

of 468 severely malnourished children and temporary involvement in supplementary feeding)

During the inundation of Chokwe town, MSF was involved in Search and Rescue activities (SAR) saving more than 100 individuals from immediate drowning, and evacuating inpatients from the flooded district hospital. Despite the pressure of the provincial authorities, who evacuated Chokwe, MSF remained in the flooded town assisting the 8,000 of the remaining residents, who were unwilling to leave.

The MSF emergency program ended in the month of July. The overall cost of the operation figured at approximately 4,000,000 Swiss Francs. Transport by air was the one of the largest cost factors.

Conclusion: A MSF-emergency intervention followed the disastrous floods in Southern Mozambique in early 2000. Experts estimated that the destruction caused by the floods annihilated 10 years of development in southern Mozambique.

The main difficulties, when facing such a complex situation involving hundreds of thousands of victims, are the coordination of activities between the different actors, the dimensioning of the respective interventions, and the availability of reliable information, in particular, in situations when the access to the populations at risk is heavily impaired. Anticipation of the evolution of the situation is crucial for providing rapid assistance.

Key words: cholera; coordination; floods; health care; interventions; malnourishment; Medicins sans Frontiere; Mozambique; rain; responses; sanitation; surveillance; water

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Medicine in the Global Village

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The advent of the information super highway permits us virtually unlimited access to public information. Shopping over the Internet now is commonplace. If you can buy groceries, why not medical supplies? If you can organise custom-made furniture, why not custom-made medical equipment?

Bohica medical is a microindustry specialising in innovative medical equipment. We are able to compete within the global market place. I had a vision, developed a plan, and made it happen. If you have ever had a dream, or wanted to make a difference, listen to my story.

Key words: equipment; Internet; manufacture; plan; vision;

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Bioterrorism: Challenges for Public Health Action

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Four components of the public health response to disease outbreaks are also important to address acts of terrorism in a coordinated fashion: detection of unusual events, investigation and containment of potential threats, laboratory capacity, and coordination and communication.

The public health effort to combat infectious diseases is based on the early detection of unexpected cases or clusters of illnesses, so that small outbreaks can be stopped before they become big ones. In the case of a bioterrorist attack, the initial detection of a disease is likely to take place at the local level. It is essential to work with members of the medical community who may be the first to recognize unusual diseases, and who are most likely to mount the initial response—especially if the intentional nature of the outbreak is not immediately apparent. Strong communication links between clinicians, emergency responders, and public health personnel are important.

As is the case for any naturally occurring infectious disease outbreak, the initial response to an outbreak caused by an act of bioterrorism, is likely to take place at the local level. Once the cause of a terrorist-sponsored outbreak has been determined, specific drugs, vaccines, and antitoxins may be needed to treat the victims and to prevent further spread.

In the event of a bioterrorist attack, rapid diagnosis will be critical to the immediate implementation of prevention and treatment measures.

In the event of an intentional release of a biological agent, rapid and secure communications will be especially crucial to ensure a prompt and coordinated response. Each hour of delay will increase the probability that another group of people will be exposed, and the outbreak will spread both in number and in geographical range. Because of the ease and frequency of modern travel, an outbreak

caused by a bioterrorist could quickly become an international problem.

Key words: bioterrorism; communication; coordination; detection; investigation; laboratory support; public health; response

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Centres of Research and Expertise for Disaster Medicine in Sweden

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The National Board is a central authority under the government, and is responsible for supervising quality and performance in Medical Care, Social Welfare, and Public Health. On the national level, the Board has the responsibility to ensure the medical preparedness for large-scale disasters and wartime medical care in Sweden. The responsibility for providing medical care to the population lies in the 21 Regional parliamentary organisations (County councils). The Board receives money from the defence budget to support the preparedness of the Country Councils for medical disasters. New threats lead to increased need of scientific knowledge in various fields. Therefore, the Board has decided to establish special centres of research and expertise in several fields of Disaster Medicine. These centres are set up as special research groups connected to university institution/equivalent in close connection with the medical/clinical society. The main aims of these centres are to perform scientific research in their respective fields, to act as experts and to participate in education. A special steering group for each centre with representatives from relevant authorities decides about the aim of the work and follows up the results.

The following centres are planned or established (through 2000): General Disaster Medicine, Psychosocial Preparedness, and Radiation Medicine in Disasters (at the Cancer Centre, Karolinska Hospital, Stockholm), Microbiological Preparedness (at the Swedish Institute for Infectious Disease Control), Disaster Toxicology and Public Health in International Disasters.

Key words: centers; county councils; Disaster Medicine; education; public health; preparedness; research; Sweden
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Clinical Audit of Hypertensive Crisis

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Introduction: The term "hypertensive crisis" (HC) suggests a rapid reduction of the arterial blood pressure. The aim of this work was an assessment of therapeutic efficiency and evaluation of results in terms of hospital mortality relative to the blood pressure (BP) at the admission of the patients, and the magnitude of its reduction during the first 24 hours.

Methods: This prospective study included 125 patients admitted to emergency room for a stroke. The patients had the benefit of indirect monitoring of the BP. Variance analysis and odds ratio calculation were been used ($p < 0.05$).

Results: At admission, the mean values for systolic blood pressure (SBP) was of 216.2 ± 29.07 mmHg, for diastolic blood pressure (DBP) was 121.8 ± 19.51 mmHg, and for mean blood pressure (MBP) was of $151.8 \pm$ mmHg. After 24 hours of hospitalisation, arterial blood pressure reduction was of 38% for the DBP and the MBP, and of 39% for the SBP. No statistical relationship was demonstrated between the reduction in DBP and the mortality; this relation for MBP was weak. Concerning the SBP, the relation is highly significant: the SBP above 220 mmHg at the time of admission increased mortality ($p < 0.003$) as was a reduction of more than 35% during the first 24 hours ($p < 0.005$).

Conclusion: The DBP proposed for the diagnosis of a HC and its therapeutic follow-up does not seem to be a deciding factor of outcome for our patients. The outcome of these patients who present with a cerebral suffering seems more dependant on the SBP in which the rapid and the important reduction is the origin of progression of the cerebral injury.

Key words: blood pressure; hypertensive crisis; emergency room; stroke

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Crisis Management: A Possible Improvised Operational Approach

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In cases of mass casualties, the French hospital and pre-hospital health organization requested the implementation of a field "structure", the Forward Medical Post (FMP). The objective of this structure is to triage, maintain life, and dispatch the victims in order to permit their evacuation in the best possible medical condition and in the shortest time to the nearest appropriate hospital.

In the Bataillon de Marins Pompiers de Marseille (BMPM), we define a Forward Medical Post not as a physical structure, but as a working organization. This organization articulates itself around six functions: a secretary, triage, an Immediate Emergency care function (IE), a Relative Emergency care function (RE), a regulation, and an evacuation. Therefore, every structure, that includes all of these functions and is set up in the field to cope with an influx of victims, can be defined as a forward medical post (whichever its physical form is.)

The organization of a FMP relies on unavoidable rules: (1) the site is decided upon in cooperation with the On-site Commanding Officer; (2) it must be situated in the "safe zone", at the vicinity of the incident as near as possible to evacuation roads and on enough ground surface to receive at least a third of the total number of victims (if known); and (3) the FMP is organized into six zones (one for each