The exudation rarely contains sufficient fibrin and leucocytes to form a crust. After healing has taken place pigmentation usually remains for a time. This in the iris form has somewhat the appearance of a target. The eruption is rarely universal or chronic, but runs a course of from two to six weeks. Relapses frequently occur, particularly in the autumn and spring. The lesions are generally situated on the hands, legs, face and neck, but may occur in any part of the body. Even the mucous membrane of the mouth is sometimes affected.

In the great majority of cases the diagnosis of erythema bullosum can readily be made out. The multiformity of the lesions, and in particular the presence of one of the iris forms, as well as the distribution of the eruption, forms a picture difficult to mistake for any other disease. However, when the lesions are either vesicles or blebs, considerable difficulty is experienced in differentiating the disease from other bullous affections such as pemphigus, dermatitis herpetiformis, bullous impetigo, bullous syphiloderm and urticaria bullosa. Pemphigus, in particular, sometimes bears a very close resemblance to this disease. Thus, in both diseases, the blebs sometimes appear on apparently normal skin, and when developed are not surrounded by red arcelæ. However, if the case is watched for a few days some other forms of lesion can usually be made out in cases of erythema bullosum. In addition, the following points of difference may be noted. Pemphigus is usually a chronic disease; erythema bullosum is acute, running its course in from two to six weeks. The eruption of erythema bullosum is more or less symmetrical, usually appearing on the arms, hands and lower limbs, whereas in pemphigus the lesions are scattered about irregularly and do not as a rule show any symmetry in their distribution. The lesions of erythema bullosum are frequently grouped and concentrically arranged. In pemphigus there is no tendency to such arrangement. These characters are usually sufficient to make a diagnosis. However, cases are occasionally met with which have part of the symptoms of both diseases, and then the diagnosis can only be made by watching the cases for some time.

The etiology of erythema multiforme is somewhat obscure. Toxines circulating in the blood are probably the cause of the majority of cases. Several cases have been recorded as the result of shock.

The bullous variety of erythema multiforme is considered by most writers a rare disease. This has not been borne out by my experience, as I have seen during the last two years seven cases. In five of these the diagnoses were readily made by the distribution and multiformity of the eruption. In the remaining two cases considerable difficulty was experienced in