

suggest that exposure to bushfire smoke causes an increased incidence of respiratory pathology.

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### (P2-82) Developing and Implementing an Emergency Preparedness and Trauma Research Program in a New Level One Trauma Center

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Our level one trauma center with a service area covering a population of approximately four-million people treats approximately 80,000 patients per year. In 2010, we anticipate more than 23,000 patients admitted, and to experience more than 850,000 patient encounters within the network. Trauma research is an important component to any level one trauma center, as well as a requirement of the American College of Surgeons/Committee on Trauma (ACS/COT). Our trauma center has recently gained level one designation and began an emergency preparedness research and trauma research (EPR/TR) program in earnest. We are fortunate to have support from executive administrators. Stewardship is a necessary element of our planning, in part because we are a county hospital serving a large uninsured patient population. The following are a few of the necessary steps we took to build an (EPR/TR) department from the beginning, to the point of submitting abstracts, manuscripts, funding grants, and presentations to regional, national, and international conferences, journals, and agencies. Structure the Emergency Preparedness Office to be a component of Trauma Services, allowing a unique opportunity for real-time disaster and mass casualty research. Secure a commitment from senior executives. Secure an experienced researcher, capable of research administration. Ensure the (EPR/TR) director, trauma medical director, trauma services director, and emergency preparedness coordinator can be a cohesive team with complimentary skills. Encourage trauma surgeons to perform research with assistance from the (EPR/TR) Office. Seek federal and foundation funding. Seek alliances with appropriate consortiums and associations. Develop a research relationship with pre-hospital emergency services. The above steps represent only some of the components used to build our (EPR/TR) department. We anticipate the planned expansion of the above steps will take our EPR/TR to the next level and increase extramural funding.

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### (P2-83) The Use of Focused Assessment with Sonography for Trauma in Patients with Blunt Abdominal Trauma or Pelvic Fracture in the Emergency Departments

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**Background:** The role of FAST in diagnostic protocols has been adopted in most major trauma centers in well-developed countries. This procedure has become the initial diagnostic way in blunt abdominal trauma patients. However there are researches which show FAST is not reliable triage tool in patients with pelvic fracture.

**Objectives:** To evaluate the usefulness of Focused Assessment with Sonography for Trauma in diagnostic of blunt abdominal trauma patients and to bring attention to patients with pelvic fracture who should receive additional tests for the presence of peritoneal fluid.

**Methods:** An analysis of high-quality evidence resources was performed, limited to the articles published since 2005 year.

**Results:** 99 articles were found during the search, of which 23 were accurate. 16 articles were based on original research.

**Conclusion:** Focused Assessment with Sonography for Trauma plays a key role in the investigation of blunt abdominal trauma and should be used in all emergency departments. FAST-negative patients can remain under observation except major pelvic injury patients. The evaluation of peritoneal fluid in this group has low sensitivity.

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### (P2-84) Upper Gastrointestinal Tract Bleeding (UGIB) Management: Belgian Guidelines for Adults and Children

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**Background:** UGIB remains a common disease affecting 100 to 170 adults per year, with an associated mortality ranging from 5 to 14%, causing thereby an important burden to healthcare resources. UGIB in children is uncommon (1–2/10,000 per year) but potentially life threatening. Since various specialists (general practitioners, emergency physicians, gastroenterologists and hepatologists, pediatricians, intensivists, radiologists and surgeons) may be involved and given the absence of evidence-based medical (EBM) recommendations – for adults as well as for children – there is considerable variability in the management of UGIB. Moreover, as even RCTs on the management of UGIB in children are lacking, many treatment strategies are simply deducted from the management of adult UGIB.

**Aim:** To provide EBM guidelines for the care of adults and children presenting with bleeding caused by gastro-duodenal ulcer or variceal rupture.

**Method and Results:** An interuniversity interdisciplinary team of Belgian experts was launched. Statements based on the published literature up to September 2010 were collected and proposed after expert opinions reconciliation and graded accordingly to the class of evidence. The current guidelines for the management of UGIB include recommendations for the diagnosis process, general supportive care, pharmacological therapy aiming at bleeding control, specific and endoscopic treatment of acute bleeding and follow-up for both gastro-duodenal ulcers and portal hypertension induced bleeding. Specificities and differences in the approach to UGIB in children compared to adults are highlighted.

**Conclusion:** Interdisciplinary guidelines for the management of UGIB based on current standards for EBM will provide an opportunity for clinicians to improve the management of their patients. However, clinical guidelines are not mandatory tenets appropriate for all patients, but should constitute a canon or