be adopted widely in the practice of Emergency Medicine; however, many staff cannot function properly when they arrive on disaster sites with large numbers of casualties.

**Initial Triage** — provides a quick determination of triage categories. Very limited life-saving procedures could be performed. Instead, try to evaluate the needs of as many victims as possible. Do not stop and be preoccupied with one patient, BUT move through the scene so as to complete the triage process. If possible, It is advisable to triage by eye using one's own sense and obtaining the chief complaint. Therefore, real emergency patients will be spotted and identified without delay.

**Secondary and Continuous Triage** — after assessing available manpower, proceed with and “AMPLE” history, “ABCDEF” to “head-to-toe assessment”. Evaluation and reassessment should be done. Therefore, new triage categories really will reflect changes in the victims’ condition. The “START” (Simple Triage and Rapid Treatment) plan, one of the commonly used field triage tools, should be adopted and followed. The essence and spirit should be followed when managing such situation. It streamlines the triage process and makes the best use of one's sense when triaging.

**Evacuation** — First, do not delay transportation of victims for treatment off scene to an area like a casualty clearing station or casualty treatment center except for immediate life-saving procedures. This is the most common mistake made by deployed hospital personnel.

Repeated exercises will help the team members to remember these rules. Less shock reaction will be noted when a real scene is encountered, and the triage process can proceed smoothly.

**Keywords:** casualty clearing; disaster, drills; evacuation; exercises; rules; START; training; transport; triage

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**Triage Guidelines for Crush Syndrome Patients in Large Earthquakes Using Logistic-Regression Models**

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**Introduction:** Triage activity is one of the most important, but difficult components of the medical response in a disaster. Although experienced emergency physicians should do triage, such physicians may not be readily available in a disaster situation. We developed a predictive model of crush syndrome to provide triage guidelines for non-experienced physicians, emergency medical staff, nurses, and any other medical practitioners coping with an unexpected natural disaster.

**Methods:** We used data from 372 crush syndrome patients reported in a previous paper. Twenty risk factors (except for the peak CK that is not available at initial triage) were employed to develop the predictive model. We used induced dialysis and/or death as an outcome. We developed two types of prediction models using logistic-regression analyses. The first model was calculated using only parameters measured without specific devices in the disaster field (initial triage model).