

February 2013 Volume 2 Issue 1

# EMSSA

The  
Emergency  
Medicine  
Society of  
South Africa

Registration for EMSSA  
2013 is open- see  
[www.emssa2013.co.za](http://www.emssa2013.co.za) for  
more details.



**This second issue is jam packed with articles, news and special features to keep you up to date with what is happening in the world of Emergency Care in South Africa and beyond.**

Hi EMSSA Members and welcome to volume 2, issue 1 of the new EMSSA newsletter.

This has already been a very busy year for emergency care in the country.

Last year ended on a high note with the EMSSA Symposium which was held in Johannesburg at the end of November. There was an excellent turn out for all three days of the Symposium and you can see photos from the event in the newsletter on pages 8 & 9. Preparations are already far advanced for the EMSSA 4th International Opportunity and Innovation in Emergency Medicine Conference to be held at the CTICC from 5-7 November 2013. Registration has already opened and visit [www.emssa2013.co.za](http://www.emssa2013.co.za) for further information.

I would also like to ask you to please have a look at the Adopt-A-Delegate section which has been running successfully for the past 4 years. Many enthusiastic emergency care workers in South Africa and the rest of

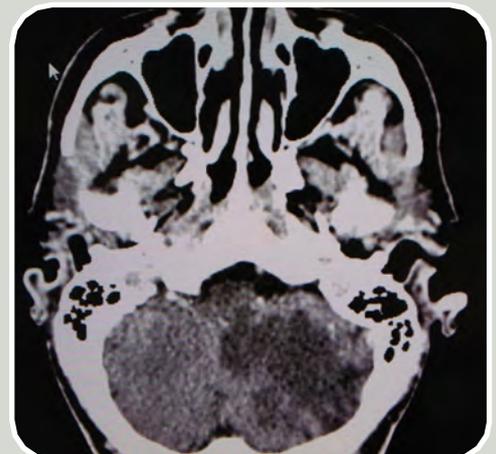
Africa are not able to attend this conference due to financial constraints. EMSSA has established an initiative where individuals or organisations can make a financial contribution to assist their fellow colleagues so that they might also be able to experience the biggest emergency care conference in Africa.

All 3 of EMSSA's new special interest subgroups are featured in this month's newsletter. Now you can read about what ARREST, Ultrasound and PECSA are all about.

It gives me great pleasure to announce that EMSSA will be hosting the 19th World Congress of Disaster and Emergency Medicine which will be held in April 2015 in Cape Town, South Africa. It is the first time that this prestigious congress is being held in Africa.

Yours in emergency care

*Dr Melanie Stander*  
President, Emergency Medicine Society  
of South Africa



# COMPETITION

We are looking for a name for the new Newsletter. If you think that you have a catchy, quirky or pertinent name then email [chair@emssa.org.za](mailto:chair@emssa.org.za) by 5 April 2013 and you could win an EMSSA goodie hamper! Please include your name, address, email, contact number and EMSSA member number in your email.

# TWITTER

EMSSA is now on twitter. Follow us @emssaorgza



## Emergency Nurses Society of South Africa



The Emergency Nurses Society of South Africa has been continuing to work on the scope of practice and competencies specific to emergency nurses and providing this information to the South African Nursing Council. This is extremely important work in the light of the developments in nursing in South Africa regarding advanced clinical nurse specialists and thanks to all the nurses who have been contributing. ENSSA meetings will be held in various parts of the country over the year and for further details please follow the ENSSA blog at <http://enssa-news.blogspot.com/> and/or follow us in Twitter @nursesenssa. At the Emergency Medicine Society of South Africa's conference in November this year, ENSSA will have dedicated emergency nurses sessions - we hope to see you all there! We also have the ENSSA awards so please nominate colleagues!

*Prof Petra Brysiewicz  
President of ENSSA*



## Clinical Pearl

### Title: Patellar Dislocations

Author: Mimi Lu

- lateral displacement is the most common
- tender with limited range of motion
- caused by sudden twisting movement, either with or without contact
- more common in females and young adolescents
- reduction by extension of the knee and medial pressure on the patella
- knee immobilizer and crutches with orthopedics or sports medicine follow up
- recurrent cases usually require surgery for definitive repair

## Paediatric Emergency Medicine

### The Emergency Centre Assessment of the Sick Child

One of the most important skills in paediatric emergency medicine is to be able to recognise the infant or child that is seriously ill or injured. Children can compensate well for respiratory and circulatory insults and mask signs of serious illness, but deteriorate rapidly when the compensatory mechanisms are exhausted. The smaller the child, the more precipitous the "crash". Every doctor who treats children should have an assessment strategy that focuses primarily on not missing any serious condition, even if a satisfactory diagnosis cannot be made at the initial presentation. This process should identify physiological abnormalities that will be present even if the pathology is not readily identifiable.

The end result is that children can be classified as “well”, “possibly seriously ill” or “seriously ill” and managed and investigated appropriately.

There are several different paediatric assessment systems in common use: the most well known are the “3 minute toolkit” approach in the United Kingdom, and the “Paediatric Assessment Triangle” (PAT) approach of the American Academy of Paediatrics / American Heart Association in the United States. Both these approaches are useful and emphasise a goal-directed history and physical examination to detect the child that is seriously ill. These methods can also be combined into a single algorithm, described below, which allows for the rapid assessment of a sick child in less than 5 minutes. An accurate assessment will allow the doctor to determine which children require immediate resuscitation, which children need further investigation and monitoring, and which children can safely be discharged home with very little danger of unexpected deterioration.

The following steps should be used for the initial assessment of every child presenting to the ED (or rooms) who might have significant illness or injury; while the steps are presented sequentially, many are accomplished simultaneously! The same approach, with minor modifications, may be used for trauma and medical presentations. It is important that if a life-threatening problem is identified at any stage of the process, the evaluation should be interrupted to initiate resuscitative treatment.

### **Brief History and General Assessment**

**(ABC):** while garnering a brief history from the child and the parents, conduct a general hands-off assessment, using the PAT.

1. **Appearance** – evaluate the general appearance of the child or infant using the TICLS (pronounced “tickles”) mnemonic: **T**one,

**Interactiveness, Consolability, Look (gaze) and Speech (or cry).**

The “red flags” to search for are:

- **Tone** – an abnormally low or floppy muscular tone.
  - **Interactiveness** – lethargy, diminished alertness or interaction. This is one of the most important clinical signs of serious illness in infants and children!
  - **Consolability** – intractable, inconsolable crying.
  - **Look (gaze)** – a fixed, unfocused gaze.
  - **Speech (cry)** – confused or slurred speech or a weak or high-pitched cry.
2. **Work of Breathing** – look for signs of respiratory distress especially tachypnoea and signs of accessory muscle use (recessions, head bobbing, grunting, tripod position); listen for abnormal sounds such as stridor or wheezing.
  3. **Colour (or Circulation to skin)** – take note of the child’s colour: pale, plethoric, mottled or cyanosed. This may be difficult in a child with dark skin.

If the general assessment, which should only take a few seconds, reveals an abnormality of the level of consciousness, an increased work of breathing or an abnormal colour, then this child should be regarded as seriously ill or possibly seriously ill. If the child appears well, proceed with the more conventional sequence of history, physical examination and necessary investigations.

→ *Interventions after the General Assessment:* begin basic life support if the child is unresponsive; commence resuscitative (primary) assessment and management in seriously ill children.



### **Website of the Month**

[www.vimeo.com](http://www.vimeo.com)

In 2004, Vimeo was founded by a group of filmmakers who wanted to share their creative work and personal moments from their lives. As time went on, likeminded people discovered Vimeo and helped build a supportive community of individuals with a wide range of passions. Today, millions of people from all around the world enjoy Vimeo, and they’re growing bigger every day.

There are some excellent short videos on Vimeo related to a wide range of emergency care topics. All you need to do is register which is free and then start searching.

The theme of the EMSSA 2013 International Conference is “Opportunity and Innovation” and this website really reflects what is possible on a global scale.

*Dr Melanie Stander*

## Primary assessment or primary survey (ABCDE):

this follows the universal Advanced Life Support Algorithm. The memory aide “3 for airway, 4 for breathing and 5 for circulation” may be used to ensure a complete assessment (courtesy of Dr W Kloeck). If a problem is detected it should be managed before proceeding with the next step of the assessment.

1. **Airway**- (3 for airway) – *is the airway threatened or obstructed by secretions, foreign body, trauma or infection? Is the airway protected and maintained?*
  - Is the airway clear?
  - Is it maintainable (self-maintained or maintained with basic airway manoeuvres including suctioning, jaw-thrust or head-tilt chin-lift positioning)?
  - Does the child need immediate intubation?

→*Interventions after the Airway assessment:* basic, advanced or surgical airway management as indicated.

2. **Breathing** – (4 for breathing) *is there respiratory distress or respiratory failure?*
  - Measure the respiratory rate (over at least 30 seconds) by observing the child's bare chest or by auscultation.
  - Evaluate the work of breathing (tachypnoea, recessions).
  - Listen to the breath sounds to establish signs of trauma (pneumothorax), upper airway obstruction (stridor), lower airway obstruction (wheeze) or lung parenchymal disease (crackles).

- Check the skin and mucous membrane colour and the oxygen saturations by pulse oximetry.

→*Interventions after the Breathing assessment:* oxygen by nasal cannula or mask to keep oxygen saturations >95%; assist ventilation if required (invasive / non-invasive ventilation); administer appropriate drugs (eg nebulised bronchodilators, intravenous corticosteroids for asthma).

3. **Circulation** – (5 for circulation) – *is there hypotensive shock, or compensated shock?*

- Check the capillary refill to assess peripheral perfusion (normal <2 seconds)
- Assess the level of consciousness.
- Measure the heart rate.
- Measure the blood pressure (do not omit this measurement!).
- Measure the urine output (not appropriate in the acute setting)

→*Interventions after the Circulation assessment:* if there is bleeding, STOP THE BLEEDING; secure intravenous or intraosseous access; administer fluid bolus (warmed Ringer's Lactate or Balso!) if appropriate. If the child has evidence of severe sepsis, commence early goal direct therapy immediately.

4. **Disability** –

- Check the blood glucose (**Don't Ever Forget Glucose**).
- Use the AVPU system to describe the level of consciousness: the child is **Alert**; responds to **Voice**; responds only to **Pain**; is **Unresponsive**.
- Examine the pupils.

→*Interventions after the Disability assessment:* give thiamine + diluted dextrose IV/IO if required; protect the airway with endotracheal intubation if the

GCS <9 (responds only to **Pain** or **Unresponsive**).

5. **Exposure and Environmental control** – ensure that the child is adequately undressed to enable a complete assessment. Check for rashes. Check the temperature (tympanic temperature or rectal temperature).

→*Interventions after Exposure and Environmental control:* prevent and / or treat hypothermia appropriately (internal / external warming); treat fever (oral or rectal paracetamol; oral ibuprofen; other agents); fully assess rashes.

**Abnormalities in vital signs can only be detected if the normal age-specific values are known. It is essential that any doctor who is involved in the emergency management of children has reference material readily available which includes normal vital signs.** If no immediately life threatening abnormalities are detected on the primary assessment, proceed with the secondary assessment.

**Secondary Assessment or secondary survey** (SAMPLE history and a top-to-toe examination): detailed history-taking is clearly not appropriate when a child is in need of resuscitation, but essential information must be obtained at some stage. When appropriate, obtain a focused SAMPLE history: **S**igns and symptoms; **A**llergies; **M**edications; **P**revious medical and surgical history; **L**ast meal and last medications (taken or omitted); **E**vents leading up to the presentation and the **E**nvironment in which they occurred.

The top-to-toe examination must be age-appropriate, comprehensive and directed towards the reason for presentation: trauma, toxin exposure or medical. For medical presentations focus on the central nervous system (CNS), ear, nose and throat (ENT), chest, and abdominal examination.



After completing the Primary and Secondary Assessments meticulously, it will be possible to discharge the “well” children with an appropriate treatment and follow-up plan (preferably written). Seriously ill children can be admitted after emergency or resuscitative treatment has been commenced and urgent investigations have been initiated. Admissions may be either to a general ward or to a monitored (intensive care) bed.

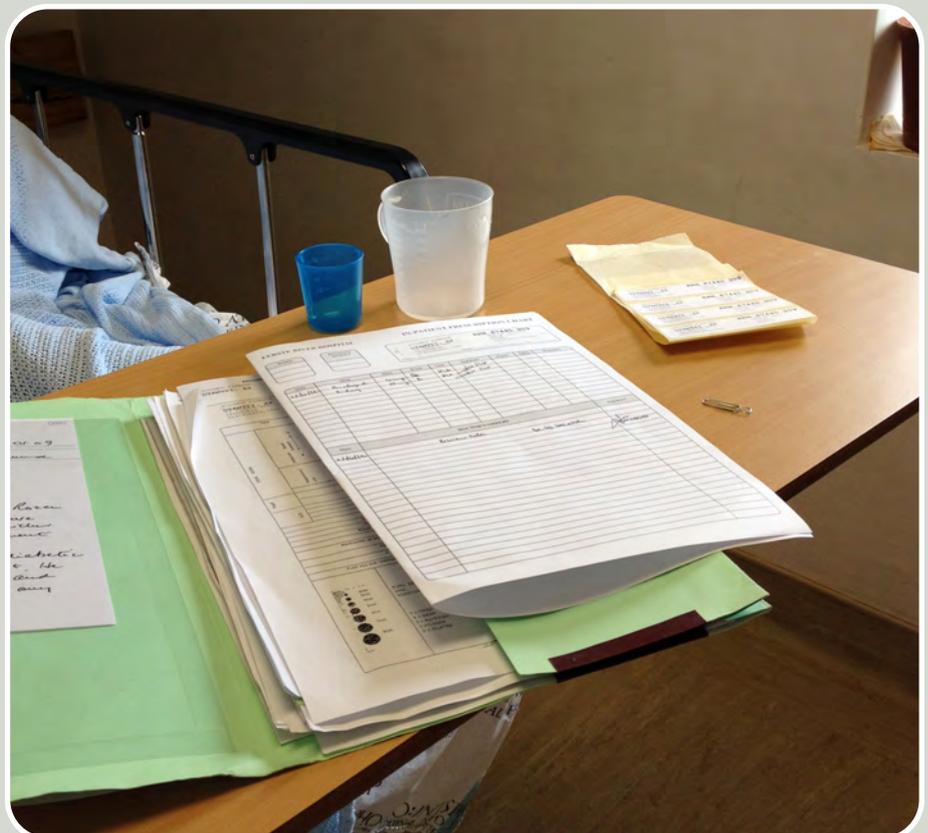


No “possibly seriously ill” infant or child should be discharged after the initial consultation; that is if there are any serious clinical findings or any significant physiological abnormalities detected. These children should either be admitted for further (and more senior) evaluation or undergo an evaluation process in the ED. This evaluation process includes initial treatment of fever or other conditions with appropriate medications, and then subsequent or serial evaluations. During this time investigations appropriate to the child’s condition can be procured and reviewed, such as a full blood count, urea

& electrolytes, c-reactive protein, urine dipstick ( $\pm$  culture) and chest radiograph. Additional opinions can be obtained on the child’s condition. The period of time spent in the ED for ongoing assessment should not be less than about 2 hours. If the physiological parameters return to normal and the child looks well, discharge with appropriate follow-up can be considered.

The elements of this system can be well shown to improve the management of paediatric emergencies by decreasing the number of children discharged inappropriately from the ED (or rooms). The system can also assist in the identification of children that can safely be discharged from the ED, with a very low risk of sudden deterioration.

*Prof Mike Wells*



## Medical Technology

### South African National E-Health Strategy

August 2012 will be remembered as a landmark month for e-health in South Africa as South Africa released its first official National E-Health Strategy for 2012 to 2017.

In the words of the National Minister of Health, Dr A Motsoaledi : “The e-health strategy for the public health sector provides the roadmap for achieving a well-functioning national health information system with the patient located at the centre.”

Whilst aimed primarily at the public sector, which has all too often borne the brunt of well-intentioned but poorly implemented e-health initiatives, the strategy is a roadmap for all sectors dealing with e-health in South Africa. By aligning software development to the strategy document, it is hoped that private enterprises can create solutions for the health sector that are cost effective and meaningful for use within the day to day care of patients and indeed adhere to the Strategy’s vision of “enabling a long and healthy life for all South Africans”.

With South Africa having a shortage of health professionals and vast geographic distances where citizens live with limited access to health care, it is hoped that the

strategy will now increase the momentum of projects and solutions aimed at improving access to care for these individuals, such as mobile health and telemedicine projects. These endeavours have proved Successful in many countries around the world and South Africa is likely to be no exception.

To download a copy of the National E-Health Strategy, please visit <http://tinyurl.com/SA-E-Health-Strategy> .

### App of the Month

WikEM (<http://www.wikem.org>) is a fantastic application that works on Android and iOS platforms.

Designed for the emergency healthcare professional, WikEM is a regularly updated source of emergency information that is categorised and fully searchable, providing you with information ranging from drug doses to environmental emergencies at the touch of a button. It functions much like a mini textbook for emergency medicine and should definitely form a part of your App Arsenal!

WikEM is available for free on *iTunes*™ and *Google Play*™. Like any open source Wiki, it has contributions from many sources so please use it as a guide and not your only source for clinical practice.

*Dr Julian Fleming*



## AfJEM and submission blues....

So there it was in my inbox: the AfJEM metrics report. It supposedly summarises how often AfJEM manuscripts have been downloaded and after putting it off for months Lee finally requested this from our journal manager at the Elsevier office. After hovering my index finger over the open button for ages, I finally decided to just open it and face the humiliation. We've given it our best shot even if it may just be my mom (and maybe Lee's) actively downloading papers and distributing it to friends, families an unsuspecting passers-by; but what a surprise! It would appear that we're actually quite popular and that thousands have gratified themselves since our launch with a download from AfJEM- clearly on track to Annals of Emergency Medicine-type adoration from the masses.

I was quite pleased actually and it took me back to my very first submissions for publication. It was three linked papers painfully extracted from a very successful masters thesis, what could go wrong? Well was I quickly demoted. One was rejected within days of submission and the others returned after what seemed like ages (21 days actually) with the simple dreaded revise and resubmit-message: Thanks for submitting, but its quite rubbish. Lucky for you everything we've received this month is rubbish so we'll give you another chance to redo. Below is some contradictory advice from our reviewers to help you improve your status from junk to sublime (well it wasn't exactly that, but that's how I understood it). I was in a state of grief. I felt anger and denial all at once. Lee emailed to say the reviews were not all that bad and that all is not lost. I considered pretending that I never submitted anything and writing to the editors to say that some unintelligent impersonator was responsible for these awful submissions.

To be quite honest, submitting ones work to be scrutinised by others is probably one of life's more humbling experiences. After spending weeks or months writing a paper, putting a lot of effort into the final draft and then finally submitting for peer review, it all becomes very personal. They may as well be rejecting the shape of your nose or the colour of your eyes. Since those first submissions (which actually

resulted in two publications), I have learned that writing for publication is more than just an art- it is a game. To play it, you first need to know the rules. Each journal gives you these rules in the form of the *instructions for authors*. Ensuring your paper conforms to these is a good start, but to succeed you'll need to do more. The rules simply state the bare minimum criteria your paper has to conform to in order to pass the first hurdle- moving on to peer review. Surely, any author serious about publishing their work will want to do more than just the bare minimum. To give your paper the edge you will need to go beyond the rules. I'm talking about aligning yourself with a skilled writing partner, attending writing workshops, studying papers previously published in the journal you are aiming to publish in and being prepared to fail a few times before succeeding. The blade runner, Oscar Pistorius, did not start his running career winning races and neither are you likely to. I recommend looking at the latest formats and styles for writing up research. The most current reference for these can be found on the Equator Network's website (<http://www.equator-network.org/resource-centre/library-of-health-research-reporting/>). It contains criteria for submitting any type of paper you can think of as handy checklists. I rarely write for publication without one of these checklists.

You can find AfJEM's instructions for authors on our website (<http://www.afjem.com>). I have previously written in this column about Author assist and the co-authorship projects. The Hinari authorship modules are a free resource and there is a link from our website as well. AfJEM is in the process of reviewing and improving our instructions for authors to make it clearer and even more user friendly. Turning your research into a publishable paper will be a lot less painful if you follow this simple advice and I for one can't wait for you to submit to AfJEM.

Writers wishes!

*Dr Stevan Bruijns*

Stevan Bruijns is one half of the editor in chief for the African Journal of Emergency Medicine



**What's On** *Dr Melanie Stander*

### Courses and events:

#### KZN Trauma and Emergency Consortium Updates:

- **9 February 2013** - thanks to all the speakers and those who attended for such a successful day!
  - **8 June 2013** - Port Shepstone
  - **26 October 2013** - Dundee
- Contact: [brysiewicz@ukzn.ac.za](mailto:brysiewicz@ukzn.ac.za)

### Upcoming Conferences:

2nd Global Network Conference on Emergency Medicine, Dubai, UAE, 2-6 May 2013.  
[www.emergencymedicineme.com](http://www.emergencymedicineme.com)

Society for Academic Emergency Medicine Annual Meeting, Atlanta, USA, 14-18 May 2013.  
[www.saem.org/annual-meeting](http://www.saem.org/annual-meeting)

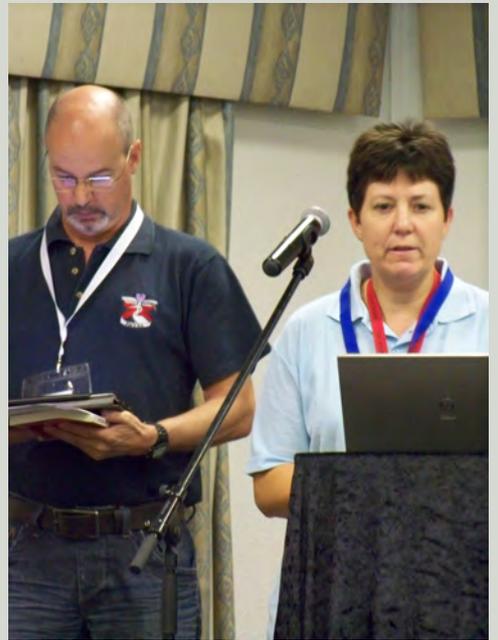
18th World Congress on Disaster and Emergency Medicine, Manchester, UK, 28-31 May 2013.  
[www.wcdem2013.org](http://www.wcdem2013.org)

11th Congress of the World Federation of Societies of Intensive and Critical Care Medicine, Durban, South Africa, 28 August-1 September 2013.  
[www.criticalcare2013.com](http://www.criticalcare2013.com)

11th International Conference for Emergency Nurses, Melbourne, Australia, 9-12 October 2013.  
[www.cdesign.com.au/icen2013/](http://www.cdesign.com.au/icen2013/)



# EMSSA SYMPOSIUM 2012





**See you all at the next EMSSA Symposium in 2014 in Durban!**

## ARREST COLLABORATION

*Advocacy for Resuscitation Research  
Education Science & Training  
Collaboration*

EMSSA is delighted to announce the launch of a collaborative science and education advisory, and a platform for research and advocacy, the EMSSA ARREST Collaboration. This subgroup is committed towards improving and developing emergency care in South Africa, and endeavours to support and advocate the activities of EMSSA.

The intent of this initiative is to establish a neutral, transparent and inclusive South African resuscitation collaborative group, that seeks to include all stakeholders, *inter alia* training organisations, academic and clinical institutions (private and government), and commercial role-players. This platform would seek to advance and encourage research, education and training, development, lobbying and advocacy around resuscitation matters in South Africa. This idea has been in development for some time and we are thrilled to now initiate this multidisciplinary EMSSA sub-group which aims to collaborate with like-minded organisations to ultimately increase awareness around evidence-based best-practice in resuscitation. By synergising our advocacy efforts, and working together under the same collaborative umbrella body, we will concentrate our labours and grow into a credible and effective organisation with more potential than other groups to lobby effectively for development and change in resuscitation issues. The ultimate goal as we combine our efforts is to make a concerted difference to broad resuscitation outcomes in our region.



### OBJECTIVES

The objectives of the EMSSA **ARREST Collaboration** are:

Under the aegis of EMSSA,

1. To promote and improve emergency care through teaching, research and education
2. To advocate for emergency care in South Africa
3. To generate funding for the accomplishment of the above
4. To create an inclusive, broadly representative multidisciplinary forum of South African resuscitation experts and role-players, including academic and healthcare establishments, and commercial role-players who influence resuscitation in some way or another
5. To actively support local research into resuscitation
6. To lobby on behalf of members of the EMSSA and the ARREST Collaboration for the promotion of and maintenance of resuscitation standards and guidelines
7. To work in collaboration with other organisations to proactively encourage and support teaching, research and education of emergency care, regardless of location or

research and education of emergency care, regardless of location or affiliation, to the benefit of emergency resuscitation in South Africa

8. To create an accreditation registry database for resuscitation resources in South Africa
9. To publish formal position statements in regard to resuscitation matters
10. To present regular CPD sessions countrywide on resuscitation topics
11. To be regarded as an expert resource for opinion on resuscitation matters
12. To endorse and encourage the development of locally relevant, nationally standardised, comprehensive evidence-based South African resuscitation guidelines, via an inclusive group of reviewers, researchers and experts
13. To endorse and be regarded as the custodian of minimum and best-practice standards for resuscitation practice in SA
14. To lobby government / regulatory bodies and to assist via strong advocacy campaigns, to propose and implement mandatory, legislated best-practises in resuscitation, in both the public and private environments

15. To contribute to standardised evidence-based guideline development

16. To liaise with international resuscitation organisations on matters of research, training and development.

## MEMBERSHIP

All health care professionals with active involvement in emergency care and resuscitation are eligible for membership of the EMSSA **ARREST Collaboration** upon completion of a membership form and payment of the required annual membership fee. Prospective members must first join EMSSA to be eligible for subgroup membership.

Membership categories:

### ➤ FULL MEMBER

Any person involved in education, research and / or patient care in the field of emergency medical care can become a full member of the EMSSA **ARREST Collaboration**. Full members pay membership fees, have voting rights and can stand for office.

### ➤ AFFILIATE MEMBER:

Any person with an interest in emergency medicine can become an affiliate member of the EMSSA **ARREST Collaboration**. Affiliate members pay a reduced membership fee, have no voting rights, and cannot hold office.

### ➤ INSTITUTIONAL MEMBER:

Any like-minded organisation, institution or corporate entity who espouses the aims and objectives of the EMSSA **ARREST Collaboration** can become an institutional member.

In the interests of legitimacy, academic credibility, transparency and capacity, the

**ARREST Collaboration** – as a subgroup of EMSSA, will be managed by appointees from the EMSSA management committee, and *ex officio* representatives from the major professional societies and institutions, including AFEM, College of Medicine of SA (representing all the academic HODs of relevant medical schools), EMSSA, ENSSA, ECSSA, CCSSA, and TSSA. Members may also be co-opted onto the management committee. This will guarantee a sustainable, multidisciplinary inclusive association, creating a broad platform for all role-players.

## ACTIVITY

The activities of the **ARREST Collaboration** will revolve around various discipline-specific Task Forces. These working groups, akin to organisations around the world, will drive research, position statements, and advocacy initiatives, by encouraging collaboration and input from all stakeholders. The **ARREST Collaboration** will arrange regular symposia and an annual conference, to showcase and communicate the Task Force efforts in terms of local and international resuscitation science, education and advocacy initiatives. With such a wealth of resuscitation expertise and experience in our country, it seems ludicrous that we have not properly consulted and harnessed this energy and potential previously. Resuscitation is practised every day in South Africa, and via this collaboration, we intend to promote and advocate for best practise and contribute to new knowledge. We hope to ultimately improve clinical care.

## Logo

The phoenix has been adopted as the logo for this newly launched EMSSA subgroup. The ancient myth of the Phoenix speaks to the themes of renewal and rebirth; the flying flames of the phoenix are a metaphor for the Sun, the spark of life, something essential for existence, which dies at night and is reborn in morning. Early Christian tradition adopted the phoenix as a symbol of both immortality & resurrection.

As the legend goes, the phoenix is able to reproduce itself. It lives on frankincense and odoriferous gums and when it has lived 500 years, it builds itself a nest in the branches of an oak, or atop a palm tree, and here collects cinnamon, spikenard and myrrh, and of with these builds a pile on which it lies to die, breathing out its last breath amidst these odours. From the body of the parent bird, a young phoenix rises.

Thus, according to legend, the phoenix consumed itself by fire every 500 years, and a new, young phoenix sprang from its ashes. That is a fitting metaphor for resuscitation – it's about reanimation and renewal. The ARREST Collaboration espouses advocacy, research and education in resuscitation, thus to offer a chance of new life. That is both an awesome responsibility and indeed a privilege. The EMSSA ARREST Collaboration has been borne. Join us if you share this vision and want to contribute.

*Mr Martin Botha, Prof Roger Dickerson &*

*Prof Mike Wells*

[martin.botha@internationalsos.com](mailto:martin.botha@internationalsos.com)

On behalf of the ARREST Collaboration  
Steering Committee

# November

# EMSSA 2013



# EMSSA 2013

incorporating  **AEROMED Africa**  
HEALTHCARE • ACCESS • SOLUTIONS

The Emergency Medicine Society of South Africa's

4<sup>th</sup> International Conference  
**Opportunity and Innovation in  
Emergency Medicine**

5- 7<sup>th</sup> November 2013  
Cape Town, South Africa

Conference to include:  
Pre-conference workshops, 3<sup>rd</sup> – 4<sup>th</sup> Nov & the  
2<sup>nd</sup> Consensus day on Emergency Care in Africa, 8<sup>th</sup> Nov

For more information  
[www.emssa2013.co.za](http://www.emssa2013.co.za)

**Registration now open**

**Abstract submission deadline: 5<sup>th</sup> August**

**For information on Adopt a Delegate**  
<http://www.emssa2013.co.za/adopt-a-delegate.html>

Sponsored by:



## WORLD CLASS TALKS

EMSSA 2013 will be show casing the best South African, African and International emergency medicine speakers. Don't miss out!

## PRECONFERENCE WORKSHOPS

Visit [emssa2013.co.za](http://emssa2013.co.za) to see what preconference workshops will be offered and how to register for them.

## ADOPT A DELEGATE

Help someone attend the conference who desperately wants to but doesn't have the funds to come. Sign up for the Adopt A Delegate programme.

## Emergency Ultrasound Society of South Africa

The Emergency Medicine Society of South Africa is proud to announce the formation of a special interest group in Emergency Ultrasound. This subgroup, which will be called the Emergency Ultrasound Society of South Africa, has been developed as a result of the importance of Emergency Ultrasound in emergency medicine practice. Across the world organisations such as the American College of Emergency Physicians, the Society for Academic Emergency Medicine and the International Federation for Emergency Medicine have similarly developed subgroups in Emergency Ultrasound. In the last five years, more and more ultrasound techniques have come to be regarded as core competencies in Emergency Medicine rather than the exclusive domain of the ultrasound fellow. This subgroup was developed in order to achieve in order to promote, develop and facilitate training and credentialing in Emergency Ultrasound.

### Purpose

The Emergency Ultrasound Society of South Africa will be responsible for the following functions *inter alia*:

- advancing the practice and training of Emergency Ultrasound at both beginner and advanced levels in Southern Africa
- setting standards and practice guidelines for the use of Emergency Ultrasound by Emergency Physicians and non-specialist Emergency Medicine practitioners
- defining the structure and content of training and teaching in Emergency Ultrasound at advanced levels
- training and credentialing of ultrasound course directors, ultrasound trainers and ultrasound courses
- credentialing of Emergency Ultrasound practitioners at basic and advanced levels

- establishing training and credentialing days (similar to the “finishing courses” in the UK) to increase the number of candidates achieving accreditation
- setting standards for pricing of ultrasound training courses
- to provide a vehicle through the website for training and examining candidates in Emergency Ultrasound
- to coordinate training on a national and international level
- to interact with international organisations on matters of training, practice and credentialing
- to interact with the College of Emergency Medicine of South Africa with regards to training and credentialing of registrars in Emergency Medicine as well as the development of diplomas, higher diplomas and fellowships in Emergency Ultrasound
- establishing and encouraging research in Emergency Ultrasound and Emergency Echocardiography

### Structure

The Emergency Ultrasound Society of South Africa will accept members from all disciplines who practice emergency or critical care ultrasound. Prospective members will need to be members of EMSSA in good standing and will be required to pay an additional fee to join the subgroup. The Society has a constitution that is consistent with that of EMSSA. The executive committee of the Society will have representation from each university that conducts training in Emergency Ultrasound. This committee will be nominated and voted on a biennial basis in the same manner as the committee of EMSSA is selected, by members of the Society. This committee would comprise at least six members, a president, vice president, training coordinator, treasurer and secretary.

### Credentialing

The Society will oversee all aspects of credentialing at all levels of Emergency Ultrasound. The Society will adopt credentialing criteria according to internationally established guidelines. These may change from time to time according to best practice. The Society will also coordinate with practitioners in other disciplines to establish common areas of interest, training and credentialing. The Society will also motivate to the College of Emergency Medicine to establish a postgraduate diploma in Emergency Ultrasound.

### Summary

The practice of Emergency Ultrasound and emergency echocardiography is rapidly developing and advancing across the world. South Africa has been, and continues to be, at the forefront of these developments across the world, at least in an academic setting. The Society will strive to maintain the academic excellence in ultrasound in emergency medicine as well as promote the use of Emergency Ultrasound at all levels of Emergency Departments in South Africa.

Prof Mike Wells

[mike@casualty.co.za](mailto:mike@casualty.co.za)

On behalf of the Ultrasound Steering Committee





## Paediatric Emergency Care South Africa

Children form a substantial proportion of EC visits worldwide. In the UK approximately 3.5 million children attend EC's each year and they account for 25-30% of all EC visits [1]. Precise figures for EC visits by children in Africa are not available – but one study in the Western Cape, South Africa found that 31.8% of EC attendances were paediatric patients [2].

Despite the high proportion of attendance by paediatric patients there is evidence that many EC's are under-prepared for handling paediatric emergencies. Only 6% of EC's in the United States (US) have all the equipment and supplies recommended for paediatric emergencies [3]. And in the UK 28% of acute hospital trusts were rated as “weak” for children's emergency services [4]. Specific data are lacking but it is reasonable to that emergency services for children in Africa are significantly poorer than in the developed world, given the lower staffing ratios, lack of skills and resources and higher acuity of patients.

Ill children present a host of challenges to the emergency practitioner – whether they are pre-hospital personnel, nursing staff or emergency physicians. To mention just a few of the problems: the spectrum of diseases is markedly different from adults; the history is often obtainable only from carers; examination is complicated by lack of co-operation; vital signs are tricky to measure and normal values change with age; equipment needs to be adapted to the size of the child and drug doses must be calculated by weight. Furthermore the skills required to perform even simple procedures such as phlebotomy, intravenous cannulation and intubation can only be mastered with experience and specific training.

A proposal has been put forward for Paediatric Emergency Care South Africa (PECSA) to be formed with-in EMSSA. PECSA would focus on all aspect of emergency care of children in the African setting. Key areas would include advising on appropriate equipment, resources and training to deal with paediatric emergencies in low resource countries. The development and dissemination of best-practice guidelines, appropriate for children's emergency care in resource-constrained settings, would be another important function.

Encouraging child-friendly environments and practices such as early pain assessment and management and avoidance of unnecessary investigations and procedures are important for the comfort and well-being of sick children and their families. Yet these are very neglected aspects of emergency care in the developing world. PECSA could do much in terms of advocacy for such concepts and ideals to be instilled in the emerging EC's of SA and Africa.

The Millennium Development Goal (MDG) no.4 aims for a two-thirds reduction in under-five mortality (UFM) rates from 1990 to 2015 [5]. The final time-point for evaluation of achievement of this goal is very close and whilst globally UFM has fallen from 12.5 million in 1990 to 7.2million in 2011 sadly SA and much of Sub-Saharan Africa is far off track [6]. The UFM rate in SA is 50.7/1000 live births which represents only a 0.8% annual rate of decline from 1990 to 2011 this compares with a 2.2% decline worldwide in the same period. It is estimated that SA, along with the majority of Sub-Saharan African countries, will only achieve MDG 4 sometime after 2040 [6].

PECSA would be fully committed to helping decrease child mortality and morbidity, in Africa and the developing world, through improved practices and care on the frontline.

*Dr Baljit Cheema*  
[baljit21@gmail.com](mailto:baljit21@gmail.com)

On behalf of the PECSA Steering Committee

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