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of acute compartment syndrome (ACS) and therefore, a fasciotomy should be not recommended. The difficulty of diagnosis of ACS in burn patients lays on the absence of clinical signs because there are patients who are often sedated and connected to mechanical ventilation and interpretation of the intracompartment measurement should be done in the clinical context of the patient.

Surgical decompression of limbs with severe burns is proposed to allow safer and more effective management. Subsequent monitoring to assess the adequacy of tissue perfusion is necessary and if there is evidence of continuous compromise particularly of muscle perfusion in closed compartment should be decompressed [1]. Measurement of compartment pressure in limbs of patients with serious burns and risk factors for ACS should be incorporated into "care-bundle" for the management of patients with major burns [2]. Using the large needle Stryker arises as a good choice for initial management of patients with suspected ACS with severe burns, but its implementation requires validation in further clinical studies. Nevertheless, in patients without risk factors for the development of ACS, the assessment of compartment pressure should be balanced to avoid possible misinterpretations of the measurement to prevent complications associated with unnecessary fasciotomies such as underlying damage to structures and infection. However, the aim of our study is not to describe the diagnosis and the surgical procedures of ACS, but to call attention to associated factors with intracompartmental sepsis [3].

Conflict of interest statement

Authors of the article declare not to have any conflict of interest related neither with the publication of the manuscript or the Letter to Editor. We disclose no financial or personal relationships with other people or organizations that could inappropriately influence our work.

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Reply to Letter to the Editor

Response to Letter to the Editor: 'Comment on epidemiology of childhood electrocution in Bangladesh'

I appreciate Dr. James M. Cross in his observation about the term electrocution specially 'non fatal electrocution' in my article. I agree with him about his comment. According to dictionary meaning author is right and even many publications supports his opinion.

However in my article I used the term 'electrocution' as the name of an injury mechanism. Many of the authors have also used this term in the same way. According to the WIKI books, electrocution is a related set of injuries caused by direct contact with live electrical connections varying from minor to cardiac arrest [1].

Burn Survivor Resource Center said electrocution can result in a variety of wounds, and sometimes in death [2]. Lee mentioned "electrocution burns result in approximately 3000 admissions to burn centers every year, while injuries due to electrocution result in death in about 1000 patients yearly"[3]. Shetty et al. used the term fatal-electrocution which in turn agrees with the term non fatal electrocution [4].

I desire to use the word 'electrocution' as a name of an injury mechanism which is caused by electricity and electrocution can be both fatal and non fatal.

The term 'drowning' was also previously used only to mean death caused by drowning. But now 'drowning' is being used as both fatal and non fatal drowning as an expression of injury mechanism.

Conflict of interest statement

The authors declare that there are no conflicts of interest.

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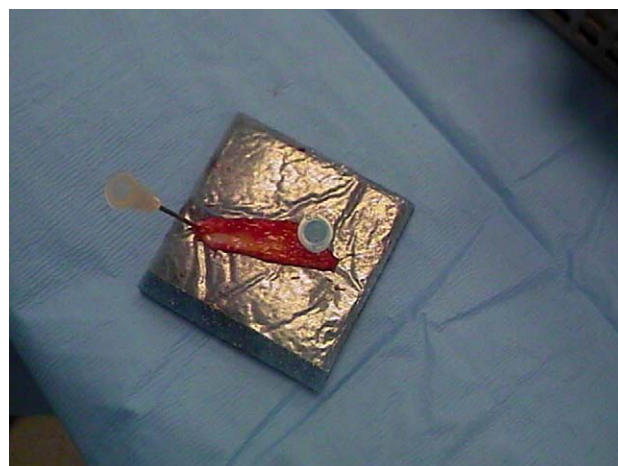


Fig. 1 – Use of scratch pad and hypodermic needles to spread out the full thickness graft, ready for fat trimming.

Letter to the Editor

A new method of trimming the fat from a full thickness skin graft

Sir,

A full thickness skin graft is a useful technique to resurface a skin defect. It is one of the important tools in the reconstructive tool box in Plastic surgery. Full thickness skin grafts have advantages of better colour match, texture and lesser degree of contraction over the split thickness skin graft. In addition, the donor site can be closed directly reducing the additional morbidity associated with split skin grafts.

Although much is known about the harvesting of full thickness skin graft in the literature, very few papers describe the technique of debulking the skin graft. The imprint of the recipient site on a piece of gauze or glove is transferred on the donor site of the skin graft [1]. Full thickness skin graft is then harvested with a layer of subcutaneous fat which is later trimmed on the surgeon's finger pulp using a sharp scissor.

Trimming of the fat from the full thickness skin graft is important as fat necroses and impairs the graft take and may lead to graft failure. Therefore, careful consideration should be given to remove the fat from the graft. The common method used to defatten the graft on the later pulp of the surgeon's finger may be inconvenient as the graft is difficult to stabilise. This method is also time consuming as only a limited area on the finger pulp is available to defatten and one has to move the graft many times on the finger. Turkaslan describes the use of a safety razor to scrape away the subcutaneous fat once the graft is harvested and pinned down with needles on a wooden board [2]. Although seemingly simple, this procedure appears to be relatively messy and is not suitable for small grafts. Also anchoring needles into the wood is not an easy task. The Gibson-Ross dermatome has been described for defatting skin grafts with a 12 inch long blade. This method is suitable for

debulking large sized grafts but its blade size would make it cumbersome and impractical when applied to smaller sized skin grafts [3].

We present an easier and simpler technique of anchoring a small sized full thickness skin graft for defatting.

The scratch pad is used to clean the tip of the diathermy needle and is commonly used in most surgical procedures. Instead of using a wooden block, we make use of the ready available scratch pad during the procedure of full thickness skin graft harvesting. After harvesting, the skin graft is placed on the sticky part of the scratch pad with the fatty layer facing upward. The sticky reverse surface of the scratch pad helps to stabilise and anchor the skin graft. Two or four hypodermic needles may then be used to further anchor the skin graft down to the scratch pad, if needed. The similar technique can be used by putting the skin on the non-sticky part of the diathermy scratch pad if one prefers. The sticky part of scratch pad can then either be placed on the dorsum of non-dominant hand or on the instrument trolley. The graft is then easily defatted with tenotomy scissors. (Fig. 1) Instead of traditionally rolling it around one's finger to spread out the graft, we find that this method makes trimming of the fat from full thickness grafts much easier.

In conclusion, the use of the scratch pad to immobilise and stabilise the full thickness skin graft is a simple and effective way to defatten the graft with no extra cost.

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