In Reply to Drs Joob and Wiwanitkit

To the Editor:

We appreciate the valuable comments from Drs Joob and Wiwanitkit¹ regarding our article.² Wild boar bite is not a common injury, but the wound condition can worsen to a severe status if not promptly treated. As we mentioned in our article, there have been no reports of rabies infection in any animals, including humans, in Japan since 1957.^{3,4} We have thus never experienced a case of rabies to our knowledge. The comments from Drs Joob and Wiwanitkit reminded us that we have disregarded the existence of rabies. Even in areas with no reported infections, we must take care not to forget the presence of rabies and the potential risk of infection.

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In Response to Cold Card by Giesbrecht

To the Editor:

We are impressed by the idea of the Cold Card developed by Dr Giesbrecht.¹ Such a review of the most important issues in a concise form (a checklist) has been used in aviation for many years to improve safety. Because accidental hypothermia is not a very common medical condition, rescue teams have limited experience in this field. Thus, the Cold Card seems to be a useful tool for a brief refreshment of one's knowledge concerning hypothermia. However, some elements of the card should, in our opinion, be reconsidered.

In its current form, the Cold Card suggests placing every patient with mild hypothermia in a sitting or lying position for 30 min. The authors of the 2014 Wilderness Medical Society Practice Guidelines highlighted that application of this recommendation should be limited to nonwalking individuals when shelter and rewarming is available.² Leaving a hypothermic patient sitting or lying down in a cold environment would likely lead to further heat loss. There is no evidence for delaying the evacuation of a healthy, mildly hypothermic individual from a hostile environment. No rescue collapse has been reported in mildly hypothermic individuals without trauma or other comorbidities.

Because the availability of intravenous fluid flow warmers in emergency medical services and mountain rescue teams is very limited, the administration of warmed fluids in prehospital settings seems not to be feasible.^{3,4} Moreover, some warmers deliver the appropriate fluid temperature at slow flow only.⁵ Thus, attempts to achieve fast volume replacement may lead to a further drop in body temperature.⁶

We believe that adding another 2 recommendations to the Cold Card would be beneficial:

- The measurement of blood glucose in hypothermic patients with altered mental status should be mandatory.⁷ Prolonged shivering may lead to the depletion of glycogen stores and, subsequently, to hypoglycemia.
- Early notification of an extracorporeal life support facility is required to prepare staff, equipment, and transportation.⁸ Because extracorporeal life support is a treatment of choice in hypothermic cardiac arrest, a specific chain of survival must be built into every rescue operation to increase the survival chances of a hypothermic patient.⁹ Rescue teams should be aware that severe hypothermia is the only reversible cause of cardiac arrest that enables survival without neurological impairment, even after resuscitation lasting several hours. Thus, the statement that “nobody is dead until warm and dead” remains true.

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