(A108) Pediatric Disasters: Key Elements for Improving Care
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80% of children are seen in non-Pediatric Emergency Departments (EDs). In a disaster, most children and their caregivers will go to the closest or their regularly identified ED for treatment. In disasters, the preservation of the Pediatric Tertiary Infrastructure for the sickest and most injured children is critical. Surge capacity for pediatrics may involve both antegrade and retrograde distribution of pediatric patients and health care staff to preserve Tertiary capacity. Reverse Triage of stable pediatric patients to other hospitals with adapted units and staff can decompress tertiary facilities. General hospitals can allow an expanded care for pediatric patients. Surge capacity needs to be addressed to allow non-pediatric facilities to surge for pediatric patients. Disaster Credentialing by immediate cross-credentialing of appropriate health care staff needs to be reciprocal and internet based to allow appropriate staff to attend pediatric patients. Pediatric consultants can augment healthcare staff to allow input into expanded care roles. Pre-hospital providers should have more pediatric training. Rotated regional caches of pediatric equipment would expedite safe pediatric disaster site care and pre-hospital transportation to definitive care. Pediatric patients should routinely be included in disaster drills and in all-inclusive disaster plans, rather than in separate drills and plans. Pediatric patients are usually accompanied by caregivers who may need care as well. Secure tracking and reunification of unaccompanied minors needs to be addressed to allow tracking across jurisdictional boundaries. Limited access to data on children, and credentialing of shelter staff would preclude access by anyone without a specific need to know. There are no clear uniform liability statutes for care in declared disasters as well as no uniform agreements for reimbursement for medical care. These issues are an important facet of disaster care that still needs to be addressed.

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(A110) Cardiac Trauma in Children
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Heart trauma is a severe form of thoracic trauma with an incidence of 7–14%. Heart trauma can be either open or blunt, with the latter more prevalent during a disaster. Possible open heart injuries include: (1) pericardial injuries; (2) superficial myocardial and coronary vessels injuries; and (3) penetrating cardiac wounds. The variants of blunt heart trauma include: (1) heart concussion and contusion; (2) rupture of the heart wall and...
intracardiac structures; (3) rupture of cusps and cords of the heart valves; and (4) cardiac septa (i.e., post-traumatic heart lesions). The latter are characteristic of injuries caused by a fall, and/or a crushing event. The course of heart trauma is severe, and is complicated by the development of shock and catastrophic hemodynamic disorders due to the sudden occurrence of post-traumatic heart lesions and infarction. Thus, verifying cardiac trauma can be complicated. Diagnosing and assessing the severity of heart trauma requires the measurement of intra-arterial and central venous pressures, chest radiography, electrocardiography, pericardial puncture, echocardiography, magnetic resonance imaging, cardioangiography, and measurement of heart enzymes. One-hundred twenty-seven patients ages 2 to 42 years with open (92.1%) and blunt (7.9%) cardiac trauma were treated. Of these patients, 16.5% were children and teenagers. The challenges of treating heart trauma include simultaneously carrying out anti-shock treatment, surgical operation, and resuscitation measures. If post-traumatic heart lesions are diagnosed, surgical correction should be performed despite cardiac decompression. The use of cardiopulmonary bypass is essential.

(A112) Awareness and Preparedness of Western Children’s Hospitals for Disasters
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Disasters involving children are becoming more and more frequent. Thus, optimal preparedness will be a challenge for every Western pediatric disaster specialist. However, for any appropriate decision to be made, there must be a practical tool for accurately evaluating the levels of specific disaster awareness and preparedness. This tool is based on the idea that child injury prevention campaigns [n = 6] are usable as a platform for the simulation of specific pediatric disaster scenarios, and that different simulations might be able to modulate overall awareness and overall preparedness levels, as well as affect the training provided. Data are gathered from a disaster phase-related (Haddon-Matrix) set of questionnaires answered by key disaster response personnel [n = 58]. Overall awareness for a pediatric disaster scored highest for the “in the world” scenarios, with less, but with similar scores for “in the country” and “in the region” scenarios. Overall preparedness scored low for “in the world”, with higher scores for “in the country” and “in the region”. Both, overall awareness and overall preparedness scored inconsistently for “in the hospital” in the first instance, but later in the matrix, “in the hospital” had the highest scores. In general, basic knowledge about disaster plans is moderate, and knowledge about existence and activation of preparedness measures is above average. Individual position-taking and feelings of personal competency in position-taking is low, especially among junior staff. Currently, only a group of seniors are able report participation in a specific training. This platform is an upgradable tool for the awareness of and preparedness for pediatric disaster assessments, regarding phases, locations, and training, with promising trends for their modulation, especially among junior staff.

(A113) A Pediatric Surgeon’s Viewpoint of a Concealed Disaster
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Childhood is one of the most vulnerable parts in a human’s life. Thus, any physical and psychological harm against children requires special attention, especially if inflicted and not accidental. Such children should be considered multi-trauma victims and managed by a multidisciplinary team and trauma algorithm. In this team of specialized carers, the pediatric surgeon will import his/her expertise on general management and treatment and simultaneously refer basic knowledge to more junior doctors that might be in charge in the future. Fifty-eight injured victims (mean age = 1.5 years of age, range 1 day–18 years of age, male:female ratio = 1:1) were analyzed in this study. Their injuries were subcategorized into battery (13), assault (11), neglect (3), sexual abuse (2), prevention failure (6), career-related (19), and miscellaneous (5). All victims were first seen by a pediatric surgeon before receiving multidisciplinary consultations. Treatment results and modalities varied according to the complexity of the diagnoses requiring a well-trained and skilled pediatric surgeon. Accompanying post-traumatic stress disorders...