determination of the cause of death. The value of the studies published in the last decade[2 7 8 9] lies in the accuracy of diagnosis and in the statistical care with which the death rates have been computed and compared—the latter being the more difficult problem as we are dealing with an abnormal population with a generalized disease.

So all aneurysms should be treated surgically, provided the general state of the patient permits it. What is the mortality rate of elective aneurysmectomy? The figures from the large centres[10] show a declining rate, from 10% in the early years to less than 5% now. This is the result of increasing technical expertise and improved postoperative care, and it argues strongly for the treatment of all aneurysms in specialized units. This is no problem in the United Kingdom, where all patients are within reach of a vascular surgeon. The difficult case for the general surgeon is the patient with an aneurysm that suddenly becomes very painful and is probably beginning to leak. Surgery is urgently required; but should it be done locally with a higher morbidity and mortality or should the patient be transferred to a specialist? If the patient has no physical signs of blood loss then he should be able to withstand a journey of an hour or so, but if he is hypotensive the aneurysm is likely to be ruptured, and it is better to operate on the spot even though his general condition improves with blood replacement. Provided an adequate incision is made and there is ample blood replacement at hand this need not be as hair-raising an operation as many expect. Almost all abdominal aneurysms start below the renal arteries and the only urgent part of the operation is the application of a clamp across the aorta below the renal arteries. Once this is done the surgeon can relax and proceed as in an elective operation.

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Marriage and Arthritis

All types of active arthritis cause pain, stiffness, and dysfunction, and they impose considerable limitations on the daily life of the sufferer. Attention has been given to the effects of arthritis on life in the home, office, workroom, and on the factory floor, and adaptations to dining rooms, bathrooms, kitchens, and lavatories described in detail to help the patient in his daily activities. But little notice seems to have been taken of the effects of arthritis on the patient's sexual activities and his or her ability, or inability in many cases, to lead a full and normal married life.

Inability to lead a normal sex life may marr or break some marriages, and in histories of patients with rheumatoid arthritis it is not unusual to hear of the unaffected party's resorting to alcohol or to other extramarital interests. Broken homes are not unusual in such situations. The disease itself may undergo periods of relapse triggered off by marital separations and differences, sometimes by true exacerbation of the pathological process. The patient may also experience a drop in the pain threshold and the onset of mental depression, with consequent failure to continue the fight against what appear then to be overwhelming odds. It is therefore timely that an inquiry into this previously almost unmentioned and unmentionable subject has been published by H. L. F. Currey[1] from the London and Notley Hospitals.

This study is confined to patients with osteoarthrosis of the hip, a group of sufferers who because of their age and absence of systemic features might have been expected to be less affected than patients with rheumatoid arthritis. A questionnaire was sent to 235 married patients. Of the 121 patients whose replies were analysed 73 were women, 48 men. All were under 60 years of age, and all had undergone surgical treatment of one or both hips in the previous 10 years at either the London or the Notley Hospital. They were therefore a selected group of patients with one particular type of arthrosis, and all had been treated surgically.

The results are of interest, though perhaps not unexpected. Of these 121 patients 81 (67%) reported some degree of sexual difficulty because of their arthrosis and nine discontinued sexual intercourse because of it. Sexual difficulties were more common and more severe in the women than the men, these difficulties being due usually to pain and stiffness in the hips rather than to any loss of libido. Only a minority, one-quarter of these patients, recognized the arthrosis as a distinct cause of unhappiness and mental tension, the frequency of marital problems being in proportion to the degree of sexual difficulty. In 70 patients the results of surgical operation on the hip could be analysed in relation to sexual difficulties, the operations performed being arthroplasty (35), osteotomy (16), total replacement (9), arthrodesis (5), Girdlestone arthroplasty (3), and femoral head replacement (2). The improvement in general symptoms was greater than was relief of sexual difficulties, though these, too, occasionally improved dramatically. The number of operations performed was too small to allow proper comparison between the different methods employed, but total replacement appeared to give best results in relieving pain and sexual difficulties. In contrast arthrodeses, while relieving pain in the hip, tended to have a bad effect on sexual function, and in two cases ended the sexual relationship.

Two-thirds of the patients with sexual difficulties welcomed some form of advice, usually for their partner as well as for themselves. Most favoured a booklet on the subject in preference to an interview with the family doctor or with a medical social worker, but one-third of patients with sexual problems ascribed to arthritis were not in favour of any form of advice on the subject. It seems that some patients are embarrassed or offended by being offered advice in these matters. Some, however, would have welcomed more exact advice from the surgeon on when it would be safe to resume sexual relationships after operation, some women in particular being frightened of damaging the operated joint. It is clear that this is a neglected subject, largely because, though of vital importance to the arthritic patient and his or her spouse, doctors, physiotherapists, and nurses are reticent about discussing such personal matters with the patient and the patient with them. Booklets have been written on "Your arthritis and your garden", but not yet on "Your arthritis and your marriage." This article seems to be the first step in that direction.

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