

2. Caustic. Nitric acid, and pare away the dead part afterwards. This is rather dangerous.

3. Corn Plasters should be made from a flattened piece of isinglass felt cut in the form of a horseshoe, with the open end proximally so as not to interfere with the circulation. This will cure, but takes a very long time.

4. Corn Paint, which contains—

Re. Salicylic Acid gr. 60,

Ext. Cannabis Indica gr. 8,

Collodion flexile ($\frac{2}{3}$ strength) 1 oz.,

painted on regularly. Like the corn plaster, will cure, but also takes a long time.

5. Excise the entire corn and sew up the edges. This will cure definitely. But in all these methods it should be remembered that as long as the over- or underlying cause (*e.g.*, hammer toe or tight shoe) persists, the corn is liable to return.

Warts.

Now we come to *Plantar Warts*. These, as the name implies, occur chiefly upon the sole of the foot, usually under the ball of the foot or under the heel, but not necessarily on weight-bearing areas. They are papillomatous growths and they are contagious; they may occur as the acutely tender centre of a callosity. They differ from warts that occur on the hands in that they have not the warty appearance, and on transillumination fine tendrils may be seen radiating from the centre. In some cases the tips of tendrils appear as black dots, representing small areas of hæmorrhage. If warts on the hand were subject to pressure they would look like those on the feet.

Prevention is best achieved by remembering the contagious nature of the growths and not using baths or towels used by infected people. Their contagious nature is liable to be overlooked, but it should be remembered that if one foot is affected, even using its stocking on the other may lead to infection of the sound foot. They may spread all over the foot, especially if the skin be moist, and whole dormitories have been known to become infected. The organism that causes them is unknown. It is said to be a filter passing virus; and its growth in tissues is said to be helped by stasis of the surrounding lymphatics, either by some infection or by pressure.

Treatment.—They can be treated by nearly all the methods applied to the treatment of corns—cautery, caustic, diathermy, electrolysis, or by excision, deep X-rays or radium, or both excision and deep therapy combined. The usual treatment employed is excision, a simple operation performed with a sharp curette; the difficulty being that they may recur in the edges if enough tissue is not removed. Deep X-rays or radium are very good, but the treatment takes about six weeks before the growth drops out.

Callosities are simply an overgrowth of the outer layer of the skin, resulting usually from some underlying deformity of the foot. They differ from corns and warts in that they have not got a well-marked central zone, although, as we have seen, the middle of a callosity is a favourite site for a wart to develop. They may develop on any part of the foot, commonly under the heads of the metatarsals, and especially under the head of the second metatarsal, owing to some deformity of the first or after a bunion operation in which the first metatarsal has been shortened. They may occur on the inner aspect of the heel in a weak foot which tends to deviate outwards so that the patient tends to walk on the inner border.

Prevention.—Correct the underlying deformity early.

Treatment may be *palliative*, where the outer layers of the horny skin are pared away; or, directed to correcting the deformity of the foot—such as correcting the alignment in a valgus, or outwardly deviated, foot by exercises to strengthen the muscles on the inner side of the ankle; or by fitting an inside wedge to the heel to throw the weight on to the outer border when walking.

Ingrowing Toe Nail.

Ingrowing toe nail is actually the only nail condition which need interest us this afternoon. Two things are responsible for the condition:—

1. An abnormality of the nail bed, whereby the nail is firmly bound down to its bed and the bed is then bound down to the phalanx so that, when the flexor tendon contracts and presses the toe firmly against the ground, the skin at the edges must bulge over the edge of the nail, and

2. Tight shoes, which compress the skin against the nail edges where infection usually occurs.

It is the so-called lateral splinter, that we are all familiar with, which is said to cause most of the trouble, this being a part of the nail which, owing to its hidden position is not cut, it causes first a pressure atrophy of the skin lining the groove, and then penetrates the subcutaneous tissue, often conveying infection with it.

Prevention.—In the natural state the nail would grow over the tip of the toe, and hence walking on it would tend to push the nail up out of its groove. It is said that cutting the nail straight is a preventative, because the projecting straight edge, by pressing on the tissues at the tip of the toe, keeps the edge out of the groove. Filing down the centre of the nail, or cutting out the mid part, is said, too, to relieve pressure on the edges—but it has not been proved that any of these methods are effective.

Treatment.

1. Plugging fine ribbon gauze under the edge lifts the nail up and it is then possible to excise the lateral splinter.

2. Placing a small steel support under the edge and then fixing it to the toe is said to be fairly effective.

3. Excising the affected part of the nail bed with somewhat less than half of the nail gives good results.

4. If very much infected it may be necessary to remove the entire nail; but by doing this the condition will not be cured, as when the new nail grows it will have all the characteristics of the old one.

5. The really certain cure is removal of the nail, excision of the nail bed, and a shortening of the terminal phalanx to allow the formation of a skin flap, which is then sewn across. While this cures the condition permanently, as the nail never grows again, many people will object to it nowadays.

Bursæ.

Just a word about these. They usually occur at the insertion of the Tendo Achillis and over the exostosis of a Hallux Valgus. In the case of the Hallux Valgus bursa there is nothing to be done except treat the underlying bone condition, or wear shoes that cannot irritate it; for it is very important that this bursa should not become infected as, if so, it may have serious consequences if later on the bone has to be operated upon. The Tendo Achillis bursa, when inflamed, has a very tender spot localised over its site. It should be treated by putting the heel at rest. This is best done by not walking at all; but, if this is not possible, it is best treated by raising the heel half an inch, either with an insole or a lift, and doing away with the stiff leather backing of the shoe heel. Some people like to apply an elastoplast bandage with the foot in the dropped position, and then raise the heel slightly, say a quarter of an inch.

Sometimes these bursæ become chronic and the only treatment then is removal.

(To be concluded.)

At a meeting of the Council of the Royal College of Surgeons of England the Jacksonian Prize for 1936 was awarded to Mr. W. E. Underwood, F.R.C.S., of St. Bartholomew's Hospital, and the following was approved as the subject for the Jacksonian Prize for 1938: "Surgery of the Heart."

[previous page](#)

[next page](#)