

- All letters must be typed with double spacing and signed by all authors.
- No letter should be more than 400 words.
- For letters on scientific subjects we normally reserve our correspondence columns for those relating to issues discussed recently (within six weeks) in the *BMJ*.
- We do not routinely acknowledge letters. Please send a stamped addressed envelope if you would like an acknowledgment.
- Because we receive many more letters than we can publish we may shorten those we do print, particularly when we receive several on the same subject.

Algorithm for managing injury from smoke inhalation

SIR,—The paper by Drs R M Langford and R F Armstrong¹ makes its main point well—that a flow chart for managing a life threatening condition such as smoke inhalation is helpful, especially for those accident and emergency departments and intensive care units that see few such injuries. This is especially important as aggressive early management lessens morbidity and probably also mortality.² It is a pity therefore that they concentrated so much on the detailed management of cyanide poisoning and glossed over equally important, easily managed problems, particularly those relating to the accompanying cutaneous burn.

Circumferential chest or neck burns receive no mention in the algorithm, yet these are a significant cause of early morbidity in the severely burnt patient. They may exacerbate pulmonary dysfunction and in the case of neck burns may render intubation extremely difficult. Urgent escharotomy must be performed, a task that should be easily accomplished by any surgeon.

Similarly, although mentioned in the text, the need to intubate early for upper airway injury, before obstruction occurs, is understated in the algorithm. Yet no anaesthetist with experience of delayed intubation in these circumstances will ever delay again, preferring rather to intubate unnecessarily on occasion.³

There is a mutual interaction between a moderate to large cutaneous burn and associated inhalation injury, both for fluid resuscitation⁴ and morbidity and mortality.⁵ The lungs and the skin in these

circumstances both require intensive care, and adequate consideration must be given to factors that affect blood flow to these organs. Meticulous, intelligent fluid resuscitation with full monitoring and inotropic support to optimise oxygen delivery is essential, and Drs Langford and Armstrong wisely emphasise the pitfalls in measuring blood oxygen content in these patients.

This is work for people experienced in managing both cutaneous burn injury and smoke inhalation, and patients should ideally be referred to a suitable centre as soon as they are stabilised. It is unfortunate that, in Britain, modern intensive care facilities are not always as available as they should be in hospitals that can treat patients with severe burns. Implementation of the Royal College of Surgeons' working party report on trauma⁶ will do little to change this unsatisfactory situation unless that report's somewhat complacent attitude to burn care is addressed.

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- 1 Langford RM, Armstrong RF. Algorithm for managing injury from smoke inhalation. *Br Med J* 1989;299:902-5. (7 October.)
- 2 Venus B, Matsuda T, Copiozo JB, Mathru M. Prophylactic intubation and continuous positive airway pressure in the management of inhalation injury in burn victims. *Crit Care Med* 1981;9:519-23.
- 3 Lawrence PJ. Respiratory problems in burns. *Bailliere's Clinical Anaesthesiology* 1987;1:604.
- 4 Herndon DN, Barrow RE, Linares HA, et al. Inhalation injury in burned patients: effects and treatment. *Burns* 1988;14:349-56.
- 5 Shirani KZ, Pruitt BA, Mason AD. The influence of inhalation injury and pneumonia on burn mortality. *Ann Surg* 1987;205:82-7.
- 6 Working Party on the Management of Patients with Major Injuries. Report. London: Royal College of Surgeons, 1988:26.

Surgical footwear

SIR,—We prefer to distinguish between surgical footwear¹⁻³ for orthopaedic patients and diabetic shoes for diabetic patients with neuropathy or ischaemic problems, which have to be designed on different principles: they require very soft leather uppers, increased depth, cushioning insoles, and, when necessary, weight distributing cradles with sinks and extra cushioning under high pressure areas.⁴ Since developing this type of footwear we have had virtually complete acceptance. All patients have two pairs of shoes and are seen regularly in the diabetic foot clinic. This is run jointly by a consultant in charge, two chiropodists, and a shoe fitter, and the shoes are designed in joint consultation. The shoe fitter is attached to a shoe making company that not only manufactures bespoke shoes but has a range of stock shoes that cost 75% less than bespoke shoes. Following the instructions of the shoe fitter the company provides a facility for modifying the stock shoes at a very small surcharge. This is done under the

fitter's direction at the factory. As a result only a third of our patients require expensive bespoke shoes; a third can be fitted with stock shoes and the rest with modified stock shoes, thereby achieving a considerable saving of money. Without this facility for modifying the stock shoes two thirds of the patients would have to be fitted with bespoke shoes.

The patients are happy with their shoes. They are made in different colours with a choice of design for the uppers and with either lacing or Velcro straps. These shoes are suitable for rheumatoid patients and plans are afoot for setting up a similar service in conjunction with the rheumatoid clinic.

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- 1 Lord M, Foulston J. Surgical footwear: a survey of prescribing consultants. *Br Med J* 1989;299:657. (9 September.)

- 2 Platts RGS. The NHS boot. *Br Med J* 1989;299:932-3. (14 October.)
- 3 Soorikumaran S. Surgical footwear. *Br Med J* 1989;299:976. (14 October.)
- 4 Tovey FI. Care of the diabetic foot. *Pract Diabetes* 1986;3:130-4.
- 5 Tovey FI, Moss MJ. Specialist shoes for the diabetic foot. In: Connor H, Boulton AJM, Ward JD, eds. *The foot in diabetes*. Chichester: Wiley, 1987:97-108.

SIR,—The discussion and correspondence concerning the provision of surgical footwear culminated in Dr R G S Platts's editorial.¹ There is a well known aphorism often seen in secretaries' offices that says "To really mess things up would need a computer," and I am certain that computerised manufacture of footwear would do little to help what is already a fraught situation. Dr Platts points out the need to provide off the shelf, attractive footwear that is accurately prescribed, and the prescribers determine where improvements in service are possible.

Ms M Lord and Mr J Foulston should not have been disappointed with the less than 50% response rate they received from consultants.² The non-responders may represent the honest half of the specialties, who did not feel qualified to answer the question on "suitability" that was asked. The essence of the problem of prescribing surgical footwear is that no adequate training is given in assessing shoes and as a consequence the accuracy of the prescription is, to say the least, haphazard. Most training programmes at best pay only lip service to the subjects of orthotics and prosthetics, despite encouragement to take on board these important subjects by both the specialty advisory committee and the specialty exam in Edinburgh.

We may take some comfort from the fact that many prescriptions for specially constructed footwear are unnecessary; in many cases even off the shelf special shoes are used haphazardly. For many common children's problems special footwear is entirely unnecessary at best and at worse may be harmful.³ Despite the lack of well funded training in orthotic and prosthetic prescription, specialists within the groups of Ms Lord's and Mr Foulston's study are requested to spend probably in excess of £20 million a year on behalf of the health authorities on providing footwear. The answer is not to provide a computer, which may or may not be able to design shoes, but to provide funding so that real training in general orthotic prescriptions can be made available within training programmes. This will almost certainly result in a highly satisfactory return on the investment as the number of prescriptions for specialist footwear would plummet.

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- 1 Platts RSG. The NHS boot. *Br Med J* 1989;299:932-3. (14 October.)