

caused by a bioterrorist could quickly become an international problem.

**Key words:** bioterrorism; communication; coordination; detection; investigation; laboratory support; public health; response

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### Centres of Research and Expertise for Disaster Medicine in Sweden

**Karl-Axel Norberg, MD, PhD**

Department of Disaster Planning, National Board of Health and Welfare, Stockholm, SWEDEN

The National Board is a central authority under the government, and is responsible for supervising quality and performance in Medical Care, Social Welfare, and Public Health. On the national level, the Board has the responsibility to ensure the medical preparedness for large-scale disasters and wartime medical care in Sweden. The responsibility for providing medical care to the population lies in the 21 Regional parliamentary organisations (County councils). The Board receives money from the defence budget to support the preparedness of the Country Councils for medical disasters. New threats lead to increased need of scientific knowledge in various fields. Therefore, the Board has decided to establish special centres of research and expertise in several fields of Disaster Medicine. These centres are set up as special research groups connected to university institution/equivalent in close connection with the medical/clinical society. The main aims of these centres are to perform scientific research in their respective fields, to act as experts and to participate in education. A special steering group for each centre with representatives from relevant authorities decides about the aim of the work and follows up the results.

The following centres are planned or established (through 2000): General Disaster Medicine, Psychosocial Preparedness, and Radiation Medicine in Disasters (at the Cancer Centre, Karolinska Hospital, Stockholm), Microbiological Preparedness (at the Swedish Institute for Infectious Disease Control), Disaster Toxicology and Public Health in International Disasters.

**Key words:** centers; county councils; Disaster Medicine; education; public health; preparedness; research; Sweden  
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### Clinical Audit of Hypertensive Crisis

**Prof. Mohamed Ouchtati**

Service des Urgences Medicales, Constantine, ALGERIA

**Introduction:** The term "hypertensive crisis" (HC) suggests a rapid reduction of the arterial blood pressure. The aim of this work was an assessment of therapeutic efficiency and evaluation of results in terms of hospital mortality relative to the blood pressure (BP) at the admission of the patients, and the magnitude of its reduction during the first 24 hours.

**Methods:** This prospective study included 125 patients admitted to emergency room for a stroke. The patients had the benefit of indirect monitoring of the BP. Variance analysis and odds ratio calculation were been used ( $p < 0.05$ ).

**Results:** At admission, the mean values for systolic blood pressure (SBP) was of  $216.2 \pm 29.07$  mmHg, for diastolic blood pressure (DBP) was  $121.8 \pm 19.51$  mmHg, and for mean blood pressure (MBP) was of  $151.8 \pm$  mmHg. After 24 hours of hospitalisation, arterial blood pressure reduction was of 38% for the DBP and the MBP, and of 39% for the SBP. No statistical relationship was demonstrated between the reduction in DBP and the mortality; this relation for MBP was weak. Concerning the SBP, the relation is highly significant: the SBP above 220 mmHg at the time of admission increased mortality ( $p < 0.003$ ) as was a reduction of more than 35% during the first 24 hours ( $p < 0.005$ ).

**Conclusion:** The DBP proposed for the diagnosis of a HC and its therapeutic follow-up does not seem to be a deciding factor of outcome for our patients. The outcome of these patients who present with a cerebral suffering seems more dependant on the SBP in which the rapid and the important reduction is the origin of progression of the cerebral injury.

**Key words:** blood pressure; hypertensive crisis; emergency room; stroke

**E-mail:** imas@mail.wissal.dz

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### Crisis Management: A Possible Improvised Operational Approach

**F. Petitjean MD; C. Mougeolle MD; D. Meyran MD**

Bataillon de Marins Pompiers de Marseille, Marseille CEDEX, FRANCE

In cases of mass casualties, the French hospital and pre-hospital health organization requested the implementation of a field "structure", the Forward Medical Post (FMP). The objective of this structure is to triage, maintain life, and dispatch the victims in order to permit their evacuation in the best possible medical condition and in the shortest time to the nearest appropriate hospital.

In the Bataillon de Marins Pompiers de Marseille (BMPM), we define a Forward Medical Post not as a physical structure, but as a working organization. This organization articulates itself around six functions: a secretary, triage, an Immediate Emergency care function (IE), a Relative Emergency care function (RE), a regulation, and an evacuation. Therefore, every structure, that includes all of these functions and is set up in the field to cope with an influx of victims, can be defined as a forward medical post (whichever its physical form is.)

The organization of a FMP relies on unavoidable rules: (1) the site is decided upon in cooperation with the On-site Commanding Officer; (2) it must be situated in the "safe zone", at the vicinity of the incident as near as possible to evacuation roads and on enough ground surface to receive at least a third of the total number of victims (if known); and (3) the FMP is organized into six zones (one for each