clear evidence for the transmission of infection to the patient This difference was significant at the 0.01 level when a paired approach was used compared with remaining silent without a face mask, this difference was not significant.

We suggest, therefore, that the act of speaking may itself promote the dispersal of bacteria from the upper airway, and that failing to control for this effect renders some of the conclusions of Philips and colleagues open to question. Face masks may help prevent the spread of bacteria, but our results show that remaining silent may achieve this aim at least as effectively. If the prevention of transmission of infection from the anaesthetist to the patient is paramount, then we suggest that the anaesthetist remain silent while performing spinal anaesthesia, whether a face mask is worn or otherwise.

Sir,—The wearing of face masks while performing spinal anaesthesia remains a controversial issue. Although there is little evidence that masks are effective in reducing bacterial infection, and consequently their use is recommended in practice. However, we believe their conclusions to be flawed in one respect. They compared contamination of agar plates when subjects were talking at the plates with and without the use of a face mask. In their study, they did not examine the effect of the subject remaining silent for the 5 min of the study period. If the aim is to find a way of eliminating transmission of bacteria, we feel that this aspect should be examined. It may be that remaining silent for most of the period of insertion of a spinal may itself help prevent the dispersal of bacteria, but our results show that remaining silent may achieve this aim at least as effectively. If the prevention of transmission of infection from the anaesthetist to the patient is paramount, then we suggest that the anaesthetist remain silent while performing spinal anaesthesia, whether a face mask is worn or otherwise.

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PAIN ON I.V. INJECTION OF METOCLOPRAMIDE

Sirs,—I was interested to read the report of Ganta and Fee [1] in which they described the use of metoclopramide 5 mg in an attempt to abate the pain produced by injection of anesthesia by propofol. Their work suggests that the drug is as effective for this purpose as the more commonly used lignocaine.

I have been using metoclopramide as an antiemetic for more than 2 yr. I give every patient I anaesthetize an i.v. bolus of metoclopramide 10 mg in an attempt to abate the pain produced by injection of anesthesia by propofol. Their work suggests that the drug is as effective for this purpose as the more commonly used lignocaine.

I believe that this response is recognized by those who use the "high dose" ampoules (100 mg) of metoclopramide in chemotherapy treatments, but not by anaesthetists. Interestingly, this side effect is not recorded in the relevant Data Sheets for this product [2]. I continue to use metoclopramide, but now administer the drug when the patient is asleep.

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