by branches given off in the front compartment. The *internal cutaneous branch* usually rises in the axilla in company with the branch which goes to the long head of the triceps, and then passes back of the arm. It supplies a middle dorsal strip of integument nearly as far down as to the elbow. The *upper external cutaneous branch* pierces the deep fascia in the line of the external intermuscular septum, at the upper third of the arm, accompanies the cephalic vein in the lower half of the arm, and supplies a strip of skin, from exit to elbow, on the antero-external surface of the arm. The *lower external cutaneous branch*, which is much larger, pierces the fascia somewhat lower down, and supplies the skin of the middle of the back of the forearm as far down as to the wrist. In its course it passes between the internal cutaneous nerve upon the inside and the musculo-spiral upon the outside.

The *lesser internal cutaneous nerve* (Wrisberg's) rises from the inner cord of the brachial plexus, passes as far down, in the front compartment, as to the inner side of the axillary vein, which latter separates it from the ulnar nerve, at the middle of the arm. At the elbow it turns backward to supply the skin over the olecranon.

The *internal cutaneous nerve* rises from the inner cord of the brachial plexus, and passes down the arm to the inner side of the brachial artery. With the basilic vein it perforates the deep fascia and supplies the skin of the upper and inner arm. Above the elbow the terminal branches, anterior and posterior, diverge slightly at the antero-internal side of the arm, to pass the elbow, where they supply the skin of the inner forearm, anteriorly and posteriorly, as far down as the wrist.

A terminal *branch* of the *musculo-cutaneous nerve* passes over the elbow and lies below in front of the radial artery. It supplies the outer side of the forearm, front and back.

Luzerne Coville.

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ARM AND FOREARM, DISEASES AND INJURIES OF THE.—In considering the diseases and injuries of the arm and forearm, I shall take up the different affections of the several structures under the following heads: I. Affections of the Skin; II. Affections of the Fascia; III. Affections of the Bones, the Periosteum, and the Joints; IV. Affections of the Muscles, Tendons, and Tendon Sheaths; V. Affections of the Blood-vessels; VI. Affections of the Lymphatic Vessels, Glands, and Bursæ; VII. Affections of the Nerves; VIII. Hysterical Lesions; IX. Tumors.

It will be my purpose to discuss more fully those affections of these different structures which show some peculiar manifestations when presenting themselves upon the upper extremities, and to deal with them less in detail when exhibiting upon the arm merely those features which are common to the same affections elsewhere in the body. Particularly in the case of diseases affecting the skin of the arm and forearm, not all the dermatic affections which may be found in this locality will be entitled to extensive consideration, but such forms of skin trouble only as are particularly prone to develop their lesions upon the arms. Furthermore, it will suffice with regard to most of these to call attention to the fact that certain lesions may be expected on the arms and forearms, and to describe their symptoms and appearance with sufficient accuracy to allow of their diagnosis, while more extended consideration of their pathology and treatment is to be sought under other headings in this work.

I. Affections of the Skin.

With regard to the diseases affecting the skin of the arms, we have to content ourselves for the most part with recording the observed fact of their appearance in this locality, owing to our ignorance of the causes that determine the outbreak of cutaneous lesions upon this part of the body.

It is necessary to bear in mind that the general principles of dermatology are applicable here as in other parts of the body, notably those which teach us that symmetrical lesions may generally be considered to be due to internal causes, while for unsymmetrical lesions there is *a priori* reason to think of local irritation as a cause of the affection. Similar weight should be given to considering the relation of the cutaneous lesion to the clothing of the part, inasmuch as certain lesions are prone to appear on unprotected parts, while others appear where the friction of the clothing, or vermin which the clothing may harbor, may give rise to local irritation. Other matters concerning the site of lesions of the skin on the arms, which may affect the diagnosis, are the lines of cleavage of the skin, and the presence of the lesions upon the flexor or upon the extensor surface of certain of the affected limb, and finally the known course of the brachial nerves and blood-vessels. Nor should the general rule of dermatological practice be forgotten which teaches us to compare the integument of the arms with that of the rest of the body and so gain an accurate knowledge of the anatomical distribution of the cutaneous lesions.

The more recent nosological systems of dermatology have sought to group the various lesions of the skin according to their pathological basis, and in the rapid review which I purpose to make of such cutaneous affections as have their common site upon the arms and forearms, I shall consider the different lesions in the general order of the classification of Jessner—to wit, functional disorders, circulatory disorders, and inflammations, superficial and deep-seated; finally, I shall consider briefly traumatisms of the skin.

(*a*) *Functional Disorders of the Skin.*—Of the first class, that of functional disorders of the skin, such as pruritus, hyperidrosis, seborrhœa, it will suffice to say that none of them have any predilection for the arms or forearms which would justify their consideration here, if we except the entirely unimportant erythema solare which is frequently seen on the arms of farmers, bathers, and laborers who work in the open air with the sleeves rolled up.

(*b*) *Circulatory Disorders of the Skin.*—Of the diseases of the skin classified by Jessner as circulatory disorders, the lesions of purpura and scurvy, while undoubtedly they show themselves with comparative frequency on the arms, yet it is rare that they should show themselves there with any special preponderance of distribution over other parts of the body. Peliosis rheumatica, however, is a purpuric affection whose predilection for the arms merits our attention in considering the cutaneous affections of these members.

In PELIOSIS RHEUMATICA, also called purpura rheumatica, a period of invasion precedes the eruption for a variable length of time, and is shown by general malaise, systemic disturbances, and painful swelling of the joints, especially of the knees, wrists, and ankles. The temperature may be normal, but more often it rises to 100° F. or more. In a few days the eruption appears and the pain then subsides. The lesions occupy practically the same regions as do those of erythema multiforme (*vide infra*), namely, the wrists, forearms, and lower legs, but sometimes they are particularly located about and around the inflamed joints. Some authorities indeed classify the affection as a variety of erythema multiforme. The lesions consist of bluish-red patches, and slightly elevated, bright-red papules which quickly become purplish; they may, however, be purpuric from the first. Their color cannot be effaced by pressure. After persisting for a few days, they pass through the various gradations of color seen in a contusion and disappear altogether. The disease may be limited to one outbreak, or the eruption may come out in several crops and run a course of from four to six weeks, or it may disappear altogether and ten days or more later a relapse occur, and the joint and other symptoms again become manifest. The recognition of hemorrhage into the skin is easy when it is borne in mind that pressure does not cause the redness to fade. Such lesions occupying the localities mentioned, and associated with the

systemic disturbance already described, with the joint swellings, pains, etc., are sufficient to constitute the diagnosis of peliosis rheumatica.

(*c*) *Inflammatory Diseases of the Corium and Subcutis.*—Of the inflammatory diseases of the skin, we can at once dismiss the specific exanthematous fevers of childhood as having no special predilection for the arms, and of the diseases under the nosological classification we are following, that known as LICHEN PLANUS is the first that arrests our attention. This is a disease whose predilection for the arms as a site for eruption is more marked than is the case in that just described. Indeed, it is often confined to the flexor aspect of the forearm, though it manifests a tendency in its course to spread over a greater part of the lower arm and of the forearm; but it never involves the whole skin as do eczema, psoriasis, and lichen ruber in certain cases. The following description of the symptoms and course of the disease is taken from Gottheil: Lichen planus occurs most frequently as a chronic and localized malady, the more acute and general form of the disease being rare. The site of the eruption is usually the flexor surface of the forearms, especially around the wrists and on the backs of the hands and the feet, but other regions are not infrequently affected, and it occurs occasionally on the palms, soles, and the genitals. It is rare, however, on the face and scalp. It is frequently symmetrical. The lesions appear first as extremely minute papules of a characteristic dusky red or purplish color, with a waxy glance, and sharply differentiated from the surrounding skin. Their sides are steep, and their shape is distinctly angular. Their tops are flat, and marked with a central depression or capped with a minute scale. On the palms and soles the individual lesions may be hard to distinguish, the entire epidermis of the affected region being elevated and thickened, cracked in places and of a dusky hue and covered with whitish scales. On the mucosæ they appear as whitish, flattened papules. They may be scattered or irregularly grouped. As they gradually enlarge to pea size, adjacent papules coalesce, and thus extensive indurated and scaly areas are formed; but the individual lesions do not increase beyond their original size. After persisting for a long time, months and years, they slowly undergo absorption, leaving atrophic, pigmented areas behind. No vesicles or pustules are ever formed, nor are the nails or the hair affected. The subjective symptoms are confined to a moderate itching, and it is only in very extensive forms that this becomes severe. The patients are sometimes debilitated and run down by excesses or overwork, but not infrequently they are in excellent health. The malady occurs with about equal frequency in both sexes. It is seen at all ages, but is most frequent during middle life.

The diagnosis rests upon the peculiar shape, size, grouping, and appearance of the papules as described above. *Papular eczema*, especially when situated on the forearm, may resemble lichen planus, but the papules are rounded and frequently have a little serum at their apices. They are intensely itchy, round, run a rapid course, and leave no pigmentation behind; and other eczematous changes, excoriation, oozing, or crusting will probably be found somewhere on the skin. In the *papular syphiloderm* the lesions are round-topped and often arranged in crescentic or circular form; they are generally distributed, and more or less polymorphic; there is no itching, their color is reddish. Other signs of syphilis are probably present, and the disease responds to antiluetic treatment. In *lichen scrofulosus* the round papules are grouped upon the trunk and are accompanied by no subjective symptoms whatsoever. Finally in *psoriasis* the lesions are pink, covered with abundant, heaped-up scales, and are situated solely on the extensor surface.

The prognosis is favorable always. The disease is chronic and obstinate, but it tends to recovery. It may be added that the disease, though not common, is not excessively rare.

The grave progressive disease known as lichen ruber may have some of its characteristic lesions situated upon the arms, but its distribution is so rarely limited to that locality that its discussion need not detain us here. When present upon the arms its tendency to follow and accentuate the folds and lines of cleavage of the skin sometimes leads, in the cubital folds, to the development of linear strings of papules, constituting what is known as "lichen ruber moniliformis."

Few of the forms of eczema confine themselves to the arms, though small patches of scaly eczema are not infrequently met on or near the wrists.

ECZEMA PAPULOSUM, however, is a form of eczema both common and obstinate which has a predilection for the limbs, both the arms and the legs, though it is met with on the trunk as well. Most forms of eczema are characterized by lesions with a more or less fluid exudation which loosens the superficial portion of the epidermis and spreads itself over the affected surface. In some cases of eczema, however, the tendency to exudation is lessened, and the probabilities are that it is less fluid in character, and under these circumstances does not gain the surface but collects at points beneath the epidermis, raising little solid projections which have received the name of papules. These may be somewhat closely aggregated, or there may be an appreciable distance between them, and the surface will be dry unless the pruritus leads to scratching and the edges of the papules are torn; in that case a small quantity of lymph may exude and dry into minute scales. In the course of time, however, the papules themselves tend to subside, and we have a surface somewhat glossy and scaly, but not to the extent usually seen in other varieties of eczema. This papular form of eczema has its seats of election. It is perhaps never seen on the scalp and some other parts, but it is quite common on the arms and forearms, thighs, and legs, especially their flexor aspects (Piffard).

ECZEMA FISSUM is still another variety of eczema in which we have neither vesicles, pustules, nor papules, nor the extensive exfoliation which characterizes the exfoliative form of this disease. We may have a more or less reddened surface, but instead of the lesions already mentioned we find small cracks or fissures extending through the stratum corneum and sometimes through the stratum Malpighii as well. The exudation in this fissured variety is slight, crusting is slight, and after a time the skin returns to the normal condition by a simple closing of the fissures and disappearance of the congestion. These fissures are perhaps more frequently met with behind the ears, on the palms and soles, and at the various flexures (Piffard).

ERYTHEMA MULTIFORME is the next disease under the head of cutaneous inflammations which claims our attention, on account of its frequent appearance on the forearms. Gottheil defines it as an acute inflammatory disease, characterized by the appearance of reddish papules, tubercles, vesicles, or blebs of symmetrical distribution, and affecting by preference the backs of the hands and the feet. Elliot remarks that it is one of the most striking and constant features of erythema multiforme that almost invariably the lesions appear first on the backs of the hands and extend to the forearms and then to the lateral portion of the neck and face. Frequently simultaneously, but more often later than on the hands, the eruption is manifested on the dorsum of the feet and on the anterior aspect of the legs. It is frequently absent altogether from these regions, and besides, the eruption will present much variation in individual cases. The eruption is always symmetrical, without, however, presenting absolute symmetry. Often one side of the body will be more severely affected than the other. Its symptoms, course, and the differential diagnosis are described by Gottheil as follows: After a prodromal period marked by a moderate febrile movement there appear on the backs of the hands and feet, or on the palms and soles, and more rarely on other parts of the body, a varying number of slightly elevated, firm, reddish-violet papules fading on pressure. This condition is known as erythema papulatum. In a few days the papules grow into tuber-

cles perhaps one-third of an inch in size (erythema tuberculatum). The centres then begin to flatten and fade out and assume a characteristic bluish-red hue (erythema annulare). At the periphery where the eruption is extending, the lesions preserve their elevated form and reddish tint. Adjacent patches may coalesce and form irregular figures, known as erythema gyratum and erythema figuratum. More rarely the appearance of blebs gives us the form known as erythema bullosum. Herpes iris is the designation given to a vesicular form of this erythema in which new concentric rings of papulo-vesicles appear in the depressed purplish centre of an annular erythema. These various forms, often looked upon as distinct diseases, are in reality merely stages of the same process with varying amounts of exudation. A case may go through several of them and even show them simultaneously, for multiformity is characteristic of the disease; but usually one type only is present, and the commonest by far is the papular one. The malady occurs especially in the spring and fall, and lasts from four to six weeks. It happens at any age, and is somewhat more frequent in females than in males. The mucosæ are occasionally affected. It is prone to relapse, and usually reappears in its original type. It is occasionally complicated with purpura, acute articular rheumatism, and endocarditis.

Its typical course and location, the papules or tubercles whose red color is removable on pressure, and the absence of desquamation are sufficient to characterize the disease. An *eczema* has exudations, scales, and crusts, and itches intensely. *Urticaria* has papules or pinkish, fugacious elevations, with much itching and reflex irritability of the skin. A *papular syphiloderm* is copper colored and not removable by pressure; the palms and soles are usually involved, and other syphilitic symptoms are generally present. *Prurigo* has deep seated, colorless papules, begins in childhood, and itches intensely. *Tricophytosis corporis* is scaly in the centre, and the parasite can usually be readily found.

While the arms are one of the rarer sites for the vesicular eruption of HERPES ZOSTER, yet the fact should be borne in mind that this disease occasionally manifests itself in the course of the brachial nerves. Its characteristic symptoms should make the diagnosis in most cases easy. Its symptomatology is this: The eruption is almost regularly preceded by distinct premonitory symptoms, consisting mainly in neuralgic pains of variable degrees of severity over the area about to be affected and lasting from a few hours to several days, occasionally even for weeks. Sometimes they are missing entirely, particularly in young children. The pain may be of a diffuse character, or, again, confined to certain points which correspond anatomically to the underlying nerves and their ramifications. The cutaneous phenomena make their appearance always in an acute manner. At first there are redness and slight swelling over the diseased area. This is soon followed by groups of small papular elevations, which in the course of a few hours are transformed into vesicles from the size of a pin-head to that of a small split pea, closely clustered together, fully distended, and filled with a clear serous fluid. The vesicles are at first sharply contoured and surrounded by an erythematous halo. Further on they may, by peripheral extension, become confluent so as to form larger bullæ. They have generally little tendency to burst, and do so only accidentally. Occasionally a larger surface may be uniformly studded with these vesicles, but as a rule there are several distinct and isolated groups of them, varying in size from a dime to the palm of the hand, of irregular shape, and arranged more or less exactly in the form of a semigirdle when situated on the trunk. In other regions the unilateral distribution of the eruption along the course of one or several cutaneous nerves forms a striking feature. These groups come out successively, the one nearest the spinal column usually appearing first, but all the vesicles constituting one patch are formed and run their course contemporaneously. Their contents remain clear for three or four days, then become gradually more turbid, puriform, and by and by dry out, forming brownish crusts which finally fall off and leave in their place reddish or bluish discolorations. These persist for some time and gradually fade away. In some instances, however, permanent marks may remain, which, by their arrangement and distribution, are quite characteristic of the preceding eruption. The time consumed for the completion of the cycle in each individual group is from eight to ten days, but through the successive appearance of fresh crops of vesicles when the older ones have almost reached the point of involution, the whole process may last up to four or even six weeks.

The subjective symptoms which accompany the eruption are very variable. While in some cases the preliminary neuralgia ceases with the advent of the cutaneous manifestations, it is more often present during the whole duration of the disease, and is intensified by a burning and smarting sensation with which every new crop of lesions is ushered in. Some patients complain very little, others seem to suffer very much, particularly from nightly exacerbations which may disturb the sleep. Even after the completion of the eruptive stage there may remain for some weeks, and occasionally for a long period, disturbances in the sensory functions of the affected area. Fever is frequently present with the zoster, but is rarely of much consequence. A very remarkable fact in regard to zoster is that it attacks a person only once during a lifetime. Exceptions to this are so few and far between that they do not materially affect the generally accepted law.

The termination of the local manifestations does not always indicate a complete restoration in the affected territory. Not only may neuralgic pains persist for some time and become the source of agonizing attacks which deteriorate the patient's health, but in some cases there remain pruritus, hyperæsthesia, or complete anæsthesia and analgesia. Of particular interest is the so-called "anæsthesia dolorosa," which occasionally follows a zoster. An explanation for this peculiar phenomenon may be found in that the pathological changes in the course of the nerve disturb the transmission of sensation from the surface to the centre, whereby the anæsthesia is produced, while the cause of the pain is located in the sensory root of the spinal column.

Although zoster is generally attributed to disturbances in the sensory nerves, the strange fact must be recorded that often muscular atrophy and motor paralysis are caused by it. Paralysis of the arm muscles after zoster brachialis was noted by Schwimmer, Joffroy, Broadbent, and Gibney.

The characteristics of zoster are usually so marked that little difficulty can exist in recognizing it. Its unilateral distribution along the course of well-known cutaneous nerves, the successive appearance of groups of vesicles, their cyclic course, and the concomitant neuralgia will easily establish the diagnosis. From eczema it is readily differentiated by the larger size of its vesicles and their tendency to persist as such, whereas in the former they burst very soon and give rise to characteristic oozing (Zeissler).

PSORIASIS is a disease which on account of its customary distribution merits a description among the cutaneous affections of the arm. The lesions of psoriasis are characterized by the formation of a thick imbricated covering of dry scales of a light yellow, pearly white, or silvery color situated on a reddish, slightly elevated, well-defined base. The disease appears without premonitory symptoms, and the first indication of its presence is the appearance of small pin-head sized, rose-colored spots, which in a day or two become covered with silvery scales, psoriasis punctata. These spots increase at the periphery, while the scales become piled up into thick crusts which, from their resemblance to drops of mortar spattered on the skin, constitute the form known as psoriasis guttata. If the attack runs an acute course, the patches rapidly increase in size, and in a week may attain the dimensions of coins, psoriasis nummularis. Generally, however, the eruption is noted for its chronicity, and months are re-

quired for this development. The tendency of the psoriatic lesion is to disappear of its own accord, although the time occupied in this process may be months or years. The activity of the scaly proliferation first begins to subside in the middle of the patch, which finally goes on to complete resolution, leaving a ring-shaped margin standing out in bold relief—psoriasis annularis. If the disease continues to extend, the rings meet, giving figure-of-eight-shaped eruptions, and as the healing proceeds, the point of contiguity in turn disappears, leaving irregular or serpentine lines—psoriasis gyrata.

The accumulation of scales, which is the most distinct feature of psoriasis, varies in different cases as well as on different parts of the body of the same individual. On the scalp the scales are thick, and the eruption tends to extend beyond the margin of the hair. On the extensor surface of the limbs, also, the scales become piled up on elevated bases to the height of several lines. On the face and penis the scales are less abundant. Although the scales are adherent to each other and to the base underneath, yet they may be detached by the finger nail, when, if the disease is of recent origin, a pale reddish surface, which readily bleeds and is but slightly raised above the surrounding skin, will be seen. In cases of long standing the base is of a dark or venous hue and markedly thicker than the normal skin. The scales thus removed are quickly renewed and in a few days attain their former thickness. There is no discharge or moisture connected with the eruption at any time, and the sensation of itching may or may not be present. Although all parts of the body may be involved, yet there are regions of predilection which are generally involved, especially at the onset of the disease. These are the points of the elbows and the anterior aspect of the legs just above the patellæ. The scalp is also a favorite position, and in typical cases the disease is more marked on the extensor than on the soft, flexor surfaces of the body. In all cases the eruption tends to symmetrical distribution.

Although psoriasis is usually a well-defined disease and easily recognized, yet it is subject to variations, and in atypical cases may baffle the skilled diagnostician. In appearance it varies from a simple furfuraceous desquamation which may be the result of friction, to a veritable inflammation as in scaly eczema. *Eczema squamosum*, however, is less frequently symmetrical, the flexor surfaces of the joints are favorite positions, while the extensor surfaces of the points of the elbows or knees are not affected as in psoriasis. In psoriasis the eruption is sharply defined, and its margins frequently stand out like a bold headland, while in eczema the patch is thickest at the centre and its margin merges gradually into the healthy skin. A history of moisture will often enable one to decide, for eczema at its outset is always moist, while psoriasis is essentially a dry eruption from the beginning. In eczema the accumulation of scales is less than in psoriasis, and they are of a bluish color rather than white. The scales in eczema are more easily detached, and the base when scraped becomes bathed with serous exudation and does not bleed as in psoriasis. Eczema of the palms and soles is more common than psoriasis in this position. It is more fissured and may be the only part involved, while psoriasis does not attack these parts alone. The nails are affected in both diseases, but in eczema they are usually all affected at once, while in psoriasis one or more nails, but never all, are involved at the same time. *Lichen planus* and *lichen ruber* may be mistaken for psoriasis when the former are of long duration. Lichen first appears in the form of small pin-head to split-pea sized, flat-topped papules which are distributed in clusters and extending at the periphery run together, giving the eruption the appearance of one continuous patch, not unlike psoriasis; but there is less scaling in lichen and the eruption extends by the formation of characteristic islets which may be seen on the outskirts of the original cluster. The characteristic position of lichen is on the flexor aspect of the wrist, a position seldom occupied in psoriasis. *Syphiloderma squamosum* often resembles psoriasis very closely, and next to eczema is most liable to be mistaken for this disease. On account of the close similarity, this form of syphiloderm was formerly called syphilitic psoriasis. But syphilis attacks the mucous surfaces as well as the skin, and is seldom present on the latter without appearing on the former; while psoriasis never attacks the mucous membranes. Syphilis but rarely occurs on the elbows and knees, but it is very commonly met with on the palms of the hands and the soles of the feet. One hand may be affected in psoriasis, while both are usually involved in syphilis. The eruption in syphilis is polymorphous, presenting from time to time papules, pustules, and moist condylomata which would at once enable one to distinguish it from psoriasis. In late syphilis the destructive nature of the disease will become apparent by scars or fissures on the tongue or at the angles of the mouth, while psoriasis leaves no mark behind. The scales in syphilis are muddy gray, and the base of the eruption is more infiltrated and of a darker color; moreover, the history of the disease should always be considered (Corlett).

(*d*) *Deep-Seated Inflammations of the Skin.*—The inflammatory diseases we have so far reviewed are classified in the nosological scheme of Jessner as inflammations of the corium and subcutis. Of the deep-seated inflammations which constitute the next category, there is an affection classed by some as a form of erythema multiforme, and by others as a distinct disease, known as ERYTHEMA NODOSUM which, while it does not often locate itself on the arms, might yet prove puzzling to one unacquainted with its course if met, as occasionally occurs, exclusively in that locality. Its prodromal symptoms are practically identical with those preceding an attack of erythema multiforme (*q. v.*), namely, fever, gastric disturbances, and pains in the joints. It attacks likewise a similar class of patients, young people in a condition of depressed vitality. Its lesions are an exaggeration of those of erythema multiforme, but its customary distribution is less frequently upon the forearms. One of its alternate names, dermatitis contusiformis, is descriptive of the appearance of its lesions. The eruption appears in nodes of a considerable elevation, rounded or oval in shape, varying in size from that of a nut to that of an egg. They are warm to the touch, surrounded by an œdematous area, painless, but tender to pressure. Their color is at first a rosy red, changing to a darker and more livid hue, and not removable by pressure. They never coalesce nor suppurate. In the course of eight or ten days they gradually disappear, going through the color changes that are seen in blood extravasations and leaving a dark discoloration behind. Three or four nodes only are usually present, and their number rarely exceeds a dozen. Though the individual lesions last only a few days, a succession of fresh ones often prolongs the malady for two or three weeks. Recurrences are rare.

Ordinary *contusions* may be mistaken for the nodes of erythema nodosum, but they never have the peculiar rosy color, are not usually multiple, are not round, there are no general symptoms, and there is the history of an injury. *Syphilitic gummata* may resemble them closely, but the antecedent pains are much severer. They are slower in their course, are very rarely seen in the young, and are almost always accompanied by other symptoms of lues, past or present. The prognosis is generally good, though complications may arise which may make the prognosis more serious.

It may be stated as a general proposition that there is but little tendency for the cutaneous lesions of SYPHILIS to localize themselves upon the arms and forearms. Particularly is this true of the earlier macular and papular eruptions, which have as a pathological distinction the involvement of the superficial anatomical elements of the skin and a generalized distribution all over the body; in which distribution, indeed, the arms are not exempt. An occasional tendency toward characteristic localization upon the arms is manifested in some of the later syphilides, whose characteristics are an involvement of the deeper cutaneous structures and a less general and less symmetrical distribution over the body. Accordingly we