Research Awards

Research Awards Presented During TraumaCare 2002–Scandinavia
Eldar Søreide, MD, PhD, and Hans Morten Lossius, MD

ITACCS Scientific Awards
First Prize – US$2000

The Scottish Trauma Audit Group (STAG) received first prize for their multidisciplinary work involving the collection and publication of national trauma process and outcome data (abstracts, fall 2002 issue, p. 30; winter 2003 issue, pp. 18 and 20). The data are used to improve trauma management throughout Scotland. STAG's work has obvious relevance to similar initiatives in other countries.

Second Prize – US$1250

Second prize was awarded to the Vienna Red Cross Research Institute from Vienna, Austria. This group presented several studies on the topics of the use of acupressure for acute pain management (abstract, fall 2002 issue, p. 33) and oxygen to prevent motion sickness in ambulances (abstract, p. 19.)

Third Prize – US$750

Dr. Stephano Di Bartolomeo from Udine, Italy, won third prize for research carried out within the cooperative bodies of the North-Italian Trauma Audit and Italian Resuscitation Council. Using epidemiologic data, this group described problems and limitations related to prehospital ALS, while also seeking ways to improve quality of care (abstract, p. 17.)

ITACCS In-Training Research Awards
First Prize – US$750

Dr. Akiyoshi Hariwara received first prize for his presentation of the successful multidisciplinary team approach used for complicated pelvic injuries (abstract, p. 15.)

Second Prize – US$250

Dr. K.J. Labori from Ullevall University Hospital, Oslo, Norway, received second prize for his study of the prognostic value of pronounced jaundice in severely injured patients (abstract, p. 6.)

Akuttjournalen Research Award for Best Scandinavian Research Paper – NOK 5000

Drs. B. Pålsson (Lund University Hospital) and C. Hammarlund (Malmoe University Hospital) received an award for their study on missed injuries in trauma ICU patients (abstract, fall issue, p. 40).

Akuttjournalen Research Award for Best International Research Paper – NOK 5000

The Trauma Audit and Research Network (TARN) in England has led the way in Europe in regard to building national trauma databases and publishing the results. TARN's new study of lack of change in process and outcome of trauma care in England and Wales may be interpreted in many ways: first, the reassuring news that only relatively simple aspects of the initial management need to be improved and standardised to improve survival; second, further improvement in process of care is not simple to detect by using improved odds ratio of survival (abstract, fall 2002 issue, p. 30).

CONTINUING MEDICAL EDUCATION

This issue of *TraumaCare* can be used to earn 10 CME credit hours.

Accreditation Statement

This activity has been planned and produced in accordance with the Essential Areas and Policies of the Accreditation Council for Continuing Medical Education (ACCME) through the sponsorship of the International Trauma Anesthesia and Critical Care Society (ITACCS). ITACCS is accredited by the ACCME to sponsor continuing medical education (CME) for physicians and takes responsibility for the content, quality, and scientific integrity of this CME activity.

Nurse Anesthetists/CRNAs: Please apply to AANA for post-activity continuing education credits. Certificates of completion will be provided.

Credit Designation Statement: ITACCS designates this educational activity for a maximum of 10 hours per issue in category 1 credit toward the AMA Physician's Recognition Award.

Faculty Disclosure Statement

It is the policy of ITACCS that faculty members disclose real or apparent conflict of interest relating to the topics of this educational activity and also disclose discussions of unlabeled/unapproved uses of drugs or devices in their presentations. The authors' completed disclosure forms are on file in the managing editor's office.

INSTRUCTIONS

- On the answer form at the bottom of page 51, circle only one response next to each number.
- Complete the evaluation form.
- Cut out or copy your completed answer form and evaluation form.
- Write a check for $150 (or $75 accompanied by verification of current ITACCS membership), payable to the International Trauma Anesthesia and Critical Care Society.
- Mail the forms and your check (and membership verification, if applicable) to ITACCS, Department of CME Credit, PO Box 4826, Baltimore, MD 21211.
- The completed test will be accepted for grading if received by March 31, 2004.
- Please allow 4 to 6 weeks for processing.

CME QUESTIONS

1. The onset of acute lung injury (ALI) in trauma patients has been related to which of the following factors:
   a. severity of injury
   b. specific type of trauma
   c. hypotension
   d. metabolic acidosis
   e. all of the above

2. Reduced host defense and subsequent secondary infections, e.g., pneumonia, wound infection, and sepsis, typify which one of the three post-trauma phases?
   a. The initial phase ((24 hours)
   b. The second intermediary phase (days 2–7)
   c. The late phase (>day 10)

3. In patients receiving enteral or parenteral nutrition, septic morbidity is probably more related to increased energy intake and hyperglycaemia than the route of feeding.
   a. True
   b. False

4. In a study of trauma patients with severe jaundice at Ullevaal University Hospital in Oslo, fatal outcome was predicted by
   a. number of blood units transfused
   b. progressive severe jaundice lasting more than 10 days
   c. a drop in serum bilirubin level
   d. systemic hyptension
   e. all of the above

5. Tachycardia, often associated with hypovolemia, is a dependable parameter for preload status in trauma patients.
   a. True
   b. False

6. In the treatment of acute renal failure, alkalization until urine pH is >6.5–7.0 is recommended because
   a. It prevents myoglobin accumulation in the kidney.
   b. It increases the solubility of the myoglobin-protein (Tamm Horsfall proteins) complex.
   c. It is accompanied by tubular washout of myoglobin casts.
   d. Neither a, b, nor c.
   e. For each reason cited as a, b, and c.

7. During interhospital transport of patients with brain injury, which of the following methods is used to facilitate control of intracranial pressure?
   a. Hyperventilation b. "Head-of-bed-up" position c. Intermittent bolus dosing

8. A meta-analysis of clinical trials involving administration of hypertonic-saline dextran (Rescueflow®) revealed statistically lower mortality in which groups of trauma patients?
   a. Patients with head trauma
   b. Patients with penetrating trauma requiring surgery
   c. Patients requiring long prehospital transport times
   d. a and b
   e. b and c

9. The most common cause of death in severely injured patients with morbid obesity who survive 24 hours post injury is
   a. Head injury
   b. Sepsis
   c. Pulmonary failure
   d. Pulmonary embolism
   e. Cardiac arrhythmia

Questions continue on page 27

10. All of the following are more common in morbidly obese patients EXCEPT
    a. Hypertension
    b. Glucose intolerance
    c. Urinary tract infections
    d. Difficult endotracheal intubations
    e. Decreased vital capacity

11. In the morbidly obese patient, caloric intake should be provided erly in their hospitalization in the form of
    a. Carbohydrate
    b. Lipids
    c. Protein
    d. Ketones
    e. Branched chain amino acids

12. Cervical spine injury becomes less common as depth of coma after head injury increases.
    a. True b. False

13. Because altered breathing patterns are common in patients with severe head trauma, early endotracheal intubation should be established early by special trained personnel.
    a. True b. False

For Questions 14–17, identify whether or not the statement supports the inclusion of physicians on paramedic-based prehospital teams.

14. Performance of drug-assisted endotracheal intubation in blunt trauma patients.
    a. Supports inclusion of physician on the prehospital team.
    b. Does not require a physician on the prehospital team.

15. Ability to provide ALS interventions such as advanced airway management and ventilation management (needle decompression/chest tube insertion).
    a. Supports inclusion of a physician on the prehospital team.
    b. Does not require a physician on the prehospital team.

16. The presence of an organized trauma system providing air and ground transport.
    a. Supports inclusion of a physician on the prehospital team.
    b. Does not require a physician on the prehospital team.

17. Patients at risk of imminent death without intervention, e.g., tension pneumothorax.
    a. Supports inclusion of physician on the prehospital team.
    b. Does not require a physician on the prehospital team.

18. Which of the following was not revealed by data collected by the Scottish Trauma Audit Group (STAG)?
    a. There is no trimodal distribution of death from trauma in Scotland.
    b. Three-fourths of seriously injured patients present "out of hours."
    c. Trauma patients in urban and rural areas have similar outcomes.
    d. Socially deprived people are more likely to be injured.
    e. The outcome of trauma patients in Scotland is significantly better than in the rest of the UK.

19. The national emergency response plan for casualty management in France is based on the concept that any terrorist chemical/biologic weapons incident should be managed as far as possible according to standard HAZMAT operating procedures.
    a. True b. False

20. Most central European mountain rescue services believe emergency physicians should be trained in skills such as climbing and rope technique, enabling them to respond to mass casualty incidents in wilderness areas, because
    a. Search and rescue personal with limited medical education may not be prepared to perform the necessary task of triage.
    b. Search and rescue personnel are trained better in victim transport than in detection of critical injuries.
    c. Evacuation of seriously injured victims from the scene to a safe triage area is often time consuming and complicated.
    d. All of the above.

Evaluation Form: Please rate this self-study activity by marking one response for each statement.

Did the articles meet their stated objectives? ___Yes ___No

How do you rank the quality of this educational activity? ___5 (high) ____4 ___3 ___2 ___1 (low)
Comments: _____

Did you perceive any evidence of bias for or against any commercial products? ___Yes ___No If yes, please explain.
Comments: _____

How do you rank the effectiveness of this activity as it pertains to your practice? ___5 (high) ____4 ___3 ___2 ___1 (low)

Did this material stimulate your intellectual curiosity? ___5 (high) ____4 ___3 ___2 ___1 (low)

Additional comments about this activity: _____
_____

Answer Form: Please circle the *one* best answer for each question.

TraumaCare Winter 2003 issue

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I certify that I have completed the "TraumaCare/Winter 2003" activity as designed and claim 10 credit hours in Category 1 of the Physicians Recognition Award of the American Medical Association.

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Signature Date

Mail answer form and check ($75, members; $150, nonmembers) to ITACCS Department of CME Credit, P.O. Box 4826, Baltimore, MD 21211. Allow 4 to 6 weeks for processing.

1.	a	b	c	d	e
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20.	a	b	c	d	

Credit for this activity is offered until March 31, 2004.

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References:
1) BMJ Volume 320, 18 March 2000
2) To Err Is Human: Building a Safer Health System/Linda T. Kohn, Janet M. Corrigan, and Molla S. Donaldson, Editors., © 2000 by the National Academy of Sciences.

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