



Fig. 2. Typical case. (a) The tip of a U-shaped flap-like wound was necrotic; (b) the V-Y closure technique was used to repair a necrotic flap.

subcutaneous scar of beveled edges contracts, leaving the flap elevated above the surrounding skin (Fig. 1). Therefore, we advise the beveled edges be excised to equalize the wound on this occasion.

Third, when the wounds occurred in functional or aesthetic areas, the widespread attitude is to be more conservative at the initial moment. This principle works for most cases. However, if a large thin flap is equipped with poor vascular perfusion and little contusion, we suggest that the subcutaneous tissues under the flap should be removed and the skin should be replanted *in situ* with pressure bandaging. In such situation, it is risky to adopt a conservative attitude because secondary skin grafting will result in additional damage to the donor site if flap necrosis occurred during the period of waiting to reevaluate.

Fourth, whether a flap-like wound should be handled more aggressively from the initial assessment depends on the perfusion of flap. Also sufficient surrounding soft tissue should be considered. We need to evaluate the benefits or risks of both conservative and aggressive attitude. Fig. 2 shows a case with a necrotic flap. A 20-year-old man presented with a 1-hour history of an injury on his forearm caused by a sharp instrument. The reverse wound flap was approximately $3 \times 10 \text{ cm}^2$ in area and was simply sutured conservatively without any special treatment. The flap tip necrosis occurred 5 days after surgery. The V-Y closure technique was performed to repair the remaining triangular wound after the necrotic tissue removed. The lesson: tenuous flap tip should be excised carefully in primary care.

In conclusion, the goal of our article was to expound the characteristics of common flap-like wounds and analyze the causes of flap necrosis. Thank you for allowing us the opportunity to clarify our points.

Declaration of Competing Interest

The authors have no financial interest to declare in relation to content of this communication.

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Anisocoria and diagnostic applications of pilocarpine – An eye opener



The article by Kokulu et al. [1] is interesting and informative from the point of patient safety and medical errors. We would like to mention the diagnostic applications and limitations of pilocarpine to differentiate anisocoria at the bedside.

Sudden onset of unilateral dilatation of pupil (anisocoria) invariably indicates an impending life threatening neurosurgical emergency especially in those cases who are unconscious/comatose, sedated or paralyzed, and at times with abnormal mental status [2]. However, it may not be an alarming one, if noticed or observed as an adverse effect of drugs such as ipratropium bromide.

It has been suggested that instillation of pilocarpine eye drops of varying strength at the bedside helps to differentiate the anticholinergic effects of drugs from other conditions causing an abnormally dilated pupil [3]. However, in an elderly patient presenting with mydriasis and a history of chronic topical sympathomimetic use, the pharmacologic testing with pilocarpine is likely to complicate the diagnosis. This is because the mydriasis caused by this agent is predominantly due to direct sympathomimetic effect on the pupil dilator rather than a parasympathetic effect of the pupil constrictor [4]. Moreover, in botulinum toxin poisoning administration of pilocarpine (1%) causes toxic pupil to constrict through presynaptic inhibition of acetylcholine release by the neurotoxin [5].

Assessment of pupil and its response to pilocarpine eye drops shall be discussed during clinical rounds so as to differentiate one condition from another, and before making statements or subjecting patients to expensive investigations. Moreover, it is suggested that assessment of pupils shall be included as one among the vitals, and the students and practitioners shall be trained and tuned to monitor pupillary response regularly in medical emergencies.

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The authors reply: pilocarpine and a proper pupillary exam



Dear Editor,

We thank the authors for their reply to and interest in our article [1]. We would like to make mention of a few important points about anisocoria and the pilocarpine test while we agree with the comments of the authors.

First, the detailed patient history (drug use, trauma, etc.) should be learned before performing a pilocarpine test in the differential diagnosis of anisocoria. Then, the pupil examination of the patient should be performed in both dim and bright light [2]. Because in a patient with anisocoria, we first need to determine which pupil is abnormal. If anisocoria is more prominent in the dark, there is a pathology in the small pupil and the diseases affecting the sympathetic system are investigated. If anisocoria is more prominent in bright light, there is a pathology in the large pupil and the diseases affecting the parasympathetic system are investigated. The reaction to light, response to near focus, eyelid position, and eye movements should also be reviewed [3].

The pilocarpine test can be performed in the differential diagnosis only if anisocoria is more prominent in bright light. If anisocoria is more prominent in dim illumination, an apraclonidine test can be performed instead of a pilocarpine test. Therefore, performing a pilocarpine test without detailed eye examination may cause confusion in physicians [3,4].

Pilocarpine is a parasympathomimetic drug and causes constriction in the normal pupil. The pupil will dilate if there is a parasympatholytic drug, such as ipratropium bromide, contact with the eye before a pilocarpine test. If pilocarpine is instilled into this dilated pupil, no constriction occurs and this information is used in the differential diagnosis. As noted by the authors, performing a pilocarpine test in a patient with a history of topical sympathomimetic use and with mydriasis may further

complicate the diagnosis. Because sympathomimetic drugs affect the symptomatic system and cause mydriasis. Pilocarpine does not have a direct antagonist effect because it is not a sympatholytic drug, but it may cause miosis by muscarinic receptors. In such a patient, if the patient does not have any symptoms or signs other than anisocoria, and the neurological examination is also normal, it is best to follow the patient closely without any intervention. Because anisocoria occurring as a side effect of the drug will regress within hours [3,5].

A careful and systematic evaluation is required for patients with anisocoria to exclude the life-threatening potential causes. Following the algorithms related to anisocoria when evaluating these patients will prevent confusion during diagnosis. With these algorithms, we can also save patients from detailed and expensive diagnostic procedures.

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Inclined versus supine position for endotracheal intubation



With great interest, we read an article by Murphy et al., which showed that inclined positioning was associated with a higher rate of first pass success than supine positioning in prehospital endotracheal intubation. [1] Better visualization in inclined position was thought to be a rational mechanism. This study is very welcoming because the patient position is one of the modifiable conditions to achieve better success during intubation. However, some concerns seem to be further explained.

First, patients were categorized into three cohorts: supine, inclined, or unknown. The way the authors dealt the patient's position may be needed in case a patient position is changed after the fail of first try