ings, and two cases which occurred before Miss Mabel Green had begun to draw for me. I include these two cases because they have already been referred to in the BRITISH MEDICAL JOURNAL, and are of especial interest.

The incisions only aimed at free removal of the cancer, with a sufficiently wide area of surrounding healthy tissue. Of the 14 patients, 3 are dead—one of nephritis and heart failure a year and a half after the operation, and without recurrence of the cancer; one of affection of the cervical glands without recurrence in the mouth; and one, who was operated on for cancer of the right border of the tongue, of cancer of the left border of the tongue, which he would not allow to be cut out until the glands were diseased beyond the reach of operation. The tongue between the two borders was quite healthy. The remaining 11 patients are alive and well at periods of eight months (1 case), one to two years (2 cases), two to three years (2 cases), three to four and a quarter years (6 cases). One patient of the last group, for whom I removed the left half of the tongue to very far behind the disease, and the lymphatic glands, suffered a year later from a fresh outbreak of epithelioma on the tip of the stump, where it was constantly rubbing against a large lower molar tooth, decayed and isolated. At the present time, three years after the removal of this second cancer, he is quite well. It may therefore be claimed that there is not a single case of local recurrence of the disease in any of the 14 patients, although 8 of them lived for three to more than four years after the operation. The glands were removed in 9 of the cases.*

The extent of the operation was generally quite out of proportion to the size of the cancer. But this was in order to remove long-standing leucoplakia and chronic superficial glossitis, from which the patient had in most cases suffered for years. On the other hand, there were two cases in which the cancer was removed between two elliptical incisions which were only just wide of its borders. In both these cases the disease was of very limited extent. The actual cancer in one of them measured about $\frac{1}{2}$ in. across by $\frac{1}{4}$ in. in thickness. It was one of the smallest cancers of the tongue which I have ever seen. The incisions passed pretty deeply into the muscular substance of the tongue. There was never any local recurrence, and the defect in his tongue was so trivial that his medical attendant, who had not been told of the operation, examining his mouth more than three years later to discover the source of infection of enlarged glands from which he was then suffering, did not perceive that his tongue had ever been operated on. Yet he died of epithelioma of his glands due to that tiny cancer. I have brought sections of another very small cancer of the tongue which was cut out by a very moderate operation, but which killed the patient through his glands, although it never recurred in his tongue.

At this moment, it would scarcely be too much to say that the air is charged with the emanations of radium. We are told that epithelioma of the tongue can be cured by radium. Had I been asked my opinion on this question a month ago, I should have said that, although two or three people in different parts of the world have claimed this power for radium, the general belief is that rodent ulcer is the only variety of malignant disease which radium is competent to cure. And I should have added that the only case of epithelioma of the mouth in my own practice to which radium had been applied (by the most skilful man with the best material) had ended disastrously. But I have, within the last few days, seen a case in which a typical epithelioma of the inside of the cheek is so much better, under the application of radium, at the end of four months that it looks as if it would be quite cured. And this has apparently been accomplished without inflammation or sloughing or profound ulceration of the disease. I understand that the radium in this case was applied by means of the disc. As this epithelioma was about $1\frac{1}{2}$ in. in diameter and ulcerated all over, when I saw it four months ago, there seems no reason to doubt that small epitheliomata of the tongue may be removed by radium, probably with a better scar than would be left by any

other efficient agent. But, having said this, it must not be forgotten that the removal of the primary disease is only part of the cure of epithelioma. Even the smallest, the youngest, and apparently the most insignificant epithelioma of the tongue is capable of affecting the lymphatic glands, as the cases I have related show. So that, unless radium is discovered to possess a far-reaching influence, spreading from the seat of the primary disease to the associated lymphatic glands, I am afraid that the surgeon must still occupy an important place in the treatment of epithelioma of the tongue.

UNNA'S METHOD OF TREATING ULCERS OF THE LEG.

By GEORGE PERNET, M.D.

WITH reference to the abstract of a German paper on Unna's bandage published in the EPITOME of January 16th, 1909, par. 33, I should like to point out that Dr. Hecker has missed an important point in the mode of application. I have treated a good many varicose ulcers of the leg by Unna's method, especially when I was out-patient assistant to Sir Victor Horsley at University Hospital. At that time I looked up Dr. Unna's original paper on the subject and carried out the method on the lines laid down by him, and I may add with very gratifying results.

In as few words as possible, the following is the *modus operandi*:

The ulcer itself is cleaned up with a 1 in 2,000 solution of mercury perchloride. Iodoform is then dusted or blown on to the floor of the ulcer only. In one instance only of the hospital series first treated (1891-2) by me in this way did I see iodoform dermatitis produced, but that was characteristic and rather severe. Some of the substitutes for iodoform are therefore to be preferred for this and other reasons.

Unna's gelatine paste, liquefied in a hot water bath, is then painted on the parts surrounding, but not on the ulcer itself, well beyond the latter, and wherever there is redness or discoloration of the leg. A good formula is that of the *U.C.H. Pharmacopoeia*:

Zinc oxide	...	...	10 parts
Gelatine	...	...	15 "
Glycerine	...	...	30 "
Water	...	...	45 "

Fig.: Soak the gelatine in the water for two hours; add the glycerine; apply a gentle heat till dissolved; stir in the zinc oxide to a smooth consistence; allow to cool.

Two or three double-headed 3 in. muslin bandages (in one piece rolled from either end, and not bandages made by stitching the ends of two ordinary bandages together) are next required. Muslin, such as is used for plaster-of-Paris work, answers very well. I now use sterilized bandages of this kind, put up separately. A two-headed bandage is wrung out in warm (sterilized) water, and the middle of the bandage is then placed on the leg opposite the ulcer, the two heads being firmly held one in each hand. The first turn is then made with pressure vigorous enough to reduce the diameter of the limb, the bandage being brought well over the ulcer. This way of employing the two-headed bandage is the crux of the whole matter, and the central idea of the method, and is a very different thing to bandaging from the toes upwards as recommended by Dr. Hecker. The bandage is then taken round the leg, with firm pressure, especially over the actual ulcer, allowing the turns to take one more or less where they list, the two hands being used for this purpose, and the turns being evenly applied, an easy matter, the bandage being wet. Meanwhile the liquefied paste is painted on the bandage as it is wound round the limb, either by the patient or an assistant. Two or three bandages can be used in this way, a few figure-of-eight turns being taken under the foot in order to fix. The result is a splint, which allows patients to go about their work as usual. If there is a great deal of discharge from the ulcer the bandage will require to be changed the next day, but after the first few days the bandage can be left on for several days together.

The method in its principles is really the same as our English one of strapping ulcers (Baynton's), but it is more

* I am not sure whether the glands were removed in another of the cases. Two of the patients were operated on by Mr. D'Arcy Power at St. Bartholomew's Hospital, and I was present at the operations. Mr. Power thinks that he removed the glands of one of these patients (the man who died of nephritis) a few days later. But the notebooks do not contain a record of the operation.

elegant and more efficacious. The point to bear in mind is the firm pressure on the edges of the ulcer in order to flatten them down. I repeat this because what is called Unna's method of treating *ulcus cruris* is frequently performed in a very perfunctory and inefficient manner, the idea which underlies it being entirely overlooked.

I have obtained very good results by this method; in some cases, indeed, excellent. In the case of women especially, such as laundresses, charwomen, etc., the patients are able to follow their occupation with comfort and earn their living, so precarious at the best of times—an important item for these poor people under existing social arrangements. Of course, wherever possible, I agree with Dr. Hecker when he says the bandages should be applied "before the patient leaves bed." Personally, when ordering ordinary bandaging of the legs from the root of the toes upwards to support varicose veins, I have for a good many years recommended patients to do this before they got up in the morning, namely, before the effects of gravity in the vertical position came into play.

Memoranda:

MEDICAL, SURGICAL, OBSTETRICAL.

X-RAY TREATMENT IN VENEREAL SORES AND BUBOES AFTER OPERATION.

THE patient is placed on his back with his head raised. A strip of lead, 9 in. wide, with a central hole, is placed over the penis; above and below this is placed foil covering the body from the neck to the knees. A small piece of lead, which has an opening just a little larger than the sore, is placed over the penis, so that the sore is exposed; the patient, using both hands, steadies the foil and the penis; the hands and arms are covered with foil. The tube is 6 in. distant from the part. The tube must be soft (about 2 in.); the ampérage about, but not exceeding 4. The exposure is of five minutes' duration. After four days, if there be no reaction, a further exposure of five minutes is given; after four more days, if there still be no reaction, a further five minutes is again given, continuing until a reaction is produced, when the exposure is reduced by one-half, other conditions remaining the same, and the interval is extended to seven days. The applications are continued until the sore heals, and stopped directly the first signs of radio-dermatitis are noticed. The patient should be made to understand thoroughly the value of absolute cleanliness.

In the case of buboes which have been operated on the method and exposure are precisely the same—a small piece of foil surrounding the part and protecting the tissues in the vicinity.

All the lead in actual contact—that is, the "apron" and the small pieces—are boiled daily after use, the larger pieces once a week, unless they get soiled in any way. Each patient has a sterile piece of lead in contact for each exposure. Iodoform, calomel powder, or other dressings must be removed from the part to be treated before exposure, as they absorb the x rays. The usual dressing subsequently employed is sterilized gauze for open buboes, mercury perchloride (1 in 2,000) on lint for venereal sores.

The results have been extremely valuable. The healing of the chancre is considerably accelerated, in all probability in less than half the time as contrasted with any other local measures.

In the case of venereal sores the tendency to suppuration of or hyperplastic matting of the nearest lymphatic glands is also reduced, a matter of extreme importance as regards the efficiency of the soldier. The healing of large operation wounds after excision of broken-down glands and scraping of the bubo is markedly accelerated, the suppuration is lessened, and more healthy granulations make their appearance.

I have no knowledge of x rays having ever been used in the above class of cases.

H. C. FRENCH, Major, R.A.M.C.

Royal Herbert Hospital, Woolwich.

AURAL IMPACTION OF A CHERRY STONE FOR TWENTY YEARS.

WHEN I first saw the patient in the following case—as a locumtenent after her confinement—I noted a discharge

from the right ear. Just inside the external meatus, and completely occluding the canal, was a rounded mass bathed in pus, which I thought might be a large polypus. Having no instruments with me I postponed closer examination, simply giving instructions for the ear to be syringed with warm boric lotion three times daily. On my next visit, two days later I found that the ear having been very painful, poultices as well as syringing had been used, and the body I had observed but not identified had been extracted in two halves; one had come away with the poultice the previous evening, the other the morning of my visit. The former had been thrown away. The latter I saw and examined. It was half a cherry stone covered with a loosely adherent membrane and cartilaginous in appearance. The interior was honeycombed and bathed in pus. Both pieces came away without any sort of assistance—simply adhering to the poultices. The patient's mother, who was present, gave me the following history:

When aged 5—or twenty years before I saw her—the patient pushed a cherry stone into her ear, and immediately told her mother. It was not far in, and the mother tried to extract it with a pin, but only pushed it deeper. For the next few years the stone remained visible, and caused periodical attacks of earache. Frequent attempts were made by the mother to extract it by means of hairpins and the like; but it got pushed further in by degrees, and eventually could not be seen. No medical man was consulted. The stone continued to cause deafness and frequent attacks of earache, but there was no discharge from the ear until the seventh month of her recent and second pregnancy. The earache then became more severe and persistent and a slight purulent discharge appeared.

During her subsequent delivery—that after which I first saw her—the patient "felt something burst" in her ear during a pain, and the discharge soon became more profuse, the earache continuing; sixteen days later the stone was extracted as stated. It would seem that it had been dislodged from its deep position, and possibly broken, during the straining of childbirth, and, once loosened, was gradually forced outward by the pus behind it, until finally, with the aid of syringing and poultices, it came out altogether.

Bournemouth.

J. E. ESSLEMONT, M.B., Ch.B.

REFLEX COUGH.

A few days ago I was called to see a boy whose parents had lately come into the district.

The history was that for the last eighteen months, following an attack of whooping-cough, he had suffered from a distressing cough, so severe that he had been sent home from school "as he kept the other boys awake at night." The patient had been under treatment the whole time in various parts of the country. On examination nothing was found in the chest, nose, throat, or mouth to account for the cough, which was of a typical reflex type. The right ear, however, showed a quantity of cerumen, and on gently syringing I was able to extract a large mass, embedded in the centre of which was a complete clover flower about the size of a marble. This foreign body had given rise to no ear symptoms nor could I fix the date of its entry. The cough ceased within a few hours and the boy has returned to school.

My only excuse for reporting this somewhat trivial case is to draw attention to the necessity of a systematic examination of all organs which may be irritated reflexly and so give rise to symptoms which refuse to yield to routine treatment.

Limpfield.

J. REGINALD BENTLEY, M.B., B.C. Cantab.

WE are requested by Dr. Grosz, Secretary-General of the Sixteenth International Medical Congress, which is to be held at Buda-Pesth from August 29th to September 4th this year, to call the attention of those who propose to take part in the proceedings of the Congress to the regulation that the manuscripts of their communications should be dispatched by February 28th, 1909, at latest, to the office of the Congress, VIII Esterházy-utca 7, Buda-Pesth (Hungary). We would also remind our readers that the subscription to the Congress is twenty-five crowns in Austro-Hungarian currency, which sum may sent by post-office order to Professor Dr. de Elischer, Treasurer of the Congress, VIII Esterházy-utca 7, Buda-Pesth.