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BOOK OF ABSTRACTS

submission were urgently attempted by endoscopy using an Olympos, Evis Exera II-CV-180 endoscopy.

Results: A number of 235 patient was evaluated. Of these, 156 (66.1%) were male, 80 (33.9) were female. The average age of all the patients were 62.5 ± 19.3 . 110 patients who were diagnosed an ulcer by endoscopic examination were classified by Forrest Classification. Of the patients, 4 (1.7 %) were class 1A, 28 (11.9 %) were class 1B, 22 (9.3 %) class 2A, 10 (4.2 %) were class 2B, 9 (3.8 %) class 2C and 37 (15.7%) were class 3. Eight (3.4 %) of the patients were undergone surgery while 65 (27.5 %) were sclerotherapied when eosophagogastroduodenoscopy was being made. Three (1.3 %) of the patients were treated by surgery after sclerotherapeutic attemp failed since sclerotherapy could not succeed to put an end to haemorrhage. By monitoring 191 patients (80.9 %) a need for eritrocite suspension transfusion appeared and an average of 5.3 ± 3.8 (1-30) unit eritrocite were transfused. Mean value of hospitalization period for the patients were 7.8 ± 5.5 days. 214 (90.7 %) of the patients were dismissed while 22 (9.3 %) were died.

Mean values for haemoglobin and calcium records were 9.6 ± 2.9 g/d L and 8.3 ± 0.7 , respectively. An evaluation based on correlation between calcium levels and other variables; a positive correlation between calcium levels and figures for haemoglobin was found ($r=0.39$, $p<0.001$).

However, calcium levels, amount of eritrocite suspension transfused and period for hospitalization were correlated negatively ($r=-0.33$ ve -0.23 , respectively. For both: $p<0.001$). On the other hand, the groups that made up the patients who died and those who survived were also compared; the group dead were detected to have less calcium levels by comparison with the group alive ($p=0.038$). Additionally, eritrocite suspension requirement was detected to be statistically higher than the other group (($p=0.035$)).

By Forrest Classification, no significant differences were found between the patient groups in terms of the criteria: Ca levels, haemoglobin values, period for hospitalization and need for eritrocite suspension.

Conclusion: Ca levels in died group were significantly lesser than in alive group although no direct correlation between serum Ca levels and gastrointestinal hemorrhage frequency is evidenced. Furthermore, a negativ correlation between Ca levels and amount of eritrocite suspension or hospitalization period makes us to consider that serum Ca levels should be screened closely and if necessary it should be added.. Future work should focus on randomised clinical studies on this issue.

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Clinical Decision Guides and Rules

RE-ATTENDERS - RECOGNISE THE RISK

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Key-words: Re-attenders ; recognise ; risk

An audit was performed in the Emergency Department(ED) of a district general hospital in the UK, on all patients who re-attended within two weeks of their initial presentation. The data was collected over eighteen months (12/10/09-21/04/2011). The number of patients who re-attended was 4483.

We looked at these patients as we felt they represented a particularly high risk group who needed extra caution when managed. This data was collected prior to the College of Emergency Medicine and UK Department of Health decision to

monitor unplanned re-attendance as one of its Clinical Quality Indicators (CQI). They chose to monitor re-attendance as the evidence base both nationally and internationally suggests this indicator is a very useful surrogate marker of the quality of care that an ED delivers.

The CQI target is for the re-attendance rate to be between one and five percent (within seven days). Our rate was 4.4%. Deeper analysis showed one third of those returning were admitted, compared to 22% of primary attenders. This suggests that the re-attendance group have a higher morbidity. We also recognised that this is an important group of patients with regards safety, governance and risk management. We feel that a robust procedure should be in place within the ED to safeguard this particular group and decrease further risk.

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IS MODIFIED EARLY WARNING SCORE(MEWS) VALUABLE FOR DETERMINING CRITICAL PATIENTS WITH MALIGNANCY IN EMERGENCY DEPARTMENTS?

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Key-words: modified early warning score(MEWS) ; malignancy ; emergency department

Objective The modified Early Warning Score (MEWS) is a triage instrument that promises to predict patient disposition and clinical outcome in emergency departments (EDs). In this study we evaluated the predictive value of MEWS in patients with hematological or oncological malignancies.

Methods: Five-hundred and one patients with hematological or oncological malignancy admitted to ED of Uludag University Hospital were included in this prospective study. The MEWS was recorded in all patients on admission. All patients were followed up for 30 days to detect mortality rates.

Results: Mean MEWS value for all patients was 3.05. Mean MEWS for surviving and dead patients were 1.66 and 6.67, respectively and the difference was statistically significant ($p<0.001$). Besides MEWS value of "2" was detected to be significant with ROC analysis for these group of patients rather than "4" for validated value for general population.

Conclusion: We suggest that MEWS should be used routinely in ED for patients with malignancy and the patients with $MEWS \geq 2$ have to be estimated as critical.

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Clinical Policy

IDENTIFICATION OF NSAID USERS AT RISK FOR GASTROINTESTINAL COMPLICATIONS A SYSTEMATIC REVIEW OF CURRENT GUIDELINES AND CONSENSUS AGREEMENTS

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