a true placebo powder that can be applied to wounds. Even a chemically or biologically inert powder may have irritant effects in an ulcer that could promote or hinder healing. Some have argued that dermatologic bases could serve as inert comparisons, but they are not necessarily inert either, and they can interfere with the action of the agent to be tested.

Finally, we should point out that we said in our paper that "Phenytoin should prove especially useful in rural areas where daily attendance at clinic or hospital is not possible." The emphasis is on the "should." We quite agree that proper preventive foot care is important for diabetic patients, and we do not make the claim that phenytoin replaces the need for antibiotics, as the letter implies. Both preventive care and ulcer treatment need to be available in rural, poor areas. Consistent with this, we do state that phenytoin's low cost, ease of use, and safety are important features for use in rural areas where poverty is a constant companion—and indeed they are. Rather substantial experience with phenytoin in different parts of the world, as documented in some of the references in our paper, as well as others (personal communications) since, indicates that neither strict bedrest nor daily dressing changes are necessary with topical phenytoin therapy. We feel that our "should" merits further evaluation in the rural setting.

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Measuring Subjective Symptoms

We read with interest the article by Tandan et al. (1) on the subject of topical capsaicin in painful diabetic neuropathy. They reported that no difference was found in visual analogue pain scores between the capsaicin- and placebo-treated groups, but those who applied capsaicin received a more favorable evaluation by their physicians. They also reported improvement or cure of painful symptoms in almost half the patients who subsequently took part in an open-label study. Despite the lack of subjective improvement, and based on the physician's evaluation of the patients and the results from the open-label study, the authors concluded that capsaicin may be of value in treating patients with painful diabetic neuropathy.

According to Huskisson (2), "Pain is a personal psychological experience and an observer can play no legitimate part in its direct measurement." Prospective double-blind studies using visual analogue pain or symptom score scales have been suggested as the appropriate methods to evaluate new treatments (3,4). In view of these recommendations, failure of subjective improvement should be interpreted as a negative finding, and the physician's global evaluation should not be considered as a valid endpoint. Similarly, results from open-label studies, given the placebo effect and the lack of proper control, cannot be regarded as surrogates for positive efficacy of new treatments of highly subjective symptoms—such as pain.

Therefore, we think that the conclusions of this otherwise interesting study are not supported by the results, and, in agreement with the authors, we believe that further studies are needed to clarify the efficacy of capsaicin in painful diabetic neuropathy.

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References

1. Tandan R, Lewis GA, Krusinski PB, Badger GB, Fries TJ: Topical capsaicin in painful diabetic neuropathy. *Diabetes Care* 15:8–14, 1992
2. Huskisson EC: Measurement of pain. *Lancet* 2:1127–31, 1974
3. Editorial: Pain perception in diabetic neuropathy. *Lancet* 1:83–84, 1985
4. Boulton AJM, Ward JD: Diabetic neuropathies and pain. *Clin Endocrinol Metab* 15: 917–31, 1986

Semantics of Plasma Glucose Thresholds for Counterregulatory Responses

Webster's dictionary defines *threshold* as "the point at which a physiologic or psychologic effect begins to be produced" (1).

Thus, if during decrements in plasma glucose, a lower than normal glucose level is required to cause a response, then the plasma glucose (or glycemic) threshold for that response is lowered or reduced. Conversely, if higher than normal glucose levels are required to elicit a response, then the glucose threshold for that response is higher or increased. Therefore, use of the opposite terminology (e.g., lower glucose level equals