(or physician) who has the courage to publish his failures, and where is the editor who will give him the space?—I am, etc.,

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Endocrine Ophthalmopathy

SIR,—In view of your reference (7 September, p. 565) to the use by Harden *et al.*[1] of metronidazole (Flagyl) in thyrotoxic ophthalmopathy, I should like to draw attention to the occurrence of a sensory peripheral neuropathy in a patient treated with this drug.

A 43-year-old woman presented in May 1967 with a nine months' classical history of thyrotoxicosis. She had wasting of the proximal muscles of the shoulder and pelvic girdles, but no other evidence of neuromuscular disease was found. She had slight bilateral lid lag but no proptosis (Hertel ophthalmometer readings: right eye 12 mm., left eye 12 mm.). She was treated with carbimazole 15 mg. eight-hourly. After a month, when she was clinically euthyroid, L-thyroxine 0.2 mg./day was added, the dose of carbimazole being reduced subsequently to 10 mg. eight-hourly. At this stage she complained that her eyes felt swollen in the mornings, but the only abnormality found was that the ophthalmometer reading for the right eye had increased to 14 mm. In July she developed periorbital swelling, photophobia, and double vision. Her conjunctivae were injected, and she had a palsy of the right superior rectus and inferior oblique muscles. Exophthalmometer readings were 16 mm. on the right and 13 mm. on the left.

No change was made in the drug regimen for the control of her thyrotoxicosis, but on 25 October 1967 she was started on metronidazole 400 mg. three times a day. There was no great benefit from this, for the exophthalmometer recording in the right eye had progressed to 18 mm. by 31 January 1968, though the patient thought that her eyes felt more comfortable. In mid-February she developed numbness and tingling in her arms and legs. There was no trophic skin change, no muscle wasting or weakness, and tendon reflexes were all normal. However, there was loss of all modalities of sensation in a glove and stocking distribution from a point 6 cm. above both knees and from both elbows, though there was heightened deep pain sensation in the Achilles tendons. No other cause for a peripheral neuropathy was found and the metronidazole was stopped. Serial neurological examinations revealed that henceforward there was a steady improvement in her neuropathy. By September 1968 all signs had disappeared from her upper limbs, but the sensory level 7 cm. above her ankles had not altered since June.

So far as I am aware, no other report of a metronidazole-induced neuropathy has appeared. It may be that the level of dosage used by Harden *et al.*,[1] which is twice that normally used in the treatment of trichomonal infections, is an important factor.—I am, etc.,

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1 Harden, R. McG., Chisholm, C. J. S., and Cant, J. S., *Metabolism*, 1967, **16**, 890.

Hypnosis in Asthma

SIR,—The evidence presented by the Hypnotherapy in Asthma Subcommittee (12 October, p. 71) to show that hypnosis was significantly more helpful than breathing exercises in asthmatics is unconvincing. Apart from the absence of objective proof of benefit in the report, the question of placebo effects looms large. Both treatment groups could be presumed to have shown some subjective response as a result of taking part in the trial, but hypnosis would seem to be a more potent inducer of the placebo response than breathing exercises. It is not an infrequent finding that placebos vary in their potency, and the results of the trial in question could well have been produced in this way.

To avoid simply negative comment, I would suggest that in the next trial all patients receive hypnosis, the placebo group being given neutral suggestions and told to forget the content of the hypnosis session.—I am, etc.,

R. J. WALDEN.

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Tests for Hearing

SIR,—May I use the appearance of your article on audiometry (9 November, p. 373) as an excuse to release a bee from my bonnet? Pure tone audiometry, being a critical test, is likely to be influenced or invalidated by the presence of aural wax blocking the external ear canal. Would it be timely to remind ourselves that the use of pure tone audiometry in schools is an adjunct, not an alternative, to clinical examination with use of the auriscope and aural syringe, and simpler tests of hearing.

I believe that a good deal of worry by parents, and some referrals to hospital, could be saved if it were more generally realized that it is often futile to draw conclusions from audiograms without a previous clear view of the drum head.—I am, etc.,

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Scabies in Africa

SIR,—I am sure many dermatologists and others will have found Dr. B. O. L. Dukes's article on onchocerciasis (2 November, p. 301) most enjoyable, as well as being an invaluable aid to the diagnosis of what is now a fairly common tropical dermatosis in this country.

He raised a small but, to me, an interesting point when he included scabies among his list of differential diagnoses. By implication he suggests that scabies is a common disease in Africa; I would doubt very much whether this is generally true, although I am prepared to admit the possibility of regional variations. I base my experience on a comparatively short period of 15 months' Nigerian dermatology, during which time I relentlessly pursued the African acarus and managed to demonstrate her with difficulty on only two occasions. Harman[1] initially assumed that scabies was only apparently rare in Nigeria and that he was being protected from contact with the disease. In a later article[2] he contrasts his incidence of 0.95% with Clarke's[3] of 25% of outpatient attenders and speculates on the interpretations of clinical pictures.

Scabies is a very commonly diagnosed disease in Nigeria, but only rarely is the diagnosis substantiated. Schulz, Findlay and Scott[4] remark on how difficult the acarus is to find on the South African Bantu, and I, who have spent the last two years in London during the present scabies epidemic, have yet to see a case of scabies in a patient of Negro origin. I would be interested to hear the experience of others on this subject.—I am, etc.,

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Tinea Pedis

SIR,—The leading article on tinea pedis (26 October, p. 204) contains useful advice on the importance of cleaning of communal bathing facilities in the control of tinea pedis. The presence of fungus infection should always be confirmed by direct examination of scrapings, and this procedure is routinely carried out in skin clinics.

However, in the differential diagnosis shoe dermatitis or pustular psoriasis (a rare disorder) does not give difficulty because of the distribution of the dermatitis and the nature of the pustules. Again, in the treatment of the acute phase the use of a weak permanganate solution 1/4,000 is preferable to saline to control secondary infection. I would deprecate the application of hydrocortisone ointment in the presence of mycotic, candidal, or secondary bacterial infection. Undecenoate ointment, the therapeutic basis of which is in doubt, is ineffective and indeed may itself irritate the skin. In most clinical phases of fungus infection of the feet and toe spaces half-strength Whitfield's ointment is the most reliable and effective therapy.—I am, etc.,

L. FORMAN.

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SIR,—While I realize that the article "Studies in the Epidemiology of Tinea Pedis" (26 October, p. 228) was not concerned with treatment, your leading article (p. 204) devotes the last paragraph to treatment, and two important points require in my opinion to be added to your summary.

Firstly, except for *Trichophyton rubrum*, almost all respond to Castellian's paint, which unlike most other treatments is tolerated by the more acute vesicular/exfoliating eruption; and, secondly, conscientious sterilizing of socks and shoes with formalin applied overnight on cotton wool and allowed to disperse during the following 24 hours prevents relapse, often for long periods.—I am, etc.,

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