

$31 \times 10^9/l$. Levamisole was immediately discontinued and a week later the platelet count had returned to normal ($150 \times 10^9/l$). Levamisole was restarted in a dose of 100 mg/day. On 21 March 1977 the platelet count had again fallen to $87 \times 10^9/l$. The haemoglobin concentration was 13.3 g/dl and the total white cell count $5.7 \times 10^9/l$. Levamisole was discontinued and on 14 April 1977 the platelet count was again normal ($159 \times 10^9/l$).

Comment

Although agranulocytosis has been reported in patients with rheumatoid arthritis taking levamisole,⁴ we can find no report of thrombocytopenia caused by levamisole therapy. Our patient was receiving only naproxen and levamisole when thrombocytopenia developed. The platelet count quickly returned to normal on stopping levamisole despite the fact that naproxen was continued. When levamisole was reintroduced in a smaller dose thrombocytopenia again resulted, and the platelet count again quickly returned to normal on stopping the drug. Levamisole was therefore almost certainly the agent responsible for the thrombocytopenia. We did not consider it justified to carry out bone marrow examination, especially as the patient was rather nervous at the thought of the procedure.

Patients with rheumatoid arthritis inevitably suffer from poly-pharmacy. This patient had previously taken indomethacin in a relatively high dose of 200 mg and had also received feprazone.

Indomethacin has only rarely been reported as a possible cause of thrombocytopenia.⁵ Feprazone has a pyrazolidine ring in common with phenylbutazone and as such might have the potential for causing thrombocytopenia. But no case of thrombocytopenia has so far been reported with feprazone treatment. It thus appears that levamisole was the likely cause of a low platelet count in this patient.

¹ *Lancet*, 1975, 1, 151.

² Huskisson, E C, *et al*, *Lancet*, 1976, 1, 393.

³ Ritchie, D M, *et al*, *Quarterly Journal of Medicine*, 1968, 37, 393.

⁴ Ruuskanen, O, *et al*, *Lancet*, 1976, 2, 958.

⁵ Duval, R, and Villiaume, J, *Revue du Rhumatisme et des Maladies Ostéo-articulaires*, 1964, 31, 204.

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SHORT REPORTS

Return to work after aortofemoral bypass surgery

The effect of aortofemoral bypass surgery on the return to full employment of 51 members of the working population is described.

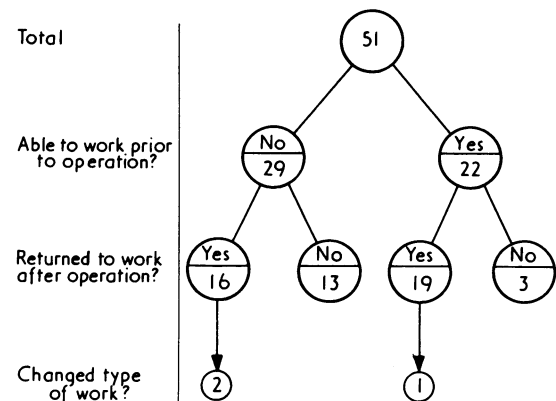
Methods and results

All patients aged 60 or under who had undergone aortofemoral bypass for severe intermittent claudication or rest pain during 1973-5 at the Royal Victoria Infirmary, Newcastle upon Tyne, or at the Newcastle General Hospital, were sent the following questionnaire:

- What was your job before you had problems with the arteries in your legs?
- Before the operation were you forced to stop work because of the arteries?
- After a period of convalescence did you get back to work? If yes, how long after operation?
- If you did return to work did you have to change your type of work?
- If you did not return to work, was this because you were unable to manage your previous job?
 - Or were you made redundant?
 - Or could you not return because of some other medical illness. If yes, please specify.
- If you were unemployed before the operation did you find employment after operation?
 - If you did find employment after operation was this as a result of the improvement produced by the operation?

There were 53 patients aged 44 to 60, eight of them women. All the patients had been in regular employment. One patient had died from a myocardial infarction shortly after return home and one could not be traced. The progress of the remaining 51 patients is summarised in the figure.

Of the 35 patients who returned to work, the average interval between operation and return to work was 4-5 months. Sixteen patients did not return to work after operation. Of the thirteen who had not worked before operation, ten were men. Of these, four had either myocardial or cerebrovascular problems, one had unrelated malignant disease, two became redundant, and the remainder felt they "just could not manage." Of the three women who did not return, one had developed an upper limb occlusion and the others had been advised to retire by either medical board or spouse, although all three commented on a definite postoperative improvement at the end of the questionnaire, and none complained of difficulties in performing routine housework. Of the remaining three patients who had worked before operation, the first sustained a myocardial infarction, the second a myocardial infarction with a cerebrovascular accident later, and the third was offered early retirement.



Working history in relation to aortofemoral bypass.

Comment

When judging the success of vascular operations patency rates tend to be quoted and the patient's return to a normal working life forgotten. In this series 29 patients were totally lost to productive employment before operation. Sixteen of these returned to active employment, 14 to their original work, and this was in a region of high unemployment. The current economic climate must naturally invite medical audit and cost-effectiveness studies.^{1 2} Without taking into account any other benefit produced by aortofemoral bypass, we conclude that the operation produces a definite return to employment in those who would otherwise draw permanent sickness benefit.

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¹ *British Medical Journal*, 1975, 4, 723.

² *Lancet*, 1976, 1, 132.

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