Letters to the Editor

Doping taboos

I read with interest your editorial entitled “Doping Taboos”. I have a particular concern at present involving the use of drugs and asthmatic athletes.

Up to 16% of children may have asthma and in adults this prevalence may approach 12%. Conventional therapy for asthmatics involves the early introduction of anti-inflammatory agents such as inhaled corticosteroids with the use of short acting β_2 agonists as required. Both these groups of substances are allowable by the International Olympic Committee, apart from the short acting β_2 sympathomimetic fenoterol which is metabolised to para-hydroxyamphetamine. A problem that is arising in clinical practice is the use of long acting β_2 sympathomimetics, notably the use of salmeterol. National guidelines on the management of asthma are moving towards the earlier introduction of this drug if the asthmatic's symptoms are not adequately controlled on 800 μ g of budesonide or beclomethasone daily. In fact, the Swedish National Asthma Guidelines¹ suggest that salmeterol should be introduced at this stage. Unfortunately salmeterol remains a banned substance, as confirmed by correspondence from the doping control unit of the Sports Council and from the International Olympic Committee Medical Commission.²

Salmeterol does not appear to have been abused to the same extent as clenbuterol, another long acting β_2 agonist. Clenbuterol decreases fat content and increases lean body mass in animals. Doses to achieve repartitioning are far in excess of those required for bronchodilator activity.³ As salmeterol is a recognised part of the management of asthma, it does seem inappropriate that this drug remains a banned substance at present, resulting in a possible reduction in asthma control.

Salmeterol by inhalation is particularly useful in prolonging protection against exercise induced bronchoconstriction, with its effects lasting for at least 12 hours⁴ and it is probably the most effective drug for this common complaint.

As salmeterol remains a banned substance at present, a large group of patients is denied the conventional treatment which is used on a regular daily basis by a growing proportion of the asthmatic population.

I would, therefore, fully support the editorial comment that theoretical consideration should not prevent the use of drugs which are given as first line orthodox treatment of common conditions.

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References

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- 2 Personal communication. Doping control unit. The Sports Council, March 1995.
- 3 Kennedy M. Drugs and athletes—an update. *Adverse Drug Reaction Bull* 1994; 639–42.
- 4 Newnham DM, *et al.* Salmeterol provides prolonged protection against exercise-induced bronchoconstriction in a majority of subjects with mild, stable asthma. *Resp Med* 1993; 87: 439–44.

Achilles tendon rupture

I read with interest the paper “Surgical treatment of ruptures of the Achilles tendon: a review of long-term results” by M Krueger-Franke, CH Siebert and S Scherzer (volume 29: 121–125, 1995).

Achilles, the Greek demigod who gives his name to the calcaneal tendon, was killed by an arrow released by Paris, a common mortal, not by Apollo.¹ According to Greek mythology, Apollo is one of the sons of Zeus and Leto, not a goddess. He merely guided the arrow shot by Paris to the only vulnerable point of Achilles, namely his heel.¹

Dr Krueger-Franke and colleagues should be congratulated for the amount of dedicated work that they have performed along the years, as theirs is probably the largest reported series to date of repaired ruptured Achilles tendons. However, their complication rate is very high, and the number of patients available for follow up is only approximately one third of the group originally treated. This low follow up rate may significantly bias the outcome of their study, as the patients reporting for further examination may be the ones experiencing symptoms.

Although the non-operative functional treatment advocated by German orthopaedic surgeons has recently been proven to be effective, a recent study of functional treatment following surgical repair has shown that calf circumference difference can be only 0.8 cm, and isokinetic strength, power, and endurance can all exceed 90% of the unaffected leg.² Even using more conservative immobilisation regimens accompanied by intensive postoperative rehabilitation, strength and endurance can closely approximate the uninjured side.³

As in other cases, “in medio stat virtus”. Younger, athletically active patients may be treated surgically. For older ones, or those with reduced functional requirements, a conservative approach can be considered. For both groups, functional treatment would probably be helpful to reduce the problems and the evils of prolonged immobilisation. The definitive answer is likely to be given by well controlled prospective randomised trials.

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