Reply

Sir,

We thank Dr Lin for his interest in our article. We would like to point out that in the article, we stressed that in our series, fasciotomies were performed as a routine procedure for the treatment of compartmental syndrome, and in none of the patients was intracompartmental pressures measured [1]. We therefore (unfortunately) cannot provide any intracompartmental pressure measurements for the present series. Also, in the paper we suggested that the practice followed by our medical community during this disaster was not correct, and our findings (that fasciotomies are potential sources of wound infections that can result in sepsis and even death) contradicted earlier suggestions in favour of early fasciotomies [2,3].

Actually, fasciotomies carry an even higher risk of infection in disaster conditions, since heavy patient overload and the chaos of the situation can result in improper wound care. Thus, one should be even more cautious about the indications for fasciotomies in disaster victims as compared with cases in routine clinical practice.

In their well-written paper, Oda *et al*. [4] reported that only in some of the Kobe disaster victims were intracompartmental pressures measured; also in their series, most cases were fasciotomized without objective criteria. Thus, we are not aware of any reports providing information on intracompartmental pressures of compartmental syndromes in disaster victims.

We would like to draw attention once more to mannitol (which is frequently administered for the prophylaxis of acute renal failure in crush victims), and can also be beneficial for the treatment of compartmental syndrome [5,6]. Thus, we emphasize the importance of a conservative approach in the treatment of crush victims' compartmental syndromes. To perform surgical fasciotomies only with clear indications can decrease the number of wound infections and sepsis, hence resulting in an improved prognosis in this patient population.

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