Reply 1

- (a) Para 1 - Comments of the reader are appreciated. I have visited the website and concur with the suggestions.
- (b) Para 2 - A model for providing the emotional first aid has been suggested in the last but one para of the article. It has been brought out that the medical officers posted to such high risk units should be given training under an experienced psychiatrist before induction who in turn should conduct classes for

commanders at all levels in his unit and religious teacher can be trained to form part of the nucleus.

- (c) Para 3 and 5 - The comments made are agreed to.

Lt Col Ajay Dheer

Medical Officer, Command Hospital (Southern Command), Pune-40.

Reply 2

We have observed large number of cases of missile injured and IED blasts in LICO in the immediate post injury periods, after sick leave and subsequently when they come for review / recat. PTSD is conspicuous by its rarity. Patients are more concerned about sick leave, courier seat, Medical category, family problems etc.

Acceptance of adversity, setbacks, pain and calamity are deeply

ingrained in the Indian psyche, which is not easily provoked into flight, fright and fear. When routine life itself is a bumpy ride from crisis to crisis a mere gun shot wound is just another ripple not strong enough to tip the boat asunder. We do not think that AFMSF 10 is a factor in the low incidence of PTSD.

Air Cmde PJ Vincent

Principal Medical Officer, HQ Southern Air Command, Trivandrum

Reply 3**From Editorial Board:**

Any individual is welcome to forward any article on a contemporary issue or of conceptual nature to MJAFI. There is no bar on any medical practitioner to participate constructively in

authoring on emerging concepts. "Guest column" is invited from eminent faculty.

Arthroscopy : No More Such a Limited Procedure

Dear Editor,

This is with reference to the original article titled "Pain relief following Arthroscopy - a comparative study of Intra-articular Bupivacaine, Morphine & Neostigmine" (MJAFI 2004;60:123-7). Following are offered as comments on the subject:

The author included many variables for assessment of drug efficacy for post arthroscopy pain, i.e. sex, weight, age, volume of injected lignocaine, anaesthetized dermatomes & surgical time. However a very important variable (perhaps, the most important) was not considered which is the nature of arthroscopic surgery performed on the knee. The arthroscopic surgeries of the knee include a wide spectrum of procedures ranging from diagnostic arthroscopy, menisectomy, meniscal repair, retinacular releases, loose body removal, synovectomy, biopsy, fracture fixation to cruciate ligament reconstruction / repair.

The tissues being operated upon range from poorly innervated menisci to extremely sensitive cruciate ligaments [1]. Therefore, the pain following arthroscopy depends a lot upon the tissues

operated upon i.e. repaired, reconstructed or excised during the arthroscopic procedure as the tissue may be meniscus, cruciate ligament, synovium, cartilage or bone. All these tissues have different extent of innervation & hence severity of pain is likely to vary and so will be the efficacy of drugs delivered locally. Now, if the author's variables considered in the study are incomplete, i.e. nature of surgery not considered in this study, then the results and conclusion of the study are not likely to be fully valid.

It should now be realized that arthroscopy includes a vast number of therapeutic & diagnostic procedures which has led to recognition of arthroscopy as a highly specialized separate subspecialty of orthopaedics. It is no more a simple diagnostic procedure of 1960 and 70s.

References

1. Mc Minn RMH. Lower limb. In: Last's Anatomy Regional & Applied. 8th ed. Churchill Livingstone 1993;183.

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