

soon as they confirm the presence of an AMI, they start the first part of the thrombolytic protocol, while SAMU dispatches the medical rescue helicopter with an emergency physician and thrombolytic drugs to the scene. If the first line is outside a reasonable time line to reach the scene by the "first line" physician, SAMU will send the helicopter team as a first response. The objective is to start thrombolytic therapy wherever the patient is. So, easy to utilize drugs (e.g. as one-shot thrombolytic and LMWH), are the best choice in such difficult areas.

In the 20 months from implementation, the network has managed nearly 100 patients with an AMI, with an average time of less than 1 hour between alert and initiation of thrombolysis, and with good results.

Key words: acute myocardial infarction (AMI); helicopter; outcome; physicians; remote areas; responses; SAMU; system; team; thrombolysis

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Typhoon-Related Disasters

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On 22 August 2000, Typhoon Bilis, by far the strongest of the season, approached Taiwan and left 14 people dead including 8 villagers buried in a mudslide in central Taiwan where a major earthquake had occurred just the previous year. Some people in a mountain climbing exploration were missing. On 28 August 2000, 6 days after Typhoon Bilis, a major bridge in southern Taiwan collapsed suddenly and injured 22 people. On 31 October, Typhoon Xangsane moved closer to Taiwan.

In the meantime, a Singapore Airlines Boeing 747 jetliner carrying 159 passengers and 20 crew bound for Los Angeles, crashed shortly after takeoff leaving 83 people dead and 56 injured. Although the weather conditions at the airport were within safe takeoff tolerances, the visibility was very poor and the pilot chose the wrong runway. The next morning after the airplane crashed, flooding in northern Taiwan killed at least 61 people: some people were down in the basements, including 14 elderly people in a nursing home.

The impact of typhoons should not be underestimated. Serious damage can occur before, during, and even days after the arrival of typhoons. Preparedness in all aspects is needed to cope with these disasters. Loss of electricity, water supply, and telephone services including cellular phone dysfunction could be serious problems in a rescue work. Alternative measures must be planned.

Key words: air crashes; damage; events; flooding; infrastructure; mudslides; typhoons

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Surveillance and Care System for Abdominal Trauma

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This is a description of a system for surveillance and care for victims of abdominal trauma. According to an objective assessment and score of the severity of the trauma to the abdomen, we classified the nursing care into three types, and drew up eleven principal nursing-care policies. In clinical practice, it has been effective both in improving the working initiatives and enhancing the comprehensive analytic ability of nurses. It has also increased the injured patient's survival rate.

Key words: abdomen; care; effects; injuries; nursing; policy; surveillance

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Disaster Medical Team Deployment for the Sydney 2000 Olympics

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Sydney hosted the 2000 Olympics during September 2000. As part of the medical support of the Olympics, a number of disaster medical teams were organised and deployed. This presentation describes the organisation of these teams and their preparation for the Olympics. In particular, the findings of the first multiagency CBR exercise will be described, and how the health teams interfaced with the other agencies. The presentation also will describe what was learnt and will discuss and debate the challenges apparent in initiating such a deployment to an event as large as the Olympics in the city of Sydney.

Key words: deployment; interface; medical support; Olympics; organization; preparedness

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Quality Care of Short Stay Unit Relevant to Critical Care and Emergency Services

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Objective: Assess care indicators of a Short Stay Unit to: (1) to know care activity, and (2) to detect modifiable problems by care improvement measurements.

Methods: A retrospective observance study was conducted and included all patients attended in a Short Stay Unit (relevant to Critical Care and Emergency Services) at Virgen del Rocío University Hospital (Sevilla), during the first semester of the year 2000. This Short Stay Unit is defined as a prolonged observation unit, basically a therapeutic, multifaceted unit for the care of patients that have

low diagnostic and therapeutic complexity, and the stays are estimated initially at <3 days. We assessed age, gender, occupation grade, pathology by RGD, procedures, mortality, number of reentries, and medicament-taking. The data were provided by Clinical Documentation and Pharmacy Services of Virgen del Rocío University Hospital.

Results: The number of admissions was 630, relative to 590 patients. The mean value for age was 75 years, and were predominantly female (59.3%). The mortality rate was 9%. The distributions of attended pathology was: shock and heart failure, 26.6%; angina pectoris, 10.6%; COPD, 11.5%; complicated simple pneumonia, 2.6%; breathing problems (excepting infections, asthma, and COPD) with main complications, 7.8%; uncomplicated heart attack (IM), 1.6%; complicated IM, 2.6%; congestive heart failure and pulse-rate alterations with main complications, 2.6%; and others, 34.4%. The mean value for a stay was 4.3 days, and the percentage of stays longer than 15 days was 5%. These patients had a high consumption of global stay (26.5%). These populations corresponding to stroke without family support, infected decubiti, retention of secretions and severe deterioration of patients with extenuating social problems. The hospital readmission rate was 3.2%. The resolution efficiency (discharge from hospital plus exitus) was 91.4%. The total cost of medicaments were 40,087e.

Conclusions: The Short Stay Unit is a highly productive unit that can be improved by using adaptation admission and has a great potential for growth.

Key words: activity; admission; critical care; emergency care; indicators; intensive care; pathology; short stay unit

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Diagnosics Agreement at Discharge from Hospital With Thoracic Pain in a Hospital Emergency Service

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Objective: Identifying diagnostic agreement at discharges from the hospital of attended patients with atypical thoracic pain and stable angina pectoris at the Emergency Section relevant to Critical Care and Emergency Services.

Methods: Cross observance study about discharges with atypical thoracic pain and steady angina pectoris diagnostics, including resolved hemodynamic angina pectoris, for 7 weeks between 08 May and 25 June 2000. A database was designed to collect data from the clinic archives (vascular risk factors, complementary data requested, and destination of patient). Thirty days later, we conducted a telephone survey of all the patients included in the study. We assessed the decrease in cardiac causes or sudden death, admission by heart attack (IM), unstable angina pectoris, malignant pulse-rate alterations, consultation at the Emergency Service by the same reason with different diagnostics, and ischemic cardiopathy diagnoses at cardiology

outpatient departments.

Results: 106 discharges were reviewed: 93 of these had atypical thoracic pain, 9 had stable angina pectoris, and 4 had hemodynamic angina pectoris. The mean age was 52 years. 52% (56 cases) had no vascular risk factors, and only 6 cases had four factors: tobacco habit, high blood pressure, diabetes, and lipidoses. Rx thoracic was done to 83 patients (78.3%). Measurement of CPK blood levels were performed in 63 patients, and troponin blood levels only for 4 patients. There were three events: previous consultation with different diagnosis of atypical thoracic pain group, unstable angina pectoris, and death. The death occurred in a senile patient who had premorbidity factors.

Conclusions: The small number of events collected indicates an acceptable level of diagnostic agreement for thoracic pain at our Emergency Service, but we noted that EKGs are underused in this type of patient.

Key words: angina; atypical; chest; diagnosis; ischemia; pain; risk factors;

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Proposal of Standardization Protocol Care of Abdominal Pain in Emergency Room

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Introduction: A patient arriving at the emergency room complaining of abdominal pain often represents a challenge for the physicians and the nursing staff. The most important aspect is the exclusion of certain pathologies and inclusion of others in order to establish the differential diagnosis.

Objectives: The objective of this work was to achieve a practical document regrouping the principal causes of abdominal pain, so as to orient the diagnosis in such a manner that is based on the anamneses of pain described.

Method: Theoretical research, inquiry in the opinion of patients suffering of abdominal pain, elaboration and testing of the anamneses document, and the gathering of commentaries from emergency nurses were used.

Results: The theoretical part of this work contains all of the pathologies that have an abdominal pain syndrome. The standard anamneses document for abdominal pain would permit one to target, in a structured manner, the appropriate questions to orient the diagnosis of a patient arriving at the emergency room for an abdominal pain syndrome.