interfered with the relationship between the doctor and his patient; where we suspect this may be happening the social worker is ready to withdraw. As doctors and social workers gradually increase their awareness of the emotional factors associated with illness and develop appreciation of the skills needed to deal with them, a closer working relationship between the two professions may be one answer to the frustration expressed by Dr. Davis.—I am, etc.,

Manchester. MADGE DONGRAY,
Social Worker,
Darbishire House Health Centre.

Aldosterone Excretion in Pregnancy

SIR,—Dr. M. G. Rinsler and Miss Barbara Rigby (*Journal*, December 14, 1957, p. 1436) have the impression that I believe the aldosterone was diluted in an increased extracellular fluid (E.C.F.), whereas I meant to state that the large amounts of aldosterone hoarded in the adrenals until the beginning of some allergic reaction are suddenly released into the circulation and that much aldosterone passes through the walls of the capillaries, actively drawing sodium ions and serum out of the circulation into the E.C.F.; and that the E.C.F. will increase as more and more aldosterone passes into the E.C.F. Haemoconcentration is the result of this, and it may very well happen that so much aldosterone leaves the circulation that ultimately only a small amount will be offered to the kidneys for excretion. The fall in urinary output of aldosterone is not caused by the rise in E.C.F., as Mr. J. Sophian (*Journal*, December 14, p. 1436) suggests, but the rise in E.C.F. is caused by the passing of so much aldosterone into the tissues in cases of severe toxaemia of pregnancy that only a small amount is available for excretion through the kidneys.—I am, etc.,

Amsterdam. R. SCHUURMANS.

Amnion Implantation in Peripheral Vascular Disease

SIR,—I have implanted "home-made" amnion into the legs of four patients with arterial obstruction. Three of the patients were male and one female, and the disease could be classed as stage 2. The results, like those of Mr. H. Dendy Moore (*Journal*, December 7, 1957, p. 1350), were unsatisfactory; in fact, no benefit at all appeared to be derived from the amnion implant. My series is a small one, but the results were so disappointing that I have reluctantly abandoned the operation.—I am, etc.,

Doncaster. DAVID AIKEN.

Treatment of Leg Ulcers

SIR,—I have followed the correspondence on ulcerated legs with interest and profit. In supporting Mr. Harold Dodd's excellent summary (*Journal*, December 21, 1957, p. 1492) of the modern approach to this problem, I would like to make a few personal observations. As Mr. Dodd says, the most important aspect of the management of these cases is the tendency to recurrence. Pressure bandaging is of undoubted value, but, in my view, this is too mechanistic an approach. Why do the majority of relapses occur at home and not in hospital? Surely because in hospital the patient has that rest to mind and body which for the most part she (for the patient is usually a woman) cannot have at home, and that attention to hygienic principles which again she tends to neglect. It is true that leg ulcers afflict all classes of society, but it is the under-privileged who suffer most—elderly pensioners, widows, middle-aged working women, mothers with large families, and the like. It is a fact, too, that the limited degree of insight and intelligence of these patients and their relatives is an added factor, although it is also fair to say that such insight is often dimmed by the enforced difficulties of the domestic state. The doctor, therefore, whether in hospital or surgery, is often compelled against his better judgment to return these patients to the very conditions which contributed to ulceration in the first place. In posing the social aspect of these cases I am aware that there seems little to be done in mitigation of them at present. Bearing them in mind, however, must surely help us in assessing the results, however good, of purely mechanical measures.—I am, etc.,

Romford, Essex. I. M. LIBRACH.

SIR,—With reference to Mr. A. Dickson Wright's interesting letter (*Journal*, November 9, 1957, p. 1111), I would like to mention a most pleasing success I have had recently in a chronic leg ulcer of 15 years' duration by using the principle of sustained pressure.

A 42-year-old farmer was seen four weeks ago with a chronic ulcer on his right leg (4×2 in.—10×5 cm.) for which he had taken various treatments at much expense and had eventually taken to self-treatment with indigenous dressings. Surprisingly he had never before been suggested the simple treatment so well emphasized by Mr. Dickson Wright. With ordinary crêpe bandage (elastic and non-adhesive) applied over many pieces of sterilized lint and chlortetracycline ointment, the ulcer healed completely in four weeks' time. The patient's gratitude was indescribable, for he had given up all hopes of cure.

I have previously treated half a dozen other cases of leg ulcers with elastic bandage, and I really don't think there is any advantage in choosing the adhesive type: the simple 3-in. (7.5-cm.)-wide crêpe bandage is just as good and very much easier to apply. I hope Drs. Keith Ball and David Phear's excellent article (*Journal*, October 12, p. 861) and the ensuing correspondence on the treatment of leg ulcers will make the importance of sustained pressure more widely known and more carefully practised.—I am, etc.,

Bhusaval, India. S. L. MALHOTRA.

SIR,—Mr. Harold Dodd's letter (*Journal*, December 21, 1957, p. 1492) is full of wisdom and help in this intriguing question of ulcerated legs. Since Trendelenburg, the severance of deep venous communications has been the object of surgical treatment, and most of them have been run to earth now. The stripping out of veins was initiated by Mayo[1] and Babcock,[2] and injections by Linser,[3] Génévrier,[4] and Sicard, Paraf, and Lermoyez.[5] The plastering of ulcers was even further back than the three hundred years mentioned by Mr. Dodd. Shakespeare[6] in 1611 gave his views:

Gonzalo: . . . You rub the sore,
When you should bring the plaster.
Sebastian: Very well.
Antonio: And most chirurgeonly.

showing that he was opposed to the physiotherapist, the nurse, and the patient in the management of the ulcer.

When I first grew interested in ulcerated legs 30 years ago, there was great neglect of the sufferers, although the value of occlusion and compression was known. It was like unto the way to salvation: many knew it but so few got saved. Now I fear that we backslide again, leaving the sufferers to various ancillaries and fox the question by bringing in sympathectomies and local dressings and salves. The condition clearly is due to a circulatory imbalance often episodal in character, as witness the long periods of cure which occur after bandaging without curative treatment being possible as regards the veins. The circulatory imbalance can be remedied in many cases by judicious operations on the veins, but there is always a hard core of cases not to be so helped. For these the bandaging techniques are the only hope. Many regain circulatory balance and can exist without support or with modified support in the daytime. There is a second hard core like the case to which I referred in my first letter, in which the alternative is amputation or perpetual support, continuing to use plastic foam beneath the elastic adhesive or other bandage which was used to heal the ulcer.—I am, etc.,

A. DICKSON WRIGHT.

REFERENCES

1 Mayo, C. M., *Surg. Gynec. Obstet.*, 1906, 2, 385.
2 Babcock, W. W., *N.Y. med. J.*, 1907, 86, 153.
3 Linser, P., *Med. Klin.*, 1916, 12, 897.
4 Génévrier, J., *Soc. méd. milit. franç. Bull.*, 1921, 15, 169.
5 Sicard, J. A., Paraf, J., and Lermoyez, J., *Gaz. Hôp. Paris*, 1922, 95, 1573.
6 Shakespeare, W., *The Tempest*, Act II, Scene 1.