A METHOD OF TREATING PSORIASIS*

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IN 1925 Goeckerman[3] described a method for treating psoriasis that has continued to be in my experience the most satisfactory way of ridding a patient of an attack of the disease. The cause of psoriasis is not known, and as there is accordingly no specific treatment for it, the therapeutic suggestions that have accumulated over the years are legion. There is no need to discuss these various programs because each one is a development of an impression gained in one way or another by the originator of the system. There are two remedies which tend to minimize or at least keep in abeyance the attacks of the disease but in so doing frequently produce sequelæ that are more serious than the psoriasis. I refer to x-ray therapy and the use of Fowler's solution (solution of potassium arsenite). Because Fowler's solution does minimize the number of plaques of psoriasis, patients frequently continue its use to the point of producing arsenical keratoses and pigmentation. The former are serious because of their tendency to become malignant. Roentgen therapy likewise melts the plaque with less inconvenience to the patient than any other method of treatment, but as the number of previous treatments is forgotten frequently and psoriatic patients change physicians often, ill effects in the skin from the x-rays which lead to cancerous changes have become too common. However, the judicious use of the x-ray by those trained in its application is not to be condemned, as it probably is the most commonly used treatment for psoriasis.

Although the method of treatment suggested by Goeckerman is successful in getting rid of an attack of psoriasis, it is inconvenient in that it requires hospitalization. Because of this fact it is used most commonly in treatment of patients who have an extensive crop of the disease and is hardly worth the effort in dealing with the patient who has only a few lesions on the elbows or knees. In our experience approximately 12% of psoriatic patients have arthritis of one type or another, either chronic infections, senescent or psoriatic arthritis. In this latter group the treatment about to be detailed has been successful, not only in causing disappearance of the cutaneous lesions but also in relieving the pain in the joints.

The two types of psoriasis in which the method is the least efficient are (1) the nummular form of the disease of recent origin and (2) generalized exfoliative psoriasis. Both of these manifestations of the disease are somewhat resistant to this treatment, requiring more time in the hospital and being attended with less success in getting rid of the lesions.

The treatment consists of the use of coal tar ointment* (2 to 4%), ultraviolet light, oatmeal baths, and autohæmotherapy. There are a few additional procedures used in special cases that will be discussed later. On the first day in the hospital all the patches of psoriasis are covered thickly with the ointment, which is left on overnight. The following morning it is removed with a light weight mineral oil, but care should be taken to leave a thin film of the oil on the skin. The reason for this is not known but experience has shown that it is essential, paradoxical as it may seem, in view of the fact that ultraviolet light therapy is given to the skin through the film of oil. At the first treatment the light is applied for one minute at 30 inches' (76 cm.) distance after dividing the skin surface into six areas. The time of exposure is increased and the distance decreased each day in order to maintain the skin in a state of mild erythema. It is advisable to keep the reaction from the ultraviolet light below the point of blistering, although in certain cases this is difficult to do when one is endeavouring to produce erythema in a large, indurated plaque. Occasionally, satisfactory erythema is difficult to obtain if the lamp has been used for a long time and is almost burned out, or if the patient has a tan from long-continued use of ultraviolet or sunlight.

After the light treatment the patient spends

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* Ointment: Crude coal tar, 1.20 or 2.40; pulv. zinc oxide, 1.20; cornstarch, 30.00; petrolatum, 60.00.

half an hour to two hours in an oatmeal bath* or an ordinary tub of water kept at approximately 95° F. This loosens the scales and allows the patient to remove them by brisk rubbing of the skin while in the tub. After the bath a thick coating of the ointment is applied again to the skin, the endeavour being made to put it mainly on the patches. It is usually advisable to apply a second coating of the salve over the first one before retiring for the night. An inexpensive cotton suit of underwear (union suit) or a gauze covering is worn to protect the bed clothing.

Autohæmotherapy is given at two-day intervals for five doses. The technique consists of drawing 10 c.c. of blood from the cubital vein and injecting immediately into the buttocks by dividing it so that 5 c.c. is given on each side.

This combined procedure is continued daily until no psoriatic scales remain and there is little if any induration left in the plaques. The period of hospitalization for extensive psoriasis under this regimen approximates two weeks. If the induration of the lesions is marked an additional week may be necessary.

The tar ointment is not pleasant to use on the scalp if psoriasis is present; therefore an ointment of 5% salicylic acid in 5% unguentum hydrargyri ammoniati is rubbed into the scalp vigorously each day, followed by a shampoo the next morning. This is continued until the scalp is rid of the thick flaky patches of psoriasis. The use of ointment is of no value in the treatment of psoriasis of the nails.

Approximately 12% of the patients suffering from psoriasis that I see have arthritis. In all of these patients the psoriasis is not the cause of the arthritis, as infectious and senescent types are encountered in addition to the form which I believe is due to the same etiological factor or is a part of the skin disease. Hench[4] has called attention to the fact that psoriatic arthritis is characterized by involvement of the terminal phalanges as the first sign of the joint disease and by a moderate degree of parallelism in exacerbations of the cutaneous psoriasis and the arthritis. In most of these patients the cutaneous lesions have been present for many years and involvement of the finger nails in the form of pitting and separation of the sides of the nail from its bed is noted commonly. Although it is not a constant finding, it is fairly common to have patients comment on the fact that the arthritis improves when the psoriasis involutes either from treatment or spontaneously with the change of the seasons. I am familiar with the fact that not all physicians agree that there is a causative relation between these two diseases, and I cannot submit laboratory evidence to prove this relation to them. Nevertheless, the frequency with which the pain disappears from the joints of these patients as the cutaneous lesions fade out under the Goeckerman regimen, only to recur with the return of the skin lesions, is too common in my experience to pass unnoticed.

In treating the patients suffering from psoriatic arthropathy in whom the involution of the joint symptoms lags behind the cutaneous improvement it is my practice to use foreign protein therapy in the form of intravenous injections of typhoid vaccine, together with baking and massage of the joints. Unfortunately, treatment does not prevent recurrences of the psoriasis nor the arthritis, so that it is not possible in some instances to halt the development of severe and crippling arthritis deformans.

Vitamin D at one time seemed to offer promise in the treatment of psoriasis. After several years' experience[1, 2] it was observed, however, that only a few patients were helped by it and they were those in whom the psoriasis was of recent origin and of the nummular type. I cannot see any objection to its use in conjunction with the tar ointment program in treatment of persons suffering from this form of the disease, especially when there is a tendency for the cutaneous lesions to involute spontaneously in the spring of the year, or in treating patients whose diet has been deficient for one reason or another.

The complications from the Goeckerman treatment are negligible, as no systemic manifestations of any type have been encountered. The occasional blistering, from the ultraviolet therapy, of the normal skin surrounding a psoriatic plaque is the most severe sequela encountered and is of only slight inconvenience.

In approximately 15% of the 2,000 cases in which I have used this treatment the disease has

* Boil 2 cupfuls (480 c.c.) of bulk oatmeal in 1 quart (1 litre) of water for thirty or forty-five minutes in a double boiler. Allow to cool for fifteen minutes and then add 120 c.c. of baking soda. Pour the entire mixture into a gauze bag and tie shut. Place in a bathtub a half to three-fourths full of water at 95° F. The patient may stay in the tub for half an hour to two hours, expressing the oatmeal mash through the gauze and applying it to the body. Wash the mash off thoroughly before leaving the tub. Dry by patting, not by rubbing.

not returned, while in approximately a similar group the plaques recur in two or three months after its completion. The remaining patients' remissions vary from several months to many years. The length of the remission is influenced by the persistence of the patient in carrying out some of the program at home at the first signs of recurrence. Although I wish to emphasize the point that I do not infer that this program of treatment is a cure for psoriasis it is, nevertheless, a procedure which psoriatic patients can resort to as often as is necessary in ridding them of their cutaneous involvement.

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OBSCURE PAINS IN THE CHEST, BACK OR LIMBS*

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THE object of this paper is to describe some obscure pains commonly encountered in practice, which are either omitted from textbooks, partially described under a meaningless term like intercostal neuralgia, or described only in advanced forms.

INTERCOSTAL CRAMP

Intercostal cramp probably affects most persons at some time. The writer has had it off and on since childhood. The public is familiar with the form called "a stitch in the side", coming on while running, but when a sudden cramp near the left nipple attacks a person at rest, it is commonly mistaken for a heart condition. So sharp and deep-seated is the pain that it feels as if the heart has been hooked on a rusty nail. The patient must remain immobile, breathing shallowly, as deep breaths are painful, until in a minute or two the muscle spasm relaxes and the ability to take a deep breath proclaims the end of the attack. A similar pain on the right side arouses little apprehension except in those aware of a dextrocardia. Explanation and reassurance is usually sufficient by way of treatment. If attacks are frequent a carminative might help, by altering the pressure relationships within the body cavity. Capps[1] advances the theory that a thoracic or abdominal stitch coming on during violent exercise is due to unilateral anoxæmia of diaphragmatic muscle, but spasm of an intercostal muscle will serve equally well to explain the type of pain described above.

LEFT INFRA-MAMMARY ACHE

Left infra-mammary ache, first adequately described by Doris Baker,[2] is encountered almost daily by the physician. Many patients mistakenly imagine it to be cardiac in origin. It is most commonly met with in nervous people, especially women. Frequently it is accompanied by neurotic symptoms such as sighing, breathing, or inability to get a satisfactory breath. Organic heart disease, and the effort syndrome, are often accompanied by this pain, no doubt due to the attention of the patient being centred on the heart. The pathology is obscure. The ache lasting continuously for hours or days at a time, usually over a period of years, at once differentiates this pain from angina pectoris. There is usually associated intercostal hyperæsthesia and tenderness. This would suggest fibrositis, but injections of local anæsthetics are ineffective. The usual treatment is reassurance, bromide and a holiday, with local heat and analgesics only if the pain warrants it. Intercostal cramp and left infra-mammary ache are not infrequently encountered in the same patient.

DIAPHRAGMATIC PLEURISY

Diaphragmatic pleurisy is another relatively common condition which often causes confusion in diagnosis. Capps[3] has shown that inflammation or irritation of the muscular part of the diaphragm is felt over the corresponding side of the lower thorax, abdomen and lumbar region in the distribution of the lower six thoracic nerves, whereas involvement of the central tendon is felt in the top of the corresponding shoulder or side of the neck, particularly along

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