None of these cases had shown any clinical pointers towards gross immunosuppression as also other cases who responded better after 6 months of MDT. Further studies on elaborate immunological work up, which was not part of this study, may be considered on as required basis depending on available facilities during the period of surveillance in these cases.

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REFERENCES

1. Job CK, Jayakumar J, Aschhoff M. Delayed resolution versus treatment failure in paucibacillary leprosy patients under six months fixed during multidrug therapy. *Indian J Lepr* 1997; 69: 131-42.
2. Sengupta U. Cell mediated immunity in leprosy; an update. *Int J Lepr* 1993; 61: 439-54.
3. Pattyn SR, Husser JA, Baquillon G et al. Evaluation of five treatment regimens using either dapsone monotherapy or several doses of rifampicin in the treatment of paucibacillary leprosy. *Lepr Rev* 1990; 61: 151-6.

IS TRAUMA RESUSCITATION SAME AS CLASSICAL CARDIAC RESUSCITATION ?

Dear Editor,

I read with interest the editorial and the article on management of chest injuries in battle casualties [1,2]. The authors are in an enviable position by virtue of having such rich experience in the field and have brought out the relevant details lucidly. It is indeed essential to stress on early evacuation, to streamline prehospital and presurgery management and timely surgical intervention. The concept of "The Golden Hour" and "Scoop and Run" is now well entrenched in management of trauma victims. However initial resuscitation of such patients during prehospital phase is conceptually different from classical cardio-pulmonary resuscitation (CPR) and should be kept in mind [3].

The triple manœuvre or the backward tilt of the head (the first thing taught and practiced in classical CPR) is best avoided in trauma cases till exclusion of cervical spine injury and stabilization of the head. Similarly external cardiac massage in presence of undetected chest injury may prove to be counter-productive besides being ineffective as these patients tend to be hypovolemic. Hence circulatory support in trauma cases consists mainly of control of haemorrhage and aggressive volume replacement. In addition, drugs like adrenaline and lignocaine which are of utmost importance in cardiac

resuscitation should be delayed till the patient is scooped and rushed to the hospital. Also, defibrillation is rarely needed in cases of chest trauma. Thus the chief components of trauma resuscitation are volume replacement, ventilation with oxygen and early but safe transport to a well equipped trauma oriented centre. These differences need to be emphasized while imparting education to medical and paramedical personnel involved in care of patients afflicted with trauma.

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REFERENCES

1. Maudar KK. Chest injuries in battle casualties (Editorial). *MJAFI* 1997; 53: 81-2.
2. Kapoor S, Garg A, Kochar HK, Singh Pal. Chest injuries in battle casualties. *MJAFI* 1997; 53: 111-5.
3. Donchin Yoel. Trauma resuscitation is not cardiac resuscitation. In: *Proceedings of the Second National & First International symposium on trauma, Anaesthesia and Critical Care*. Madras. International Trauma Anaesthesia and Critical Care Society. 1995; 100-1.

Authors' Reply

I fully agree with the writer of the letter, "Is Trauma Resuscitation same as classical cardiac Resuscitation?"

As already emphasized in our article, prehospital resuscitation, though essential, should be minimum to ensure safe and early evacuation of the patient to the hospital. Overenthusiastic prehospital resuscitation, will not only delay evacuation but may also complicate the injuries as aptly brought out by Maj Sreevastava. The training of all medical and para medical staff, who are likely to handle these casualties before they reach the hospital, should stress on a patent airway, oxygen inhalation and replacement of lost blood

by intravenous fluids (preferably Ringer's Lactate and Haemaccel) given through a wide bore venflow needle, and secured in a suitable vein. It should be emphasized on them that the above should be done in the minimum of time, without missing out the "The Golden Hour".

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