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.

Pitfalls for Upper Limb Injuries in Emergency

S. Abrassart, P. Hoffmeyer
Orthopédie, Geneve, Switzerland

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 diagnostic 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 stumps 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 circonflex 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) epicondyle and epicondyle; (3) radial head fractures; or (4) pullout capitellum.