They should be reassured that if a severe adverse reaction occurs it will quickly disappear if the drug is stopped. At first, close supervision is necessary, and patients often require encouragement to persevere with treatment during the several months that may elapse before real benefit accrues. After the maximum tolerated dose has been reached it may be redistributed in the 24 hours to obtain optimal benefit throughout the day, and minor adjustments may be required from time to time. Even patients who show a sustained improvement on levodopa may notice a fluctuation in their functional ability from day to day. Once a patient has become familiar with his treatment he need be seen only infrequently, and it is reasonable to prescribe at least one month's supply of drugs at each attendance.


Short-leg Syndrome

When faced with otherwise unexplained musculoskeletal symptoms the clinician may be tempted to postulate mechanical stresses associated with asymmetry of the limbs or limb-girdles. There have been several studies of unequal length of legs and pain low in the back. Techniques have included intricate measurements on radiographs taken in the erect position, measurement of true and apparent leg-length by tape measure, and simple palpation of the iliac crests while correcting pelvic tilt with heel blocks of different heights. The results suggest that the last method is quite adequate for routine clinical practice. From x-ray measurements W. A. Rush and H. A. Steiner found that 77% of 1,000 soldiers with low back pain had an average inequality of leg-length of 7 mm. Similarly A. Stoddard found that 17 of 100 patients had 0-5 in (12-5 mm) or more of femoral shortening compared with 8% of symptomless control subjects. P. J. R. Nichols and N. T. J. Bailey studied the observer-error in measurement of the apparent length of the legs by tape measure from the anterior superior iliac spines to the medial malleoli and concluded that differences of 0-5 in (12-5 mm) or more were diagnostically significant. Using this method, Nichols found leg shortening in 22% of 180 airmen with back ache compared with only 7% of controls. B. J. Sicuranza and his colleagues screened 1,000 obstetric patients by palpating the iliac crests and found 63 (6%) with unequal legs. Of these 53 complained of either low back or flank pain for which no gynaecological cause was evident. They claimed that 90% of these patients were relieved by compensatory heel raise.

Simple developmental inequality of length of the legs is usually not gross. The patient stands with a slight pelvic tilt, and there is commonly a compensatory thoraco-lumbar scoliosis. There may be some asymmetry of the height of the shoulders—which may well have been noted previously by an observant tailor. On the short side the flank will appear less hollow, the hip less prominent, and the gluteal fold lower. Many years may elapse before symptoms develop. Presumably the younger mobile spine is capable of adapting to unequal mechanical stresses.

More extreme cases may be due to congenital or acquired hip disease, while growth of the bones may be retarded by polyomyelitis and accentuated by chronic osteomyelitis and vascular malformations. Some degree of shortening is common after major fractures of the lower limb, and compensation is essential if the patient is to walk without a limp; an ill-fitting leg prosthesis can produce similar effects. In such cases the knee joint of the longleg may be kept flexed to compensate. A. St. J. Dixon and S. Campbell-Smith have shown that in patients with real or apparent inequality of leg-length of more than 25 mm present for more than one year the knee joint on the longer side was subject to greater arthritic damage.

It seems, then, desirable to treat any inequality in the length of the legs of more than 12-5 mm even if it is not currently causing symptoms. If the deformity is longstanding correction should be performed in stages. Adjustments of up to 25 mm can be made simply by raising one heel and lowering the other. If, however, a raise of more than 12-5 mm is required on one side some thickening of the sole is necessary.


A Psychiatrist in Space?

Four hundred and fifty years ago Ferdinand Magellan entered the Mar Pacifico by the straits that now bear his name. He was on a voyage to circumnavigate the world, and he called on his priest to bless the ships, led his crew in chanting a Te Deum, and fired off his guns. No doubt this ceremony gave comfort to the explorers of the sixteenth century, but from where can the astronauts of the twentieth century draw sustenance when they pass through their Straits of Magellan?

With the advent of another journey to the moon one cannot help but think of Apollo 13. It was during this mission that the mental reserves of three men were tested, perhaps, to the limit, and yet they came through the ordeal without the need for spiritual or psychological support provided by a third party. Their only contact with civilization was what may have seemed to be the impersonal voice of mission control supplying technical information in a stereotyped manner.

Do the astronauts need a psychiatrist? The aerospace world is divided—though not equally. The vast majority of aerospace doctors can see no role for the specialist in psychological medicine during a space flight. They argue that astronauts are essentially self-selecting individuals whose experience and skill in aviation fit them for their role and whose ability to complete the training programme excludes the possibility that they may not be able to cope under pressure. The very few who can see a part for the psychiatrist argue the need for a person able to understand their difficulties and advise them in their time of need. The astronauts claim to feel a personal relationship with mission control and have not considered the need for a doctor trained in psychological medicine. It would appear that the voice of mission control and the skill and experience which it represents is their support.