not always command the cases in the order in which I wish to present the subject. I shall therefore have to take the cases in a desultory manner, and afterward group them together. I will first show you some simple cases before we commence the study of the more obscure ones.

CASE I. PSORIASIS TREATED WITH CHRYSOPHANIC ACID.—This case is very interesting from the fact that, without our intending it, we have had quite a remarkable improvement in the eruption from a treatment which has been advised but which has not been frequently employed—namely, the internal use of copaiba. The patient came here first on account of a gonorrhœa, and not for his psoriasis, which he had had for twelve years, and was put on the treatment for gonorrhœa—on what is known as the Lafayette mixture—a mixture containing an alkali and a little spirits of nitre. When he first came, on April 12th, the psoriasis was in full bloom, very much more marked than now. He was given the mixture of copaiba, but with no local treatment, and as the gonorrhœa diminished his psoriasis greatly improved, so that now his eruption is not of half or quarter its former extent. He says there are no new spots, and, as you see, the eruption is fading. His name is J.B., aged twenty-four. He has had psoriasis for twelve years, with occasional improvement, followed by relapses or increase of the eruption from time to time, it having never entirely left him since its first appearance. What I show you now is not the eruption of psoriasis as you are apt to see it; it has decidedly faded, some of the spots have disappeared, and many are much broken into. On the elbow you will still find the white, slightly adherent, imbricated scales, which very readily come off with light scraping: they are seated on a red base, which, as always, is perfectly distinct and sharply defined, and not with the indefinite outline commonly seen in eczematous patches. On scraping off the scales lightly we soon come to a membranous pellicle, which is adherent, and, if the scraping is carried still further, this comes off and is followed by the appearance of a drop of blood. The eruption, as you see, consists of dusky-red spots, of a size varying from that of a minute pin-head to almost any size, always sharply defined, tending to cover themselves with a white scale, which, on being scraped off, leaves a red base, which bleeds very readily. Remember that the separate spots of psoriasis always appear first as small points, gradually enlarging, and that even when seen as patches of large diameter they have always thus begun; in some localities you may observe the mode of disappearance of the eruption, it gradually fading out, the scales ceasing to form, and finally the redness itself vanishing. We see on the legs very much less eruption than is usually seen on these parts; as a rule, in psoriasis, the legs have more of the eruption proportionately than the body; almost always the patches are larger on the lower extremity, more scaly, and of a darker hue.

Differential Diagnosis—Why do we speak so confidently of its being psoriasis, and state that it is absolutely impossible that it could be anything else? The reasons are found in the character of the lesions, taken in conjunction with the history of the duration of the eruption. There are only four eruptions which could with the slightest reason be supposed to be the one before us; these are: a squamous syphilitic eruption, an eczema, a ringworm, and psoriasis. First, of syphilis: this man has had the eruption for twelve years, with varying severity, and this eliminates syphilis absolutely, as such a general syphilitic eruption never continues that number of years. You may have an ulcerative syphilide for five or more years, but never an acute, distinct from this kind. In the next place, the syphilide would be on the flexor and extensor aspects alike, while in psoriasis the extensor surfaces are always the seat of preference. In the general large papular syphilitic eruption you could never have any such extensive patches of disease as are seen on this man's legs.

Second, in regard to any possible form of eczema which might be mistaken for the present eruption; Eczema seldom, if ever, presents so many separate points of eruption as are seen here; and it may be said that it never exhibits so many of such small size and so sharply defined. Upon some portions of the body psoriasis may resemble eczema, and you see the characteristics it very commonly may take on the lower extremities—namely, the patches are larger, more dusky-red, and of more undefined outline, often more resembling an eczema of the lower extremity. It would be difficult, but not impossible, to make the diagnosis from the eruption on the lip alone.

In certain points this eruption might be thought to resemble ringworm, but yet you would certainly not have such a vast expanse affected with the parasitic disease, and an examination of the scales by the microscope would show the parasite in the latter. The individual spots present differences from those of body ringworm in the pearly character of their scales, the absence of a clearing in the centre, and the rather livid redness of the base of the psoriatic spots. We then make the differential diagnosis from syphilis, eczema, psoriasis, and ringworm; and, recognizing the lesions of psoriasis, we conclude with certainty as to its nature.

This patient continued the use of the balsam of copaiba until the eruption was a good deal faded and broken up, and some weeks ago he was put upon another treatment which has recently been advocated. He has been under the internal use of chrysophanic acid, which has been reported on favorably by several observers, some claiming brilliant results from it. I have several patients under this treatment, but am not ready yet to speak definitely concerning it. He began with a quarter of a grain, in a powder with sugar of milk, taken three times a day directly after eating; and a week ago I doubled the dose. It is best always to begin with a quarter of a grain, and after a few days