to bed and rest. Therefore he was treated with non-adhesive dressings and "elastoplast." These were changed approximately every four weeks. By the end of August it was evident that, although the ulcer had slightly decreased in area, its depth was increased; also there was a large black foul-smelling slough covering the whole area; in fact it was becoming gangrenous.

He was finally induced to rest in bed. A local application of "varidase" in carboxymethylcellulose jelly was applied to the ulcer, and the whole was covered by a non-adhesive dressing and gauze and bound up with ordinary bandages. The dressing was changed in 24 hours, and a similar dressing was reapplied for a further day. When this was removed the black slough was seen to have liquefied and to be draining well. Non-adhesive dressings only were then applied for 14 days and changed every third day. A small portion of adherent slough was treated with the varidase jelly after the fourteenth day—for one day—and non-adhesive dressings alone were then reapplied and changed weekly. The ulcer responded very rapidly, and after an interval of only five weeks from the first application of varidase jelly it was completely healed.

The new epithelium is extremely sound, and the patient is more than thankful to be rid of this lesion which has caused him so much trouble.

I should like to take this opportunity of thanking Mr. H. Evers, M.P.S., who has been most helpful to me in obtaining supplies of varidase, carboxymethylcellulose jelly, and non-adhesive dressings.

—I am, etc.,

Swansea. JOHN A. BOWLES.

Treatment of Pilonidal Sinus

SIR,—The correspondence aroused by Mr. A. J. H. Rains's paper "Treatment of Pilonidal Sinus by Excision and Primary Closure" (*Journal*, August 15, p. 171) shows once again that this is still a controversial subject. Indeed, of the large number of papers devoted to this condition which have appeared in the past 20 years (I am able to trace over 250), those dealing mainly with treatment constitute the majority. A notable feature, also reflected by the present correspondence, is the diversity of the results obtained by ostensibly similar methods. In the light of a recent personal study of 38 cases, I should like to offer one or two further comments.

Excision and Primary Closure.—Reported results vary from 94.5% success[1] to 100% failure in recurrent cases.[2] In my own series, 29 patients were treated in this way. Three of these, all recurrent cases, broke down within a few weeks. At long-term follow-up (five years to one month post-operatively) 19 of the remaining 26 were seen and all were still fully healed. No late recurrences are known among the seven defaulters. This seems to indicate 100% success among the non-recurrent cases selected for this form of treatment. Success depends on the avoidance of infection, dead-space formation, haematoma, exudation of serum, and, later, hair intrusion. Selection of cases is important and lesions; grafting is for very large ones and recurrences. or new lesions with distant secondary openings, in which complete excision would entail a defect more than 5 cm. in width. The combination of extreme obesity, hairiness, defective cleanliness, and chronic excoriation of the adjacent skin also appeared to contribute substantially to one of the three early recurrences and should be regarded as a contra-indication to primary closure. Dead-space elimination and skin eversion are provided by Oldham's method of suturing,[3] advocated by Mr. D. Lang Stevenson (*Journal*, September 12, p. 430). Buried sutures or ligatures and diathermy coagulation are unnecessary and are best avoided. Oldham reports using a fine catgut ligature only four or five times in around 100 operations, and none was used in any of my cases. The application of hot packs for five minutes suffices. After discharge from hospital, all my patients are instructed to scrub the scar-line daily with a soft scrubbing-brush. Most have co-operated, and I believe that the absence of late recurrences is largely due to this measure. Scrubbing toughens and cleanses the skin and brushes out the matted wisps of converging stiff hairs (which undoubtedly cause many late recurrences) into a loose fluff.

Excision and Immediate Thiersch Grafting.—This method, recommended by Mr. P. G. Collins (*Journal*, September 12, p. 430) and Mr. Eric Vernon (*Journal*, October 3, p. 633), succeeded in one personal case after both granulation and re-excision with primary closure had failed. In recurrences and cases requiring wide excision, it is the method of choice and should give a wide, shelving, mobile, hairless, fully healed scar within 14 days of the operation.

Open Wound Care.—This is prolonged, tiresome, and uncertain. Bridging and hair intrusion often lead to failure. The method of "marsupialization" favoured by Mr. Collins and Mr. Robin Burkitt (*Journal*, September 26, p. 579), though redescribed by Buie,[4] was used by Anderson in 1847,[5] and can hardly be regarded to-day as a recent advance. The possibility of first-intention healing, either by primary closure or immediate grafting, renders it totally obsolete.

Scrubbing.—Scrubbing alone was the only treatment advised in five of my cases. The patients had minimal lesions, and four were females with macroscopically hairless skin and comedo-like primary openings. These have attended for follow-up and are symptom-free. In one, the primary opening can no longer be detected.

I believe that, if the correct choice is made between scrubbing alone, excision, and primary closure according to the principles outlined above, and excision with immediate grafting, the results should approach 100% success. Excision and primary closure is suitable to the majority of cases. Scrubbing alone is for very small lesions; grafting is for very large ones and recurrences. Scrubbing should be advised routinely after discharge in all cases treated by primary closure and should be continued indefinitely.

I should like to acknowledge the kindness of Mr. R. W. Doyle and Mr. J. A. Martinez for allowing me full freedom in the treatment of all their cases of pilonidal sinus. These constitute the 38 patients reported above.

—I am, etc.,

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The Wolfenden Report

SIR,—Dr. C. G. Learoyd must be sadly out of touch if he really believes (*Journal*, November 21, p. 1099) that the 17-year-old son of a Consett steel-worker would think along the lines that he indicates ("That Sir John Wolfenden—you know the chap on the T.V., he says these things don't matter a bit. He says they're not crimes"). I very much doubt whether this unfortunate lad knew the meaning of the word homosexual.

Tragic as his suicide was, it is not a good starting-point from which to argue the need for legal reform, because, as Dr. Learoyd points out, the case may have been one of persistent sexual assault. Yet I believe that it is the present attitude of the law towards young offenders which is most in need of reform. Homosexual