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LETTERS

To the Editor:

The article by Meyer, et al. [*J Hyperbaric Med* 1990; 4(4):211–216] describing a technique of noninvasive blood pressure monitoring in the monoplace hyperbaric chamber was interesting and informative. However, the article is a little misleading. I contacted the manufacturer of the Oscillomate 930H noninvasive blood pressure monitor (CAS Medical Systems, Inc., Branford, CT) to request information concerning availability, price, and product approval (by the manufacturer for this application). They informed me that at the present time this unit is not approved by the company for monoplace hyperbaric use and is still undergoing testing. They were uncertain if the unit would be available, but stated that if it were it would probably be on the market by the end of this year. Furthermore, the standard Oscillomate 930 will not perform in the manner described in Meyer's report. It would have been appropriate for the authors to have commented that this device was modified for the hyperbaric application and may or may not be commercially available in the future. It would also have been informative to have performance data at higher chamber pressures (up to 3.0 ATA) because it was evident that the cuff inflation time was a function of chamber pressure. It is conceivable that the device may not function or function inadequately at higher chamber pressures. Finally, the authors provide no information regarding approval of this investigation by the hospital's Investigative Review Board or if they were funded (and by whom) to perform the investigation.

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To the Editor:

Although I enjoyed reading and learned from the literature review of the article, "Wound Care and Maintenance of Skin Integrity Protocols" (*Journal of Hyperbaric Medicine*, Vol. 5, No. 1, 1990), I take exception to several of the points. I do not know what specialty H. T. Vincent and J. R. Landry represent, but I am a practicing plastic surgeon and have been dealing with complex wounds for 10 years. I have tried most of the products mentioned in their review.

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Personally I think it is a mistake to rely on a wound classification system that gives a numerical value to the problem. Each wound should be evaluated by a physician knowledgeable in wound care management, and treatment individualized to that particular patient's total care.

My more important objection relates to the routine involvement of enterostomal therapy nurses in the care of complex wounds. Unfortunately, I have seen many wounds that were inappropriately cared for by enterostomal therapy nurses. I have seen too many cases where expensive occlusive dressings such as Duoderm and Opsite were used to cover grossly necrotic tissue. I strongly believe that pressure and vascular ulcers should be managed by plastic surgeons or general surgeons experienced in wound care, just as a patient with a myocardial infarction should be managed by a cardiologist or internist and not a coronary care unit nurse. My point is not to denigrate the value of ET nurses or any other type of nurse; my point is that a significant health problem such as a pressure ulcer should be managed by a physician trained and experienced in such problems, with nurses used in the supportive role that they do so well.

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