

severe burns can be accepted at the same time, and 74 moderately injured patients could be received in Osaka Prefecture.

**Conclusion:** The triage of burn patients seems to be performed satisfactorily according to EMSS in Osaka Prefecture. The capacity for severe burn patients is limited in Osaka Prefecture, so it is an urgent issue to prepare the system for mass burn casualties.

**Keywords:** burn centers; burn victims; capacity; casualties, mass; emergency medical services system; fire department; incidence; inhalation injury; hospitals

#### G-90

##### Emergency Medicine Models: International/ Mexico 1998

*Armando Iturbe Fuentes, MD*

Postgraduate in Emergency Medicine, President of the Mexican Society of Emergency Medicine

Around 1910, the first emergency room for prehospital emergency medical care was born. In Mexico City, the 1950s and 1960s, gave origin to hospitals for emergency and pediatrics emergency hospitals. In 1985, the earthquake in Mexico City resulted in the formation of postgraduate in training in Emergency Medicine with the objective of serving as the initial point of contact for the provision of emergency care to injured persons. The Mexican Society of Emergency Medicine formed in 1987, and in 1992, the Mexican Board of Emergency Medicine was born. In 1994, one year was added to the postgraduate training in Emergency Medicine, which was called Reanimatology. Between 1987 and 1996, three national congresses, three international congresses, and two Pan-American congresses were conducted in Mexico.

**Emergency room:** The emergency room that area within a hospital that has the principal objective is to provide the first contact with and to provide emergency medical care to patients who immediately are in need of such services.

**Organization:** Leader, postgraduate student leader, and pregraduate students.

**Support services:** Nursery, pharmacy, laboratory, radiology, and general services are immediately available for patients in the emergency room.

**Destinations:** Patients in emergency room may be transferred to a critical care unit, surgery room, pathology, hospital area, trauma-shock room, or discharged.

**Characteristics of the Emergency Room:** The ideal stay in the emergency room is up to six hours; a prolonged stay lasts for 12–24 hours or longer. There are many causes for a prolonged stay in the emergency room including the provision of dynamic services for patients who remain unstable, need of resolution of diagnosis using finer diagnostic studies, or persons who require swift, frequent management.

**Future:** Algorithms for the practice of emergency management of trauma will diffuse throughout Latin America. There will be a shock room in each hospital, a trauma

team configured, efficient prehospital care, and efficient exchanges arranged with first world countries to form the Emergency rooms of the XXI Century.

**Keywords:** algorithms; emergency medicine; emergency room; future; hospitals; Latin America; Mexico; organization; reanimatology; support; training

#### Panel Discussion IV

##### Medical Response Against Terrorism

Wednesday, 12, May, 9:50–12:00 hours

Chair: *Mauricio Lynn, Makoto Aono*

#### PN4-1

##### Epidemiological and Medical Aspects of Terrorism

*M. Lynn, MD; U. Farkash, MD; R. Maor, MD;*

*A Eldad, MD*

Israeli Defense Forces, Medical Corps Headquarters, Israel

Fourteen suicide bombings occurred in Israel between the years 1994 and 1997. A total of 1,242 citizens were injured including 165 deaths (13.2% overall mortality). Most victims (70%) suffered minor injuries (ISS = 0–8). Six percent were classified as moderate injuries (ISS = 9–14), and 10% were severely injured (ISS >16).

Forty percent of the victims were injured due to secondary blast. Twenty percent suffered primary blast injuries. Limbs were found to be the body area injured in 30% of the victims followed by ear drum rupture and head injury in 17% and 15%, respectively.

The scoop and run philosophy was implemented to almost all victims. In the last two bombings that occurred in Jerusalem in 1997 (a total of 410 injured), all victims with an ISS above 16 were primarily triaged to a Level I Trauma Center in <45 minutes from the explosion. Minor and moderate injuries were triaged to three other hospitals.

Mortality was compared among three types of bombings: 1) Open air; 2) Bomb inside a bus; and 3) Car bomb striking a bus. High mortality (32%) was observed when the suicide bomber was inside the bus. Open-air bombings caused the largest number of victims and 10% mortality. Most of deaths (85%) occurred at the scene. Four percent were dead on arrival (DOA) and 11% died during hospitalization.

Body identification was performed using different techniques: personal identification was used in almost half of the deaths. Other techniques included fingerprints, documents, dental identification, and DNA testing.

Several factors were found to have a major impact on prehospital management of mass-casualty situations: 1) access routes to attack site; 2) control of initial chaos; 3) extent of field medical care; 4) evacuation routes; and 5) primary distribution of victims.

**Keywords:** body identification; bombing, suicide; bombings; injuries, blast; mass casualties; prehospital; terrorism; trauma center; triage