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ON

LUPUS ERYTHEMATOSUS;

OR

BAT'S-WING DISEASE.

BY

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LONDON:

J. & A. CHURCHILL,

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1887.

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ON LUPUS ERYTHEMATOSUS.

LUPUS ERYTHEMATOSUS (or *Vespertilio*), although one of the rarer diseases of the skin, is nevertheless an important one.

It derives its importance from the circumstances that it attacks the face in preference to any other situation; that it invades especially the front of the face; that here it is wont to cause disastrous disfigurement, which as a rule is not only very considerable in extent but very considerable in degree also,—disfigurement which is furthermore of very lasting duration and exceptionally difficult to get rid of; and lastly, but not least, that, having such characters as these, it exhibits also a special preference for attacking the female sex.

It is not accompanied by any particularly distressing sensations, nor indeed by symptoms of any kind other than the mere fact of its securely occupying and blotting out tracts of previously healthy skin. It in no way affects the general health.

It is mainly as a formidable and definitive destroyer of feminine good looks that "Vespertilio" offers itself for consideration: this is its favourite capacity. It does not appear in old age, nor is it a disease of childhood or of adolescence. It is at the period of full maturity, at the prime of life, that it generally develops itself.

The disease has been described by Biett under the name of 'Dartre rongeante qui détruit en surface,'[1] or of 'Érythème centrifuge,'[2] by Hebra as 'Seborrhœa congestiva,'[3] by Parkes as 'Lupus superficialis,'[4] by Cazenave as 'Lupus erythematodes,'[5] a name which was subsequently adopted by Hebra,[6] by Veiel as 'Erythema lupinosum,'[7] by Volkmann as 'Lupus seborrhagicus.'[8]

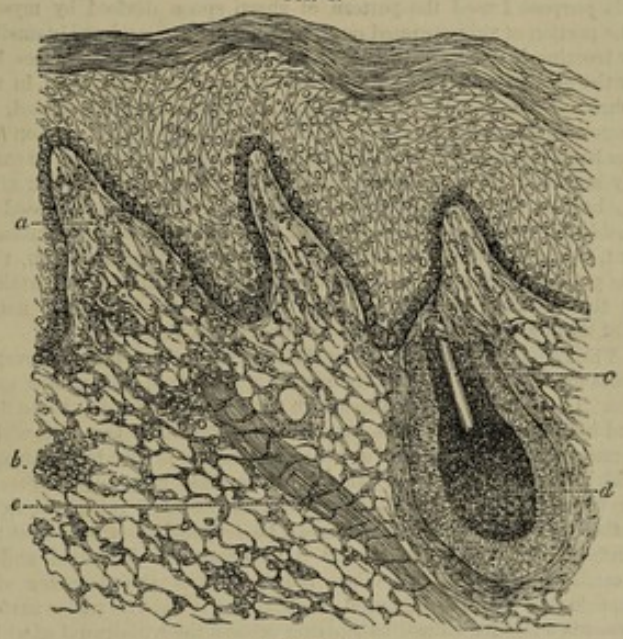
The most characteristic feature of the disease is its tendency to arrange itself on the front of the face in a definite and peculiar shape. In this its favourite situation it is wont to produce with its greenish-yellow scabs a pattern of very striking configuration. This pattern has been compared by some to the shape of a bat with extended wings, by others to that of an outspread butterfly; the body, whether of bat or butterfly, is represented by a central patch on the bridge of the nose, and the wings by much larger lateral patches on the cheeks. The lateral portions of the pattern are commonly each of them joined on to the central portion by a narrow prolongation, and thus the fanciful resemblance is rendered complete.

A scarcely less important characteristic of Vespertilio is its tendency to invade also, and that with remarkable constancy, another situation, namely, the pinna of the ear on either side. The part of the pinna affected is most commonly the lobe or the skin immediately beneath the lobe, next commonly the hinder edge of the pinna (above the lobe), namely, the lower two-thirds of that edge, less commonly the hollow of the concha, and sometimes the back surface of the pinna or the skin covering the mastoid bone. This invasion either of the lobe or of the hinder edge of the ear often takes place simultaneously with the very earliest appearance of the disease on the front of the face, so as in such cases to constitute in the earlier, as indeed in all, stages of the disease a diagnostic sign of very considerable importance. I have met with many cases of Vespertilio, but I have met with but few in which this phenomenon was absent. I therefore lay some stress on its diagnostic value.

There is yet another constantly present phenomenon of Vespertilio which is as special to this disease as is either the bat-like pattern it produces on the face or its often initial development on or close by the lobe of the ear. This phenomenon is constituted by the peculiar appearance presented by the under surface of the hard tough dry and often fissured greenish-yellow scabs, and equally by the corresponding peculiarity exhibited by the surface of the reddened, raised and remarkably indurated skin on which these scabs rest. On detaching a portion of the scab with the finger-nail—a proceeding which discloses that the scab adheres with special tenacity to the skin beneath it—it is found that the under surface of the scab (which is perfectly dry) is studded with quite a crowd of very distinct little tapering pegs or processes which are white or of a greyish-white colour. On examining the surface laid bare by this removal of the scab, it is seen that in addition to its other characters above stated this surface presents a number of funnel-shaped and somewhat coarse pin-holes into which the above described little tapering pegs obviously fit. These holes are the dilated orifices of sebaceous follicles, and the little pegs are composed of the altered secretion of the diseased sebaceous glands, and very often also of the epithelial lining of the sebaceous ducts. This "phenomenon," taken in conjunction with the faintly unctuous, or rather, as one may more fitly express it, the dried-up-cheese-rind consistency of the scabs, points to the disease being primarily and essentially a lesion of the sebaceous glands—a conclusion which is moreover amply supported by the results of microscopical research.

A further main characteristic of the disease, but this is one which it shares in common with some others, is that as a patch of the disease gradually spreads the central portion of the affected patch of skin becomes in parts atrophied and cicatricial. This scarring takes place without, however, the intervention of ulceration, excoriation, or indeed any actual breach of the surface of the skin.

FIG. 1.



VESPERTILIO.

a, Enlarged papilla with cell-infiltration; *b*, denser aggregation of cells; *c*, hair (cut through); *d*, sebaceous gland with infiltration; *e*, arrector pili. (Neumann.)

THE HISTORY OF THE CASE represented in the coloured illustration is as follows: The patient, an unmarried Scotswoman residing in Glasgow, was admitted on July 9th, 1883, as in-patient of the British Hospital for Skin Diseases. Her age at that time was 37, and the duration of her disease 3 years. The disease commenced with a small spot on the *upper part* of the right cheek and with (about the same time) another spot partly close by, and partly on, the lobe of the right ear. Very soon indeed a third spot appeared on the *upper part* of the left cheek. From the two spots on the cheeks the disease spread, gradually extending over the upper part of each cheek and then spreading by degrees downwards to the extent occupied by it at the time of her admission. The bridge of the nose and the forehead became affected later than the ears and the upper part of the cheeks. The forehead had only been affected for about one year.

Close by the right ear, in addition to the patch already referred to on the lobe, there is a patch over the mastoid bone, and opposite this latter patch there is a further patch on the back surface of the pinna of the ear. By and on the left ear there are corresponding patches, namely, one over the mastoid bone and one on the back of the pinna.

[1] Abrégé pratique des Maladies de la Peau par Cazenave et Schedel, Paris, 1828.
[2] Traité élémentaire des Maladies de la Peau par Cazenave et Chausit, Paris, 1853.
[3] Zeitschrift der K. k. Gesellschaft der Ærzte in Wien, Vienna, 1845.
[4] On Diseases affecting the Skin by the late Dr. Thomson completed by Dr. Parkes, London, 1850.
[5] Annales des Maladies de la Peau, Paris, 1851.
[6] Atlas der Hautkrankheiten, 1 Heft, Vienna, 1856.
[7] Mittheilungen über die Behandlung chronischer Hautkrankheiten, Stuttgart, 1862.
[8] Sammlung klinische Vorträge, No. 13, Leipzig, 1870.

She never had any spots on the hairy scalp, nor indeed in any other situation than those above detailed. The disease is therefore in her case limited to the ears and their immediate neighbourhood, and to the face. Her disease presents remarkable bilateral symmetry: one cannot say that one side is worse than the other. Viewed from the front the disease looks like the two wings of a bat or of a huge butterfly. If the latter simile be adopted the spots on the forehead might serve to pass for the enlarged ends of antennæ.

The disease is without sensation of any kind. The patient even goes so far as to say, "Unless I look at myself in the looking-glass and see the disease, I never know that I have it." So far as sensation of any kind is concerned the disease has not troubled her in the least. When she got heated she felt it—it felt if anything inclined to itch, and she thinks that in very cold weather, for example during the prevalence of a cutting east wind, she felt the cold more on her face than if this disease had not been there.

The disease first appeared in July 1880, during her holidays when she was down at the coast, namely, at Rothesay, in the Island of Bute. The weather was dreadfully hot. She attributed the appearance of her disease to the excessive heat. Her general health is excellent, and she has nothing whatever the matter with her excepting only this eruption. No one else of the family she belongs to has had any disease at all resembling her complaint. Neither her father nor her mother nor any of the other of their children, excepting only this one. Their children are six in all, three male and three female. All are strong and healthy.

The Treatment I adopted in this somewhat extensive but very typical example of Vespertilio was the treatment by erasion. For this purpose I used the pattern of sharp spoon devised by myself. The portion of skin operated on at each sitting was rendered insensible by freezing it by means of the 'æther-spray.' The raw surfaces left by the erasion were dressed with oxide-of-zinc ointment until, in the course of a few days, they healed. In this manner I erased, in successive instalments, the whole of the disease, taking care on the one hand to erase the disease completely, and on the other not to carry my erasion at all deeper than was absolutely necessary. When after the healing of the raw surfaces a sufficient interval had elapsed to enable the previously diseased skin to pale down to its permanent tint, it was impossible to detect, unless on very close inspection, that the patient's face had ever been affected with any disease. Certainly at the distance of only a couple of yards one could not notice that there was anything wrong with her complexion.

VESPERTILIO commences in the form of one or more red elevated spots or tubercules of from the size of a pin's head to that of a split pea. On pressing one of these with the finger-tip it is felt to be firm and indurated, and on close inspection the centre of the spot, which corresponds to the orifice of a sebaceous follicle, is seen to be covered with a firmly adherent greyish-white somewhat greasy-looking scale, or with a darker coloured somewhat greenish-hued minute scab, or rather comedo. If the scale or scab be detached it is seen that the surface immediately covered by it is somewhat depressed and is cicatricial in character. When the scale is of the character of a comedo it is furthermore found on detaching it that its under surface presents a slender villus-like tapering process the withdrawal of which discloses the gaping pin-hole-like orifice of a dilated sebaceous follicle. This scale or comedo is surrounded by a reddened elevated and indurated ring or areola which is abruptly limited at its periphery. Such a spot constitutes what may be termed the elementary lesion of Vespertilio.

From such a beginning, originating in one or more places, the disease gradually spreads, but maintains always the characters above described as essential to the elementary lesion. That is to say, its circumference is formed by a narrow red indurated abruptly defined areola, the thin red line of advance. Within this is a broader band of indurated and more or less reddened but scab-concealed skin, the scabs being in well developed cases of a greenish-yellow hue. Within this broader band is a central area consisting of pale somewhat depressed supple cicatrix. These three constituents of a fully developed patch constitute in the order above given the three progressive stages of the disease. In an actively spreading patch they advance *pari passu*, but in the course of time, when the activity of the disease has here or there abated, the broader greenish-yellow scab-covered band catches up the narrower red band so as completely to cover it, and then much later on is itself caught up and, in its turn, completely obliterated by the advancing central area of cicatrization, and thus complete spontaneous cure of the disease takes place in such situations, while the disease continues to spread in other situations.

The above brief description of a typical patch of the disease will however not suffice for all cases. The central area of cicatrization is sometimes imperfectly covered by thin white dry or greasy-looking scales, and in some cases the scar left by the disease, as well as the skin immediately around the scar, is the seat of numerous teleangiectases or dilatations of the minute veins of the skin. The reddened infiltrated band which surrounds the central area may, in place of being scab-covered, be studded with a number of isolated yellowish-green or dark-brown comedones, or, these having become detached, it may present a corresponding number of coarse pin-hole-like depressions. Even when this band is scab-covered the scab does not always present itself in the condition which I have described as most characteristic of it. The face and ears, the customary situations of the disease, are subjected to more frequent washing than most parts of the skin, and so the scab is often more or less completely worn away; while not unfrequently the patient diligently soaks and detaches the scabs in order to lessen the disfigurement. Even the general arrangement of the constituents of a patch is liable here and there to considerable variation from the typical condition; for while the circumference of a patch may, as I have already explained, come to be at parts completely cicatricial, yet, on the other hand, the central area may be found occupied at places with islets of still active disease, that is to say, islets of red indurated and even scab-covered skin which have lingeringly withstood the process of involution. Furthermore, although, as I have said, there is as a rule almost complete immunity from local irritation in this disease, nevertheless in some individuals the patches of disease are the seat of intense itching and burning sensations.

FIG. 2.

LUPUS.

a, rête malpighii; *b*, cell-infiltration in the papillæ; *c* and *d*, clusters of cells in the superficial and in the deeper layers of the cutis; *e*, cell-infiltration in the panniculus adiposus. (Neumann.)

The situations most commonly occupied by Vespertilio are, as has been already stated, the bridge of the nose, the upper part of the cheeks, the lobes of the ears and their immediate neighbourhood, and the lower two thirds of the hinder margin of the ears, but the disease may often be met with also on other parts of the face and ears, namely, on the face, on the lower part of the nose (tip and alæ), the lower part of the cheeks, the forehead and the eyelids, and more rarely the lips. On the ears it may often be seen affecting the concavity of the concha and the orifice of the meatus. It also occurs on the hinder surface of the ear and on the skin covering the mastoid bone.

The disease, furthermore, often invades the hairy scalp (usually the anterior portion of the scalp), and that sometimes very extensively, the inevitably-resulting scars producing, as in the case of scars in general, permanent and irremediable baldness.

In any other situations than those above named the occurrence of Vespertilio is extremely rare. It is met with exceptionally on the backs of the hands and of the fingers, and also even on the palmar

aspect of the hands and fingers, and still more rarely on the feet and toes.

Kaposi[9] describes a form of Lupus erythematosus in which the eruption, instead of consisting of a limited number of patches which slowly increase in size, is constituted by very numerous minute spots of the size of a lentil or less. Each spot presents the characters which have been above described as proper to the "elementary lesion" of this disease. These spots are either diffusedly scattered or are aggregated into clusters. The eruption may be developed gradually or acutely, and, after first invading the face and other parts of the head, may, by successive acute outbreaks, invade the neck and portions of the trunk and limbs, or may at length become almost universal. This form of the disease is accompanied by various local and general symptoms such as:—Nodular doughy painful subcutaneous swellings situated especially over the larger and smaller joints. Boring rheumatic pains in the bones and joints. Numerous bean-sized sanious blebs. Inflammatory swelling of the lymphatic glands and of the parotid glands. Erysipelas affecting various portions of the skin but preferably the face, or another condition described by him as Erysipelas perstans faciei. As to general symptoms, he mentions fever of an irregularly remittent type. In connection with the Erysipelas perstans facici, he enumerates fever of a typhoid character, great prostration with unconsciousness resulting in coma or complicated with pleuropneumonia and ending sometimes in death.

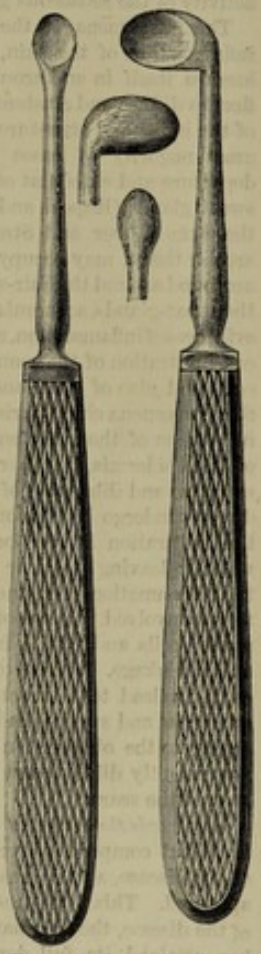
This "disseminated or aggregated" form of the disease may coincide or not with the "discoid" form, that is to say, with the disease which has above been described as "Vespertilio." In the course of five years he had under care in all 22 cases of Lupus erythematosus, 7 of them being males and 15 being females; this disseminated form was confined to the females, but 10 out of the 15 were thus affected; of this 10 as many as 9 had repeated attacks of erysipelas, and 3 of the 9 died under the complications above named. For my own part, I have never seen this "disseminated" form which makes up nearly one half of the total number of Kaposi's cases of Lupus erythematosus, and I have no reason for supposing that in this country the "disseminated" form ever occurs.

The course followed by Vespertilio is in every case an extremely chronic one. Individual patches of the disease may last for several years: the disease usually persists for a very long series of years. In its tedious progress it undergoes here and there, as I have already mentioned, spontaneous cure, while continuing to spread at other parts. Whether it have disappeared spontaneously or under treatment, the disease always, or almost always, leaves behind it a scar. This scar if situated on the scalp constitutes a permanent bald patch, and if situated on the face, is in some few cases complicated with permanent and sometimes very disfiguring telcangiectases.

As to the causes of Vespertilio we know but little. I have already adverted to the influence of sex and of age in its causation. Kaposi[10] has observed in some cases, as a local cause, the pre-existence of a pronounced local seborrhœa.

In the diagnosis of Vespertilio it is necessary to bear in mind the comparative rarity of the disease, namely, the fact that on an average only one or at most two cases of it present themselves amongst a thousand cases of skin disease, so that, in the presence of doubt, probability is always strongly against Vespertilio, while in the case of a male the chances against Vespertilio are at the least quite the double of what they are in the case of a female. Next it is requisite to take into consideration not only the appearance of the eruption itself, but to a certain extent also its history as related by the patient, that is to say, its hitherto duration and the rate of progress of its individual patches, and furthermore to enquire what portions of the eruption appeared first and in what order of sequence, and at what intervals the remaining portions of it have followed. Then the age as well as the sex of the patient will afford material assistance in coming to a conclusion. So also will the presence or absence of local subjective symptoms, that is to say, itching or burning: and finally the map of the disease on the skin, or in other words, its situation on the face, the pattern formed by it on the face, and its presence at or absence from other portions of the skin. In judging by the map of the eruption it is however not to be taken for granted that the complete bat-like map will always present itself; thus, in some cases the bridge of the nose will alone be involved: in some the whole length of the dorsum of the nose down to the tip of it, together with part of the scalp, will be the only regions involved: and so on. Nor will the scab always, or indeed often, present the characteristic appearance that it did in the case represented in the coloured illustration. It is generally far too much frayed and rubbed off for that. The diagnosis of Vespertilio however stands within a comparatively narrow limit. It is in effect the diagnosis of an eruption of the face. It is never a very difficult matter. A patch with an ancient history and a scar in its centre can scarcely be taken for a patch of Herpes circinatus. It is equally obvious that a patch of the disease, such as I have described it, cannot readily be confounded with a patch of scaly eczema nor with a ringed papular syphilide. It would be difficult even to confuse it with an early rodent ulcer, whose elevated scabless border is whiter than the surrounding skin and whose depressed scab-covered centre presents a moist raw ulcer. Still more difficult is it to make a mistake between Vespertilio and Lupus (vulgaris). The name 'Lupus erythematosus' as applied to the disease under consideration is indeed an extremely misleading one. It has nevertheless been retained by most modern writers on the subject. In deference to general custom I have felt constrained to employ it here, but there are strong objections to it. One is that this disease is not Lupus, another is that it is not from any point of view an erythematous eruption, and another is that the name has already for long been commonly employed in an altogether different sense, namely, to designate one of the phases of Lupus (vulgaris). I have myself,[11] amongst others, been accustomed to use it in that different sense. I therefore venture to propose the Latin name Vespertilio (*vespertilio*, a bat) for this disease. It has in fact long been known in this country under the name of Bat's-wing-disease. The name has the advantage of being an arbitrary name just as Lupus is. It is perhaps for choice even a little more appropriate to its purpose than Lupus is for the condition that more properly comes under that name, for, as Devergie[12] asks, "Quelle analogie y a-t-il en effet entre la figure d'une personne atteinte de lupus et celle d'un loup!"

Fig. 3.



Volkmann's sharp spoons (full size).

It is difficult to conceive that any person familiar with Vespertilio on the one hand and with Lupus on the other can fail to perceive that these two diseases are clinically distinct from one another. In fact, in most of the more recent treatises on the diseases of the skin 'Lupus erythematosus' is described under a distinct heading, just as Psoriasis is. It is commonly recognised that in it we have a distinct genus, just as in Psoriasis we have a distinct genus. Out of this situation has arisen the awkward necessity of elongating the name of the disease Lupus (properly so called) and of terming it 'Lupus vulgaris.'

As to the differences between Lupus and Vespertilio I may mention some of them.

First I may instance the respective maps of the two diseases, a subject to which I have adverted more fully in another place.[13] The normal map of Vespertilio occupies the upper half of the nose and the upper part of the front of the cheeks, that of Lupus occupies the lower half of the nose and the lower part of the cheeks; Vespertilio commences almost always in adult life, Lupus commences almost always in childhood; Vespertilio hardens and toughens the affected skin, Lupus softens it and also renders it much more friable; Vespertilio never produces ulceration of the skin, Lupus often produces ulceration; Vespertilio never leads to destruction of the cartilages of the nose or eyelids, Lupus, when it invades the nose or lids, often, nay generally, destroys the cartilages with eventually total loss of the

[9] 'Neue Beiträge zur Kenntniss des Lupus erythematosus,' Archiv für Dermatologie und Syphilis, 1 Heft, Vienna, 1872.

[10] 'Zum Wesen und zur Therapie des Lupus erythematosus' in the Archiv für Dermatologie und Syphilis, 1 Heft, Vienna, 1859.

[11] A Manual of the Diseases of the Skin, Fourth smaller Edition, London, 1887.

[12] Traité pratique des Maladies de la Peau, 2ème Éd. Paris, 1857.

[13] On the Topography of Skin Diseases as a means of determining their diagnosis. London, 1875.

lower part of the nose or total loss of the eyelids, hence the name Lupus. But to mention all of the numerous marked differences between these two diseases would necessitate a complete description of Lupus.

The Histology of Vespertilio has been investigated by Neumann[14] Geddings,[15] Kaposi,[16] Thin,[17] Geber,[18] and Stroganow.[19]

In considering the histology of the disease it is expedient to bring to bear on the subject such light as may be derived from a consideration of the clinical history and naked-eye-characters of the eruption; to take into account that the tendency of the disease is to restrict itself almost invariably to a definite limited area; that the situations to which it is wont to confine itself, the nose, the front of the cheeks, the concha and other portions of the ears, the scalp and the forehead, are situations in which the sebaceous glands are especially large and (in youth) especially active; that in these situations the disease, as examined with the naked eye, is obviously in the main a lesion of the sebaceous glands; and furthermore that in the great majority of cases the disease attains its full development at that period of life when the functional activity of the sebaceous glands has begun rapidly to decline.

The phenomena of the disease are produced by a chronic diffuse inflammation of the skin, which has however a special tendency to localise itself in and around the glands of the skin and which leads first to diffuse and clustered cell-infiltration, then to fatty degeneration of the infiltrated structures, and finally to cicatricial atrophy. In the great majority of cases the sebaceous glands form the point of departure and chief seat of the disease, but it has been shewn that the sweat glands (Kaposi and Thin) and all the structures and layers of the skin (Geber and Stroganow), even including the subcutaneous areolar tissue, may occupy the same position. In fresh patches there are found around the hair-sacs, around the sebaceous glands, and around the sweat-glands, accumulations of cells, together with other histological evidences of inflammation, namely, dilatation of the blood-vessels, œdema, cell-infiltration of the connective tissue, proliferation of the infiltration-cells and also of the glandular epithelium, the outcome of which are the phenomena characteristic of the disease, that is to say, swelling and induration of the cutis, enlargement of the papillæ and desquamation of the epidermis, together with an altered condition of the sebaceous secretion and dilatation of the sebaceous follicles. If at this stage the disease undergo involution, the phenomena of inflammation subside, the infiltration is reabsorbed, and the patches of disease disappear without leaving any scar behind them. But if, as usually happens, the inflammation continues, it soon leads to fatty degeneration of the tissues involved, namely, of the cells of the rete mucosum, of the inflammation-cells and of the infiltrated cutis, with subsequent absorption and shrinkage. Similar changes in the glands and their epithelial contents lead to destruction of the hair-follicles as well as of the sebaceous and sweat-glands, and so baldness and scarring are induced. Owing to the obliteration of some of the blood-vessels others become permanently dilated, and thus teleangiectases are produced on and around the scars.

As regards the treatment of Vespertilio, it must be borne in mind that, in all but comparatively recent patches or recent portions of patches of the disease, a scar must inevitably be left after the patch has disappeared. This is the result after spontaneous involution of portions of the disease, the skin having become, at the places where the disease has attained its full development, too thoroughly and too deeply degenerated to permit of any other issue. When, therefore, it is sought to remedy the disease by assisting and expediting involution, or rather by inducing premature involution of it, no better result than a scar can even at the best be obtained, at all events in long-standing patches. But on the other hand it should not be forgotten that when the disease has undergone spontaneous involution the scar left by it is always a smooth soft unpuckered scar, and one which is not bound down to the subjacent tissues—in short, not a very disfiguring scar. In treating the disease, therefore, especial care should be taken at the least to avoid the production of a more disfiguring scar than the disease itself produces.

The material that one has to deal with in a fully developed patch of the disease is, as I have intimated above, not skin but rather the débris of skin awaiting a slow process of absorption. This may be dealt with in either of two ways. The one is to expedite the process of absorption or to induce premature absorption. The other is to remove the débris with a view to the prompt cicatrization of the thus unburdened surface.

The former of these two different methods of treatment may be undertaken by means of various remedies, all of which are of a more or less stimulating character. It is best suited to patches of comparatively recent standing, or to patches the healing of which it may be hoped can be effected without the production of a scar.

As to the other method, which consists in the removal of the débris, this is preferable in the case of all patches which are of long standing or are deeply seated. It may be carried out by either of two means. The one is the destruction of the degenerated tissue by cauterizing it and then leaving it to undergo separation in the form of a slough. The other is to remove the débris mechanically and at once.

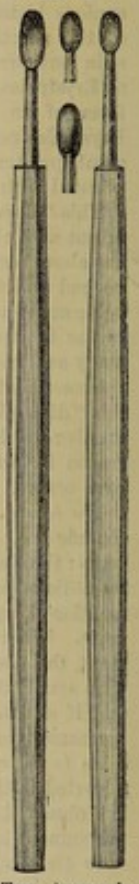
The remedies adapted to promote the absorption of the débris are: A solution of soft soap in half its weight of rectified spirit as devised by Hebra,[20] Soft soap applied as an ointment or as a plaster, Sulphur lotion (60 grains of precipitated sulphur suspended in a fluid ounce of distilled water or of rectified spirit), Ointment of Iodide of Sulphur (gr. 60 in 1 oz.), Ointment of the Red Iodide of Mercury (gr. 10 to 1 oz.), Ointment of Ammoniated Mercury (gr. 60 to 1 oz.), Ointment of Chrysophanic Acid (gr. 120 to 1 oz.) as devised by myself.[21] Pine-Tar, Birch-Tar, Juniper-Tar, Coal-Tar, Vigo's Plaster with Mercury, the manufacture of which I have described elsewhere,[22] The Liniment of Iodine (gr. 60 to 1 oz.), The Glycerole of Iodine (gr. 240 to 1 oz.). To these may be added the process of puncturation (Stichelung) as devised by Volkmann and the process of linear scarification as devised by myself.

The cauterizing agents adapted to the treatment of Vespertilio are: Carbolic Acid Solution (1 oz. dissolved in fl. ʒj of water), Chromic Acid Solution (1 oz. dissolved in fl. ʒv of water), Caustic Potash Solution (½ oz. dissolved in 1 fl. oz. of water), Glacial Acetic Acid, Fuming Nitric Acid (Sp. gr. 1·420), Canquoin's Paste (Chloride of Zinc and Oxide of Zinc equal parts in powder, with a few drops of water added), and Cosmo's Paste (Arsenious Acid, 20 grs., Red Sulphide of Mercury 60 grs., Benzoated Lard 1 oz.), this last named demanding considerable caution in its use.

The methods for removing the débris mechanically are two. The one is excision, the other is the process of erasion as devised by Volkmann and modified by myself.

Having made trial of each and all of these various agencies, I am induced to regard as the most efficient of the first-named class the Soft Soap Solution, of the second-named class the Fuming Nitric Acid, and of the last-named class the Method by Erasion.

Fig. 4.



The Author's sharp Spoons (full size).

It will be seen from the woodcuts in the margin that there is a considerable difference in size, in outline, and in degree of concavity between my erasion-spoons and Volkmann's, but the methods of using the two kinds of spoon are also different. Volkmann's spoons, which I have seen used in Vienna by the late Prof. Hebra, are held in the hand in a direction the reverse of that in which mine are held, mine being held in the same position that a pen or a pencil is held. Volkmann's spoons are used with a pushing movement *from* the operator, mine with a raking movement *to* the operator. His, during use, are held perpendicularly to the skin, mine are held at an acute angle with it. Volkmann's operation is literally a process of scraping off (Abkratzung), my operation is rather a process of ploughing off. In conclusion I may say that the precision attainable by any one practised in the use of the English modification of the erasion-spoon renders "erasion" a far preferable plan for dealing with fully developed patches of Vespertilio than cauterization of any kind, since the effect of the latter is necessarily very uncertain in the here important matter of precise depth of action.

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24 *Weymouth Street, Portland Place*, 1887.

[14] Weiner med. Wochenschrift. Vienna, 1863, and Ibid. 1869.
[15] Sitzungsb. der K. k. Ak. d. Wien, II. Abth. März. Vienna, 1868.
[16] Arch. f. Derm. u. Syph. 1 Heft. Vienna, 1872.
[17] Med.-Chir. Trans. Vol. lviii. London, 1875.
[18] Viertelj. für Derm. u. Syph. 1 Heft. Vienna, 1876.
[19] Centralb. f. medicin. Wissensch. Vienna, 1877.

[20] Lehrbuch der Hautkrankheiten. Erlangen, 1874.
[21] On the Treatment of Psoriasis by an Ointment of Chrysophanic Acid. London, 1878.
[22] The Pharmacopœia of the British Hospital for Diseases of the Skin. Third Edition. London, 1884.