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Original Article

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Role of Systemic Coolant as an Adjunct in Laser Assisted Ear Piercing

Nishad K.[1], Neljo Thomas[2], Ravi Kumar Chittoria[3], Barath Kumar Singh[4], Jacob Antony Chakiath[5]

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Abstract

A plastic surgeon's earlobe piercing is a regular office practice. Ear piercing has been described in a variety of ways. We discuss a new method of laser ear piercing that uses a systemic coolant in this publication. After systemic precooling, a 56-year-old female patient had her ear pierced with an Er:YAG laser with a power of 10J/cm^2 in continuous mode. Ear piercing using the Er:YAG laser was quick, painless, and highly effective. More precision, minimal stress with less pain, no bleeding due to the coagulation action of the laser, and decreased possibility of infection due to the thermal heat impact of the laser were the benefits we found when using the systemic coolant over conventional approaches.

Keywords: Ear piercing; Er:YA Glaser; Coolant.

INTRODUCTION

For people in industrialised countries, body piercing is a centuries old practise. However, it has now become a part of their fashion approach, with the ear being the most commonly pierced body part.[1,2] Despite the fact that it is a common surgery, it is not without risks, including as oedema, haematoma, infection, and keloid formation. In medicine, lasers have a wide range of applications. The laser scalpel is most widely used in dental surgery, although it is now utilised practically everywhere because to its safety, precision, convenience of use, haemostasis, reduced post-operative discomfort and oedema, and reduced scarring. We'd like to describe a new method of laser ear piercing that uses a systemic coolant in this post.

Author's Affiliations: [1,2,4,5]Senior Resident, [3]Professor & Head of IT Wing and Telemedicine, Department of Plastic Surgery & Telemedicine, Jawaharlal Institute of Postgraduate Medical Education and Research Institute, Puducherry 605006, India.

Corresponding Author: Ravi Kumar Chittoria, Professor & Head of IT Wing and Telemedicine, Department of Plastic Surgery & Telemedicine, Jawaharlal Institute of Postgraduate Medical Education and Research Institute, Puducherry 605006, India.

E-mail: drchittoria@yahoo.com

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MATERIALS AND METHODS

After receiving departmental ethics clearance and patient permission, the study was conducted in the Department of Plastic Surgery in January 2022. A 56-year-old female patient came to the outpatient plastic surgery department with the wish to get her ears pierced (Fig. 1). The treatment was carried out in the department laser operating theatre after normal blood testing were completed. There were

enough safety procedures applied. The piercing site was marked, and 5 minutes of non-contact cooling was applied. After ensuring proper cooling and local anaesthetic, a tract was created using a Doc Medica Er:YA Glaser TM Quanta system (Corso Casale, Torino, Italy) with a Fluence of 10.0 J/m^2 and a pulse width of 0.3ms in continuous mode using a 2 mm tip in the anterior and posterior direction (Fig. 2). Once the area was marked and haemostasis attained, a gold stud was introduced through the tract (Fig. 3). The same procedure was repeated on the opposite side.

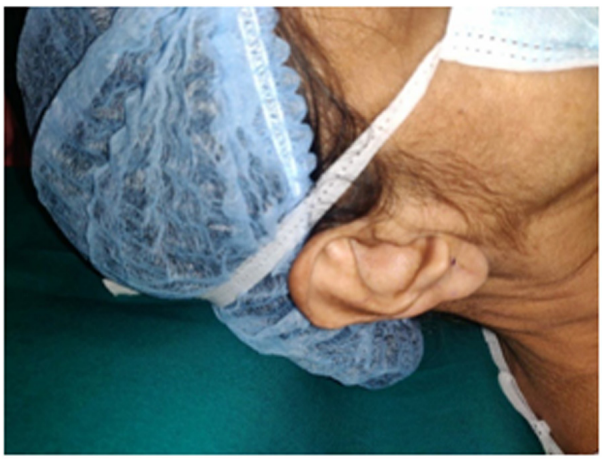


Fig. 1: Ear lobe of Patient

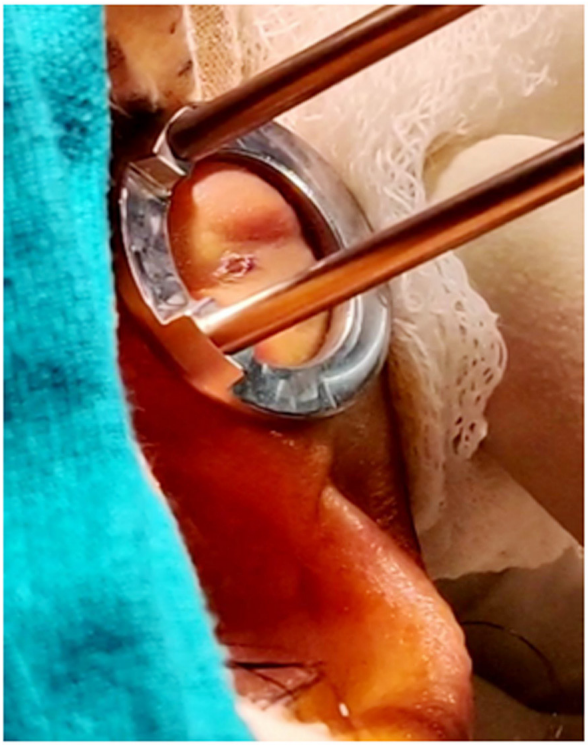


Fig. 2: Laser applied to earlobe

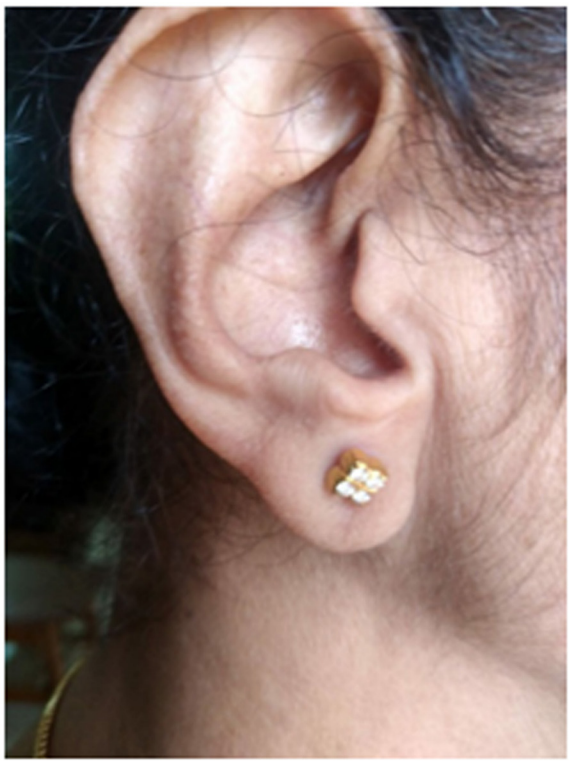
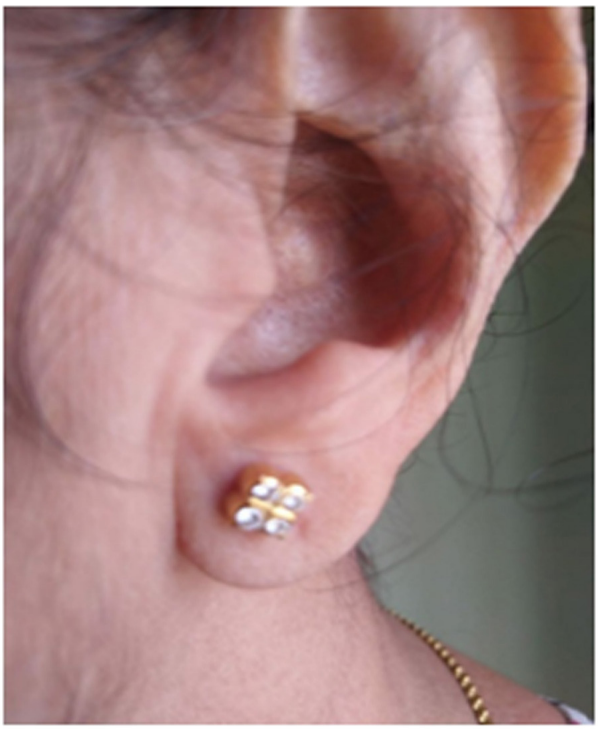


Fig. 3: Ear rings placed (photo after 2 weeks)



RESULTS

The ear piercing was performed with the help of a systemic coolant and an ErYAG laser, which proved to be beneficial during the treatment. Despite the use of coolant on end artery regions, no complications were seen.

DISCUSSION

Topical local anaesthetic can be utilised in conjunction with other pre-cooling procedures used in traditional laser therapy, such as cold gel administration and cryospray application. This eliminates the need for an injection before to the treatment and is especially beneficial in children. The laser scalpel ablates the tissues it cuts immediately, resulting in good haemostasis.[7] The use of systemic coolant in piercing has this excellent advantage in the ear, where there is a rich blood supply and bleeding is a regular concern. The wound is instantly sterilised, and bacteraemia is decreased.[8-10] This reduces the risk of keloid formation by lowering the risk of post-operative perichondritis or wound infection.

Er:YAG laser was first used in dental practice. The electric current is the pump source which produces photons which are conducted through a laser active medium. It works on three wavelengths, 810, 940 and 980 nm.[5] It is cheap, small in size and has a long flexible fibre cable which makes the ErYAG laser scalpel easy to use.[6] The use of ErYAG laser for ear piercing has many significant advantages over the conventional techniques.

Topical local anaesthetic mixed with various pre-cooling procedures utilised in traditional laser therapy, such as cold gel administration and cryospray application, can be employed to carry out the procedure. This eliminates the need for a pre-procedure injection and is especially beneficial in children. The laser scalpel ablates the tissues it cuts almost instantaneously, resulting in good hemostasis.[7] The use of systemic cooling in piercing has this wonderful advantage in the ear, where there is a lot of blood flow and bleeding is a common problem. The wound is immediately sterilised, and the bacteraemia is decreased.[8-10] This reduces the risk of keloid formation by minimising the risk of post-operative perichondritis or wound infection.

The tissue damage caused by the Er:YAG laser is quite low. As a result, there is less oedema, wound contraction, and scarring. According to studies, piercing with a piercing gun or a 16 gauge cannula causes the perichondrium to be stripped from the cartilage, especially at the exit location.[11] The relatively avascular cartilage is damaged, making the ear more susceptible to infection. Because the Er:YAG laser probe is precise and causes minimal tissue injury, the risk of cartilage damage is considerably reduced, as is the risk of post-procedure keloid formation.

CONCLUSION

The use of systemic coolant in laser assisted ear piercing offers distinct advantages over the traditional methods of ear piercing however needs large scale randomised control trial for wide spread clinical use.

Conflicts of Interest: None.

Declarations: Authors' contributions

All authors made contributions to the article

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Original Article

Journal of Emergency and Trauma Nursing
Volume 4 Number 1, January - June 2023

Role of Dermabrasion Assisted Debridement in Burns

Naresh Kumar Codandabany[1], Ravi Kumar Chittoria[2], Barath Kumar Singh. P[3]

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Abstract

Burn injury of second degree deep dermal and full thickness delays in healing and heals by scarring. Deep dermal burns need early treatment by tangential excision and skin grafting to promote healing. Dermabrasion is an alternative method for tangential excision where the depth of excision up to viable tissue demarcated by punctate capillary bleeding. It is a useful alternative to early excision of the scar. In this case report we were assessing the role of dermabrasion assisted debridement in burn Injury.

Keywords: Dermabrasion; Burns; Debridement.

INTRODUCTION

Dermabrasion, which was developed in the 1950s, mechanically abrades the epidermis and upperportion of the dermis.[1] The epidermis is entirely abraded and there is partial removal of the dermis, which undergoes incomplete regeneration. It is a common procedure used by plastic surgeons. It is used for a variety of indications like acne scars, surgical scars, benign tumors, facial rejuvenation and many other uses.[2] The process of burn wounds healing includes the removal of necrotic tissue, the hyperplasia of granulation tissue and epithelialization. The removal of necrotic tissue is the first step in dealing with burn wounds. Although there are a variety of adjuvant drugs for removing necrotic tissue, surgical debridement is still the main way of debridement of burn wounds. Surgical debridement of burn wounds includes escharotomy, tangential excision and dermabrasion. Escharotomy and tangential excision have been widely used in clinical practice, while dermabrasion has not been known to the majority of burns colleagues. This article summarizes the clinical application and progress of dermabrasion in burn wounds. Here we describe a use of dermabrasion assisted debridement of burn wounds. There were no many studies on dermabrasion assisted debridement.

Author's Affiliations: [1]Visiting Resident, [2]Professor & Head of IT Wing and Telemedicine, [3]Senior Resident, Department of Plastic Surgery, Jawaharlal Institute of Postgraduate Medical Education and Research Institute, Puducherry 605006, India.

Corresponding Author: Ravi Kumar Chittoria, Professor & Head, Department of Plastic Surgery & Telemedicine, Jawaharlal Institute of Postgraduate Medical Education and Research Institute, Puducherry 605006, India.

E-mail: drchittoria@yahoo.com

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MATERIALS AND METHODS

This study was conducted in the Department of Plastic Surgery in a tertiary care institute. Informed consent was obtained from the patient under study. Department scientific committee approval was obtained. It is a single center, non-randomized, non-controlled study. The patient under study was a 45 year old male, with no other known comorbidities presented with multiple second degree superficial and deep burns involving face, scalp, neck, chest and abdomen (anterior aspect), bilateral thigh due to contact with electric wire at time of presentation. In this case report we were using dermabrasion assisted debridement for the Scalp wound which was deep burns with mixed varying degreeswith normal and in between non-viable necrotic tissue (Fig. 1). The patient was intubated at the time of admission due to right frontal lobe contusion due to associated fall from height. The electrical burn will undergo progressive skin necrosis, so the debridement was done after demarcation of necrotic patch and stabilisation of the hemodynamic of the patient. The dermabrasion is done using the high-speed rotating head dermabrader with 4200 rpm (Fig. 2). The non-viable necrotic tissue was debrided (Fig. 3) without damaging the normal tissues in both horizontal and vertical planes with motor-controlled hand probe.After wound debridement with derma-abrasionwas done till the removal of unhealthy tissues (Fig. 4). After debridement biological collagen scaffold dressing done (Fig.5). Small portable hand held dermabrader are available in market. End pieces are of various different size and shapes available say wire brushes, serrated wheels, diamond fraises, blunt tip. Dermabrasion can be done with local anesthesia. Post procedure patient may need adrenaline saline to stop the punctate bleeding and closed dressing system like NPWT (negative pressure wound therapy) for improving granulation and wound bed preparation post dermabrasion.

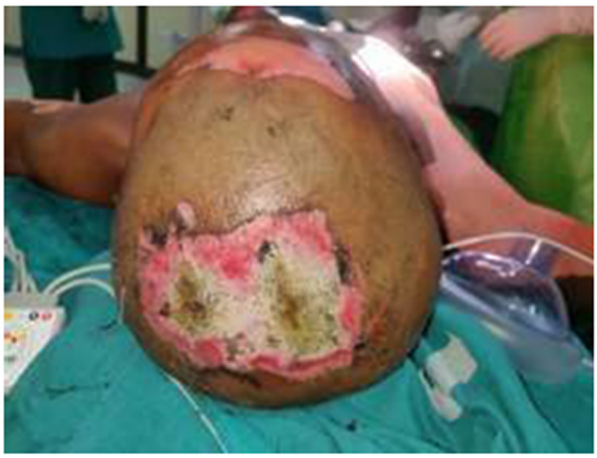

Fig. 1: Scalp electrical burns–at the time of presentation

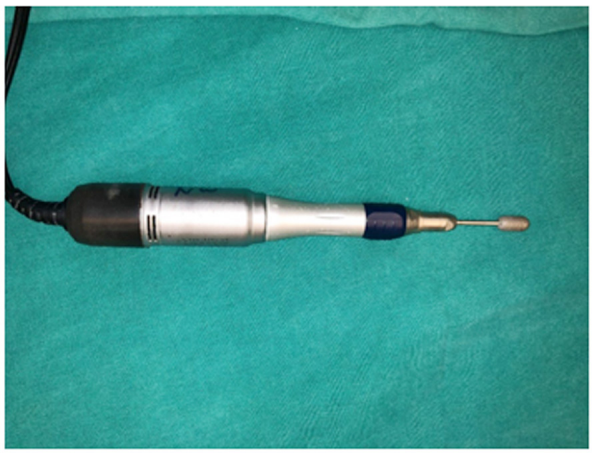

Fig. 2: Dermabrader

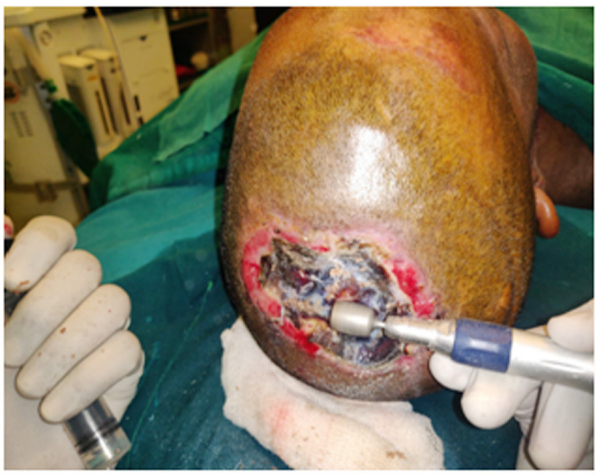

Fig. 3: Dermabrasion of the necrotic skin over the scalp

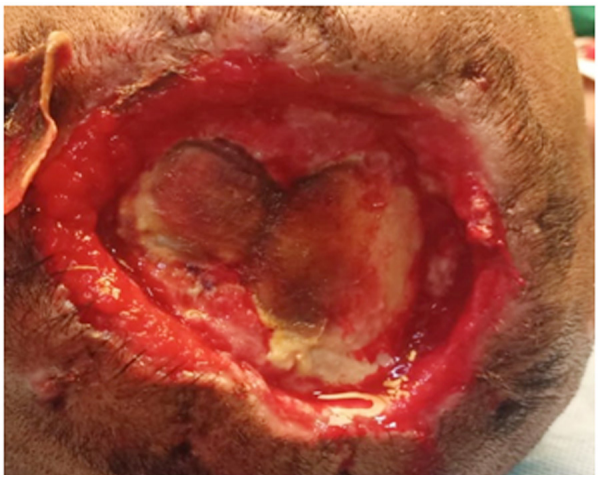

Fig. 4: Post Dermabrasion assisted debridement

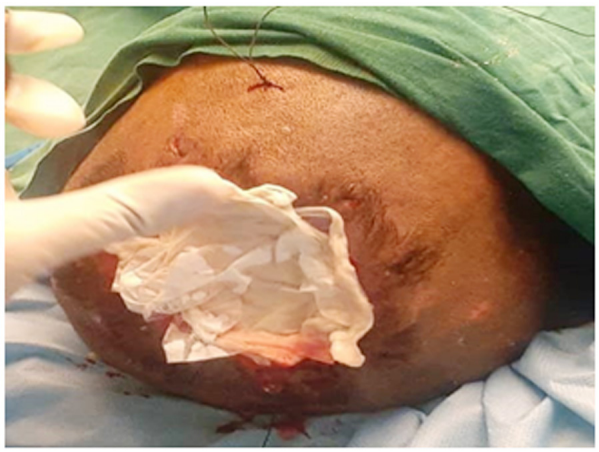

Fig. 5: Post dermabrasionassisted debridement collagen scaffold dressing.

RESULTS

Dermabrasion is an effective alternative to the debridement of the wound in burns. Patient compliance was good with this procedure. In this method of wound debridement with dermabrasion helps in layer-by-layer debridement without damaging the normal tissues. Post-operative period was uneventful.

DISCUSSION

Dermabrasion is a simple, cost-effective means of skin resurfacing that can provide repeated and reliable results when used on the face or many other areas of the body. Numerous studies have demonstrated that dermabrasion is a reliable and effective method for skin resurfacing and should be a part of a plastic surgeon arm amentarium in resurfacing damaged skin and the aging and damaged face. Deep dermal burns and full thickness burns are treated by early tangential excision followed by a split skin graft. After three weeks (sometimes a little more), deep dermal burns heal spontaneously as a result of a combination of formation of granulation tissue and epithelialization of the surrounding healthy skin.[3] In full thickness burns, all epithelial cells are destroyed and skin grafting is required. In this case report we preferred Dermabrasion as an alternative method for early excision of burn. In literature, Dermabrasion done for deep dermal burns, not a full thickness wound, conjunction with more formal early tangential excision of deep dermal or full thickness burn. The patients had a more rapid healing, stable end result, a better final appearance, prevents hypertrophic scarring.[3] The wound did not require grafting, Evidence that a skin graft on a burn wound that is in the process of healing will be rejected by underlying epithelialization but will have acted as a biological dressing.[4] Derma-abrasion compared with a classic method of excision. In addition, they all found a considerable reduction of blood loss, smaller planed surfaces compared with excised surfaces, reduced costs, and excellent graft setting in all cases.[4] In dermabrasion there is better control on depth, preserving the viable tissues, stable end point, rapid healing, less blood loss.[5]

CONCLUSION

In our study we found that dermabrasion was useful and effective tool in debridement of the burn wound. Debridement is the effective process in preparing the wound bed, dermabrader assisted debridement reduces the bioburden with less damage to the healthy and normal tissues. The limitation of the study includes that it is a case report with a single center study with no statistical analysis. Further randomized controlled studies are required to validate the efficacy of the dermabrasion in deep dermal burn.

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Case Report

Journal of Emergency and Trauma Nursing
Volume 4 Number 1, January - June 2023

Dengue Encephalitis Nursing Approach and Nursing Careplan

Amandeep Kaur[1], Kishalay Datta[2]

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Abstract

Dengue fever is the most common viral fever caused by the bite of Aedes aegypti female mosquito. Dengue fever is prevalent in the south east asian country especially in low and middle income countries. Poor sanitary conditions contribute to the major factor for spread of this disease. Dengue encephalitis is arareentity where the patient's central nervous system gets infected by the viral particle, and has varied outcomes from recovery to death of the patient.

In this case report, we will be seeing the nursing care plan and role of good nursing efficacyin the treatment of dengue encephalit is patient.

Keywords: Dengue encephalitis; Dengue shocks syndrome; Mechanical ventilatorin; Dengue fever.

INTRODUCTION

Encephalitis is a very common neurological complication of dengue fever. Dengue virus is a single stranded RNA virus of the Flaviviridae family causing dengue fever and its related complications. Dengue encephalopathy is usually secondary to multisystem derangement like shock, hepatitis, coagulopathy, and secondary bacterial infection.[1]

Author's Affiliations: [1]Senior Staff Nurse, [2]Director and HOD, Department of Emergency Medicine Max Hospital, Shalimar Bagh, New Delhi 110088, India.

Corresponding Author: Kishalay Datta, Director and HOD, Department of Emergency Medicine Max Hospital, Shalimar Bagh, New Delhi 110088, India.

E-mail: dr.kishalay@gmail.com

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Nursing care plan for dengue encephalitis and dengue fever persevaries from continuous vitals monitoring, close monitoring of patient coagulation profile, effective infection control, controlled medications, family members and patient counseling and teaching, ventilator management.

CASE

A 23 year old male patient was admitted to the Emergency room with diagnosis of dengue fever (NS1 positive). Patient had history of bleeding from gums and nose 1 day back. Today, he had altered sensorium. He was newly married for last 10-15 days. In the emergency room he was examined by the doctors team and treatment was started according to the guidelines.

The nursing care plan involved in this patient was taking care of the bleeding dias thes is, counselling the newly married bride about the patient condition

and providing mental support, following doctors orders for the patient well being.

The patient suddenly had seizure attack in the ER and was stabilised by local seizure control guidelines. Patient GCS remained compromised forlong time (timely checked and recorded in the nurses vitals record form) and the doctors were informed about the unstable condition and poor GCS of the patient. He was then incubated and put on ventilatory support. It was difficult to counsel the newly wed bride but, in the nursing education, we are taught for the same.

The patient condition gradually improved over the few days and extubated on the fifth day and was discharged on the 8th day of admission.

DISCUSSION

The nursing care plan involved thr following functions from day 1 till day of discharge.

1. ***Proper vitals, report and medication records:*** As a major role in the treatment of patients, maintaining of the vital records, daily reporting of blood samples, medication administered records are role important for the healthy outcome for patient illness. This includes timely informing the concerned doctor and the treating physician regarding any deterioration in the patient condition, any drug overdose or allergy, any record abnormal and deviated from normal parameters which must be looked and actupon.
2. ***Infection control:*** Infection control is a major factor in the hands of the health care providers. Nurses per se play one of the most import factor inprevention (and transmission) of infections in the health care setup. Hand washing, hand sanitising, wearing of disposable gloves and masks and head caps are all measures to prevent transmission of infections.
3. ***Ventilator management***: Though neglected many a times, ventilator management is the role of both doctors and nurses. All the nursing team should be trained in basic interpretations and handling of ventilators. Taking care of ventilated patients is a big task faced by nurses. This includes ventilator alarm management and interpretation, care of Endotracheal tube, oral care, eye care, patient positioning.

Post extubation care also impacts the outcome (positive) inventilatory patients as care must be given to the airway (clearing of airway, chest physio -therapy, medications and oral hygiene).

4. ***Family counselling and education:*** Of tenmissed and overlooked by health care professionals, it's the job of both doctors and nurses to explain and impart knowledge regarding the patient health status to the family members. This factor in nursing care plan is often missed by young and also the experienced nursing team.

Medications help patient health recover but the care given by the nurse helps the patient's soul to recover. The tender love and care given by the nurse to the patien the lpsin speedy recovery of patients which supports the medical management.

CONCLUSION

To conclude, the nursing care plan varies from person to person, importance is given in this case to ventilatory management in denguee ncephalitis. There are many medical articles and case reports for the management of denguee ncephalitis but there are very few articles and case reports supporting nursing care plans and importance must be given to improve the education standards and encouragement must be given at the basic level for such publications.

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Short Communication

Journal of Emergency and Trauma Nursing
Volume 4 Number 1, January - June 2023

Cardiopulmonary Resuscitation Knowledge & Skills among the Nursing Professionals in the ER of a Superspeciality Hospital, New Delhi

Amandeep Kaur[1], Kishalay Datta[2]

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Abstract

Nurses are generally the first responder to identify the need for and initiate cardiopulmonary resuscitation (CPR) on patients with cardiopulmonary arrest in the hospital setting. Cardiopulmonary resuscitation has shown to reduce in-hospital deaths when received from adequately trained health care professionals. Nurses, therefore, should possess adequate competency to provide effective resuscitation.

Keywords: Cardiopulmonary Resuscitation; CPR; Nursing education.

INTRODUCTION

Cardiopulmonary resuscitation (CPR) is a well established procedure performed by medical and non-medical professionals, in which both chest compressions and artificial ventilation are provided to maintain adequate blood flow to the brain and other vital organs.[1] Cardiopulmonary resuscitation has been shown to reduce in-hospital cardiac death and related fatalities when patients are managed by adequately trained health care professionals.[2] The American Heart Association (AHA) is the leading authority on resuscitation science. Its approved training courses are taught across the globe. In an effort to practice evidence based medicine, AHA updates are released every 5 years. The 2015 AHA update for CPR and emergency cardiovascular care (ECC) focuses on topics involving significant new developments in resuscitation science or ongoing controversies, and serves as an update to the 2010 AHA Guidelines for CPR and ECC rather than as a complete revision of the guidelines.[3] In this study, we evaluate the nursing team of our emergency department regarding their skill and knowledge in handling cardiac arrest patients.

CASE

This observational study was carried out for a two month period (November 2022, December 2022) in the emergency department of our institute. The study involved observation of the CPR provider skills imparted during the training session to the nursing officers working in the emergency department. The focus was given more on young

Author's Affiliations: [1]Senior Staff Nurse, [2]Director and HOD, Department of Emergency Medicine, Max Hospital, Shalimar Bagh, New Delhi 110088, India.

Corresponding Author: Kishalay Datta, Director and HOD, Department of Emergency Medicine, Max Hospital, Shalimar Bagh, New Delhi 110088, India.

E-mail: dr.kishalay@gmail.com

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new trainee nursing officers. All the components of high quality CPR were noted, knowledge about the administration and handling of medications, rhythm identification on the cardiac monitor was noted.

Daily nursing lectures are carried out and CPR and BLS topics are covered in these lectures by the nursing educators of our institute. Apart from this, BLS and Acls provider courses by the AHA are also organized for the medical professionals in our institute for getting registered with AHA.

DISCUSSION

This observational study found that the basic knowledge and skill of Cardiopulmonary Resuscitation needed to be possessed by the nursing officer was lacking among the new joinees. The senior staff had good knowledge and skill to carry out the CPR and BLS protocol. It was also observed that the nurses who had taken the AHA course prior, had better skills and knowledge in handling cardiac arrest patients.

High quality CPR is the cornerstone of first aid and emergency medical care that can optimize outcomes beyond return of spontaneous circulation.

High quality CPR consists of 5 components push hard and push fast, minimize interruptions, adequate ventilation, complete chest recoil, depth for chest compression about 5 cm.

Knowledge about the medications handling and administration are not explained in the BLS course but, being in the emergency room, the nursing team must be fully aware of these medications and use, adverse effects, indications and contra indications.

The knowledge of CPR plays a vital role in the final outcome of acute emergency situations.

CONCLUSION

This study was an observational study and involved nursing officers of the Emergency department of our institute. The study showed that the knowledge and skills among the new nursing officers were lacking when compared to the senior nursing officer.

This study was limited by its time frame, participants involved and limited department exposure. A further study involving more participants and live demonstration with pre-test and post-test skill and knowledge gain will be required for the better assessment of nursing officers.

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Standard journal article

[1] Flink H, Tegelberg Å, Thörn M, Lagerlöf F. Effect of oral iron supplementation on unstimulated salivary flow rate: A randomized, double-blind, placebo-controlled trial. J Oral Pathol Med 2006; 35: 540–7.

[2] Twetman S, Axelsson S, Dahlgren H, Holm AK, Källestål C, Lagerlöf F, *et al*. Caries-preventive effect of fluoride toothpaste: A systematic review. Acta Odontol Scand 2003; 61: 347–55.

Article in supplement or special issue

[3] Fleischer W, Reimer K. Povidone-iodine antisepsis. State of the art. Dermatology 1997; 195 Suppl 2: 3–9.

Corporate (collective) author

[4] American Academy of Periodontology. Sonic and ultrasonic scalers in periodontics. J Periodontol 2000; 71: 1792–801.

Unpublished article

[5] Garoushi S, Lassila LV, Tezvergil A, Vallittu PK. Static and fatigue compression test for particulate filler composite resin with fiber-reinforced composite substructure. Dent Mater 2006.

Personal author(s)

[6] Hosmer D, Lemeshow S. Applied logistic regression, 2nd edn. New York: Wiley-Interscience; 2000.

Chapter in book

[7] Nauntofte B, Tenovuo J, Lagerlöf F. Secretion and composition of saliva. In: Fejerskov O,

Kidd EAM, editors. Dental caries: The disease and its clinical management. Oxford: Blackwell Munksgaard; 2003. pp 7–27.

No author given

[8] World Health Organization. Oral health surveys - basic methods, 4th edn. Geneva: World Health Organization; 1997.

Reference from electronic media

[9] National Statistics Online—Trends in suicide by method in England and Wales, 1979–2001. www.statistics.gov.uk/downloads/theme_health/HSQ 20.pdf (accessed Jan 24, 2005): 7–18. Only verified references against the original documents should be cited. Authors are responsible for the accuracy and completeness of their references and for correct text citation. The number of reference should be kept limited to 20 in case of major communications and 10 for short communications.

More information about other reference types is available at www.nlm.nih.gov/bsd/uniform_ requirements.html, but observes some minor deviations (no full stop after journal title, no issue or date after volume, etc.).

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