

drugs should aim at an even larger number of patients and continue longer. The planning of this study started in 1985 after our first results² were available; at this time there were no human data suggesting a renal protective effect of angiotensin converting enzyme inhibitors.

Peter T Sawicki and Michael Berger seem to recommend a comparison of enalapril and metoprolol treatments during the follow up period from six months onwards, and that only patients with follow up times of one year or more be included. A total of 18 patients treated with enalapril and 13 treated with metoprolol are evaluable in this respect. During this period the mean (SD) rate of change in glomerular filtration rate was 0.8 (4.7) ml/min/year in the enalapril treated and -3.3 (4.2) ml/min/year in the metoprolol treated patients ($p=0.016$). The mean arterial blood pressures (mean of supine and standing pressures) were 102 (5) mm Hg and 103 (4) mm Hg, respectively. Multiple regression analysis shows that enalapril or metoprolol treatment was correlated to the rate of fall in glomerular filtration rate ($p=0.02$) but mean arterial blood pressure was not ($p=0.8$). If supine or standing mean arterial blood pressure is used, neither result is significant ($p=0.26$ and 0.4 , respectively).

Thus, in our enalapril treated patients there was no fall in glomerular filtration rate after the first six months. Blood pressure was less important for the prognosis of renal function than type of anti-hypertensive treatment in these patients with well controlled blood pressure.

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Rehabilitation of amputees

SIR,—S J D Chadwick and John H N Wolfe rightly point out that early referral of a patient with critical ischaemia of the lower limb is essential and that if salvage is not possible sufficient time will be available to prepare the patient for amputation.¹ They fail to emphasise, however, that rehabilitation must start immediately, not postoperatively.

Most amputations should be planned procedures that allow time for full medical and social assessment, improvement in general condition, adequate control of pain, counselling, and psychological help. Early assessment allows patients to collaborate in setting realistic, achievable goals and may prevent the disappointment, disillusion, and despair resulting from overoptimistic promises about future capabilities.

Patients who are referred late to prosthetic centres for assessment and measurement, only to be advised that wheelchair independence is a more realistic goal, inevitably plead for the chance to walk. In this forlorn struggle ritual visits for physiotherapy may ensue and amputees and professionals alike become increasingly frustrated. Repeated attendances at clinics focus on the discomfort of prolonged periods sitting in a wheelchair wearing the leg, its weight, and requests for a lighter leg as the grieving process continues—fuelled by failure to extinguish memories of youthful vigour and cope with the harsh reality of loss of the limb. This more common result of above knee or Gritti-Stokes amputation emphasises that preserving a functional below knee stump as a new organ of locomotion is probably the single most important physical factor in maximising functional ability.

Rehabilitation has major consequences for effective use of resources. The rehabilitation team can have a major impact on reducing hospital stay and repeated outpatient physiotherapy visits and improving use of prostheses.² The importance of specialist interdisciplinary, hospital based teams dedicated to rehabilitating amputees working in close cooperation with prosthetic centres cannot be emphasised too greatly. Some districts have already achieved this, but others lag far behind in affording amputees the special consideration they require. Some changes recommended by McColl have now been implemented.³ The Disablement Services Authority was finally integrated into the NHS in April last year, and most prosthetic centres are now led by consultants in rehabilitation. As Chadwick and Wolfe point out, new elderly amputees require extensive support and supervision if they are to return to the community. Therefore, rehabilitation consultants should coordinate the support and specialist services required to enable efficient and effective integration back into the community.

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SIR,—In their article on rehabilitation of amputees S J D Chadwick and John H N Wolfe make the point that an amputee who can walk is the main aim.¹ This is a good general rule but perhaps not one to be pursued at all costs.

For a considerable proportion of elderly patients who have had above knee (and especially bilateral) amputations, persevering in the attempt to obtain prosthetic ambulation is futile and even dangerous.^{2,3} The energy cost of ambulation with one above knee prosthesis is roughly twice that for someone with two normal legs. For someone whose cardiac or respiratory system is compromised that might be too much. The energy costs of wheelchair independence are less, and, provided that the patients do not have any problems with their arms, this might be the preferred option.

Much disappointment on the part of both the patient and the doctor can be averted if, for these selected few patients, wheelchair independence (as against prosthetic mobility) is opted for in the first instance, with support from the occupational therapist and social worker to adapt the home. Foam "trouser fillers" to restore the body image are required for some of these patients. Some above knee amputees use the prosthesis only as a prop for transferring themselves, and this may be a legitimate use of a prosthesis.

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Morbidity due to asthma

SIR,—K P Jones and colleagues have confirmed previous reports of the level of morbidity among patients with asthma.¹ I am concerned, however, about their analysis of the correlates of morbidity and the claims made for their morbidity index.

I assume that subjects were asked to summarise their asthma over the previous year (this is the

interval used by Hilton *et al*, from whose work the questionnaire was developed, and is the interval noted in table II).² I suspect that having to review morbidity over such a long period may result in considerable overreporting. I have observed some overreporting with my own questionnaire, which reviews only the previous six months.³ The usefulness of such lengthy reporting in subjects under 15 years old is even more doubtful as symptoms are more likely to come and go in children.⁴ Subjects aged under 15 comprised more than a third of the subjects in Jones and colleagues' study.

The diary of peak flow was completed in the week after the interview and reflects the state of asthma then. The questionnaire, on the other hand, described the asthma over the previous year. Though the peak flow recorded in the diary will probably be related to the reporting of morbidity because they were both reported by the same patients, it is not reasonable to claim that the index constructed from symptoms over the past year "relates to lung function" as lung function was not measured at the same time.

I believe that the authors have given an important signal to doctors treating asthma. We should not fail to assess the long term impact of asthma in our history taking. In testing the value of our strategies to improve care in asthma, however, we must continue to refine our measurement of morbidity in patients with asthma.

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Occupational causes of disorders in the upper limbs

SIR,—N J Barton and colleagues miss the point in their review of occupational causes of disorders in the upper limb.¹ They are guilty of the crime of diagnostic greed, for they want clear cut physical signs and histological evidence as well, presumably in individual cases. How else can any condition be prescribed as an industrial disease if it is to be unambiguously defined, both clinically and pathologically?

We suggest a simpler approach. History taking concerning the onset and relief of pain may provide clear clues in individual cases. Pain occurring later during working days and later on during the week suggests that the complaint may be related to work. Pains that improve over the weekend or remit during holidays or during intercurrent illness add weight to a clinical suspicion that symptoms are related to work. If the patient's job is analysed and ergonomic measures taken and if symptoms respond then a "therapeutic test" has supported the hypothesis that the condition is related to work. This is a reasonable approach in less acute cases. In cases of the so called repetitive strain syndrome, however, it may be too late to apply such a therapeutic test.

European Community legislation adds weight to the views of ergonomists. Simply because pain is an everyday part of working life does not mean that it should not be prevented or relieved, and legislation and the recognition of "prescribed disorders" are inevitable. The only approach that will work, particularly where diagnostic entities overlap so frequently and the measurement of disability is so