

minimal training of 10 supervised nerve blocks. Brachial plexus, forearm, and lower-limb nerve blocks were performed as deemed necessary. Verbal analogue scale (VAS) was used to quantify pain, before and five minutes after the procedure. The outcomes for feasibility and safety were the percentage of cases in which no further anesthesia was required, the median reduction in VAS score, median time to completion of procedure and the complication rate noted during the procedure.

Results: All procedures were completed without additional anesthesia. The different nerve blocks performed were brachial plexus (20 cases, 71.4%), forearm (3 cases, 10.7%), femoral (2 cases, 7.1%), combined femoral and sciatic (2 cases, 7.1%) and tibial (1 case, 3.6%). Median reduction in VAS score was 7.0 points (interquartile range 6.0, 8.0; $p < 0.001$). The median time to completion of nerve blocks was 5 minutes per patient (interquartile range 2 minutes 25 seconds, 10 minutes 0 seconds). There were no immediate complications noted after the procedure.

Conclusions: Emergency physicians with minimal training can perform ultrasonography-guided nerve blocks safely, quickly and without the need for additional anesthesia in the ED.

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(P2-78) The Unique Role of Emergency Medical Services (EMS) in an Earthquake – A Community Based Approach

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Introduction: The goal of most EMS is to provide treatment to those in need of urgent medical care, with the purpose of satisfactorily treating the problem, or arranging for timely removal of the patient to the next point of definitive care. Earthquakes are among the most destructive types of natural disasters, striking suddenly with no accurate method of prediction or warning, thereby taking a heavy toll on life, injury and property. The damage created affects all aspects of the community - transportation, telecommunication, and infrastructure and can easily overwhelm local health services, damage clinics, hospitals and render them useless.

Aim: To review the pertinent literature and to analyze the information in order to set practical guidelines for EMS work in earthquakes with a community-based approach.

Results: Survival of casualties extricated from under the rubble depends upon early medical interventions by emergency teams on site. EMS needs to strive for: • early arrival • early qualified treatment • Earthquakes differ from other disasters, where the system is intact.: early transport and definitive care. • They present a vast number of patients • problems concerning availability of medical personnel, • accessibility to patients, means of transportation & communication.

Conclusions: A routine national community-based approach will strengthen the ability to provide early response in both daily and disastrous events, improving both morbidity and mortality rates. Possibly no immediate definitive care.

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(P2-79) Retrospective Review of Mortality in Patients with Traumatic Brain Injury from Rural India

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Objective: Trauma is one of the leading causes of morbidity and mortality across the world with traumatic brain injury (TBI) being an important cause of trauma related deaths. The aim of our study was to review the medical charts of patients who died within 24 hours of presentation to our Hospital after head injury.

Methods: We received approval from the institutional review board to conduct a retrospective review of patient charts at Acharaya Vinoba Bhave Rural Hospital, in Sawangi (M), Maharashtra (India). All patients who died within 24 hours of the presentation to the emergency department (ED) and had been diagnosed with TBI were included in the study. We collected data from 113 charts between January 2007 and December 2009.

Results: During this three year period, 113 patients died within 24 Hours of admission to the hospital. Of these, 37% (42/113) were diagnosed with (TBI). We conducted a chart review of these 42 patients. All our patients were brought to the ED by relatives or bystanders in non-ambulance vehicles. At the time of presentation to the ED, nearly all patients were normotensive, with only one patient with hypotension. The Majority of our patients had a Glasgow Coma Scale of less than 5.

Conclusion: Our study brings to light various deficiencies in rural India, trauma care which include immediate rescue and transportation. Although patients were provided the optimum care in the ED, however it was not associated with favorable outcome. This highlights the need of a Trauma Registry to record real-time data which will help to improve care and systems.

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(P2-81) A Survey of the Health Effects of Bushfire Smoke on Patients Attending Two Sydney Emergency Departments

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The objective of this survey was to investigate the incidence of respiratory symptoms reported by emergency department patients during the Christmas 2001–2002 Sydney bushfire disaster. Two hundred and thirty patients attending two Sydney emergency departments for any reason completed questionnaires regarding respiratory symptoms. The symptoms investigated were cough, shortness of breath, chest tightness and wheeze. The same questionnaire was subsequently administered to a similar control group who were not exposed to bushfire smoke. 51% of those surveyed during the bushfires reported one or more of the respiratory symptoms investigated compared to 31% of the control group. This difference was statistically significant ($p < 0.01$). A significantly higher proportion of respiratory patients in the study group reported an exacerbation of their condition and increased medication use during the bushfires ($p < 0.01$). The results are consistent with other research on the subject and

suggest that exposure to bushfire smoke causes an increased incidence of respiratory pathology.

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(P2-82) Developing and Implementing an Emergency Preparedness and Trauma Research Program in a New Level One Trauma Center

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Our level one trauma center with a service area covering a population of approximately four-million people treats approximately 80,000 patients per year. In 2010, we anticipate more than 23,000 patients admitted, and to experience more than 850,000 patient encounters within the network. Trauma research is an important component to any level one trauma center, as well as a requirement of the American College of Surgeons/Committee on Trauma (ACS/COT). Our trauma center has recently gained level one designation and began an emergency preparedness research and trauma research (EPR/TR) program in earnest. We are fortunate to have support from executive administrators. Stewardship is a necessary element of our planning, in part because we are a county hospital serving a large uninsured patient population. The following are a few of the necessary steps we took to build an (EPR/TR) department from the beginning, to the point of submitting abstracts, manuscripts, funding grants, and presentations to regional, national, and international conferences, journals, and agencies. Structure the Emergency Preparedness Office to be a component of Trauma Services, allowing a unique opportunity for real-time disaster and mass casualty research. Secure a commitment from senior executives. Secure an experienced researcher, capable of research administration. Ensure the (EPR/TR) director, trauma medical director, trauma services director, and emergency preparedness coordinator can be a cohesive team with complimentary skills. Encourage trauma surgeons to perform research with assistance from the (EPR/TR) Office. Seek federal and foundation funding. Seek alliances with appropriate consortiums and associations. Develop a research relationship with pre-hospital emergency services. The above steps represent only some of the components used to build our (EPR/TR) department. We anticipate the planned expansion of the above steps will take our EPR/TR to the next level and increase extramural funding.

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(P2-83) The Use of Focused Assessment with Sonography for Trauma in Patients with Blunt Abdominal Trauma or Pelvic Fracture in the Emergency Departments

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Background: The role of FAST in diagnostic protocols has been adopted in most major trauma centers in well-developed countries. This procedure has become the initial diagnostic way in blunt abdominal trauma patients. However there are researches which show FAST is not reliable triage tool in patients with pelvic fracture.

Objectives: To evaluate the usefulness of Focused Assessment with Sonography for Trauma in diagnostic of blunt abdominal trauma patients and to bring attention to patients with pelvic fracture who should receive additional tests for the presence of peritoneal fluid.

Methods: An analysis of high-quality evidence resources was performed, limited to the articles published since 2005 year.

Results: 99 articles were found during the search, of which 23 were accurate. 16 articles were based on original research.

Conclusion: Focused Assessment with Sonography for Trauma plays a key role in the investigation of blunt abdominal trauma and should be used in all emergency departments. FAST-negative patients can remain under observation except major pelvic injury patients. The evaluation of peritoneal fluid in this group has low sensitivity.

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(P2-84) Upper Gastrointestinal Tract Bleeding (UGIB) Management: Belgian Guidelines for Adults and Children

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Background: UGIB remains a common disease affecting 100 to 170 adults per year, with an associated mortality ranging from 5 to 14%, causing thereby an important burden to healthcare resources. UGIB in children is uncommon (1–2/10,000 per year) but potentially life threatening. Since various specialists (general practitioners, emergency physicians, gastroenterologists and hepatologists, pediatricians, intensivists, radiologists and surgeons) may be involved and given the absence of evidence-based medical (EBM) recommendations – for adults as well as for children – there is considerable variability in the management of UGIB. Moreover, as even RCTs on the management of UGIB in children are lacking, many treatment strategies are simply deducted from the management of adult UGIB.

Aim: To provide EBM guidelines for the care of adults and children presenting with bleeding caused by gastro-duodenal ulcer or variceal rupture.

Method and Results: An interuniversity interdisciplinary team of Belgian experts was launched. Statements based on the published literature up to September 2010 were collected and proposed after expert opinions reconciliation and graded accordingly to the class of evidence. The current guidelines for the management of UGIB include recommendations for the diagnosis process, general supportive care, pharmacological therapy aiming at bleeding control, specific and endoscopic treatment of acute bleeding and follow-up for both gastro-duodenal ulcers and portal hypertension induced bleeding. Specificities and differences in the approach to UGIB in children compared to adults are highlighted.

Conclusion: Interdisciplinary guidelines for the management of UGIB based on current standards for EBM will provide an opportunity for clinicians to improve the management of their patients. However, clinical guidelines are not mandatory tenets appropriate for all patients, but should constitute a canon or