

scurvy which then prevailed. He found that the food-supply of the inhabitants, considered not merely as to its quantity, but also and chiefly with regard to quality, exerted a most important influence in bringing about the disease, since not only the meat and wine, but also the vegetables then obtainable in Paris, were far from fresh, and hence were largely deprived of those elements—the potash-salts—most indispensably required for the maintenance of health.

PROGNOSIS.

This depends upon the character of the symptoms. It is favorable in cases of simple, uncomplicated cutaneous hemorrhage, but when effusions take place into internal organs the complaint assumes a more serious aspect, especially if it breaks out repeatedly upon the skin and is accompanied by high fever. The prognosis is bad when hemorrhages occur in vital organs, as they may become so profuse as to cause a fatal result. The constitution, the age, and the vital relations of the patient must also be taken into account, and the probable consequences of anæmia should never be overlooked when the loss of blood is considerable.

In scurvy, the prospect of recovery is much improved at the present day, since sanitary rules have been based upon a broader and more intelligent comprehension of hygiene; nevertheless, a cure is always more likely to be effected in sporadic than in epidemic cases.

TREATMENT.

Rational procedures will nearly always insure us a result either partially or wholly satisfactory.

The empirical use of acids, especially sulphuric acid, and of preparations of iron and bark, by some of the older physicians, was attended with success, and this must now be regarded as the only proper method, since the leading indications are, first, to invigorate the vascular structure and restore the nutritive properties of the liquor sanguinis, and, second, to compensate for the loss of blood. In accordance with these principles, we administer, on the first appearance of the spots, Elixir. acid. Halleri 1.0–1.5 grm. pro die, lemon-juice, pure or dissolved in sweetened water; in cases of larger extravasations, Liquor ferri sesquichlorati (1.0–2.0 grm. pro die), Extract secalis cornuti in solution (2.0–2.5 grm. to 100.0 Aq. d.) or by subcutaneous injection (Ergotini, Aq. dest., ana 5.0. D. S., $\frac{1}{2}$ to 1 syringeful twice daily), which last is often of the greatest service. For scorbutic affections of the gums we employ a wash composed of Ext. ratanhia (5.0–10 grm. to 300.0 of fluid). The gums are also painted with citric acid or dilute chromic acid (5.0 to 200 solution, Millard). For the debility, quinine and iron in suitable doses, and a generous diet of meat and fresh vegetables, with wine, are best adapted to restore the saline ingredients of the blood, since potash and iron constitute equally important elements in the composition of its corpuscles. In cases of hemorrhage into internal organs, cold applications by means of wet compresses, ice-bags, injections (when they can be made directly into the affected cavities), etc., according to the locality of the effusion; in purpura with rheumatic or articular pains, salicylic acid in the usual doses.

To hasten the removal of the cutaneous spots, we may resort to lotions, though these act only by increasing vascular tension. Tripier observed that absorption was promoted by local faradization, which, however, was unsuccessful when the extravasations were large and scattered over all parts of the surface. When there is marked atony of the skin, especially on the lower extremities, constant pressure by means of roller bandages will also facilitate absorption.

DERMATITIDES SUPERFICIALES

BY

DR. TH. VEIEL,

OF CANNSTATT.

We shall class as superficial inflammations, first, those due to thermal, chemical, and mechanical influences, and, second, catarrh of the skin, eczema.

Affections of the former variety present all the signs characteristic of inflammation in general, viz., redness, swelling, heat, infiltration and pain. Like other inflammations also, they terminate either by resolution, by suppuration, or by gangrene.

According to their respective causes, they are divided into:

1. Dermatitis calorica.
2. Dermatitis traumatica.
3. Dermatitis e venenis et causticis.

Dermatitis Calorica is subdivided into dermatitis ambustionis et congelationis.

DERMATITIS AMBUSTIONIS.

BURNS.

The alterations on the cutaneous surface and in the system at large produced by burns, differ according to the capacity for heat possessed by the substance which inflicted them, the length of time during which the action is kept up, the extent of surface acted on, and the individual susceptibility of the patient. The resulting lesion is the more dangerous, the greater the capacity for heat (*i. e.*, in the case of fluids, the higher their boiling points, and the more they are concentrated), the larger the area involved, and the less the subject's constitutional power of resistance (children).

Burns are caused:

1. By radiant heat (of the sun).
2. By the action of fire (including explosions of gunpowder, illuminating gas, and fire-damp).
3. By direct contact with heated bodies.

According to their degree, they are divided into:

Dermatitis ambustionis erythematosæ, bullosæ, escharotica.

A.—*Dermatitis Ambustionis Erythematosa.*

A temperature of less than 60° C. gives rise only to an erythema, which soon disappears after the removal of the cause. At 60° C. and above, inflammation and transudation are produced in addition to redness. The latter is accompanied by considerable pain, and lasts several days; it is confined to the surface first acted upon, and does not disappear entirely under pressure; generally also there is slight swelling.

In the course of a few days the cuticle peels off, and the redness and swelling disappear. There frequently remains a trifling discoloration.

Burns of this degree result in most cases from prolonged exposure to the solar rays, or from the speedier operation of ignited gases and vapors.

B.—*Dermatitis Ambustionis Bullosa.*

A temperature of 75° to 100° C. gives rise to more pronounced transudation and inflammation. Either immediately or within a few hours, the epidermis rises into blisters and bullæ as large as a hen's egg. These are filled with a thin, limpid serum, which, however, after a time, often attains the consistency of jelly, and is then only forced out by pressure. The serum contains epithelial debris, fibrinous clots, and white blood-corpuscles; it abounds in inflammatory lymph, as distinguished from that of engorgement, and shows but few red blood-corpuscles.

Through increased exudation of serum internally, or in consequence of force applied from without, some of the blisters rupture. The epidermis then lies in white, pulpy layers, or rolls of soft, white membrane, on the bright-red corium dotted with numerous bloody points. The pain is exceedingly severe. The formation of the bullæ takes place between the rete Malpighii and the epidermis. Hence the bullæ are frequently chambered because the transudation, as v. Biesiadecki has shown, draws out the epithelial cells of the Malpighian layer into slender fibres resembling the connective-tissue fibres. In the most favorable cases, the fluid is subsequently absorbed, and the bulla itself collapses, shrivels, and falls off, leaving a red spot covered with delicate epidermis. When the bulla is ruptured, a scab, beneath which cicatrization takes place, is formed by atmospheric action upon the exuded fluid and shreds of epidermis, unless suppuration ensues and protracts the process of healing.

C.—*Dermatitis Ambustionis Escharotica.*

A high degree of heat, or the continued action of a lower degree, results in the formation of an eschar; this is smooth and white, or ashen-gray, yellow, brown or black; moist or dry; of a leathery hardness; firmly adherent, and without sensation. A section of such an eschar reveals tree-like ramifications, marking the course of carbonized blood-vessels, which are not met with when the injury has been inflicted after death (E. Hoffmann). How far downward the eschar extends cannot be inferred from its external appearance. As the healing proceeds, the eschar gradually sloughs off. It is encircled by an erythematous blush, and on the third to the fifth day, a purulent border (the line of demarcation) makes its appearance. The accompanying pain, which at first is generally very slight, becomes exceedingly severe. The time occupied by this process depends on the size of the eschar. When the latter is confined to the outer integument, it is generally cast off in from ten to twelve days. It is usually succeeded by a group of very painful granulations having an uneven surface. Cicatrization begins at the borders

of the eschar and around isolated portions of healthy epidermis. The resulting scars are generally stellate in shape and reticular in structure, and they shrink during their formation, giving rise to ugly contractures and adhesions. The direct action of flame, contact with molten metals or with caustic lime, etc., are the accidents by which burns of this degree are chiefly occasioned.

The constitutional affections produced by burns are of the greatest importance.

Burns involving one-half of the cutaneous surface are inevitably fatal, while those which cover only one-third are hardly less dangerous. Persons thus injured usually feel comparatively well for the first day; they are lively, and complain only of severe pain. After the lapse of from twenty-four to thirty-six hours, however, they become dull and sleepy; the extremities are cold, the pulse small, and the temperature two or three degrees below the normal, though rising again at the approach of death. The somnolence deepens into insensibility, and in this condition the patient succumbs. In some cases, the closing scene is preceded by great restlessness, clonic spasms, and even jactitation. Oftentimes small but repeated hemorrhages take place from the nose, bronchi, stomach, bowels, and bladder. There is frequently retention of urine; when drawn off, the fluid is acid, and, as a rule, not albuminous, so that nephritis may be excluded as an immediate cause of death in these cases.

Hebra found that on opening any of the veins, no blood would flow, and that the vascular lumen was often filled up by thrombi.

The results of autopsies are usually negative. The immediate cause of death cannot be assigned with certainty. Among the many explanations may be mentioned:

That death is owing to congestion of the internal organs resulting from suppression of the cutaneous activity and of the perspiration.

That the patient dies just as a rabbit dies when its skin is varnished. The incorrectness of this notion has been proved, as was shown in another part of this work, by the experiments of Senator.

Sonnenburg advances the opinion that when death follows immediately upon a burn it is owing to an overheating of the blood, and consequent heart-paralysis; but that, when the fatal result is delayed for a few days, it is caused by an excessive irritation of the nervous system, which, by reflex action, produces a lowering of the vascular tension.

V. Lesser, on the other hand (*Virchow's Archiv*, Vol. LXXIX., p. 248, 1880), maintains that oligocythemia, considered as a functional disturbance, is the cause of death from these accidents.

M. Schulze and Klebs have shown that death and the destruction of the red blood-corpuscles may result from a temperature of 43° C.

V. Wertheimer, Ponfick, and V. Lesser found after death well-marked alterations in the red blood-corpuscles, an abundance of serrated forms, blanched discs, many fragments of red blood-discs and blood-pigment, in granular form as well as in a state of solution, which colored the serum a rich dark-red. This destruction of some red blood-corpuscles, and the functional inactivity of others which preserve their forms, but are, as it were, paralyzed by being forced through over-heated tissue-tracts—these, according to V. Lesser, constitute the immediate cause of death in cases of burns.

Catiano's supposition, that death is caused by hydrocyanic acid which is generated from the formic ammonia existing on the skin, has yet to be chemically confirmed.

If sopor does not come on within the first thirty-six hours, the prognosis is decidedly favorable. In this case, it is during the period of reaction and suppuration that dangerous symptoms are to be looked for, and they will arise from extension of the inflammatory

process, arterial hemorrhages, opening of joints, thromboses, and emboli of all kinds; inflammations of the bowels (duodenal ulcers), of the kidneys, the lungs, the pleura, and the meninges not infrequently supervene. Death is often caused by exhaustion, consequent upon fever and protracted suppuration. Tetanus, pyæmia, and erysipelas are the traumatic accidents most commonly encountered.

Treatment.—In burns of the first degree, which soon heal spontaneously, the only indication is to alleviate the severe pain. Rest, cold, wet compresses (saturnine lotions), immersion and irrigation, are best adapted to secure this end. Coating the sore with collodion is a very painful process, although, in many cases, it prevents the formation of blisters. In burns of the second degree, besides relieving pain, we have to promote the growth of new epidermis. It is best not to open the blisters; but if these are very tense and prevent the application of dressings, they should be pricked at their bases with a needle, and the fluid pressed out, taking care not to destroy the blisters themselves. If the epidermis has been detached in small circumscribed portions only, it will suffice to powder the denuded surface thickly with iodoform, in order to form a crust under which the healing may go on. When larger spaces are laid bare, they should be dressed with the strictest antiseptic precautions. After thorough disinfection with a five-per-cent solution of carbolic acid, the sores should be covered with protective silk dipped in a four-per-cent solution of borax in water, and wrapped around with several folds of borax lint. When the sloughing is still more extensive, carbolized gauze or salicylated cotton is to be applied over the borax lint in order to absorb the fluids, and the whole enveloped in Mackintosh cloth or India-rubber silk. Whenever the dressing becomes soaked, it must be renewed. Lister has recently recommended the direct application to the burn of lint dipped in a 1:30 solution of carbolized oil, and over this several layers of antiseptic gauze, that may be changed when saturated with the secretions, while the lint remains until healing is completed. The advantages of the antiseptic dressing consist in the speedy relief from pain which it affords, and its effect in preventing the luxuriant growth of inflammatory granulations, which so frequently give rise to extensive adhesions and strongly contracting scars. Busch spreads Lister's borax ointment over the sore, and covers it with carbolized gauze.

Where antiseptic dressings are not required, the lime liniment (aqua calcis, oleum olivarum, ana) is the best application. The sore is covered with folds of linen dipped in this mixture, and kept moistened with it without being disturbed. The dressing need not be renewed oftener than once or twice daily. When adhesions are threatened, cauterizing with nitrate of silver is the best mode of preventing them. Either the solid nitrate or a strong solution may be employed. As often as the eschar loosens, it must be detached, until at last it is found to adhere so firmly as not to admit of removal.

Burns of the third degree, when seated on the extremities, are best treated with antiseptic dressings, combined, after the eschar has fallen off, with skin-grafting according to Reverdin's method. In extensive burns of the trunk, on the other hand, the continuous water-bath is to be preferred. The sloughing of the eschar is thus hastened, the sore is kept constantly clean, the pain lessened, and the troublesome process of changing the dressing entirely dispensed with, while the mortality from the disease is not increased. Hebra witnessed no injurious results even from keeping his eczematous patients in the bath for two hundred and seventy successive days (*Wien. Allg. Med. Zeitung*, No. 43, 1861, and in his "Text-book of Skin Diseases"). When this appliance is not available, the patient simply sits or reclines in a large bath-tub, in which is placed a common mattress or bed-comforter, with one or more horse-hair cushions for the body to rest on. A large

linen cloth should be spread over the cushions, having its ends fastened to a cord which is stretched around the vessel. At first, the water in the bath is heated to 35° C.; sometimes, however, chilliness is experienced, making it necessary to raise the temperature to 40°. In cases of threatened collapse, wine and other alcoholic stimulants must be freely administered, with subcutaneous injections of camphor, ether, and musk. Auto-transfusion (performed by placing elastic bandages around the extremities) or transfusion constitutes the final resort.

DERMATITIS CONGELATIONIS.

CONGELATIONS.

Congelations are distinguished from burns by their very tedious course. Inflammation and its sequelaë continue to be manifested long after the cold has produced its immediate effect. The predisposition to congelations varies to a remarkable extent in different individuals. The chief predisposing condition in both sexes is anæmia. Girls will begin to complain of these troubles when laboring under chlorosis, becoming again exempt as soon as the general health is restored. A temperature of from 4 to 5° C. will suffice to bring on congelations, so that a degree of cold below the freezing point is by no means necessary. They occur more readily in a state of repose, especially during sleep, than when the subject is moving about.

In congelations, as in burns, we distinguish three degrees.

A. DERMATITIS CONGELATIONIS ERYTHEMATOSA.

The first effect of excessive cold is a contraction of the blood-vessels and paleness of the skin; when the cold abates, the vessels are again dilated. The retardation of the blood-current causes a bluish-red discoloration, which is accompanied by a circumscribed cutaneous œdema. Such is the mode in which chilblains (perniones) make their appearance. The fingers, toes, nose, ears, and penis, that is, those parts which have the largest superficies in proportion to bulk, are most frequently attacked. The discoloration disappears under pressure, while it is deepened as the result of warmth. Chilblains burn, itch or smart, and may continue with more or less improvement or aggravation for a long period. When this is the case, the œdematous swelling becomes more tense, the nodules feel harder, and the epidermis covering the latter is thin and shining. Usually the complaint disappears in summer, to return again at the advent of the cold season. Some degree of vascular enlargement, however, often remains when the active symptoms have subsided. Blisters containing bloody serum are produced on chilblains in consequence of external injuries, as pressure or friction (scratching). These may degenerate into running sores, with denudation and ulceration of the papillary body, and may give rise to venous and glandular inflammation.

B. DERMATITIS CONGELATIONIS BULLOSA.

When the action of cold has been of longer duration, blisters are formed, containing a clear or bloody serum, and varying in size from that of a pea to that of an apple. After these are opened, an ulceration of the underlying tissues often takes place, which reaches to the bone and is exceedingly protracted.

C. DERMATITIS CONGELATIONIS ESCHAROTICA.

In cases of congelation, gangrene may occur underneath the blood-blisters or where no blisters have been formed. The affected part becomes pale, livid, cold, and insensible,

and when, for instance, the toes are frozen, the patient goes on walking without complaint for days together. The process of sloughing generally takes place very slowly, while the line of demarcation is being formed, and often requires to be aided artificially. Extensive congelations not unfrequently result in pyæmia or septicæmia, since the blood-vessels of the affected region continue to discharge their office, and in this way putrid substances may be admitted into the circulation.

Treatment should first of all be prophylactic. When their development is favored by anæmia, this condition should be remedied, and the patients be directed to wear woolen stockings and gloves. Recent congelations should be rubbed with snow or cold water, and not restored to warmth too rapidly. Chilblains will generally bid defiance to all remedies so long as the patient continues to expose himself to cold. When they are inflamed, the affected member should be kept in a horizontal position, and wrapped in cold lead-water cataplasms, and these measures should be continued as long as they are agreeable to the patient. In cases of swelling and the formation of ganglia, tincture of iodine (even the colorless preparation) has proved of decided benefit. Lemon-juice, dilute hydrochloric or nitric acid, creasote, pyroligneous acid, chloride of lime, caustic lime, collodion, camphor, petroleum, and turpentine have each been likewise recommended. Gentle pressure, applied by means of Martin's elastic bandage, has often produced good results. Sprinkling with iodoform or chrysarobin is often very serviceable in promoting healthy granulations on ulcerated chilblains. When symptoms of irritation predominate, Lister's borax ointment or the emplastrum fuscum is to be preferred. Blisters should be broken, and their bases thoroughly and repeatedly cauterized with nitrate of silver, until a clean suppurating surface is presented. In extensive gangrene, antiseptic dressing, together with vertical suspension of the extremities (Bergmann) or the continuous water-bath (Hebra), should be resorted to.

Dermatitis Traumatica.

In this variety are displayed all the phenomena of inflammation with their sequelæ. It is produced by blows, concussions, pressure (as from trusses, tight boots), or by friction (in rowing, scratching, etc.). The treatment is in accordance with general surgical principles.

Dermatitis e Venenis et Causticis.

Under this head are included a large number of inflammations, arising from the injurious action of various substances upon the skin. These substances either produce merely redness, swelling, vesicles, and bullæ, or eruptive blotches, or they entirely destroy the skin by effecting chemical changes, which frequently put an end to life itself. Such are the caustic agents (concentrated mineral acids, caustic potash, caustic lime, arsenic, etc.). The treatment of this class of inflammations is similar to that already described in connection with burns.

ECZEMA.

Catarrh of the Skin.

Eczema is by far the most frequent, and hence practically the most important of cutaneous diseases. According to our experience, it includes more than one-third of all cases of those diseases that come under treatment—an estimate which agrees with the statements of Erasmus Wilson, McCall Anderson, of Glasgow, and Bulkley, while Hebra found that, in Vienna, it constituted only sixteen per cent of all the cases. Hebra also

found that twice as many females as males were affected with the malady. According to our observation, the proportion of the sexes in this respect is about equal. No period of life is exempt, although it occurs most frequently in childhood, when the skin is peculiarly soft, delicate, and susceptible.

Eczema is remarkably protean in its manifestations, showing itself under the most varied forms.

Definition.—Eczema is a simple, non-contagious, catarrhal inflammation of the skin, acute or, more frequently, chronic in form, beginning as an erythematous redness, or as an eruption, either scattered or in groups of papules, vesicles, or pustules, or of all these together. It is associated with more or less redness and swelling of the skin, and with severe burning and itching, followed by the appearance of moisture and the formation of crusts, partly yellow and gummy, partly green and brown, or by a dry scaly eruption upon a red base.

Eczema is precisely analogous to catarrh of the mucous membrane. Just as catarrh of the mucous membrane consists in a more or less increased secretion from the mucous glands and an abundant desquamation of the peculiarly altered superficial epithelial layer, combined with an increased exudation from the overloaded vessels of blood-serum, containing a greater or less amount of cell-elements (serous or purulent catarrh), so, in eczema, there is a similar discharge of blood-serum and cell-elements, with a similar shedding of the horny layer, and as chronic catarrh of the mucous membrane is characterized by swelling, infiltration, and increased redness, so chronic eczema presents infiltration and hyperæmia of the skin. We may convince ourselves that the process is the same in both cases by observing it in situations where the epidermis passes into mucous membrane.

The *symptoms* presented in every case of eczema are as follows :

1. Hyperæmia—active as a rule, though frequently passive, especially in dependent portions of the body—forms the initial stage (*stadium erythematosum*). This may pass directly into desquamation, and I fully agree with Kaposi, who maintains, in opposition to Auspitz, that there are eczemas which do not advance beyond this stage, although this process is not entitled on that account to be called an erythema, especially when it occurs in cases of eczema, and is associated with intense itching.

Exudation.—This constitutes the eruptive stage. Small punctiform papules, vesicles, or pustules make their appearance on a reddened base; these may dry up and pass into the third stage, or the epidermis may break, and the serous or purulent secretion be discharged upon the surface of the skin (*moist eczema*).

Desquamation.—This is the final stage of eczema (*eczema squamosum*). The typical succession of phenomena just described may be most clearly traced in acute eczemas.

Eczema is regarded as *chronic* :

1. When it recurs frequently in the same situation. This, however, strictly speaking, is only a relapsing form of the acute disease.

2. When certain insidious secondary processes have set in, such as occur in some cases of chronic catarrh of the mucous membranes. Among these complications are diseases of the absorbent apparatus, and conditions of engorgement, accompanied by atrophic alterations in the glands and adipose tissue.

Eczema is divided into the following varieties, according as one or another of the above symptoms predominates :

1. Eczema erythematosum exhibits a diffuse or punctiform redness and swelling of the skin, gradually subsiding at its circumference, sometimes confined to small spaces,

sometimes extending over the whole body. It either terminates in desquamation, or passes into other forms.

2. Eczema papulosum (Hebra) shows itself in the form of small, round or acuminated, irregularly-scattered papules, as large as a pin's head, and attended with troublesome itching. The apices of the papules being rubbed off by scratching, small, black points of dried blood appear in their places. They are either confined to circumscribed blotches, or dispersed over large areas, which sometimes include the entire bodily surface. In the latter case, the intolerable itching renders this form one of the most distressing and intractable of cutaneous maladies. Usually it begins and ends with the papular eruption, which, however, is sometimes succeeded by vesicles or pustules.

3. Eczema vesiculosum consists of an eruption of vesicles no larger than the head or point of a pin, on a surface uniformly red, or dotted with that color; these are generally very numerous, and distributed in groups, less frequently isolated. They often coalesce so as to form large blisters, in places where the epidermis is thickened, as on the palm of the hand or sole of the foot. The individual vesicles are tensely filled with a transparent, yellowish fluid; their surrounding surface is red and swollen, and the accompanying itching is intolerable. The vesicles may collapse, dry up, and disappear by desquamation, or the variety to be afterwards considered under the name of eczema madidans may be produced, partly through the destruction of the vesicles by scratching, partly through their spontaneous rupture. The usual seat of eczema vesiculosum is the face, the hands, or the fingers.

4. Eczema pustulosum s. impetiginosum differs from the preceding varieties in the fact that the fluid of its vesicles contains a larger proportion of pus-corpules. It is either developed from eczema vesiculosum, or its pustules are formed without any intermediate process. The pustules are usually larger than the vesicles. This form of eczema is most frequently found upon the heads of children, and in scrofulous individuals.

5. Eczema madidans s. rubrum; eczema inflammatorium, follows uniformly one of the preceding varieties, and is characterized by a moist and reddened superficies, in which the ruptured vesicles and pustules are often discernible as minute fossæ. From this there is a free discharge of serum or pus, which dries into a firmly-adherent crust of a yellow or green color, or brownish from the admixture of blood. Any part of the body may be affected, but especially the legs (salt-rheum), ears, scrotum, and bends of the joints.

6. Eczema squamosum (psoriasis diffusa et palmaris, Wilson; eczema psoriasiforme, Devergie) constitutes the final stage of typical eczema; it may arise from any of the preceding forms, but may itself persist for years. It is characterized by red spots varying in extent, and with a dry and scaly surface. The scales are of every size, from a grain of dust to large shreds of epidermis. The affection is generally associated with infiltration of the skin.

7. Eczema rhagadiforme is characterized by fissures, either superficial or penetrating the entire integument, extremely painful and often rendering all movement impossible. They occur most frequently over the joints, and are caused by the brittleness of the infiltrated skin, which gives way on movement. The finger-ends are particularly liable to this form; their skin becomes dry, brittle, and traversed by numerous easily-bleeding and exceedingly painful fissures. As heretofore explained, all these varieties are but manifestations of a single disease; they may pass into each other, and are frequently met with in different localities on one and the same individual at the same time.

ACUTE ECZEMA.

This is ushered in by the appearance, either at a single spot or in several places, of inflammatory redness and swelling, resembling erysipelas, with a feeling of burning and tension, accompanied by general uneasiness, gastric derangement, sleeplessness, shiverings, and even rigors, the bodily temperature being above the normal, and the pulse rapid. In about forty-eight hours, numerous small papules or vesicles containing a clear or turbid fluid arise on the affected surface. The eruption extends, scattered spots, papules, or vesicles breaking out around the first crops, or the disease manifests itself *de novo* on remote regions; for the entire integument becomes excessively sensitive during an attack of eczema, and the slightest irritation will suffice to call forth the above symptoms, in previously healthy parts. In the most favorable cases, the vesicles and pustules dry up and disappear, with intense itching and the formation of crusts and scales, or else those phenomena supervene which have been already described under the title of eczema madidans. The entire process occupies from two to six weeks. The eruptions often return in the same or different localities, and thus the disease gradually becomes chronic. Moist eczema is the most common form; next in frequency are the papular and erythematous varieties (eczema intertrigo). Every portion of the skin is liable to the attacks, but they occur most frequently in the following situations:

(a) *Eczema acutum faciei.*

After the precursory chill, the face begins to redden and swell, the eyelids are puffy and immovable, the ears also are greatly swollen, and the lips are bloated and cannot be opened. Careful examination and palpation of the skin will disclose an unevenness, often perceptible only under oblique illumination, which is caused by the presence of numerous minute papules and vesicles. The vesicles break quite early, especially on the ears, and discharge their contents very profusely. Hearing is impaired when the eczema extends to the auditory canal. Recovery takes place in from three to six weeks, but small spots are often left unhealed, and lay the foundation for chronic facial eczema.

(b) *Eczema acutum genitalium virilium*

Is associated with great swelling of the penis and scrotum; the latter part is very subject to moist eczema, while the penis usually throws off the disease at once by desquamation.

(c) *Eczema acutum manuum et pedum.*

Either isolated vesicles appear on the fingers or toes, together with slight redness, or the whole hand or foot swells, and the instep or back of the hand becomes highly œdematous. The fingers are enlarged, painfully swollen, and covered with numerous vesicles which often pass into pustules. The corium is frequently denuded to a considerable extent, and the nails may fall off. The pustules and crusts dry up, and the skin returns to a healthy condition in the course of a few weeks.

(d) *Eczema acutum universale.*

This is fortunately of rare occurrence; it results from the coalescence of numerous localized eczemas. I shall not soon forget the appearance presented by a gentleman afflicted with this form of eczema; he received me in a state of complete nudity, being unable to endure the contact of even the lightest garment. His pulse was 110; temp. 39.5° C.; tongue thickly coated; face red and bloated; scalp covered with a scurfy erup-