

(C, lights and sirens) for 31% of thrombolyzed patients during the 1st period, and for 80% during the 2nd period. The mean time ambulance personnel spent at the home was 20 minutes during both periods. In-hospital door-to-needle time was < 60 minutes in 11% of patients during the 1st period, and in 56% during the 2nd period. Ambulance personnel treated 1,094 stroke patients during the study. All procedures were performed and documented correctly in 10% of visits. The most frequent deviation from guidelines was under-reported values of blood glucose. In 44.7% of patients, an ECG was performed, which is not required by guidelines.

**Conclusions:** Acute stroke management improved significantly. Adherence to recently developed stroke guidelines in the ambulance services must be improved.

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#### (P2-6) Evaluation of Air Rescue Missions Using a Helicopter—Analysis from a German Helicopter Base

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**Introduction:** In Germany, emergency medical care is provided by ambulances. Emergency physicians also are used in the German rescue system to ensure primary care. Additionally, rescue helicopters are insertable. The rescue helicopter in Dresden covers the city of Dresden and its surrounding areas, with 517,000 inhabitants and distances up to 70 km. The goal of this study was to evaluate emergency cases in helicopter rescue missions according to primary diagnoses and severity of the mission on the basis of NACA Score.

**Methods:** Data from all emergencies using the German Air Rescue (DRF-Luftrettung) Helicopter Base Dresden were recorded on a standardized protocol and transferred to a central computer database (MEDAT®). Data from all emergency cases between January 2006 and July 2010 were analyzed.

**Results:** There was a total of 6,310 emergencies during the study period, with a significant increase over time. The helicopter was on-scene within 10.9 minutes. In total, 54% of the patients were male. The rate of female patients > 80 years of age was 64.5%. A total of 63.4% of patients suffered life-threatening injuries or dysfunctions and a NACA score ≥ 4. A total of 7.6% of patients were classified in NACA 6 or 7. The most common cause for rescue missions was an acute coronary syndrome (20.4%). Other frequent diagnoses included brain injury (13.3%), unconsciousness (12.5%), stroke (12.9%), general cerebral convulsion (7.9%), polytrauma (6.4%), and cardiac arrest (5.0%). The rate of prehospital endotracheal intubation was 15.1%. In 1.1% of patients, a thoracic drainage was established.

**Conclusions:** In recent years the number of helicopter rescue missions increased, along with injury severity. The total number of patients with NACA 6 and 7 was extremely high, and demonstrates the need for an efficient emergency medical rescue system that includes helicopters.

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#### (P2-7) Patient Distribution during a Mass-Casualty Incident: The 25 February 2009 Turkish Airlines Crash in Amsterdam

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**Background:** Difficulties have been reported in patient distribution during mass-casualty incidents (MCIs). In this retrospective, descriptive study, the regional Patient Distribution Protocol (PDP) and the management of the patient distribution after the Turkish Airlines airplane crash on 25 February 2009 near Schiphol Airport in Amsterdam were analyzed.

**Methods:** Analysis of the PDP involving the 126 surviving victims of the crash, by collecting data on Medical Treatment Capacity (MTC), number of patients received per hospital, triage classification, Injury Severity Scale (ISS) score, secondary transfers, distance from the crash site, and critical mortality rate.

**Results:** The PDP holds two inconsistent definitions of MTC. The PDP was not followed. Four hospitals received 133–213% of their MTC, and five hospitals received one patient. There were 14 receiving hospitals (distance from crash: 5.8–53.5 km); three hospitals within 20 km of the crash did not receive any patients. Major trauma centers received 89% of the “critical” casualties and 92% of the casualties with ISS score ≥ 16. They also received 10% of “minor” casualties and 29% of casualties with ISS score < 8. Only three patients were secondarily transferred, and no casualties died in, or on the way to, the hospital (critical mortality rate = 0%).

**Conclusions:** Patient distribution was effective, as secondary transfers were low, and the critical mortality rate was zero. The regional PDP could not be followed during this MCI. Uneven casualty distribution was seen in the hospitals. The regional PDP is inconsistent, and should be updated in a new cooperation between Emergency Services, surrounding hospitals and vSchiphol Airport, a high risk area, for which area-specific PDPs must be designed.

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#### (P2-8) Analysis of the Performance of Emergency Medical Services Management of 51 Mass-Casualty Incidents in Israel

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**Introduction:** Between February 2002 and January 2004, a total of 51 terrorism-related mass-casualty incidents (MCIs) occurred in Israel.

**Objective:** The objective of this study was to analyze data provided in After Action Reports (AAR) held by Magen David Adom (MDA), after each MCI.

**Methods:** Information relating to the type of MCI, location, number of ambulances dispatched in five-minute intervals from time of notification, and number of casualties evacuated by