

(EMS and medical centers), forensic medicine, and Iranian Red Crescent is necessary.

Prehosp Disaster Med 2011;26(Suppl. 1):s52–s53
doi:10.1017/S1049023X11001683

(A152) Is There a Need to Reconsider the Policy of Evacuating All Casualties from Remote Mass Casualty Incident (MCI) to the Closest Hospital? Lessons Learned from a Rural MCI

B. Adini,¹ R. Cohen,² E. Glassberg,² B. Azaria,³
D. Simon,² K. Peleg²

1. Israel National Center for Trauma and Emergency Medicine, Ramat Gan, Israel
2. Ramat Gan, Israel
3. Ramla, Israel

Background: Inappropriate distribution of casualties in mass casualty incidents (MCIs) may result in patient overload in primary medical facilities.

Objective: The aim of this study was to review the consequences of evacuating casualties from a bus accident to a single rural hospital and lessons learned regarding policy of casualty evacuation.

Methods: Hospital medical records of all casualties from primary and tertiary hospitals were independently reviewed by two senior trauma surgeons. In addition four senior trauma surgeons reviewed the impact of treatment provided in the primary hospital on patient outcomes.

Results: 31 survivors from the accident were transferred to the closest local hospital; 4 died en route to the hospital or within 30 minutes of arrival. 27 casualties were air evacuated from the local hospital within 2.5 to 6.15 hours to level I and II hospitals. Under-triage of 15% and over-triage of 7% were noted. 4 casualties did not receive treatment at the local hospital that might have improved their condition.

Discussion: Over and under-triage might have been due to minimal trauma related experience of primary hospital personnel. Evacuation of casualties from an MCI to a limited capacity hospital may overwhelm the facility and affect its ability to provide appropriate medical care.

Conclusions: In MCIs occurring in rural areas, only immediate unstable casualties should be transferred to the closest primary hospital. On-site Advanced Life Support (ALS) should be administered to non-severe casualties until they can be evacuated directly to tertiary care hospitals. First responders must be trained to provide ALS to non-severe casualties until evacuation resources are available.

Prehosp Disaster Med 2011;26(Suppl. 1):s53
doi:10.1017/S1049023X11001695

(A153) Does Prehospital Delay Change Trauma Outcomes in Mumbai?

V. Kumar,¹ P. Suryawanshi,² S.B. Dharap,² N. Roy³

1. Surgery, Mumbai, India
2. Mumbai, India
3. Public Health, Mumbai, India

Introduction: Prehospital delay in trauma victims has been associated with worsened trauma outcomes, and forms the

basis of emergency medical services (EMS). Survival rates of severely injured patients with life and limb threatening trauma were studied and correlated with prehospital delays in Mumbai, India, where there is no central EMS system.

Methods: From October 2010 to March 2011, a researcher collected Injury Severity Score and prehospital time delay data in all severely injured patients arriving at the Trauma Centre. The time of injury, and time and mode of transport to the Trauma Centre were recorded, along with the details of the injury and the physiological parameters upon admission. Information regarding time and place of the crash, arrival to a trauma care facility, injuries, and survival were noted.

Results: A taxicab was the most common mode of transport followed by a police van, private ambulances, and government ambulances. Patients reached the Trauma Centre more quickly when accompanied by relatives or police, and took longer if they were examined at peripheral centers, were unknown victims, or arrived by Government ambulances. Better outcomes were observed in patients with informal carers. The majority of the victims presented within three hours of trauma.

Conclusions: Prehospital delay did not correlate well with poorer outcomes. Further research is needed to determine how many injured die on the way to the hospital in countries without a formal EMS system. Implementation of a high-cost, state-funded EMS system in a congested, resource-poor, urban setting must be balanced with the insufficient evidence about whether prehospital field interventions actually improve survival outcomes.

Prehosp Disaster Med 2011;26(Suppl. 1):s53
doi:10.1017/S1049023X11001701

(A154) Overcrowding of Ambulances at the Scene of a Disaster: Pitfalls and Implications

H. Waseem,¹ S. Shabbaz,² J. Razzak²

1. Research, Lahore, Pakistan
2. Emergency Medicine, Karachi, Pakistan

Introduction: Pakistan is a developing country with a basic prehospital system in some cities. The prehospital services are a mixture of government and private ambulances. There is no central regulatory body for them and no central command to control the influx and out flux of ambulances from the scene.

Objective: In this paper, five episodes of terrorist incidents in the country and will try to estimate the number of ambulances on the scene.

Methods: Retrospective data was collected and triangulation was done by three sources: (1) ambulance records; (2) visual estimation; and (3) print media. An estimate of total ambulances was reached along with dead and injured. Furthermore medical transport capacity was calculated where possible.

Results: In majority of the incidents, it was found that there was a huge influx of ambulances beyond the need. This further adds to the chaos and confusion already present on the scene of disaster.

Conclusions: A Command and Control Center should be established to direct all ambulance control and movements.

Prehosp Disaster Med 2011;26(Suppl. 1):s53
doi:10.1017/S1049023X11001713