Surgery remains the core of treatment. Although occasional reports still advocate incisional surgery (Meleney's original suggestion³),¹¹ larger series have shown that radical excisional surgery improves survival, albeit at the cost of greater final deformity.^{4,5,7,8} Skin and fat, but not usually the deep fascia, are excised. Muscle is not usually involved and amputation is not required unless this fascial barrier has been breached. The limits of surgery may be guided by microscopy but are essentially decided clinically. The aim is to perform definitive surgery, no matter how radical, at the first operation. Good quality survival has been achieved after excision of as much as 45% of a patient's surface area. In experienced centres, in early disease, aggressive surgery and antibiotics can yield death rates less than 10%. Where these conditions are not met mortality may be 30-60%.^{4,6,8}

Necrotising fasciitis has been with us for a long time; it is common enough that most hospital doctors will see a few cases yet rare enough that each new generation has to relearn the lessons of the past. Early diagnosis on clinical grounds, aggressive surgical clearance, and the full range of intensive

care support can yield a low mortality and acceptable morbidity.

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Application of quality standards to hearing aid services

Outcome measures should be based on listeners' needs

Recent years have seen a welcome increase in emphasis on robust outcome measures to assess the effectiveness of intervention in clinical practice. For diseases that are severe or life threatening the outcomes can be relatively simple and robust (for example, survival rates). For conditions resulting in chronic disability, however, deriving outcomes to assess quality standards is harder. Because of epidemiological evidence that hearing disability in adults is common¹—and fewer than one third of candidates for hearing aids have one²—attention is now turning to the effectiveness of hearing aid services for adults³ and the assessment of the quality of the devices provided.⁴

Sounds Like Quality, guidelines produced by the National Committee of Professions in Audiology, suggests sensible targets for the delivery of hearing aids and rehabilitation to people with impaired hearing. Notably lacking, however, are recommendations for assessing outcome, either in terms of the ability of hearing aids to improve the understanding of speech or in terms of the extent to which the hearing aids and rehabilitation alleviate the disabilities suffered by hearing impaired people.

Discussing the assessment of hearing aids, Lyregaard has advanced two main arguments.⁴ Firstly, he says that the traditional electroacoustic specifications for the performance of hearing aids inadequately describe the aids' performance in everyday life, especially given the added complexity of modern techniques of signal processing. Secondly, he says that the rational application of new technology will require

clinical trials that incorporate measures that are based on listeners' needs rather than laboratory measurements. Current knowledge indicates that, as well as measures of performance (such as the discrimination of speech), subjective (self reported) measures of hearing disability are needed. Although substantial advances have been made, suitable outcome measures to assess the overall and differential health gain are not yet available. Evaluation of the efficacy of current services and national decisions about future changes are impossible without them. Such measures need to be tailored for use in several circumstances: routine practice as part of ongoing audit; large scale studies of change in the NHS hearing aid services; and evaluation of new technologies. These may seem daunting requirements, yet audiology has a much better track record in developing outcome measures than many other disciplines concerned with disability.

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