

will press on the lateral furrow, and this, coupled with compression from a shoe, will cause a paronychia lateralis. At first, there will be great irritability of the parts, later, inflammation, sup-puration, great proliferation of granulations, destruction of the cutis, of the tendon, opening of the phalangeal joint, caries and necrosis of bones. Usually the internal angle of the great toe is affected, rarely the outside of the little toe, seldom any other toe. It may assume a mild form or become chronic, with now and then an exacerbatory character, may be covered with irregular, spongy, easily-bleeding granulations. It may last for years.

Ingrowing toe-nail almost invariably occurs on the outer side of the nail of the great toe. Psoriasis may affect the nail. It may be although not necessarily so an evidence of syphilis. Central part of nail diseased; scabrous thickened, rough, convex, splits, deep fissure between the skin and finger. Nail resembles the concave shell of an oyster. Affection chronic and difficult to cure.

*Syphilis may attack the nail.* Jonathan Hutchinson† was one of the first to draw attention, not only to the state of the nail in syphilitic psoriasis but in congenital syphilis. Nails, symmetrically affected, dry, brittle, fissured and broken at their edges, superficial layers alone diseased. There is, however, a more remarkable affection in the form of a chronic general onychitis. The nails decay and fall off; they first become opaque and much thickened, their substance is soft. The disease is due to inflammation of the matrix which is swollen and readily bleeds. Syphilitic onychia usually attacks the toe-nails, and is often associated with ulcerative fissures between the toes. The inflammation is not so severe as in the non-syphilitic form. Perionyx is a syphilitic inflammation surrounding the nail, exists in a dry and moist form. It also has a simple and ulcerative variety. Deep ulcerations forming in the latter. Mucus patches are sometimes seen under the free border of the nail.

The surgery of the nail resolves itself into operative and general treatment. If it be troublesome on account of its longitudinal growth, this must be removed with the scissors in simple cases; when the thickness is increased at the same time, use cutting pliers or saw. Paronychia lateralis in its early stage may be treated by removing that part of the nail which threatens to grow in, besides putting into the groove fine threads of charpie, and ordering wide shoes. When the inflammation is extensive it is well to use the method of complicated pressure, as devised by Kaposi of Vienna. This consists in first removing that portion of the nail projecting into the inflamed surface, then the swollen edge of skin is carefully pressed downward, and the widened space thus gained at the furrow is filled with accurately inserted threads of charpie

cotton. In doing this, care should be taken that the sharp edge of the nail does not come in contact with the irritated part of the skin. This done, strips of adhesive plaster (emplas diachylon) are wound round the ungual phalanx, commencing at the affected part from above downwards, each turn being moderately stretched, so as to remove the border of the skin as much as possible from the edge of the nail, to crowd it downwards. If this is done skilfully, it will cause no pain to the patient, and eases his condition at once. He can not only walk, but wear his shoes. After twelve or twenty-four hours, the dressing is taken off, foot bathed and bandaged anew. Kaposi claims that this will cure the patient in from two to four weeks. Some add medicated solution to the charpie, carbolic acid, etc. If greatly developed fungous granulations are present, they should be cut with the scissors, down to the base, and the bleeding points touched with nitrate of silver. In rare cases will be obliged to resort to Dupuytren's radical operation, that is, inserting pointed end of scissors beneath the nail, divide it into two parts firmly seizing the diseased side of the nail with pliers, and pulling it out. The nail usually re-appears. A great object in in-growing toe-nail is to give the feet all necessary room. In the early stage, when there is no considerable mass of overhanging integument or fungous granulations, pressure of the nail on the soft parts may be relieved by packing into the groove on the affected side, oiled cotton wool with the flat end of a probe or pen-knife. This may be done without pain. The quantity of wool may be increased at each application, until the soft parts are raised and pushed aside. The free edge of the nail is exposed, beneath which wool should be inserted until the natural state is restored. Nails should be allowed to grow so as to form a right angle at the outer corner. If much inflammation, the toe may be kept in water dressing during treatment. Overlapping integument kept in natural relation to the nail by strips of adhesive plaster. Dr. Tribury Fox says, "In-growing toe-nail is easily cured by softening it, and then scraping off as much as possible, so as to thin it in the middle." A similar plan may be adopted to remove splinters imbedded in the nail. Nail scraped thin over the splinter and then cut through. It can in this way be painlessly removed. When the nail cuts deeply into the flesh, causing ulceration and fungous granulations, remove it at once, using either spray or cocaine. Dupuytren's method, as described above, is the one usually employed by surgeons. Nails may be cut by knife instead of dividing by scissors. Some surgeons prefer to remove the whole nail.

Dr. Monks has kindly called my attention to Dr. Cotting's, of Boston, method of treating in-growing toe-nail. Anything emanating from Boston is sure to bear the impress of sterling worth. It seems to me to be the most feasible of all methods. He removes the fleshy part of the toe at

†British Medical Journal, 1865, p. 45.