most of the patients on insulin attend daily for their injection. The cost of transport, tropical rain, and any mild intercurrent illness resulted in irregular attendance. In the long run, therefore, management with oral preparations would probably be cheaper for the patients.

While not all diabetics will respond to oral therapy, this study shows that a large number of selected patients will respond satisfactorily to this particular drug. In view of its safety, as evidenced by liver-function, blood, and urine studies, stabinol appears to be a worth-while addition to the therapy of diabetes.

Summary

The antidiabetic effect of stabinol has been evaluated on a group of 33 patients with diabetes of the maturity onset type. Of this group three were lost to the study.

Of the remaining 30 patients, 15 (50%) were better controlled with the oral agent than they had previously been on insulin therapy, 9 (30%) were controlled equally well on either regimen, and 6 (20%) were not as well controlled on oral therapy as they were on insulin therapy.

Liver-function studies and blood and urine findings remained normal throughout the study.

There were no side-effects or abnormal reactions.

We wish to thank Frank W. Horner Ltd. for supplies of stabinol used in this study, and for a grant to one of us (M. F. H.); Ames Company for supplies of clintix; Dr. J. Ray MacDougall, medical director, Frank W. Horner Ltd., for advice and help; and the patients who volunteered for the trial. We are grateful to the Minister of Health, Water and Sanitation, and the Director of Medical Services for permission to publish these findings.

ADDENDUM.—Since the completion of this trial in April, 1959, 16 of these patients have been maintained on stabinol with very good or good control for a further eight months. They have been on the drug for over one year.

REFERENCES

- Baender, A. Conference on Current Trends in Research and Clinical Management of Diabetes. N.Y. Acad. Sci., N.Y., April 10-11, 1959.
 Chubb, F. L., and Nissenbaum, J. (1959). *Canad. J. Chem.*, **37**, 1121.
 Davis, T. W., Kerr, R. B., and Bogoch, A. (1959). *Canad. med. Ass. J.*, **81**, 101.
 Krall, L. P., and Camerini-Davalos, R. (1958). *A.M.A. Arch. intern. Med.*, **102**, 25.
 McColl, J. D. (1960). *Applied Therapeutics*. To be published.
 Mehnert, H., Camerini-Davalos, R., and Marble, A. (1958). *J. Amer. med. Ass.*, **167**, 818.
 McKendry, J. B. R., Kuwayti, K., and Sagle, L. A. (1957). *Canad. med. Ass. J.*, **77**, 429.
 Tulloch, J. A. (1957). *W. Indian med. J.*, **6**, 43.

Medical Memoranda

Callosities with Horny Plugs

Patients are often sent to dermatological departments with the diagnosis of plantar wart, when the lesion consists of a callosity in the centre of which is a little horny plug (Fig. 1). The callosity usually lies under the heads of the second and third metatarsals and may be associated with some degree of hammer-toe in the second digit. The condition is described in some orthopaedic books, where it is thought to be a form of callosity, but often it is diagnosed by general practitioners as a plantar wart; some dermatologists

believe this is correct. The treatment of these two conditions is so different—a wart being removed whilst a callosity requires an orthopaedic adjustment—that I have investigated a number of these lesions to see if it is possible to decide their true nature.

The histology of a plantar wart is characteristic, with ballooning of the cells and fragmentation of the nuclei spreading right up into the horny layer and giving a very bizarre appearance. In contrast to this the horny plug (Fig. 2) under discussion shows perfectly regular parakeratosis with uniform non-fragmented nuclei and a well-formed horny layer without any ballooning of cells or vacuolization. The column of parakeratosis

FIG. 1.—Callosity with little horny plug in centre.

FIG. 2.—Photomicrograph of section of horny plug.

ends more or less abruptly and passes into the hyperkeratotic horny layer of the surrounding callosity.

It seems clear, therefore, that these lesions are not plantar warts and that such treatments as radiotherapy or even curettage are unlikely to produce a permanent cure. They should be dealt with along the usual orthopaedic lines for a callosity.

F. F. HELLIER, O.B.E., M.D., F.R.C.P.,
Dermatologist, the General Infirmary at Leeds.