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 300 words in length, *double-spaced throughout*, signed by all authors and fully referenced. The edited version will be returned for approval before publication.

Percutaneous repair of the ruptured tendo Achillis

Sir,

We read with interest the article by Webb and Bannister[1] in the September 1999 issue describing a modification to the technique of percutaneous repair of tendo Achillis which is intended to reduce the risk of injury to the sural nerve. We agree that a prospective study comparing this with other standard techniques is essential to determine its role in the management of rupture of tendo Achillis.

They describe a regime of six weeks in a cast after operation. Several other studies[2-7] have shown that functional treatment with early movement using dynamic bracing does not compromise the operative repair and produces results which are better than those of immobilisation of the ankle. Functional treatment allows earlier return to work and sporting activities with higher patient satisfaction. We believe this to be the optimum method of postoperative management of the repaired tendo Achillis. Adherence to an outdated regime may make it more difficult to demonstrate the benefits of any new surgical method. Perhaps it may be possible for these authors to take account of this in their further studies.

S. DEAKIN, MSc, FRCS
J. WOOD, BSc, SROT
J. L. BARRIE, FRCS Orth
Blackburn Royal Infirmary
Blackburn, UK.

1. **Webb JM, Bannister GC.** Percutaneous repair of the ruptured tendo Achillis. *J Bone Joint Surg [Br]* 1999;81-B:877-80.
2. **Buchgraber A, Pässler HH.** Percutaneous repair of Achilles tendon rupture: immobilisation *versus* functional postoperative treatment. *Clin Orthop* 1997;341:113-22.
3. **Carter TR, Fowler PJ, Blokker C.** Functional postoperative treatment of Achilles tendon repair. *Am J Sports Med* 1992;20:459-62.
4. **Cetti R, Henriksen LO, Jakobsen KS.** A new treatment of ruptured Achilles tendons: a prospective randomised study. *Clin Orthop* 1994;308:155-65.
5. **Mandelbaum BR, Myerson MS, Forster R.** Achilles tendon ruptures: a new method of repair, early range of movement and functional rehabilitation. *Am J Sports Med* 1995;23:392-5.
6. **Mortensen NHM, Jensen PE.** Early motion of the ankle after operative treatment of a rupture of the Achilles tendon: a prospective, randomised, clinical and radiographic study. *J Bone Joint Surg [Am]* 1999;81-A:983-90.
7. **Solveborn S, Moberg A.** Immediate free ankle motion after surgical repair of acute Achilles tendon ruptures. *Am J Sports Med* 1994;22:605-10.

0301-620X/00/311045 $2.00
J Bone Joint Surg [Br] 2000;82-B:461-4.

Author's reply:

Sir,

We thank Messrs Deakin, Wood and Barrie for their interest.

We agree that functional bracing is now established as a proven technique for early mobilisation after repairs of tendo Achillis. We began using the new percutaneous repair in 1992, however, when functional bracing was only just becoming established.

We are currently carrying out a randomised, controlled trial, comparing percutaneous repair and the non-operative management of acute ruptures of tendo Achillis. We have recruited 70 patients to date and both groups have functional bracing in their rehabilitation programme. The non-operative group begins controlled mobilisation of the ankle after 2.5 weeks and patients in the operative group, who have had a percutaneous repair, are braced one week after surgery.

We hope to present the results of this trial within the next year.

J. M. WEBB, FRCS Orth
North Bristol NHS Trust
Bristol, UK.

Work practice and histopathological changes in the tenosynovium and flexor retinaculum in carpal tunnel syndrome in women

Sir,

It is with some concern that I read the conclusions of the article by Chell, Stevens and Davis[1] entitled 'Work practice and histopathological changes in the tenosynovium and flexor retinaculum in carpal tunnel syndrome in women' in the September 1999 issue. While I acknowledge the difficulties in producing any research on the subject of occupation in relation to disorders of the upper limb which will stand up to rigorous scientific appraisal, I do not believe that the conclusions stated can be drawn from the research undertaken.

There are a number of deficiencies. First, it would appear that the group of patients in which there may have been a relationship between high force with repetition and the presence of carpal tunnel syndrome numbered only seven. In the other group in which an association would not be expected there were 51. I believe that this imbalance seriously flaws the conclusion.

Secondly, careful review of the results seems to confirm the contention that in certain circumstances repetitive, forceful acts can lead to tenosynovitis, which in turn can give rise to carpal tunnel syndrome. For example, the authors report the case of a horse handler in whom they found a marked inflammatory cell infiltrate. Also, they note that certain non-occupational yet repetitive acts can aggravate symptoms in carpal tunnel syndrome, examples being knitting, sewing and gardening, and they report an association between these hobbies and the presence of tenosynovial fibrosis. I would, however, remind them that many people earn their living undertaking such activities.

Finally, chronology is of the essence in work-related disorders of the upper limb. While this may seem somewhat pedantic the authors make no mention of any time lag between cessation of working and surgery. If this time period is sufficiently long it may well be that any inflammatory response has subsided.