

electrocardiograph (ECG) transmission to the specialist in the ECG transmission center, and in return received an interpretation of sent data along with guidelines concerning further treatment and transportation. This would allow patients with myocardial infarction (MI) eligible for PCI to be transported directly to the catheterization laboratory. The aim of this study was to present the results of the first four months of operation of the ECG transmission system in WAS, and assess the frequency of its use and the amount of MI it covered. Furthermore this study, attended to the main issues that might have had a negative impact on the surveyed system.

Methods: Since September 2009, each attempt of transmission was described by a number of factors by the staff attending to ECG transmission center. Documentation created from September to December 2009 was subjected to a thorough analysis.

Results: From September to December 2009, there was a total of 1,650 attempts of transmission, 292 (18%) of them were unsuccessful. Of 1,358 successfully transmitted ECGs, 39 (3%) suggested a ST-Segment Elevation Myocardial Infarction (STEMI) and 149 (11%) suggested a Non-ST-Elevation Myocardial Infarction (NSTEMI). The number of attempted ECG transmission carried out by individual ambulance teams per intervention was significantly different ($p < 0.001$) and showed a relation with a place of stationing. The proportion of unsuccessful attempts was significantly different for individual ambulance teams ($p < 0.001$) and was higher for ambulance teams with lower amount of attempts ($p < 0.0001$).

Conclusions: Prehospital 12-Lead ECGs help to reduce emergency medical services-to-Balloon times. It often was used as a support in case of patients without symptoms typical for MI. Motivation and personal opinion of individual ambulance teams about the system affected frequency of its use. More frequent use of the system by ambulance teams resulted in a lower percentage of unsuccessful attempts of ECG transmission.

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(P2-12) Emergency Medical Procedures Provided by Paramedics in Prehospital Sudden Cardiac Arrest – Analysis of the Example of District Siedlce (Poland)

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Introduction: The organization of the medical emergency system in Poland has been revised substantially since 2007. Rescuers were able to perform certain life-saving procedures and to administrate some drugs without doctor's order.

Aim: The efficiency of advanced life support (ALS) performed by emergency medical service with paramedics (without doctor) was assessed for cases of cardiac arrest (CA) in prehospital conditions. It was correlated with quantity of basic life support (BLS) procedures undertaken by casual witnesses and with the knowledge of automated external defibrillation (AED) in people without medical training.

Method: Forty-eight cases of CA were analyzed, which took place in District Siedlce in the first three quarters of 2009. Data were

collected retrospectively, from medical reports. Advanced life support procedures adhering to the guidelines of the European Resuscitation Council were investigated in terms of pharmacological and electrotherapy. Additionally, the study of the knowledge of AED was conducted through a survey, in which 103 randomly selected persons without medical training took part.

Results: Adrenaline and amiodarone were given by paramedics correctly in 94% of patients. Defibrillation was performed in all patients with documented ventricular fibrillation or pulseless ventricular tachycardia valid values of energy. Cardiopulmonary resuscitation was successful in 33% of the cases. At the scene of the accident BLS was performed before the arrival of ambulance in only 7% of cases. Of the respondents, 41% (non-medical) could use the AED safely, but only 13% of them knew the guidelines for using defibrillators.

Conclusions: Paramedics were properly implementing ALS procedures for prehospital CA. The percent of effective cardiopulmonary resuscitations may improve the early implementation of BLS, including the use of AED. It is necessary to educate people without medical training in this field.

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(P2-13) Pitfalls for Upper Limb Injuries in Emergency

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Sternoclavicular dislocation usually requires a Computed Tomography (CT) scan and surgery. This injury is rare because costoclavicular ligaments are strong. They appear in motorcycle accidents and sports collisions. Compression of the neurovascular structures or trachea involving the vital prognosis is not rare. Practitioners must be aware of symptoms such as dysphagia, dyspnea, hoarseness, or neurologic disorders. On the printing of thoracic standards, the medial clavicle appears misplaced superiorly in previous dislocations and posterior inferior dislocations. Fracture of the scapula (less than 1% of all fractures) rarely requires surgery, but should not be ignored because they signal a very high-energy trauma. The posterior shoulder dislocation is 2–4% of all delayed dislocations. Diagnosis is most often attributed to inadequate x-ray photographs. The main causes of this dislocation are epilepsy and electrocution. Radiography in front and profile observed a duplication of the humeral head. Joint space is not completely in view, and the CT scan can confirm the diagnosis if there is any doubt. Fracture of the clavicle is common in young patients. Fractures with lesions of the clavicular vessels and nerves are common. Practitioners also must be wary of intermediate fragments, which can puncture skin. Pneumothorax should always be excluded by a complete chest auscultation. The stump of the shoulder must be minimized in young patients, or an active patient operative indication can have negative functional and aesthetic consequences. Neurovascular examination must be complete, and circumflex nerve damage should not be confused with injury of the rotator cuff. These two injuries reduce abduction. The elbow is complex and a number of lesions could be missed, including: (1) the tip of the coronoid process; (2) epitrochlea and epicondyle; (3) radial head fractures; or (4) pullout capitulum.

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