

need permanent treatment with elastic stockings to prevent recurrence,<sup>1</sup> there are several reasons why this should not be organised and supervised by individual general practitioners in the community. One of the problems in managing leg ulceration is establishing the precise aetiology of the ulcer as this has considerable bearing on the selection of the most appropriate treatment. If possible a diagnosis of venous disease should be confirmed. In trials of treatment of venous ulcers we include only patients with ulcers with a venous abnormality as shown by ascending and descending phlebography or calf pump studies and exclude those with concomitant ischaemia.<sup>2</sup> In all, in 25% of the patients with leg ulcers who present to our clinic the ulcers are associated with evidence of appreciable ischaemia. In a further 10% the ulcers are related to collagen disorders, haemoglobinopathies, trauma, tumours, skin disorders, and other causes. In about 5% no obvious aetiology can be determined. The diagnosis of ischaemia should not be post hoc, as suggested—that is, when bandages are painful or in patients with slowly healing ulcers that recur frequently. It is important to exclude ischaemia before treatment is started as application of 30-40 mm Hg compression bandaging<sup>3</sup> to an ischaemic leg can lead to loss of the leg. The presence of pedal pulses is often difficult to ascertain in an oedematous ulcerated leg, and few general practitioners have access to Doppler equipment let alone phlebography, light reflection rheography, or foot volumetry.

Dr Allen implies that hospital referral leads to either bed rest or surgery. We manage 95% of our patients with venous ulcers as ambulant outpatients whose compression bandages are changed at weekly or fortnightly attendances. This system works well and allows the patients careful initial diagnostic screening, closely supervised management (with rapid admission for surgical intervention when required), and suitable surgical or conservative preventive care after healing. It is crucial at this stage to evaluate the nature, if any, of the venous abnormality as more than half of the patients with venous leg ulcers are likely to have superficial and communicating vein incompetence, which if treated by the appropriate surgery results in a 5% rate of recurrence at five years.<sup>4</sup> Recurrent ulceration in legs of patients with post-thrombotic deep vein damage is much more difficult to prevent and requires careful assessment to discover if vein bypass or valve interposition, repair, or replacement is appropriate. The mainstay of treatment in these patients will remain obsessional wearing of good quality class 3 compression stockings and stanozolol to alleviate lipodermatosclerosis until the newer forms of direct venous surgery described above have been fully evaluated. These stockings are not currently available on FP10 prescription, also necessitating hospital referral.

ANDREW D R NORTHEAST  
NICHOLAS M WILSON  
KEVIN G BURNAND

Surgical Unit,  
St Thomas's Hospital,  
London SE1 7EH

- 1 Allen S. Venous ulcers. *Br Med J* 1990;300:826-7. (31 March.)
- 2 Northeast ADR, Layer GT, Stacey M, Wilson NM, Browne NL, Burnand KG. The effect of fibrinolytic enhancement on venous ulcer healing. In: Davy A, Stemmer R, eds. *Phlebologie* 89. London: Libbey, 1989:1167-9.
- 3 Blair SD, Wright DDI, Riddle E, McCollum CN. Sustained compression and healing of chronic venous ulcers. *Br Med J* 1988;297:1159-61.
- 4 Burnand KG, O'Donnell T, Lea Thomas M, Browne N. Relation between post-phlebotic changes in the deep veins and results of surgical treatment of venous ulcers. *Lancet* 1976;i:936-8.

SIR,—Dr S Allen makes several questionable assumptions which need qualification.<sup>1</sup> He seems to assume that all leg ulcers are caused by insufficiency of deep veins, and he makes no suggestion about how an accurate diagnosis might be made in

general practice. Accuracy of clinical examination in venous disease is notoriously poor, and even experts have difficulty agreeing about whether or not a pulse is present in the foot. There is an association between venous disease and peripheral vascular disease, and thus indiscriminate use of compression bandages or stockings in a population of patients of whom a tenth may have appreciable arterial occlusion seems to be a recipe for disaster. Such treatment for patients with arterial disease has resulted in amputation of the limb to which inappropriate compression bandaging has been applied. We suggest that assessment using simple non-invasive Doppler ultrasound of the arterial tree is mandatory in patients with apparent venous ulcers.

A second oversight is that between a quarter and two thirds of patients with venous ulceration have only superficial venous reflux, with or without varicose veins. Such reflux is amenable to surgery. In many cases the diagnosis can be made using a hand held Doppler ultrasound probe. To deny such a large proportion of patients the possibility of lasting cure, by omitting such a simple and inexpensive test, seems illogical. Ideally, a precise assessment of the patient's venous pathology should be made using duplex scanning, but we concede that this is available only in specialist centres.

We agree with Dr Allen that oedema and lipodermatosclerosis should be more widely recognised as early harbingers of ulceration. But a patient with those signs should have adequate venous investigation by the general practitioner or in a vascular laboratory, rather than be subjected to immediate and possibly inappropriate conservative treatment. When the cause of the ulcer has been elucidated fully the patient should be treated in the community, as Dr Allen suggests.

TIMOTHY CHEATLE  
PHILIP COLERIDGE SMITH

Department of Surgery,  
University College and Middlesex School of Medicine,  
London W1N 8AA

- 1 Allen S. Venous ulcers. *Br Med J* 1990;300:826-7. (31 March.)

## Walking frames

SIR,—Further to the article by Professor Graham Mulley on walking frames we would like to inform readers of the recent evaluation of frames carried out at the disability equipment centre at our hospital.

The study, which was funded by the Department of Health, evaluated the design features of the 28 walking frames (15 Zimmer type frames, nine rollators, and four gutter frames) most preferred by established users. Each of the 86 subjects tested three frames, for a week at a time, from the group in which their own frame belonged. All tests took place in the subjects' homes, and data on the ease of use, safety, and comfort were collected by means of questionnaires.

The results showed that no one frame was superior, and the design features most important to users' needs were identified. Generally, Zimmer type frames under 2.5 kg were acceptable; the weight of rollators and gutter frames was not important as long as the aid was easy to manoeuvre. Frames with front swivel wheels and back fixed wheels of diameter >11 cm were favoured for their easy manoeuvrability both indoors and outdoors. The stability of the frame, governed by its base area and height, influenced the user's feelings of safety, as did the width between the handgrips (or in the case of gutter frames the width between the forearm supports). Of the frames which folded or had brakes, most were unsuitable for the subjects to use effectively and independently. Four of the frames incorporated seats that were found to be uncomfortable, and all subjects experienced great

difficulty when turning around to sit down. Trays were considered very useful only on wheeled frames.

The compromise between a stable frame and one which is easy to use within the confines of the home makes it imperative that prescription takes place in the user's home. We recommend that walking frames are prescribed by experienced therapists, who should be aware of the diversity of design features and the large number of frames on the market and will be able to match up the most suitable frame to meet the needs of the user in terms of disability, environment, and lifestyle.

For copies of the full report, which will be published shortly, contact Mr D Sturrock, Department of Health, Kingston Bypass Road, Surbiton, Surrey, KT6 5QN.

J HALL  
A K CLARKE

Royal National Hospital for Rheumatic Diseases,  
Bath BA1 1RL

- 1 Mulley G. Walking frames. *Br Med J* 1990;300:925-7. (7 April.)

## NZ medicine after Cartwright

SIR,—Two gynaecologists who worked at the National Women's Hospital in Auckland have been charged by the New Zealand Medical Council with "disgraceful misconduct."<sup>1</sup> The basis for this charge is that active treatment was withheld from women with carcinoma of the cervix after convincing evidence had emerged that such treatment could be expected to do more good than harm.

There is a sad irony in the fact that it was at the National Women's Hospital that evidence was first produced showing that giving corticosteroids to women who were expected to give birth before term reduced the chances that their babies would die. Yet although these immensely important observations have been replicated in subsequent trials,<sup>2</sup> many obstetricians continue to withhold this life saving form of care. Indeed, this reluctance to use an effective form of care has been encouraged by views expressed in an editorial in this journal.<sup>3</sup>

What are fair minded people supposed to make of these apparent double standards? How should the conduct be assessed of doctors in many, if not all, medical specialties who fail to inform patients that they are being denied forms of care that have been shown in well controlled trials to be more likely to do good than harm? Unless the medical profession starts to confront this issue more squarely external forces will probably begin to influence clinical practice more directly, as Grant Gillett reports they are already doing in New Zealand.<sup>4</sup>

IAIN CHALMERS

National Perinatal Epidemiology Unit,  
Radcliffe Infirmary,  
Oxford OX2 6HE

- 1 Gillett G. NZ medicine after Cartwright. *Br Med J* 1990;300:893-4. (7 April.)
- 2 Liggins GC, Howie RN. A controlled trial of antepartum glucocorticoid treatment for prevention of the respiratory distress syndrome in premature infants. *Pediatrics* 1972;50:515-25.
- 3 Crowley P, Chalmers I, Keirse MJNC. The effects of corticosteroid administration before preterm delivery: an overview of the evidence from controlled trials. *Br J Obstet Gynaecol* 1990;97:11-25.
- 4 Robertson NRC. Advances in respiratory distress syndrome. *Br Med J* 1982;284:917-8.

## Correction

### Thyroxine replacement treatment and osteoporosis

An author's error occurred in this letter by Dr P B S Fowler (21 April, p 1074). In the study described in the second paragraph the number of women who developed ischaemic heart disease later was 16 (3%) and not 26 (4.9%) as published.