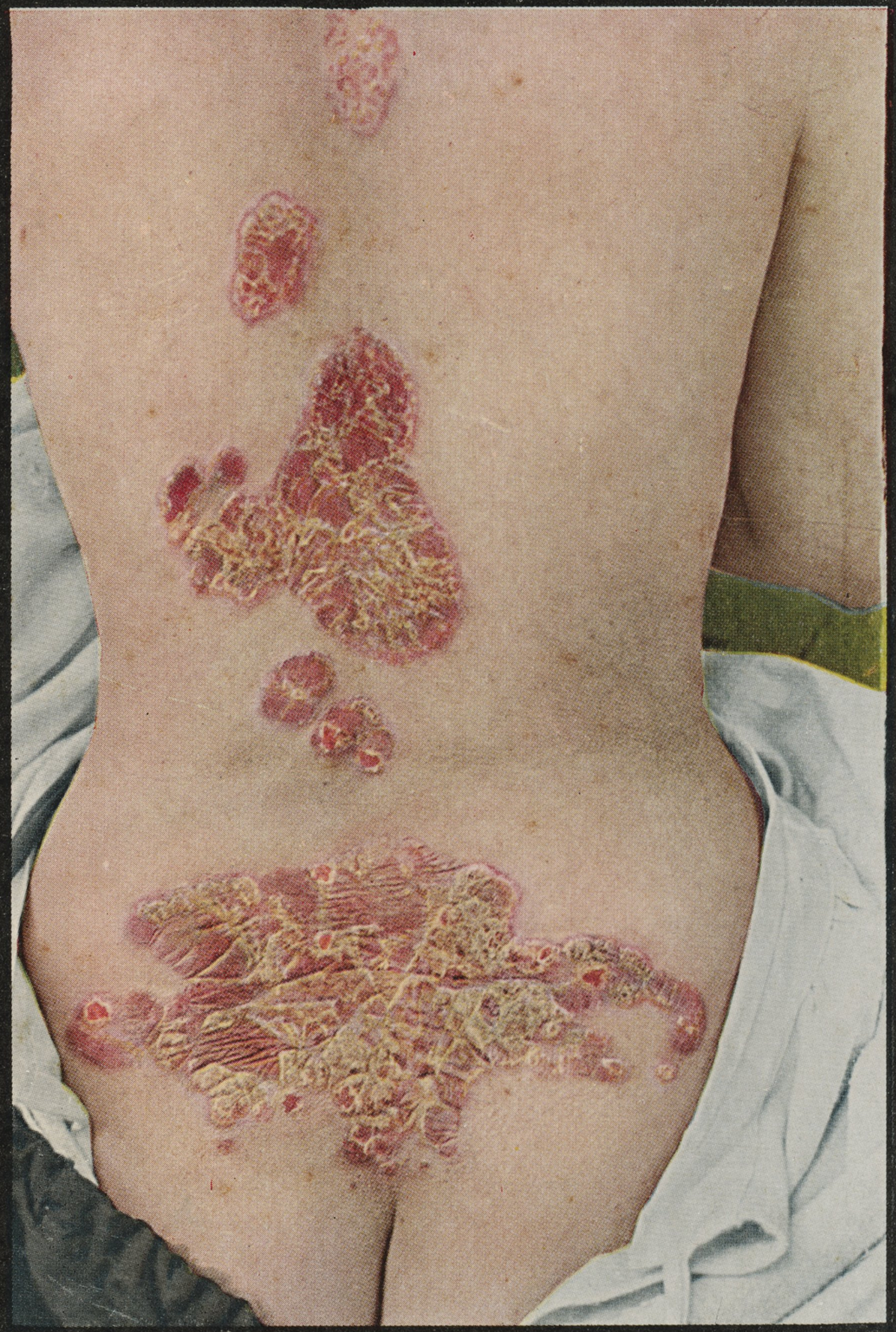

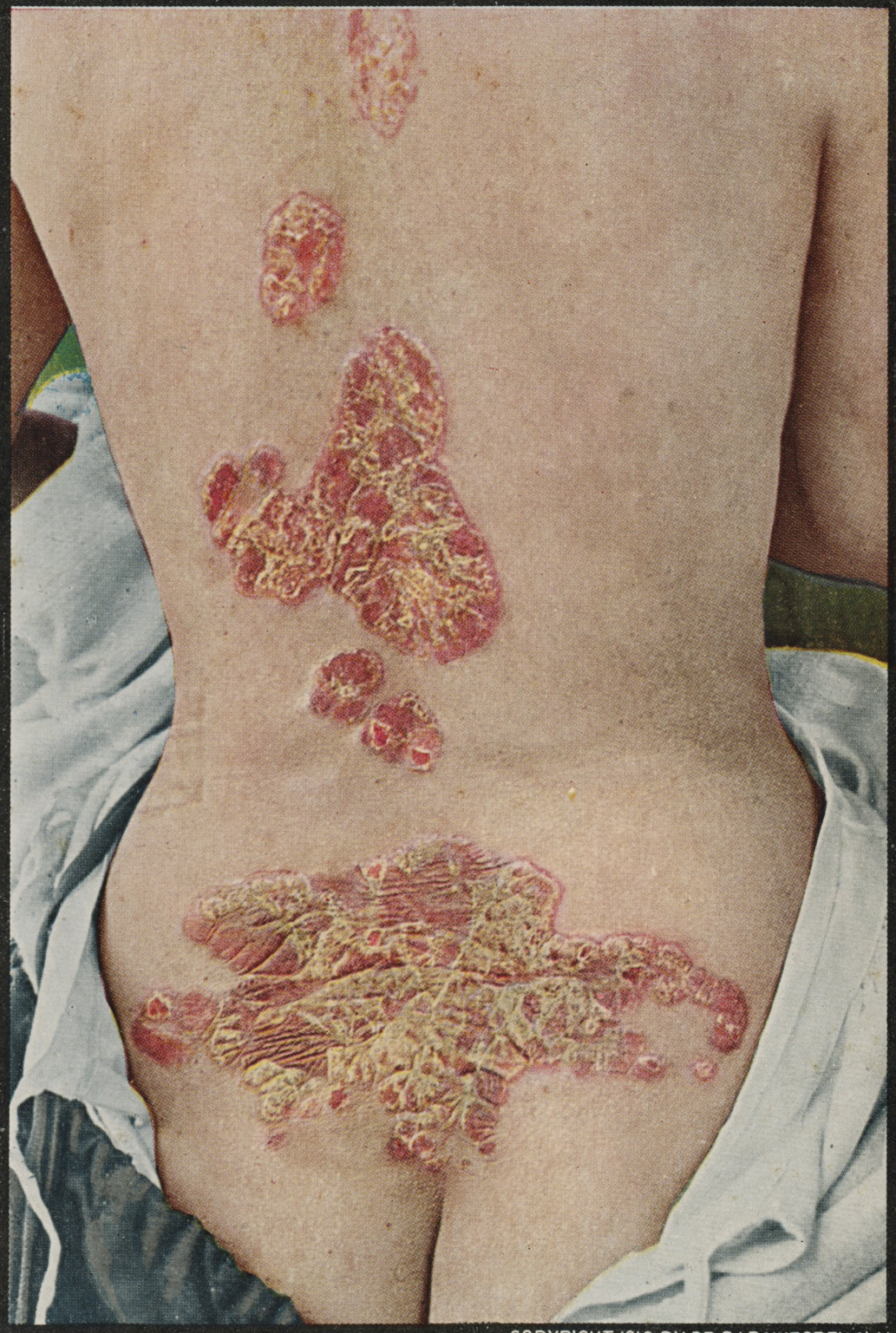

PSORIASIS

PSORIASIS

Psoriasis is a chronic frequently relapsing disease of the skin, characterized by more or less numerous, small or large masses of white or yellowish dry imbricated scales loosely adherent to circumscribed red patches of epidermis. The redness nearly always extends a little distance beyond the scales. The primary lesions are pinhead sized slightly elevated papules. By peripheral growth they develop into pea sized, glistening white scaly lesions that look like drops of mortar on the skin. When the scales are completely removed a smooth red surface is exposed upon which several minute bleeding points may be seen but often only with the aid of a lens. Further growth and coalescence of the lesions give rise to coin-sized plaques and larger irregular patches. Occasionally lesions may undergo involution at the center; in this way ring formed, segmental and serpiginous figures are formed. The efflorescences vary greatly in number and are rarely of uniform size. The scales are more abundant on some patches than on others. Now and then there may be large red plaques covered with only a single translucent, wrinkled film. Only in old lesions is there any infiltration of the skin, but in extreme cases the thickening may be sufficient to cause fissuring about the joints. The evolution of a lesion may occupy a few weeks or many months. The distribution is roughly symmetrical. Marked preference is shown for the extensor surfaces of the extremities, particularly in the neighborhood of the elbows and knees, and for the scalp. Any part of the trunk may be affected. The palms and soles are very rarely involved. The nails may be brittle and stippled with minute depressions. On the scalp the thick masses of scales often mat the hair, but alopecia is uncommon. Not infrequently the patches extend a half inch or more onto the forehead. The face is otherwise rarely affected. Itching may be present in some cases but is not often intense. Psoriasis begins most often after puberty, sometimes in childhood, rarely in infancy or old age. **DIAGNOSIS:** The scales of *lichen planus* are less abundant, more adherent, and their removal does not cause punctate hemorrhages; disappearing patches leave pigmented areas; the gray striations and polygonal papules are pathognomonic. *Dermatitis exfoliativa* begins in the flexures, attacks the hands and feet, becomes universal and causes constitutional symptoms. Dermatitis exfoliativa may develop from a generalized psoriasis. *Eczema seborrhoicum* on the scalp does not leave areas of normal skin between the patches as does psoriasis, and its scales are greasy. **TREATMENT:** Internally arsenic is most often administered in increasing doses to the limit of tolerance. It is to be used only in very chronic cases. Saline diuretics and large doses of potassium iodid may be given at any stage and are often quite as helpful. For external use chrysarobin is the drug of choice. Tar and salicylic acid are also valuable and an excellent preparation is a combination of these: Acid, salicyl. 10, Chrysarobin., Ol. rusci, aa 20, Sapo. moll., Petrolati, aa 25. This should be applied to the lesions only after the scales have been removed with water and soft soap. When chrysarobin causes too intense a dermatitis its use should be suspended. It is not to be employed on the face for it may produce a severe conjunctivitis. Its staining of the skin is temporary, but of the clothing permanent. Ung. hydrargyri ammoniati is a clean and efficient application for mild cases and for use on the face and scalp.