AMBULATORY TREATMENT OF VARICOSE ULCER.*

BY

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VARICOSE veins are met with in men and women in all grades of society, but varicose ulcer is almost entirely confined to the wives of working-class men—women who, as a rule, have had large families, and who have to work all the waking hours all the days of their lives. So injured are some of these women to the pain that they hesitate to have the ulcer healed lest some other and greater misfortune should overtake them.

Our experience, gained during the past twelve months, shows that most ulcers of the leg can be healed, and over 80 per cent. can be cured; it favours a special clinic for ulcers of the leg, since it is difficult to give these patients the attention they require in the ordinary course of a mixed clinic.

In each case of chronic ulcer a complete history is taken and a description of the ulcer is recorded for future reference. The Wassermann reaction is always determined, and should this be positive appropriate treatment is given. Varicose veins are treated by injection, and their cure has rendered the prognosis for varicose ulcer much better than formerly.

INJECTION OF VARICOSE VEINS.

This operation is performed in the out-patient clinic, and the following solutions are used.

1. Quinine hydrochlor.	...	...	...	4 grams
Urethane	...	...	...	2 grams
Aqua dest.	...	...	...	30 c.cm.
2. Sodium salicylate	...	...	...	111 grains
Novocain	...	...	...	5 grains
Aqua dest.	...	...	...	444 minims

The initial dose of either of these is 1 c.cm., and if no idiosyncrasy is observed 2 or 3 c.cm. can be injected at future sittings; it is advisable that 1 c.cm. should be given at each puncture, and at intervals of about two inches on the vein. The injections are given weekly.

Technique.—The patient is seated at a convenient height with the foot of the leg to be treated on a rest. The site for the injection is painted with iodine, and a tourniquet is applied above the selected site. When the needle of the syringe has been introduced into the vein the tourniquet is released and the forefinger of the left hand is placed on the distal side of the needle to compress the vein, the middle finger being used to compress the vein above the needle. The middle finger is then firmly separated from the forefinger so that the underlying vein will be emptied. The injection is made and, before the needle is withdrawn, a pad is so placed that compression will prevent the solution from passing along the needle tract. The fingers and pad are kept in position for three to four minutes, after which they are released and collodion is applied to the puncture.

It is not advisable to inject veins very near the ulcer, lest infection of the thrombus supervenes. Hard edges of ulcers are freely scarified, and if, as frequently happens, there are aneurysmal dilatations on the veins immediately above the ulcer, they should be opened and allowed to bleed empty. Following scarification a dry gauze and wool dressing is applied for twenty-four hours.

The "ulcer and leg" is now dressed with Unna's zinc-gelatin, which dressing is kept on for one week; at the end of this period the dressing is removed, the leg is cleansed, and a new dressing is applied. The formula for the zinc-gelatin is:

Zinc oxide	...	...	...	...	10 parts
Gelatin	...	...	...	...	6 "
Glycerin	...	...	...	...	14 "
Aqua	...	...	...	...	24 "

This forms a stiffer dressing than the usual formula for this preparation and is strongly recommended.

Technique.—The patient is seated at a convenient height and the foot is placed on a rest. The zinc-gelatin, warmed to make

* Read before a meeting of the Lancashire and Cheshire Branch of the British Medical Association.

it liquid, is painted on the leg and ulcer with an ordinary paint-brush and a gauze bandage is applied—two or three layers of bandage are employed. It is important to note that the entire ulcer is covered with the dressing, no window being left.

Those who have not tried this dressing often object to a discharging ulcer being covered, but it can be done with confidence, and though the ulcer may, as frequently happens, be bathed with pus, when the dressing is removed the edges of the ulcer will show a tendency to heal, which will eventually go on to complete cure. Such a procedure will rapidly cure varicose ulcers.

A word of warning is necessary with regard to the injection of very small varices which are met with in many patients. If such cases are injected the patient should be put to bed for twenty-four hours following the injection, since swelling ensues, and gangrene with the formation of a slow-healing ulcer is liable to occur.

We have during the past twelve months treated nearly seventy ulcers, with marked success in every case. Ulcers of long standing—in one case of twenty-three years—have healed, and still remain so. Patients are asked to report at regular intervals after discharge, so that we may observe the result.

THE TREATMENT OF PROGRESSIVE MUSCULAR ATROPHY BY PARATHYROID, CALCIUM, AND VITAMIN D.

BY

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By the administration of parathyroid extract, calcium, and vitamin D recently in the Presidency-General Hospital, Calcutta, results have been obtained in two cases of non-luetic progressive muscular atrophy which, while they have not attained a degree exceeding mediocrity, perhaps, are nevertheless striking and gratifying.

The method of treatment employed at the outset was the hypodermic injection of parathyroid extract 1/10 grain daily, together with cod-liver oil 1 ounce twice daily by the mouth, and calcium chloride in solution 15 grains three times daily. Later this treatment was modified: ampoules were substituted for the tablet form of parathyroid extract, colloidal calcium took the place of calcium chloride, and ostelin, 4 minims twice daily, was given in addition to the cod-liver oil.

CASE I.

The first patient, admitted on November 26th, 1927, was an Anglo-Indian, aged 34, who gave a history of sixteen years' duration of gradually progressing muscular weakness and wasting. This case was clinically of the pure lower motor neuron type, weakness and wasting being especially marked in the ulnar muscles of both hands and forearms, the biceps and triceps of both sides, the muscles uniting the scapulae to the spinal column, the muscles of the back, and the anterior tibial muscles with marked foot-drop. Weakness without appreciable wasting was present in the hamstring muscles of both sides. A somewhat remarkable feature of the case was excessive wasting of the sterno-mastoid muscles, amounting to almost complete absence. With the exception of the sterno-mastoids all the muscles reacted to faradism. The gait consisted of a peculiar goose-step, owing to the weakness of the hamstrings and the foot-drop. There was considerable lordosis; the patient had to be assisted to his feet, and could not walk unaided.

The treatment above outlined was begun on December 12th, 1927. About three weeks later he surprised all concerned with the statement that he was improving. It was found, however, that he could dorsiflex both feet just a fraction of an inch. Further slow progress occurred, and at the present time he can approximate his scapulae in the mid-line posteriorly with the hitherto completely paralysed rhomboid muscles, exert quite an appreciable grip with both hands, and can flex and extend both arms at the elbow against some slight resistance, which he could not do previously. He sits more erect in a chair, and there is unquestionably great improvement in general health and muscular tone. There is but little change in his gait, though he walks with greater steadiness, and has somewhat greater facility in lifting his toes from the ground.

CASE II.

In the case of the second patient, a European aged 40, admitted on January 5th, 1928, the progress of the disease had been far more rapid, the first sign of weakness having occurred less than three years previously. This was a case of amyotrophic lateral sclerosis with profound wasting and *main-en-grippe* deformity of both hands, with ankylosis of the metacarpophalangeal joints. There was extreme general wasting and spastic paralysis of the