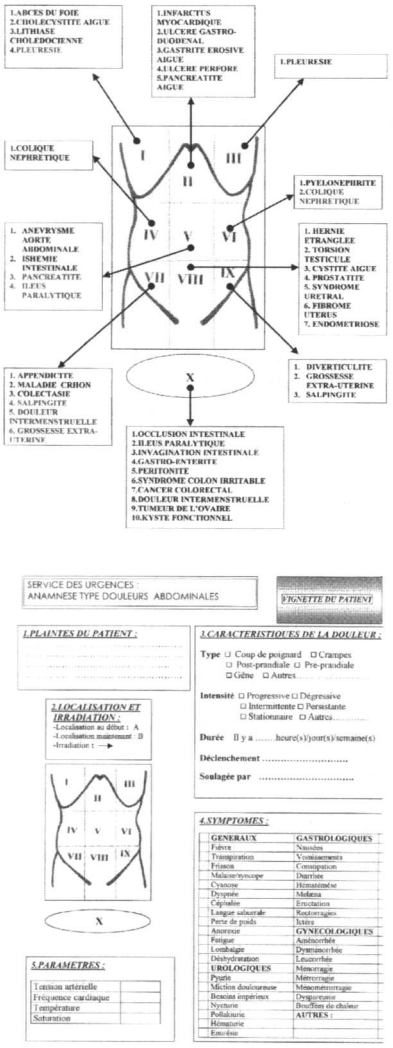

Conclusions: This is a vast subject that is difficult to comprehend in a short period of time. However, the crucial basic analysis was brought into more easily understood proportions, by the nursing staff.

Key words: abdominal pain; diagnosis; differential; protocol; syndrome

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Difficulties with Identification of Living Patients after Fires in a Hospital

M. Desmaizières; P. Bertrand; J.M. Agostinucci; J. Catineau; F. Adnet; M. Salashour; M. Fleury; C. Lapandry; F. Lapostolle

SAMU 93, Hôpital Avicenne, Bobigny, FRANCE

Introduction: Identification of patients in cases of disaster is a currently studied problem and most studies have been based on dead patients. Many identification systems have been suggested in order to centralize patient hospital files. However, in cases of an emergency or disaster event occurring in an hospital, some patients may still be alive but may not be identified, and their past medical history, treatments, and hospitalisation motives may remain unknown as is demonstrated in the following cases.

Case 1: A fire occurred at 03:00 hours, in a private hospital in the Seine-Saint-Denis area in France. Fifty-six persons were potentially poisoned by smoke inhalation including 4 patients with clinical signs of severity. The mean age was 72 years old. Six patients (11%) where not identified, including one comatose patient.

Case 2: A fire occurred at 04:00 hours, in a medicalised home for the elderly in the Seine-Saint-Denis area in France. Seventy-eight persons were potentially poisoned by smoke inhalation. Every patient was more than 71 years old; 7 patients died (9%), 12 patients were severely poisoned (15%) requiring intubation in 10 cases, and 14 more patients were admitted to the hospital. Ten patients (13%) were not identified, including 3 dead patients and 5 intubated patients.

In both cases, past medical history, treatments, and motives for hospitalisation were unknown because patient files were not accessible

Casualties		Unidentified			
	N	Dead	Intubated	Others	Total
Case 1	56	0	1	5	6
Case 2	78	3	5	2	10

Conclusion: In both cases, the identification of the patients was difficult even though patients were alive and conscious. Although reliable methods exist for the identification of dead patients in case of a disaster, identification of hospitalised patients remains difficult when the patients are not able to identify themselves. Impairment of consciousness is not the only reason for this difficulty. In elderly people, patients suffering dementia were not identifiable. Identity bracelets associated with a chip or a bar code could be helpful in these situations. Furthermore, this identification method would be even more useful if it could give access to the patient's medical file. Indeed, in case of a disaster occurring in a hospital, medical care must take into account a patient's past medical history, hospitalisation motive, and current treatments. Only an accessible hospital data system in association with this identification system would be able to optimise a patient's care in case of disaster occurring in a hospital.

Key words: disaster; elderly; hospital; identification; living; medical records; patients; system

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Salvador 2001

Dr. De Lagrevol Dominique;[1] Dr. Lecarpentier Eric;[2] Dr. Paillet Pierre;[1] Dr. Bonnefoy;[3] Dr. Marx Jean Sébastien;[4] Mr. Céolin Gérard;[2] Mr Garrigue Bruno;[5] Mme. Laplace Claudine;[4] Mr. Maupou Patrick;[2] Melle. Dagron Christelle;[4] Cdt. Cova Philippe;[6] LtC. Coural[6]

1. Sécurité Civile USC7, Brignoles, FRANCE
2. SAMU Mondial, SAMU 94 Créteil, FRANCE
3. Sécurité Civile USC1, Nogent le Rotrou, FRANCE

4. SAMU Mondial, SAMU 75 Paris, FRANCE
5. SAMU Mondial, SAMU 93 Bobigny, FRANCE
6. Sécurité Civile DDSC, Asnières/seine, FRANCE

After a violent earthquake occurred in El Salvador (magnitude on the Richter scale, 7.9), the Salvadorian government requested international help. In response to their call for assistance, French and German teams were sent. The poster illustrates the cooperation with many teams in order to give help and assistance to the Salvadorian population.

Key words: assistance; earthquake; El Salvador; French; German; teams

E-mail: usc7@club-internet.fr

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Disaster and Airport: Boarding Area Sorting Center as an Advanced Medical Post (280 M2)

F. Dubouloz;[1] A. Champenois; B. Morosoff; M. Fournier; M.H. Feuillin; M. Corsetti[2]
1. SAMU de Marseille, Hôpital la Timone, Marseille, FRANCE
2. Aéroport Marseille/Provence, Marignane, FRANCE

A sudden concentration of victims on an airport is not always due to a flying accident; air terminals are high risk areas (Hambourg = fire, Orly = armed attack, Marseille = hostages), and are important mechanisms used for transport during disasters or evacuations of the injured (Furiani = 300 patients in 6 hours). This eventuality justifies the creation of a "ready to use" structure.

In the last 15 years, SAMU and Marseille airport (6 millions passengers, 3rd airport of France) have a Medical Advanced Post or sorting center inside the airport. Its boarding area already is equipped and a new version will be finished in June 2001. It is 280 m^2, on ground floor, and open on tracks. It contains 12 heavy emergency boxes, a zone for moving 20 to 50 injured, and a small emergency area. From this place, you can directly call police or the authorities. We've got different movable desks with telephone and radiophony.

Next, in this place, a 25 m^2 tall section for equipment, drugs, water, shower ,and everyday instructions. For the airport authorities and SAMU, the problem was to select an area and to foresee, when building, the oxygen/emptyness, and sound protection. However, this type of organization has a lot of advantages. First, for the airport, it is economical, since the area can be used everyday by passengers—it is not unusable space—and walls, equipment, oxygen, etc., are hidden from view. The general operation of the airport includes the maintenance of this area by employees and technical agents. For SAMU, it provides adapted and clean quarters near the tracks and terminals. Management requires doctors and nurses to verify all of the equipment once a month. In case of disaster, we will add to this equipment, one more PMA batch.

During last 10 years, we have managed eight serious incidents, and have conducted several simulations. It improves our concept and also encourages, if necessary, collaboration between airport direction and SAMU 13.

Key words: airport; cost; disasters; equipment; planning; preparedness; SAMU
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Clinical Evaluation of New Ways of Administration of Oxygen: Tusk Mask II and Double Trunk Mask

F. Duprez;[1] A. Laghmiche;[1] F. Van Trimpont;[2] E. Gatera;[1] G. Bodur[1]
1. Ch Hornu-Frameries, Hornu, BELGIUM
2. Chu Ambroise Pare, Mons, BELGIUM

Objectives: Administration of oxygen in the emergency department or in the intensive care unit can be provided in different ways: (1) nasal oxygen cannula, (2) oxygen catheter, (3) normal mask, or (4) non-rebreathing mask(NRM). We compared the efficiency of each of these ways in relation to new systems: the Tusk Mask (TM II), and Double Trunk Mask (DTM)

Method: The TM II is a modification of the Tusk Mask described by Hnatiuk.[1] It is composed of a normal mask in which a lateral hole of 22 mm is made on each side. A ringed tube, 19 cm long and 22 mm in diameter, is attached to each side. Thirty patients requiring the administration of oxygen in the intensive care unit were studied. Oxygen was given first through an oxygen catheter. Thereafter, oxygen was delivered by oxygen catheter and normal mask.

This then was replaced by a TM II. The data measured are the PaO_2, the $PaCO_2$, and the breathing rate. Oxygen was given at the rate of 3 litres per minute. The DTM is the same system with a ringed tube of 38 cm. The oxygen was given first through NRM and replaced by a DTM. Fifty patients were studied. The data measured are the same. Oxygen was given at the rate of 8 litres per minute.

Results:

First part	**Oxygen catheter**	**Normal mask**	**TM II**
PaO_2 (mm Hg)	75.1	83.6 (+11%)	116 (+54%)
$PaCO_2$ (mm Hg)	36.0	33.1(-8%)	33.7 (-7%)
Breathing rate	19	24	22
Second part	**Oxygen nasa cannula**	**Normal mask**	**TM II**
PaO_2 (mm Hg)	88.8	104.8 (+18%)	154.2 (+74%)
$PaCO_2$ (mm Hg)	41.1	40.9(-1%)	42.6 (+4%)
Breathing rate	20	19	20
Third part	**NRM**	**DTM**	
PaO_2 (mm Hg)	171.48	278.05 (+62%)	
$PaCO_2$ (mm Hg)	39.28	41.15 (+5%)	
Breathing rate	17	17.5	

Conclusion: The TM II and the DTM appear to be very efficient in increasing the PaO_2 in patients without noticing any rise of the $PaCO_2$.

References

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Key words: administration; cannula; catheter; efficiency; masks; oxygen; double trunk mask; tusk mask
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