

Dear Editor:

I read with great interest the article by Ashkenazi *et al* titled "Precision of in-hospital triage in mass-casualty incidents after terror attacks", which was published in *Prehospital and Disaster Medicine* 2006;21(1):20–23.

This article addresses the very interesting topic of precision of in-hospital triage in relation to final Injury Severity Score, with the conclusion that triage officers were unable to identify as many as 50% of the victims who suffered from life-threatening injuries. However, it is unclear if the triage was performed using a specific algorithm, or if it was at the discretion of the individual physicians. The description in the article only states that triage was performed by two "board-certified physicians with >10 years of experience in the treatment of trauma victims and previous experience in mass-casualty incidents (MCIs) caused by terrorist attacks". After this triage, which was performed in close proximity to the entrance of the emergency department, patients were transferred to one of three different areas within the emergency department, according to their priority (mild/moderate/severe). The authors state, "the few seconds allowed to triage each casualty in a MCI is not long enough to allow for careful decision-making, which relies on physiological parameters". This is a curious statement, since basal physiological data will be much quicker to obtain than to do (even a quick) a physical examination.

A useful triage system should be quick, easy to perform, reproducible, and accurate. Thus, it has been concluded that triage based on the evaluation of anatomical injuries does not fulfill these criteria, since it requires the complete exposure of the casualty, which is time-consuming and risks the violation of privacy if performed in the entrance to the emergency department. The reproducibility of triage based on anatomic criteria also is highly variable between different triage officers, based on their previous training and experience. To overcome these drawbacks, triage based on the physiological responses of the casualties has been introduced. As far as I am aware, two similar such systems exist—START and MIMMS Sieve/Sort. Both of them are intended to be used in the prehospital setting and are based on a rapid assessment of airway/breathing, circulation, and disability. These actually are the variables included in the advanced trauma life support concept that the authors advocate as a triage tool.

Since the study is retrospective, it would be interesting using the same data to calculate the precision of the START, MIMMS system, or any other system based on physiologic response when applied to the casualties of these two terrorist bombings.

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