

caution for resuscitation of patients in traumatic hypovolemic shock with or without head injury.

Keywords: hypertonic saline; isotonic; prehospital; Ringer's Lactate; traumatic shock

Prehosp Disast Med 2007;22(2):s74–s75

(123) Case Report of Survival in a Patient with 90% of their Total Body Surface Area Burned

A.P. Ferro;¹ O.A. Gvindzhyliya;² L.K. Krebs¹

1. Santa Maria University Hospital, Lisbon, Portugal

2. Santarm District Hospital, Santarm, Portugal

Background: During the last 10 years, there has been a decrease in the mortality rate of burned patients. Despite this improvement, mortality is still high in the presence of inhalational injury, or patients with large total burn size and >60 years of age.

Case Report: A healthy, 17-year-old man was burned by ignition of his clothing in an enclosed space. He was taken to the local hospital where his burn area was evaluated as 90% of his total body surface area (mainly 3rd degree burns with 7–10% of 2nd degree burns). After initial treatment and stabilization, the patient was transferred to the Burn Unit of Santa Maria University Hospital. He was mechanically ventilated for 43 days, and was treated successfully for pneumopathy, various infections, and acute cholecystitis. The patient underwent 11 surgeries, and early skin graft was done successfully for all the burned area. After 80 days of treatment in the Burn Unit, he was discharged to the plastic surgery ward of his local hospital, where he continued specific physical therapy and antidepressant treatment. At the time of discharge, he was able to communicate, feed himself, and ambulate with help.

Conclusions: There are few multi-center, prospective, clinical burn trials, leading to divergent methods of practice. Survival of patients with 90% of total body surface area burned in their first hours is rare. Proper treatment in this period is crucial. To the authors' knowledge, this is a unique case of survival of such a patient in Portugal.

Keywords: burn injury; burn patient; survival of burn victims; total body surface area

Prehosp Disast Med 2007;22(2):s75

(124) Emergency Transport for Acute Chest Pain Patients: Does it Affect Hospital Treatment?

M. Haque;¹ M. Haque;² Y. Abmady;² G. Ali;² K. Islam;² H. Kabiri²

1. Georgetown University Hospital, Washington, DC USA

2. USA

Introduction: Emergency transport of patients to the hospital for acute chest pain is critical for timely access to medical treatment. Transport management decisions may affect transitions between first responders and emergency department (ED) personnel. This study investigates whether patient characteristics factor into decision algorithms regarding emergency transport and whether these characteristics affect in-hospital treatment times.

Methods: Emergency medical transport decisions such as circumstances leading to use of lights and sirens (LAS) were analyzed to determine whether any patient character-

istics were related to the decision to use LAS and whether LAS affected the time interval between arrival to the hospital and patient treatment.

Results: Patients transported by ambulance were older and had a higher prevalence of previous cardiac event. The median interval between symptom onset and ED arrival was 121 minutes (range 5 to 590 minutes). Transport by emergency medical services (adjusted hazard ratio 0.28 [95% confidence interval 0.19 to 0.41]), increasing age (hazard ratio 0.99 [95% CI 0.98 to 0.99]), and symptoms considered urgent were the factors most strongly associated with a shorter out-of-hospital interval. LAS were used 87% to the scene and 26% to the hospital. Hospital staff responded more quickly to ambulances coming in with LAS; ER physicians evaluated patients in 9.8 minutes versus 17.2 minutes without LAS.

Conclusions: Patients who receive emergency transport with LAS for acute chest pain to the ED will be evaluated sooner and the interval between symptom onset and time to ED arrival are decreased. Potential rationale for this result is discussed.

Keywords: acute chest pain; cardiac event; emergency department; emergency transport; lights and sirens

Prehosp Disast Med 2007;22(2):s75

(125) Amatoxin Intoxication After Wild Mushroom Ingestion

D.S.E. Varin; S.A.M. Ennecker-Jans; P.L.A. van Daele; M.I. Blonk; J.A.M. van Laar; T.M. Mulligan

Department of Emergency Medicine, Erasmus Medical Center, Rotterdam, The Netherlands

The case of three patients with gastrointestinal symptoms and hepatitis after ingestion of *Amanita phalloides* (Deathcap or Death angel) mushrooms will be presented. Patient A, a 54-year-old Chinese man, and Patients B and C, a 51 and 55-year-old Chinese woman respectively, presented with stomach pain, nausea, vomiting, and diarrhea after eating home-made soup with wild mushrooms. Patient A looked ill, with RR 132/78, pulse 55/minute, a temperature of 37°C, and active peristalsis. Liver enzymes were elevated slightly. Patients B and C presented similarly. The suspicion of amatoxin intoxication was confirmed by measuring urinary a-amanitin concentration. The patients received fluid infusion, activated charcoal, high dose IV benzylpenicilline, N-acetylcysteine (NAC), and silibinin, an experimental antidote. After 3–4 days, their liver enzymes reached maximum elevation and then decreased. All patients recovered fully and were discharged after eight days.

Amanita phalloides is a highly toxic mushroom. One specimen can contain enough poison (amatoxin) to kill a healthy adult. Amatoxin inhibits RNA polymerase II, leading to cell death, with mortality rates of >90%. The intoxication is divided into four phases: (1) the latent phase; (2) the gastrointestinal phase; (3) the second latent phase; and (4) the hepatic phase, leading to hepatic-renal failure and death. The classic treatment is supportive. However, an experimental drug silibinin has shown to be effective against amatoxin by decreasing drug conversion, but it is

not available in The Netherlands. The described three patients received high-dose penicillin, NAC, and silibinin in addition to classical supportive treatment, which may account for their full recoveries.

Keywords: amanita phalloides; amatoxin intoxication; ingestion; silibinin; wild mushrooms

Prehosp Disast Med 2007;22(2):s75–s76

(126) Mass Envenomation by Africanized Bees in a 90-Year-Old Woman

G. Spiessens; R. Smit; T. Mulligan

Erasmus Medical Center, Rotterdam, The Netherlands

Introduction: Patients presenting to the ED with a history of insect stings usually show a local reaction of swelling, pain, and erythema at the site of the stinging. In 0.3 to 0.5 percent of stings, an IgE-mediated anaphylactic reaction occurs, possibly after a single sting and can lead to an emergency requiring prompt recognition and treatment. Mass envenomation, sometimes involving hundreds of stings are less common, but can cause severe systemic toxic reactions that also require recognition and initiation of aggressive treatment. The syndrome is difficult to distinguish from systemic allergic reactions and maybe fatal.

Discussion: The patient received more than the mean lethal dose of honeybee venom and did not reach the hospital within the first hour after the stinging incident. Hemodynamic instability, rhabdomyolysis, and acute renal failure developed shortly and proved fatal, despite aggressive treatment at the Intensive Care Unit (ICU). It is unclear whether immediate hemodialysis or plasmapheresis would have saved this patients life, but it remains a treatment option to consider if a patient with a toxic dose of honeybee venom is admitted. The dilution and faster removal of the toxin could prevent a more severe course of the condition. These higher risk patients should be transferred to the hospital without delay and immediately admitted to an ICU to be monitored more closely, so that the first signs of imminent collapse can provoke further action.

Keywords: anaphylactic reaction; envenomation; honeybee venom; IgE-mediated; insect stings; intensive care unit

Prehosp Disast Med 2007;22(2):s76

(127) Pheochromocytoma: A Rare Cause of Dyspnea and Hypertensive Emergency in the Emergency Department

P.P.M. Rood, T. Mulligan

Erasmus Medical Center, Rotterdam, The Netherlands

Pheochromocytoma rarely is seen in the emergency department (ED), and may present in uncommon ways. A case of pheochromocytoma in a young, severely dyspneic patient is reported in this presentation. A 21-year-old male was brought into the ED with symptoms of sudden-onset dyspnea and hemoptysis. He had experienced cough and headaches for several months. Weight loss was reported, with no night sweating. The patient denied taking medications, drugs and alcohol, or having any allergies. Past medical history included pharyngitis two months earlier, and asthmatic bronchitis.

On examination, the patient was in respiratory distress with O₂ saturation of 60% on room air, and 85% on 15 liters of 100%O₂ non-rebreathing mask. Vitals were: respiratory rate: 24, blood pressure: 235/139, pulse: 125, temperature: 35.4. Lung sounds: bilateral rates; cardiac tachycardia, without murmurs. There were no sweating or extremity abnormalities.

Laboratory results included: Creatinine: 128umol/l; K⁺:4.1, BUN:3.8mmol/l; LDH:915U/l, lactate:5mmol/l; and respiratory acidosis. Chest x-rays demonstrated diffuse, bilateral pulmonary edema. The electrocardiogram showed sinus tachycardia with LVH; there were no signs of ischemia.

Antihypertensive treatment started and the patient was admitted to the intensive care unit for mechanical ventilation. Differential diagnoses included post-streptococcal glomerulonephritis, renal artery stenosis, pheochromocytoma, and other causes of kidney failure. A swelling of the right adrenal gland (6.5 x 5 x 4 cm) was seen on abdominal ultrasound and magnetic resonance imaging (MRI). Meta-Iodobenzylguanidine (MIBG) testing and SMS testing confirmed the diagnosis of pheochromocytoma. The adrenal tumor was excised surgically.

This report has presented a rare cause of hypertensive crises and highlights the importance of considering the diagnosis of pheochromocytoma in dyspneic patients and in hypertensive emergencies in order to avoid delays in treatment of this potentially life-threatening condition.

Keywords: dyspnea; emergency department; hemoptysis; hypertensive emergency; pheochromocytoma

Prehosp Disast Med 2007;22(2):s76

(128) Collaboration between Indonesian and Japanese Emergency Medical Teams during the Sumatra Earthquake in 2004

A.Y. Asai

Sapporo Medical University, Sapporo, Japan

Introduction: In February 2004, the earthquake in Papua Province, Indonesia, resulted in severe damage to infrastructure and injuries to residents. Concerning this disaster, Japanese and Indonesian disaster relief teams shared information on management tactics.

Methods: Japan International Cooperation Agency (JICA) dispatched a team of five registered medical personnel and two recorders of the Japanese Disaster Relief Team to Indonesia to hold the joint seminar and exchange information. The JICA team also discussed the possibility of cooperation with Indonesian authorities in the sector of emergency response.

Furthermore, the JICA mission invited Indonesian counterparts to the subsequent meeting involving Japan, Malaysia, and The Philippines. The purpose of the next meeting was to share the output of the seminar and meet with key persons of Japan, Malaysia and The Philippines. On 12 October 2004, the joint seminar between Indonesia and Japan emergency medical teams on emergency medical care in sudden-onset events was held in Jakarta sponsored by JICA. Coordination between Indonesia, Malaysia, and The Philippines via a communication satellite was discussed. **Result:** This discussion occurred two months after the Sumatra earthquake. The early medical mission was welcomed in Indonesia and coordinated with Indonesian medical staff.