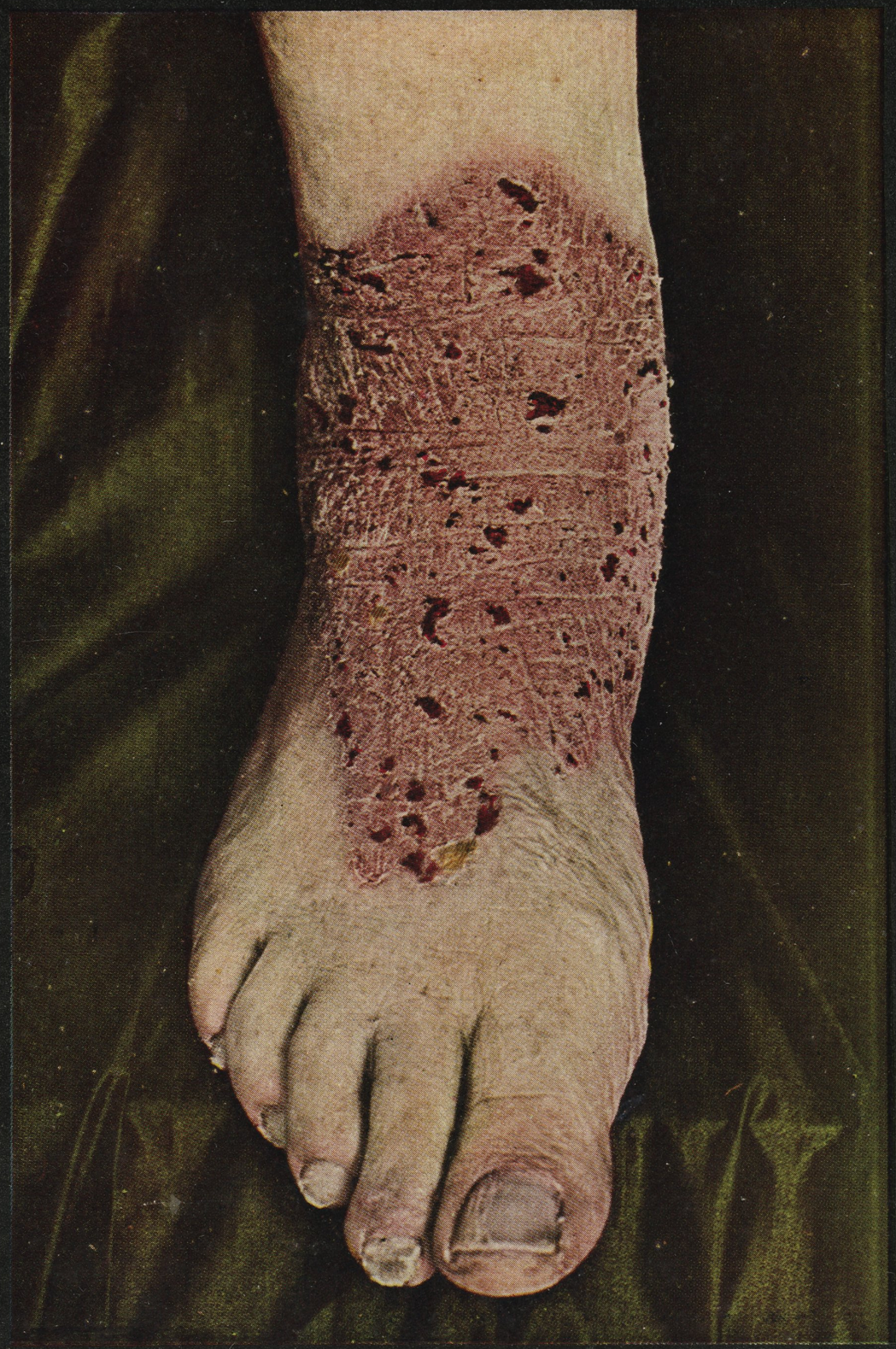

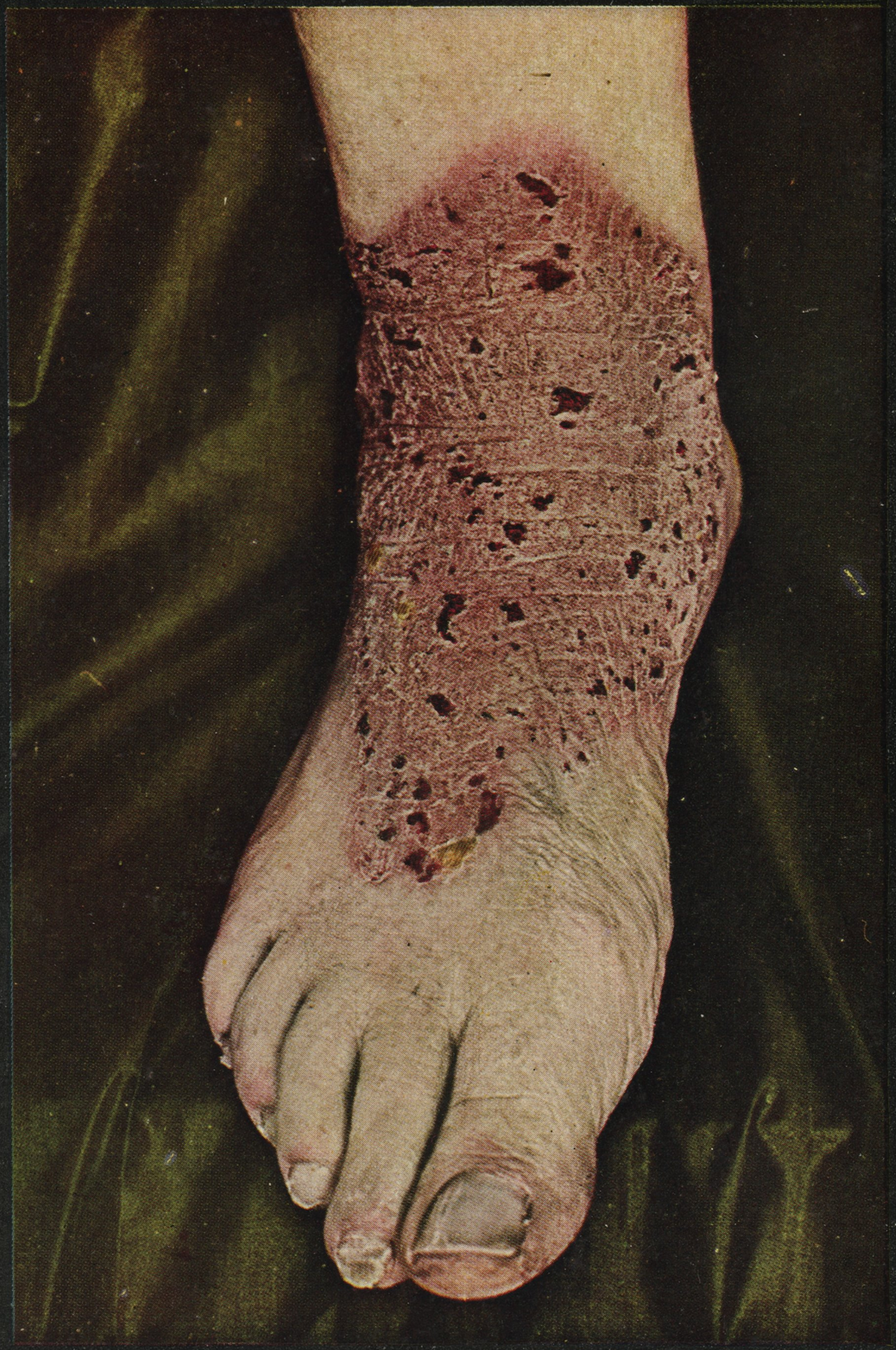

ECZEMA SQUAMOSUM

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All types of eczema assume a squamous form as a terminal stage on their way to recovery, but the typical persistent lesions of squamous eczema develop usually from erythematous areas or from patches of closely aggregated papules. The skin becomes considerably infiltrated, dry, red and covered with more or less numerous, thin, large or small, flaky scales, which vary in color from light gray to brownish yellow. There may be only one large patch or several smaller plaques. The borders fade gradually, as a rule, though not very infrequently the margins are quite clearly defined. In an affected area the natural lines and furrows of the skin are always deepened. About the joints and especially on the palms and fingers the thickened, inelastic skin is prone to crack in the furrows with the production of bleeding, painful fissures. Excoriations may be caused by scratching and the moisture from these, or the true, gummy eczematous exudate that sometimes appears during an exacerbation of more acute symptoms, may cause the scales to partake somewhat of the nature of crusts. This type of eczema occurs on any part of the skin, but is seen most frequently upon the scalp, back of the neck, palms, legs, and in the joint flexures especially of the elbows and knees. It pursues a chronic course and may persist for years. Like all the other varieties of chronic eczema, this is likely to fluctuate in intensity, recrudesce with acute symptoms, and relapse. Itching may be slight or intense. The rhagades are usually very painful. **DIAGNOSIS:** The lesions may resemble patches of *lichen planus,* but in that disease the polygonal papules, and the gray striations on the surface of the patches, are pathognomonic. Moreover, lichen planus is a dry disease throughout, and the occasional vesicles, pustules, and rounded or acuminate papules often associated with the eczematous patches are not to be found in lichen planus. *Psoriasis* has a more general distribution usually, with a predilection for extensor surfaces. It is uncommon on the hands. The patches are always dry, always sharply defined, usually small and sometimes ring-shaped. The scales may be very abundant, and the skin beneath them is not infiltrated but looks thin and membranous and when it is gently scraped punctate hemorrhages are easily produced. Itching is often absent. **TREATMENT:** Oleum cadini is one of the most reliable remedies. It may be added to unguentum zinci oxidi in the proportion of one drachm to the ounce. The amount of oil should be increased if the eczema proves very sluggish, and decreased when too much irritation is produced. After the scales have been softened with a sweet oil poultice they are to be removed by washing with soap and water. Then the cade ointment should be rubbed well into the patch and the part covered with a snug bandage. When the induration is dense and its absorption slow the circulation may be stimulated by washing the patch once a day with green soap just before each dressing. Another excellent method of reducing the infiltration and removing the scales is to bind a sheet of rubber over the patch. The rubber should be cleaned daily and reapplied. After a time the tar treatment may be commenced.