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CORRESPONDENCE

We welcome letters to the Editor concerning articles which have recently been published. Such letters will be subject to the usual stages of selection and editing; where appropriate the authors of the original article will be offered the opportunity to reply.

Letters should normally be under 500 words in length, double-spaced throughout, signed by all authors and fully referenced. The edited version will be returned for approval before publication.

AMPUTATION FOR REFLEX SYMPATHETIC DYSTROPHY

Sir,

We wish to comment on the article in the March 1995 issue by Dielissen et al entitled 'Amputation for reflex sympathetic dystrophy' (1995;77-B:270-3). The authors describe 28 patients with reflex sympathetic dystrophy (RSD) who were treated by amputation for "untenable pain, recurrent infection, or to improve residual function".

The complex pathophysiology of RSD (also known as complex regional pain syndrome-type I: International Association for the Study of Pain (IASP)) makes it less than surprising that amputation was entirely unsuccessful, and it is not clear why such surgery might have been thought to be helpful. We agree with the authors' conclusion that amputation is not a reasonable treatment for RSD, but feel that a stronger condemnation of such practice is essential.

The article reported three forearm amputations, one above-elbow amputation, eight above-knee amputations and ten knee or below-knee amputations with no improvement in pain or function. Recurrent infection may sometimes be an indication for amputation, but it was not clear that such a drastic treatment was justifiable. The desire of a patient to undergo amputation, or a surgeon to perform amputation, is not an indication in the absence of medical need or anticipated benefit.

The authors cite other reports of amputation as treatment for RSD and we have found one additional case report presenting amputation as a treatment for RSD (Geertzen and Eisma 1994). The results in all cases were equivocal at best, and we consider that these case reports provide an argument against the use of amputation for RSD, and that there is no indication. We feel that the patients studied by Dielissen et al had amputations despite compelling reasons for not performing such surgery. One hopes that such a study need never again be published by the Journal.

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Dielissen PW, Claassen ATPM, Veldman PHJM, Goris RJA. Amputation for reflex sympathetic dystrophy. *J Bone Joint Surg [Br]* 1995;77-B:270-3.

Geertzen JH, Eisma WH. Amputation and reflex sympathetic dystrophy. *Prosthet Orthot Int* 1994;18:109-11.

Authors' reply:

Sir,

We value the comments of Drs Thomas and Fast on our paper. There is no doubt that amputation is not a treatment for reflex sympathetic dystrophy (RSD), but for some extremely debilitating conditions resulting from RSD such as chronic lymphoedema with recurrent infection, it should be considered with great care.

Before our paper was published only case reports had been presented. Since poor results are less likely to be published, and arguments for and against amputation have not been clear, we decided to study all such cases which we could identify in The Netherlands.

We reported that untenable pain was an extremely poor indication for amputation, but for recurrent infection amputation sometimes resulted in cure. We did not include three cases presenting with a limited area of chronically-infected scar tissue; in these local excision with free revascularised graft reconstruction was successful. Such extensive operations - as well as amputation - should be very carefully assessed and automutilation should be considered as a cause.

The third indication, improvement of residual function, also proved a good indication if considered with great care. This group included patients with longstanding RSD complicated by severe hyperpathy of a fully defunctionalised limb. Amputation can improve function in such patients. A hyperpathic stiff finger may obstruct the use of the hand because of fear that the finger will be touched. Amputating this finger cannot cure RSD but will improve hand function.

The experience gained during 12 years of over 1500 patients with RSD has taught us that in carefully selected cases with longstanding severe RSD, amputation may result in a considerable improvement in the quality of life. Never say never!

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SECOND-LOOK ARTHROSCOPY AFTER MENISCAL REPAIR

Sir,

I would like to comment on the paper in the March 1995 issue by Horibe et al on 'Second-look arthroscopy after meniscal repair' (1995;77-B:245-9). I agree with the view that the repaired meniscus may diminish the risk of subsequent osteoarthritis, but am critical of this particular paper.

It is well recognised that tears of the anterior cruciate ligament affect the outcome of repair quite dramatically, but in this report 75% of the patients had an associated anterior-cruciate lesion and yet we are given no information on the interval between cruciate injury and the diagnosis of the meniscal tear or the delays between ACL reconstruction and meniscal tear.

In the brief discussion of the effect of ACL injury it is reported