ* which precede epithelial cancer, there is a true psoriasis of the organ, which though rare may be met with in cases of the disease; and I have twice observed it in connection with lichen planus of the body.

The following are notes of the points indicated in fifty-five consecutive cases of psoriasis lately under treatment:

No.	Sex.	Age.	Form and distribution.	Duration.	Family history, &c.
1	M	35	Ordinary *Ps. diffusa*; elbows and knees affected	33 years; once free for 3 years	One brother.
2	F	18	Ditto	Since childhood	
3	M	Adult	Ditto	6 months.	
4	F	9	Ditto	2 years; every spring and fall.	
7	M	7	Ditto, extensive; face, scalp, hands, and feet only free	2 years.	

No.	Sex.	Age.	Form and distribution.	Duration.	Family history, &c.
8	M	22	*Ps. guttata;* elbows and knees free; both used to be affected	First at 15.	
9	M	20—25	Almost universal, including palms and bend of elbows	Several years.	
10	F	18	Elbows, knees, and limbs	Ditto	Mother and two sisters.
11	M	4	*Ps. guttata;* elbows and knees	?	
12	M	28	*Ps. guttata;* elbows and knees not affected	5 or 6 years; began at Gibraltar.	
13	F	6	Ordinary psoriasis; elbows and knees	?	
14	F	11	Ditto	4 years; every spring.	
15	M	21	Ordinary, but extensive and obstinate	1 year	Father and mother died of phthisis.[1]
16	F	13	Ordinary; scalp much affected	10 months	
17	F	38	Ordinary, extensive, including palm and soles, and a patch of *Ps. linguæ*	6 months	
18	F	7	Ordinary; elbows and knees	?	
19	F	5	Ordinary, including scalp	2½ years	Father.
20	F	9	Ordinary; elbows and knees	?	
21	F	40	Knees, thighs, and calves; nowhere else	One attack 7 years ago in the same situation.	
22	F	44	Ordinary	4 years.	
23	F	8	Ordinary	Second attack	Father and brother.
24	F	24	Ordinary	?	Mother of 25.
25	M	8	*Ps. punctata;* trunk only	?	Son of No. 24.
26	F	26	*Ps. guttata;* limbs only	Frequently recurs.	
27	M	20	Ordinary; scalp	?	
28	M	15	Ordinary; legs only	?	
29	M	27	Ordinary; scalp	?	
30	F	14	Ordinary	7 years; spring and autumn.	
31	M	50	*Ps. guttata;* trunk. Acute eczema of head and neck	?	
32	M	20—25	Severe and general, chiefly *Ps. gyrata;* not specially on knees and elbows	First attack; several months.[1]	

[1] This patient was himself a robust well-built young man, a working engineer. He had been free from all affections of the skin until the spring of 1879. He was treated elsewhere from September to December with no benefit, first with iodide of potassium and then with small doses of arsenic. He completely recovered by February under full doses of arsenic and local application of tar.

No.	Sex.	Age.	Form and distribution.	Duration.	Family history, &c.
33	M	35	Ordinary, chiefly *Ps. guttata;* trunk and limbs, including palms	Second attack; first at 30.	
34	M	18	Ordinary, including scalp	?	
35	F	39	Ordinary, very general; complicated with ordinary eczema, intertrigo of mammæ and groins	Third attack; with each, lactation.	
36	M	28	Ordinary, complicated by a subsequent syphilitic eruption from a hard chancre	Several years; usually each spring.	
37	M	34	Ordinary, very general, not specially on elbows and knees	From childhood; worse in spring and autumn	Mother.
38	F	43	*Ps. gyrata;* neck, throat, chest, and nape, down to scapulæ	After each delivery, *i.e.* twelve times.	
39	M	27	*Ps. nummulata;* elbows, knees, abdomen	2 months; second attack; first last summer.	
40	F	21	Ordinary; elbows and knees	Third attack; 5 years	
41	M	20	Ordinary; extensive	Fifth attack since 9 years old.	
42	F	47	*Ps. guttata;* both forearms	First attack; 6 months	
43	F	13	Ordinary; arms and legs	First attack; 2 months.	
44	M	40	Ordinary; limbs and scalp	4 years.	
45	F	44	Ordinary; arms and legs	Third attack.	
46	F	53	*Ps. guttata;* knee and ankle; very irritable	First attack	Has had gout.
47	F	14	*Ps. guttata;* arms, chest, back, and knees	Second attack; first when 11	
48	F	12	Knees and elbows	Repeated; every spring.	
49[2]	M	20	General; guttata and diffuse	First.	
50	F	30	Elbows and knees	Second; first 18 months ago	Father had a "disease of the skin."
51	F	44	Arms, &c., palms, nails	Several years	
52	M	54	Ordinary; general	Since 14	Mother had the same.
53	M	19	Ordinary	First at 17	
54	M	10	Ordinary	First at 9	
55	M	58	Elbows, hips, legs	Several years	

[1] This patient had been previously treated for syphilis without benefit. The distribution was somewhat misleading, but he rapidly improved under arsenic.

[2] While this young man was under treatment, and the eruption gradually disappearing under solution of arsenic, of which he was taking ♏vij three times a day, there suddenly occurred an acute outbreak of numberless fresh spots of

The following is an anomalous case of disease, remarkable in more than one aspect, which I have with some hesitation regarded as an aberrant form of psoriasis.

Case.—George T—, æt. 17, is a florid, fairly nourished lad, with the left leg wasted and contracted from obsolete disease of the hip. He never remembers being free from the affection of the skin for which he now seeks relief (Feb. 1, 1878). He believes it used to be on his face, and is sure that when he was a patient under Dr. Frederick Taylor, in 1876, his neck was affected. About Christmas time (1877) it spread over his abdomen and loins. The adjacent parts of the trunk and limbs have been the constant seat of the disease. It is now distributed over the shoulders, arms and forearms, flanks and abdomen, buttocks and thighs, with an imperfect symmetry. The scalp and face, ears, neck, legs, hands and feet, and genitals, are entirely free, and (excepting the head) appear to have been always so. The diseased surface is for the most part slightly injected, without pigmentation, papules, or other lesion, and with no evident cicatrices. Towards the margins, which are more or less gyrate, it becomes more red, somewhat raised, and covered with small, white, adherent scales, which in most parts form a series of concentric margins.

On removing these scales, a somewhat pigmented and injected surface is found beneath, without the least trace of moisture.

Though there is no pigmentation of the regions now affected there are maculæ on the chest and abdomen, where the patient states that the same eruption has existed. There is moderate irritation, no active symptoms. The colour is red or slightly purplish, without a coppery tinge. Careful investigation shows absence of all signs of either acquired or congenital syphilis. Repeated microscopic examination demonstrates that there is no fungus present. The sebaceous glands are apparently not affected.

After some trouble I found the mother, who is herself a healthy woman. She says that her husband is deaf, but free

Ps. guttata, chiefly on the arms, but also on the trunk and legs, where the original eruption was marked by little more than pigment spots. He was finally cured by taking him into the hospital, using tar thoroughly and pushing the dose of Fowler's solution to ♏xv thrice daily.

from any disease of the skin. She has suffered from sore hands, apparently *eczema rimosum*. She has four other children, one older and three younger than my patient. One only of them has any affection of the skin. This girl afterwards also came under my care.

M. T—, æt. 15, a healthy, well-developed girl. Like her brother she was born healthy; but he was first attacked by his present complaint when about seven years old, and she at the same age or perhaps a year later. The skin of face is somewhat red and rough. The shoulders, upper arms, and chest are covered with a reddish, serpiginous, scaly eruption, with smooth, rather pale patches inside the circles, or the gyri which are made by their confluence. There is no moisture, no cicatrisation, and the disease is in all respects identical with that described in her brother. Here, again, there was no fungus present, and absolutely no evidence of syphilis, hereditary or acquired.

Putting aside the diagnosis of lupus erythematosus, from the absence of nodules, of sebaceous implication, and of cicatrisation; and that of tinea, from the absence of spores—it appeared to me that the only name to give it, if any known disease, was that of psoriasis. The appearance in brother and sister, the dryness and scaliness, the mode of progress, the inveteracy and proneness to exacerbations, as well as the itching and the pigmentation following its involution, all weighed with me in this decision. I accordingly prescribed Fowler's solution in gradually increasing doses, and George T— continued his medicine with great regularity up to June (1878), when he was taking fifteen or twenty drops daily. He then came to show how much better he was, and indeed the eruption had almost but not entirely disappeared. He then gave up attending, and I did not see him until the end of August, when he came again almost as bad as before. Again I lost sight of him till the 8th of October, when he resumed his former prescription, and again improved. After three weeks, thinking himself better, he gave up treatment once more. He came towards the end of November with increase of the disease and fresh circinate spots on the chest; there was also more irritation than before. I then ordered a larger dose of arsenic and Liquor Carbonis Detergens locally; but as soon as he improved

again he ceased to attend, and I have not been able to see him since, though I have heard of him at other hospitals.

So far, the result of treatment would seem to confirm the diagnosis. I should add, that before seeing me he had been treated with arsenic with apparent benefit, that he had taken *Liq. Hyd. Perchl.* for several weeks without any effect, and used sulphurous acid lotion with the same negative result.

On the 13th of November, 1878, I showed both this patient and his sister at the Hunterian Society. Several experienced dermatologists, who then saw the cases recognised their resemblance in certain points to erythematous lupus, syphilis, and tinea, but all agreed that it was none of these. Mr. Hutchinson, to whom I sent the patient, told me that the nearest resemblance to it he had seen was in a young man from Canada, the subject of an eruption which had existed from birth; it was not syphilis or tinea, but resembled ichthyosis and resisted all treatment.

I have no doubt that George T— is the same patient whose case was described to the Clinical Society two years later by Dr. T. C. Fox ('Lancet,' November 20th, 1880), as persistent gyrate erythema. Whether erythema should be extended to a scaly eruption which persists for years is a question of terms; but if erythema is used as a synonym of dermatitis, the question still remains as to the pathological nature of the disease.

I am indebted to my friend Dr. Cavafy for the suggestion that my case might, perhaps, be regarded as coming under what Dr. Duhring has described as Pityriasis maculata et circinata: see his treatise on 'Diseases of the Skin,' 2nd ed., 1881, p. 305.

IV. Lichen and other Papular Forms of Dermatitis.

If we examine the descriptions given by Willan and his followers of the three classical papular diseases, lichen, prurigo, and strophulus, with their several species, we find very little which corresponds with the necessities of modern pathology.

Willan defines LICHEN as "an extensive eruption of papulæ affecting adults, connected with internal disorder, usually terminating in scurf, recurrent, not contagious." Except the first anatomical character and the last negative one, there is nothing here to help us. STROPHULUS appears to mean nothing but papules occurring in children, which are not contagious, *i.e.* neither scabies nor measles. The term is deservedly neglected at present; and the varieties of "red gum" are referred to papular erythema. Bateman's seven species of lichen are *L. simplex, pilaris, circumscriptus, agrius, lividus, tropicus* and *urticatus.* The last would seem to be indistinguishable from *Prurigo infantilis* as described by Hutchinson and other writers, which is generally accompanied with more or less consecutive erythema and urticaria, the wheals and the diffused redness being alike the result of scratching, and not the origin of the papules.

The term lichen with a former generation included what we now call papular syphilis. It was also applied to the accuminated papules most marked on the extensor surface of the upper arm, the calf, the outside of the thigh and the buttocks in brawny men (*Lichen pilaris, pityriasis pilaris* of Devergie); these are due to accumulation of dry sebum and dead epidermis in the large sebaceous ducts and hair sacs of these regions; and they sometimes form minute centres of inflammation and even of suppuration. The condition is removable by friction with soap and hot water, and scarcely deserves a pathological recognition.

The same condition, however, occasionally occurs in a more remarkable form as the following case shows:

Lichen pilaris of limbs in a child.—A thin, delicate looking girl, twelve years of age, was brought to me for "roughness of the skin." There was slight branny desquamation without redness or seborrhœa of the face and scalp; but the limbs were covered with small, hard, pale, pointed papules, more readily felt than seen. Each corresponded to a hair-sac, and resembled the ordinary lichen pilaris of the thighs and legs in adult males. The papules, however, were harder and closer set, and affected not only the extensor aspect of the limbs, but the soft skin of the elbow and ham, covering in fact the whole of the thighs, legs and arms. The back and trunk generally] were free.

The affection was not congenital and had only appeared since the child was eight years old. Though thin and pale, the patient had no disease of the lungs, lymph glands, joints, &c., which could enable one to call this *Lichen scrofulosorum,* and it will be seen that the eruption did not correspond with Hebra's description of that affection. On the other hand, it was obviously different from *Lichen ruber,* or any inflammatory disease, and would pathologically seem rather to be allied to pityriasis, xeroderma, and the rough dry condition of the skin in children which is connected by intermediate grades with ichthyosis.

Lichen agrius, with small vesicles and liability to terminate in a chronic pustular disease, is certainly a form of acute eczema. So is *L. tropicus,* of which I have given a case above. *L. lividus* is purpura affecting the vascular hair sacs. There remain only *L. simplex* and *L. circumscriptus.* The acute course and slight desquamation of the former seems to mark it as a true erythema. The latter alone of all the species would probably be admitted as lichen by a modern physician.

The acute papular eruptions, especially on the limbs, which have been described as lichen by later writers, may be fairly classed under papular erythema, when, as is often the case, they justify the name by their rapid course, their frequent recurrence, their appearance in patches, their distribution, and their connection with gastric disturbance. Lastly, I would recognise as eczema all papular eruptions which are chronic in course, diffused and spreading in their distribution, and localised in the flexures of joints, the back of the ears, and other favourite eczematous sites; which are attended with itching rather than pain, which lead to infiltration of the skin, and which either follow or precede ordinary moist eczema.

The species of Prurigo described by Bateman are: 1. *Pr. mitis,* mostly affecting young persons, and sometimes ending in "contagious scabies." 2. *Pr. formicans,* occurring in adults and affecting the whole of the trunk and limbs, except the feet and palms, "but most copious in those parts over which the dress is tightest." 3. *Pr. senilis,* in the course of which "pediculi are not infrequently generated." 4. Local prurigo,

differing from the above varieties in not being papular, and only resembling them in itching, viz. *Pr. præputii*, *Pr. pubis*, *Pr. urethralis*, *Pr. podicis*, and *Pr. pudendi*.

The first of these is the result of irritation from dirt, and the second of pediculi. The third is not prurigo at all, for it is secondary to affections of the bladder, and modern pathology separates those affections in which papules if present are the effect and not the cause of itching, the direct traumatic result of scratching, and names them "Pruritus." *Prurigo podicis* and *Pr. pudendi*, still so called by some French writers, is named *Lichen podicis* by Hardy and *Eczema ani* by Bazin. It is the well-known chronic, intensely irritable dermatitis, usually papular, but often made eczematous by scratching, which affects the vulva, the perinæum, or the anus in persons past middle age, and has been included above under Eczema.

Much of what was called *Pr. formicans* and nearly all *Pr. senilis* was probably due to pediculi corporis and now known to be curable by destruction of these vermin.

There remain two valid diseases called Prurigo. One is Hebra's prurigo, which I have seen at Vienna, and which appears to occur occasionally in its full severity in America. Such cases, however, seem to be only remarkably severe, and possibly over-described, cases of what we see in England, obstinate and chronic prurigo of adults, with thickened and pigmented skin, but without the characteristic localisation of *Pr. pedicularis*, and unaffected by parasiticides. Such cases are in fact recognised by Hebra as *Prurigo simplex*. The other distinct form of disease is that called *Prurigo infantilis*, *Strophulus*, and *Lichen urticatus*, an obstinate eruption of large, flat, rather pale papules, chiefly confined to the trunk and adjacent part of the neck and limbs, and always avoiding the face, scalp, hands and feet, attended by intolerable itching, subject to periodical exacerbations (whence it has received such names as summer prurigo), and rarely seen before weaning or after the approach of puberty. It is possible that some of the worst of these cases may go on to the prurigo simplex of adults, or even to its severer forms; but as observed in children the skin is not thickened, pigment is not increased, and the hands and feet are markedly exempt. That some of these cases are due to irritants, and especially to fleas and other vermin, is possible,

but there must be more than the direct result of such irritations to produce prurigo; for they often seem to have little effect, and when this follows it is usually an erythema, which disappears when the cause is removed. In contrast with *Prurigo pedicularis* we may therefore fairly call this disease idiopathic. I have seen one marked case of this form of prurigo following weeks after an attack of varicella, as described by Mr. Hutchinson.

The following are brief notes of cases of prurigo as above defined:

Case 1.—M., æt. 43. January. Papules on shoulders, forearm, and loins; slightly on abdomen. Head and face and limbs free. Large, flat, discrete papules, with scratch marks and slight erythema. Severe itching. Subject to it since childhood. Two months later the forearm, buttocks, and thighs were also affected. Treated with quinine without apparent benefit. No pigmentation. Not due to any discoverable irritant.

Case 2.—M., æt. 42. July. A similar case, but more extensive, the limbs as well as the trunk being affected. Back and shoulders less so than loins, buttocks, and limbs. Head, face, hands, feet, and genitals alone free. Papules separate, and many capped with dried blood. Scratch marks, with a good deal of erythema and urticaria. Seven years' duration, always worse in summer and better in cold weather.

Case 3.—F., æt. 15. October. Generally distributed; papular. Was, during the summer, a patient of Dr. Fagge, who treated her with marked success by full doses of quinine. Three grains of the sulphate taken three times a day appeared again to be extremely useful, and after a few weeks' treatment she was again freed from her troublesome complaint.

Case 4.—M., æt. 12. May. Large scattered papules, some with bloody tips, over back, nates, thighs, arms and foreams. Six months, from November to May. A thin pale boy.

Case 5.—M., æt. 12. Papules and scratch marks, without pigmentation, on back, loins, thighs, and (slightly) on upper arms. A pale thin boy. Pediculi corporis.

Case 6.—M., æt. 12. Scattered pruriginous papules. Great benefit while taking quinine and using hydrocyanic acid (ʒiv of the dilute acid to a pint) as a lotion.

Case 7.—M., æt. 6. May. Small, colourless, almost invisible papules, none closely set, with raised patches of urticaria. Loins, abdomen and limbs. Head and face, shoulders, and hands and feet quite free. Has lasted two years. Impetigo capitis before.

Case 8.—M., æt. 1½. Large, flat, pale, discrete papules over back and abdomen. Some urticaria. Slight eczema of one axilla. A fair, well-nourished child. No source of irritation discovered.

Case 9.—M., æt. 4. January. Papules and scratch marks over back and shoulders. Began last summer.

Case 10.—M., æt. 3. Small discrete papules, with a few vesicles and scratch marks, but no erythema. Abdomen and trunk generally; arms and legs also affected. Excessive irritation. A healthy child. No irritant discovered. Treated with quinine without benefit. After several months, gradual improvement independent of treatment. Next August relapse.

Case 11.—M., æt. 2. March. Had chicken-pox about a year ago. For three months has suffered from exceedingly irritable papules, with pustules. The disease was first called *Lichen urticatus*, then "Erythema pustulosum et bullosum." When I first saw it, I suspected scabies, but a careful search failed to discover not only the acarus (a common failure in the case of infants), but any runs, vesicles, or other characteristic lesion. Moreover, the distribution was unlike that of scabies, the papules being irregularly scattered over the trunk and limbs, and there was no other case. The pustules and blebs were due to the child's scratching, and were accompanied with wheals of urticaria. It continued very obstinate for several weeks.

Case 12.—M., æt. 3. January. Colourless papules, with slight erythema on chest, hips, &c. Head and limbs free. A well-nourished, healthy child. No trace of vermin or other irritant.

Case 13.—M., æt. 2. Papules with slight erythema, without wheals, over loins, back, arms, thighs and legs. Five months' duration; began in September.

Case 14.—F., æt. 4. Papular rash on abdomen, flanks and loins; head and limbs free. Summer prurigo. Well during the winter, and came again the next spring.

CASE 15.—In a child, æt. 2. June. Pale scattered papules, one only having become vesicular, over the abdomen, arms, thighs and legs. Has existed since birth. No eczema, impetigo, erythema, or urticaria. Very irritable.

CASE 16.—M., æt. 7 months. August. Large pale discrete papules, chiefly upon the trunk. Four months duration. Very irritable.

CASE 17.—M., æt. 15 months. May. Rather small papules, scattered over abdomen, back, and arms. Much urticaria, which was more prominent than the prurigo; and papular eczema of one arm. Appeared a fortnight before with the warm weather. A fat, healthy child. No appearance of flea bites or other irritants.

There is one form of papular dermatitis of which we find no account in the earlier works on dermatology—I mean *Lichen planus.*

No one who has seen a well-marked example of this affection can doubt the accuracy of Mr. Wilson's original description of it. The raised, flat patches—miniature plateaux rather than plains —their dull, glistening surface, deep purple-red colour, and the frequent marks it leaves behind, are very characteristic. The localisation is not constant. Most frequently, perhaps, the back of the hand and wrist are the seat of the disease; scarcely less so the leg or thigh, and the patches are not confined to the extensor surface of the limbs. The trunk is also not unfrequently affected. It does not seem to have been observed in children. It is usually said to be more frequent in women than men, and in thirty cases collected from various sources I found eleven were men and nineteen women; but the numbers are too small to be conclusive, and the difference too slight to be important. It is, however, worth noting that almost all Hebra's cases occurred in men.

As in psoriasis, the amount of itching varies greatly; some patients feel scarcely any irritation, others complain greatly of this symptom, and scratch marks or secondary dermatitis sometimes confirm their complaints. The course of the affection is always chronic. Arsenic and local application of tarry compounds are sometimes very quickly efficacious, but I have sometimes found the cure tedious.

I have most often seen Lichen planus mistaken for syphilodermia.[1]

There can be no doubt of the close alliance (illustrated by one of the cases given below) of this affection to certain other forms of papular dermatitis, especially to what Hebra describes as Lichen ruber. They are both essentially papular, both chronic, both dark, both irritable; they are somewhat similar in distribution, and they sometimes occur together. Indeed, Mr. Wilson recognises the close resemblance or identity of his Lichen planus with the disease previously described by his colleague in Vienna, and frankly yielded him the priority. Nor can we fairly question the relation of Lichen planus to psoriasis, which has been so well supported by Mr. Hutchinson. It is very seldom that the resemblance is one of appearance or distribution; but it depends on the clinical features of dryness, chronicity and irritability, the common character of solid hard papules becoming afterwards scaly, the liability to pigmentation, the readiness to return, and the reaction to the same therapeutic measures. All these physiological characters point to a true kinship. A case exhibited at the Pathological Society by Mr. Morrant Baker, in the session 1880-1, showed the occasional difficulty of diagnosis between psoriasis and Lichen planus.

On the other hand, I would, at present, separate *Lichen planus*, and even *Lichen ruber*, somewhat sharply from other so-called species of "lichen." The word by itself has come to mean little more than a chronic eruption of papules, and I doubt whether we can at present use it to any better purpose.

The following cases of Lichen planus seem worthy of being put on record.

Case 1.—A man, aged 30, presented himself among the outpatients with eight or nine flat, raised, slightly-scaly red patches, from a pea to a threepenny-piece in size, situated on the back of the wrists, the forearm, and the dorsum of the hand. On the right leg there were several similar *plaques*, which had united, and here there was a good deal of ordinary dermatitis,

[1] So Dr. Duckworth ('St. Barth. Hosp. Rep.,' vol. viii), who also agrees with me in regarding *Lichen planus* and *Lichen ruber* rather as closely allied than identical.

set up by scratching. The eruption had lasted three months, and had never appeared before. Next week he came with a fresh crop of scattered papules upon the inside of the left thigh. He was ordered Fowler's solution, but disappeared before he was cured.

CASE 2.—A lady, aged about 45, came to me, having been previously treated with mercury for what was supposed to be a syphilitic eruption. For three months she has noticed small red patches on her hands and feet, and they have gradually increased. They began as "pimples," and a few separate papules are still present, but the lesion consists chiefly of raised, flat, bright red elevations of the skin, covered with faint indications of minute scales. They do not spread, but fresh papules appear and coalesce. The parts affected are both hands, on the backs, between the fingers, and on the palms; less so the feet, including the soles. The eruption is very irritable. There are two smooth patches inside the cheek and on the dorsum of the tongue (psoriasis linguæ). No other lesion; healthy aspect. History of a rash several years ago which affected the arms, legs, and waist. The colour and the uniformity of the eruption, the irritation, which was decided though not severe, the account of a previous eruption which was pretty certainly not venereal, and the absence of all other signs of syphilis, convinced me that the affection was not of that character, notwithstanding the suspicious localisation and the curious coincidence with an affection of the tongue, which is often mistaken for a specific lesion. I accordingly prescribed five drops of Fowler's solution three times a day and only cold cream locally. A week later there was slight irritation of the conjunctiva, and the rash was much improved, paler, and no longer irritable; while no fresh papules had appeared. But after another week fresh spots with fresh irritation were observed on the forearm and at the bend of the elbow. Somewhat later the same papular eruption affected the legs and abdomen, and was accompanied by great itching. The patient, however, persevered in the use of arsenic, to which I had added Liquor Carbonis Detergens as an ointment (ʒij to the ounce of vaseline), and wrote to me from the country, in October, that she had lately improved. The final result I have not been able to ascertain.

Case 3.—A very similar case to this last one is the following: —A stout, healthy-looking woman of fifty-three came to the hospital with a chronic lichenous eruption on the back of the hands, the forearms, upper arms, hams, and thighs. Besides papules, there were the flat, smooth-topped, scaly, raised patches of Lichen planus, and here and there the scales were so much developed, and the affected surface so large, that the case looked like psoriasis. There were flat, smooth patches on the tongue and cheeks (psoriasis linguæ), but no sign of syphilis. Similar treatment, by arsenic internally and tar ointment locally, succeeded much better than in the former case. Maculæ remained after the cure was complete.

Case 4.—A case, of which I have only a short note, occurred in a woman of thirty-eight, who came among my out-patients with "Lichen ruber, papulatus et planus" affecting both fore-arms and wrists on the flexor side. Colour dark red, smooth surface, irritable. The affection had lasted three months, and had never occurred before. I treated it in the same way as the last, but did not learn the effect.

Case 5.— A remarkably strong, large-framed labourer, 35 years old, came with four well-marked patches of Lichen planus on the back below the angle of the left scapula and somewhat lower down on the right flank, and on the flexor surface of the right forearm. There were papules, separate as well as coalesced into the raised *plaques*. The colour was a dark purplish red, the surface glistening and covered with small, fine scales. In a few weeks, under tar ointment locally and arsenical solution, increased to eight drops three times a day, internally, the eruption disappeared, leaving decided pigmentary stains behind.

Case 6.—A patient of mine, suffering from mitral insufficiency as the result of rheumatism, an otherwise healthy young man, somewhat under thirty, showed me an eruption which he suspected to be syphilitic, although he had never had a chancre. It had lasted several months. There were scattered papules on both legs, some of them covered with small scales, and patches looking like *psoriasis nummulata*. The colour was a deep red. There was great itching. The knee-caps were free, the parts affected being the shin, calf, ham, and adjacent part of thigh. The arms were also free. I ordered Liquor arsenicalis, five

minims after each meal. There was some old, dry, chronic dermatitis of the hands, the remains of what in former years seemed to have been ordinary eczema. A few weeks later the patches were more distinctly raised, flat, shining, and fissured, and the scales more scanty and minute. As Fowler's solution produced disturbance of the stomach, I now ordered five drops of Liquor Sodæ Arseniatis three times a day, with perseverence in the use of the ointment. When the smell of this last became insupportable to the patient, I substituted a strong ointment of Liquor Carbonis Detergens (ʒiv to ℥j of vaseline), and increased the dose of Pearson's solution to seven minims three times a day. The eruption had been steadily fading, no fresh spots appeared, and the cure was complete in about eight weeks; slight pigment stains were left behind.

Case 7.—A man, aged 21, but looking older, of dark complexion and strongly built, came as an out-patient, with characteristic Lichen ruber and Lichen planus affecting the face, chest, back, and trunk generally, as papules; and the elbows, forearms, and thighs, as raised, flat patches. The colour was dark, but not coppery; itching not severe. He recovered under treatment with tar ointment and moderate doses of arsenic.[1]

V. Dermatitis exfoliativa. Pityriasis rubra.

The species of Pityriasis as defined by Bateman are none of them entitled to permanence. *P. capitis* or dandriff is in most cases seborrhœa sicca, in others a slight local dermatitis; an eczema squamosum, often (as he remarks) due to want of cleanliness, and removable by soap and water, but apt, if neglected,

[1] I may refer students of this remarkable form of disease to the following descriptions and cases:—Wilson, 'Diseases of the Skin,' 6th ed., 1867, p. 190; Hillier, Tilbury Fox, 'Brit. Med. Journ.,' April, 1871, and in his 'Text-book,' p. 144; Hilton Fagge, in vol. xv, of the present series of these Reports, p. 341; Liveing, 'Hand-book,' 2nd ed., p. 133; Hutchinson, 'Lectures on Clinical Surgery,' p. 207. Dr. R. W. Taylor, of New York, has published four carefully observed cases of the disease in the 1st vol. of the 'Archives of Dermatology,' which show that its features in America resemble the English disease. We have two models of it in our Museum, No. 259, 260.

"to degenerate into Porrigo," *i. e.* to become pustular. Occasionally it is Psoriasis of the scalp, the scales being small and mixed with sebum owing to the locality. *P. versicolor* is a parasitic disease. *P. nigra,* observed by Willan in children born in India, was not identified by Bateman, nor I believe since. A case of Alibert's, which Devergie calls Pityriasis nigra with prurigo, was apparently Prurigo pedicularis with pigmentation and leucodermia. The fourth and last species, *P. rubra,* "resembling Psoriasis diffusa," denotes like it a stage in the involution of eczema. *P. rubra* of Cazenave seems to be only *P. versicolor* with more irritation than usual.

The word Pityriasis denotes, as its etiology implies, a branny, furfuraceous desquamation; and if we continue to use the term it is only as "roseola," "erythema," or "herpes" to denote a certain anatomical condition, without deciding upon its cause or predicting the event.

But the specific term, PITYRIASIS RUBRA, is now used no longer to denote such desquamation occurring on a red skin, as in eczema or scarlatina, but to signify a substantive disease. This application was made by Devergie in 1854. In his 'Traité pratique des Maladies de la Peau,' p. 263, we read:—"PITYRIASIS RUBRA.—Je place auprès de l'eczéma l'histoire de cette maladie, à cause des difficultés de diagnostic qu'elle présente, et de sa grande analogie de forme avec cette affection."

He describes the disease as beginning with an erythematous redness, usually on the chest or flexor surface of the limbs, and spreading rapidly, with a well-defined margin, deep colour, abundant scales, and more or less thin serous discharge. It covers the whole body,[1] is very obstinate, lasting for months, and occasionally proves fatal by exhaustion and diarrhœa. As a rule, however, patients slowly recover. Relapses are frequent. Devergie admits the difficulty of distinguishing this new disease from eczema, and bases the diagnosis on the following points, which I will put in a tabular form.

[1] "C'est la seule affection qui, avec le psoriasis aigu, puisse envahir à la fois toute la surface de la peau de l'homme" (loc. cit., p. 264).

Eczema.	*Pityriasis rubra.*
Bright red colour.	Rougeur foncée.
Border ill defined.	Sharply-marked border.
Is never universal.	May affect the whole skin.[1]
The skin is not thickened.	The skin, and even the subcutaneous fascia are thickened.
Itching severe.	Less itching, more burning.
Secretion stiffens linen.	Secretion thin, and does not stiffen linen.
Scales small, adherent, and only form during involution.	Scales abundant, readily detached, and present from the first.
État ponctué.	No red secreting points under the scales.

Devergie adds :—" Cette maladie ne se montre guère que vers l'âge de quarante à quarante-cinq ans. . . . on l'observe plus souvent chez la femme que chez l'homme." He ends his account of the disease by giving two cases in which "pityriasis rubra se transforma en pemphigus." The description of these cases resembles that of the Pemphigus foliaceus of Cazenave (which is not mentioned by Devergie, though it had been shortly before described and figured), but it does not appear that any bullæ formed, only a thick "mucous" liquid of faint fœtid odour was secreted under the scales. One of these patients was a woman of sixty-one, who recovered; the other a man of fifty-two, who was still under treatment when the report was made, eight months after his admission to St. Louis, and five years after the beginning of the disease.

Dr. McGhie narrated, under the title "Pityriasis rubra acuta,[1] a rare form of skin disease," a case which he rightly regarded as coming under the description given by Devergie ('Glasgow Medical Journal' for January, 1858, p. 421). This was, I believe the first published in this country, and intervened between Devergie's work and those by Hebra and by Wilson. The case was in a young man: it began with ordinary vesicular eczema of the elbow, rapidly spread as a dry red desquamating dermatitis to the whole body, and ended in recovery in rather more

[1] It must be observed that *aigu*, to which Hebra afterwards took exception, refers to the onset not to the duration of the disease. All Devergie's cases are chronic.

than three months. The desquamation was branny (pityriasis in the literal sense), and there was some pyrexia. Dr. McGhie carefully distinguishes his case from eczema and from psoriasis.

This same patient was brought forward by Professor Gairdner, of Glasgow, seventeen years later ('British Medical Journal,' March 13th, 1875). He had suffered repeatedly from returns of the same disease, each lasting for some months and affecting the nails as well as the skin. In the last attack, from October, 1874, to February, 1875, the temperature was found to vary from a little under 100° up to 103·8°.

In the first volume of his 'Hautkrankheiten' (1860), Hebra adopts the term of Pityriasis rubra in Devergie's sense. His description, based upon three cases, agrees essentially with that just given, and he especially lays stress on the universality of the disease, its remarkable red colour, its great obstinacy, the dryness and desquamation, and the absence of itching. On three points, however, Hebra's account differs from that of Devergie. He makes infiltration of the skin the characteristic sign of chronic eczema rubrum, and its *absence* the peculiarity of pityriasis rubra. Instead of an abundant formation of large, thin, easily detached scales, Hebra speaks of *ganz unbedeutende Schuppenmengen;* and again of *geringe Schuppenbildung, ganz unbedeutende Abschuppung.* He omits all mention of moisture. Moreover, in his experience the prognosis was more unfavourable than in Devergie's; for the three cases he had observed all died. In his table of diagnostic points he contrasts the moisture of eczema with the dry scales of P. rubra, the papules of eczema with their absence in P. rubra, and the irritability of eczema with the constitutional symptoms of P. rubra.

The discrepancies in the accounts of these two eminent observers show the difficulty of making positive and conclusive statements from a small number of cases, for there can be no doubt that Devergie's and Hebra's cases were both distinct from eczema and both examples of the same disease. Further experience has shown (in Vienna as well as elsewhere) that the Pityriasis rubra is far from constantly fatal. Infiltration of the skin is not an invariable character of either eczema or Pityriasis rubra, but I have certainly found it present in almost every case of chronic eczema, and much less marked, or absent, in those of Pityriasis rubra which I have seen.

How Hebra can have made so little of the abundant desquamation can only, I think, be explained by the effects of his treatment: lukewarm baths continued for hours and the use of softening ointments, "verursachten insoferne eine Veraenderung, weil dadurch die Epidermismassen (so the Schuppenbildung must have been considerable) transparenter und die Haut geschmiediger wurde."

In 1861 Dr. Wilks described, in the seventh volume of the present series of these 'Reports,' a case of "General Dermatitis," acute, universal, red, dry, and scaly, the desquamation being very abundant and including the finger- and toenails. It lasted two months, and ended in complete recovery.

In 1867 Mr. Erasmus Wilson described three cases, which he identified with the Pityriasis rubra of Hebra, and proposed the names Eczema foliaceum, Pityriasis foliacea, or Pityriasis foliacea rubra.

The second case, termed Psoriasis squamosa rubra (psoriasis in Mr. Wilson's language meaning at that time dry scaly eczema), occurred in an old lady of 71; it was confined to the hands, and might be fairly regarded as obstinate eczema manuum.[1] But the other two cases, both in old men, are typical cases of Pityriasis rubra, in their universality, redness, dryness, and profuse desquamation, as well as in the uniformity of the lesion, and the absence of severe irritation and constitutional disturbance. One of these patients died of an attack of bronchitis, the other lived to recover of his disease.

Hebra did not admit that Mr. Wilson's cases were Pityriasis rubra in his sense of the word. The chief points of difference are in the scanty desquamation and the ill end of the three cases observed in Vienna. Dr. Hans von Hebra has, however, since published three cases (1876), which were presumably

[1] The obstinacy of the disease is attested and possibly explained by the following list of remedies given without success during ten months—An arsenical course of three months; a course of Donovan's solution for three weeks; bichloride of mercury for one month; nitro-muriatic acid with a bitter; small doses of sulphate of magnesia with quinine, with nitrate of potash, and with colchicum; iodide of potassium with colchicum; citrate of iron and quinine; liquor cinchonæ with ammonia and with sulphuric acid; gentian with soda; and various remedies besides. Meantime were applied locally oxide and chloride of zinc, acetate of lead, ammonio-chloride, nitrate, and nitric oxide of mercury, sulphur, iodide, carbolic acid, and tar.

recognised by his father as genuine pityriasis rubra. Two were in men; in one desquamation was profuse and in large flakes, in the other it was less abundant; both patients died of advanced phthisis, with tuberculosis of several organs. The third case began with impetigo of the scalp in a woman of 64, and agreed in the characters of universality, redness, dryness, and desquamation. She left the hospital after two months' unsuccessful treatment. Other cases have since been published by the late Dr. Hillier, in 1864,[1] as Pityriasis rubra, and by Dr. Fagge in these 'Reports for 1876,'[2] as "Eczema squamosum universale seu Pityriasis rubra."

Mr. Wilson in his "Lectures on Eczema" (1870), describes the disease at length and gives an additional case. It occurred in a young man of 28, and was developed out of an ordinary chronic eczema. It showed the characteristic features of universality, deep red colour, dryness, absence of itching, and profuse exfoliation of large, thin scales, which Mr. Wilson compares to dried hops. There was decided infiltration of the skin, and the nails were affected. The disease lasted from October to January after an acute onset; by the end of three months the patient was entirely free from it.

In these lectures, Mr. Wilson proposed to substitute the title "exfoliative dermatitis," or ECZEMA EXFOLIATIVUM for pityriasis rubra or pityriasis foliacea. Pityriasis was an ill-chosen word, for the desquamation is anything but branny, but the term is now established and is distinctive. Moreover, most pathologists deny that the disease is eczema, and I think on good grounds.

The late Dr. Tilbury Fox (writing in 1873),[3] while agreeing with the descriptions of Devergie, Hebra, and Wilson, not only separates Pityriasis rubra altogether from association with eczema, but maintains that it is not truly a dermatitis at all. Dr. Liveing,[4] on the other hand, agrees with Dr. Fagge in regarding it as only a peculiar form of eczema. He admits the absence of visible exudation, but has found traces of it on the under surface of the large thin scales. He also describes the cutis as not thickened by inflammatory infiltration. In two

[1] 'Handbook of Skin Diseases,' p. 101.

[2] 'Guy's Hospital Reports,' 3rd series, vol. xiii.

[3] 'Skin Diseases,' p. 252.

[4] 'Handbook of the Diagnosis of Skin Diseases,' p. 99 (1878).

cases he had observed albuminuria. One of the patients recovered, the other died of chronic Bright's disease. In a third case, under Dr. Henry Thompson, there was no albuminuria; but the patient died, and *post mortem,* no organic disease was discovered.

Mr. Hutchinson, in the following year (1879), published three most interesting lectures on Pityriasis rubra.[1] He admits that the absence of liquid exudation and of thickening of the skin distinguish it anatomically from eczema, but regards its essential features as universality and resistance to treatment. He would therefore regard it as a type of a group of affections differing in their anatomical features and including "Pemphigus foliaceus, certain rare cases of diffuse eczema and psoriasis, which end fatally, some forms of senile psoriasis palmaris, some of onychitis, and some of lichen psoriasis" (*i.e.* Lichen planus and rubra). As to the pathology of this group, Mr. Hutchinson compares them with generalised destructive inflammation of the joints, and thinks that like that condition they will prove to depend on a neurosis. He argues that their symmetry and universality are conclusive against Pityriasis rubra and its allies having a local origin. "We have therefore to choose between the blood and the nervous system, and in the entire absence of any proof of implication of the former I prefer to suspect the spinal cord." To my mind, I confess Pityriasis rubra is symmetrical because it is universal, and is universal because the skin is universal. The universality is no doubt an important feature of the disease, but it belongs also to Ichthyosis, which is totally different in its natural history no less than its anatomy. Moreover, eczema may be more nearly universal than many undoubted cases of Pityriasis rubra without losing its characters of eczema. The resistance to treatment is another important feature, but this also applies to several other diseases of the skin which have no other bond of union. And reference to the table at the end of this paper will show that most of the cases recorded have recovered, and that many have in the judgment of the recorders been cured by treatment.

As to the pathology of Pityriasis rubra, in the absence (as it seems to me) of any proof of implication of the blood or the

[1] 'Lectures on Clinical Surgery,' pp. 240—274.

nerves, I prefer to suspect the skin. For whatever else the disease may be, it is certainly a dermatitis; and there seems to be no reason why the living cells of the skin should not be liable to idiopathic inflammation as much as those of the mucous membranes, the kidneys, or the lungs. Beside the clinical evidence we have also histological facts proving that Pityriasis rubra is a true dermatitis, which have been observed independently in Vienna and in London.

A microscopic investigation of the skin made by Dr. Hans von Hebra showed that in a fatal case of the disease, which had lasted a year, the whole of the cutis, papillæ, and deep layer, with part of the subcutaneous fascia, was filled with leucocytes. In the other fatal case, which had lasted several years, the condition was very different; it resembled cicatricial tissue. The Malpighian layer of epidermis was thin, and its cells shrunken; the papillæ were also atrophied, and only few remained; the papillary layer was represented by a thin layer of connective tissue, under which a thick layer of yellowish-brown elastic fibres with abundant granular pigment represented the deep layer of the cutis. No sweat glands could be found, and but few sebaceous glands.[1]

In the same year (1879) in which Mr. Hutchinson's lectures were published Dr. Buchanan Baxter published a valuable paper on the subject in the 'British Medical Journal' for July 19th, under the title "General Exfoliative Dermatitis." He details five cases.

The first was a universal dull, red, dry eruption, with infiltrated skin and profuse desquamation, and occurred in a little girl, six years old—a truly acute case, running its course in less than two months, with albuminuria and moderate pyrexia, and proving fatal by œdema of the lungs and diarrhœa. Beyond chronic peritoneal adhesions and bronchial flux, with emphysema and œdema, no lesion was found after death. The kidneys are not mentioned, and therefore we may assume they were not the subject of Bright's disease. Sections made of the skin showed slight swelling of the papillæ and enormous thickening of the cuticle, while the Malpighian layer, instead of being sharply-defined from the latter, passed very gradually into it, the intermediate "granular layer" of epidermis having disappeared.

[1] I quote this account from a report in Behrend's 'Hautkrankheiten,' 1879.

The second of Dr. Baxter's cases occurred in an infant six months old who, after suffering several weeks from ordinary eczema of the head and face, was attacked with universal dermatitis of a dull red colour, dry, and producing abundant large thin scales. It proved fatal in eight weeks.

The third case was in a woman, aged twenty-eight. It presented the characteristic features of Pityriasis rubra, and ended favourably after a course of between two and three months.

The fourth was a remarkable one. It occurred in a boy of seven, and was at first regarded as Lichen ruber; as it gradually spread over the whole body it assumed rather the characters of an "acute psoriasis," but on the whole Dr. Baxter regards it as belonging to the series of Pityriasis rubra or general exfoliative dermatitis. Notwithstanding its wide diffusion, dryness, and profuse desquamation, the fact that some parts of the body appear to have escaped, and the presence of papules, appear to me to be important points of difference. After three months' treatment (begun three weeks after the appearance of the disease) by warm baths, with arsenic and cod-liver oil internally, the eruption had disappeared, but the boy was weak and thin, and died a few weeks afterwards from some acute febrile affection. There had been no albuminuria during his illness.

Dr. Baxter's last case was one of pemphigus (apparently not syphilitic) coming on ten days after birth, which passed into general dry exfoliative dermatitis. The infant recovered in two or three weeks under arsenic. This, Dr. Baxter says, would probably be called a case of Pemphigus foliaceus; but he argues for the recognition of general exfoliative dermatitis as a common meeting point of the four "dartrous" or herpetic disorders which are curable by arsenic, viz. Eczema, Psoriasis, Lichen, and Pemphigus, whenever they become universal.

The objections to this ingenious hypothesis seem to me to be the following:

1. Eczema in its ordinary moist form may be universal or, at least, as nearly so as many of the cases which Dr. Baxter would include, without changing its character, and may so continue for years without either the peculiar anatomical structure or the physiological effects which characterise the typical cases of "general exfoliative dermatitis: witness my case in a lad who had suffered since birth from eczema (p. 215).

2. Though few, if any of us, in England have seen a case of universal and chronic Lichen ruber as Hebra described it, yet he carefully, and apparently with justice, distinguished it from Pityriasis rubra.

3. We may find the characteristic anatomical characters of exfoliative dermatitis or "Eczema foliaceum," not as a universal but as a local affection. Of this I shall give several examples presently (p. 272).

4. Pemphigus foliaceus is not ever, I believe, universal; it is almost limited to women; and its obstinacy and the considerable and often fœtid discharge explain its constitutional effects: whereas some of the most marked cases of Pityriasis rubra, free from irritation, and almost from apparent inflammation of the skin, are yet productive of grave internal effects.

5. That the whole of the skin may be occupied by a thick scaly disease without interference with health is proved by many cases of Ichthyosis. I have now under my care, in Miriam Ward, a child whose entire skin, from head to foot, including the palms and soles and scalp, is occupied by the severest form of Ichthyosis cornea; and she suffers greatly from itching. Yet she has an excellent appetite, sleeps well, and is fat and firm in flesh. The urine is free from albumen and, in fact, she is not "bodily ill" at all.

The course of opinion upon the nature and limits of Pityriasis rubra has been even more divergent in France than in England. Some dermatologists accept Devergie's term in nearly his meaning. Bazin writes of a "Pityriasis rubra aigue généralisée qui s'étend à la presque totalité du corps," and the abundant exfoliation of large scales which he describes confirms the belief that this is Devergie's, Hebra's and Wilson's disease; but he also describes a "Herpétide exfoliatrice," and the case so named by M. Guibout (No. 19 in the table at the end of this paper) is certainly one of Pityriasis rubra. Hardy describes[1] Pityriasis rubra in Willan's, or rather, perhaps, in Cazenave's, sense of the term, as a branny desquamation on a red skin, commonly occupying the head and neck, but "quelquefois toute la surface du corps." General symptoms not unfrequently accompany it, especially fever and digestive derangement. These last two characters recall Devergie's

[1] 'Leçons,' p. 125.

account, but Professor Hardy is careful to express his disbelief in its validity, and decides that the two cases with bullæ, "Pityriasis rubra se transformant en Pemphigus," were nothing but Pemphigus foliacé from the [first, and that all the rest were eczema. I have, however, little doubt that the eloquent professor of St. Louis has seen cases which would be called Pityriasis rubra in Vienna and London, and has described them as psoriasis. He says ('Leçons,' p. 111) that in rare cases psoriasis may become generalised and occupy the whole surface of the body. The scales are thin, not imbricated, and but slightly adherent; the skin is red, tense, and not much thickened, and scored as if with cross-hatchings. "Quelquefois même on peut se demander si c'est un psoriasis ou un pityriasis rubra." He elsewhere speaks of Psoriasis généralisé as "une maladie très rare, très grave." Hardy would no doubt distribute the cases in the table below between eczema (Nos. 8, 15, 18, 21, 37), Psoriasis (Nos. 20, 39, 40), Pityriasis rubra (Nos. 16, 26), Pemphigus foliaceus (Nos. 1 and 2, and also Dr. Baxter's fifth case and Dr. Sherwell's, which he quotes), and Lichen ancien et invétéré (Dr. Baxter's fourth case).

An elaborate monograph on this disease was published by Dr. Percheron, in 1875. He narrates very fully a well-marked and remarkable case (No. 18 in table), quotes some others, and comes to the conclusion that, if we separate cases of Pemphigus foliaceus with bullæ, extensive eczema, and psoriasis, we may recognise a single clinical and pathological group of cases, which agree essentially with the exfoliative dermatitis of Wilson, and with most of the cases recorded as Pityriasis rubra. He would admit the following varieties :—1. Acute erythematous exfoliative dermatitis running a rapid course and without serious effects. 2. The commoner form, with more profuse desquamation of large, thin scales, either chronic or acute in its course, either accompanied with pyrexia and other constitutional symptoms or free from them, either idiopathic or appearing as a complication of local affections of the skin.

In Germany, the classical definition of Hebra has been carefully followed, and the only question has been whether Wilson's cases should be admitted as genuine Pityriasis rubra, or whether all cases of acute and weeping dermatitis ought not to be classed as more or less extensive eczema.

The rising school of dermatology in America recognises for the most part the existence of Pityriasis rubra in Devergie's and Hebra's sense, and its identity with Wilson's and the other English cases. The term "dermatitis exfoliativa" has been adopted by the Dermatological Society of New York. A case described before the Society by Dr. Sherwell, and published in the American 'Archives of Dermatology' for January, 1877, as Pemphigus foliaceus, was recognised as resembling, but not coinciding with, Pityriasis rubra. Dr. Bulkley, in the same periodical (April, 1879), calls the disease "dermatitis exfoliativa (Pityriasis rubra)," and justly remarks that the former term is the more expressive.

I will now give my own cases, and finish this paper by offering with some hesitation the conclusions to which the facts and opinions before us seem to me to lead, and by adding a table of the real or supposed cases of this remarkable disease which I have been able to collect.

Case 1.—*Pityriasis rubra; exceedingly chronic course; dry branny desquamation; no constitutional symptoms.*—A woman, aged 55, was admitted under my care while taking charge of Mary Ward for Dr. Wilks in November, 1879. She had white hair, and looked upwards of sixty. By her own account, which was clear and intelligent, she had scarcely been free from her present complaint since it first appeared, when she was nine years old. It very much improved at about her sixteenth year, and almost (though never entirely) disappeared as she grew into womanhood. But at twenty-eight it returned, and has continued with occasional exacerbations ever since. The eruption is now, and has apparently been for years, literally universal. Not only the whole of the head, trunk, and limbs, but the scalp, palms, and soles are affected. Everywhere it offers the common characters of a dry "superficial dermatitis," the skin red, and decidedly though but slightly thickened, the surface rough and scaly. But local varieties are observable. The scalp presents an ordinary pityriasis, and there is very little mixture of dried sebum with the branny epidermic scales; the arms and legs might be described as affected with dry eczema, but on the extensor surface, and especially on the elbows and knees, the scales are large and more adherent, simulating psoriasis; lastly, the face, back, and abdomen look like severe eczema

beginning to heal by desquamation. There is now no moisture anywhere, and the patient assures me that there never has been, even at the flexures of the joints. There is abundant exfoliation of small, white, branny scales, but none of the large, thin, hop-like squames seen and described in most cases. The curved white edges of exfoliation, compared by Mr. Wilson to frills, to scale armour, and to the ribbed sand on the shore, are well marked. The skin is not very painful, and less irritable than one would suppose. The colour is a full, bright, "inflammatory" redness, without lividity or the slightest pigmentation. The various organs appear to be normal, and the urine is free from albumen. The patient says that her general health is very good, except when the eruption has receded, as it did between the ages of sixteen and twenty-eight. No treatment had a decisive effect, and she left the hospital in May much as she came in.

Case 2.—*General exfoliative dermatitis, with free eczematous secretion; acute course; albuminuria; recovery.*—A woman, æt. 26, was transferred to my care by Dr. Galabin in October, 1878, with general acute dermatitis. The following is a summary of the case:

Ann S—, suffering from pelvic cellulitis, was attacked while in the ward with a papular, measle-like rash on the trunk and legs, accompanied with slight sore-throat and raised temperature. Two days later, the temperature rose to 104°, and albumen appeared in the urine. The rash was not like that of scarlatina, measles, or rubeola; nor was the state of the tongue, throat, or other organs, like that in any of these exanthems. It had spread over the whole body excepting the palms and soles in a week, vesicles appeared on the chest, bullæ, on the arms and legs, and a raw weeping patch behind one ear. Three weeks from the first appearance of the rash, the fever and albuminuria had disappeared, and free desquamation was going on; branny, like pityriasis, on the scalp and face, in large flakes on the hands. Impetiginous crusts had formed on the chin and on the limbs, and there was profuse serous secretion from the ears, neck, and arms. As involution went on, the previous pain was succeeded by intolerable itching, which gradually also disappeared. An abscess formed in one axilla; and a fresh papular eruption appeared on the chest and limbs on

the 6th of December, which only lasted three days. The patient was discharged perfectly well on the last day of the year.

This case resembles that of Dr. Wilks' referred to above (p. 262), and also one which I published in the twenty-third volume of this Series (1877). That was an acute universal, vesicular, and weeping, but also desquamative, dermatitis with pyrexia, occurring in a patient who was the subject of chronic tubular nephritis. It ran an acute course and proved fatal in four days.

CASE 3.—*General exfoliative dermatitis, beginning as recurrent eczema; profuse desquamation; weeping; acute course; albuminuria; recovery.*—Ellen D—, æt. 42, was admitted under my care into the clinical ward in July, 1879, presenting the characteristic features of universal exfoliative dermatitis. I may add that Dr. Baxter was so kind as to come down to see this case, and entirely agreed in the diagnosis. Her account was that in her two last pregnancies she had suffered from a slight eruption on the feet, and that this has spread during the last three years to the rest of the body. The whole of the surface (except the scalp and face), both trunk and limbs, including the palms and soles, was covered with a dusky red, scaly eruption. There were a few large scattered vesicles and some petechiæ. Here and there moist weeping spots were to be found; but the surface was generally dry. The scales were large, thin, not imbricated and not adherent, and were continually shed in great flakes which filled the bed. There was moderate pyrexia; and not only albumen in the urine, but also pus and mucus with other symptoms of cystitis. For a time she was exceedingly ill, but gradually and slowly improved, the scales became less abundant, the redness disappeared, the urine became normal, and she went out well at the end of August.

There was then only slight ordinary "dry scaly eczema" on the upper limbs.

She came to me during the following October and November with one spot of still persistent dermatitis on the flexor aspect of the left forearm just above the wrist. This presented no characteristic features except its obstinacy, and the fact that it produced superficial ulceration, so that slight scars remained after she was finally cured.

The following cases show that the same anatomical condition which is seen in general desquamative dermatitis or "Eczema foliaceum universale" (as distinguished from the perfectly dry cases of "pityriasis rubra") may also occur as a local affection.

I. A big florid woman of 44, came among my out-patients with somewhat extensive inflammation of the skin. It had lasted for two years. She had not before suffered from anything like it, and said that she was always perfectly well. There was no evidence of gout. Both legs were covered with large, thin, coherent flakes of epidermis, yellowish-white in colour, not closely adherent to the skin beneath, and when removed, leaving a dry, red, somewhat tender surface, like that of psoriasis. The affection was not confined to the flexor or extensor surface, covered both hams and extended in a less severe degree to the thighs, nates, and abdomen. On the outside of both arms a similar condition was observed, but it was less marked, and occurred in patches instead of being continuous. There was not much itching or pain, there had never been any weeping, and the skin was not infiltrated. A week later, after the application of an ointment containing two drachms of Liquor Carbonis Detergens to an ounce of lard, there was active ordinary exudative dermatitis set up (traumatic eczema). A superficial ulcer formed on one leg below the calf and there was considerable pain and disturbance. Gradually the acute symptoms thus produced subsided, and under treatment by alkalies and saline laxatives, with lead and zinc ointment externally, the skin recovered. After two or three month's observation, the patient was so nearly well that she ceased to attend. The treatment I here adopted had a more severe effect than I intended, but it appears to have acted as we often see stimulant applications prove useful; by substituting a more acute ordinary traumatic inflammation for the previous condition and so leading to the removal of the original disease.

II. An old man of 76, somewhat pale and thin, but in good health for his age, appeared with a chronic inflammation of both legs, which at the first glance looked like eczema. But it was strictly limited to the parts below the knee, it involved the whole of both feet except the soles, where the skin was hard and thick; it was dry, and the surface was covered with thin epidermic flakes as large as a crown piece and larger. On

removing them a very scanty, thick, tenacious secretion was found adhering to their deep surface, quite unlike eczematous fluid. There were no fissures, no ulcers, no varicose veins; and the skin was uniformly affected from a sharp line just below each knee downwards. The arms, trunk, and other parts were perfectly free from any lesion. There was considerable itching but no other constitutional disturbance. The affection had lasted two months. He gradually improved under local treatment chiefly with Ung. Plumb. Carb., and after several weeks was discharged with only a slight ordinary dry dermatitis.

III. A little pale woman of 40 came with a very simple "exfoliative dermatitis" of one leg. She had been under my care two years before for psoriasis, which was cured and had not returned. The anatomical condition closely resembled that last described, but the case was as much less severe than No. II as that was than No. I. The patient disappeared from observation before the effect of treatment could be ascertained.

IV. Hannah C—, æt. 41, has attended me on several occasions in 1879 and 1880 with large patches of inflamed skin on both legs above the ankle. The surface is red, angry, very irritable, and covered with a scanty, thick, white secretion, more like mucus than pus in appearance. This is seen when the large flat scales which conceal it are removed. These are not scabs, as in eczema, but epidermic scales, much larger and thinner than in psoriasis. Under the microscope they consist entirely of epithelium, with scanty pus-corpuscles on their under surface.[1] They are easily detached in flakes as large as a crown. This patient twice recovered under ordinary local treatment.

The following two remarkable cases are in accordance with what Dr. Baxter has observed, that a condition regarded by competent physicians as ordinary local psoriasis may assume the characters of a more serious and universal, dry, scaly disease, Pityriasis rubra. The hereditary character is also worthy of note.

Ellen P—, æt. 17, a stunted girl, looking four or five years younger, is still under my care in Miriam Ward. She has been more than once in the hospital under Dr. Wilks and Dr. Moxon,[2] sometimes for the disease of her skin, sometimes for

[1] See Dr. Liveing's 'Handbook,' p. 121.

[2] It is this patient to whom Dr. Moxon refers in his Croonian Lectures.

epilepsy, to which she has been subject from the age of ten. Once, also, she was attacked with acute pleuro-pneumonia, from which she completely recovered.

Her father, brothers, and sisters have healthy skins, but her mother has long been subject to a disease like that of her daughter (see the following case).

She was healthy when born, but when eighteen months old inflammation appeared behind the ears. This soon departed, but the following year returned and spread to the head and neck. Since then she has again and again recovered, and again and again the disease has returned with greater obstinacy. For several years it has been almost universal and constant. In February, 1879, when under Dr. Moxon's care with severe epileptic fits, the whole body was covered with a dry, scaly eruption, there was moderate pyrexia, but no albuminuria, and she went out much improved.

When she came under my care last April, the whole body was covered with a dry scaly eruption—scalp, face, trunk, and limbs, including the palms and soles. The skin was red, but there was no moisture, and scarcely any fissures, nor were the integuments infiltrated or thickened except by the masses of epidermis. Those on the scalp were small, and mixed with sebum; on the face, back, and trunk generally, they were comparatively scanty, the scales being thin, small, and readily detached, a true pityriasis. On the limbs this branny desquamation was replaced by a thick encasement of scales, covering the knuckles and fingers and toes, as well as the elbows and knees. The scales, however, differed from those of ordinary psoriasis in being more opaque, yellowish and dull, smaller and less adherent. The nails of both hands and feet were broken and deformed. There was no attempt at involution, and consequently no trace of an annular or gyrate form. The urine was normal. By a diligent use of baths and ointment constantly applied, the state of the skin was much improved; all the scales were removed, and the surface became apparently normal, except that it was still somewhat red and tender, and showed several pigment spots. She went out in this condition.

Sophia P—, æt. 48, the mother of the patient whose case has been just described, is now one of my out-patients. She also is the subject of a universal, dry, scaly disease, which I think

should be called Pityriasis rubra. Other good observers, however, consider it and her daughter's disease to be unusually severe and general psoriasis. The pathology of the two is certainly the same. In the mother's case there was no appearance of the disease until she was nearly forty. A scaly eruption then appeared on both forearms, and this gradually but quickly spread until it covered the whole of the body. At the present time there is not a sound spot anywhere. Scalp and face, palms and soles, every region is affected. The nails are brittle and deformed. There is not, and never has been, any exudation. The scales are generally numerous, small, loose, and not "pearly" in appearance. On the whole, they are not so thick as in her daughter. The face is almost free, being only red, smooth, and somewhat brawny, and the hands are in a similar state. Only on the limbs are the scales thickly massed, most so on the elbows, knees, and shins, but the distribution is much less regular than in ordinary cases of psoriasis. There are no patches or rings. The hair and teeth are fairly good. The tongue is clean and free from disease, the urine not albuminous. There is a great deal of irritation, the itching being sometimes intolerable. The patient is thin and weak, and there is slight pyrexia, but she eats well. There is chronic ophthalmia with great photophobia. Since the disease became universal it has never disappeared, but the condition of the skin is generally worse in the autumn. Ointments suit it best, especially vaseline. Arsenic she has found does her no good.

She has several children beside the one whose case has just been given, but no others of them have any affection of the skin. Her father's family were also free from any disease. Her mother, however, was subject to what she believes was the same disease—a general dry redness and scaliness of the skin—as long as she can remember. This, the only person affected in that generation of the family, died aged forty-eight. In the preceding generation the father (grandfather of Sophia and great grandfather of Ellen P—) was the subject of "the same complaint." He died an old man. Further back the family traditions do not go.

These two cases have considerable resemblance to Dr. Fagge's of acute general psoriasis proving fatal in a boy; indeed, the model of the face of that patient in our museum (No. 251)

would, I have no doubt, have been labelled pityriasis rubra by Devergie. The difficulty of diagnosis in this case and the two preceding ones is not between Pityriasis rubra and Eczema, but between Pityriasis rubra and Psoriasis. Indeed, the case of the daughter was called psoriasis by some of my colleagues in Guy's Hospital, and that of the mother was called psoriasis at an earlier period of the disease by Dr. Payne in St. Thomas's. In favour of this view are, I admit, the hereditary transmission and the occurrence of pigment spots in the girl. Nor can I doubt that the mother's case once presented the characters of ordinary psoriasis.

The objections to regarding either of the cases intheir present state as psoriasis are, I submit, the universality of the eruption; the want of any selection of the favourite seats of psoriasis before it became universal, and of any special profusion in the same regions afterwards, together with the full and complete occupation of parts which it rarely affects; the absence of any attempt at a process of involution like that which almost always attends psoriasis, however inveterate; the presence of large loose squames in some parts and of branny desquamation in others, with the entire absence of the silvery, coherent and adherent, imbricated scales of psoriasis; lastly, the resistance to treatment, especially by arsenic.

Dr. Baxter would solve the difficulty by explaining my two cases as he does those of M. Guibout and of Dr. Fagge, to be psoriasis assuming the characters of, or developing into, Pityriasis rubra. But the cases are not similar. M. Guibout's patient had suffered from ordinary psoriasis for nine years. The universal deep redness with profuse exfoliation and severe constitutional symptoms which suddenly set in was clearly Pityriasis rubra in Devergie and Hebra's sense, notwithstanding that it received the odd designation of "Herpétide maligne exfoliatrice." It ran an acute course of six weeks, and then left the patient to his psoriasis. In Dr. Fagge's case there was no previous psoriasis; the disease, whatever it was, was the same throughout. In my two cases, even supposing that they were originally psoriasis, the gradual progress of the disease in an unusual, if not an unprecedented course, has at last completely changed its characters.

Dr. Baxter's hypothesis I take to be that eczema, psoriasis,

lichen, and pemphigus, show their pathological affinity by a common capacity of becoming universal and assuming new and unusually severe characters; but that, while thus converging, they in most cases preserve some mark of their origin. Thus eczema when generalised, becomes the moist, secreting form of universal exfoliative dermatitis (exemplified by Nos. 28 and 37 in the subjoined table). Psoriasis preserves its characteristic dryness and appears as Pityriasis rubra (in the restricted sense of Hebra, Nos. 3 and 4). Lichen develops into the severe general disease called Lichen rubra by Hebra. Lastly, Pemphigus assumes the well-known form described by Cazenave as Pemphigus chronique foliacé, of which he says: "L'éruption s'étend alors et peut prendre un charactère de généralité grave." To this last form would belong Devergie's two cases of Pityriasis rubra (Nos. 1 and 2), "qui se transformaient en pemphigus." Such a simplification is ingenious and attractive. But I do not think that it can be at present accepted. For (1) most of the recorded cases of exfoliative dermatitis have begun from none of these four local and ordinary diseases. (2) Others have arisen from erythema (No. 26), or from impetigo (No. 34), which no one, I believe, supposes to be "dartrous." (3) If we allow these four varieties of exfoliative dermatitis, may we not with little more extension of terms admit Hebra's prurigo as the generalised and inveterate development of infantile prurigo, or of the prurigo mitis of adults? (4) As I have already pointed out, universal dermatitis does not always assume the same characteristic anatomical features, and does not constantly affect the temperature, the urine, or the general health.

The difficulties of forming a judgment on the several questions raised concerning pityriasis rubra are extreme. I hope that this paper may contribute to a more extended knowledge of the facts upon which, when tested by future and larger experience, we may hope to found a sure and final judgment.

At present every fresh case which I have myself met with or which has been recorded by others, has added some fresh obstacle to making satisfactory generalisations. But I think a consideration of the evidence before us will lead us to admit the following statements as true.

1. The characteristic anatomical features of exfoliative

dermatitis present themselves under different clinical conditions. They may occur locally (p. 68) or universally; as a sudden acute attack having a short and favourable course (Nos. 32, 37); as a series of recurrent acute attacks (Nos. 4, 10, 11); or as a chronic disease from the beginning (Nos. 3, 24, 36).

2. The same disease, as judged by its redness, peculiar form of desquamation, and universality, may be perfectly dry throughout, or may be moist here and there in the flexures of the joints, or may secrete profusely.

3. Even when defined by terms made arbitrarily strait, a universal, dry, red exfoliative dermatitis may be accompanied by pyrexia or be free from it; it may produce severe emaciation, or leave the patient well-nourished; the kidneys may "sympathise" with the diseased integument, or the urine may remain healthy.

4. Instead of being confined, as Devergie thought, to persons who have passed the prime of life, subsequent observation has shown us that Pityriasis rubra may occur at almost every age.[1]

5. Lastly, the grave prognosis of Devergie, made still more gloomy by the experience of Hebra, has been altered by the record of numerous cases which ended in complete recovery; and (what is more remarkable) of others in which the disease persisted incurable and unchanged for years but without seriously affecting the general health.

All we can at present do is to separate from one another such groups of cases as appear to be clinically and pathologically distinct, to look rather to these criteria than to anatomical variations in forming our groups, to bear in mind the practical objects of prognosis and treatment to which classification and nomenclature are a means, and to deviate as little as possible from the nomenclature most generally recognised in civilised countries, and especially from that of the greatest authority on the subject, the late Professor Hebra.

I would therefore separate as distinct from Pityriasis rubra the following forms of disease:

[1] The following are the ages of the patients affected with the more typical form of pityriasis rubra in the Table below:—Under 10, four cases, beside a fifth of pemphigus foliaceus (?) in an infant, which I have not included. Between 10 and 20, two cases. Between 20 and 40, seven cases. Between 40 and 60, ten cases. Above 60, five cases.

1. Acute universal dermatitis: a somewhat rare form of inflammation of the skin, superficial, *i.e.* affecting the Malpighian and papillary layers, so as not to leave scars, and ordinary, *i.e.* such as can be produced at will. It therefore resembles eczema in its anatomy, and runs through the same stages; first hyperæmia (the erythematous stage), then secretion (the weeping stage), usually assuming the appearance of *Eczema madidens* at once, but often showing vesicles, and occasionally papules or bullæ; lastly desquamation. Such cases are often called acute Eczema, but although idiopathic, superficial, and "common" dermatitis, they differ in their very rapid course, in their universal distribution, and in the absence of recurrence. Moreover, they are usually accompanied with pyrexia and general disturbance, and not unfrequently with albuminuria, approaching erysipelas in these respects. The prognosis is grave, but recovery is more frequent than death. The treatment is unlike that of eczema; it is essentially corroborant, quinine, stimulants, and mineral acids having been found most successful.

2. Cases in which Psoriasis becomes general and inveterate, but still preserves the characteristic form of the scales, the absence of exudation, except as the direct result of scratches or of cracks of the skin, and at least some trace of the predilection for certain regions. The successful treatment by arsenic in full and continuous doses shows the true pathology of such cases, but I cannot deny that severe and almost universal psoriasis may resist all treatment and lead to death.

3. Local exfoliative dermatitis, as I have described above (p. 68); differing from eczema in the abundance and size of the scales, in its sharp border, and its independence of the ordinary localisation; differing from Pityriasis rubra by not being universal.

4. Pemphigus foliaceus, as described by Cazenave, Hebra, and later writers. The few cases which I have seen of this remarkable disease occurred in women; they differed both anatomically and clinically from the exfoliative dermatitis as described by Wilson, and still more from the Pityriasis rubra of Hebra. One was certainly cured by an arsenical course of treatment.

I would—at least, for the present—classify as a single natural group of diseases, cases which conform to the descrip-

tions of Hebra and the three detailed cases of Mr. Wilson (Nos. 8, 9, and 10 in the table).

The most marked feature is their universal distribution, and also their rapid and irregular spreading, which is very unlike the gradual and, so to say, methodical extension of eczema.

The characteristic lesion is the production of large, thin, papery, or hop-like squames, unlike the silvery, imbricated, tenacious scales of psoriasis, the small, dirty, irregular scales of syphilis, the branny desquamation of measles or scarlatina, and the squamous stage of ordinary eczema. Their profusion and easy detachment are also remarkable.

In the most typical cases the skin is dry throughout, but sometimes a certain amount of secretion has been observed, apart from accidental cracks or injuries. This may be thick and gelatinous, or thin and malodorous, but it never has the stiffening property due to the richness in albumen of eczematous secretion, nor is it purulent.

The irritation is usually greater than in psoriasis, and the skin is redder and more burning.

In the more acute cases, possibly in all if they were observed at the outset, there is some pyrexia and general disturbance. Albuminuria is rare. If the disease becomes chronic (as is most frequently the case) these symptoms usually disappear.

The prognosis is not what Hebra supposed, and most of the cases recover; but when it has become chronic, pityriasis rubra is probably as incurable as ichthyosis.

The treatment is not satisfactory. Arsenic has failed in most cases to be of service. Even when the skin is perfectly dry, liquid applications, and especially warm baths, are much valued by many of the patients; but inunction with vaseline, or with lead or zinc ointment, made almost liquid by the addition of olive oil, is more commonly effectual. Tarry preparations are, I believe, ill borne.

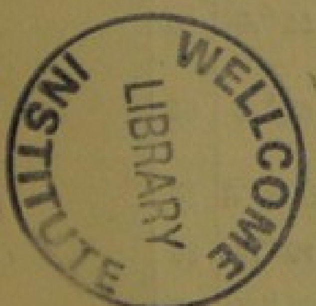
Table of Cases of General Exfoliative Dermatitis.

No.	Sex and age.	Origin.	Lesion.	Extent.	Constitutional symptoms.	Course.	Result.	Name given.	Author.
1	F., 61	Acute, idiopathic	Large scales, redness, exudation, bullæ	Not universal; head, back, and arms free	Fever and diarrhœa	Intermittent	Recovery	P. rubra, ending in pemphigus	Devergie, Mal. de la Peau., p. 268, 1854.
2	M., 52	Gradual (?)	Desquamation, bullæ	Not universal	,, ,,	Chronic, 5 years	Improvement	,, ,,	Ibid.
4, 5, 6	Sex and age not given	Gradual (?), idiopathic	Dry, deep red, scanty branny desquamation	Universal	Marasmus	Chronic, several years	Death	P. rubra	Hebra, Hautkrankheiten, i, p. 321, 1860.
3	M., 24 to 41	Acute, began with vesicular eczema of elbow	Dry, red, branny desquamation	,,	Fever during each attack	3 mos., frequent attacks, each lasting several months, during 17 years	Recovery from last attack	,, acuta of Devergie	M'Ghie, Glas. Med. Journ., 1858, p.431. Gairdner, Brit. Med. Journ., March 13, 1875.
7	M., 34	Acute, idiopathic	Redness and desquamation	,,	Fever	6 weeks	Recovery	Acute general dermatitis	Wilks, Guy's Hosp. Rep., 1861.
8	M., 68	Acute, began with dermatitis of hands and feet; erysipelas	,, ,,	,,	Rapid pulse	Several months	Improvement	P. foliacea rubra	E. Wilson, Dis. of the Skin, p. 177.
9	M., 69	Acute, idiopathic	,, ,,	,,	Absent	6 mos.; second attack, 18 mos. later, 3 months	Recovery from first attack; death from bronchitis during second	,, ,,	Ibid., p. 186.
10	M., 50	Acute	Red, dry, desquamation	,,	,, (?)	Repeated attacks	—	—	
11	M., 55	,,	Desquamation	,,	,, (?)	,, ,,	Recovery	—	Rayer, Mal. de la Peau, Cases cxxii, cxxiii.

No.	Sex and age.	Origin.	Lesion.	Extent.	Constitutional symptoms.	Course.	Result.	Name given.	Author.
12	F., 13	"Same rash" on limbs a year before	Redness, with punctiform injection; desquamation	Universal	Absent, slow pulse	5 months	Recovery	P. rubra	Hillier, Handbook of Skin Dis., p. 101.
13	F., 50	Gradual, idiopathic	Redness and desquamation	Palms and soles only free	Absent	Several months	Death from lobular pneumonia	Eczema squamosum universale, seu P. rubra	Fagge, Guy's Hosp. Rep., 1867, p. 208.
14	M., 8	Gradual, idiopathic (previous rheumatism)	Redness, desquamation, rimæ, profuse discharge	Feet only free	Severe (no albuminuria)	5 weeks	Death from bedsores and exhaustion (adherent pericardium)	Acute psoriasis eczema	Ibid.
15	M., 28	Acute, began with ordinary eczema	Dry, red, desquamation	Universal	Absent	4 months	Recovery	Exfoliative eczema	Wilson, Lect. on Eczema, 1870.
16	F., 9	—	Dry, red, branny desquamation	,,	,, (morbus cordis)	Several years	Not fatal	P. rubra of Hebra	Moore, St. Barth. Hosp. Rep., 1874.
17	F., 48	Gradual (previous rheumatism)	Redness, desquamation, pustules	,,	Pyrexia	—	Recovery	General exfoliative dermatitis (P. rubra)	Sparks, Brit. Med. Journ., Nov. 6, 1875.
18	M., 20	Acute, idiopathic	Redness, desquamation, slight exudation	,,	,, angina, and bedsores (no albumin.), temporary bruit	8 months	,,	Dermatite exfoliatrice généralisée	Percheron, Etude sur la Dermatite, 1875.
19	M., 51	Acute, previous ordinary psoriasis persisting throughout	Dry, red, desquamating	,,	Severe	6 weeks	,, ; a second similar attack	—	Guibout, ibid.
20	M., 51	Gradual, psoriasis from 21, becoming general at 44	Dry, imbricated scales	Universal; began on elbows and knees	Absent	5 months	Recovery under arsenic	Psoriasis généralisée	(Case under Hardy). Baggio, Thèse de Doctorat, 1875.
21	M., 64	Gradual, beginning with ordinary eczema	Red, dry, with slight moisture; profuse desquamation	Universal	Ophthalmia; night sweats no albumen, boils, &c.	12 months	Death from acute pneumonia	Dermatite exfoliatrice généralisée	Blachez, 1875; quoted by Dr. Baxter.

22	M., 26	Gradual, beginning with ordinary psoriasis	Red, dry, desquamation, slight secretion	,,	Not severe	2 months	Recovery	—	Besnier; quoted by Percheron, p. 46.
23	M., 29	Acute	Large scales, moisture	Not quite universal	Absent; slight bruit (?)	3 weeks	,,	Eczema	Ibid., p. 54.
24	M., 38	Gradual	Red, dry, large scales	Universal	Absent (apart from phthisis)	Several years	Death from phthisis	P. rubra	Hans Hebra, 1876; quoted by Dr. Baxter.
25	M., 53	,,	Red, dry, desquamating	,,	Absent	About a year	,, ,,	,,	Ibid.
26	F., 64	Acute, previous impetigo capitis	Red, dry, small scales	,,	Feeble health	2 months	Uncured	,,	Ibid.
27	F., 50 (?)	Gradual, began with ordinary eczema	Red, dry, desquamating	,,	Absent	18 months	Recovery	Dermatitis exfoliativa, or P. rubra	Finney, 1876; quoted by Dr. Baxter.
28	F., 39	Acute, during the course of M. Brightii	Red, profuse desquamation, discharge	,,	Severe; pyrexia, &c.	4 days	Death	Acute general dermatitis	Pye-Smith, Guy's Hosp. Rep., 1877, p. 168.
29	F., 77	Began with pruritus	Red, dry, profuse branny desquamation	,,	Slight	Several months	Recovery	P. rubra	Hutchinson, Lect. on Clin. Surgery, vol. i, p. 243, 1879.
30	F., 30	Gradual, idiopathic	Red, dry, desquamation	Not quite universal	,,	3 months	Not known	,,	Ibid., p. 248.
31	M., 30	Began with pruritus	Red, dry, profuse desquamation	Universal	Absent	2 years	,,	,,	Ibid., p. 249.
32	F., 6	Acute, idiopathic	Red, dry, desquamation, slight discharge	,,	Pyrexia	2 months	Death from bronchitis	General exfoliative dermatitis	Baxter, Brit. Med. Journ., July 19, 1879.
33	M., six months	Acute, after eczema capitis	Red, dry, desquamation; a few pustules	,,	Severe	8 weeks	Death	,, ,,	Ibid.
34	F., 28	Acute, pityriasis capitis and erythema	Red, dry, large and branny scales	,,	Wasting, diaphoresis, intercurrent rheumatism	4 months	Recovery	,, ,,	Ibid.
35	M., 7	Beginning as lichen ruber	,, ,,	,,	Emaciation	,,	,, ; while convalescent death from a fever	,, ,,	Ibid.
36	F., 55	Gradual, idiopathic	Red, dry, branny and flaky desquamation	,,	Absent (no albuminuria)	More than 40 years	Unchanged	P. rubra of Hebra	Pye-Smith, Guy's Hosp. Rep., 1881, vol. xxv, p. 269.

No.	Sex and age.	Origin.	Lesion.	Extent.	Constitutional symptoms.	Course.	Result.	Name given.	Author.
37	F., 26	Acute, idiopathic	Red, vesicles and bullæ, profuse desquamation	Universal	Pyrexia, albuminuria	2 months	Recovery	Exfoliative dermatitis	Pye-Smith, Guy's Hosp. Rep., 1881, vol. xxv, p. 270.
38	F., 42	Gradual, previous local dermatitis during pregnancies	Red, dry, except a few vesicles, profuse desquamation	„	Pyrexia, albuminuria, cystitis	—	„	„ „	Ibid., p. 271.
39	F., 48	Gradual, beginning as psoriasis on forearms (not elbows or knees)	Red, dry, profuse desquamation	„	Pyrexia, no albuminuria, ophthalmia	8 years	Unchanged	P. rubra	Ibid., p. 274.
40	F., 17	Gradual, beginning in ordinary eczema (?)	Red, dry, profuse desquamation, pigmentation	„	Doubtful, apart from severe epilepsy	From infancy	Improved	„	Ibid., p. 273.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