breathing becomes unduly shallow the CO_2 absorbed can be partially or completely cut out of the circuit for a while. Furthermore, the technique for shocked cases should be adaptable to special requirements such as endotracheal administration and controlled respiration, and this is not possible with open ether.

If, however, ether and air is to be the first choice, is not the Oxford vaporizer the most accurate and most controllable means of administering it? The air can be enriched with oxygen through the special tap provided, and if the correct size of face-piece is chosen and correctly applied there is a gas-tight joint with no danger of hypotony and with both eyes readily accessible for inspection and, if deemed necessary, for palpation. Few, however, are the anaesthetists who elicit the corneal reflex these days, and even fewer are the ophthalmologists who would give the practice their blessing.

With regard to the use of ether, there appear to be two sharply divided schools of thought among most anaesthetists and some surgeons. In the one ether is condemned and never used, while in the other it is the agent of choice. It may be helpful if both sides aired their views in the light of experience and up-to-date knowledge, and an authoritative and unbiased pronouncement made.—I am, etc.,

W. N. ROLLASON,
Fl. Lieut., R.A.F.V.R.

Haverfordwest.

Frequency of Micturition after Injection of Haemorrhoids

SIR,—Dr. Kenneth Hazell's case of haematuria following an injection of haemorrhoids (Dec. 15, 1945, p. 864) calls to mind several patients that I have seen who developed disturbances of micturition after the same procedure. I can recall three such cases. They all complained of the onset of frequency of micturition within a few hours of the injection; in one case the symptom began within fifteen minutes of this treatment of piles; in another there was terminal haematuria and dysuria as well as frequency. I regarded all these instances as evidence of the connexion, through either the venous or lymphatic system, between the lowest segment of the alimentary canal and the neck of the bladder. It is possible that Dr. Hazell's case is explicable along similar lines.

Probably a reversed process is demonstrated in the frequent incidence of piles in patients suffering from bladder-neck changes even without obstruction, or with different forms of posterior urethritis. I have seen many cases in which haemorrhoids have followed the above-mentioned urinary-tract conditions.—I am, etc.,

H. P. WINSBURY-WHITE.

London, W.1.

Varicose Ulceration

SIR,—I am glad to have seen so many letters in your correspondence columns lately on this subject. Apart from the few people who have specialized in varicose veins and ulceration, this subject has been sadly neglected by the average run of the medical profession.

I see on an average 50 cases of ulceration per week—cases sent to my clinic by other doctors. I have been appalled by the number of years that each individual patient has suffered from his ulcer before I see him. These patients have attempted under medical supervision to get their ulcers healed merely by the application of ointment and a silly piece of bandage just around the ulcer.

Unless the pathology of these ulcers is understood cure will never result. The primary causation of these ulcers is gravitation, and the only treatment that will effect the healing of the ulcer is to rid the limb of its congestion. It is therefore essential to study each limb individually, and, if necessary, to get rid of any causative or concomitant veins, either by appropriate injection or, in a few instances, by ligature of the internal saphenous vein where it enters into the deep femoral vein, together with the ligaturing of the five branches of the internal saphenous vein in that neighbourhood. In long-standing cases the injection or the ligature, or both treatments combined, will not, however, get rid of the brawny, oedematous swelling. This can be effected either by the unnecessary and absurd treatment of putting the patient to bed for three months or by tight bandaging with "elastoplast." I am aware that there are a few cases which will not tolerate "elastoplast" next to the skin, but this difficulty is overcome as stated below.

My own technique in every case of ulceration is to apply "jelonet" to the ulcer base—occasionally in addition a sulphonamide powder; on top of that the whole leg from the toes to below the knee is enveloped in "ichthopaste"; then a pad of sponge-rubber with well-pared edges is applied over the ulcer and sometimes even several pads lying built-up over the ulcer. Then more "ichthopaste" is applied, and finally "elastoplast" is applied with a back stirrup so as to prevent the lateral subsequent turns of "elastoplast" from cutting into the leg. Moreover, this "elastoplast" is applied from above downwards to prevent the rucking up of the "elastoplast" by the stocking which would occur if it were applied from below upwards. Incidentally, this dodge was taught to me by my friend Mr. Dickson Wright.

The usual story in these cases is to get an ulcer which has been existing for six years healed in two or three months, the bandages being changed on an average once a month. Once the ulcer is healed up, however, there arises the question of after-care of the ulcerous leg. Even when all possible has been done for the vein by injection and/or ligature as above described it is necessary that the patient should keep the leg supported for many months ahead, or even for the rest of his life, either by the daily application by the patient of an "elastocrepe" bandage with a pad over the old ulcer site, exerting pressure, or, in less serious cases, by wearing an elastic stocking. I always tell patients also that standing is bad and walking is good, and to put their legs up in the evenings at home whenever possible on the sofa rather than have them dangling down.—I am, etc.,

STUART MCAUSLAND.

Liverpool.

SIR,—With reference to previous correspondence on this subject, I feel that Dr. R. K. Brooks and other G.P.s who do likewise should be commended and encouraged to print their methods of treatment and experiences, as in this way the standard of general practice can be raised by helpful and accurate criticism from experts. On the contrary, there are some who see in such letters an occasion to deride and correct, and in this case in a manner which is only less accurate and useful than it is courteous. If consultants and others engaged in hospital practice were to engage in general practice for a few weeks from time to time many would learn a great deal worth knowing, apart from tolerance.

The subject can be summarized as follows: The treatment of varicose ulcers is primarily the treatment of an area of nutritional gangrene, and secondarily the treatment of the accompanying varicose veins. The predisposing cause: lack of venous drainage, and thus lack of adequate blood supply; exciting cause: usually a blow causing an abrasion and permitting entrance of bacteria; these latter proceed to destroy the devitalized area until better-nourished tissue is reached.

Treatment: (*a*) To increase the nutrition of the part affected by promoting venous drainage; (*b*) to apply non-irritating bacteriostatics, for, as every medical schoolboy knows, sepsis is a potent barrier to repair. Venous drainage is promoted by: (1) elevating the limb; (2) supporting the limb with elastic bandage or stockings, etc.; (3) thrombosing or removing the varicose veins to the full extent of the defective system concerned, provided the deep venous system—supported as it is by muscles, fascia, etc.—is patent and healthy.

The method or methods adopted will depend upon the age, condition, and circumstances of the patient, but it is useless injecting veins in an ambulatory patient with a positive Trendelenburg sign—that is, a saphenous vein which fills from above when the patient assumes the erect position. In such cases the saphenous must be ligated and a portion excised at its entrance to the femoral vein. Furthermore, never inject a varicose vein in the region of the knee-joint. Finally, the elastic stocking is a valuable measure against recurrence of a healed ulcer and in treatment of varicose veins generally.—I am, etc.,

JOHN F. JENKINS.

London, W.1.

SIR,—In the treatment of varicose ulcers there are three conditions to which attention must be paid: (1) venous stasis; (2) lymphatic stasis; (3) infection. All three must be treated before lasting cure can be obtained.

I have treated several thousand cases in the past fifteen years, and so far I have not failed to heal an ulcer, at least tem-