It should also be mentioned that if further trouble is encountered, we can always have the Syme amputation since the heel pad has not been disturbed by the partial foot amputation. The authors feel that this will be unnecessary, since our result to date has been gratifying. The prosthesis has been functional and cosmetically accepted. The dynamic type of fitting allows the patient to bear weight on the residual foot, affording a more comfortable and secure application, since the surface area for weight bearing is greater than that of a Syme amputation.

The prosthesis was plastic, with a conventional foot. A patellar cuff suspension will be provided after the planned removal of the waist belt.

"To P.T.B. or Not To P.T.B."

With Apologies to William Shakespeare's "Hamlet"

By ROBERT W. KLEIN, M.D.

Repatriation Department, South Melbourne, Australia

On reading the article "The Decline and Fall of the P.T.B." by Dr. Robert G. Thompson, M.D. (O.P.A.J. March, 1965), a question posed by Dr. Eugene Murphy regarding the "Weiss technique" comes to mind and it might be asked "What was the P.T.B. which declined and fell?"

P.T.B.'s have been prescribed and supplied by the limb fitting facilities of the Repatriation Department (the equivalent of the U.S.A. Veterans Administration) in the Commonwealth of Australia since 1961 and in the last 12 month period 437 were issued. However, great stress has been placed on the necessity to follow the principles of cast taking, cast modification, alignment and walking re-education as taught to officers of this Department at a U.C.L.A. Prosthetic Course. All stages of casting, modification and manufacture are supervised to ensure that the patient receives this particular concept of a P.T.B.

Not only have these prostheses proved more functional, more comfortable, and more economical, but they have enabled short stumps to be fitted which previously were precluded from wearing below knee prostheses. In fact, quite a number of patients with "kneeling" prostheses, some of quite long standing, have been fortunate enough to be able to change to below knee fitting.

Contraindications in our experience have been minimal and virtually confined to the relatively rare unstable knee (these are fitted with "conventional" prostheses and not "P.T.B.s" with side irons). Few patients have had the misfortune of being unable to enjoy the excellent function and comfort of the P.T.B.

Problems are encountered from time to time as with any patient and any prosthesis, but it is thought that the fault lies, not with the prosthesis or patient, but in our own shortcomings.

Mr. W. Tosberg in his article "Temporary Prostheses" (O.P.A.J. June, 1965) gives timely warning of an impending "decline and fall" in prosthetic treatment in pointing out that "temporary" prostheses *must* be constructed with full consideration of proper fit and alignment, and the anatomical and biomechanical requirements.

With respect, might not Dr. Thompson's P.T.B. experience be a case of "How a good meaning may be corrupted by a misconstruction."