septic lesions of the skin, however trivial." They were not encouraged to do anything about any septic lesions they may have in their mouths. It is possible that a source of reinfection is being overlooked.—I am, etc.,

Royal Alexandra Hospital, Rhyl. F. G. HARDMAN.

REFERENCE

[1] Ministry of Health, Central Health Services Council, Standing Medical Advisory Committee, *Staphylococcal Infections in Hospitals—Report of the Subcommittee*, 1959, H.M.S.O., London.

SIR,—Dr. L. G. Tulloch and co-workers in their article on the treatment of chronic furunculosis (July 30, p. 354) rightly stress the importance of disinfecting carrier sites (nose, perineum, ears, eyelids) by means of a local antibiotic, particularly neomycin, and hexachlorophane dusting powder. It is also essential to prevent further seeding of staphylococci from boil-bearing areas, for which they recommend swabbing twice a day with 1/3,000 aqueous solution of mercuric chloride. The most reliable method in my experience consists in sponging the boils and surrounding skin for five minutes once daily for about a week with 70% alcohol followed by painting with 1% aqueous gentian violet. Patients should be told to avoid adhesive dressings and all macerating remedies (poultices, kaolin, magnesium sulphate) and to stop bathing when active boils are present, so as not to spread the infection via towels. As the authors state, patients must be given a clear and simple explanation of the nature of staphylococcal carriage and infection. The correct therapeutic approach to recurrent boils certainly is an external one and not with systemic antibiotics, which get ordered far too often. These have no preventive effect; indeed, it is noteworthy that of the 58 causative staphylococci in the authors' cases, 25 (43%) were penicillin-resistant, some of them being resistant also to streptomycin and tetracycline.—I am, etc.,

London W.1. E. W. PROSSER THOMAS.

Pain after Short-acting Relaxants

SIR,—In their article comparing post-operative pain and stiffness after the use of suxamethonium and suxethonium compounds (August 20, p. 579), Drs. G. D. Parbrook and G. F. M. Pierce explain the difference between their figures and mine[1] as due to a difference in anaesthetic technique, but this I cannot accept because my technique was constant throughout and I was comparing suxamethonium and suxethonium side by side.

In my investigation (the reference to which is omitted from your article) a comparison was made under closely similar conditions, inasmuch as all operations were performed by one surgeon and all anaesthetics were given by myself. The age-groupings were roughly comparable and the sex incidence the same. I was able to compare directly in the same patient on several successive operations. Furthermore, I employed approximately equipotent doses of the two drugs, doses which were almost the same in proportion as those used by Drs. Parbrook and Pierce.

My figures show that when all patients are questioned directly there is a reduction in the incidence with suxamethonium (50% to 34%). This, however, is not so significant as the change observed in the severity of these pains, which I found so slight that spontaneous complaints with suxethonium only occurred in 12 patients out of a total of 285, as compared with 10 out of 60 for suxamethonium. Drs. Parbrook and Pierce record "severe stiffness or pain" in 13 out of 50 patients with both suxamethonium and suxethonium, but their criteria for "severe stiffness or pain" must be different from mine because they state also that "very rarely did any patient complain of symptoms directly to us." I used for my investigation the gradings by Hegarty,[2] and by these standards mild pains will probably pass without complaint, but moderately severe and severe pains will always be accompanied by spontaneous complaints.

I can state with confidence that after considerable experience with suxethonium I have encountered very few moderately severe or severe pains, and I have little hesitation in employing it in my practice to-day. Even though it is only relatively pain-free, it is vastly superior to suxamethonium.—I am, etc.,

London W.1. G. E. HALE ENDERBY.

REFERENCES

[1] Enderby, G. E. H., *Brit. J. Anaesth.*, 1959, **31**, 530.
[2] Hegarty, P., ibid., 1956, **28**, 209.

*** We much regret the unintentional omission of the reference to Dr. Enderby's article.—ED., *B.M.J.*

Suxamethonium Muscle Pains

SIR,—With reference to the letters by Dr. R. J. T. Woodlands (July 30, p. 393) and Dr. P. J. Tomlin (August 20, p. 604) in connexion with muscle pains after suxamethonium in conjunction with electroplexy, I had occasion to see recently a woman of 55 with a straightforward endogenous depression who had had a radical mastectomy for carcinoma. She had previously been given E.C.T. for the same condition but had declined to continue because of the severe pain. However, I persuaded her to start treatment and a muscle relaxant was used with thiopentone, but she again refused to continue owing to the pain. I subsequently tried using thiopentone alone, and the pain throughout the general site of the operation was very much reduced and the patient was quite prepared to continue and benefited from the treatment.—I am, etc.,

Springfield, nr. Chelmsford. J. E. G. VINCENZI.

Hypnotic Treatment of Asthma

SIR,—I enjoyed reading Dr. Griffith Edwards's interesting paper (August 13, p. 492) and would like to congratulate him on a thoughtful study. There are several points which I feel should be made.

For a pilot study of the effectiveness of treatment the choice of patients was perhaps unfortunate in that, of six, two were poor hypnotic subjects and one developed pulmonary tuberculosis during the period of observation, presumably with impairment of pulmonary function. This leaves only three patients (Cases 1, 3, and 4) in whom the effect of treatment might be measured.

No reason was given for the choice of only "several days of suggestion under hypnosis" on in-patients, with no supportive out-patient treatment. Hypnotherapy is still looked on by some as magic, by others as nonsense, and only occasionally is it employed in a common-sense fashion. In the present instance drama was anticipated, perhaps unwisely. Of the three who can be seriously analysed, asthma had been established for 7, 18, and 28 years respectively, yet hypnotherapy was given on only six, six, and five occasions (Case 4 was given five further "booster" sessions as an out-patient and was taught the technique of auto-hypnosis). Surely an "asthma habit" of many years' standing cannot be lastingly broken by so few treatments extending over such short intervals.

With regard to the ventilatory function tests in these three patients: maximum breathing capacity (M.B.C.) of the first rose from 42 to 104 litres during the course of seven days' treatment and a month later rose to 114 litres; the fact that it could be raised by another 14 litres by using a spray, although noteworthy, does not detract from the