

Methods: Two working models of a Children's Field Hospital (ChFH) were reviewed. In the first model, a ChFH was implemented for 14 months (April 2001–July 2002) during a military conflict in the Chechen Republic. There were no other hospitals rendering medical aid to children in the area. In the second model, a field hospital was created for children following a terrorist act in Beslan, Northern Ossetia in 2004.

Results: Over the 14 month period, the Chechen Republic ChFH rendered medical aid to 102 adults and 20 (16.4%) children with gunshot wounds. Self-made explosives and unexpected munitions were blamed for explosive trauma in children. Two children died in the ChFH, and one child with amputated lower limbs was transported to Moscow for prosthetics placement. Three hundred eleven children presented to ChFH, including 55 children not requiring medical aid, and 256 wounded children, who were divided into 3 groups: 5 dying; 52 wounded and requiring emergency treatment; and 199 wounded who were transported to hospitals in Vladikavkaz after receiving initial medical aid at the ChFH. In total, 47 operations were performed, including seven abdominal and chest surgeries. Re-animation aid was provided at the Intensive Care Department of the ChFH for the stabilization of the critically wounded prior to their evacuation.

Conclusion: In the situation of mass admissions of wounded patients, the most important considerations are triage and the arrangement of operations according to urgent indications.

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(P1-105) Osteosynthesis of Children with Femur Fractures from Traffic Accidents

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Introduction: The growing number of children suffering poly-trauma from traffic accidents dictates the expansion of the indications for osteosynthesis. Elastic-stable intramedullary osteosynthesis (ESIN) is the optimum treatment of fractures of long bones in children.

Methods: Closed intramedullary osteosynthesis of diaphyseal femur fractures with flexible nails was performed in 74 patients (76 fractures) during 2006–2010. The patients were children ages 1–8 years. Titanium elastic nails (TEN) (Synthesis, Switzerland) were used in the procedures. AO Foundation recommendations were adhered to when selecting the size of the implant (i.e., diameter approximately 1/3 the diameter of the femur medullar canal at its narrowest part).

Results: There was a prevalence ($n = 53$) of simple fractures (D3 by AO classification) in this group of patients. Sixteen children had D2-type fractures, five with spiral (D1), and two with slanting (D2) fractures. There were no type D1 or D3 complex fractures in this group. Good functional results of closed intramedullary osteosynthesis with TEN at diaphyseal fractures of the femur in children with isolated and associated damages were achieved. There were no post-operative complications. This method provided stability of osteosynthesis, which allows activating patients in the short-term, i.e., during the post-operative period.

Conclusion: Treating femur fractures in children with ESIN provides optimum treatment of polytrauma. Osteosynthesis without

exposure to the area of damage, and the early activation of children can prevent infectious complications and contractures.

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(P1-106) Scarce Resources Planning Summit for Pediatric Critical Care and Transport Stakeholders

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There are six children's hospitals in Chicago, Illinois and the surrounding region. These hospitals often have bed limitations due to high censuses in daily operations. The Pediatric Committee of the Chicago Healthcare System Coalition for Preparedness and Response had provided two conferences in pediatric emergency preparedness in Spring 2010 that identified a need to examine scarce critical care resources in the region. A "Pediatric Critical Care and Transport Stakeholder's Summit" was convened in April 2010. This meeting brought together the Pediatric Critical Care Medical and Nursing Directors along with Transport Team representatives from major hospitals to identify the key issues related to pediatric emergency preparedness and scarce resources. The four-hour Summit, was held in a Conference Center, away from any hospital or clinical setting, was organized into seven sections: (1) Welcome & Introductions; (2) Issues Identification; (3) Scenario Introduction; (4) Specific Issues Identification; (5) Prioritization of Specific Issues; (6) Development of Action Steps; and (7) Moving Forward. A Facilitator with specific knowledge of hospital-based preparedness led the Summit process. He utilized a pediatric scenario to engage the participants in discussion, interaction, and planning. Action steps, with statements of need and specific action items were developed, based on the following prioritized issues: (1) lack of pediatric training and experience for front line personnel; (2) alternate care sites/bed capacity/surge planning; (3) ethical issues; (4) transport; (5) credentialing/pediatric specialist availability; (6) incident command/community integration; (7) pediatric supplies and equipment; (8) patient identification; (9) financial tracking/reimbursement; and (10) Crisis Standards of Care/Crisis Operation Standards Moving forward, the participants of the Summit will reconvene into small workgroups to develop plans and training for the areas specified above. In May, 2011 a statewide exercise utilizing the special population of children will occur to test these plans.

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(P1-107) Paediatric Emergencies

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Paediatric asthma is a frequent presentation to Emergency departments. Early intervention may prevent progression of the acute phase to a severe or life threatening stage. Magnesium is a wonder molecule that has repeatedly undergone vigorous trials. Magnesium is used by intravenous and nebulized route in many guidelines across the world. Heliox keeps coming in