

PN5-3

Trauma Surgery in Germany*L. Kinzl; F. Gebhard*

University of Ulm, Department of Trauma Surgery, Hand and Reconstructive Surgery, Ulm, Germany

Depending on his experience and skills, the trauma surgeon in Germany is destined to coordinate trauma management and therapy as the responsible leader of the trauma team. This does not imply that he is the new surgical all-rounder, who takes the place of all of the surgical specialties.

Rather, the trauma surgeon must have the skill to lead the trauma team in close cooperation with the anaesthetists. S/He must decide in due course and should define priorities and the sequence of the treatment. The trauma team leader must prevent unsuitable treatment of the multiply injured victim, and forestall the likelihood that "new specialists" divide the patient into several anatomical parts according to their individual sub-specialization.

S/He is the representative for an organization that stands for precise and quick diagnostic procedures leading to an optimum of therapy. His/her virtue is not the ultimate specialization in a small specialty, but practicality and common sense in decision-making and conduct. Trauma surgery is more than the arithmetic sum of therapeutic strategies, which are used in a single injury. Only when the surgeon has gained insight into the pathophysiology of trauma, and agrees to additional help and advice from other specialties, then the treatment of casualties will be optimized.

Keywords: anaesthetists; coordination; leadership; multiple injuries; pathophysiology; skills; surgery; trauma; trauma surgery; treatment; sequence of

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Trauma Surgeons in Japan*Kunio Kobayashi, MD*

Trauma and Critical Care Center, Teikyo University School of Medicine, Tokyo, Japan

Trauma is a major social issue in every developed country, and it is the principal cause of death in children and young adults. It is estimated that there are approximately 1,100,000 injured people annually, about 60% of which are due to traffic accidents. Among those injured, one-third are moderately injured requiring hospital admissions, and about 8% are severely injured who need special care at trauma centers.

It may be fair to say that traumatology is a neglected part of surgery in Japan. Traditionally, the major part of surgery has been surgical oncology of abdominal organs. Traumatology in Japan evolved as a part of Emergency Medicine. As tertiary emergency centers are founded in private, university hospitals, many surgeons have become responsible for the care of tertiary emergency patients, among which severely injured patients are a main target. Thus, trauma surgeons in Japan do not belong to the

Surgery Department, but to the Department of Emergency Medicine. It is common for trauma surgeons to take care not only trauma cases, but also other emergencies such as patients with major burns, of hanging, drowning, acute poisoning, and others.

Post-traumatic and surgical intensive care is an important field of responsibilities for trauma surgeons.

Training of trauma surgeons is a matter of great concern in Japan. Many of the surgeons have a good standard of surgical skills before they come into traumatology. However, as each emergency center has only a few hundred major trauma cases per year, and more and more patients with major trauma are treated non-operatively, the number of cases is insufficient for proper training of young trauma surgeons.

Trauma care in Japan as well as those problems related to trauma surgeons will be discussed.

Keywords: Emergency Medicine; Japan; prevalence; surgeons; training; trauma; trauma surgeons; traumatology

Wednesday, 12 May, 13:00–14:40 hours

Symposium II

Educational Models of Disaster Medicine

Chair: Morgan Fabrey, Masamitsu Kaneko

S2-1: Medical Disaster Response: An Educational Model for the Management of Earthquake Victims

Carl H. Schultz, MD, FACEP

Emergency Medicine, University of California-Los Angeles (UCLA), Harbor-UCLA Medical Center, Los Angeles, California USA

The management of injuries and illnesses after a massive earthquake differs significantly from the treatment of these same conditions under normal circumstances. Hospitals are damaged, supplies are limited, large numbers of patients require medical care, outside assistance will not arrive for 2–3 days, and most preventable deaths occur within the first 24 hours. Medical providers lack the training to deliver appropriate care under these conditions. The Medical Disaster Response (MDR) Project was created as a model to address this deficiency. The MDR model has two components: 1) an operations plan; and 2) a training course. The operations plan directs the initial management of personnel and casualties. Medical care is provided at surviving hospitals or at disaster medical aid centers (DMACs), and casualty collection points (CCPs) containing medical supplies. The training course provides health-care workers with information about the unique medical problems of earthquake victims. The MDR curriculum is taught in a two-day course using lectures, a tabletop exercise, and laboratory workshops. The lecture portion of the course covers mass-casualty triage using the START (Simple Triage And Rapid Treatment) and SAVE (Secondary Assessment of Victim Endpoint) techniques, field anesthesia and analgesia including the use of ketamine, airway interventions, use of intravenous fluids, management of crush injuries including amputations and