Letters to the Editor

As A&E departments are getting used to medicine by protocol, they will be in a good position to offer a prompt service for early administration of the thrombolytic agent. They should resist any suggestions of patients with chest pain bypassing them on their way from the community to the coronary care unit (Richards, 1987). Although this suggestion may be implemented in a few places, it is unlikely that the average CCU would be able to cope with the large number of false positive cases (Tachakra, 1987). Also, the tacit assumption that a certain number of false positive cases will be treated should be avoided. Just as defibrillation, now hailed as the biggest advance in the management of MI, is being taught to ambulance crews, so, 10 years from now, thrombolytic therapy may be started by ambulance men and paramedics.

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REFERENCES


Lower limb skin loss: simple outpatient management with meshed skin grafts with immediate mobilization

Sir

Messrs Shankar & Khoo’s paper advocating the use of mesh skin grafts and out-patient management of minor lower limb skin loss (*Archives of Emergency Medicine* 4, 187–92) is an advance in the management of this condition. However, it would seem unnecessary to inflict a further wound on the patient in the form of a donor site, when the traumatized skin should itself be used as the skin graft. If the injury is fresh, this skin should be viable. That this is often the case was demonstrated by King (1987). With a little ingenuity, the excised skin can be defatted or shaved of its underlying layers, to provide a thin Wolfe graft or split skin graft, as was described by McGruther & Sully (1980) for very large lower limb degloving injuries.
It has become the practice within our Unit to distinguish between a mesh graft, which is split skin which has been put through a machine which makes very regular cuts, so that the skin can be spread to form a net; and fenestrated grafts, where piercing or perforation of the graft has been performed with an ordinary scalpel. The photographs in the article clearly show what I would describe as fenestrated grafts. My colleague, P. L. Levick, showed me how these could be rapidly prepared when spread on a wooden skin graft board, using a large sized scalpel blade, 22 or 23. The scalpel is held loosely between the fore-finger and thumb close to its butt end and bounced on the board rapidly, moving it from one end of the graft to the other. Using this technique a large number of perforations can be made in even very large sheets of skin in next to no time. Virtually all sheets of skin applied to patients in our Burns Unit now undergo this treatment in order to ensure ‘a better graft take’.

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