sary. The stimulation is used purely as an educational aid to increase the patient's awareness of the pelvic floor musculature in order that she can actively retrain the muscles herself by repeated exercises.

It seems to be a reasonable rather than an extreme view to try to cure stress incontinence, for merely to control it with continuous electrical stimulation involves the permanent use of an electrode bearing device either in the vagina or anal canal and recurrent expense on batteries to the patient ad infinitum. It also seems reasonable to cooperate with physiotherapists whose special experience and skill can increase the effectiveness of these modern techniques.—We are, etc.,

C. D. COLLINS
EILEEN MONTGOMERY

Bristol

1 Collins, C. D., Brown, B. H., and Duthie, H. L., *Scandinavian Journal of Gastroenterology*, 1968, **3**, 395.
2 Collins, C. D., *Proceedings of the Royal Society of Medicine*, in press.
3 Jones, E. G., and Kegel, A. H., *Surgery, Gynecology and Obstetrics*, 1952, **94**, 179.
4 Tanner, E. R., *Physiotherapy* 1969, **55**, 372.
5 Moore, T., and Schofield, P. F., *British Medical Journal*, 1967, **3**, 150.

SIR,—It is indeed the case that the hopes raised when Caldwell's work was first published have not been fully realized. But it was ever thus. There is always undue optimism when any new thing is described. Your leading article (17 June, p. 670) fails to make the important point that the majority of patients treated by electronic stimulators have already undergone several operations to relieve their incontinence;[1] this is why we here refer to it as resistant incontinence. Further surgery in such patients is bound to be attended by less certain success. In the light of this, the 50-60% improvement rate of implants is not to be scorned.

We would stress, however, that the electronic implant is only one of the techniques available to treat resistant incontinence. It is important that centres specializing in this work be thoroughly conversant with all the methods available—drugs, simple pessary and spring devices, internal and external electronic stimulators. When such an armamentarium is available and appropriately employed the overall success rate in treating these cases is well above 60%.

We are not as pessimistic as you with regard to this work; the step forward has not been as big as was first hoped, but it is a surer footing than you imply.—We are, etc.,

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STUART L. STANTON

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London W.C.2

1 Edwards, L., Harrison, N., and Williams, J. P., *British Medical Journal*, 1971, **1**, 543.

Benign Breast Swelling

SIR,—I would like to go further than Dr. P. M. F. Bishop (24 June, p. 770). Our main difficulty in understanding the common breast complaints for which women consult doctors—pain and variation in the consistency of the breasts—arises from our using morbid anatomical terms, such as chronic mastitis or fibroadenosis, to designate functional variations in the vascular response of the breasts to hormonal, and I suspect also emotional, stimuli.

Such terms imply disease, whereas we are in fact dealing with physiological or paraphysiological phenomena. Is not the first essential, therefore, the abandonment of these morbid anatomical terms?—I am, etc.,

DAVID PATEY

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Serological Reactions in Erythema Multiforme

SIR,—Drs. A. Macdonald and M. Feiwel report an interesting and unusual case (3 June, p. 570). The fluctuations in complement fixing antibody titres to many viral antigens are most unusual, and it seems scarcely adequate to dismiss them as anamnestic. The complement fixation technique is not described. Since serum from the early stage was anticomplementary, did the controls exclude the possibility that this activity rather than specific antigen-antibody reactions was involved in the phenomena? Were reactions given by control antigens prepared from non-infected eggs and tissue cultures? Were the tabulated titres obtained by simultaneous titration of all seven sera, or might intertest variations have contributed to their differences? Were the antibody responses shown by any tests other than complement fixation? Although neutralizing antibodies to herpesvirus were not found at an unspecified stage of the illness, were the tests designed to detect complement-requiring antibodies which are often found in primary herpes infection? Were tests with bacterial and nonmicrobial antigens performed, and did these also show the variation in titre?

Information on these points would be helpful.—I am, etc.,

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Skin Trauma and Corticosteroids

SIR,—I read with interest "Skin Trauma in Patients Receiving Systemic Corticosteroid Therapy" (10 June, p. 614). The problems in this hospital are in many ways the same as Mr. D. J. David's, and after many years of trial and error the following simple and inexpensive method has been found to be the most satisfactory, safe, and least uncomfortable for the patient.

The majority of patients were women aged between 40 and 65 with lesions on the mid to lower tibia. They had often had several previous hospital admissions and were loath to be admitted again. They were therefore treated as outpatients. On arrival, the patient was taken into theatre and given 10 mg of diazepam, by mouth or intramuscularly. The leg was elevated and covered with a large dressing soaked in Cetrihex (chlorhexidine gluconate 7·5%, cetrimide 15%). After half an hour, by which time the patient was sedated, the wound was cleaned with gauze soaked in the same solution. Usually no anaesthetic was required but occasionally 1% lignocaine without adrenaline was used. As Mr. David noted, most of these unpleasant looking injuries were due to trivial trauma in the house so the risk of infection was slight.

Bleeding was never a problem, and haemostasis was easily achieved. Micropore surgical tape (Steristrip) was used to approximate the wound edges, applied in strips 4-5 in (10-12·5 cm) long, starting well away from the wound and passing diagonally across it, using the most stable part of the wound as the fulcrum for the first few strips and using the minimum number of strips which would hold the wound edges together. After leaving the leg elevated for a further half an hour, several layers of dry gauze and an elastic blue line bandage were applied, and tetanus toxoid and antibiotics were given. If the patient's condition was satisfactory, she was sent home to bed for 24-48 hours, then seen again, and if all was well, told to walk, wearing the elastic web bandage all the time she was out of bed until the wound had healed.

The patient was then seen weekly, the micropore tape removed or replaced where necessary, until healing was complete. Though this could take up to eight weeks, the final result was good. The patient had been spared admission, the risk of infection with hospital organisms, general anaesthesia, and a surgical procedure. Alteration in steroid requirements was not needed, and the possibility of thrombophlebitis from immobility was reduced.

Those of our patients who had previously been admitted for similar type of injuries have stated their preference for this outpatient treament.—I am, etc.,

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Child Abuse Syndrome

SIR,—While we read with interest the article by Dr. Graham Jackson (24 June, p. 756) on the misdiagnoses of cases of child abuse, we believe that it contained little new thought on the subject.

The battered child has emerged as a medicosocial problem, and only by a joint detection scheme in the community is there hope that these tragic cases will be prevented.[1] Regular re-examination of hospital records, although valuable, is only secondary to a proper co-ordinated scheme of community detection. Our experience in Nottingham has shown that a battered baby can occur in any family, irrespective of social class or standing (4 September 1971, p. 584).—We are, etc.,

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MARGARET W. SEYMOUR

City of Nottingham Health Services,
Nottingham

1 Parry, W. H., and Seymour, M. W., *Community Medicine*, 1971, **126**, 121.

SIR,—Dr. Graham Jackson is to be congratulated on pointing out (24 June, p. 756) that many children who present to hospital with trauma are unrecognized cases of children who have been physically abused by their parents. Over the last 18 months we have had personal experience of 103 cases of "unexplained injuries" in children under 5 years of age in the course of a broadly based research project. Some facts which emerge from analysis of the first 50 cases are the following. Their mean age is 14 months, over half being under 18 months of age. Boys were injured in 56%, girls in