ciently adhesive to make it adhere to the part to which it was applied; its melting point was such that it did not liquefy at the ordinary heat of the body; and being spread upon substances as deficient as possible in elasticity and stiffness, it readily took the shape of the part to which it was applied, its adhesiveness keeping it in close contact with the skin. The plaster is dull white, about the thickness of the back of a table-knife, and is spread either upon paper, or on a paper made of palm-fibres, or upon thin kid or strips of muslin. In cold weather the surface of the plaster may need to be slightly warmed before the fire or firmly pressed on the skin if it is wished to make it adhere readily. Care must be taken in warming the plaster not to melt it. Before putting it on, all crusts, scales, etc., must be removed from the affected parts, either with the soap treatment or other means, in the same manner as before applying diachylon-ointment spread on rags. The skin to which the plaster is to be applied having been carefully dried, and the plaster being cut so as to slightly overlap the part which it is to cover, it is to be firmly pressed on the skin, when it will adhere sufficiently to maintain its position.

If the part is discharging, it is advisable to put on a new piece of plaster two or three times daily, the part being thoroughly cleansed, washed, or bathed with lotion in the same way as when diachylon-ointment is used. In cases where little or no discharge is present it will suffice to put on a fresh piece of plaster once or twice daily, removing the discharge, if any is present, before putting on a fresh piece. If there is no irritation and the part is quiescent, the same piece of plaster may be left untouched for two or three days or a week. The plaster itself gives some mechanical support to the skin to which it is applied, which has a remedial action. If it is desired to give a part a more pronounced support, a bandage can be placed over the plaster in the way in which it is applied to a limb dressed with diachylon-ointment. For the limbs, if it is desired to envelop the whole limb, the most suitable form of plaster is that spread on strips of muslin, which can be applied overlapping one another, and crossing in front, in the same way as limbs are usually strapped with diachylon-ointment.

One of the advantages of plaster over ointment spread on rags is that, by its own adherence, it will remain applied to parts to which it is difficult to keep ointment in close contact. The plaster which I have had made will maintain its position without the aid of bandages, etc.; for example, on the face (especially in children), round the neck, under the arms, in the flexures of the elbows and knees, on the wrists, the palms or backs of the hands and fingers, and, of course, on any part of the body. In cases of eczema, the groins, and penis, and scrotum can often, with advantage, be enveloped in it spread on thin kid. In parts exposed to much friction, such as the wrists or hands, the plaster will last longer if protected by a glove or piece of bandage. The plaster on muslin is neither detached from the skin nor destroyed by immersion of the part in cold water.

The conditions of disease in which such plaster can be used with the greatest advantage are those in which spread diachylon-ointment is of so much service. This is chiefly eczema. In eczema of the palms and soles, and in the drier forms of this disease, it has, in my experience, proved especially useful. In most cases of this complaint in the flexures of the limbs it gives comfort and causes rapid amendment, while in eczema of the neck and of the groins, scrotum, etc., it will often give relief, and remove the disease when other local measures have failed; and it takes away the necessity for the galling and inefficient bandages and supports that are required to keep dressings in position in cases of this distressing complaint on the lower part of the body and under the arms. It can also take the place of the cumbersome and unsightly masks spread with ointment in which it is sometimes found necessary to enclose the faces of children suffering from eczema. The plaster can also be used in other complaints in which spread diachylon-ointment is serviceable, such as *syccosis*, very inflamed *psoriasis*, etc.

For some years past I have used the plaster I describe in a large number of cases of cutaneous disease, and I have found it very useful, many cases of eczema in the hands and lower part of the body yielding to this treatment when other measures had failed. The form of plaster I now use has only been arrived at after repeated experiments and modifications. Any drug the action of which is desired can be incorporated in the diachylon-ointment plaster, in the same way as it can be with diachylon-ointment, but it must not be of such a kind as to combine chemically with the lead base of the plaster.

The advantages of this plaster are:

1. Its ease of application.
2. Its healing and soothing influence, principally in cases of eczema—especially in its less acute forms—retaining the remedial action of diachylon-ointment without its inconveniences.

3. The mechanical closeness of its application to the skin.
4. No additional means are required to keep this dressing in position, but can be used with it if required.
5. Its neatness, cleanliness, and cheapness.

THE ETIOLOGY OF VARICOSE VEINS, WITH NOTES OF DISSECTIONS.

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THE causes of varicose veins have been differently explained by various writers, such as the effects of gravity, the passage of veins through constricted openings in fascia, debility, pregnancy, the pressure of tumours, and a host of other causes, but I wish to mention causes which are readily explained by studying the anatomical arrangements of the veins, more especially of the lower extremity, where the varicose condition is most common.

During the past two years I have dissected four subjects, where there were well-marked varicose veins, and certain points which I noticed seem to me to offer a more satisfactory explanation than those usually mentioned.

1. In all cases the internal or long saphenous vein was varicose.

2. The only portion of the short saphenous vein which was varicose was that part which lies in the popliteal space after it has pierced the deep fascia.

This part of the vein was distinctly varicose in each, and in one it was enormously dilated and sacculated, while the rest of the vein was normal. In these I could find no trace of valves at the point where the saphenous vein enters the popliteal.

3. The deep veins were not affected in any of the cases.

In one other subject I have noticed a well-marked varicose condition of the popliteal vein, while the rest of the deep veins were normal.

I must mention that in a frozen section of the leg, kindly shown me by Professor Chiene, there was some dilatation of the deep veins, but this I believe to be exceptional.

One of the most important factors in carrying on the venous circulation is compression during muscular contraction, and this affects most forcibly the deep veins which are mostly surrounded by muscles, while we find that the circulation in those veins which are not supported by muscles, such as the superficial veins, the hæmorrhoidal and spermatic veins, always tends to be sluggish, and often results in varicosity.

Now, in walking and standing, the contraction of the muscles compresses the deep veins, and the amount of blood passing through the superficial veins is increased, and, in consequence, these veins tend to become dilated.

This affects more especially the long saphenous vein, which lies between skin and bone, in a great part of its course, being thus unsupported by muscles, but, this determination of blood to the superficial veins does not cause a dilatation of the short saphenous vein, because the contraction of the muscles of the calf compresses it against the skin, which is rendered tense by the thickening of the limb caused by the contraction of the muscles; but that part of the short saphenous which lies in the popliteal space does tend to become dilated, as it is not supported by the contracting muscles, in fact, as regards muscular support, its position is comparable to that of the long saphenous vein, thus explaining the fact of its being varicose in this part, and healthy in the rest of its course.

One often notices that during pregnancy, a varicose condition of the superficial veins of the lower extremity appears rather suddenly, and this condition appears usually in two distinct and fairly constant positions, one being in the popliteal space, where the short saphenous becomes much dilated and tortuous, which is explained by want of support, the other position, being just above the ankle in the course of the long saphenous vein, the predisposing causes here being want of support, together with a curve that exists in the vein in the region of the internal malleolus, the blood from the foot meeting at this point with the pressure of a vertical column of blood in the vein beyond.

I am aware that a varicose condition is sometimes seen extending along the whole course of the short saphenous vein; but what I maintain is, that in a large proportion of cases the dilatation commences above in the short saphenous, but below in the long saphenous vein, conditions which I think are satisfactorily explained by the points mentioned above.