is distinctly a complex one, and while this division is made for the sake of convenience, it must be understood that the two classes of causative factors often act conjointly.

Constitutional Causes.—Eczema is a disease of debility; no healthy individual, in my opinion, ever suffered an attack of eczema. Even in those cases in which the disease is dependent upon local causes alone, there is always some constitutional defect which enables these causes to become operative. My views in regard to the nature of eczema conform, in a measure, to those held by Erasmus Wilson. He considered the disease one of *debility*, either "*assimilative*," "*nutritive*," or "*nervous*." As far as it goes, this, I think, is the true conception of the nature of eczema.

Foremost among the constitutional causes of eczema are those dependent upon disorders of the gastro-intestinal tract. Dyspepsia in its various forms, constipated or irregular bowel action, intestinal and gastric flatulency, sluggish or disordered liver action, all these impair the general health and affect the nutrition of the skin. Improper and insufficient food, errors in diet, etc., while perhaps not affecting the gastric function, do debilitate the system and weaken the resisting power of the skin. In infants, these latter are the direct exciting causes of the eczema in a great majority of the cases, and are, therefore, of the very greatest importance in the management of infantile eczema. The ingestion of certain drugs, as arsenic, mercury, iodide of potassium, etc., is capable of bringing forth an eczema in certain individuals. I have only recently had under my care a case of generalized eczema due to the internal administration of mercury in the treatment of syphilis.

That there is a causative relation between the so-called gouty state and eczema there can be no question. The association of both rheumatism and gout with some form of eczematous disease is a matter of frequent observation. It is true that many sufferers from chronic gout or rheumatism never have eczema, but, *per contra*, these conditions are frequently observed to stand in a direct causative relation to the disease. Cases, for instance, have been observed in which an attack of constitutional gout has been relieved immediately upon the outbreak of an eczema, and patients remain free as long as the eczema lasts. It is also interesting to note the frequency with which we find a history of gout, rheumatism, chronic bronchitis, asthma, etc., in the antecedents of eczematous patients. In every eczema in middle-aged or elderly people the possibility of a gouty origin should be borne in mind.

Various disorders of the nervous system are potent factors in producing and keeping up an attack of eczema. This is not surprising when one considers the abundant nerve supply of the skin, the intricate and special termination of the nerve filaments and the very delicate mechanism which governs, through the vaso-motor nerves, the blood supply of this great organ. The most common condition observed in this connection is that of nervous exhaustion due to overwork, anxiety, excesses of various kinds, or direct shock of the nervous centres. Examples of neurotic eczema dependent upon one or another of these conditions are of very frequent observation. A recognition of the etiological relations in this class of cases is essential for the successful management of the disease.

The derangements of the nervous system in lithæmic subjects, as well as in those suffering from gastric, liver, or intestinal disturbances already referred to, deserve mention in this place. A train of nervous phenomena is sometimes engendered which reacts upon the original disorder, and thus a vicious circle may be established which is a powerful factor in causing or aggravating an existing eczema. Among other disorders of the nervous system may be mentioned direct injury to the nerves themselves, and also neuritis and some neuralgias. These have all been directly responsible for an eczematous outbreak.

Besides the causes just enumerated certain physiological states and functional or organic disease of remote organs may cause eczema through the influence of the reflexes. Among these may be mentioned pregnancy, lactation, the climacteric, dentition, retained smegma, misplacements, tumors or congestions of the uterus, movable kidney, etc. The intimate relation between asthma and eczema in certain instances has been noted by a number of observers. The two may coexist in the same individual or eczema may alternate with the asthmatic paroxysms. It is not known what the true relation is between them, but their association is frequently enough observed to warrant mention. An interesting instance of this came under my own observation. The mother of a family of four children, two sons and two daughters, suffered from asthma and eczema. One of the children (the eldest son) was also a subject of both asthma and eczema, and his daughter, an only child, was hopelessly crippled in consequence of an inveterate asthma, and she was likewise a sufferer from eczema. Diabetes may also be considered a cause of eczema. An eczematous eruption frequently develops about the genitals in diabetic subjects, but in many cases this disappears upon removing the sugar from the urine. In these cases the eruption would be more properly classed as a dermatitis. In a certain number, however, the eruption persists as an eczema and may develop elsewhere upon the body.

In concluding the consideration of the constitutional causes of eczema it is only necessary to mention that chlorosis, malaria, tuberculosis, or any systemic disorder which lowers the general nutrition, may stand in an etiological relation to the disease.

The doctrines of French authors attributing eczema and some other skin affections to the existence of certain diatheses, as the "*dartrous*," "*herpetic*," or "*arthritic*" diathesis, have few adherents at the present day.

Local Causes.—The agencies that may excite an eczema by their action externally upon the skin are exceedingly numerous and at the same time very important. Their actual position and importance as causative factors, however, are still a subject of considerable controversy. There are those, notably the pupils of the German school of dermatology, who regard them as the prime factors in the etiology of the disease, while other equally distinguished dermatologists consider them of altogether secondary importance. I believe that, for the successful treatment and management of eczema, it is essential to weigh fully every condition or agent that may stand in any way as a causative factor in the disease, whether of external or internal origin. I attribute very great importance to both classes of causes, for to be operative it is often necessary that they should act conjointly. I have already said that I did not believe a healthy person ever suffered from eczema; nevertheless, to call forth the disease an exciting cause is necessary, whether it acts from without or within the economy. Eczema is never engendered through the action of local causes alone, there is something else necessary, call it predisposition if you will, but there is, in my opinion, always some contributing factor which stamps the eczematous character upon the eruption thus excited.

It would not be possible to enumerate all the local causes of eczema. They usually comprise, however, three classes of agents, namely, those of a thermal, mechanical, or chemical nature.

The *thermal* agents, heat and cold, are sometimes important factors in the evolution of the disease. Both solar heat, either direct or reflected from water, and the artificial heat to which laundresses, cooks, stokers, firemen, etc., are subjected may be responsible. The first constitutes "*eczema solare*," and should be distinguished from erythema solare or sunburn which is a simple dermatitis. "*Eczema intertigo*," which develops in fat people and in infants through the action of heat upon moist surfaces, in the various folds of the body, must likewise be distinguished from erythema intertrigo. The action of cold in the production or aggravation of eczema is of common observation. This applies to climatic changes, including the action of cold winds, and to the contact of

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cold substances. Eczema is almost always worse in winter, and sudden changes from warm to cold may excite the disease or aggravate an existing eruption. I have had occasion to see a number of cases of eczema of the nails and surrounding tissues in ice-cream workers, who in the course of their work were compelled alternately to put their hands into very hot water and then into freezing mixtures.

Among the *mechanical* causes may be mentioned pressure and friction by either the clothing or such extraneous objects as trusses, braces, artificial limbs, etc., the dust and dirt incident to certain occupations, and traumatism of various kinds including scratching. Scratching is one of the most important of the local causes of eczema. There may be a pruritus as an early symptom of the disease or the itching may result from an urticaria, or from the bites of insects, such as fleas, pediculi, mosquitoes, itch-mites, bedbugs, etc. The prurigo of Hebra is often complicated by an eczema induced by scratching. Scratching will also invariably aggravate an existing eczema and cause it to spread rapidly.

Water used either too hot or too cold, as in the Turkish and Russian baths, is an exciting cause of eczema in a certain number of cases, and the washing of an eczematous surface almost invariably increases the trouble.

Vaccination will often cause the eruption to develop in one subject to the disease or having a predisposition to the same. I do not believe, however, that it is ever solely responsible for the disease, though it is generally regarded so by the laity.

The *chemical* agents that may produce eczema are very numerous, and only a few of them can be mentioned. The most common are the various acids and alkalies, strongly alkaline soaps, mercurial frictions, sulphur, arnica, alcohol, ether, chloroform, turpentine, iodine, iodoform, etc. The different dye stuffs and the various chemicals used in the trades are responsible for many of the so-called trade eczemas. Bricklayers, masons, printers, washerwomen, photographers, bleachers, dyers, and painters are often thus affected. Cooks and bakers may suffer from eczema caused by the action of the sugar, alum, borax, etc., used in making bread and pastry. Bartenders, waitresses and waiters, bottle-washers, and cigarmakers are another class who sometimes suffer from trade eczema. Exposure to the poison ivy, or *rhus toxicodendron*, and also to the poison oak, sumac, and some other poisonous plants will produce eczema in some individuals.

Animal and vegetable parasites may likewise be regarded as causes of eczema, and micro-organisms which are known to produce special types of skin lesions may possibly be responsible for some forms. Satisfactory proof, however, of the causative relation of any form of micro-organism to eczema has not yet been obtained.

Any one of the agents above-mentioned is capable of causing a skin eruption of greater or less severity. This may wholly subside upon removal of the cause and would then be regarded as an artificial dermatitis. In a certain number, however, the eruption persists and continues to spread and even develop in remote places long after the cause which excites it had ceased to operate. This latter is eczema, and any local irritant that acts in this way does so in a subject who is predisposed to the disease. The predisposition may be hereditary or acquired, but without it a true eczema will not be produced. One has only to study closely a few cases of trade eczema to be convinced of this. It is a very common thing in patients suffering from a severe eczema of this kind to hear them say that they have worked for years at the same trade, but never before had anything more than a slight irritation.

In summing up the causes of eczema it will readily be seen that the etiology of the disease is a very complex one. This would account for the rapid changes in the severity of the process and the great multiformity in the type of the lesions, as already referred to while considering the general symptomatology.

Diagnosis.—The diagnosis of eczema is, as a rule, comparatively easy. The disease is so common that the ordinary types of the eruption are readily recognized by most physicians. I think the mistake of diagnosing some other affection as eczema is more often made than that of failing to recognize the disease when it is present. In some of the mixed forms, however, the diagnosis is often attended with the greatest difficulty, and even the expert is occasionally deceived in differentiating eczema from some of the rarer affections of the skin. It must also be remembered that eczema is often found associated with some other skin affection, and the greatest care is sometimes necessary in differentiating them.

The diagnosis of the special forms and local varieties will be considered when we come to study these later on. In this place the differential diagnosis will be made between eczema and the affections for which it is more liable to be mistaken.

Erysipelas.—This is an acute febrile disease, usually accompanied by severe constitutional symptoms; these alone will distinguish it from eczema. The disease begins at one point and spreads very rapidly, the area affected presenting a well-defined margin; the surface of the part thus affected has a shining, tense appearance, is reddened and swollen, and feels very hot to the touch. Eczema spreads more slowly, often begins at several points, is ill-defined, and the surface is roughened and scaly, very little swollen, and does not feel very hot. Pain and burning are complained of in erysipelas, while eczema generally itches. Vesicles may develop upon a patch of erysipelas, but they are larger than those in eczema, even attaining in some cases the size of bullæ. Erysipelas of the face, if at all extensive, is almost sure to extend up over the forehead into the scalp. Erythematous eczema in this situation does not extend beyond the hair border. Eczema rubrum is sometimes mistaken for erysipelas of the leg and is often wrongly spoken of as "*chronic erysipelas*." The absence of the constitutional symptoms and clinical characters stated above, its chronic course and tendency to weep and form crusts are distinguishing features.

Erythema.—*Erythema simplex* is an acute evanescent eruption and would rarely be mistaken for eczema. There is neither scaling nor swelling of the tissues, and the itching and usual symptoms of eczema are wanting. Sometimes an erythema will persist, becoming chronic, but it maintains the same hyperæmic character, though of a passive nature, lacking all the clinical symptoms of eczema. *Erythema multiforme* itches but slightly, generally begins upon the back of the hands and forearms, the papules are larger and more succulent than those of eczema, and there is often a history of recurrence with the change of the seasons. *Erythema scarlatiniforme* simulates acute generalized eczema, but the outbreak is preceded by prodromal symptoms of general malaise, backache, slight fever, etc., which are absent in eczema. It generally begins with more or less diffuse redness and swelling, accompanied by burning and tingling and on about the fourth day commences to desquamate. This is fine and branny upon the limbs and face, but large flakes are shed from the trunk, palms, and soles. It likewise lacks the weeping catarrhal characters of eczema.

Lupus Erythematosus.—This disease often bears a very close resemblance to erythematous eczema, and mistakes in diagnosis are frequent. Lupus erythematosus, however, is more chronic in its course than eczema, and while it also appears most commonly upon the face, it occurs in variously sized, irregularly outlined, well defined infiltrated patches of a dull red color, bearing thin but quite firmly attached scales. The patches of eczema are not well-defined, the infiltration is less marked, and the scales are loosely attached. If the scales in lupus erythematosus are forcibly removed, there are numerous tiny plugs attached to them, which fit into corresponding openings of the sebaceous follicles; this is never seen in eczema. The itching is very slight in erythematous lupus, and there are no vesicles or weeping areas as seen in eczema. The eruption is also generally symmetrical in

its distribution, and smaller foci are frequently seen upon the lobes of the ears and on the scalp. Finally, small white atrophic scars form sooner or later in every case—a manifestation entirely foreign to eczema.

Acne Rosacea.—This form of acne is confined to the middle zone of the face, including the nose, and adjacent part of the cheeks, the chin, and forehead, while eczema is more diffuse. The eyelids are never affected as in eczema, the color is a brighter red, and there is generally no itching. The surface temperature is cool, while that of eczema is increased and the infiltration is less than in eczema. Telangiectases are generally present, together with pustules and indurated papules which are not seen in eczema of this region. Often a seborrhoic eczema is subjoined which is generally associated with more or less dandruff in the scalp and seborrhœa oleosa about the nose and forehead. Little difficulty should be experienced in recognizing this complication. Acne rosacea is a disease of middle or advanced life, while eczema may occur at any age.

Urticaria.—Papular urticaria, a form of the disease frequently observed in children, often bears a close resemblance to papular eczema. The papules in urticaria, however, are scattered without tendency to confluence or grouping, and are comparatively short-lived. When scratched they often swell, and wheals or erythematous spots appear from time to time, which would distinguish the disease from eczema.

Lichen Planus.—Eczema is perhaps more often confounded with lichen planus than with any other disease. The papules of lichen planus, however, are distinctive in character. They are angular in outline, flat and shining, slightly scaly, often umbilicated, and of a dull red or purplish color. The eczema papule is acuminate or has a round top with circular base, and has a bright red color. Lichen planus papules develop slowly, increase in size, often becoming quite large, but they never lose their characteristic form, and when they disappear leave a well-marked pigmentation. The eczema papule develops quickly, frequently undergoes change in form and character, and disappears without pigmentation. Lichen planus papules have a peculiarity of developing along a scratch, a feature not often observed in eczema. The patches of lichen planus are more irregular in outline than those of chronic eczema, and often appear in a linear form; the characteristic papules making up the patch are generally to be seen at the periphery. Lichen planus has a predilection for the flexor surfaces of the wrists and forearms and inner side of the knees and thighs, while the patchy form is more commonly seen upon the back or sides of the neck and on the lower legs.

Pityriasis Rubra Pilaris.—This affection is almost invariably mistaken for eczema by the practitioner, for it is of rather rare occurrence and is seldom seen outside of dermatological practice. It is a very chronic disease, and extends over a period of many years. The distinguishing lesions are small, hard, yellowish or red, horny, conical papules, each of which is located at the orifice of a hair follicle. They impart to the hand passed over them the sensation produced by a nutmeg grater. These are especially prominent on the arms, forearms, thighs, and the dorsal surface of the phalanges. In the last-named location they appear as hard, black points, and when present are a certain diagnostic sign. There is nothing in eczema resembling these lesions. The disease may become generalized and then resembles squamous eczema; it may even become universal, but there are never any signs of scratching as in eczema. The skin is uniformly dull red, infiltrated, and covered with fine, horny scales. Eczema is a brighter red, the scales are larger, and somewhere there is generally evidence of scratching with oozing or crust formation. There is also a severe symmetrical hyperkeratosis of the palms and soles, and great thickening of the nails—features not generally observed in eczema.

Psoriasis.—The average case of psoriasis offers no difficulties in diagnosis from eczema. The patches are sharply defined, are covered with dry micaceous imbricated scales, are generally seen in the neighborhood of the elbow or knee, and show a preference for the extensor surfaces of the limbs. The patches of eczema are ill-defined, the crusts are darker, and are composed of dried serum mingled with epidermic scales, and they show preference for the flexor surfaces. Removal of psoriatic scales reveals numerous punctate hemorrhages, while beneath the eczema crust is a red, oozing surface. Psoriasis is always a dry eruption; eczema, even in the dry squamous form, shows catarrhal tendencies at times as a result of scratching or traumatism. The subjects of psoriasis are almost always in robust health, while eczema patients are often in ill health. The history of long duration and relapses in psoriasis is often of much service in diagnosis. Psoriasis of the scalp resembles eczema closely at times, but the eruption is drier, presents a patchy character instead of being more or less diffuse, and where it extends beyond the hair, as upon the forehead, the eruption has a sharp margin which would distinguish it from eczema. Some patches of chronic infiltrated eczema resemble those of psoriasis very closely, but they are not apt to be so sharply defined, the itching is more intense, they often become wet by scratching or rubbing, and crusts of dried blood and serum form at times. Small guttate psoriasis is sometimes mistaken for papular eczema, but scraping off the scale with the nail will usually reveal the small bleeding points; this, together with a careful examination as to the localization of the lesions and the history of the disease, will generally enable one to make the correct diagnosis.

Syphilis.—Some of the syphilodermata resemble eczema quite closely, and mistakes in diagnosis are not infrequently made. The lesions of the small papular syphiloderm generally show a tendency to grouping, often in the form of crescents or segments of a circle. Papular eczema lacks this characteristic. The color of the syphilitic papule is dull red instead of bright red as in eczema, and it is hard and shot-like to the touch, while in eczema the papule is not so firm. There is rarely itching in papular syphilis, while the itching in papular eczema is generally intense.

The pustular syphiloderm, especially that upon the scalp, is difficult sometimes to distinguish from eczema pustulosa. The syphiloderm, however, soon forms scabs, which when removed reveal a small, sharply cut ulcer, and eventually it leaves a scar. Upon removing the crusts of pustular eczema, a smooth, red, moist surface remains, and there is never any ulcer or scar formation. Squamous papular syphilis of the palms and soles is often mistaken for eczema, but it presents a circinate, sharply defined border, which by close inspection is found to be made up of separate papules which have fused together. Eczema in these regions forms a uniformly scaly patch, usually lacking the sharp definition, and the border is not made up of papular elements.

In syphilis a history of infection can often be obtained, together with evidences, at some time, of lesions upon the mucous membranes and remains of former ulcerations in the form of scars.

Granuloma Fungoides.—This disease often develops from erythematous scaly patches indistinguishable from eczema. These spots develop anywhere upon the body, sometimes in the form of erythematous plaques of round or oval form, or in distinctly eczematous scaly patches. They resist every kind of treatment and often last for years, or they may disappear spontaneously only to return again often in the same localities. Patches of eczema showing this life history should be looked upon with suspicion. When infiltration and tumefaction begin the diagnosis of mycosis fungoides is easy.

Tinea Circinata.—Ringworm is sometimes confused with eczema, especially when the lesions are numerous. The course of the two diseases, however, is very different. Tinea circinata is an acute eruption, begins usually in a small scaly spot which enlarges rather rapidly, forming a patch with a raised, red, scaly border and a more or less clear centre. The patch of squamous eczema enlarges in the same way, but there is no distinct, raised,

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well-defined border, only a scaly, uniform, slightly infiltrated patch, without tendency to clear in the centre. The itching in tinea circinata is slight; in eczema it is always a marked symptom. The former disease runs an acute course; the latter is a chronic form of eruption.

In *eczema marginatum*, or ringworm of the crotch and axilla, there is an eczema with a subjoined infection with the trichophyton fungus. From an ordinary eczema it can be distinguished by its raised, sharply defined, circinate or festooned border and the gradual diminution of the eruption toward the point from which the disease spread.

Whenever there remains any doubt in diagnosis, an examination of the scales by the microscope will reveal the trichophyton spores and mycelia if the eruption is one of ringworm.

Tinea Versicolor.—The clinical features of this disease are generally distinctive enough to prevent any mistakes in diagnosis. It occurs in fawn-colored or light brownish spots upon the front or back part of the upper portion of the trunk, and only rarely upon exposed parts, as the face and neck. The patches are covered with fine furfuraceous scales, but there is an entire absence of infiltration and inflammatory symptoms. The itching is slight or absent, the patient often being unaware of the presence of the eruption until attention is called to it. All of the foregoing features would distinguish this disease from eczema. Microscopic examination of the scales will always reveal the characteristic fungus which is the cause of the trouble.

Herpes.—It is necessary to differentiate herpes from vesicular eczema, although usually it is not difficult. Simple herpes, or *herpes febrilis*, either of the face or of the genitals, is an acute affection consisting of a group of vesicles which are generally larger than those of eczema. The vesicles in herpes dry up in a few days without discharging and forming a weeping patch as in eczema. Vesicular eczema appears generally in several localities, and does not consist of one or two patches in close proximity as in herpes. *Herpes zoster* generally develops in the course of a nerve or its branches, is preceded by neuralgic pains, and is made up of groups of larger vesicles or even bullæ seated on an erythematous patch; it is also unilateral. Eczema vesiculosa occurs in a disseminated manner, is not associated with neuralgia, and the vesicles are smaller and more closely set. As in herpes simplex, the vesicles in zoster dry up without discharge. Scars are often left after herpes zoster, while scarring is never seen in eczema.

Dermatitis Herpetiformis.—The mistake is very commonly made of diagnosing this disease eczema. In the papular and vesicular varieties of dermatitis herpetiformis the eruption is very much like that of eczema. The disease, however, belongs to the herpetic group of eruptions, and by keeping in mind this fact little difficulty need be experienced.

The lesions of dermatitis herpetiformis develop in crops of grouped papules, vesicles, pustules, or bullæ, accompanied by more or less erythema. These lesions often dry into scaly, red patches, which, after remaining a short time, disappear spontaneously, only to be replaced from time to time by new crops. Eczema rarely behaves in this way, though certain forms of neurotic eczema present much the same picture. There is always rupture and discharge of the lesions, however, in eczema, while in dermatitis herpetiformis they dry up as in other herpetic eruptions without discharging. Dermatitis herpetiformis runs a very long course, lasting often for years with periods of comparative freedom, but ultimate cure in any case is not to be expected. Eczema may last a long time and become chronic, but there is never the history of repeated recurrences covering many years of one's life, as occurs in dermatitis herpetiformis. Eczema is, furthermore, a curable disease. The itching in dermatitis herpetiformis is productive of more suffering than in almost any other known dermatosis. The itching of eczema is bearable as a rule, and can be modified by treatment, whereas in this disease it is only a little or not at all relieved by therapeutic measures.

Dermatitis.—The clinical symptoms of dermatitis and eczema are about the same and are often indistinguishable. The history and course, however, are entirely different in the two affections. A dermatitis is an acute eruption, wholly of artificial origin, produced by some irritant coming in contact with the skin. It remains confined to the region irritated, and generally disappears quickly when the source of irritation is removed. Eczema excited by local means spreads beyond the area first subjected to the irritant, even though the cause is removed, and may develop in remote regions, becoming more or less chronic.

In poison-ivy dermatitis the eruption commonly appears in remote parts by auto-infection; active treatment is always needed to destroy the effects of the poison. Its acute character, however, and the history of contact with the plant, will generally distinguish it from eczema.

Eczema of constitutional origin is rarely confounded with dermatitis, for its nature is soon revealed by the history and subsequent course of the eruption.

Pemphigus.—Bullous eczema, especially as it occurs in elderly people, may resemble pemphigus vulgaris. The bullæ in pemphigus develop suddenly and without apparent cause from a perfectly normal-looking skin, no redness nor even an areola being seen. Eczema bullosa is, on the other hand, always associated with inflammatory symptoms and the bullæ rupture and produce a weeping patch. When the bullæ in pemphigus break, a painful non-exuding bright red area remains. Pemphigus is generally preceded by constitutional disturbances and is a grave disease, the patients dying in either the first or the second attack.

"*Pemphigus foliaceus,*" a more generalized form of the disease, spreads rapidly over the body surface, with the production of large flaccid bullæ, which dry into large thin flakes or are rubbed off, leaving raw areas of variable extent without infiltration. Flaccid blebs are never seen in eczema, there is always infiltration, and the disease rarely becomes universal as in pemphigus foliaceus. Moreover, the latter disease goes on to a fatal termination, while eczema never imperils life. Itching is generally absent or slight in both forms of pemphigus, which would distinguish them from eczema.

Pityriasis Rubra.—This is another rare and fatal disease, which in its early stages bears a resemblance to eczema. It begins with redness and scaling, as in squamous eczema, but soon becomes generalized and universal. Large, thin epidermic flakes are continually exfoliated, leaving a bright red moist surface, but there is no infiltration nor weeping as in eczema. Eczema rubrum and eczema squamosum, on the contrary, have a more localized distribution and exhibit the exudation, infiltration, and crusts which are characteristic of the eczematous process. There is likewise no itching in pityriasis rubra, which would distinguish it from eczema. The disease, when once begun, continues without abatement until it eventually destroys the life of the patient.

Impetigo Contagiosa.—This is an acute affection of short duration, occurring most commonly upon the face and hands, though in some cases it may extend over the body. The lesions begin as vesicles or small blebs, which speedily become pustules; these rupture and dry into dark crusts. The whole process is superficial, the lesions, generally few in number and scattered, springing from an uninfiltrated base. In pustular eczema the lesions are small and more numerous, are not so isolated, and develop from an infiltrated base, drying into thin scales, from beneath which pus can be expressed.

In impetigo contagiosa there is often a history of the same eruption in other members of the family, or evidence, if in an adult male, of direct infection from a barber shop.

Pediculosis.—Pediculosis corposis is often mistaken for eczema. The lesions seen in this affection, however, occur particularly about the back and chest, around the neck and shoulders, and about the waist and over the