prevalence of morbidity and mortality due to respiratory disease and the likelihood of successful treatment for many patients should persuade those in the district of the need for a specialist in thoracic medicine. The document produced by the college committee, based on work carried out by the regional representatives of the British Thoracic Society, should also stimulate a greater awareness of this need. Whether every hospital will now rush to appoint someone trained in thoracic medicine is another matter, but at least now each district has some idea of what is required to provide a basic service. All this does not circumvent the central problem of too many subspecialists chasing too few openings in the districts, which needs further thought. Perhaps between the monospecialist and the general physician we need consultants trained in two or three subspecialties. Is it time to consider, say, a geriatrician who has specialised in thoracic medicine and can cover acute medical duties (together with consultant expansion, of course)?

T J H CLARK

Subdean and Dean Elect,
Guy's Hospital Medical and Dental Schools,
London SE1 9RT

- 1 Anonymous. Requirements for thoracic medicine. *Thorax* 1984;39:400.
- 2 Social Services Committee. *Fourth report. Medical education with special reference to the number of doctors and the career structure in hospitals*. London: HMSO, 1981. (Short report.)
- 3 Crofton J, Douglas A. *Respiratory diseases*. 2nd ed. Oxford: Blackwell Scientific, 1975.
- 4 Gregg I. Epidemiological aspects. In: Clark TJH, Godfrey S, eds. *Asthma*. 2nd ed. London: Chapman and Hall, 1983.
- 5 Anderson HR, Bailey PA, Cooper JS, Palmer JC. Influence of morbidity, illness label and social, family and health service factors on drug treatment of childhood asthma. *Lancet* 1981;iii:1030-2.
- 6 Speight ANP, Lee DA, Hey EN. Underdiagnosis and undertreatment of asthma in childhood. *Br Med J* 1983;286:1253-6.
- 7 Dodge RK, Burrows B. The prevalence and incidence of asthma and asthma like symptoms in a general population sample. *Am Rev Respir Dis* 1980;122:567-75.
- 8 British Thoracic Association. Death from asthma in two regions of England. *Br Med J* 1982;285:1251-5.

Injuries to the lateral ligament of the ankle

Once the diagnosis of a torn ligament is made the surgeon is left with a difficult decision. Should he explore the area at once to attempt a primary repair? Or should he treat the injury conservatively, using surgery later if reconstruction is required? The choice is made more difficult by the problems of selecting materials for reconstruction. Traditionally nearby tendons have been used, either as an active reinforcement or as a tendodesis to replace the damaged structure. Braided nylon has been tried with little success. The advent of carbon fibre, into which tissues will grow, was hailed as a breakthrough—but problems have now been encountered with this material, especially when it lies within the joint.

Injuries to the lateral ligament of the ankle exemplify these problems. The ligament is divided into three bands, all attached proximally to the tip of the fibula. The middle band, which runs vertically to the os calcis, is known as the calcaneofibular ligament. The other two run forwards and posteriorly from the fibula to the talus and are known respectively as the anterior and posterior talofibular ligaments. They passively stabilise the ankle by preventing excessive inversion of the ankle-hindfoot complex. They are ruptured when the hindfoot is adducted violently, and the anterior division may also be damaged when the foot is violently inverted when plantar flexed. More severe violence leads to fractures of the malleoli.

Cass and Morrey have reviewed the management of injuries to the lateral ligament of the ankle and given firm and sensible

guidelines for treatment.¹ They emphasise the need for a carefully taken history, which should not only elicit the traditional story of a twisting injury to the joint suffered in a fall or step on uneven ground but should also exclude other important illnesses. Careful examination is essential. The area will be bruised and swollen. Local tenderness on palpating the individual elements of the ligament may help in assessing the extent of the damage. Radiography is essential to exclude bony injury—and, if total disruption is suspected, x ray films will also be necessary to assess the stability of the ankle both on inversion and on drawing the foot forward on the tibia. These examinations must be performed under an anaesthetic, either given locally into the haematoma or general, and the movements compared with the other side. An increased talar tilt of 30° or more compared with the normal side denotes a complete tear of the lateral ligament. An anterior shift of 2 mm of the foot on the tibia indicates a rupture of the anterior talofibular ligament.

Cass and his colleagues divide the injuries into three grades. Grade 1 is a mild stretch of the ligament with no instability, grade 2 is a moderate but incomplete tear of the ligament with mild instability, and grade 3 a complete tear with gross instability. In grades 1 and 2 the treatment does no more than improve the patient's comfort, for the lesion will heal whatever is done or not done. Supportive bandages, partial weight bearing with crutches, and physiotherapy will provide a satisfactory regimen if the pain is not severe. When pain is a problem strapping or a short spell in plaster of Paris may be required; this will allow the patient to return to full activities in his own time, as the symptoms subside. In grade 3 injuries a stricter regimen is recommended by Cass and his colleagues. They do not believe in surgery in the acute stages, basing their decision on the results of a long term follow up study of ankle injuries treated either by primary repair or by delayed reconstruction. Nine years after treatment the results for each group were similar (American Association of Orthopedic Surgery, General Session, March 1983). Since ankles treated conservatively rarely require surgery later and late reconstruction gives as good results as early primary repair a "wait and see" policy makes sense. This procrastination is supported by Freeman, who found that routine surgical repair of tears of the lateral ligament of ankle produced results inferior to a conservative regimen.² The consensus is that these patients should be put in plaster of Paris for six weeks and then gradually returned to activity with the joint protected by strapping. Physiotherapy should be used to strengthen the peroneal muscles.

Even if the ankle shows signs of chronic instability—pain, swelling, and recurrent giving way—surgery is not always required. The patient should be advised to lose weight, wear a float out heel, and women should be advised to use lower heeled shoes. Physiotherapy is rewarding—especially wobble board exercises to re-establish the proprioceptive function of the local muscles and tendons. If despite these measures symptoms persist surgery is effective. Most procedures (for example, of Watson-Jones, Evans, etc) require rerouting one of the peroneal tendons to replace the ligament.

C D R LIGHTOWLER

Consultant Orthopaedic Surgeon,
Essex Nuffield Hospital,
Brentwood CM15 8EH

- 1 Cass JR, Morrey BF. Ankle instability: current concepts, diagnosis and treatment. *Mayo Clin Proc* 1984;59:165-70.
- 2 Freeman MAR. Treatment of ruptures of the lateral ligament of the ankle. *J Bone Joint Surg* 1965;47B:661.