failure. Acute kidney injury (AKI) is preventable with early management. Insight into factors determining the population-at-risk is indispensable to allow for adequate logistical planning, a prerogative for success in disaster management. Many factors may affect the frequency of AKI: hampered rescue and transport possibilities; destroyed medical facilities; availability of sophisticated therapeutics; and the structure of the buildings. Dialysis therapy saves lives that otherwise would be lost. Currently, the primary problem is organizational. If huge catastrophes occur, complex therapeutic options must be offered to a large number of victims.
Methods: A systematic review was conducted through meta-narrative mapping to create a repository of literature of disaster acute kidney injury management. Using a broad-based search strategy covering electronic databases (Cochrane, MEDLINE, EMBASE, etc.) and searching journals reporting on disasters, prehospital care, nephrology, dialysis and transplantation, and organizational management. The findings were grouped under themes and a picture was developed using contributions from different research approaches.
Results: The results will be presented at the Congress.
Conclusions: Awareness of evidence related to epidemiology, diagnosis, therapeutics and organizational issues, and development of guidelines in the area of disaster nephrology is critical to allow adequate logistical planning that is vital for this cohort of patients to prevent significant morbidity and mortality.
Keywords: acute kidney injury; acute renal failure; crush syndrome; disasters; patients
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(B17) How Many Resources or Telephone Lines are Needed during a Mass-Casualty Incident?

Chun Y. Chang
Taichung, Taiwan

There are six emergency operation centers in Taiwan. During the response phase of a mass-casualty incident, the responsibilities of these operation centers include coordinating healthcare resources and collecting the names of casualties. In October 2007, there was a mass-casualty incident in a mountainous area of central Taiwan. The event involved three emergency operation centers. There were 38 casualties in total. As the event occurred in a mountainous area, few medical resources were available.

All the patients were transferred to a hospital approximately 100 km away. The total response time was 16 hours. Five personnel were assigned to coordinate patient transportation, prepare the hospital to receive multiple casualties, and collect the names of the casualties. After the event, all of the telephone calls from an electronic recording system were reviewed in order to enhance future responses. After the event, a questionnaire was distributed to collect operational problems.

There were 205 total telephone calls during the event. Forty-six percent of phone calls were to confirm the names of casualties.

Between operators, there was a difference in the duration of each telephone call. In the post-event questionnaire, all five operators noted they were "very busy" in the first four fours of the event, and the major problem was communication between operators. After this event, pre-designated worksheets and a white board for inter-operator coordination was designed.
Keywords: disaster management; emergency operations center; event; resources; telephone operator
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(B18) Development of Command and Control System and its Education of Disaster Medical Assistance Teams in Japan

Kazuma Morino;[1] Hiroshi Henmi;[2] Masato Honma;[2] Yasuhiro Otomo;[3] Yuichi Koido;[2] Hisayoshi Kondo[4]
1. Yamagata Prefectural Medical Center for Emergency, Yamagata, Japan
2. National Disaster Medical Center, Tokyo, Japan
3. Department of Acute Critical Care and Disaster Medicine, Tokyo Medical and Dental University, Tokyo, Japan
4. Department of Emergency and Critical Care Medicine, Nippon Medical School, Tokyo, Japan

In 2005, the Disaster Medical Assistance Team (DMAT) training system began as a national disaster management measure. There were 500 DMATs, >2,000 healthcare providers, and 1,000 logisticians that were dispatched to the Chuetsu-oki earthquake in 2007 and the Iwate-Miyagi earthquake in 2008. A Japanese DMAT is characterized as a small team of five with emergency vehicles to go to the affected areas. The first team arrived in the affected area within three hours, and >40 teams gathered in the base hospital within 12 hours. A clear chain of command is critical in the effective use of these limited medical relief teams during the disaster, however, the DMAT system in Japan does not control the command and coordination of the disaster response organization, and thus, has an ambiguous strategy. The DMATs have been only trained in triage, medical procedures, and air transport management. There has been no training on the chain of command to facilitate organization. A two-day training course on the chain of command and control was developed last year. The training mainly consists of tabletop exercises with some mnemonics and discussion; 200 members have been certified.
Keywords: command and control; Disaster Medical Assistance Team; Japan; organization; training
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(B19) Assessment of Hospital Disaster and Non-Operational Defense Maneuver Performed in Imam Hossain Hospital

Mehrdad Esmailian; Shahram Alamdari; Hamid Kariman
ISEM, Tehran, Iran

Iran is ranked tenth in the word and fourth in Asia as the country most affected by disasters. Tehran, the capital, is the heart of the country's disaster planning. In this study, the training exercises of hospital personnel (including nursing, medical, administrative, and executive staff) were assessed. The exercises were based on scenarios, and tpersonnel were presented with problems (regarding patients and administration) that considered the operational maneuvers prac-