

In Ostergotland, these demands created a solution, in which a *status key setup*, a computer terminal with a code line scanner, and a small printer is mounted in every ambulance, combined with a complete personal computer including a laser writer on all hospital emergency units (plus parts of this hardware in the hospital disaster command centers) for receiving alarms, status reporting, and record handling. The information also is transferred to a communication computer operated by the chief medical director for later evaluation of work, the individual cases (if needed) as well as major statistical calculations. Attempts are being made to make this concept a national standard. Within a few years, there probably also will be a GPS satellite positioning system mounted on all ambulances. With a digitalized map, the directing unit has minute-to-minute information on all available, and non-available, ambulances in the organization.

Later, the transferring of data (ECG, blood pressure, pulse, oxygen saturation, etc.) on-line to the hospital during the mission may be included. The technology exists, but in Sweden, there rarely is a competent receiving doctor immediately ready for decision-making based on the information sent.

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Demands on Equipment in Emergency and Disaster Medicine

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In-hospital equipment obviously is designed for optimal performance under indoor conditions.

- Ambient temperature is relatively constant, and rain is no problem.
- Size and weight of the equipment is of some, but not of major importance, since it can be wheeled around and positioned as desired.
- Monitors often have a number of more or less sophisticated functions and alarms, giving a high grade of security against patient and/or equipment failure.
- Electrical power usually is supplied from the wall, but there is a battery backup.
Equipment for out-of-hospital field work must be designed and bought from another point of view, or the risk of malfunction rises rapidly.
- Ambient conditions vary a lot, from day-to-day as well as from country-to-country, but the equipment still must work.
- Size and weight are of great importance: in the worst case, two persons must carry the stretcher, the patient, and the equipment simultaneously.
- A number of sophisticated functions and alarms might prove suboptimal in ambulance work, since too much time may be consumed in checking the causes of different beepings, adjusting alarm limits, etc. Simplicity in operation is very important.
- If the equipment is powered electrically, batteries are needed, making low-energy-consumption technology highly desirable.

- The equipment must be usable under poor light conditions where, for example, LED displays often are superior to LCD varieties.
- The equipment must be durable and shock resistant.
- For use in cars, helicopters, etc., electromagnetic compatibility must be borne in mind, or the risk of equipment or vehicle malfunction, with a helicopter crash as a possible outcome, increases.

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Minimizing Motion of the Unstable Cervical Spine during Control of the Airway: A Fluoroscopic Evaluation of Technique

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Objective: The technique of airway control least likely to produce motion at a site of cervical instability is unknown. Comparisons were made of motion created by different intubation techniques at a C5–C6 injury site.

Methods: Subjects were six fresh cadavers with a lesion unstable in flexion created at C5–C6 achieved via ligamentous release excepting the anterior longitudinal ligament. Techniques compared were oral intubation with direct visualization (OI), with the aid of the lighted stylet (LS), the augustine guide (AG), blind nasal intubation (BN), cricoid pressure (CP), translaryngeal jet catheter placement (TJ), and cricothyrotomy (CT). Forceful technique (FT) was applied with OI to simulate airway control in the combative trauma victim. After confirming instability of the spine in flexion (F), each subject was intubated once with each method. Videofluoroscopy was used to record spine motion during all phases of airway control, then digitized for motion analysis in three dimensions: distraction (D), sagittal plane translation (T), and rotation (R). Data were examined with MANOVA and Scheffe's technique for multiple comparisons; 95% power to detect 4(T), 2(D), and 5(R).

Results: Motion in all axis was noted to be significant ($p < 0.05$, in bold) for instability of the spine in flexion (F) and forceful technique (FT), as was rotation for cricoid pressure (CP).

	T(mm)	D(mm)	R (deg)
F	16.0 ±3.0	27.0 ±38.0	36.0 ±11.0
OI	9.0 ±6.0	1.0 ±2.0	7.0 ±1.3
FT	4.0 ±2.9	3.0 ±0.7	13.0 ±4.0
BN	0.7 ±0.4	2.0 ±0.9	4.0 ±2.8
LS	0.8 ±0.6	6.0 ±0.2	4.0 ±1.2
AG	1.0 ±0.4	1.0 ±0.3	4.8 ±1.0
CP	2.0 ±0.4	4.0 ±0.4	13.0 ±3.0
TJ	0.5 ±0.2	1.0 ±0.4	3.6 ±1.0
CT	1.0 ±0.8	2.0 ±0.7	9.0 ±2.0

Conclusion: In a cadaveric model of cervical injury with a C5–C6 lesion unstable in flexion, no significant difference was shown in motion created by the intubation techniques tested, save FT and CP.