Twelve (eight per cent) were addicts, 17 (13 per cent) had organic illnesses, five (four per cent) had reactive depressions, and 12 (eight per cent) suffered from endogenous depression. This left 101 (69 per cent) whose symptoms were simply a cry for help—the famous *cri de coeur* of the hysteric. It looks as if the hysteric is as up to date as the schizophrenic—no paralyses for him, but a great deal of depression and anxiety. Of these 47 (32 per cent) have marriage and sex problems, 29 (20 per cent) can't cope with modern life, and 26 (17 per cent) are simply selfish.

We were a little shattered to find that marriage has more to answer for than any other reason, thus confirming the truism that interpersonal relationships remain the most important element in people's lives. We may therefore conclude that the novelist still has a major role to play in our modern world in holding up the mirror to life!

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Sir,

We find the classification of disease as described and used by Dr W. E. Dobson-Smyth (December *Journal*) interesting and practical and we intend to use the classification in our practice. We would take issue with him, however, over his criteria for diagnosis. To require specialist aid in some of the categories described is quite unnecessary, but in other ways our faith in general practice is restored. We are allowed to diagnose, totally unaided, when a patient has lost a limb or an eye!

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Reference

Dobson-Smyth, W. E. (1976). *Journal of the Royal College of General Practitioners,* **26,** 934-937.

ERRORS IN THE MORBIDITY STUDY

Sir,

Dr M. J. Jameson recently commented on the use of patient identity as a "denominator of general research" (November *Journal*) and quoted a range of 1-20 per cent as the non-match rate from the practices in the National Morbidity Study (NMS) 1971. We should like to point out that, taken out of context, these figures are rather misleading. The 1-20 per cent range related to the number of episodes (or parts of episodes) of illness for which a suitable identity could not be found in the practice register at a fairly early stage in the final processing cycle.

When the study files were complete, the distribution of non-matched people was as follows:

Percentage of non-matched people	*Number of practices*
0-	8
1-	25
2-	17
3-	6
4-	3
5-	—
6-	—
7-	1
8-	—
9-	—
10+	—
Total	60

These non-matches included a small number of temporary or private patients who should not have been included in the study and were therefore quite properly not matched in the register of NHS identities. This was particularly appropriate in the practice with the highest proportion.

The problems of linking the morbidity records to the practice registers in the NMS, using three letters of surname, initial, date of birth, and sex of the patient as the identifier, were fully detailed in the report but it may be helpful to emphasize two major sources of difficulty:

1. Transcription errors were possible at three different stages: from the MREs to the practice register cards, from the MREs to the diagnostic index sheets, and from the source documents to the computer input.

2. For new patients the participants were required to record morbidity and complete a register card from the time that the patient indicated his intention of joining the doctor's NHS list, even though this anticipated formal documentation and the receipt of the MRE from the Executive Council. Occasionally morbidity data were processed before receipt of the corresponding registration record.

Despite these problems over 80 per cent of the practices had rates of non-matching below three per cent and only one practice was above five per cent, and some of these were properly excluded as being the result of over zealous morbidity recording.

The method of calculating the population denominator from the data in the practice registers is described in the report in the chapter entitled "Some Statistical Considerations".

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References

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AN AID TO THE TREATMENT OF STASIS ULCERS

Sir,

When I was a clinical assistant in dermatology my chief would bet me one pound that he could heal any stasis ulcer in three months. I can recall his losing only once: his recipe for success was active movement of the ankle.

Stasis ulcers—erstwhile varicose ulcers—occur in the 'spat' area, the lower third of the leg above the ankle. They are one of the commonest and most chronic of skin problems that present in general practice. With proper and energetic treatment the majority can be healed, which is very rewarding to both patient and doctor. The cause of the skin breakdown is stasis and oedema. Treatment is by pressure either by elastic stockings or by adequate elastic bandages properly applied, perhaps with the additional pressure of a sponge rubber pad. The choice of dressing is a matter of personal preference and relatively unimportant.

Exercise materially assists in dispersing both oedema and induration. In addition, it re-educates the patient's lower leg muscles. I used to exhort my patients to spend some time each day either playing the foot pedals of a harmonium or the old-fashioned treadle sewing machine. Those who did improved so rapidly that it was apparent that a simple ankle exerciser was desirable, and so the present apparatus was born, as shown.

It consists basically of two pieces of wood, hinged at one end, with a resistance in between to increase or decrease the pressure necessary to pedal. The simplest resistance has been found to be a cube of foam rubber, with an arrangement of steps of wood to vary the load.