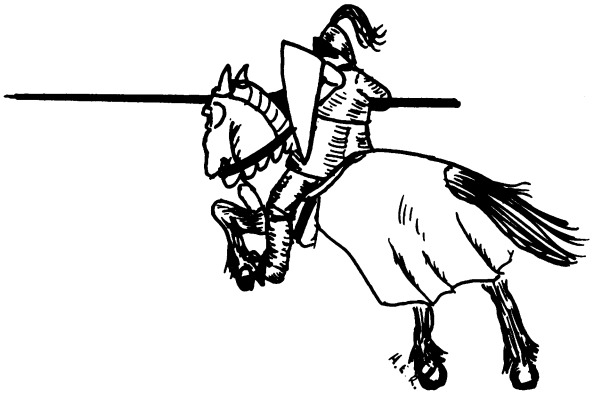
The importance of finding new resilient materials for footwear is so important that we cannot risk one possibly promising new compound falling into disrepute because of such an unscientific and subjectively biased paper. Perhaps a communication might be sought outlining the scientific and biologically favourable characteristics of this particular polymer. As a next step, a critical trial based on sound and acceptable differential diagnosis should be sought in the usual way, comparing the clinical merits of the different materials available. Furthermore, it would seem hazardous to standardise all subjects' symptoms without looking at the specially provocative features of their sports activity. Does, for instance, a squash player have to contend with the same forces in the same way as a marathon road runner? This seems highly relevant to any study of this nature.

This paper, in effect, tells us that headache nearly always gets better with Aspirin.

Yours sincerely,

PETER SPERRYN, MB, BS, MRCP, DPhysMed
Consultant in Physical Medicine,
Hillingdon Athletes Clinic
Hillingdon Hospital, Uxbridge, Middlesex, England

RIPOSTE! –



With regard to Dr. Sperryn's challenge I could answer all his points in detail. Clearly some are valid and some are not. The paper I submitted to the British Journal of Sports Medicine with a view to publication was captioned a "pre-

The paper I submitted to the British Journal of Sports Medicine with a view to publication was captioned a "preliminary report". It was precisely that. At the time of submission of the paper there was no clear evidence as to why efficient energy absorption of this type should relieve the symptoms of Achilles tendonitis so consistently. As regards the pain beneath the heel, we simply believe that by the appropriate combination of efficient energy absorption with efficient pressure redistribution beneath the heel, the great majority of patients with pain as a result of local trauma rather than underlying pathology such as Reiter's disease or ankylosing spondylitis will get better. This is as true for "Sever's disease" and "heel spurs" as for the soft tissue bruising, fat pad shear syndrome, and various other conditions related to direct trauma that have been described. Again the observation I made was that this appeared to be a most efficient and consistently beneficial way of managing these problems. In short, the body is able to repair damage even in the presence of continuing activity provided the appropriate physical conditions exist to allow repair to continue. The balance between breakdown and repair is tilted in favour of the patient.

Dr. Sperryn is aware of a subsequent study with numbers up to forty of Achilles tendonitis presented at the International Conference of Sports Medicine in Utrecht 1981, the details of which were given to a Round Table Conference on Achilles tendonitis at that meeting. Those that have used the heel inserts since this paper was published have found a consistently good result and, in fact, a number of high class athletes have avoided surgical decompression of their

Achilles tendons and returned to top level athletics simply by the use of the heel inserts and no other management. One thing is abundantly clear to me. 30 out of 40 of the patients that I have studied had used heel raises for their Achilles tendonitis, in some cases for as long as six years. All of these still have their symptoms and yet by removing their heel raise and inserting a small energy absorbing material in its place their symptoms were resolved. A heel raise is not the appropriate form of treatment for Achilles tendonitis. It does not remove the tension from the Achilles tendon at the point of heel strike. When it does work it only does so because it provides efficient energy absorption.

Finally, may I say that the physical properties of Sorbothane as used in the heel inserts and insoles will be supplied on request by the marketing company to doctors and therapists engaged in the treatment of patients with heel strike associated conditions.

The motives behind the challenge seemed far from clear to me and it would command little respect from the thousands of athletes around the world who have used these heel inserts and insoles with remarkable benefit. Finally I would say that there is no such thing as scientific proof in medicine. One case cured is proof as far as that patient is concerned and any control trial where one of the body senses are left completely uncontrolled, in this case proprioception, is wide open to scepticism. I am afraid this situation will have to be proved by personal experience and traditional clinical trials are not an appropriate way of studying these phenomena.

Yours sincerely,

GORDON E. MacLELLAN, FRCS
Royal National Orthopaedic Hospital,
234 Great Portland Street,
London W1N 6AD

CORRESPONDENCE

3 Bridge Avenue,
Maidenhead,
Berkshire,
UK

To the Editor:

Dear Sir,

VISCO-ELASTIC HEEL SUPPORTS

I read with interest the article in Volume 15 page 117. Being a practicing Podiatrist I find the management of subcalcaneal pain and Achilles tendonitis by Sorbothane visco static heel cushions together with orthotics is a remarkable therapy. However, I am writing to warn your readers that other appliances than those described in the article are being marketed.

In a personal letter to me from the originator of the study, Mr. G. E. Maclellan, FRCS, he stated he has not been consulted in any way regarding the manufacture or quality control or provision for medical data, supportive literature, etc. by any firm other than EIM, who provided the appliances described in the article. It may be therefore that these products possibly are inferior to those marketed by IEM and practitioners should be sure of the type they are using with regard to patient care and management.

Yours sincerely,

David R. C. Bell, MChS, SRCh