Psoriasis

With especial reference to its etiology and treatment

Introductory Remarks - I am anxious in my thesis on this disease to call special attention to its etiology and treatment; for I know that I have chosen a well thresher subject; indeed had I not been aware of this before, I ought to have been, for my friends one and all exclaim on hearing my choice "surely this is rather a stale subject or something to that effect; but stale or all as it may be, its etiology is still a matter of great dispute, and as long as that remains clouded in obscurity, our treatment is bound to be uncertain to say the least of it; and in addition to this obscurity, there is the great drawback, to use an American term, the "inelegance" of the great majority of local afflictions for psoriasis; this inelegance is of little consequence in poor class or hospital practice, but it is of the very greatest moment.
amongst the upper classes, whom
you cannot persuade to preserve with
such remedies as Chrysophanic
Acid or Tar the two most spe-
cially relied on: and it is with
the object of urging the impor-
tance of suitting our treatment to our
patients that I have called
especial attention to this part
of my thesis. I am afraid it
is not scientific but it is prac-
tical. I remember when I was
a student hearing Professor
Cheyne say in one of his lectures
"Gentlemen, it is not the diseases
that will bother you but the
patients" i.e. no disease is
this more true than in psoriasis.
As regards the etiology of
psoriasis - I must confess
so to a feeling of disappointment
that so eminent an authority
as D. Jameson should support
the parasitic theory of the
disease. The poor unfortunate
microbe has indeed a heavy
burden to bear, but I cannot
help thinking that its task
is at its heaviest now, and
that e'er very long it will be found to be almost as rare as it is now ubiquitous: at the beginning of this century bleeding held the same position in treatment as the microscope does today in ophthalmology: where is bleeding now? Where will the microscope be 50 years hence? Even granting that a parasite is generally to be found (which it is not), may it not be the result of the psoriasis and not the cause? It seems to me that the evidence brought forward in support of this view is very slight and until something more convincing is adduced, I am content to regard psoriasis as dependent on a functional weakness of that part of the nervous system which regulates the nutrition of the skin: this condition may or may not be hereditary; it very often is. I think this peculiar condition of the nervous centre regulating the nutrition of the skin is the essential cause of psoriasis; thus we can
I understand how psoriasis occurs in the healthy. Whether this condition of the nervous centre exists from birth I do not know. I am inclined to think that very often it does not, but these such things as fright, worry, climate, digestive disorders etc. are then the exciting cause of this morbid change in the nervous centre.

And lastly, I should like to mention in my introductory remarks how greatly psoriasis has been narrowed down lately. By this I mean that many cases which were before called psoriasis are now known to be other diseases e.g. syphilis.

Psoriasis is now called a scaly syphilid, psoriasis palmaris and psor. scroti are now known to be eczema. Indeed W. Scott Lang has suggested to me the possibility of there being no such disease as psoriasis bringing forward in support of this. What I have just mentioned. But I do not
think we need go as far as this if we look upon psoriasis as merely local evidence of a general constitutional state to that state jointly, serpula, or what not; but lots of people have gout and serpula without having psoriasis — true; but if in addition to these states we get the morbid condition of the nervous system aforementioned, then psoriasis supervenes. Of course, psoriasis often occurs in the healthy; then only the last factor is responsible, and if we wish for a word to express this condition, I think the term "dastous" of M. Metten, Hutchison as good as any. M. Hutchison, I may mention, defines dastous diathesis as that state of constitution that causes liability to common psoriasis. I will conclude the portion of my thesis with the following aphorism - Functional weakness of the nervous center regulating the nutrition of the
Skin may cause psoriasis as in the healthy, very often an exciting cause is necessary to bring this weakness into notice such as the wine acid or surtulous diatheses, mental emotions etc.

**Nomenclature and Frequency of Occurrence** - Psoriasis is a very common disease; amongst the upper & middle classes I should rank it the most common next to eczema. Of course amongst the lower classes scabies and acne are both more frequently met with.

As regards the nomenclature of the disease, an old name, and I think a good one in that it expresses one of its chief characteristics, is Dry Tetter. Under the name of lepra Willan describes a disease which is probably identical with psoriasis, tho' he maintains they are different, and is followed in this respect by Sir Erasmus Wilson who says that the similarity
Of lepra and psoriasis in their essential nature is so complete as to render them almost identical: and yet he describes two separate diseases under the above names and gives as his reason for doing so "that time has rendered them classic sounds which could not well be dispensed with; that the terms are so well understood that no error can arise out of their separate existence, and moreover that certain differences of moment are admitted between them such as extent of surface occupied, duration and severity." But great confusion has arisen out of their separate existence: for lepra with the majority of writers is the term given to true leprosy, an utterly different disease from psoriasis, and it is therefore desirable to restrict the term lepra to leprosy, and describe the lepra of Willan and Erasmus Wilson under psoriasis.
Some authorities, e.g. Hebra, think that psoriasis and pityriasis rubra are very closely connected: indeed some go so far as to maintain that psoriasis may pass into pityriasis rubra. Paget quotes the case of a woman, who had been in St. Thomas' Hospital with psoriasis of elbows and knees, who came under his care with marked and typical pityriasis rubra. I confess however that I have never seen this, and I agree with Living in regarding them as distinct diseases. Lastly it may be mentioned that psoriasis has been thought to be the remnant of the leprosy of the Bible: this however is more than doubtful when we think of the contagiousness of the latter disease.

Varieties - different varieties of psoriasis used to be described according to the part affected e.g. *psoriasis capitis, psoriasis unguum*. 
but if different varieties have to be described (and I think it is unnecessary and confusing) it is better to take the character and distribution of the eruption as our foundation. I think it would be more strictly correct to say that the following are the different stages rather than the varieties—

1. **Poriasis punctata** is the name given to the disease at its very commencement when the spots are very small. When the face is attacked, which is sometimes rare, the disease does not often advance beyond this stage.

2. **Poriasis guttata**—here the spots are still small and round and look exactly like drops of mortar sprinkled on the skin. This form especially affects children, particularly those who are scrofulous, and it is this variety that is identical with leprosy.

3. **Poriasis mammillaris** is the name given to the next stage in which the spots are larger.
4. Psoriasis orbicularis is the next stage and gets its name from the ring-like form which the spots tend to assume, owing to their tendency to spread at the circumference and heal in the centre.

5. Psoriasis pustulosa is the name given to the disease at the stage in which segments of these circular spots have coalesced with segments of adjoining circular spots, giving the whole a somewhat irregular appearance, especially as some of the intersting portions may be completely healed. We next get

6. Psoriasis Diffusa in which we have large irregular patches but even then the patches retain some of their roundness.

7. Psoriasis Alpboidea - this is the name given to the disease when there is abundant formation of white scales.

8. Psoriasis Rupioides is an exaggeration of the last variety in which the scales get piled up like a limpet shell, and is
only met with in patients with a strumous constitution.

9. *Psoriasis inversa* is the name given to the disease when it has lasted many years and is pretty universal over the whole body.

The above division into nine varieties, or stages, is purely arbitrary, and, beyond the fact that it reminds us of some of the characteristics of the cutis, useless, except to baffle and confuse the student. I quite agree with Living that the only varieties which it is important to distinguish are the so-called scrofulous and pustulose, occurring in persons of these constitutions: the importance of distinguishing resting in the fact that they require totally different treatment; but we must remember that patients when young may be scrofulous and have *psoriasis* and be cured by cod liver oil and sea air; in later years they become pustular, the *psoriasis* again appears, and
They betake themselves to their old remedies only to find their case become aggravated: therefore the patient's age, family history and general appearance should always be born in mind and will greatly assist us in arriving at a correct conclusion as to which variety we are called upon to treat.

Anatomy. Naked Eyes - The disease is characterised by an inflammatory overgrowth of the epithelial layers of the skin. It begins as papules which rapidly increase in size; there is production of morbid epithelium and thus we get flat circular patches. The primary papule is due to redness of the papilla. Scales are not formed immediately though they very soon make their appearance. The typical colour of these scales is a silvery white, due, according to Tagge to the abundance of air between the layers of horny epidermis. On the scalp the
scales are often of a greyish white or even yellow colour from the abundance of sebaceous secretion and dust. The scales vary in thickness, being sometimes very scantily produced, at other times being heaped up like a limpet shell in the variety known as psoriasis infundibuliform. When removed, the scales come off either as flakes or powder. The colour of the skin beneath varies: it is generally of a reddish tint and has a peculiar dry shining appearance: this red area generally extends slightly beyond the scales especially when the process is extending and when the disease has existed for some time and from some cause or other has become aggravated. This hyperemic congested subjacent skin tends to become fissured and excoriated and exudes serum and blood: as a result from mixing with the scales we get actual scabs.
Microscopical Appearances - there is a great increase in size of both the papilla and the interpapillary prolongations; the degree of enlargement varies, but it may amount to ten or twelve times the normal. The enlargement is due to dilatation of the vascular loops i.e. exudation and hence we get exudation of leucocytes into the surrounding tissues with great proliferation of round cells. This only takes place at first in the upper parts of the corium but in chronic cases the deeper parts is also affected. The cornous layers of the epidermis are also at first unaffected, but the changes in the rete and corium induce a more rapid formation of horny cells, and thus we get the typical scale formation. These scales can be easily removed, and beneath them we reach the cylindrical layer of the rete with the greater papillary vessels shining through it.
Symptoms and Course - Psoriasis is occasionally acute though very seldom: it generally begins on one or both elbows, or on the knees, or on both knees and elbows; in a week or two it becomes pretty general, though if it is going to subside as quickly as it began it never becomes general enough to be called psoriasis diffusa. But much more commonly it is a very chronic disease: one patch on the elbow or on the knee may exist for a long time without any further development of the disease: or the scalp may have been what is called 'scurfy' for many years without a single patch on the body to help us in our diagnosis, in which case the diagnosis of psoriasis from either a dry eczema or seborrhea sicca is very difficult. But from some cause or other, hereafter to be considered, a patch appears on the body, or a previously existing small patch becomes larger; other
patches appear which gradually assume the characteristic silvery scaly appearance, and unless appropriate treatment is resorted to, the disease may become so universal that scarcely any of the skin remains unaffected. Sometimes when psoriasis has existed for some time, part of the skin, unaffected by the actual disease, become abnormally dry and hard, a condition somewhat resembling atrophy. I have seen this in two cases, both ladies, whose hands became peculiarly dry and hard and most noticeable the moment one shook hands with them.

It is generally stated that psoriasis produces no constitutional effects; this I am inclined to doubt, for in a case that came under my care, a lady who had previously suffered from psoriasis but which had quite disappeared a year previously, went to Westgate-on-Sea in August and whilst there was far from well wit
a continued feverish attack, the
temperature on two occasions
reaching 102° F.; during this
attack a copious efflorescence
of psoriasis occurred. In addition
we very often find the digestive
functions much impaired, and
perhaps it is sometimes owing to
this faulty digestion that
psoriasis appears: certain it is
that if you improve the digest-
ion the psoriasis diminishes.
The local symptoms of psoriasis,
are not, as a rule, important;
there is no pain, only a feeling
of stiffness over the affected
areas: the amount of itching
varies considerably: it is greatest
when the disease is spreading
and in young subjects.
Psoriasis of long standing on
the scalp may cause baldness,
though it is generally stated
that the hair is unaffected.
In his admirable
work on the skin, says that
he has generally only found
this in young men in whom
one might naturally have
expected a certain amount of thinning of the hair; but this is more often than one occasion in young women and I do not think there can be any doubt that it may actually cause baldness.

Whatever treatment we adopt psoriasis seems to have in itself a tendency to self cure: but far more marked is its tendency to recur, Spring and Autumn being its favorite seasons for reappearance. Many writers lay much stress on the wasting that sometimes occurs during a long and obstinate attack of psoriasis; but this I think only occurs where the digestive functions are much impaired, and like the psoriasis, is merely another symptom of the faulty process.

_Distribution_—with the exception perhaps of eczema, psoriasis is of all diseases the most symmetrical. Its favorite and almost constant seat is the elbows.
and knee, in the former position the olecranon and the extensor aspect just below, and in the latter immediately below the patella being the spots almost invariably affected. This predilection of the disease for the extensor surfaces is one of its most marked characteristics.

The scalp is another very favorite seat of psoriasis; here it often remains for a long time unrecognized without any patches on the body, the patient only thinking that his head is very scabby. The limbs are more frequently affected than the trunk, on the body the eruption is more copious on the back than on the chest and abdomen: the trunk is more frequently attacked than the face which usually generally escapes; very rarely indeed are the palms and soles involved, this the disease sometimes extends down the extensor surface of the forearm or to the back of the hand,
finally involving the nails.

Psoriasis of the palms was formerly thought to be fairly common; but what was formerly described as psoriasis palmare is now known to be probably eczema squamosum. When psoriasis does attack the palm, the scales are very small and there is no tendency to fissure, and thus the soreness and irritation which is so marked in eczema, is absent here. Psoriasis of the nails has been fully described by John Hutchinson; the points of which he lays stress are

1. The nail is never thickened as in simple onychitis.
2. The disease begins either at the sides or free edge of the nail, never at the root.
3. The bed of the nail is primarily involved, the nail itself secondarily.
4. The disease is always influenced for good by arsenic.

It is most curious that even
in most diffuse and moderate psoriasis, the bend of the elbow and the popliteal space should almost invariably escape, while the especial seats of predilection are situated so near.

Psoriasis is very rare on the genital organs, what used to be described as psoriasis orotis is probably syphilide. Whether psoriasis occurs on mucous membranes is very doubtful. Sometimes meget white, or blueish white, shining smooth opacities of the epithelium with normal interstices to which Bazin gave the name of psoriasis buccalis.

Psoriasis labialis is really eczema of the lips; it has been called psoriasis on account of the thin white scales with which it gets covered in the chronic stage.

Psoriasis of the tongue, or leukoplakia is supposed to be caused by irritation from rough teeth or from smoking; it occurs in the form of white
patches and is very similar to syphilitic patches, this Fayle declares they are distinct. These patches have been observed to be the starting point of epithelioma. It is doubtful whether this psoriasis of the tongue is dependent on the psoriasis elsewhere or whether it is merely a coincidence; I incline to the latter view as similar patches occur in other diseases e.g. leukaemia.

**Aetiology**—Much diversity of opinion has been expressed as to the causes of psoriasis. I have already expressed mine at some length in my introductory remarks, and need only add that I agree with Dr. of the Skin. H. 150.

In this case 'Functional Weakness'
of the nervous centre controlling the nutrition of the skin. Without this functional weakness of the nervous centre psoriasis cannot occur: but other affairs may be the actual exciting causes and I will proceed to enumerate them. Scabies and in children and joint in adults are the commonest exciting causes: by the latter I mean rather the uric acid diarrhoea: in this condition according to Meckel the liver is at fault, gastric and intestinal catarrh ensuing, and if the nervous centre regulating the nutrition of the skin is what we may call "dartrous", psoriasis supervenes: I think the digestive derangements are here directly responsible for the psoriasis, and it is in these cases that Climate may be the exciting cause, very possibly by aggravating the digestive symptoms. Mental conditions such as worry, fight...
etc. are undoubtedly sometimes responsible for psoriasis: this we can easily understand if we recognise the nervous origin of psoriasis. Closely allied to this, I should like to mention a cause, notice of which I cannot find anywhere viz. the morphia habit; I have notes of two cases - one, a student took morphia for sleeplessness and after some months psoriasis appeared, which disappeared when the patient broke himself of the habit - the other, a lady who used to take large quantities of laudanum and in whom psoriasis appeared; the laudanum was given up and after some time the psoriasis disappeared, this I think this was due to a change of air and alkaline baths. However a year afterwards she again took to chloroform, and this was immediately followed by a recrudescence of the disease. I think these two cases so striking, that
They must be something more than a mere coincidence, and have greatly strengthened my belief in the nervous origin of the disease, as the marked effect of opium on the brain is well known. Living considers that local irritation may be a cause of psoriasis, and mentions a most remarkable case of a boy who had typical psoriasis around every varicella spot and there only this: he had had psoriasis previously, but it had quite disappeared when he came under his care for an attack of varicella. The case I believe is unique: but I have seen psoriasis in the perineal space, a very rare place, in a lady, which was doubtless due to the irritation from her garters. Syphilis was till quite lately thought to be a potent factor. What was so commonly called syphilitic psoriasis is now known to be a scaly syphilide.
The Parasitic origin of the disease has, I know, many and powerful supporters: No doubt the remarkable centrifugal appearance of some of the patches accounts for this; added to which Lang declares he has found a fungus situated in the thin reptile layer immediately above the papilla which is readily visible after the addition of a 5% solution of potassium hydroxide; but as I have said before this may be the result and not the cause of the disease, and the clinical objections to this theory are to me insurmountable.

**Diagnosis** — The diseases most likely to be mistaken for psoriasis are:

- Eczema Squamosum
- Seborrhoea Sicca
- Lichen Planus
- A Squamous Syphilide
- Ichthyosis
- Lupus Erythematosus
- Pityriasis Rubra
- Favus.
The only two diseases of the above list really difficult to distinguish from psoriasis are eczema squamosum and a scalp syphilide.

1. Eczema squamosum - the points that will help us to distinguish this from psoriasis are:
   (a) In eczema there are some moist patches as well as dry ones.
   (b) The heaping up of scales is not so peal in eczema and the thickening is generally in the centre and not at the circumference as in psoriasis. In eczema too, the scales are not so white, being of a yellowish tint.
   (c) The itching in eczema is generally greater (not always)
   (d) Eczema squamosum is common in infants, psoriasis is very rare.

2. Seborrhea sicca - this generally extends over the whole head without any normal interface, also the skin beneath the scales is pale in seborrhea, whereas in psoriasis we have seen that it is red; and in seborrhea it is the rule for the
hair to be destroyed, whereas in Psoriasis it is the exception.

3. Lichen Planus - this does not attack the same regions as Psoriasis, the patches of which in addition pass gradually into the normal skin, whereas in Lichen Planus we can generally see its composition out of individual nodules.

4. Squamous Syphilide - the diagnosis here is sometimes very difficult: attention to the following points will help me-
(a) The syphilide prefers the flexor surfaces, Psoriasis the extensor
(b) The syphilide never itches
(c) The scales are less pronounced in the syphilide
(d) Presence of other eruptions i.e. polymorphism in syphilis
(e) Other constricting tertiary symptoms of syphilis

5. Icthyosis - always first shows itself in infancy, Psoriasis hardly ever. In this disease too, the skin is everywhere affected with no healthy interspaces, being harsh & dry, without any signs of inflammation, the scales being of a
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more yellowish colour.

(6) Lupus erythematosus usually occurs on the face, perniosis rarely so, and never alone. When the scales are removed, it is somewhat difficult to do in lupus erythematosus, the skin is depressed and has little holes into which little processes of the scales fit. Again, this disease only occurs in adult life and is usually accompanied with a varying amount of pain.

(7) Psoriasis Rubra is much more angry looking than any case of psoriasis I have ever seen; in fact psoriasis Rubra is as acute looking as psoriasis is chronic.

(8) Trachoma - the mousy odour is very characteristic and the microscope removes all uncertainty.

Treatment must be

Local or External, Constitutional or Internal: We will consider the latter first. Those writers who consider psoriasis as only a
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disease of the healthy and strong, or to use an Irishism, a disease of health, will think this part of the treatment comparatively unimportant. My own experience however is that psoriasis is as common in the delicate as the healthy, and that constitutional treatment, especially as regards hygiene, is quite as important, if not more so, than local treatment: added to which there is the undeniable fact that in arsenie we possess a drug, by the internal administration of which alone, without any external treatment, we can cure many cases of psoriasis. And I will go further than this and state that I believe a certain number of cases of psoriasis could be cur'd by stricter attention to hygiene. First and foremost in the internal treatment of psoriasis stands arsenie: Whether it is a specific for it as Mercury is for syphilis, Quinine for Ague, Colchicum for acute joint and the
calculates for rheumatism, is an open question; I think not; but there can be no doubt but that it is extremely useful in many cases. Many and various are the ways of administering it: the commonest and one of the most convenient being Fowler's solution, 5 minims being the ordinary dose to begin with, given either at or after meals, freely diluted either with plain water or flavoured with cinnamon or peppermint, either of these being preferable to the bitter infusions which is generally prescribed. The dose of arsenic should be gradually increased. Letra used to begin with 6 minims and increase one drop every two or three days up to 12 minims: then by slower stages up to twenty or even thirty minims if necessary. Of course the effects of the arsenic must be carefully watched: the dose should be at once diminished if the patient begins to complain of a feeling
of soreness about the eyes: if this be not done other symptoms supervene e.g. puffiness of the face, dryness of the throat, pains in the stomach and diarrhea, the latter often of a very intractable character. The diarrhea exists from the commencement of the disease as is often does in forty subjects, arsenic is contraindicated. Besides Fowler's solution, arsenic may be administered in the form of the arseniate of soda, liquor soda arsenicos. Chadroo says it is less likely to irritate the mucous membranes than that solution, and should be therefore tried when the latter disappears. Astrea used to administer arsenic in the form of pills. The pill he used was known as the Asiatic Pill and was made up as follows: Arsenici Pistoridi gr. 7, P. His. grs. xii, Pulv. Aca. grs. xi, Ag. distill. grs. divide into 12 pills - he began with one pill daily and gradually increased up to three pills twice
daily if necessary.
In anemic patients we may wish to combine arsenic and iron:
we then prescribe the liq. Arsen. Hydrochlorate with the Fv. Ferr. Perchlor.
When arsenic disagrees alone, a few drops of Fv. Caps. or tinct. Canth. C. will sometimes enable the drug to be tolerated.
Again, it may sometimes be desirable to give arsenic combined with Mercury and Iodine in the form of Donovan's solution, liq. Arsen. at Hydriog. Hydriodate. This used to be extensively employed in what was called syphilitic psoriasis with excellent results.
Since however the restriction of the term psoriasis to the ordinary disease, it has not been so much employed, but it is certainly worth a trial in obstinate cases of genuine psoriasis without any signs of a syphilitic taint.
Lastly in obstinate cases McCall Anderson advises the subcutaneous injection of the liq. Sol. Arsenii beginning with 10 minims daily.
and if the drug be found to agree, the quantity may be gradually increased to 20 minims in 24 hours - the injection should be made into the buttock.

When arsenic fails, diving recommends the internal administration of Carbollic Acid, with which he got very fair results in a considerable number of obstinate cases; he recommends the following pill: -


If there is evidence of the urine acid diathesis, I think that Colchicum may be advantageously given either with or without arsenic: preferably the latter. I think in any case, if arsenic had not been tried, I should begin with it; if it failed and there was evidence of "jout," I should add the colchicum; for if one began with the arsenic and colchicum, the anticolchicists would say that if improvement followed it would be
due to the arsenic, unless indeed they happened to be antiarsonists as well. When they would say the improvement was due to the poisons of the tig. arsenic, as I know one well known practitioner in London does. As the Colchicum may have to be administered for some time, we should begin with small doses, say 5-10 minims of the tincture, three times a day. It is always advisable to console a few grains of the Carbonate of Alum with it, to counteract its depressing effect.

But, as in these cases it is the liver which is generally at fault, (for I agree with Muri- ston, considering the urine acid state, "lithemia" he calls it, to be the result of faulty action of that organ,) an occasion this pill should be ordered; the following will be found useful:

Pil. Hydrocar. gr. 1, Pil. Rhiz. Ops. iii, Pulv. Phal. gr. ½, 4th pil. one every third night.

But more important than the
medicinal treatment in psoriasis, is, I think, the hygiene. The diet should be most carefully regulated and as few sweet things and as little alcohol taken as possible. Total abstinence from the latter is preferable, but if any stimulant must be taken, a little weak whisky (Scotch) and water is the least objectionable. A matter of great importance is exercise. This should be taken regularly and systematically always of course stopping short of fatigue; the best form of exercise for these patients is undoubtedly riding. Change of air is often most beneficial in psoriasis, and will often bring about a favorable result when all other means have failed. Of course in selecting the place we must bear in mind the constitution of our patient, bubonic cases requiring bracing air such as Westgate, Margate, Yarmouth etc., whereas the southern cases do best at such places as Bath, Buxton, Worthing. In connection with psoriasis
cases. I should, of course, have mentioned cod liver oil and the
supp. Drr. Todid.
Before passing to the last part of my
subject, I should like to call
attention to a drug which I have
no experience of in this disease,
but which seems to me not
unlikely to prove of great use,
especially if it is proved that the
nervous system is concerned in
the production of psoriasis. Refer
to antipyrin. It is now pretty
universally recognised that this
drug has a great effect on the
nervous system, lessening the
excitability of the centres in a
marked degree. But in addition
to this it evidently has an
especial action on the skin, for
numerous cases are recorded of
antipyrin rash; it has therefore
occurred to me that, if full or
even ordinary doses of antipyrin
have this action on the skin,
the rash probably resulting from
paralysis of the Vasomotor nerves,
small doses say, of 1 or 2 grains
might be beneficial in psoriasis.
by stimulating the Viscernotor nerves: for substances which paralyze a nerve in large doses, often stimulate it in small doses.

**Local Treatment** - It is most unfortunate that the most efficacious remedies in the local treatment of psoriasis are so extremely objectionable; I refer of course to tar and chrysophanic acid: but if patients can be got to persever with them, there is no doubt as to their efficacy.

The first thing to be done in the local treatment is the removal of the scales: this may be done by the old fashioned oil plan, or carbolic oil (1 in 60) may be substituted with advantage for the olive oil, especially when there is much irritation: or the scales may be removed by soft soap, or by baths (of which mercury) or by famous stone. I am with Faye in thinking that the berg. Pice is beyond the most effective preparation, but to allow of its smell and colour it is not
Of the question in better class practice. For these patients the dig. Carb. Detergens is a convenient, but certainly less effective substitute. Jonathan Hutchinson recommends 3 of the dig. Carb. Deterg. to the 3 of Landline, which I have tried in one case and which promised well, only unfortunately the lady refused to continue its use as she said it took her the whole morning to wash off the Landline!

Chrysarobin Acid is a more active remedy than tar and undoubtedly useful especially in chronic cases unattended with any irritable symptoms. One of its great drawbacks is its staining indelibly everything black with which it comes in contact, and also its aptitude for setting up a certain amount of inflammation on which account it should only be applied to a small area at a time - 10-20 parts to the 3 of Landline is quite strong enough to commence with, gradually increased if necessary up to 3.
Pyrogallic Acid has been strongly deprecated; amongst others by
Taffe who writes of it "for
rapidity of cure with freedom
from unpleasant smell, it
is perhaps the most eligible
of all preparations." It is best
prescribed with Benzoate of
or Laudanum, 20-30 ps to the
3rd.
Nearly as efficacious and far
pleasanter is the local treatment
by Alkaline Baths: it is in
fact the treatment that I
nearly always commence with,
especially in verifiable cases. All
that is required is a long bath
depth enough to enable the
patient's body being covered &
3ii. of hot Br. The
temperature of the bath should
be maintained at about 100° F.
and the patient must remain
in the bath for an hour at
least. This remedy is no
doubt one of great value, and
on account of its freedom from
unpleasantness, I do not hesitate
to accord it the first place in
local treatment.
Mention must just be made of the treatment by camphor or indiarubber which has been employed in Germany with some success: this consists in enveloping the affected area in either rubber cloth or india rubber bandages, which probably stimulates the skin, and more especially by not absorbing the excretory products these tend to soften it: as however it is apt to set up an acute dermatitis, it is advisable not to employ it over too large an area at a time.

In very severe and obstinate cases, Stebra used to advise the rubbing in of soft soap with flannel into the affected area until they bled: this is certainly heroic treatment, and I have never heard of its ever being done now!

And lastly, I should like to mention the places which may be recommended with advantage in certain cases. Irritable psoriasis derives most benefit from some
mild place such as Bath—gouty patients do best at Hanf- 
gate or Buxton in this country, 
or if the continent is preferred 
Kieseyden, Vichy & Carlsbad— 
scrupulous cases should be sent 
to such bracing places as 
Margate, Westgate, Cromer, Yarm 
Whitby, North Berwick and 
many other places on our 
East Coast.
I will conclude by saying that 
in treating psoriasis we should, 
I think, attend to the following points: 
Ranking their importance in 
the order named

1. Improvement of Hygienic 
   Surroundings.
2. Change of air.
3. Alkaline Baths.
4. Medicinal Treatment.
Psoriasis.

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