

In the article by Milner and Bennett (1991) the performance of a cricothyrotomy is advocated as a standard treatment for a suspected respiratory injury associated with burns. The authors also note that the high incidence of subglottic stenosis following unconverted cricothyroidotomy encountered by Chevalier Jackson could have been attributed to pre-existing laryngeal inflammation.

Inhalation injuries from burns cause significant laryngeal inflammation. The prospect of an increased incidence of complications as a consequence of performing cricothyroidotomy on such patients must be considered.

Cricothyrotomy may not be the safest and quickest way of obtaining an airway when intubation is difficult or contraindicated (Milner and Bennett, 1991). Whilst serving in the Gulf, I only encountered one patient whose severe burns necessitated tracheal intervention to secure an airway. The General Surgeon who had performed the operation found that the patient's neck was so oedematous as a result of the burn that the thyroid and cricoid cartilages could not be palpated and the cricothyroid membrane could not be identified. A standard tracheostomy was successfully performed.

Clearly a prospective trial is needed to investigate the role of cricothyrotomy or cricothyroidotomy in such a setting. A protocol was designed for this purpose, but the eventual lack of casualties prevented us from undertaking it—a situation that can hardly be regretted.

Yours faithfully,

J. A. J. Deans,  
Major, Royal Army Medical Corps.,  
Ear, Nose and Throat Department,  
Sunderland Royal Infirmary,  
New Durham Road,  
Sunderland SR2 7JE.

#### References

- Cole, R. R., Aguilar, E. A. (1988) Cricothyroidotomy versus tracheotomy: an otolaryngologist's perspective. *Laryngoscope*, **98**: 131–135.
- Esses, B. A., Jafek, B. W. (1987) Cricothyroidotomy, a decade of experience in Denver. *Annals of Otolaryngology, Rhinology and Laryngology*, **96**: 519–524.
- Freezer, N. J., Beasley, S. W., Robertson, C. F. (1990) Tracheostomy. *Archives of Disease in Childhood*, **65**: 123–126.
- Frei, F. J., Meier, P. Y., Lang, F. J., Fasel, J. H. (1990) Cricothyrotomy using the Quicktrach coniotomy instrument set. *Anasth-Intensivther-Notfallmed*, **25 Supplement 1**: 44–49.
- Holst, M., Hertegard, S., Persson, A. (1990) Vocal function following cricothyroidotomy: a prospective study. *Laryngoscope*, **100**: 749–755.
- Kuriloff, D. B., Setzen, M., Portnoy, W., Gadaleta, D. (1989) Laryngotracheal injury following cricothyroidotomy. *Laryngoscope*, **99**: 125–130.
- Milner, S. M., Bennett, J. D. C. (1991) Emergency cricothyrotomy. *Journal of Laryngology and Otology*, **105**: 883–885.
- Waldron, J., Padgham, N. D., Hurley, S. E. (1990) Complications of emergency and elective tracheostomy: a retrospective study of 150 consecutive cases. *Annals of the Royal College of Surgeons of England*, **72**: 218–220.

#### Reply:

Dear Sir,

We are most grateful to Major Deans for sharing his disquiet over the problems of cricothyrotomy.

The Casualty Treatment Regimes for the British Army stipulate that under certain circumstances this is the pre-

ferred management of potential and/or life-threatening upper airways obstructions, one of the commoner causes of which in modern warfare is inhalational injury.

We would agree that convincing evidence from field experience sufficient to settle the issues raised is not available, but an attempt should be made to collect such data when the opportunity next arises.

Yours faithfully,

Major J. D. C. Bennett, BSc., F.R.C.S., D.C.H., R.A.M.C.,  
Senior Specialist in Otolaryngology,  
Queen Elizabeth Military Hospital,  
Stadium Road,  
Woolwich SE18 4QH.

#### Atrophic Rhinitis

Dear Sir,

I enjoyed Mr Kameswaran's article 'Fibreoptic Endoscopy in Atrophic Rhinitis' (*JLO*, December 1991). He has made some interesting and useful points. Unfortunately there is yet another reference to the antediluvian use of 25 per cent glucose in glycerine in the management of atrophic rhinitis. Having had extensive experience in the management of atrophic rhinitis in leprosy patients I concluded '... 25 per cent glucose in glycerine, contrary to what is generally accepted, resulted in ... the colonization of the patient's nasal cavities by a dry, white fungal growth' (Barton, 1973). I was unable to culture and identify this growth as there was no microbiology service in the hospital where I worked.

In the light of limited funding and facilities, I formulated an ointment composed of:

Vaseline	1 kg
Glycerine	200 g
Vioform	300 g
Crystal violet	5 g

(The quantities can obviously be reduced proportionately for individual prescriptions). After decrusting the nasal cavities, application of this ointment at a thrice weekly 'Nose Clinic' gave excellent results.

Yours faithfully,

R. P. E. Barton, F.R.C.S.,  
Consultant ENT/Head and Neck Surgeon,  
The Leicester Royal Infirmary,  
Leicester LE1 5WW

#### References

- Barton, R. P. E. (1973) *Leprosy Review*, **44**: 186–191.

#### Reply:

Dear Sir,

I would like to thank Mr Barton for his valuable suggestions. While it is true that we used 25 per cent glucose in glycerine in all our patients, it was for the express purpose of reducing the crusting in the nasal cavities prior to surgery and not with the idea of curing the condition. Used in conjunction with alkaline nasal douche solutions for a few weeks prior to surgery, there is an appreciable reduction in the crusting. I certainly agree with Mr Barton, that glucose in glycerine solution is not very effective when used as the only therapeutic option in atrophic rhinitis. As to the secondary colonization of the nose after application of the agent, which Mr Barton alludes to, we have not had occa-

sion to note this phenomenon in any of our patients. Perhaps this might have represented a nosocomial infection in the hospital where Mr Barton served or perhaps our patients with primary atrophic rhinitis represent a different group from his patients with secondary atrophic rhinitis following Hansen's disease.

Yours faithfully,  
Mohan Kameswaran,  
Abha Branch,  
College of Medicine,  
King Saud University,  
Abha, P. O. Box 641.