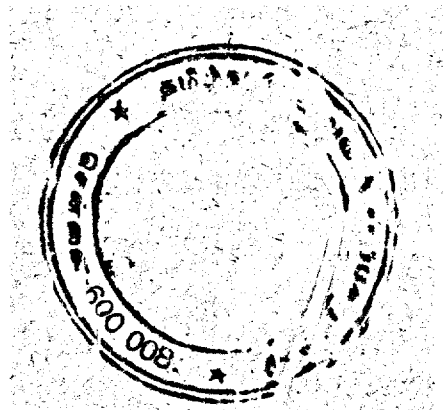


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MEDICAL BULLETIN

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MEDICAL BULLETIN.

Vol - 1

No. 21

APRIL 1961

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FOREWORD

To endeavour to do justice to a speciality with four hundred and eighty-three distinct disease entities—Dermatology—within this compass, is, to attempt the impossible. A work like this to be both informative and useful to the larger crowd, has to be based mainly on practical lines. Such a basis has been obtained from the analysis of 17,451 new cases seen during the period of six months in the skin clinic. The graphic depiction of this analysis is found within and gives an idea of the Dermatological problem obtaining here. No apology is given for the brevity in the description and interested people can always obtain fuller information in this field from standard works.

The inclusion of a section on inspection of camps would serve as a guide for a complete survey, i.e., of inmates and site of any camp.

The knowledge of the speciality appears to be in its infancy and the aim of this work is to establish a sound foundation for all those who would intend to specialise further. In Dermatology to borrow a remark "there is always something more than what actually meets the eye" and it is felt that this would be the impression obtained by a perusal of this bulletin.

JL

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IMPORTANT NOTICE

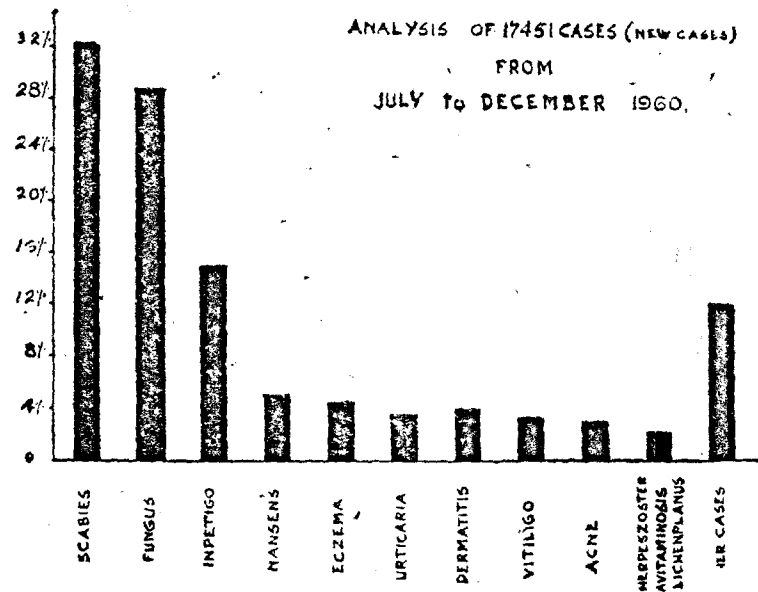
It is imperative that these quarterly Medical Bulletins are published regularly as they are in great demand by the Medical Profession all round, even outside this State. For this purpose sufficient number of articles of scientific interest are absolutely necessary. You are requested to kindly co-operate by regularly contributing any articles of scientific interest. Such articles may be sent in duplicate.

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Analysis of 17,451 new cases from July-December 1960.

	PER CENT.
1 Acne Vulgaris	2.5
2 Abscess	0.024
3 Alopecia Areata	0.6
4 Allergic Dermatitis	0.28
5 Avitaminoses	0.8
6 Cellulitis	0.1
7 Chicken-pox	0.008
8 Chloasma	9.033
9 Chronic Ulcer	0.054
10 Contact Dermatitis	0.9
11 Corn	0.15
12 Creeping Eruption	0.006
13 Darier's Disease	0.002
14 Dermatitis	2.9
15 Dermal Leishmanoid	0.12
16 Eczema	3.438
17 Exfoliative Dermatitis	0.0
18 Fissuring	0.06
19 Fixed Drug Eruption	0.06
20 Fungus	29.538
21 Furunculosis	0.518
22 Granuloma Pyogenicum	0.018
23 Hansen's Disease	3.5
24 Herpes Zoster	0.8
25 Hyperidrosis	0.002
26 Icthyosis	0.18
27 Idiopathic Atrophy	0.03
28 Impetigo	12.392
29 Insect-Bite	0.018
30 Keloids	0.066
31 Lipogranuloma	0.006
32 Lichen Planus	0.75

	PER CENT.
33 Lichen Amyloid	0.003
34 Lupus Erythematosus	0.054
35 Lupus Vulgaris	0.336
36 Melanoderma	0.09
37 Miliara Rubra	0.384
38 Molluscum Contagiosum	0.184
39 Naevus	0.09
40 Neurodermatitis	0.1
41 Paronychia	0.0002
42 Pediculosis	0.1
43 Pemphigus	0.0006
44 Phrynoderma	0.1
45 Pityriasis Capitis	0.006
46 Pityriasis Rosea	0.0002
47 Pruritus	0.012
48 Psoriasis	0.5
49 Scabies	32.5
50 Seborrhoeic Dermatitis	0.04
51 Small-pox	0.02
52 Stasis Dermatitis	0.03
53 Sycosis	0.0002
54 Urticaria	0.3
55 Vitiligo	2.674
56 Warts	0.1
57 Other cases	0.9598

Total number of new patients from July
to December 1960 17,451

Essential laboratory facilities in a skin clinic.

1. Blood count and E.S.R.
2. Urine analysis. -
3. Scrapings for Fungus, Acarus Scabiei.
4. Smears for A.F.B., L. D. bodies, Tzanck cells (cytodiagnosis).
5. Culture for Fungus.
6. Skin Biopsy.
7. Patch testing.

*Equipment required for an out-patient examination room
(Dermatological).*

Furniture—

1. Table.
2. Chair.
3. Screen.
4. Stool.
5. Examination couch.
6. Wash basin with stand.
7. Table lamp with 100 watts bulb.
8. Writing pad with stationery.
9. Necessary linen.

Equipment—

1. Hand torch.
2. Tongue depressor (plastic).
3. Hand lens.
4. Epilating forceps (two).
5. Comedo extractor (one).
6. Scalpel with replaceable blade.
7. Forty per cent KOH.
8. Slides (microscope).
9. Coverslips.
10. Microscope with low, high power and oil immersion.

Essential Dermatological preparations.

1. *Cremor Zinci*—
Zinc Oxide 1 oz.
Hydrous wool fat 2 drs.
Sol. of calcium Hydrozide 11 fl. drs.
Olive oil 11 fl. drs. mix.
2. *Lotio Alumini co*—
Purified Alum 5 gr.
Strong sol. of lead subacetate 1 fl. dr.
Water to 1 fl. oz.
3. *Mistura Hydrag Perchloridi*—
Solution of mercuric chloride 10 m.s.
Dilute Nitric acid 5 m.s.
Compound infusion of Giention ad 1 oz.
4. *Pasta Acidi salicylica (Lassar's paste)*—
Zinc oxide 2 dr.
Starch 2 dr.
Salicylic acid 10 grs.
Yellow soft paraffin 4 drs.
5. *Ung Acidi Solieylie Co (Whitefield ointment)*—
Salicylic acid 1 dr.
Benzoic acid 1 dr.
Coconut oil 1½ fl. oz.
Yellow soft paraffin 2 oz.
6. *Unguentum Anti-scabies (Danish ointment scabies)*—
G.H. Pharmacopeia.
7. *Solution of methylene blue*—
Silver nitrate 5 gr.
Methylene blue 5 gr.
Water ad 1 oz.

8. *Ung Petrolei Co*—
Alcoholic solution of common coaltar.
Liquor Carbon Detergens 1 dr.
Ammoniated mercury 20 grs.
Salicylic acid 10 grs.
Paraffin ointment ad 1 oz.
9. *Benzyle Benzoas cream*—
Benzyle Benzoate and soft soap each 1½ oz
Zinc oxide and calamina each 1 oz.
Lime water to 6 oz.
10. *Antihistamine drugs*—
(a) Tablets.
(b) Injections.
(c) Lotions.
- Antibiotics*—
(a) Penicillin.
(b) Streptomycin.
(c) Tetracyclines.
(d) Nystatin.
(e) Mystecilin.
(f) Griseofulvin.
11. *Antimalarials Atabrin, Chloroquine, Resochin, etc.*
12. *Calcium*—
(a) Cal-lactus.
(b) Cal-Gluconate injections.
13. *Cortico-Steriods*—
(a) Tablets.
(b) Ointments.
(c) Injections.
14. *Dapsone tablets.*
15. *Emetine injections.*

16. Hormones—

- (a) Adrenaline.
- (b) Oestrogens.
- (c) Thyroid.

17. Isonicotinic acid Hydrazide tablets P.A.S. tablets.

18. Tranquillisers.

19. Tolbutamide group of drugs.

20. Urea stibamine.

21. Vitamins A, B, C and B-12.

22. Neutrapen (Penicillinase injectable).

Practical guide in the management of cases.

1. Unguentum Danish to be repeated for three days only.
Zinc Cream to be prescribed from the fourth day.

2. Scrapings for fungus if negative to be repeated thrice.

3. Staphylococcal vaccine to be given intradermally. Total of six injections every fourth day. Start with one minim, increase by one minim, to a total of 6 minims.

4. Auto-hæmotheraphy: 2.5 c.c. blood to be drawn from the vein and injected deep intramuscularly in the thigh every fourth day.

5. Auto-vaccine to be given every fifth day.

6. Sulpha tablets to be repeated for one week only.

7. Calcium gluconate injections—

Below 45 years 5 c.c. intravenous.

Above 45 years 3 c.c. intramuscular.

A scheme for inspection of camps for incidence of skin diseases.

In an inspection of a camp, the following should be noted:—

(a) General idea of camp.

1. Site of camp.
2. Amount of money spent on it, total and per head.
3. Sleeping accommodation.
4. Water-supply—source, availability and adequacy.
5. Facilities for personal hygiene—water, soap, combs.
6. Laundry arrangements.
7. Daily ration—its nutritive and calorific value.
8. Available power—Electricity or Gas.
9. Presence of Quarantine section.
10. Public Health prophylaxis—for cholera, smallpox and typhoid.

(b) Inspection of inmates in camp.

The incidence of skin diseases with emphasis on the commencement can be studied if the following scheme is utilised for the examination:—

Serial number.	Name.	Age.	Hands.	Elbows.	Axillae.	Thighs.	Nipples.	Genitals.	Umbilicus.	Buttocks.	Fungus.	Hansen.	Impetigo.	Remarks H.C.
320	Krishnan	24	.	.	.	.	.	.	.	.	.	.	.	.

The detailed columns follow the site of election of scabies and this involves the examination of the entire body surface. In addition presence of common skin diseases as fungus, Impetigo and Hansen are seen. The remarks column contain information regarding presence of other diseases and the abbreviations H & O indicate presence of Hansen and Oedema. This oedema may be due to secondary impetigo in scabies or nutritional oedema—a point of interest in large care camps."

The individual is then issued an O.P. ticket giving the same serial number and the name and age along with diagnosis. The treatment is outlined with the O.P. ticket as follows:—

Ung Danish.

Or Ung Danish with Sulfadiazine tablets (Sulfadiazine).

Or Ung Danish and test urine for Albumen before giving a course of sulfonamides.

Or Ung Danish followed by the Ung Whitfield, etc.

In cases of impetigo in scabies treat scabies first. In cases of impetigo in fungus treat impetigo first and then scabies.

The chart and O.P. ticket ensure proper record and guidance. The O.P. tickets should be filed by the Medical Officer in charge of camp. It is worthwhile to have adequate stock of the following in camps and bivouacs:—

1. Ung Danish (General Hospital Pharmacopœia).
2. Ung Whitfield (General Hospital Pharmacopœia).
3. Zinc Cream (General Hospital Pharmacopœia) to which 10 grs of methylene blue is added to each ounce for treating cases of impetigo.
4. Sulfadiazine tablets.
5. Aqueous Penicillin.
6. Anti-histamine drugs.

Scabies.—This is a contagious disease caused by a mite termed *sarcoptes Scabiei Var Hominis*. It is a strictly human parasite and the constant symptom is itching worse at night. The mite produces a characteristic lesion termed "burrow" seen often on the hands. The majority of cases do not show this as they are all secondarily infected by scratching. The secondary infection causes pustules.

The diagnosis is—

(a) *By demonstrating the mite*—a not so easy task except when burrows are seen. When seen, a drop of 40 per cent KoH is put on it and the site scraped and the scrapings are mounted on a glass slide and the coverslip applied. The mite along with eggs or only eggs are seen, which is diagnostic. The female mite is the one seen in the burrows and is 1/60th inch in length, the posterior pair of legs end with bristles.

(b) *Distribution of lesions.*—Webs of fingers, front of wrists, elbows, anterior axillary folds, umbilicus inside of thighs, penis in male, breast in female, buttocks; in children palms and soles and also scalp. The lesions seen are vesicles, pustules and burrows at these sites. Any case with lesions on these sites with the symptom of itching has scabies. In addition enquiry would show other members of the household also having it or symptom of itching.

(c) Response to anti-scabetic treatment, (b) and (c) are the main stay in diagnosis of the majority of cases.

TREATMENT.

In adults.

1. Hot bath with soap.
2. Scrub with nail brush or rough towel to open up all lesions.
3. Dry thoroughly.
4. Smear Ung Danish (G.H. Pharmacopeia) from neck to feet for three days.
5. No bath for three days.
6. Bath on fourth day and wear fresh dhobie-washed clothes.
7. Treat all inmates of the house simultaneously.

In children.

Follow the same regime but use—

Sulphur præcipitate—15 grs.

Zinc Cream ad—1 oz.

After third day use in both adults and children only, Zinc Cream. Retreatment if needed should only be done after two weeks when definite evidence of scabies is present.

In cases which are secondarily infected with evidence of pustules and swelling of hands, a course of sulfonamides by mouth for seven days, e.g., Sulfa diazine tablets 2 tds. for seven days only in case of adults, and in children lesser dosage is given.

Always remember in secondarily infested scabies to treat scabies first as when once the itching by the mite is abolished secondary infection will disappear owing to absence of scratching. More over sulphur itself is an antiseptic agent.

In cases of scabies with oedema of face and legs test urine for Albumen as secondary nephritis to skin infection may occur. In these cases sulfanomides are to be avoided and the patient given Penicillin or other antibiotics but the anti-scabetic treatment will be the same.

As an alternative 20 per cent Benzyl Benzoate emulsion has been used. In this regime the patient is painted after a bath from neck to foot with solution which is left overnight with a bath next morning. A week later this is repeated, i.e. it takes on the whole one week for completion of therapy while with Ung Danish it is over in three days.

Infestation with scabies in a community is always due to (1) over-crowding and (2) low personal hygiene.

The transmission of scabies by fomites is *not* accepted now. Personal contact is necessary.

Fungus diseases.—In human beings Fungus diseases are divided into three main groups—

1. Superficial Mycosis (Dermatomycosis).
2. Deep Mycosis (e.g., Maduramycosis and actinomycosis).
3. Systemic Mycosis (e.g., Coccidioides).

No. 2 is of interest to surgeons mainly, No. 3 is of interest to physicians mainly. We are concerned with Dermatomycosis. There are three groups of dermatomycosis—

- (a) Microsporum group—affects hair, body.
- (b) Trichophyton group—affects hair, body, nails.
- (c) Epidermophyton group—affects body.

The trichophyton group is the commonest and most resistant one to treatment.

The groups (a), (b) and (c) are differentiated by culture and study of the macroconidia.

The useful classification of Fungus diseases (dermatomycosis) is by the area that is affected—

1. Fungus of scalp.
2. Fungus of body.
3. Fungus of beard area.
4. Fungus of groin.
5. Fungus of feet.
6. Fungus of nails.

1. *Fungus of scalp.*—This is mainly a disease of childhood. One clinically suspects fungus of scalp when there is (a) patch or patches or alopecia with scaling and the hairs in the patch are lustreless and broken up, (b) patch or patches of baldness with no scaling but black dots due to the hair broken up at the surface of the scalp—black dot ringworm, (c) circumscribed areas of suppuration in scalp with alopecia this is a pustular reaction to the fungus and goes by the name of kerion. Such a kerion may occur in the beard area of a man and be over looked as, coecal cycosis.

Diagnosis.—(1) The affected area examined under Wood's light would show a greenish fluorescence in cases of microsporum infections. If no fluorescence is seen it may still be fungus and probably of Trichophyton strain.

(2) Remove hair from affected site and mount in 40 per cent Koh on a slide; apply the coverslip and examine after an hour or soon after gently warming the slide, without boiling the KOH. The affected hair would show spores of fungi within and round it. The appearance has been likened to a hair dipped in gum and rolled in sand.

(3) To identify the species (microsporum or Trichophyton) culture in sabouraud's agar is indicated. The colony characteristics and morphology of the macroconidia helps in identification.

Treatment.—The present treatment is by the oral Fungicide: Griseofulvin. This is marked as Grisovin (glaxo) or Fulcin (I.C.I.). The tablets are 250 m.g. in strength. The average adult dose is 1 tablet four times a day for four to six weeks and in case of children $\frac{1}{2}$ tablet b.d. or $\frac{1}{2}$ tablet three times a day for 4-6 weeks. The scalp hair must be clipped short—so that there is a quicker shedding off of the affected hair by the new

hair which is growing up. In pustular cases simple warm Boric acid fomentations are given in addition and those with secondary adenitis are given sulfonamides by mouth. When using Griseofulvin for a long time it is wiser to keep an eye on the white cell count. Periodic white cell count—total and differential are required to avoid agranulo-cytosis.

In the event such a thing happens, the Griseofulvin is withdrawn, when the white cell count rapidly comes back to normal.

(a) X-ray epilation—risk of permanent alopecia and X-ray dermatitis.

(b) Oral thallium acetate 8 mg. per k.g. body wt. (naked) with a maximum dose of 200 mg. is given. Children above nine years are not treated. Hair loosens in a week and epilation is complete in three weeks. If the dosage is exceeded death results.

2. *Fungus of body*.—In this condition you have round or oval patches with scale and with vesicles in the border. These lesions are termed Ringworm or Tinea Circinata. The patient has itching.

Diagnosis.—(1) Clinical appearance of ringed lesions with vesicles at margin.

(2) Scraping taken from the edge of the lesions and mounted in 40 per cent KOH show the fungus hyphae cutting through the outlines of the cells of the stratum corneum.

(3) *Culture*.—Culture characteristic and nature of the macro conidia identifies the species.

Treatment.—Use of Whitfield ointment (G.H. Pharmacopoeia). In secondary infected cases secondary infection must be treated first with oral sulfonamides and local use of 2 per cent Methylene Blue in Zinc Cream. It is better to avoid Penicillin as the fungi flourish under this therapy. If sensitive to sulfonamides, then a broad spectrum antibiotic is used for a period of four to five days. Once the secondary infection is controlled Whitfield ointment is used.

In cases with extensive areas of involvement Griseofulvin in the dosage mentioned is useful. The therapy period is shortened with simultaneous use of the Unguentum Whitfield. The clothes next to the skin must be changed daily and washed with soap and water, dried in sun and then used. The use of anti-septics for sterilising clothes is not advised.

3. *Fungus of beard area*.—Clinically this is seen as (1) Red scaly areas. (2) Areas of Pustular reaction (Kerion).

Demonstration of fungus in scales as in hair confirms the diagnosis. The use of Whitfield ointment is satisfactory in 1 and in 2 Griseofulvin by mouth. If Griseofulvin is not available, epilation of the hair in the suppurating area with forceps and painting with tincture iodine is all that is needed. When acute stage is past the Ung Whitfield is all that is needed.

4. & 5. *The fungus of groin and feet*.—This is quite common and is picked up from the same clothes or bathing in the same place. Excessive sweating and alkalinity of sweat makes one susceptible to the infection.

The symptom is itching in the groin or feet and on examination one sees in the groin a marginated circinate lesion with vesicles at the periphery. Scrapings show the fungus with scales obtained from periphery of the lesion.

Treatment.—In secondarily infected cases use of 2 per cent Meth. Blue in Zinc Cream with oral sulfonamide is first given for seven days and later Ung Whitfield is used.

Fungus of feet may manifest as soddening of skin between toes or as vesicles or as localised thickening of the soles of the feet. Diagnosis in case of vesicular type is by clipping up the vesicles and mounting them in KOH and looking for the hyphae. Treatment: acute cases are given a local paint with 1 per cent AgNo₃; 1 per cent Methylene Blue in water along with sulfonamides. When acute stage has subsided Whitfield ointment is used. Griseofulvin too may be used in these cases.

6. *Fungus of nails*.—The affected nail loses its lustre, becomes brittle and in some cases pigmented. The diagnosis is by clipping out a chunk of nail, soak overnight in 40 per cent KOH and look for the hyphae of the fungus. Culture identifies the species; barring the appearance there are no symptoms.

Treatment.—Griseofulvin by mouth is the only answer. The affected segment of the nail is excised fully and oral Griseofulvin started. A new nail replaces the old one which is pushed out. As it takes nearly six months for a nail to grow from its bed to free edge the treatment has to be for about this time. Prior to this the treatment was total excision of nail with destruction of nail bed so that no new nail grew.

Miscellaneous fungus infections—

1. *Tinea versicolor*.
2. *Erythrasma*.
3. *Moniliasis*.

1. *Tinea versicolor*.—This is a common infection and the patients have multiple scaly macules on the trunk and arms which itch periodically. The diagnosis is by testing for the fungus in the scales obtained by scraping. A profusion of hyphae and spores are seen in every scraping. The organism is microsporum for fur. Treatment is with Ung Whitfields or 12 per cent Sodium Thiosulphate solution, i.e., 1 drachm of sodium thiosulphate in one ounce of water.

2. *Erythrasma*.—This infection with the fungus called microsporum or Nocardia minutissimum produces reddish scaly patches usually in the flexures. The scales are collected on a glass slide fixed and stained with lacto-pheno blue. The organism is seen only under the oil immersion lens as it is bacterial in dimension.

3. *Moniliasis*.—Its exact pathogenic role is not settled. Only one type, i.e., *Candida albicans* is of importance. It manifests as thrush (Mouth) soddened patches in skin folds as under breasts and groins; vaginitis and paronychia. Its diagnosis is by smear and culture and its elimination is by using 1 per cent Aqueous Genetion Violet locally and nystatin antibiotic by mouth. The long term use of broad spectrum antibiotic leads to over growth of monilia and this is now controlled by using a combination of tetracycline with an antimonial antibiotic like mysteclin.

All cases with extensive moniliasis must be screened for diabetes mellitus, tuberculosis and parathyroid deficiency.

Coccal affection of skin.

A. *Impetigo*.—This is a coccal infection of skin and the types commonly seen are—

1. *Impetigo of scalp* (with and without Pediculi).
2. *Impetigo contagiosa*.
3. *Bockhart's Impetigo* (follicular impetigo).

1. *Impetigo of scalp*.—This is a childhood ailment. Mainly the child has many pustules on scalp and some have regional adenitis of the cervical lymphatic glands. In all cases an underlying pediculosis must be ruled out. Pediculosis is often the cause of *Impetigo* resulting from scratching of the scalp due to the bite of the lice.

The management of these cases is—

- (1) Clip the hair short.
- (2) Wash scalp with soap and water.
- (3) Apply the following cream:—
Methylene Blue—10 grains.
Zinc Cream ad—1 oz. at night.
- (4) Sulfonamides by mouth for the septic adenitis.

If pediculosis is present it should be tackled first. For this 10 per cent Benzyl Benzoate emulsion is applied to scalp and washed off next day. After 14 days repeat the same to tackle any of the lice that have hatched out of nits (eggs of louse).

2. *Impetigo Contagiosa*.—This affects mainly infants and children. The face is affected chiefly. There are a number of vesicles which rapidly become pustular and dry up giving yellowish crusts. The general health is unaffected.

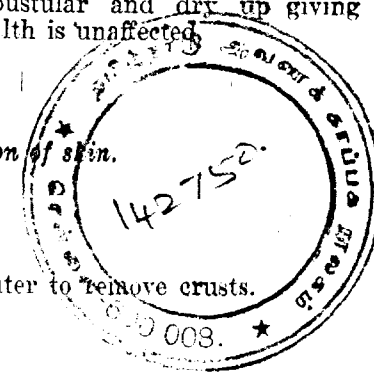
Coccal affection of skin.

Treatment—

- (1) Wash with soap and water to remove crusts.
- (2) Apply the cream—
Methylene Blue—10 grs.
Zinc Cream ad—1 oz. for external use.

(3) In the few cases with fever and oedema sulfonamides by mouth.

(4) Child must be isolated from other children and its linen especially towels kept separate.



(4) Elimination of offending agent in the environment or in food.

When secondarily infected the use of an antibacterial cream as 2 per cent Meth blue in Zinc Cream with sulfonamides is best. Use of Penicillin in these cases is not safe. The condition is likely to recur and it is well to treat each attack as it occurs.

C. Nummular Eczema.—In this condition you get circular patches of eczema on hands and feet. The entire area of the patch is studded with vesicles. There is also crusting. Occupations involving handling of fat solvents seem to precipitate this. In others it is associated with a dry and scaly skin which appears to have lost its resistance to the skin bacterial flora. The treatment is like other eczema. In acute stage a lotion like Lotio Alumini Co (G.H. Pharmacopeia) and internal antihistamines. When dry use Lassar's paste for external use and in this stage worthwhile giving a course of Auto-hamotherapy, 2 cc. intramuscular every 4th day six injections in all.

In a few cases painting with crude coal tar sometimes resolves the condition quickly. Local Cortico-Steroid preparations have not been very useful in this condition.

Contact Dermatitis.—In this dermatitis (inflammation of skin) results from contact with an external substance. The substances are of two groups: (1) Primary irritants, and (2) Sensitisers.

Primary irritants.—Primary irritants are substances which cause an acute inflammation of the skin soon after one comes into contact with it. The person is usually able to give the cause.

Sensitisers.—In this an usually innocuous agent in course of time sensitises the skin and this type of sensitisation is now being increasingly detected with the increase of industrialization. Bakers, carpenters, machinists, dentists, chemists, dye-makers, cosmetic-users, etc., all undergo a risk of sensitisation to the article they handle. An enquiry into the occupation of the individual therefore is helpful. Contact dermatitis of the hands usually start on the dorsum of the fingers and webs and on back of the forearms.

These sensitising (contact) dermatitis are often picked out by patch testing. The suspected agent is applied to an area on the back on a piece of gauze, covered with cellophane and plaster applied, on another area control is done with only gauze and

cellophane paper. The patient is instructed to report after forty-eight hours and earlier if there is any irritation in the tested area. Patch testing must be deferred till the acute dermatitis has subsided. A positive patch test is known by the erythema and vesiculation produced at the site of the patch test.

Treatment.—As in eczemas acute stages are treated with lotions and when dry a 1 per cent Hydrocortisone ointment is used which helps resolution. Internal antihistamines too are given. The causative agent must be eliminated and an effort to desensitise made which unfortunately is not often successful.

Stasis Dermatitis.—This condition is seen in the lower 1/3rd of leg and proximal 1/2 of the foot in people with varicose veins. The skin is pigmented and itching and periodically oozes and crusts. There is often oedema of the lower 1/3rd of the leg.

Treatment.—If infected an antibacterial cream as 2 per cent Methylene blue along with internal sulfonamides. When dry Lassar's paste for external use. The foot of bed must be raised by blocks for about eight inches. Oedema of feet must be got rid off with drugs like Esidrex or Chlorotride, Maelix, 1/2 bd. for three or four days. It is important these cases are treated carefully or sensitisation dermatitis might set in by injudicious applications like sulfonamide powder or acriflavine. When the acute stage has subsided use of an elastic crepe bandage is recommended. A surgical opinion on the varicose veins is of value.

In cases with stasis ulcers use of an elastic adhesive bandage from base of the toes up to the knee with a felt pad round the ulcers is of value. The ulcers must be distinguished from arterio-sclerotic ulcers which are small painful and not to be treated by elevation of foot which may lead to gangrene.

Urticaria.—This is a malady characterised by weals. It is a pruritic disorder and may be acute or chronic, localised or generalised. The lesion consists of linear or oval white swellings on skin (weal) with an erythema round them.

Causes—

- (1) Foodstuffs belonging to the shell fish class, various types of meat and some vegetables.
- (2) Drugs-like aspirin, bowel laxatives and sedatives.
- (3) External agents like insect bites and caterpillars.
- (4) Foci of sepsis.
- (5) Bowel infestations, particularly ascariasis.
- (6) Microfilarial infestation.
- (7) Psychic.

3. *Impetigo of Bockhart's*.—This is chiefly an affection of the hair follicle mouths, i.e., it is an ostial folliculitis. The lesion is a pustule at the mouth of the hair follicle and from the centre of the pustule a hair protrudes. This condition chiefly affects the hairy legs of men. Its natural cure is when all the hair follicles are destroyed. This disease recurs as long as there are hairs in that area. Hence treat with simplest and cheapest of remedies—

(1) Lotio Alumini Co (an astringent antiseptic lotion) for external use every night after washing with soap and water—

Purified alum—5 grs.

Strong solution of lead subacetate—1 dr.

Aqua ad—1 oz.

(2) Internally sulfanomides.

(3) Once the attack is under control daily swabbing at night with 1 per cent Aqueous Cetavlon diminishes the number of recurrences.

B. *Sycosis Barbae*.—Sycosis barbae is a further stage in Bockhart's Impetigo. In this the lesion instead of just being in the mouth of hair follicle goes down into the hair follicle and forms a small nodule. This type of affection is seen in the beard area.

Treatment.—Treatment is as in Bockhart's impetigo. But in the old cases it is worth while examining the hair from the area for fungus as Sycosis may be variety of ringworm. Also in cases in upper lip it might be manifestation of syphilis when a blood test for syphilis too must be done.

The eczema.—The word eczema means to boil out. This is a common disease wherein one finds erythema (fair skin) vesicles, oozing and crusting. To these clinical findings one could often trace an element of allergy to exogenous or endogenous agents.

The following types of eczema are of interest:—

(a) infantile eczema, (b) atopic eczema, (c) nummular eczema.

(a) *Infantile eczema*.—Infantile eczema is a disease of infants born into families with an allergic history of eczema, asthma, hay fever, vasomotor rhinitis and migraine. These infants break out into a skin rash of redness, vesiculation and crusting with itching over the cheeks, foreheads and arms and

legs. The serous exudate gets readily secondarily infected. A careful history on the diets and clothing would reveal some agent which is precipitating the trouble. This type of eczema is often precipitated by vaccination and in these families such a procedure must be cautiously done. A good number of these cases often are seen in artificially fed babies. Proprietary tinned foods are also causative agents.

Management.—(1) In acute and infected cases an anti-septic lotion like 1/4 per cent Argylol in calamine lotion is used.

(2) The child can be bathed daily after softening the crusts with liquid paraffin and washing off with a super fatted soap.

(3) When dry external application of 1 per cent Hydrocortisone ointment is used.

(4) Internally an elixir of an antihistamine drug is used.

(5) The proprietary food must be changed to a more digestible one like Eledon.

(6) External irritants like wool and excess clothing must be avoided.

(7) Fruit juices like tomatoes and citrus fruits aggravate this condition and hence must be stopped.

Vaccination.—This is deferred in cases with extensive or acute eczema. When the skin has quietened down completely give an elixir antihistaminic for about ten days before vaccination and after vaccination continue for another ten days. Vaccination in the acute stage must not be done.

B. *Tropic Eczema*.—These cases are a group wherein there is: (1) History of allergy in the family. (2) History of allergy in themselves. (3) Evidence of reacting in a peculiar manner (Atopy—Strange) to substances to which normal persons do not react. The average case has patches of eczema chiefly on the bends of elbows and backs of the knees and about the neck and eyelids. The individual complains of paroxym of itching and is often miserable.

Treatment—

(1) Local application of 1 per cent Hydrocortisone ointment.

(2) Internal antihistamine drugs.

(3) Toilet of skin with liquid paraffin and super fatted soap.

Treatment is (a) to eliminate any operating factor, (b) antihistamine drugs by mouth; local use is of no value; (c) Adrenaline 2-8 minims intramuscularly for quick relief, provided there is no cardio-vascular disease; and (d) in selected cases corticosteroids.

Dermographism is tendency to produce weals on light stroking of skin; these weals do not itch as in urticaria. The cause is not known and antihistamine sedation is the one employed.

Angio-Neurotic Oedema.—In this, localised areas swell up considerably and if about the larynx would cause serious problems. The exact cause has often not been easy to detect. The treatment however is as in acute urticaria with adrenaline, antihistamine and steroids.

Papular urticaria is a disease of children and they show itching papules chiefly on exposed areas. The cause is often due to fleas and the treatment is by dusting with D.D.T. powder and elimination of pets like cats from the house.

Common virus diseases of skin.

1. Herpes Zoster.
2. Herpes Simplex.
3. Warts.
4. Molluscum contagiosum.

1. *Herpes Zoster*.—The lesions are grouped vesicles on an inflamed surface and in segmental distribution. At times one sees lesions of zoster in contralateral areas at distant sites. These cases are termed Herpes Zoster Varicelloses and present the problem of being chicken-pox. Fuller details, of zoster may be obtained from any book.

Treatment.—Local painting with lotion of 1 per cent Silver-nitrate with 1 per cent Methylene Blue in water. Emetine $\frac{1}{2}$ to 1 gr. intramuscularly every night for three nights. In case of zoster of fifth nerve the use of cortico-steroids with broad spectrum anti-biotics is advised and in case of generalised Herpes Zoster one should exclude leukemia and internal malignancy when treating the zoster.

2. *Herpes simplex*.—This is a recurrent affection and consists of grouped vesicles either on lip or genitals or any other site. The lesions recur at the same site. It is wiser to treat each attack with a local paint of 1 per cent Ag. No. 3, one per cent Methylene Blue in water rather than employ other means which are of doubtful value in preventing recurrences.

3. *Warts*.—These are of wide distribution in the public and occur on hands, face and feet. Their treatment, if few, is by electro dessication or under local to curette or excise them. Painting with 10 per cent Formalin or 33 per cent Trichloroacetic acid too is suggested. If solitary on sole elastoplast strapping kept on for six weeks softens the wart which by then has disappeared or is soddened and falls off.

4. *Molluscum Contagiosum*.—The lesions are skin coloured dome shaped papules with central depression. They are highly auto-inoculable and frequently seen in children. When punctured they let out a whitish mass the molluscum bodies. Treatment is to puncture them with a sharp pointed wooden applicator which has been dipped in Tincture of Iodine. If extensive on face in children a general anaesthetic and curette of lesions is best.

Pigmentary disorders.

1. Vitiligo.
2. Pigmentation.

Nos. 1 and 2 are two main disorders met with commonly.

1. *Vitiligo* (acquired achromia) Depigmented patches occur on any part of the body surface. There is no alternation in the texture of the skin and the hair in the patch is also depigmented. The routine investigation of a case is by blood serology, Ear, Nose, Throat and also Dental opinion on focus of sepsis and irradiation of the same; local painting with Luederm Oil with or without Ultraviolet rays; plain U.V. Ray therapy are lines of treatment generally used. Use of Melanin tablets by mouth and Melanin lotion locally is advocated by some but the use of oral tablets must be carefully supervised as there is a tendency for the normal skin to pigment more. On the whole vitiligo is a cosmetic problem and the use of cover marks is of value in all cases where the lesion is in an exposed area.

2. *Pigmentation*.—These cases usually are of increased Melanin pigmentation (other cases of increased pigmentation are blood pigment, carotenoid and exogenous tattoo pigmentation) Melanin pigmentation may be universal or occurring only in light exposed areas. If universal a thorough systematic examination of the patient is necessary. In case of pigmentation in light exposed areas the pigment is due to the skin becoming sensitive to sunlight. The sensitivity is either due to external agents or due to internal factors. Of the external agents the commonest are scented preparations like scents, creams and oils. All scented preparations contain an essential oil and these essential oils are potent causes for increased pigmentation. A history on the habits of the individual would reveal this and it is essential that these preparations are given up.

Internal factors like drugs produce pigmentation, for e.g., sulfonamides, and laxatives containing phenolphthalein. In these pigmentation are of the nature of a fixed drug eruption. Disturbances of porphyrin metabolism, e.g., porphyria also gives rise to pigmentation especially, to light exposed areas. It is thus seen that pigmentation especially is not an easily resolvable problem. The following method of investigation is suggested:—

- (1) Pigmentation universal or light exposed areas.
- (2) If universal—a thorough systematic examination.
- (3) If light exposed areas only involved enquiry about—
 - (a) Intake of drugs (Habitual).
 - (b) Use of scented preparations.
 - (c) Evidence of porphyria.

Management.—This depends entirely on the cause. Any aetiological factor must be eliminated and then the pigment already formed is tackled by internal Vit. C. 50 Mg. tid for six months and external use of light screening preparations to be used as paraminol cream or stearic acid paste and an advice to avoid direct exposure to sunlight as far as is possible.

Tuberculosis of the skin.

Two distinct groups are seen:—

1. True tuberculosis—
 - Lupus Vulgaris.
 - Lupus verrucosa cutis.
 - Scrofuloderma.

In these there is a possibility of demonstrating the bacillus and obtaining a positive guineapig inoculation. The lesions of lupus vulgaris usually seen on face or buttocks and consists of brownish red patches which do not cause any discomfort. In fact they look like patches of Tuberculoid Hansen but with the cutaneous sensations intact. In verrucosa cutis the warty surface of the lesion is the characteristic feature and the long history and scrofuloderma is a skin manifestation of underlying bone or gland tuberculosis. The diagnosis is by the history, clinical appearance, biopsy and smear examination for the bacillus.

11. The Tuberculids—

- Papulonecrotic Tuberculid.
- Lichen scrofulosorum.
- Bazins disease.

These 'ids' are due to sensitisation of the skin to the T.B. bacillus. Practically all cases have an internal focus of T.B. and their Montoux test is positive. In papulo necrotic type the lesions are symmetrically distributed papules with a central area of necrosis. The lesions are indolent unlike the appearance of pyococcal pustule.

In lichen scrofulosorum.—Usually seen in children there is papular rash chiefly on trunk with no itching; the histology and Montoux test aid with diagnosis.

In Bazins disease.—It is seen as indolent nodule in the callosities of women; they may or may not ulcerate. Its relation to tuberculosis is at present being questioned.

Treatment.—At present the line of treatment of T.B. skin is by chemotherapy—

- (a) INAH alone 100 mg. tid.
- (b) INAH plus PAS 10 grams daily.
- (c) INAH plus PAS plus Streptomycin 1 gm. twice a day (100 mg. tid) (10 grms. daily) week.

Inah	Pas	
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The treatment is continued till 2-3 months after a complete clinical cure. In case of 'ids' the internal focus of tuberculosis too is treated along the conventional lines. In selected cases where the lesion is small surgical excision is also employed.

Collagen Diseases.

1. Lupus Erythematosus—Discoid and systemic.
2. Scleroderma and Dermato-myositis.
3. Peri arteritis. Nodosa.
4. Drug reactions.

1. *Lupus erythematosus*.—The discoid type consists of erythemaous patches on face chiefly in malarregion with plugging of follicles with keratin. The lesion resolves by scarring.

The systemic type may not have any skin lesions and is often suspected in cases with (1) Pyrexia of unknown origin, (2) Raised E.S.R., (3) Reversal of Alb: Globulin ratio, (4) Presence of L.E. cells in blood and marrow, (5) Albuminuria and/or Haematuria and (6) Heart murmurs (Libman-Sachs disease).

The treatment of Discoid L.E. is by use of anti-malarials like chloroquine 250 mg. b.d. for six weeks to two months and then tapering it off. The entire duration is decided on the response of individual cases. The systematic type is treated with bed rest, corticosteroids and Broad spectrum anti-biotics. However the Renal changes are irreversible and this eventually does the damage to the patient.

2. *Scleroderma*.—A rare Disorder. In case of scleroderma one meets with (a) solitary patch of ivory coloured hardened skin termed morphea, (b) marked 'Hidrobund' state of fingers and forearms and also of the face termed arosclerosis; (c) case of (b) with evidence of visceral involvement like oesophageal strictures. Prognosis, of course is not good.

The treatment therein too is with steroids but the course is eventually fatal particularly in group (b) and (c).

Dermatomyositis.—This is sometimes seen along with scleroderma or independent of it and the patient often reports with generalised weakness, with fever and puffiness of face. The diagnosis is mainly by a careful examination with a biopsy of skin to include the muscle. Treatment again is with corticosteroids. Prognosis, of course is not good.

Drug eruptions and reactions.

This group must always be kept in the fore front when examining a case of skin rash. The variety of eruptions produced by different drugs are all well listed, in standard works of Dermatology.

Erythema.	Pustules,
Papules.	Bullae.
Urticaria.	Purpura,
Vesicle,	Acne,

are all the types that could be met with.

In an enquiry a methodical approach is:

- | | |
|--------------------|---|
| 1. Headache drugs | Aspirin and other analgesics. |
| 2. Bowel laxatives | Specially chocolate laxatives containing phenolphthalein. |
| 3. Blood Tonics | Those which contain Iodides, Arsenic. |
| 4. Nerve Tonics | Those which contain Arsenics, Barbiturates. |
| 5. Cough mixtures | Those with Iodides, opium. |

Lists 1 to 5 usually elicit evidence of an habitual intake of drugs and references to a standard book would help in the final conclusion. The withdrawal of the drug usually leads to a rapid amelioration of the symptoms.

Sulfonamides.—A morbilli-form rash with fever is seen after intake of sulfa drugs in some people. In addition erythema and swelling of light exposed areas—photo sensitisation—is very common sight in the tropics. These people should never again take sulfonamides; nor should sulfonamides ever be used locally on the skin.

Penicillin.—Various types of rashes are produced with this of which urticaria is common. The use of Penicillin should be prohibited in those who have had once a reaction with penicillin. Exfoliative Dermatitis and Anaphylactic shock may ensue. It is reported that reactions with penicillin are met more often with those having Fungus infections.

Antimalarials.—Chloroquine. This is used fairly extensively and its prolonged use may lead to certain reactions which must be remembered.

Blood Dyscrasia	
Double Vision	
Blurred Vision	Eye lesions.
Halos	
Deposit in cornea	

Depression, Indigestion, Diarrhoea.

Depigmentation of hair particularly the forelock.

Treatment of drug reaction in general.—A. Prophylactic; Proper supervision of cases so that as intake of drugs is avoided and also earliest detection is ensured.

B. Curative—

1. Withdrawal of drug.
2. Use of antihistamines and cortico steroids.
3. Intravenous calcium gluconate.
4. Use of specific agents like B.A.L. for arsenic reactions: chloroquine for light screening in photo-dermatoses.

Fixed drug eruptions.—These are eruptions like erythema or weals which recur at the same site on exhibition of the drug. The eruption may itch. Drugs like phenolphthalien and phenacetin cause this also barbiturates and sulfonamides.

Drug Dont's in Dermatology.

1. Never ever use sulfonamides locally as powder, paste or cream.
2. Never ever use Penicillin locally or parenternally in cases of secondarily infected Fungus; Atopic dermatitis and Eczema.
3. Never ever use laxatives with phenolthalien.
4. Never ever use Antihistamine ointments locally.
5. Never ever use Iodides and Bromides due to risk of Acne form eruptions (Halogen Acne) and Halogen granuloma.
6. Never ever use streptomycin locally.

As a point of interest a large group of photo-sensitive dermatitis is now being met with owing to an extensive use of a local sulfonamide preparation for treatment of wounds, bruises and minor disorders.

Bullous dermatoses.

In infancy and childhood

Impetigo
Erythema Multiforme } Are commonest causes.

Conjential syphilis
Epidermolysis Bullosa
Congenital porphyria
Urticaria Pgmentosa
Block-Sulzberger syndrome
Drug eruptions } Are rarer causes.

In adults:
Insect bites
Erythema Multiforme
Drug eruptions
Pemphigoid } Common causes.

Dermatitis from plants
Pemphigus group
Dermatitis Herpetiformis
Porphyria
Subcorneal Pustular eruptions
Herpes Gestationis } Rarer causes.

The main groups of importance is the Pemphigus and Dermatitis Herpetiformis group. The differentiation between the two is now easily done by Cytodiagnosis of the scrapings from floor of a bulla when the Tzanck cells of Pemphigus are noted in pemphigus but mainly Eosinophils seen in Dermatitis Herptiformis and no Tzanck cells.

The histology too is diagnostic. In pemphigus it is an intra epidermal bullae and in D.H. it is a sub-epidermal bullae.

Erythema Multiforme.—This condition is a vascular reaction pattern wherein one sees erythematous papules, macules and sometimes bullous lesions on the extensor aspects. In some lesions there is a central darkening with peripheral erythema and these lesions are termed target erythema or erythema Iris. When bullae predominate it is called Erythema Multiforme Bullosum.

Since it is a vascular reaction pattern the causes are many:

1. Post herpes simplex; this is the commonest cause.
2. Drug reactions.
3. Post Radiation.
4. Pre-exanthematous.
5. As a manifestation of occult tuberculosis or internal malignancy.
6. Idiopathic.

The average attack lasts about 3-6 weeks and resolves without residual damage to skin. The treatment is by (1) elimination of any causative factor; (2) Antihistamine sedation; and (3) in selected cases Cortico Steroids.

Special types of Erythema Multiforme.

Stevens Johnson's Syndrome.

Reiters Syndrome.

Becheets syndrome.—Are all now grouped as special types of Erythema Multiforme with lesions grouped at special sites. These syndromes are treated now with steroids and broad spectrum antibiotics.

Dermatitis Herpetiformis.—This is a disorder chiefly of adults. In this you get grouped lesions of papules vesicles and pustules over the scalpulae, sacrum and limbs associated with itching. Very often the lesions are bullous and the patient complains of a burning sensation. The mucous membranes are free of lesions. The bullous type is distinguished from Pemphigus by the erythematous halo round the bullae, the absence of Tzanek cells in the bullae and the subepidermal location of the bullae. The fluid from the bullae show quite a number of eosinophils.

Treatment.—Dapsone 100-200 mg. daily usually precipitates a remission but the disease is prone to recur.

Herpes Gestationis is dermatitis Herpetiformis in pregnancy. Lesions of vesicles pustules and bullae occur about the 3rd month and last till about the six-month of pregnancy. Abortion or miscarriage may occur.

Pemphigus.

1. Pemphigus vulgaris (common).
 2. Pemphigus vegetans.
 3. Pemphigus foliaceus.
 4. Pemphigus erythematodes,
- are the four main groups.

No. 1 is the commonest and the lesions are bullae on uninflamed skin and m.m. and seen usually in adults. Bullous dermatitis must be subjected to a Tzanek test. In this test the bulla is opened and fluid is drained. Scrapings with blunt side of the scalpel is done on the floor of the bulla and material transferred to a slide. The smear is dried in air and then stained with leishman stain. In the case of pemphigus the epidermal cells which normally are polygonal and with prickles keeping them in the groups are discrete from one another and without prickles. The cells further are rounded with nucleus condensed. These are the Tzanek cells of pemphigus. Cases of pemphigus must be admitted. Their treatment is with cortico steroids a sufficient amount so that no fresh blisters form. They have to be for a considerable time on a maintenance dosage of steroid Hormone. During high dosage an antibiotic is given to prevent secondary infection and daily recording made of the blood pressure; lung bases and pretibial areas must be examined to detect the onset of any oedema and if so the use of oral diuretics is indicated. The ultimate cause of death in these cases is due to suprarenal failure.

Sweat retention syndrome (miliaria rubra).

This is a disease seen in Tropics wherein there is a high temperature associated with humidity. The basic mechanism is sweating and the sweat being unable to come out on the surface of skin due to blockage of the sweat pore, i.e., poral closure. The sweat pore is closed by a disc of keratin and the reason for the disc to form is not settled. Some attribute it to activity of staphylococci in the skin.

The patient complains of itching and a rash; on examination one sees pin head papules with a small vesicle surmounting them. These papules are chiefly formed in covered areas and are often grouped. The affected areas are erythematous. The sweat rash as explained above is worse when conditions favouring sweating are present.

Treatment.—People prone to this are advised to stay in cooler environment and to avoid spicy foods, and hot drinks which increase the sweating. During the attack it has been found useful to use an astringent lotion like Lotio Alumini Co. In addition a course of staphylococcal vaccine 2 minims intradermally every 4th day six injections. However it is wiser to avoid all factors contributing to sweating; further, obesity if present must be reduced.

Alopecia Areata.

This is a non-scarring Alopecia. The cause is unknown. The hair falls off in small patches on scalp beard eyebrows and in severe cases from the entire body surface—Alopecia universalis.

The patches are non-scarring and the activity of the process is indicated by "exclamation mark" hair stumps in the patch and the tendency for the hair to loosen off when gentle traction is put on it. The hair in these patches would grow any time from the fall up to five years beyond which time there is no possibility of it growing.

In the management attention to focus of specis in E.N.T. and Dental must be done and locally painting the patches with 10 per cent lactic acid in rectified spirit is all that is needed. Massage or vigorous local treatment is best avoided as the tender hairs which sprout would be needlessly brushed off or avulsed.

Acne Vulgaris.

This is a problem of adolescence. The face has black heads as well as pustules. The diagnosis is a simple matter. In the management emphasise:

- (a) frequent washing of face with warm water and soap;
- (b) express all black heads (comedones);
- (c) in diet avoid butter, chocolate, bacon, cheese, ghee, ovaltine, coco, horlicks;
- (d) encourage outdoor exercises and plenty of intake of fruits and vegetables.

Drugs.—Locally a peeling solution of 3-5 per cent sulphur in calamine lotion; internally a long term use of a broad spectrum antibiotic 250 mg bd for six weeks to three months; **in pustular cases synthetic oestrogens like ethinyl oestradiol 0.05 mg tablets daily for ten days after the period and three such courses; in other cases use of Tolbutamide groups of drugs, e.g., Rastinon by molth is of value.**

Acne is prone to remissions; and it is well that the general measures (a) to (d) are followed till about the 25th year. In acne form eruptions without black heads enquiry must be made

about intake of drugs with Halogens (Iodine and Bromine) and also occupation involving contact with oil which gives in some an acne eruption.

Papulo and Maculo Squamous eruptions of unknown Aetiology.

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|---------------------|--------------------|
| 1. Pityriasis rosea | (Macula-squamous). |
| 2. Psoriasis | } Papulo squamous. |
| 3. Lichen planus | |

1. *Pityriasis rosea*.—This disease is characterised by a solitary patch which is circular and with scaly edge. This patch is often mistaken for a patch of tinea which of course would show a vesicular edge. The solitary patch is termed an herald patch. Ten days later there is a shower of patches on the trunk and limbs. On the trunk the patches are along the cleavage lines of the trunk, oval in shape and with their long axes parallel to the lines of cleavage. Each patch has a peripheral collarette of scales. The distribution is over the area of the body covered by long necked, short sleeved vest. The disease is non-puritic and lasts usually about six weeks, and resolves without leaving a trace.

The management is (1) by a routine check on the blood serology; (2) external application of lotio Alumini Co; (3) a course of staphylococcal vaccine injections (total six).

2. *Psoriasis*.—In this the early lesion is a scaly papule. On scraping the lesion silvery white scales are seen and when these are removed a shiny membrane, the membrane of Buckley is seen. This membrane on removal shows pin point bleeding points.

Psoriasis affects scalp but causes no alopecia; affects palms and soles and gives thickened patches over them—affects extensor surface of limbs and resolves without scarring; affects the small joints of the fingers giving Psoriatic arthropathy. There is often a family history.

Treatment.—Use of 2 per cent sulphur salicylic acid ointment three nights a week clears up the lesions well or Liq Picis carb dri in one ounce of acetone painted to the lesion is very good. For the body lesions use of the tar-acetone lotion is very helpful; of late Tolbutamide groups of drugs, e.g.,

Rastinon is found usefull in precipitating a remission. It is given either as one tablet daily or one tablet twice a day daily for about four to six weeks. The aim is to ent short the course of the attack of Psoriasis. Extensive cases of Psoriasis do well with rest in bed and oral salicylates. Use of corticosteroids is *not* advocated.

Psoriasis being a disease prone to remission it is wiser to treat each attack in the quickest possible way and encourage the patient. In late occurring *Psoriasis* with no family history a blood test is needed to exclude *Psoriasiform* secondaries.

3. *Lichen Planus*.—In this one sees flat tapped violaceous papules with waxy appearance on the front of the wrists and ankles and in the general body surface in extensive cases. In a definite group whitish or purplish spots in a pattern arrangement are seen in gastric mucosae and rectalmucosae; unlike the former two diseases it is a puritic disorder.

Management.—Control the pritus with sedation employing an antihistamine drug by mouth. After testing the urine for albumen the person may be prescribed Mist Hydrarg Perchlor one ounce twice a day after meals. Test the urine every week and if there is no albumen continue the mixture for six weeks only and stop the drug if there is any side reactions. Corticosteroid is indicated in lichen planus in (1) extensive cases of an acute nature specially those precipitated with drugs like atabrine and gold; (2) extensive cases where in the scalp is involved since if the lesion is not rapidly resolved alopecia would result.

There are various types of lichen planus of which the Hyperkeratotic one is commonly met with. This type resolves with local use of Ung Petrolei Co and also local infiltration with Hydrocortisone.

