Detection of peripheral sensory loss is not straightforward

Sir, Detection of clinically significant neuropathy is essential for good diabetes care. We read with interest the article by Devoy *et al* (*Practical Diabetes*, vol 9 (5), page 197) describing the standard approach to examination of the peripheral sensory nervous system. A number of points arise which may be of particular importance in the assessment of elderly diabetic patients, who suffer the majority of foot ulcers[1,2]. Firstly, although thorough examination may be desirable, it is impractical in the average diabetic clinic where it may be more appropriate to concentrate on the diagnosis and exclusion of significant sensory loss.

It has been shown on many occasions that abnormalities of peripheral nerve function, indistinguishable from those of neuropathies including diabetes mellitus, may be found in apparently healthy elderly people[3]. Perception of vibration is most commonly impaired in old age. The loss of vibration perception is also quantitatively greater than for the other sensory modalities such that the distinction between significant sensory loss and age related change is difficult. In contrast perception of pin prick and light touch appear to be relatively preserved in old people and are probably the best clinical indicators of significant sensory neuropathy[4], hence the best 'screening' modalities.

The role of the Biothesiometer in the diagnosis and assessment of neuropathy in elderly individuals is questionable. Vibration perception threshold (VPT) increases with age and the 'normal' VPT for octogenarians approaches the upper end of the Biothesiometer scale[5]. We have also demonstrated that in elderly people the variability of this instrument (for both consecutive and sequential readings) is considerable[6].

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Reflex zone therapy in use

Sir, One case report never proves anything, and whilst the case report "Reflex Zone Therapy in Use" from S C Martin and D J B Thomas was interesting (*Practical Diabetes*, vol 9 (5), page 198), their last paragraph suggests that this one case proves that reflex zone therapy works. They also describe the neuropathy as intractable, yet only give a three month history. Dr Peter Watkins' follow-up study has quite clearly shown that acute onset diabetic pain for neuropathy is virtually always self-limiting. Why this is, is not entirely clear, but it certainly can explain with great ease the last sentence in the letter which reads "success with reflex zone therapy has not yet been explained in the context of Western scientific medicine".

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Isophane insulin not Ultratard™

Sir, Dr Mansell's study comparing isophane insulin with crystalline insulin zinc suspension (*Practical Diabetes*, vol 9 (6), page 214) confirmed my own feeling that most patients prefer an isophane insulin to provide 'basal' insulin cover, rather than the longer-acting Ultratard. At least, I think it did, but I am confused! While the abstract, the results and the conclusions all state that most of the patients in the study preferred isophane insulin, the first paragraph of the discussion concludes with the words "Most patients expressed a preference for and wished to use Human Ultratard".

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The author apologises for this mistake: the sentence should have read "Most patients expressed a preference for and wished to use Human Insulatard™ and not Human Ultratard™ at the end of the study". *An erratum to this effect was published on page 31 of the January/February issue of the journal, vol 10 (1).*

Editor

Difficulties in interpreting blood pressure readings

Sir, I am grateful to Dr K Shotliff for his letter regarding my article "Quality control of blood pressure readings performed by practice nurses". I entirely agree with him that size of cuff is an important consideration when measuring blood pressure and this aspect was discussed in the teaching video. It was difficult to gain useful information from the questionnaire, however, as when I first wrote the article it was by no means certain that using the available large cuffs on all types of electronic and random zero machines gave reliable results. As Dr Shotliff points out, just because a large cuff is available does not mean it is used.

Other aspects were also omitted from the paper (although again highlighted in the video); for instance, the support of the arm. This is a neglected area and difficult to assess in practice. For example, in *Practical Diabetes*, vol 8 (2), page 47 a nurse is depicted measuring blood pressure in an unsupported arm.

I hope that my article and Dr Shotliff's letter will highlight the difficulties in interpreting blood pressure reading unless quality assurance procedures exist.

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