

canvas should be easy to clean and it shall be possible to transfer the stretcher from one vehicle to another without having to remove the patient.

For years this has caused great national and international problems. After years of negotiations, the NATO countries in 1983 consented to the Standard NATO agreement, STANAG 2040. This was a follow up of an earlier recommendation from the International Organization for Standardization, ISO R-168 on these measurements.

Accepting the fact that a patient has to wait and has to be transported and treated on the stretcher, we decided in Norway to manufacture a stretcher that can be used as a sleigh, bed, operating table, etc. It can be stacked one on top of the other, put in a lot of different positions, equipped with an infusion stand and much more.

“SMASH HIT”: A REVIEW

Harry F. Oxer, M.D., Belmont, Australia

This video documents and shows extracts from “Smash Hit”.

“Smash Hit” is a multi-media show, based on the New Zealand idea “Road Show”. It was produced in Western Australia and shown to thousands of school children.

The aim was to influence attitudes of young people to drinking and driving, and emphasizes the right of choice.

“YOU COULD HAVE SAID NO!”

OPERATION CRASHPOINT PLUS

**S.S. Tachakra, M.S., F.R.C.S., London,
United Kingdom**

The medical management of casualties when hospitals are overwhelmed, was simulated in a civil defence exercise. Two First Aid Posts triaged and treated patients before discharging them or transferring to a Casualty Collecting Center manned by volunteer doctors, nurses and first aiders. The Casualty Collecting Center decided priorities, gave early treatment and sent the seriously ill to hospitals when facilities became available.

Predictable problems were partly overcome. They included communications, traffic regulation, policing, inexperienced doctors, lifting patients, leadership, records, lack of discharge facilities, press

arrangements, information center and casualty lists. We knew when casualty care became compromised, equipment was inadequate, along with vehicles required for transport and the capability of volunteers and rescue services.

These arrangements would have relieved the hospitals of a large number of cases and would have been useful in natural disasters, civil unrest and conventional war.

MASS CARBON MONOXIDE POISONING INVOLVING 129 VICTIMS: THE USE OF NEUROPSYCHOLOGICAL SCREENING TEST AND HYPERBARIC OXYGEN THERAPY

**Steven J. Rottman, M.D., Timothy Cannis, M.D.,
Nancy Kaser-Boyd, Ph.D. and John Alexander,
M.D., Los Angeles, California, U.S.A.**

In December, 1985, 300 students and faculty dormitory residents at a local women's college were exposed to carbon monoxide (CO) due to a furnace malfunction.

Five victims had marked neurological symptoms and acute carboxy-hemoglobin levels ranging from 17.5% to 22.1%. All five were treated with hyperbaric oxygen (HBO). Within a few days of the incident, many of the remaining victims whose exposures were considered mild, developed neurological symptoms including headache, inability to concentrate, memory and language loss, confusion, and irritability. One hundred twenty-nine of these students were treated at 3 ATA 100% oxygen for 46 minutes, with a subset of 35 victims receiving neuropsychological testing, both before and after HBO treatment. The neuropsychological testing followed a protocol established at the Maryland Institute for Emergency Medical Services Systems in Baltimore. Test scores indicated a statistically significant improvement after treatment with HBO, with concurrent resolution of symptoms.

To control for possible practice effects due to repeated use of the neuropsychological test battery, a control group of twenty additional students were given the tests, and then retested a week later. Management of this mass CO poisoning incident and the

evaluation of subtle, potentially permanent brain dysfunction from low level CO poisoning will be discussed.

A CASE OF RUPTURED CORNUAL ECTOPIC PREGNANCY: EMERGENCY MANAGEMENT

Javier A. Pero, M.D., Lima, Peru

A 29 year old female was brought into the ED* because she had fainted after complaining of intense lower abdominal pain and vomiting. We found her awake, slightly confused, weak, pale, sweating, tachycardic and complaining of generalized abdominal pain. Upon questioning her, she told us she had missed her menstrual period for the past 3 months and she'd had a laparotomy 3 years ago with left salpingectomy and appendectomy because of an ectopic tubal pregnancy. She also had a normal pregnancy with vaginal delivery 10 months ago and wasn't using any contraceptive method. The PE showed signs of hypovolemia and a distended and very tender abdomen, painful in the low half and sides. The BP was 100/50 and pulse 100. Our first impression was that of a ruptured ectopic pregnancy so a large bore IV line was started with fluids, blood samples drawn for H/H and cross-match for 2 units of whole blood. The H/H was 22/7.4 so another line was started for transfusion. IM analgesics were provided. The gynecologist on-call arrived 30 minutes later and made an abdominal sonogram which showed a fetus without signs of activity outside the uterus and a good amount of free fluid inside the abdominal cavity. The margins of the uterus weren't clear. The OR was prepared for a laparotomy and the anesthesiologist called.

Five hours after her arrival at the ED the patient was stabilized and in the OR. The findings were: about 1,500 cc of blood and clots; a dead male fetus 12 weeks old; placenta and membranes, all of them free in the abdominal cavity. The uterus was large (15cm), with a right cornual rupture. An hysterectomy and irrigation were done. The patient stayed with IV line 1 day, analgesics and cephalosporins 2 days. Discharged after 4 days feeling well. Evolution fine.

* 100-bed private community hospital, an ED with ER physician, nurse staff, attendings on-call and X-ray, lab and OR technicians 24 hours.

PARAMEDICS AREN'T (ALWAYS) NECESSARY

Harry F. Oxeer, M.D., Belmont, Australia

Provision of a paramedic service may not be the most effective way to provide prehospital care, even in a large city.

In Perth, Western Australia, a city of a million people, a needs analysis was performed. This identified the type of case carried, frequency of severe injury or illness, and the skills needed to care for these patients.

The most cost-effective way for Perth is to provide all ambulance crews with selected Advanced Life Support (A.L.S.) skills.

This is economic in terms of training, skills maintenance and equipment, and results in an effective prehospital care system.

Seatbelt laws and motorcycle helmet laws decrease greatly the amount and severity of blunt trauma. Very infrequent recourse to knife or gun as a means of settling arguments means that there is little acute penetrating trauma. These two factors produce a large reduction in the number and percentage of serious trauma, and alter the balance of care skills needed.

RESUSCITATION EQUIPMENT FOR THE PREHOSPITAL ENVIRONMENT

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The delivery of basic and advanced life support within prehospital immediate care systems, field medical and office dental practice are currently being subjected to very radical research, analysis and development.

There is a concurrent need for similar scrutiny of life support technology in order to complement such development. Evaluations of performance and "learner and user friendliness" of life support equipment have been collated and augmented: oral and nasopharyngeal airways; endotracheal and cricothyrotomy apparatus, including the laryngeal obturator; respiratory support equipment; cervical, spinal and limb splinting devices and circulatory and