Herpes phlyctænoides.
Herpes impetiginosus (impetigo herpetiformis).
Eczematous and pemphigoid efflorescences upon an angioneurotic basis, in hysterical individuals and the like.
Hemorrhagic form : purpura (peliosis) rheumatica.

2. With predominant spasm of the vessels of the skin.
Cnidosis (urticaria essentialis, chronica).
3. With dilatation and new formation of vessels :
Erythema angiectaticum (acne rosacea).

Third Class.

Neuritic Dermatoses.

Dermatoses produced by an affection of sensory (at the same time trophic ?) nerve elements.

I. Family. Neuritic dermatoses with a cyclical course.
Herpes neuriticus (zona, herpes zoster).
Herpes febrilis (hydroa febrilis) (?).

II. Family. Neuritic dermatoses with a cyclical course.

1. With predominant inflammatory congestion (neuritic inflammatory processes of the skin) :
Erythanthema neuriticum.
Varieties :
Maculo-papular forms : erythema neuriticum.
Vesicular and bullous forms : herpes, pemphigus, and eczema neuriticum.
Pustular forms : furunculi and ecthyma neuriticum.
Hemorrhagic form : purpura neuritica.
2. With predominant spasm of the vessels of the skin (neuritic œdema of the skin) :
Urticaria neuritica.
3. With predominant atrophy of the skin (neuritic atrophy) :
Liodermia neuritica (glossy skin).
Onychogryphosis neuritica.
Alopecia neuritica.
Leucodermia neuritica.
4. With true necrosis of the skin (neuritic necrosis) :
Neuritic phlegmon (chronic).
Decubitus neuriticus (acute).

Fourth Class.

Stasis-Dermatoses.

Dermatoses with the character of a passive disturbance of circulation and impaired veno-so-lymphatic absorption.

A. With incomplete stasis.

I. Family. Stasis-hyperæmias and anæmias.
Cyanosis.
Local ischæmia of the skin.
Hemorrhage of the skin from mechanical stasis.

Hæmoglobinorrhœa from mechanical stasis.

II. Family. Stasis-transudations.

1. The transudation remains in a fluid form :
Œdema.
2. The transudation leads to induration and hypertrophy of the connective tissue :
Elephantiasis Arabum.
3. The transudation leads to atrophy of the connective tissue :
Sclerema : *a.* neonatorum.
b. adultorum (sclerodermia).

B. With complete stasis.

The only Family : stasis-necroses.
Traumatic decubitus.
Idiopathic gangrene.
Local asphyxia with symmetrical gangrene.
Malum perforans of the foot.
Ainhum.

Fifth Class.

Hemorrhagic Dermatoses.

Dermatoses in consequence of increased passage of red blood-globules through the walls of the vessels without inflammatory congestion or local stasis.

I. Family. Traumatic hemorrhages.
Ecchymoses (petechiæ, vibices).

II. Family. Essential (independent of external injuries) hemorrhages.

1. With slight general disturbances of the organism.
Purpura : *a.* simplex.
b. papulosa.
2. With predominance of general disturbances :
Morbus maculosus (purpura hæmorrhagica).
Scorbutus.

Sixth Class.

Idioneuroses of the skin.

Functional anomalies of the distribution of the cutaneous nerves without trophic changes in the skin.

A. Sensory neuroses of the skin.

I. Family. Neuroses of the tactile sense (æsthesionoses).
Hyperæsthesia.
Anæsthesia.
Paræsthesia.

II. Family. Neuroses of cutaneous general sensation (dermatalgias).

1. The neurosis occcurs as pain :
Neuralgia.
2. The neurosis occurs in the form of itching :
As a pure sensory neurosis :
Pruritus.

Combined with a motor neurosis (spasmodic contraction of the arrectores pilorum).
Prurigo.

B. Pure motor neuroses of the skin.
A single family. Dermatospasm.
Cutis anserina.

Seventh Class.

Epidermidoses.

Anomalies of development of the skin of an epithelial origin and type.

A. Anomalies of the formation of horny matter and of the secretion (keratonoses).

First Series. Keratoses in the narrower sense.

I. Family. Hyperkeratoses.

1. Diffuse :
Ichthyosis diffusa : *a.* simplex.
b. histrix.
2. Around the follicles :
Lichen pilaris.
Ichthyosis follicularis.
3. In spots, but independent of the follicles.
The tegumentary horn, cornu cutaneum.
Callosities, tyloma.
Corn, clavus.

II. Family. Parakeratoses.

1. Diffuse :
Psoriasis.
2. Follicular :
Lichen ruber and planus.

III. Family. Keratolyses.

Pityriasis : *a.* (alba) simplex.
b. (rubra) essentialis.
Dermatitis exfoliativa infantum.

Second Series. Trichoses.

I. Family. Hypertrichoses.
Hypertrichosis congenita.

II. Family. Paratrichoses.
Trichorrhexis nodosa.
Trichoptilosis.

III. Family. Atrichoses.

1. Diffuse :
Diffuse alopecia : *a.* simplex.
b. pityrodes (Pincus).
2. In spots :
Alopecia areata.

Third Series. Onychoses.

I. Family. Hyperonychoses.
Hyperonychia.

II. Family. Paraonychoses.
Onychogryphosis idiopathica.

III. Family. Onycholyses.
Onycholysis idiopathica.

Fourth Series. Steatoses.

I. Family. Hypersteatoses.
Seborrhœa : *a.* oleosa.
b. crustosa.

II. Family. Parasteatoses.
Grutum.
Milium.
Atheroma (in addition to acrochordon and nævus follicularis).
Colloid milium (colloid degeneration of the parenchyma of the sebaceous glands) and
Haloid milium (vitreous degeneration of the parenchyma of the sebacous glands).

III. Family. Asteatoses.
Xerodermia (dry skin) : *a.* congenital.
b. acquired.

Fifth Series. Idroses.

I. Family. Hyperidroses.
Idiopathic hyperidroses.

II. Family. Paridroses.
Chromidrosis.
Bromidrosis.
Hæmatidrosis.
Uridrosis.

III. Family. Anidroses.
Idiopathic anidrosis.
Dysidrosis (cheiropompholix).

B. Anomalies of pigment formation in the skin (chromatoses).

I. Family. Hyperchromatoses.

1. Congenital :
Nævus pigmentosus :
Varieties : spilus.
verrucosus.
pilosus.
2. Acquired :
Chloasma : fuscum (uterinum).
nigrum (melasma).
Lentigines (ephelides).

II. Family. Parachromatoses.
Discoloration of the skin from icterus, argyria.
From tattooing.
From Addison's disease.
From the cachexia of intermittent fever, etc.

III. Family. Achromatoses.

1. Congenital :
Albinism : *a.* universalis.
b. partialis.
Poliosis.

2. Acquired :
Vitiligo.
Premature canities.

C. Anomalies of the prickle layer of the epidermis (akanthoses).
I. Family. Hyperakanthoses (simple akanthomata).

1. Proliferation of the prickle layer upon the surface (warty akanthomata) :
Verruca.
Condyloma acuminatum.

2. Proliferation of the glandular coils (cutaneous adenoma) :
Idrotadenoma (sweat-gland adenoma).
II. Family. Parakanthoses.

1. With transformation of the prickle cells into so-called molluscum corpuscles (which are not known accurately) :
Molluscum (contagiosum of authors).

2. With formation of nests in the cutis (alveolar akanthoma) :
a. With distinct cornification of the new-formed epithelium cells.
Epithelioma :
Varieties : superficial (rodent ulcer).
deep.
b. Without cornification of the new-formed cells :
Cutaneous carcinoma :
Varieties : soft.
colloid.
melanodes.

III. Family. Akantholyses.
Pemphigus essentialis :
a. Acute.
b. Chronic.
Varieties : bullosus.
foliaceus.
Cachectic gangrene of infants.

Eighth Class.

Chorioblastoses.

Developmental anomalies of the skin of connective-tissue origin and type.

A. Excessive development of the connective-tisue layer.
Single Family. Hyperdesmoses.
Macrosomia.

B. Paratypical growth of the connective-tissue layer (Paradesmoses).
I. Family. Granulomata of the skin.
Lupus esssentialis (idiopathic) :
a. Tuberculosus. Varieties : L. scleroticus.
L. exuberans.
b. Erythematosus.
Scrophuloderma :
Papulosum and vesiculosum (lichen scrophulosus).
Squamosum (pityriasis scrophulosa).
Tuberculosum (lupus scrophulosis).

Gummosum.
Ulcerosum.
Tuberculosis of the skin.
Leprosy :
Tubercular.
Macular.
Anæsthetic.
Syphiloderma :
Maculosum.
Papulosum and squamosum.
Vesiculosum.
Bullosum.
Pustulosum.
Tuberculosum (lupus syphiliticus).
Gummosum.
Ulcerosum.
Rhinoscleroma.
Granuloma fungoides (Lymphadenoma cutis [?]).
II. Family. Desmomata (connective-tissue tumors).
Fibroma cutis.
a. Disseminatum.
b. Keloides.
Osteoma (new formation of bone).
Chondroma (new formation of cartilage).
Lipoma (fatty tumor).
Myxoma (mucoid tumor).
Hyaloma (vitreous swelling of the skin).
Colloid tumor.
Xanthoma (fat-like change of the skin).
Myoma (new formation of muscle).
Neuroma (new formation of nerves).
Angioma (new formation of vessels).
a. Phlebangioma } Varieties : simplex.
b. Lymphangioma } cavernosum.
Sarcoma.

C. Disappearance or congenital defective development of the connective-tissue layer.
Single Family. Adesmoses.

1. General and diffuse :
Liodermia essentialis (congenital [?]).

2. Partial :
Striæ atrophicæ cutis.

Ninth Class.

Dermatomycoses.

Fungoid diseases of the skin and its appendages.
I. Family. Mycosis scutulata (favosa, lupinosa, Favus).
Dermatomycocis favosa.
Trichomycosis "

Onychomycosis favosa.

II. Family. Mycosis circinata (herpes tonsurans, ring-worm).

Dermatomycosis circinata :

Varieties :

D. Maculo-vesiculosa.

D. marginata (eczema marginatum)

D. diffusa (imbricata Manson).

Trichomycosis circinata.

Onychomycosis circinata.

III. Family. Mycosis pustulosa.

Dermatomycosis pustulosa (impetigo contagiosa [?])

Trichomycosis pustulosa :

Varieties :

Tr. barbæ (sycosis parasitaria).

Tr. capillitii (kerion Celsi).

IV. Family. Mycosis furfuracea (pityrodes).

Dermatomycosis furfuracea (pityriasis versicolor).

VI. GENERAL TREATMENT OF SKIN DISEASES.

The treatment of skin diseases depends to a great extent upon the prevailing pathological views and changes with them.

As matters stand to-day, there is a general tendency to treat purely local affections of the skin by local remedies, with the greatest possible avoidance of internal remedies. In skin diseases, on the other hand, which are due to a nutritive disorder of other organs of the body, the treatment of the diseased internal organs must be carried out according to general therapeutic principles.

It goes without saying that we are far from believing in the vicarious nature of the localization of the disease, in the possibility of "driving back" the skin affection into the organism. Nor, on the other hand, may the dermatologist deny certain truths which the physiology of the skin allows us to recognize. We refer, for example, to the undoubted connection between local circulatory tracts and the general circulation, and, therefore, between the amount of blood in the skin or in individual parts, and the circulation in general (condition of the heart and the peripheral resistances to circulation) and in other peripheral circulatory tracts. Also to the action of cutaneous irritants upon nutrition. Recent investigations have shown that feeble cutaneous irritants produce contraction of the peripheral vessels, thus increase the force of the heart's action and the rapidity of the current of the blood. Result: increased temperature. On the other hand, vigorous cutaneous irritants produce dilatation of the peripheral vessels, and may thus diminish the temperature. According to Roehring, a coincident irritation of the vagi slows the pulse and circulation, and diminishes the respiration, so that this constitutes a compensation to too-marked coolness.

Accordingly the action of external cutaneous irritants is settled beyond a doubt, but they should not be employed in skin diseases, except in the two cases in which we desire to increase the intensity of any local process, for example, a torpid inflammation, or when the cutaneous irritant is employed as a caustic for the production of necrosis of the tissues.

A further application of the physiology of the skin to therapeutics consists in the fact that we can divorce ourselves from the previous conception that the office of the integument as a respiratory organ is so extensive and important, that an affection of the former over an extended surface per se endangers nutrition.

It also follows that no harm follows the application of substances which coat the skin over a great extent, and this is as true of water as it is of salves and plasters.

I will here make an observation, however, with regard to the employment of the continuous bath recommended by Hebra. As is well known, this was first employed only in severe burns, then also in chronic diffuse diseases of the skin, and in extensive suppurative processes, for weeks and even months. As a rule, it was found that no injurious effects upon nutrition occurred even in very feeble individuals; in some cases the restoration of large losses of substance and in some the relief of the pains of burns occurred in the bath. But I have become convinced from prolonged personal observation that, in the large majority of cases, neither a favorable influence upon the cur of chronic skin diseases, nor upon the diminution of pain or pruritus, or upon the course of extensive suppurative processes and burns is effected thereby. Many patients cannot tolerate them in the least; the foudroyant toxic symptoms (convulsions, etc.) which constitute the last scene in severe burns, occurred in the bath as constantly and certainly as when applications of oil and cotton batting and the like were employed. I think, therefore, that a very restricted curative effect can be attributed to Hebra's continuous bath, and that this is not proportionate to the requisite preparations, the exciting effect upon the patient, etc.

In skin diseases, external local procedures must be mainly considered. General therapeutics, on the other hand, furnishes the standard of general internal treatment, when this is indicated.

With regard to the local treatment of skin diseases, it must be pointed out that, as a rule, only the symptoms and not the diseases are cured by them. We possess remedies which will improve or cause to disappear anthemata of various kinds, erosions, swelling or dryness of the skin, changes of pigment, anomalies of cornification, etc., but we possess no external remedies against eczema as such, against ichthyosis, prurigo, etc., regarded as diseases.

Attention must also be called to the fact that the number of external remedies is small, but the capacity of manipulating them is very great, and that the chief secret of success depends more upon technical skill than upon the number of remedies.

I will now glance hastily at the most important internal and external remedies, in order to call attention to a few points of general importance.

When employed in moderation, water is a remedy which is very useful for the functions of the skin (cleansing, softening, removal of the secondary morbid products). When applied too frequently or at too high or low a temperature, it acts as an irritant even upon the healthy skin, and produces eczema.

Upon inflamed parts it acts favorably by conveying higher or lower temperatures (warm and cold compresses), or by producing evaporation in the form of Priessnitz' compresses. Water compresses should therefore be wrung out well before being applied, and, as a rule, they should not be placed directly upon the skin, but upon some intervening substance impervious to water.

The application of hydro-therapeutics has proven less suitable, in general, to produce recovery of local chronic processes and, on the other hand, even mild procedures are apt to give rise to irritative conditions of the skin. However, advantage will often be derived in psoriasis, prurigo, etc., from systematic packs, half-baths, and rubbings, in nervous dermatoses from douches (especially with warm water), in epidermidoses in general, from macerating steam baths and steam douches.

Baths containing medicinal substances have always been employed in skin diseases. With regard to those prepared artificially, it may be stated that the addition of an alkali to the bath, for example, potash, soda, borax (perhaps with the addition of starch, Bulkley), softens the epidermis and diminishes congestion of the skin.

Sulphur is employed either as sulphide of calcium or potassium, for example, 30–50 Grm. of Vlemingkx' solution being added to the bath, or the body of the patient being smeared with a solution of the sulphur before entering the baths.

The action of artificial sulphur baths upon the skin in those cases in which we desire to kill parasites (scabies), etc., is similar to that of its medicinal application. Like the natural sulphur waters, they produce good results occasionally in chronic itching skin diseases.

Hebra has employed tar baths, the patients being first smeared with the tar and then placed in the bath.

Baths of corrosive sublimate are employed occasionally in syphilis as a substitute for or adjuvant to the ordinary anti-syphilitic measures (5.0 to 30.0 for a full bath of 32–35° C.[1]), or locally in chronic dermatoses of various kinds, for example. as a hand-bath (1:2,000 to 1:500).

With regard to natural mineral baths, special attention must be called to the fact that their action upon the skin is mainly macerating and solvent, they remove secondary deposits, and occasionally are slightly irritating, *i. e.*, they chiefly affect the epidermis.

The passage of substances from the bath through the human integument is not so easy as is commonly believed. If we grant that gases pass through in small quantity and that some solid substances, especially in a fatty emulsion, may be pressed through after long inunction, we must also remember that the living skin does not permit the passage of substances from watery solutions of salts which simply come in contact in the bath with the intact skin, and that even the absorption of water by the layers of the skin is usually moderate.

We now pass to the consideration of the substances employed with water, and in the first place soap. Soap is a combination of fatty acids and alkalies, which are dissolved upon being rubbed in some water on the skin, and again undergo a new combination of the constituents which have become free and the alkalies of the surface of the skin.

In combination with water, especially when poor in salts or distilled, it serves as the best agent for cleansing the surface of the skin. A carefully-prepared, simple soda soap, made of good materials, always proves sufficient, either cold or warm; it should contain no excess of free alkali, which will macerate the skin.

For curative purposes, stronger potash soaps, which present at the same time a softer consistence, are employed with more success. The so-called soft soap, which is now manufactured with tolerable purity, is a sort of ointment which, when not used as a caustic, should not produce an alkaline or burning taste on the tongue. Stronger potash soaps act like solutions of caustic potash, *i. e.*, not merely macerating, but even caustic, if they are employed for a prolonged period ; this was often done formerly in chronic skin diseases, for example, in prurigo, etc., by Hebra or others, in cycles of soap inunctions and soap poultices. I no longer employ this plan of treatment.

In like manner, I rarely employ combinations of soap with other remedies, because

[1] It is best to prepare the following solution: Hydr. bichlor. corros., 20.0; Natrii chlor., 50.0; Aq. dest., 200.0 for four baths. The water must be distilled, the bath-tub covered, and not made of metal.

it is very difficult to make an accurate quantitative determination of the remedy employed in this form, and it is not always easy to secure a uniform distribution in the soap. I never use glycerin soaps because the amount of glycerin contained in them (up to fifty per cent), is withdrawn from the saponaceous substance, and, instead of a soap, a smeary mass which acts the reverse of cleansing is uselessly applied to the skin.

It is self-evident that the addition to soap of substanees for which the skin is impervious is entirely useless.

I recommend tar, creasote, and carbolic soaps less strongly than distilled tar in substance, which is rubbed well into the skin in a thin layer, by means of a strong brush.

In parasitic diseases, especially scabies, I have seen very good results with an avoidance of all inconveniences, from a storax soap.

Additions of dusting powders or sand, pumice stone, marble dust, sand soap, in order to rub the skin more vigorously, are employed occasionally with good results.

Finally a combination which Hebra recommended highly, that of soap and alcohol in the form of spir. saponatus, I employ only in those rarer cases in which we have to deal with direct irritation of the skin, especially in morbidly changed peripheral innervation, in torpid inflammatory processes, because alcohol, a drying, water abstracting remedy, like water, glycerin, etc., does not act favorably on the nutrition.

Fats also play a great part in the therapeutics of skin diseases. Their first object is to cover the diseased parts uniformly, and thus protect them against external irritants, especially against the air and its contents. For this purpose they are especially suited by their flexibility, smoothness, and the readiness with which they may be applied.

This property of the fats is heightened still further by their undoubted power to maintain and stimulate the nutrition of the skin. According to physiological experiments, finely subdivided drops of fat pass so much more readily through the epidermis to the vessels, the more vigorous and prolonged their contact with the surface of the skin.

Associated with these, on account of their similar consistence, are glycerin, which, combined with powdered starch, is employed as an admirable, ointment-like substance (glycerolate, glycerolé d'Amidon of the French Pharmacopœia), and vaselin and paraffin, gelatin-like substances of great flexibility, which do not become rancid like fats, like them are very suitable for application as protective substances, but as I believe are inferior in their direct conserving and nutritive action on the tegumentary tissue.

Fats produce the greatest effect upon the skin when they are employed in the greatest possible density. Accordingly, an ointment upon an eczematous surface would have a more permanent curative effect than a fluid fat or oil, and a plaster would be still more effective than an ointment. With regard to the first case, this is really in accordance with facts, granted that the ointment—like the oil—is kept constantly on the skin, *i. e.*, not merely rubbed in with the finger, but applied carefully with linen cloths, and properly renewed. With regard to the plaster, however, its consistence can be secured only in two ways, either by the admixture of fatty acids, or wax with resin (gum resins, balsams), or caoutchouc dissolved in turpentine, or by a combination of the fatty acids with lead. The first are resin plasters, the others lead plasters.

On account of the extreme irritating action of the resin contained in them upon the skin, the application of the resin plasters is restricted to a minimum when we have to deal with inflammatory processes, or those which readily pass into inflammation.