In the attempts of the editorial staff to improve the readability of these two abstracts, we apparently lost the essence of what the authors intended. Therefore, these two abstracts are printed here in their original form and should replace those that appeared in the abstracts supplement of Volume 12, Number 3 for the 10th World Congress on Emergency and Disaster Medicine. We apologize for any inconvenience associated with the edited versions.

*—MLB, Editor-in-Chief*

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**Capillarity in Burn and Wound Dressing**

*Wahid Mikhail, MD*
King Fahad National Guard Hospital, Riyadh, Saudi Arabia

This article describes a technique which I developed over the past 20 years. For burn and wound dressing. It utilizes the theory of Capillarity and considerable general interest, utility and application. It maintains a proper balance between humidity and absorption with a predetermined absorption capacity. The dressing is built up in four layers. I utilize a non-adherent oil-in-water impregnated viscose fabric product as the contact layer. In the second stratum, I use a non-woven swabs made from viscose in a filamented form. These are moistened with sterile normal saline, and applied on top of the contact dressing in minimum of four layers. This layer experts high capillarity and actively draws the secretions away from the contact layer, providing pooling and mascerations. The third layer is made of non-occlusive material which allows free passage of gases. This is a hydrophobic material and as such does not itself become stained or impregnated with discharges and in the meantime controls the evaporative process from the wound surface. The final layer commonly consist of gauze bandage or a light plaster cast. The dressing is sterile, non-toxic and allows air permeability with a non adherent surface. Its thermal insulation will result in high mitotic activity with rapid epithelialisation and improved granulation. It is impermeable to airborne micro-organisms with no strike through of exudate from wound to surface. It is also free from particle and toxic wound contaminants. Dressing is easily removable without causing any pain to the patient. It is my custom to leave this dressing untouched for seven to ten days until healing is complete. This dressing is simple, available, quickly applied and in most cases patient could be discharge home, effecting a huge saving in hospital bed occupancy, medical time and material.

**Estimating Acceptable Cost for Disaster Response Planning**

*Aoki N; Sugimoto K; Nishimura A; Pretto EA; Fukui T; Beck JR; Safar P*
HAM/TMC Jesse Jones Library, Houston Texas USA

**Introduction:** The adequate budget of disaster response to large-scale disasters has not been determined, because of lack of objective data. We estimate the acceptable cost for saving protracted death based on the theory of cost effectiveness analysis.
**Methods:** Total of 3,651 autopsy data obtained from the Office of the Medical Examiner of Hyogo Prefecture, and 926 were excluded form the analysis, because of lack of data. The "protracted death" was defined as the death which was occurred from 3 to 24 hours after earthquake. We estimated saving-life-years of protracted death from victim's age and life table. We estimated the baseline capacity of actual response efforts based on hypothetical "well-organized' response efforts (response within 3 hours after impact and a life saving capacity of 30% of protracted deaths), and annual probability of earthquake (2%/year) arbitrarily agreed upon by expert opinion. The annual acceptable cost for life saving was determined $40,000/saving-life-year.
**Results:** There were significant differences among the causes of death. Time course oriented survival analysis resulted in the following distribution of time of death: 90.5% died within 3 hours (instant deaths); 8.4% died between 3 to 24 hours (protracted death), and 1.1% died after 24 hours (delayed death). Estimated saving-life-years of protracted death with discount (0.03%/year) was 4,266.93. Estimated acceptable cost for disaster response plan is $1,024,063/saving-life-year with baseline data.
**Conclusion:** Survival analysis showed that we might be able to save an additional 10% of lives if we could prepare a well organized disaster response. In Japan this would result in $1,024,063 per year using the widely accepted cost per year of life saved parameter. Further outcome research of hospitalized patients and CE analysis based on these data is needed to more precisely determine a cost-effective annual level of investment in disaster preparedness
**Key Words:** cost -effectiveness analysis; Hanshin-Awaji earthquake; disaster management