tallow—and accordingly any object resembling tallow might be so called. However, this is not to say that the contents of the cysts were ever produced by sebaceous glands. Clearly, tallow is not so produced. In Ackerman's *Surgical Pathology*[2] is the statement, "True sebaceous cysts are lined by sebaceous cells. . . ." But I cannot recollect ever seeing such a specimen.

It is submitted, therefore, in all seriousness, that one of the commonest conditions diagnosed in the casualty department either does not exist or at best is exceedingly rare. It is further submitted that since surgeons still apparently teach that it occurs frequently—and is diagnosable—they should produce evidence. In default of such evidence I suggest a more critical evaluation of "Seb. cysts." "Epidermoid cyst" is perhaps the best current term for the cyst composed of stratified squamous epithelium, without appendages, and whose contents are shed squames.—I am, etc.,

Sheffield. J. L. EDWARDS.

REFERENCES

[1] Lund, H. Z., *Tumors of the Skin*, 1957, sec. 1, fasc. 2. Armed Forces Institute of Pathology, Washington.
[2] Ackerman, L. V., *Surgical Pathology*, 1953, p. 95. Kimpton, London.

Topical Steroids for Skin Conditions

SIR,—I have recently carried out a small therapeutic trial of prednisolone ointment, the results of which seem worth publishing.

The trial was carried out on in-patients, and the effect of 0.25% prednisolone was compared with 1% hydrocortisone, each used in a water-miscible base. When local steroid hormone treatment was ordered by me, the test substances were dispensed to alternate patients by the sister in charge and I was ignorant of which application the individual patient was given. Thirty patients in all were treated, the ages varying from 12 to 80, and the diagnoses being Besnier's prurigo, intertrigo, flexural psoriasis, "varicose" dermatitis, solar dermatitis, contact dermatitis, exfoliative dermatitis, and endogenous eczema. On final analysis, at the conclusion of the test, the age, sex, and diagnoses were found to be almost identical in the two groups.

The results of all the applications were noted at the time as being "satisfactory," no difference being noted then or on analysing the notes subsequently. Prednisolone is approximately four times as active as hydrocortisone when given systemically, and it now appears that it is equally potent when used topically. In general, a greasy base is more efficacious than a water-miscible base as a vehicle for hydrocortisone, and the same will probably be found for prednisolone.—I am, etc.,

London, W.1. PETER BORRIE.

Ethanolamine Oleate

SIR,—For many years I have used ethanolamine oleate as the sclerosant in the treatment of varicose veins by injection, but recently I encountered an alarming reaction to it.

I was treating a woman of 32 with only moderate varicosities. When she came back for her second injection a week after the first she complained of having had a severe rigor in the night after the first. She had been shivering and shaking for about half an hour. Although this might have had nothing to do with the injection, I decided to give her a much smaller dose the second time to be on the safe side. But again she had this alarming rigor during the night. Obviously she was allergic to ethanolamine oleate.

Apparently this is not common, for Bailey and Love in their well-known textbook *A Short Practice of Surgery* (10th edition, 1956) write of the drug: "Allergy can occur, but only after a prolonged course which, with modern treatment, should not be necessary." In the present case the reaction occurred after the first injection, however.—I am, etc.,

Merioneth. CLAUD C. M. WATSON.

Industrial Dermatitis

SIR,—Dr. Sydney Thomson in his article (*Journal*, May 17, p. 1135) mentions friction (from scratching) as a perpetuating factor in dermatitis. But there is another way in which friction plays a part in dermatitis and it is one which concerns the industrial doctor. Friction is one of the "plurality of causation factors," to use Dr. Thomson's own expression. Some violent agents need no help from friction to cause dermatitis. But most chemicals used in industry are mild in action and need the aid of friction to start a rash. Examples are numerous. Cutting oils do not cause a rash where the oil contaminates the skin, but only where the oil is rubbed into the skin, as when oil-soaked trousers are worn. In fact it seems safe to work with the bare skin if the oil can flow on and off without hindrance or friction. Similarly with mild alkalis.

I can recall much dermatitis from a case-hardening compound. The workplace was thick with charcoal and sodium bicarbonate, but the dermatitis occurred on the backs of the hands, which were used for tamping the substance into case-hardening pots. If a gardening trowel was used the handle was used for the tamping process and no dermatitis was seen, even though the skin became dusty. In the construction of gliders during the last war dermatitis from the resin-glues started on the backs of the fingers because this portion of the skin was rubbed into the resin while inserting tacks or screws into the wood. It did not matter so much that dried resin contaminated other non-friction-bearing areas of skin.

This simple observation sometimes suggests a remedy in that the cure lies in a slight alteration of technique. It entails also recognition that the friction which triggers the rash must perforce also remove a barrier cream.—I am, etc.,

Chester. G. WHITWELL.

Ulceration after B.C.G.

SIR,—Serious complications following B.C.G. vaccination are fortunately rare, but minor local complications are not uncommon. The latter cannot be dismissed as unimportant, however, because they are unpleasant, and a tiresome experience with one child may make parents reluctant to have other members of the family vaccinated. The common local complications are prolonged ulceration at the vaccination site and adenitis in the regional lymph glands. Although lymphadenitis always resolves spontaneously, glands may remain palpable for a very long time and may eventually calcify. If adenitis progresses to abscess formation then healing is usually extremely slow, but recovery can be accelerated by surgical curettage.[1]

In the past it has been common practice to treat persisting B.C.G. ulceration with local application of anti-tuberculous drugs such as para-aminosalicylic acid (P.A.S.) or isoniazid. The response to these drugs is slow, however, and it was therefore thought worth while to search for a more rapidly effective treatment. The ideal local application should be effective against both B.C.G. and secondary pyogenic invaders. It would have added advantage if at the same time it suppressed inflammation and discouraged the formation of unsightly scar tissue. Neomycin is effective against tubercle bacilli,[2] and together with bacitracin forms an antibiotic combination which is topically active against the majority of common pyogenic organisms. Hydrocortisone was selected as the anti-inflammatory agent, and a preparation containing these three drugs, "hydroderm" (hydrocortisone 1%, neomycin sulphate 0.5%, and bacitracin 1,000 units per gramme), was therefore obtained for trial. All patients were vaccinated with 0.1 ml. of Danish vaccine intradermally and were selected for treatment if ulceration was present three months after vaccination and was not showing signs of healing. The hydroderm ointment was applied to the ulcer twice daily on cotton gauze until healing was complete. During the last two