

troenterologic antecedents were found in respectively 12.7% and 10.2%. 78% of the GT are passed by nurses and 23.5% by prehospital personnel. Characteristics of GT and tracheal tubes are included in the Table 1.

Table 1—Characteristics of GT and Tracheal Tubes

	Gastric tubes	Tracheal tubes
n	80	64 (80%)
Mode of installation	Nasogastric tube: 95%	Nasotracheal tube: 56.9%
Sizes	18 and 21: 76.5%	7 and 7.5: 80.3%
Types	PVC: 97.5%	Low pressure : 63%
Problems with the installation	22%	24%

The results of the two tests used to check the position of the GT are presented in Table 2.

Table 2—Results of the Tests to Check GT Positioning

	Air control (%)	Radiologic control (%)
In place	97.4	86.5
doubt or not in place	2.6	13.5

After their installation, 13.5% of the GTs are not in place after their installation (stops, 30%; pharynx, 20%; esophagus, 40%; trachea, 10%), and there exists a significant difference between the results of these two tests ($p < 0.05$). There does not seem to exist any predictive criteria of difficulties during the installation or anomalies of position after the installation ($p > 0.05$).

Conclusion: The recommendation of the systematic checking by a radiological control of the position of a GT must be extended to the fields of emergency medicine. The continuation of this study will allow the definition of predictive criteria.

Key words: feedings; enteral; gastric tubes; insertion; placement

References:

1. Health Care Practice Recommendations. ANAES. April 2000. *Prehosp Disast Med* 2001;16(2):s17.

The "Coordinating-Emergency Physician" in the German Rescue System: Mass Casualties and their Results over Five Years in a Midsize, Populated Region

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Purpose: The aims of this analysis were to determine whether the German rescue system is prepared sufficiently to respond to mass casualty situations of degree two or higher¹ and to identify the incidence of these events in a midsize, population-dense region in the south of Germany. **Material:** The rescue region of Augsburg covers a region of 4,100 km² with a population of about 823,000 (city: 265,000; surroundings: 558,000 inhabitants). Since 1996, all mass casualty incidents (MCIs) that included the additional call of a coordinating emergency physician (CEP) have been registered separately by our Rescue

Coordination Center (RCC). The indications used to call the CEP include: (1) 3 or more emergency physicians needed at the scene, (2) there are more than five severely injured victims, or (3) more than 10 injured persons.

Since 1999, there were 34 events, all of which were prospectively registered and reviewed to identify if the CEP Group—Augsburg is prepared to handle successfully future events, especially MCIs of third degree level that have been occurring with increasing frequency all over the country during the last few years.

Methods: To gain a good reliable documentation allowing quality control efforts, we applied some elements of Villareal's quality control modules:[1]

1st degree (minor): Only parts of local resources involved

2nd degree (mutual aid): Managable with local facilities
3rd degree: Regional resources exceeded

Results: 34 calls occurred and all of them were analyzed: 20 calls happened during the night and 14 during the day (three in the morning, 11 in the afternoon). There were 19 fire alarms, six traffic accidents, four poisonings, three explosions, one mass gathering, and one natural disaster. In total, about 580 patients were served. The lowest number per event was two people landing a duck plane, and the highest number was about 150 people during a great outdoor event in the city. According to the seasonal distribution, there was an increase of events from six calls in spring to 12 calls in winter. There were 26 events classified at a 1st degree level; seven events at a 2nd degree level; and one at the 3rd degree level.

In each of the events, individual emergency medical care was provided to all of the victims, and none of these died due to triage reasons. Afterwards, each event was exactly analyzed for quality of the response and care delivered. From these results, we developed a new documentation sheet to facilitate the immediate, full, and standardized documentation at the scene.

Conclusion: All over Germany, the increasing number of MCIs requires specially trained physicians and coordination of the rescue in order to handle these events and to provide sufficient prehospital care to all of the victims. The establishment of official CEP groups with clearly defined tasks, rules of liability, and fields of competence as indicated under German law will help to guarantee individual emergency medical care to all of the victims. In the future, further work must be done to be prepared for greater events. Excellent documentation and analysis of each event is necessary.

References:

1. Villareal M: QC module for mass casualties. *Prehosp Disast Med* 1997; 12(3):200–209.

Key words: coordinating emergency physician; management; multicase incident; rescue; system; victims
Prehosp Disast Med 2001;16(2):s17.