mended to direct urine away from the fistula. This allows the patient to recover fully from the primary insult. Re-exploration 3–4 weeks later allows definitive repair in a fit patient through dry tissues. Success without nephrectomy is then more likely.

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**Reference**

*1* Cetti NE. Delayed urinary fistula from high-velocity missile injury to the ureter—a salutary lesson. *Ann R Coll Surg Engl* 1983; **65**: 286–8.

## Evaluation of the modified Alvarado score in the diagnosis of acute appendicitis: a prospective study

We read with interest the report by Messrs Kalan *et al.* (*Annals*, November 1994, vol 76, p418) on the modified Alvarado score in the diagnosis of acute appendicitis. The authors conclude that a score of $\geqslant 7$ worked "extremely well in children and men". Unfortunately, however, their figures do not appear to support their contention as six of 21 men (29%) had a score of $<7$ and four of these had appendicitis. While the principle of striving to reduce the negative appendicectomy rate is to be applauded, all such diagnostic aids and scoring systems are inherently flawed because, for the attending surgeon, clinical impression will always sway a final decision. This is amply illustrated by this paper in that although six of the 21 men had scores $<7$, the authors were nonetheless prompted to proceed to appendicectomy in these six cases.

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## Lower limb amputation: striking the balance

The length and shape of the stump are relevant in prosthetic rehabilitation as mentioned by Mullick (*Annals*, November 1994, vol 76, p420). The length influences the energy consumption *(1,2)* and the shape and volume dictate the fit of the socket. However, there are many other factors which contribute to the quality of the stump. Obviously, for the total rehabilitation numerous other factors need to be considered.

Recently we completed an audit about the quality of the stump and its influence on rehabilitation, ignoring all other factors. The amputees seen between 1 January 1993 and 31 December 1993 were chosen at random. Stumps were scored according to the format shown in Fig. 1. Those patients who were prescribed prostheses were reassessed in July 1994. The minimum follow-up period was 6 months.

Our usual practice is that an amputee is assessed by a multidisciplinary team at the first attendance and a photograph of the stump is taken. With the help of a pulse oximeter and peak expiratory flow estimation we predict the mobility grade for the individual *(3)*. We feel our confidence in predicting the mobility grade has improved due to the use of the above equipment.

*Name* .....

*DoB* ..... *Ref. No*.....

*Operator*.....

*Hospital*.....

*Date of Amp* .....

*Amp. Site R/L Level*.....

*Date of Assessment* .....

| | | | |
|---|---|---|---|
| Wound | Healed | +10 | |
| | Unhealed | −5 | |
| | Infected | −10 | |
| Oedema | None | +10 | |
| | Minimal | +5 | |
| | Significant | −5 | |
| Scar | Fully Mobile | +10 | |
| | $<\frac{1}{4}$ Adherent | −5 | |
| | $>\frac{1}{2}$ Adherent | −10 | |
| Tenderness | None | +10 | |
| | Moderate | +5 | |
| | Severe | −10 | |
| Proximal Joint Contracture | None | +10 | |
| | <20° | +5 | |
| | >20° | −20 | |
| Bone End Sculpted | Satisfactory | +10 | |
| | Acceptable | +5 | |
| | Unsatisfactory | −10 | |
| | Bone End Exposed | −20 | |
| Skin | Sensate | +6 | |
| | Insensate | −6 | |
| | Insufficient | −6 | |
| Length | Suitable* | +10 | |
| | Acceptable | −5 | |
| | Unsuitable | −10 | |
| Shape | Conical/Cylindrical | +6 | |
| | Bulbous | −6 | |
| Dog-ears | None | +6 | |
| | Minimal | 0 | |
| | Significant | −6 | |
| Redundant Tissue | None | +6 | |
| | Minimal | +3 | |
| | Significant | −6 | |
| Additional Scars or Other Factors† | No | +6 | |
| | Yes | −6 | |

* To affect prosthetic fitting
† For a transfemoral stump, at least 10 cm of space available above the knee joint line, 14–16 cm distal to the knee joint line in a transtibial stump.

*Figure 1.* Stump grading.