The entire surface of the body is sprinkled with these guttæ; but in certain localities, and more especially on the flexor surfaces of the joints of the extremities, they are most abundant, and form more or less continuous scaly masses with but little healthy skin between them. So abundant is this scaling that the patient scatters a cloud of minute lamellæ round her as she moves when stripped, and several large handfuls can be gotten from her clothing. The epidermic proliferation is quite rapid in these cases; but it is only on parts not often washed that it occurs to so great an extent as you see. On the face and hands, where soap and water have not been quite so sparingly employed, there are no scales at all, only the low reddish papules mark the existence of the disease. It is important to note this fact, for in some cases, where the disease is not extensive, the patients have removed all the scales before they come, and the apparent absence of so characteristic a symptom may lead to an error in diagnosis. The scalp is covered with more or less confluent psoriatic patches, but the palms and soles are free.

The second case is a male of about the same age, with a very different, but just as characteristic disease appearance. Only the knees and elbows are affected. Each of these surfaces, where the skin is naturally thicker and rougher than on other portions of the body, shows a more or less extensive infiltrated patch, with apparently but little scaling; but scraping reveals the characteristic lamellæ. Here also the condition has existed for many years; the scaly infiltrated patches disappear at times, especially during the hot weather; but they always reappear during the winter.

Both patients are evidently in good health,—in fact, most psoriatic patients are robust, even when the disease is very extensive. Its cause is absolutely unknown. Heredity certainly plays no part in it. It may be of parasitic origin; but no microbe has been found. The Epidermophyton described by Langer is certainly not the etiological factor.

It is to the treatment of these cases, however, that I would call your special attention. Internal medication is of the greatest importance, especially in cases so extensive as our first one. Arsenic, so little employed by the dermatologist, is undoubtedly of use here, German opinion to the contrary notwithstanding, but it must be taken regularly, and in large doses, for a long time. It is therefore better given in the pill form. Ichthyol is also beneficial, and we will put both patients on a combination of the two, using a modification of the famous "Asiatic Pill," which is a favorite formulæ of mine:

℞. Ammon. Sulph-ichthyolat. ʒ ii.
Acid. Arseniosi, gr. iii.
Pulv. Pip Nig., θ iii.
Pulv. Glyc. Rad., θ iii.
M. Ft. pil. No. 90.

One of these is to be taken three times daily, after meals. The amount of arsenic may be gradually increased until a maximum dose of 1-20 or 1-15 grain is attained.

Local treatment, however, is of even greater importance than internal medication. It is essential in all cases, and is especially important when the face and hands are affected with the disease. The deformity must be removed as rapidly as possible.

Our local treatment will differ in the two cases. In the first and general one it should be systematic and thorough, and it may be summarized as follows:

1. Daily general bath of hot water and green soap. The scales must be entirely cleaned off from the surface of the body, to permit the appliance of topical remedies.

2. After leaving the bath, paint each spot with:

℞. Ol. Rusci, or Ol. cadini, ʒ ii
Spirit. vini,