THE TREATMENT OF TROPICAL ULCER.

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DURING my three years as a Prisoner of War in Siam, I personally treated 637 cases of tropical ulcer in our camp hospital. This does not include hundreds of tropical ulcers who were treated as out-patients.

The following is an exact copy of notes I made about his condition while I was still a Prisoner of War.

TROPICAL ULCERS.

These were one of our biggest menaces. At first I was unable to find anything to check their rapid growth and the destruction of tendons and bones. I was forced to amputate above the knee in eight cases. Later, I discovered a very efficient method of treatment. I received the idea from Manson Bahr's "Tropical Medicine." This treatment was as follows:

We will assume that a case is admitted to hospital with a tropical ulcer three or more inches in diameter over the anterior surface mid-third of the leg. The edges of the ulcer are raised and the floor is covered by a thick layer of pus. The skin surrounding the ulcer is inflamed.

Treatment.—Six times per day, the pus is washed or syringed off with warm water (preferably containing P.P.). Adherent portions of the pus which are not removed with the washing are gently removed with Kapok or cotton-wool swabs made with bamboo sticks. The floor of the ulcer having been freed of pus a thin layer of pure carbolic acid is applied to the whole surface of the ulcer by means of a Kapok or cotton-wool swab, as already described. The carbolic acid is washed off five minutes later. Pure carbolic acid is harmless to the ulcer but is likely to trickle over the edge and cause nasty ulceration of the surrounding skin. While the skin around the ulcer is inflamed, as many foments as possible are applied in the interval between the carbolic acid treatments. At night, and during the intervals of treatment during the day, an oily dressing is applied. When the condition of the ulcer shows improvement, i.e. raised edges disappear—the floor of the ulcer becomes a red granulating surface free from pus—the treatment is gradually changed as in the following example:

June 1.—6 daily applications of pure carbolic acid.
June 6.—3 applications of pure carbolic acid and 2 applications of 1 in 13 carbolic.
June 10.—2 applications of pure carbolic acid and 3 applications of 1 in 13 carbolic.
Clinical and Other Notes

June 18.—5 applications of 1 in 13 carbolic.
June 30.—4 applications of 1 in 13 carbolic.
July 20.—3 applications of 1 in 13 carbolic.
Aug. 20.—2 applications of 1 in 13 carbolic.

Seldom is the treatment ever reduced below two daily applications of 1 in 13 carbolic (to prevent recurrence). The carbolic applications are maintained until the ulcer is completely healed. Even when used on the largest ulcers (over 7 inches in diameter) no signs of carbolic acid poisoning (such as albuminuria) ever appeared.

In order to economize on carbolic acid we have been using a mixture of 2\(\frac{1}{2}\) per cent carbolic in 1 per cent perchloride of mercury, instead of the 1 in 13 carbolic. It has worked equally as well but is slightly painful. Iodoform does increase the rate of healing in the later stages when all signs of the active tropical virus have disappeared. Sulphonamides used locally, have the same effect as iodoform. I have found sulphonamides and iodoform of little or no value at all in dealing with the ulcer during the active stage. We have not, of course, had sufficient available to give it a proper trial.

Had I used this treatment at the beginning I consider that I should have been able to avoid some of the amputations. At one period, in 1943, we had over 200 cases of tropical ulcers in the hospital and in order to carry out this treatment a large staff was necessary. The staff allowed by the Japanese for 900 hospital patients was quite insufficient. The difficulty was got over by the employment of sixteen volunteer Regimental Officers who completely took over the ulcer patients.

THE CITADEL, CAIRO.

We have received from Brigadier K. A. M. Tomory, O.B.E., Deputy Director of Medical Services, British Troops in Egypt, a note on the handing over of the Citadel in Cairo to the Egyptian Army.

The ceremony was simple but impressive. Guards of Honour, furnished by the 1st Battalion, The Highland Light Infantry and the 1st Garrison Battalion of the Egyptian Army, presented arms as the British and Egyptian National Anthems were played. The Union Jack was lowered, and the final return of the Citadel to Egyptian care was symbolized by the gift of a silver key which was presented by Lieutenant-General Sir Charles Allfrey, K.B.E., C.B., D.S.O., M.C., General Officer Commanding British Troops in Egypt to Lewa Ferik Ibrahim Attallah Pasha, Chief of General Staff of the Egyptian Army.

Many serving and former members of the Royal Army Medical Corps, The Army Dental Corps and the Nursing Services will regret this loss. The Citadel was not an ideal station; Mohamed Ali’s harem was never quite an ideal hospital building; the magnificently painted ceilings had lost some of their freshness; the woodwork provided many safe refuges for the families of Cimex lectularius which were never quite exterminated (unless perhaps in the last few years the use of D.D.T. has changed the picture); Mohamed Ali’s stables and his coachmen’s quarters, though extensively converted, did