Adaptability of the Revised Trauma Score in Urgency Classification

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It is suggested that the application of the Revised Trauma Score (RTS) of Champion et al during triage in the event of a large number of field casualties. The classification into four urgency classes, as presently is advocated in the Netherlands, can be very problematic for the physician who must choose between the casualties within Urgency Class I (T1). A method to further differentiate within T1 will ensure this decision. After a description of the various trauma scores and their application, the adoption of the RTS is taken into consideration. This method should avoid time consuming physical examinations and mathematical calculations. Therefore, the T-classification has been divided into four urgency groups (G1-G4) based on the probable survival of the casualties, as described by Champion.

A New Approach to Trauma Assessment

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Introduction: Most major emergency medical services (EMS) textbooks and training programs in the United States stress rapid transport and short scene times as the standard of care for the management of major trauma. However, very little guidance is given to prehospital providers as to how best to accomplish this goal.

Objective: To teach paramedic students to minimize scene time by stressing teamwork and prioritization in decision-making.

Methods: In addition to a brief primary survey, paramedic students were taught to make all decisions regarding patient care by evaluating mechanism of injury, severity of injury, immediate life-threats, barriers at the scene, available personnel, and transport time. The students also received training in risk/benefit ratios of various prehospital procedures. Then, they were evaluated subjectively by senior instructors and by the medical director on their ability to use these concepts, and to assess and care for trauma patients under simulated conditions.

Results: The vast majority (52 of 53; 98%) of the students were used with CPB.

Conclusions: It is suggested that the application of the Revised Trauma Score (RTS) of Champion et al during triage in the event of a large number of field casualties. The classification into four urgency classes, as presently is advocated in the Netherlands, can be very problematic for the physician who must choose between the casualties within Urgency Class I (T1). A method to further differentiate within T1 will ensure this decision. After a description of the various trauma scores and their application, the adoption of the RTS is taken into consideration. This method should avoid time consuming physical examinations and mathematical calculations. Therefore, the T-classification has been divided into four urgency groups (G1-G4) based on the probable survival of the casualties, as described by Champion.

“Suspended Animation” Research for Otherwise Infeasible Resuscitative Traumatologic Surgery

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Background: Bellamy (U.S. Army Medical Research) suggested studies into “suspended animation” with drugs for use in the field. “Suspended animation” for resuscitative surgery under total circulatory arrest with hypothermia (Hth) was studied. This is meant for use of surgical resuscitation teams of (mobile) ICUs or emergency (field) hospitals, when victims with “uncontrollable” exsanguinating hemorrhage reach pulselessness.

Methods: In five sequential studies on 55 dogs, a new dog outcome model of hemorrhagic shock and emergency cardiopulmonary bypass-(CPB)-induced circulatory arrest with Hth and blood washout was used. Recirculation and re-warming also were used with CPB.