

| | 2005-2009 | 2010-2011 | 2016 | 2009-2011 | 2016 |
|------------------------------|--------------|-----------|------|------------|------|
| | Thrombolysed | | | All stroke | |
| Dispatch high priority | 66.2 | 88.9 | 87 | 61.9 | 72.7 |
| Mean response time (minutes) | 9 | 6.9 | 6.6 | 9.4 | 8.1 |
| Recorded blood sugar (%) | NA | 66.7 | 93.1 | 25.9 | 52.1 |
| ECG/ monitoring done (%) | NA | 54.2 | 49.5 | 43.6 | 31.5 |
| DNT (minutes) | 75.7 | 55.4 | 28 | | |

Table 1. Changes in door to needle times at WTCH-SS (West-Tallinn Central Hospital). Since 2014 thrombolysis started in computed tomography (CT) room and pre-arrival information is provided by TEMS (Tallinn Emergency Services).

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Resuscitation Team and Code Blue Practicing in Çanakkale State Hospital, Turkey

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Study/Objective: This study has two research objectives. The first aim is to evaluate the quality of resuscitation team and code blue practicing. The second is to determine which factors affect the code blue process.

Background: Code Blue Teams (CBTs) have crucial roles in every hospital or health care center in the world. With this important role, CBT must be well trained to save more lives. To train this team properly, hospitals and other health organizations have some responsibilities. If they do their responsibilities, and provide some conveniences to CBTs, the team can practice more and be trained well.

Methods: The authors conducted a retrospective data review of code blue frequency in three months (June 1- September 1, 2016). To carry out this study, permission was obtained from the hospital authority, then code blue forms reviewed. The personal information of the patients is not used in this paper.

Results: CBT has 40 code blue calls from different locations in the hospital. Of those calls, 20% (f = 8) are from the angiography unit, 35% (f = 14) from clinics, 30% (f = 12) from patient's rooms, 5% (f = 2) from cafe for syncope, and 10% (f = 4) from intensive care units. There was 45% (f = 18) of patients who were resuscitated by giving CPR and saved their life. There was 2.5% (f = 1) patients could not be saved in the angiography unit and 52.5% (f = 21) patients were given only first aid.

Conclusion: The arrival time to the patients is between in 20-120 seconds. Code blue forms need to be standardized. Having practiced regularly will be helpful for CBTs. Timing is very important and could affect the code blue quality. People who activate the CBT in hospitals must be educated about first aid and code blue process.

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Quick Assessment of Intra Abdominal Pressure in an Emergency: An Option for Better Decision Making in Cases of Blunt Trauma Abdomen

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Study/Objective: The study was designed with an objective to measure intra abdominal pressure using intra vesicular pressure monitoring, in conditions predisposing to abdominal compartment syndrome in surgical trauma patients.

Background: Intra-Abdominal Hypertension (IAH) is defined as a sustained or repeated pathologic elevation of Intra-Abdominal Pressure (IAP), of greater than 12 mm Hg. Serial monitoring of IAP warrants early initiative for conservative treatment of IAH before dangerous levels of IAH develops.

Methods: This study comprised of 30 patients, who were above the age of 10 years, and presented with acute abdomen with suspected intra abdominal hypertension. IAP was measured at 0 hr, 8 hr, and 16 hours. Data included demographics, main diagnosis on admission, APP (MAP-IAP), APACHE II score; ICU stay, hospital stay, complication and mortality.

Results: Total data of 30 patients was taken and IAH (IAP ≥ 12-20 mmHg) was observed in 18 (60%) of cases and ACS (IAP ≥ 20 mmHg) was noted only in 3 (10%). There was male preponderance 2.33:1 and raised IAH in 61.9% of males. Majority (46.7%) of patients were admitted with perforation peritonitis with significant abdominal distention (96.7%). The mean IAP at the time of study was 14.73 ± 2.83 (P = 0.92) in IAH group and was 19 ± 2.98 (P = 0.74) in ACS group whereas the mean APP was 53.60 ± 11.01 (P = 0.92) in IAH group and 39 ± 11.43 (P = 0.97) in ACS group. Mean Acute physiology score was 19.4 ± 6.4 while majority (47.6%) observed high APACHE II score (>20). Mean APACHE score in ACS group (27.3 ± 10) was higher with higher mortality rate 58.3 ± 31.94 as compared to IAH group (20.4 ± 6.04, mean mortality 34.78 ± 18.25). Medical therapy (isotonic crystalloids in 100%) and surgical therapy (midline laparotomy 86.7%) was offered in majority.

Conclusion: Raised IAP leading to IAH and ACS, is a hidden threat to the surgical abdomen. For early prompt diagnosis and prediction of mortality, IAP and APP monitoring are effective.

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Patient Isolation Units, Performance-Avoidance: A Patient with Heat Stress Risk during Temporary Isolation and Transportation by the EMS Biohazard Team

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