



## The evolving management of penetrating neck injuries

To the Editor:

In their article that appeared in the October 2000 issue (page 762), the authors provide a relatively wide literature overview. However, they neglect to provide the historical aspect of treating penetrating neck wounds. I find their final conclusion that zone II neck wounds can be managed by physical examination alone questionable.

Perforations of the esophagus may result in mediastinitis carrying major morbidity and mortality if not drained properly. It is true that zone 2 injuries are mostly above the esophagus, but it is also true that the exact route of high velocity penetrating bullets and even stab wounds cannot always be accurately anticipated.

While pre-World War II experience with observation of penetrating neck wounds (American Civil War) resulted in 15% mortality, it is believed that the change in attitude regarding mandatory exploration of the neck in World War II lowered this number by half, mostly due to the insertion of drains to drain undiagnosed esophageal perforations. The authors should also have acknowledged that no real double-blind study exists comparing surgical to conservative approaches.

Since exploration of zone II is relatively easy, and even if not cost effective, it should probably remain the golden standard for treating penetrating neck wounds.

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To the Editor:

Regarding the comments of Feinmesser and Reifen, we acknowledge that the mortality associated with penetrating

neck injuries has decreased from 15% in reports from the American Civil War to 7% during World War II due to the practice of mandatory surgical neck exploration. One should realize however that during the Second World War no investigatory procedures like angiography, duplex ultrasonography, spiral CT scan, esophagoscopy or esophagography were available, making surgical exploration the only safe means of management. Since the development of these investigatory modalities, and especially better monitoring and follow-up, the policy of mandatory surgical exploration has been challenged.

A double-blind study on this subject is extremely difficult to perform in this setting; nonetheless, contrary to Feinmesser and Reifen's claims, since 1980 at least two prospective randomized studies [1,2] have shown no benefit from a mandatory exploration policy and demonstrated that a selective approach is safe and cost effective. Moreover, another eight large prospective non-randomized studies validated protocols of the selective approach [3–10]. Only one modern prospective study used the above mentioned investigatory modalities, demonstrating that a selective management policy would have missed six injuries in 5 of 113 patients not detected in the initial survey [11]. This study, however, could not show what would have happened to these "missed" injuries since surgical exploration was performed immediately in all patients, regardless of the initial findings.

One can speculate that with careful follow-up, the significant injuries would have been discovered early and treated with no negative consequences. This hypothesis, that watchful follow-up is effective in the early detection of the rare missed injuries, has been proved correct in the eight prospective studies advocating a selective conservative policy.

Based on the modern literature and the combined experience of large trauma centers, the management of penetrating

neck injuries has evolved since the era of mandatory neck exploration, and selective surgical management has become the new standard of care. It is important to stress, however, that when the appropriate investigatory and careful follow-up facilities are not available, surgical exploration remains the safe alternative.

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## “Will for equal opportunity stronger than the wish to die?”

To the Editor:

I recently had the opportunity to review an article for IMAJ that shared with us aspects from the valuable experience that the author had acquired along the years. On reading it, some of my personal experience came to mind. One story in particular – depicting aspects of the controversial issue of “The patient’s wish for the Exit Option” – seems more actual now than ever.

Many years ago, during my early residency, I took care of a 40 year old painter with advanced multiple sclerosis that struck him at the peak of a successful career. He was completely paralyzed except for some movement of the neck muscles that enabled him to move his head back and forth. We accepted him from a nursing home, where he had been placed by his wife after she had sold his most valuable paintings ...

We attempted some rehabilitation by fixing him a wheelchair with a special device operated by the movements of the head, making it possible for him to look at picture albums. He had a clear mind and a sharp intelligence, and we soon became friends beyond the usual doctor-patient relationship. We used to have long talks about his condition. During those talks he expressed again and again his wish to die. He even asked me to give him a shot and bring his “meaningless life” to an end.

One morning he suddenly complained of chest pain. We diagnosed an acute myocardial infarction and informed him about it. His reaction was astonishing – he raised his voice and demanded to be immediately transferred to the intensive coronary unit; otherwise, he said, it

means we are discriminating against him and he would sue us! He was transferred to the ICU, returned after several days, completed his rehabilitation and went back to the nursing home as mentally competent as he had come to us.

I learned then that even when a patient clearly expresses the wish to die, he or she does not always really mean it. Seemingly, this patient’s sense for equal opportunity overcame his wish to die. Ever since, when encountering the subject of “patients’ wish to die,” I tell this story to my students, making it the starting point for an ethical dispute.

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## Moses Maimonides was born in 1138, not 1135 C.E.

To the Editor:

Moses Maimonides is the most illustrious figure in Judaism in the post-Talmudic era and one of the greatest of all times. He was famous as a rabbi, philosopher, physician, legal codifier, theologian, astronomer, mathematician, ethicist and much more. It is widely accepted that he was born on 30 March 1135, corresponding to Passover eve, Saturday the fourteenth day of Nissan in the year 4895 of the Hebrew calendar.

The nearly universal acceptance of 1135 as the year in which Maimonides was born has recently been challenged. Convincing evidence is now available that the correct date of his birth is 1138 and not 1135. The evidence that 1138 is the correct date is based on at least two autograph manuscripts of Moses Maimonides’ Mishnah Commentary, at the end of which the great sage clearly states that he was thirty years old when he completed his commentary in the year 1168 (1479 Sel.). Thus, he was born in the year 1138.

The incorrect assumption that he was born in 1135 is based on several manu-

script fragments whose authors are unknown and who perpetuated several errors and confusion of dates from a single early manuscript. These errors and inconsistencies are detailed by several recent scholars [1–5] who reject the suggestions by earlier writers that corrections of these “scribal errors” be made to fit the notion that Maimonides was born in 1135. These recent scholars [1–5] prove definitively that Maimonides was born in 1138 and not in 1135 as was previously thought.

The words of Maimonides himself in his autographs are the strongest proof of the accuracy of 1138 as his birth year. Primary sources from early authentic manuscripts are much more authoritative than the unclear, deficient fragments of manuscripts written by unknown authors and replete with errors and inconsistencies. The latter were perpetuated for centuries until Sassoon, Havlin and Goitein called attention to the Maimonides autograph of his Mishnah Commentary in which Maimonides states that he was thirty years old in the year 1168 when he completed his commentary and was thus born in the year 1138 of the Common Era.

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