Control of Urinary Infections

SIR,—Mr. W. G. Q. Mills (December 24, p. 1884) rightly draws attention to the possibility of ascending infection alongside the catheter, but does not differentiate the problem in the two sexes. In the female the short urethra and the to-and-fro movement of the catheter make this type of infection almost inevitable, but unfortunately it is normally due to the patient's own coliform organisms, which are usually sensitive to antibiotics,[1] whereas the causative organisms involved in open catheter drainage are hospital organisms and usually resistant.

In the male we have so far been unable to prove bacteriologically, after serial swabbing of the urethra in patients in the post-operative period, that infection of the bladder does take place via the film of mucopus lying between the catheter and urethral mucosa, but this may well be a more serious problem in those on long-term drainage. We know, however, that our infection rate in post-operative patients has been reduced from over 90% to under 10% by the use of closed drainage and that the few infections resulting from the "peri-catheter route" are probably due to sensitive organisms.

Concerning prophylaxis, I agree a self-retaining Gibbon-type catheter would go a long way in preventing urethritis, but I believe there are certain practical difficulties in their manufacture, remembering that the introduction of a two-way lumen will immediately bring the calibre into that of the lower range of Foley balloon-catheters. The use of chlorhexidine ("hibitane") cream, applied by the patient himself at regular intervals to the external meatus, and of a cuffed Foley-type catheter in the female (preventing to-and-fro movement in the short urethra) are at the moment under consideration and trial in Bristol.—I am, etc.,

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REFERENCE

[1] Slade, N., and Linton, K. B., *Brit. J. Urol.*, 1960, **32**, 416.

Status Asthmaticus Treated by Hypnosis

SIR,—May I crave your indulgence to reply to Dr. Alan Akeroyd's letter (December 31, 1960, p. 1953)? While I cannot be certain that further questioning might not have revealed an unconscious death-wish, nevertheless, from the limited questioning of this patient that was possible, it would not appear to be likely. He had been successful in his career, his marriage, and his social relationships both before and after the onset of asthma. His onset had not been accompanied by any change in his life or severe psycho-trauma that might explain it. On the other hand, the family history of asthma suggested a constitutional factor. In addition he had suffered for several years from angina pectoris and he was a likely candidate for coronary occlusion.

It is well known to all who practise hypnosis that it is extremely difficult to make a patient give up his symptom if such a symptom is part of his adjustment to life. An interesting factor in this case was the absence of such a "need" for asthma, and in fact he had coped well for many years without it. Thus it seemed reasonable to postulate that emotional factors alone could not exclusively explain this patient's asthma, neither could they explain his sudden death.

May I conclude by saying that the relationship of asthma to psychodynamics is a vexing one, not easily studied by conventional scientific means? All that can be said is that in many patients suffering from asthma emotional factors have occurred. Whether *post* or *propter hoc*, and whether these factors were causal, has not always been clearly established. Needless to say, in many such patients who appear to have a psychodynamic basis for their asthma, hypnosis or drug therapy would be insufficient. In such patients these would have to be combined with psychotherapy and environmental adjustment where possible.—I am, etc.,

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SIR,—Dr. J. Maxwell's and Dr. Alan Akeroyd's comments (December 31, p. 1953) on Dr. A. H. C. Sinclair-Gieben's fascinating report on "The Treatment of Status Asthmaticus by Hypnosis" (December 3, p. 1651) are most illuminating and constructive. While I agree strongly with their remarks, it strikes me that further points need to be made. Firstly, the "panic state" which Dr. Maxwell describes as arising even in anticipation of an asthmatic attack in patients subject to status asthmaticus is a logical attitude based on past experience of hypoxia, and should be distinguished from the primary affective disorder which is so widely held to contribute to the aetiology. None the less, this panic state is clearly a useful pointer to the prognosis, and doubtless fortifies the vicious circle which manifests itself in bronchospasm. It is not, however, the primary lesion.

Secondly, the attendance at the bedside of a patient in status asthmaticus is not the occasion to embark on a protracted course of psychotherapy, however desirable that may be in the long term. The first task is to relieve the medical emergency by whatever means are expedient, and in this context symptom-banishment by hypnotic command may be justified, provided, as Dr. Akeroyd so rightly points out, the need is recognized to investigate the underlying psychodynamics, and that without undue delay. In this respect a recent article by Raginsky[1] is of great value in stressing the importance of evaluating "(1) what the disease means to the patient; (2) how the patient uses his symptoms, even a specific organic abnormality in the service of his neurosis; and (3) how the patient responds to the treatment situation."

According to French and Alexander[2] the commonest emotional conflicts of the asthmatic include "threats to dependent relationships"; therefore in undertaking the treatment of such a case by any psychotherapeutic means the doctor may be tacitly accepting responsibility for indefinitely bolstering up a threatened dependency state, and unless he is prepared to meet the demands implicit in this role the therapeutic relationship will collapse. That the symptom of asthma can be of priceless value to the patient I have experienced to my cost. Amongst half a dozen asthmatics treated by hypnosis in this practice, there was one 25-year-old man in status asthmaticus, to whom I was called. Since he was adrenaline-fast and intolerant of therapeutic doses of intravenous aminophylline (however slowly given), I resorted to symptom-removal by direct suggestion under hypnosis, and was gratified by the immediate and complete response. I was able to leave him altogether symptom-free within half an hour, and he appeared delighted at his relief. I did not start psychotherapy. On the next occasion I was required to treat his asthma I offered to provide the same relief by hypnosis again,