LETTERS TO THE EDITOR

John G P Williams

EDITOR, - I am moved to write, having just read the obituary of Dr John GP Williams, published in Volume No 29, Number 4, December 1995.

I was a trainee of Dr Williams in the early part of 1979. During my time with him at the Farnham Park Rehabilitation Centre I learnt an enormous amount of sports medicine and, more importantly, the practice of sports medicine.

As described in Dr Williams' obituary he was primarily a physician and then a surgeon. His hands-on approach to patients was a hallmark of his practice and I believe was the single most important thing impressed upon me at the time. I still teach his philosophy to my students today.

I wish to emphasise to all the readers of your journal that the contribution Dr Williams made to sports medicine around the world is enormous. He has influenced many of my colleagues directly through his teaching and research and we owe him a huge debt.

At a personal level, I attribute my success in sports medicine largely to the teaching of Dr Williams who was, in every sense, my mentor. He will be greatly missed.

PETER FRICKER

Professor of Sports Medicine (University of Canberra),
Director, Medical Services
(Australian Institute of Sport)

Acetabular fractures

EDITOR, - I would like to comment on the article on acetabular fractures sustained during competition cycling by Bass and Lovell, published in the September issue.¹ I would like to point out that further investigation of the fractures illustrated would be required before declaring them "minimally displaced" and assigning the patient to conservative management. This is particularly true in case 2, where we are presented an x ray which shows an anterior column fracture (iliopectineal line broken)

and a posterior wall fracture involving the weightbearing zone. All acetabular fractures warrant iliac and obturator (Judet) oblique views as a minimum, bearing in mind that the acetabulum is dome shaped and no number of views will show all parts of the articular surface tangentially to best reveal displacement. In cases such as this where a significant fracture is detected, CT scanning with multiplanar reconstruction is almost certainly justified to rule out articular steps which could lead on to early degenerative change within the joint. I believe this should have been pointed out as a "take home message", though I realise the full details of the cases presented may have been omitted for conciseness.

DAVID LIMB

Academic Department of Orthopaedic Surgery
St James's University Hospital, Leeds

- 1 Bass A, Lovell ME. Two cases of acetabular fractures sustained during competitive cycling. *Br J Sports Med* 1995;29:205-6.

The accessory soleus muscle

EDITOR, - We read with interest the paper by Featherstone on the MRI diagnosis of accessory soleus muscle strain which appeared in the December issue.¹

The accessory soleus muscle is the most common accessory muscle in the calf, present in 1-6% of the population^{1 2} and well recognised in cadaveric dissections, but relatively unknown in sports medicine clinics. Specific injuries to this muscle have not been well documented.

Our experience suggests that athletes with this condition have low grade symptoms of exertional or postexertional pain and stiffness for many years. The discomfort is felt around the Achilles tendon, particularly after running long distances. It is not clear why some athletes become more symptomatic and why, in bilateral cases, one side is affected more than the other.

In our experience MR scans have not shown any abnormality in the accessory muscle and we wonder whether in the case described the scans were postexercise?

We support the conservative treatment approach in the case. We strongly reassure the athlete that this condition is benign and we proceed with six to eight months of conservative treatment (orthoses, physiotherapy, and activity modification). We have

reserved formal excision of the accessory muscle for those rare cases presenting as tarsal tunnel syndrome, as we have found this procedure may be associated with prolonged morbidity and failure to return to the pre-surgical level of activity within the first post-operative year.

Unfortunately, few studies have reported the long term outcome of the various surgical techniques available.²

STEVE MOTTO
GRAHAM HOLLOWAY
The London Bridge Clinic
1 St Thomas Street
London SE1 9RY

- 1 Featherstone T. MRI diagnosis of accessory soleus muscle strain. *Br J Sports Med* 1995;29:277-8.
- 2 Peterson DA, Stinson W, Carter J. Bilateral accessory soleus: a report on four patients with partial fasciectomy. *Foot Ankle* 1993; 14:284-8.
- 3 Sammarco GJ, Conti SF. Tarsal tunnel syndrome caused by an anomalous muscle. *J Bone Joint Surg [Am]* 1994;76A:1308-14.

Author's reply

EDITOR, - I was interested to read the comments made by Dr Motto and Mr Holloway with regard to my paper on MRI diagnosis of accessory soleus muscle strain. I agree that specific injuries to this accessory muscle have not been well documented and I have not seen any other cases in my clinical practice. In the case described the affected individual was a professional footballer and the scans were obtained within 24 hours of a recent game. This player was actively involved in heading the ball and was an established goal scorer. The affected side was his take-off leg when jumping and I assume that this contributed to the exertional muscle pain which he experienced following a game due to the tenuous blood supply from the posterior tibial artery.¹

I concur with my colleagues at the London Bridge Clinic that conservative treatment in affected individuals is very worthwhile. I have no experience of the long term outcome of any surgical techniques which have been suggested for treatment in these cases.

T FEATHERSTONE
Memorial Hospital,
Dartington,
United Kingdom

- 1 Percy EC, Telep GN. Anomalous muscle in the leg - soleus accessorium. *Am J Sports Med* 1984;12:447-50.

BOOK REVIEWS

Practical Math for Health Fitness Professionals. DK Flood. (Pp 214; £18.00.) Champaign, Illinois: Human Kinetics, 1996. ISBN 0 87322 758 1.

Anyone over a certain age who teaches students will agree that the mathematical ability of today's students is in decline.

This is undoubtedly due to the all-pervading electronic calculator: there is no need to know how to get from A plus B to C. At least, there is no need to know *why* A plus B equals C. At the lowest level, this is frustrating: the inability to manipulate numbers (such as the average of duplicate readings) without an external aid makes laboratory work much slower. More alarmingly, it indicates a lack of conceptual awareness that restricts understanding: for example, the inability to convert - at least approximately - molar quantities to weights in grams when dealing with something like glucose results in a real loss of information. It gets worse too: some students, when asked how much

of a 7% glucose solution an athlete should drink in the first hour after exercise to obtain 100 grams of glucose, recently came up with the suggestion of 8 litres - and that with the help of a calculator. Pity the poor athlete.

You might think then that I welcome this book, with its step by step approach to leading the reader through mathematics (no, the title is not a typo: math is American for what we call maths) as it applies to cardiorespiratory and metabolic physiology. There is certainly much useful information here, and most of the formulae necessary for the relevant calculations are included. The aim, however, appears to be to use exercise