limited resources at our disposal, and in an attempt to minimize dependence in the relationships between the therapeutic agents and the victims. An attempt is made to enhance efficacy for effective coping with changing needs that emerge in the wake of the disaster. An attempt is made to prevent CPTSD, which can inhibit the functioning of the community residents. We will present these principles and describe how they were implemented in community intervention at two refugee camps in Haiti following the earthquake there, and at a refugee camp in Georgia.

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(A68) 7 Options for Evolving the Concept of Disaster Health

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Introduction: The World Association for Disaster and Emergency Medicine (WADEM) has been the primary innovator and incubator for the concept of disaster health. This presentation puts forth 7 options for consideration for evolving the concept of disaster health.

Discussion: (1) Promote disaster health from an adjective to a noun phrase. Disaster health has been a modifier for too long, tucked into expressions such as disaster health management or disaster health education. It is time for disaster health to emerge in its own right. (2) Elevate disaster health from a discipline to an endpoint, a defined and desired outcome. (3) Liberate disaster health from the confines of medicine and health care. Disaster health originated there, but is much more expansive. One of the distinctions of disaster health is its multidisciplinary nature. (4) Fully integrate the mental health and psychological dimension of disaster health. WADEM has been at the forefront, championing psychosocial issues in disasters, yet to date, this dimension of disaster health has been underdeveloped and underappreciated. (5) Consider the parallels inherent in optimizing disaster health for both disaster responders and disaster survivors. Also consider using plain language to create a common set of strategies for achieving disaster health that is equally applicable for responders and survivors. (6) Consider disaster health applied at the community level in a manner that subsumes community health, resilience, and disaster resistance. (7) Give disaster health its own framework. Clear and comprehensive WADEM-driven frameworks now exist for disaster health education, for example. Disaster health needs a framework that is simple, supple, and explanatory.

Conclusion: WADEM has promulgated disaster health as a vital, pivotal concept. The 7 options presented here have come from our own engagement with this concept. They are, in fact, defining features of our SAFETY FUNCTION ACTION framework for disaster health.

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(A69) Epidemiological Study of Trauma in Pregnancy: An Emergency Department-Based Study of a Level-1 Trauma Center

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Background: Trauma during pregnancy poses a challenge in assessment and management due to its unique anatomical and physiological changes. Trauma is the leading non-obstetrical cause of death. There is paucity of epidemiological data in this subgroup in India. An emergency department (ED)-based epidemiological study was conducted.

Methods: Female trauma victims of reproductive age with both positive and negative urinary pregnancy tests (UPTs) were selected retrospectively. Documentation was done by the nursing staff from the ED case records. Mode, mechanism, severity, site of injury, and ED disposal time were noted, compiled, and analyzed.

Results: Of 64 patients, 32 patients were UPT-positive and 32 were UPT-negative. The mean age was 26 (range 18–36) years. A total of 75% of UPT-positive and 59.3% of UPT-negative cases had assault due to domestic violence. As per START triage protocol, 84.3% of UPT-positive and 59.3% patients in UPT negative were triaged as yellow. Blunt trauma to the abdomen was the most common mechanism and site of injury in all patients. FAST and ultrasonic evaluation of the fetus was performed for all UPT-positive patients. The average ED disposal time was 2 hours 62 minutes in UPT-positive and 1.9 hours in UPT-negative.

Conclusions: Limited data suggest domestic violence as leading cause of trauma in pregnancy. A large, epidemiological study is required to validate this.

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(A70) Traumatic Brain Injuries at a Rural Teaching Hospital: Pattern of Presentation and Documentation

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Background and Objectives: Analyses of causes and trends of traumatic brain injuries help to define public health policy priorities. There are not much TBI registries, thus making documentation of injuries inadequate and accessing these data problematic. This study is aimed at identifying the characteristics of TBI and determining the efficiency of documentation of patients' records in a tertiary hospital.

Patients and Methods: Based on WHO guidelines "Standards for Surveillance of Neurotrauma" we designed a proforma to collect data on traumatic brain injuries. A prospective data collection was done from January to June 2010. Data was collected on a paper form and then entered into the self-developed TBI registry database. Descriptive analysis was performed.

Results: Data for a total 414 patients were collected. Mean age was 33.00 years (SD ± 16.725, range 1–85 years), and 81% male.