



Patient Priority: High or Low? EMS Case Studies

by Julie Aberger

EMT Objectives

After reading this article, the EMT will be able to:

- identify differing signs and symptoms of heart attack in women;
- identify high priority trauma patients based upon the CDC Guidelines for Field Triage of Injured Patients
- discuss important considerations when managing elderly trauma patients;
- list possible causes of abdominal pain;
- identify signs & symptoms of shock in children & infants;
- understand the importance of tetanus immunization for patients with animal bites
- understand the importance of identifying critical conditions during the primary assessment and initiating immediate transport.

Introduction

As most experienced EMTs know, no two calls are alike. “Difficulty breathing” can take many shapes depending upon the time, the location, and, of course, the patient. In EMS, our most important job is to recognize the high priority patient with life threatening conditions and immediately intervene at the most basic level – Airway, Breathing and Circulation. It is also our duty to transport these patients as quickly, but as safely as possible.

In this article, we will focus on different EMS case studies with patients whose chief complaints may not be

readily apparent. Determining what to do with these patients will test your assessment ability as an EMT. To help you, *Figure 1* contains normal vital signs for adults, children and infants. While sufficient patient information is provided, it may not be everything you want to know – just like a real call.

As you read, identify what actions you, the EMT, need to take. Throughout the scenarios, questions will be posed. Before you continue reading, see if you can answer them, to yourself or with your crew members. Be honest: Do you really know what to do?

After you read the case study, determine patient priority – **high** or **low**? High priority patients must be quickly assessed, managed and given immediate transport to the appropri-

ate medical facility. ALS, the paramedics, should be dispatched. For low priority patients, however, time is not as critical and ALS is not indicated. And although you are not trained to diagnose, try taking a “provisional guess” of each patient’s condition. The five scenarios will be followed by a discussion of each case and its result.

“In Perfect Health”

● **Case Study #1:** 55-year old (y/o) female, sitting upright in kitchen chair. Chief Complaint (CC): shortness of breath, upper left quadrant abdominal pain, extreme fatigue.



Figure 1:

Normal Vital Signs for Adults & Children of Various Age Groups		
Age Group	Respiratory Rate	Heart Rate
Infant	30-60 BPM	100-160
Toddler	24-40 BPM	90-150
Preschooler	22-34 BPM	80-140
School Age	18-30 BPM	70-120
Adolescent	12-16 BPM	60-100
Adult	12-20 BPM	60-100
Age Group	Systolic Blood Pressure	Diastolic Blood Pressure
Infant	>60 mm Hg	2/3 of Systolic
Toddler	>70 mm Hg	2/3 of Systolic
Preschooler	>75 mm Hg	2/3 of Systolic
School Age	>80 mm Hg	2/3 of Systolic
Adolescent	>90 mm Hg	2/3 of Systolic
Adult - Male	100 + age in years (to 40)	60-90 mm Hg
Adult - Female	90 + age in years (to 40)	60-90 mm Hg

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Husband states spouse is "an active woman in perfect health," until this morning.

Vital Signs: Patient alert & oriented; BP 160/86; heart rate 100 regular (R); respiratory rate 30; lung sounds clear; skin, cool/dry/pale. Past medical history and medicines: none. Allergies: none.

What is your first course of action? 15 liters per minute (lpm) oxygen via nonrebreather. Position of comfort: seated upright.

What other information do you require?

When did the symptoms begin and what was she doing? She was making her bed around 8 a.m. when the symptoms suddenly began.

Is the pain relieved by change of position? No.

What was her last oral intake? Did anyone else in the family eat the same thing with any bad result? Patient and spouse ate breakfast of grape nuts, toast, juice and coffee. Husband has no complaint.

What does the pain feel like? Is it crampy, severe or constant? Constant and severe.

On a scale from one-10, 10 being the worst pain she's ever had, how does she rate the abdominal pain? Nine.

Is she nauseous, vomiting or does she have diarrhea? Slight nausea; no vomiting/diarrhea.

Does the pain radiate anywhere? Is there guarding? Pain localized to upper left quadrant. Guarding (voluntary or involuntary contraction of the abdominal muscles in response to severe pain) is not present.

Has she taken any over-the-counter medication or perhaps ingested alcohol or drugs? Denied by husband.

What do you think? Is this a high or low priority patient?

Moderate Damage

● **Case Study #2:** 65 y/o male, conscious and oriented, sitting in driver's seat in car involved in a head-on motor vehicle crash (MVC). The windshield of his old model car is



cracked and the steering wheel is slightly bent. The front end is moderately impacted. CC: minor laceration on forehead; right upper chest tenderness, slight redness; patient guards area with his hand.

What is your first course of action? Manual immobilization of the head, subsequent cervical collar. 15 lpm oxygen via nonrebreather. Laceration dressed and bandaged. Bleeding stopped. Patient will be log rolled onto a long spine board and moved to the stretcher.

Vital Signs: Patient alert & oriented; BP 110/70; heart rate 120 R; respiratory rate 24; lung sounds clear; skin, warm/dry/pale; pupils equal & reactive to light (PERL). Patient speaking in 4-6 word sentences. Past medical history: hypertension. Medicines: Inderal®. Allergies: morphine.

What other information do you require?

Was the patient wearing his seat belt and did an airbag deploy? Old model car contains no airbag. Patient states he wore lap belt.

Does he have pulses/movement/sensation in all extremities and are his grips equal? Normal on all counts.

Does he remember the accident and did he lose consciousness at any time? Patient states he was driving 50 mph when car in front stopped suddenly and he rear-ended it. Denies loss of consciousness.

What do you think? Is this a high or low priority patient?

Belly Pain

● **Case Study #3:** 60 y/o male, lying curled-up on bed. CC: sudden onset extreme abdominal pain, vomiting and diarrhea.

Vital Signs: Patient alert & oriented, but in extreme pain; BP 100/70; heart rate 126 irregular (I); respiratory rate 24; lung sounds clear; skin, cold/wet/clammy; PERL. Past medical history: atrial fibrillation. Medicines: Coumadin®, Lanoxin®. Allergies: Quinidine.

What is your first course of action? Oxygen via nonrebreather mask, 15 lpm. Patient position: right



lateral recumbent, feet elevated slightly.

What other information do you require?

What was his last oral intake? Did anyone else in the family eat the same meal with any bad result? Husband and wife ate the same lunch they eat everyday. Wife has no complaint at this time.

What does the pain feel like? Is it crampy or constant? Constant and severe.

Where exactly is the pain? It originated between the xiphoid and the umbilicus (navel), but now encompasses entire abdomen.

Does it radiate? No.

On a scale from one-10, 10 being the worst pain he's ever had, how does he rate this pain? Eleven!

Are his bowel and bladder output normal? Patient reports diarrhea containing bright red blood one hour prior to EMS arrival.

Are you going to palpate this patient's abdomen for tenderness? No, his pain is agonizing; he won't let you touch his belly.

What do you think: Is this a high or low priority patient?

Child Struck

● Case Study

#4: Five-year old male weighing approximately 50 lbs. struck by car while running after a ball, lying supine on pavement. No family on scene.

Vital signs: Patient responds when asked his name and age. CC: "I want my mommy." Denies pain anywhere. BP 90 systolic by palpation; heart rate 130 R; respiratory rate 28; skin, cold/wet/ashen. Past medical history/medicines/allergies: unknown.

What is your first course of action? Manual immobilization of the head, subsequent cervical collar. 100% oxygen via pediatric nonrebreather. Check for obvious bleeding. Patient will be log rolled onto a long spine board and moved to the stretcher.

What other information do you require?

What do I see when I cut off his clothing

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and do a rapid trauma assessment? Head and neck show no sign of deformity or bleeding. Chest rise and fall normal. Lungs clear. PERL. Abdomen rigid; increasing discoloration around the umbilicus. Extremities intact; no deformity/abrasions/puncture-penetrations/burns/tenderness/laceration/swelling noted.

How long is his capillary refill? Four seconds.

Does the child have a medical bracelet or necklace? No.

What do you think: Is this child a high or low priority patient?

Bark Worse than Bite?

• Case Study

#5: 74-year old female found at home sitting in chair, crying. CC: multiple dog bites on both hands and lower legs. Pet poodle attacked without provocation as patient was walking across the room, biting her lower legs. Patient able to carry dog into garage, but in addition, sustains multiple bites to both hands. The patient refuses medical treatment and does not wish to go to the hospital.

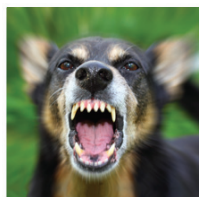
Vital Signs: Patient conscious and oriented; agitated. Multiple puncture (teeth) marks in both hands and lower legs. Minimal bleeding from punctures; no other obvious bleeds. BP 160/90; heart rate 90R; respiratory rate 16; skin, warm/dry/ pale. Past medical history: non-insulin dependent diabetes; hypertension; depression. Medicines: Lozol®, Paxil®, Atenolol, Diabinese®. Allergies: Sulfa.

What is your subsequent course of action? Check all extremities for pulses, sensation and movement. Inspect and bandage wounds. Immobilize the extremities if needed. Put the patient at ease.

What other information do you require?

When has the patient had her last tetanus shot? Fifteen years ago.

What do you think: Is this a high or low priority patient?



Case Study Review #1

Your 55-year old female patient is having a myocardial infarction, or heart attack. She is a high priority patient.

How can that be? She doesn't exhibit all the classic signs and symptoms of heart attack: No crushing chest pain, radiation to the left arm and hand, no cold, clammy skin. Slight nausea, but no vomiting.

Women often have subtle signs and symptoms when having a heart attack. Indeed, delays in diagnosis and treatment can sometimes occur because their symptoms differ from those of men. These delays can have deadly consequences. Although men have a greater risk of heart attack than women, *more women than men die of heart disease each year, and women are more likely to die within one year of heart attack than men.* This may be because women are less likely than men to receive appropriate treatment after a heart attack.

Men more often have the classic 'Hollywood' heart attacks where they clutch their chests, fall down and die. Women frequently don't.

Because of these vague heart attack symptoms, physicians often misdiagnose women's heart attacks as the flu, acid reflux, or anxiety. In some cases, the doctor may think the woman is too young or too healthy to be having a cardiac event. Likewise, women don't take their symptoms seriously enough and wait to go the emergency room. Most put the needs of their families first and their own health needs last.

EMTs should remember that gender often makes a difference in the way in which the patient presents. Men more often have the classic "Hollywood" heart attacks where they clutch their chests, fall down and die. Women frequently don't. Some women only experience symptoms like stomach or jaw discomfort, upper back pressure, dizziness, fatigue, or

nausea and vomiting.

EMTs should also remember that heart attack signs and symptoms differ for diabetics and the elderly. The elderly often have "silent" heart attacks and may present with vague symptoms such as confusion, syncope, dyspnea, neck pain, dental pain, epigastric pain, and fatigue. Diabetics may also present similarly with symptoms such as fatigue, shortness-of-breath, general malaise or history of syncope. Be alert to these differences!

Your 55-year old female patient needs ALS and immediate transport.

Case Study Review #2

Your 65 year-old male has been in a minor MVC and has no apparent critical injuries. He is conscious and oriented, but his vital signs are marginal: Respiratory rate of 22 breaths per minute, heart rate of 120 beats per minute and a systolic blood pressure of 110. You are also concerned that his right upper chest is tender and slightly red and the patient is guarding the area with his hand.

And then, he is 65-years old, considered "the young old."

As we age, our organ systems undergo changes that alter our ability to withstand illness and injury. Although sixty-five years old is not classified as "elderly," this man is considered a geriatric patient. The elderly are most likely to have cervical spine injuries even with minor MVCs and falls. Therefore, spinal immobilization – immediate manual immobilization of the head and neck and a cervical collar – is a high priority.

Note: BLS use of long boards as "splints" for transporting trauma patients is now in dispute. There is no scientific evidence to support that use, but there is evidence that their use causes pain, discomfort and even decubitus ulcers! In some EMS systems in New Jersey it is now recommended the long board be used primarily as an extrication device, to move the patient (with c-collar) from the site of injury to the comfortable stretcher. *But statewide we're not there yet; check your squad's medical director for specific spinal immobilization protocols.*

Old people withstand trauma poorly

compared to younger persons. The compensatory mechanism to withstand shock is often missing. The body lacks the ability to increase the heart rate, constrict the blood vessels and increase the blood pressure, and/or increase and deepen respirations.

An older person's body lacks the ability to increase heart rate, constrict the blood vessels and increase the blood pressure, and/or increase and deepen respirations.

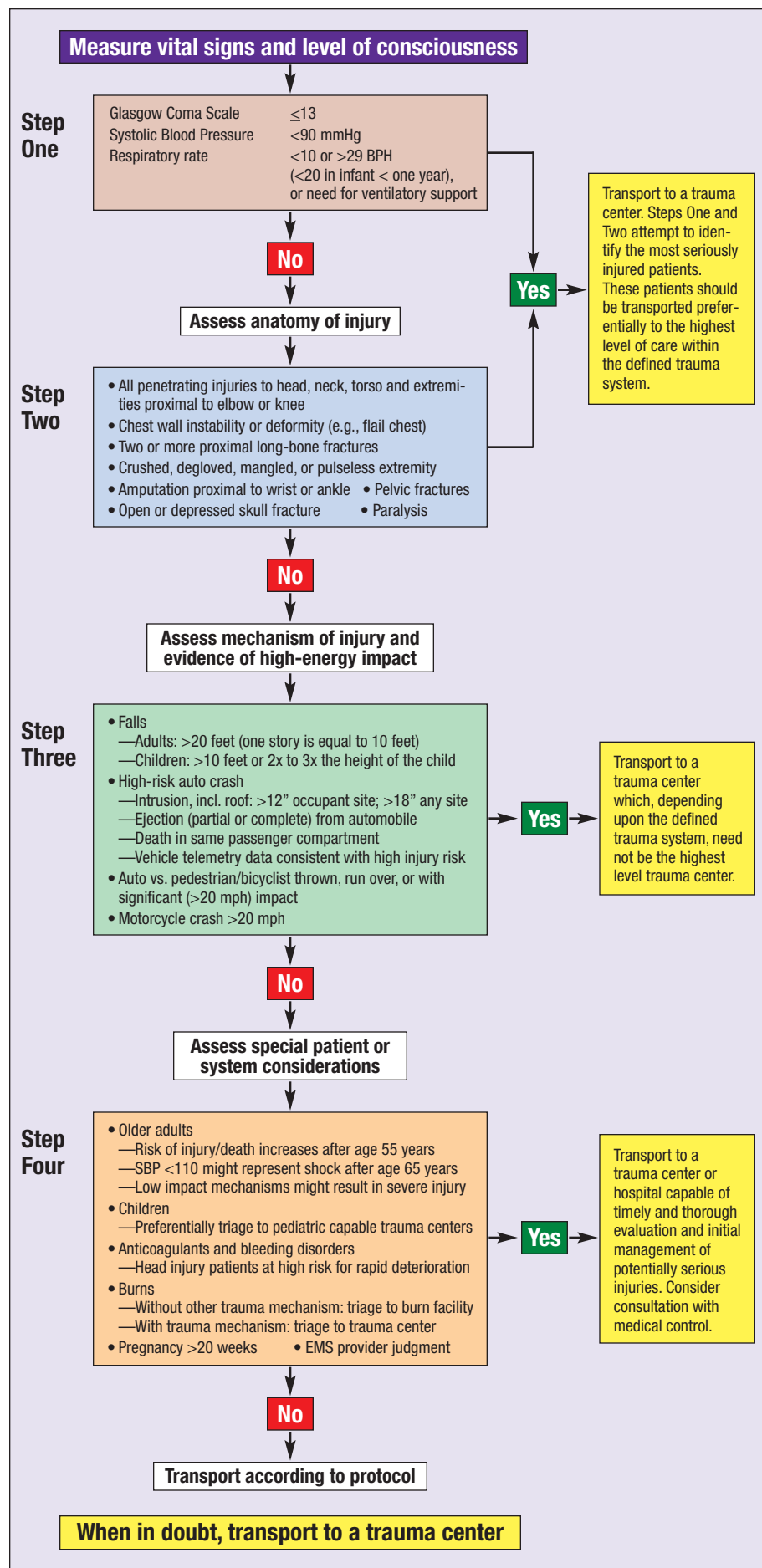
In addition, injury has far more serious consequences for the elderly who most often have comorbidities, e.g., weakened hearts, damaged blood vessels and ineffective lungs. Older persons involved in an MVC are nearly twice as likely to be admitted to the hospital, and are twice as likely to die, compared to their younger counterparts. It's the patient's *overall* physical condition that dictates his ability to recover.

In this scenario, it is also the mechanism of injury that is significant: the broken windshield and bent steering wheel. The patient has red marks on the right side of his chest and he is guarding. A patient with chest wall or rib injury will likely place his arm or hand over the injured area to guard and splint it during breathing. There is potential for life-threatening injury to the organs that lie beneath his ribs, e.g., his lungs, liver and blood vessels. He is not exhibiting any extreme shortness-of-breath, but remember that the drive to increase the respiratory rate in response to injury is reduced in the aged.

Pay attention to this man's medical history: hypertension. His blood pressure on scene is within normal range for his age, but is it normal for someone with chronic hypertension? No. Always be suspicious of MVC patients who have a history of hyper-

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Figure 2: CDC Guidelines for Field Triage of Injured Patients



tension but are found to have a normal blood pressure. Suspect internal bleeding! (The Centers for Disease Control's *Guidelines for Field Triage of Injured Patients* remind us that a systolic blood pressure of less than 110 mmHg might represent shock after age 65 years. CDC conclusion: "Undertriage [to trauma centers] of the elderly is a substantial problem." See Figure 2, previous page)

After you have performed your initial assessment and rapid trauma assessment, you determine your 65-year old MVC patient is a high priority. His broken ribs have lacerated his liver and he is hemorrhaging internally. If not transported to a trauma center immediately, he will quickly bleed out and die. He is highly unstable. Do not waste time immobilizing the patient with a short spinal immobilization device (Kendrick Extrication Device, aka KED), but use rapid extrication to remove him from his vehicle. Your partner needs to doublecheck the location of your incoming ALS unit.

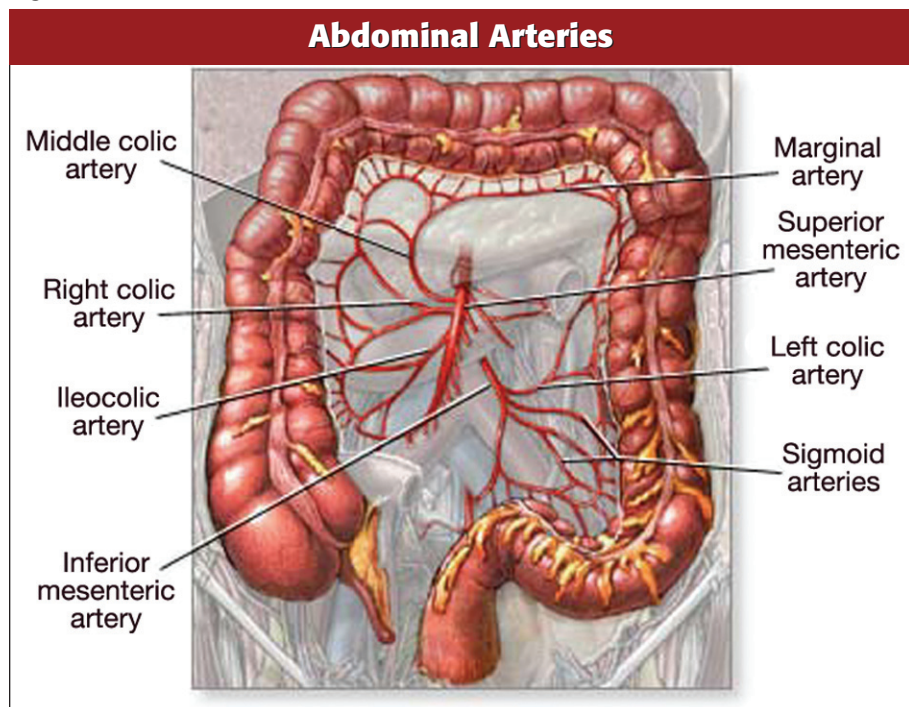
With trauma patients over the age of 65, take a hard look at anatomic, physiologic, and mechanism of injury trauma-triage considerations, and above all, maintain a high index of suspicion. Don't accept the obvious.

Case Study Review #3

Abdominal pain may be caused by a number of conditions: poisoning, trauma, infection, disease, surgical scarring (adhesions), bleeding, the list goes on and on. Diagnosis is difficult and until the advent of high-tech noninvasive devices, accurate diagnosis was at best a 50-50 proposition, no matter how good the physician.

Assessing abdominal pain in the field is almost impossible. A proper assessment takes place in a controlled environment (e.g., hospital), with CT scans, proper lighting, heat and quiet. It is a methodical process that takes time and medical expertise; it cannot be hurried. This, of course, is a practical impossibility for EMS crews. Therefore, it is best for you to assume that the acute abdominal emergency

Figure 3:



with severe pain is a serious problem until proven otherwise in the operating room. Your crew should not linger on scene.

Indeed, for our 60-year old male patient with severe belly pain, time is of the essence. To understand his condition, we must first investigate the circulation of blood through the abdomen.

It is best for you to assume that the acute abdominal emergency with severe pain is a serious problem.

All cells need perfusion, i.e., a constant supply of oxygen and the removal of carbon dioxide. When an organ is not perfused, its cells begin to die. If cellular death is not reversed, eventually the organ itself dies.

What common conditions compromise perfusion?

- Hemorrhage. This may be caused by a stab wound, blunt trauma, or a weakening, and subsequent tearing of an arterial wall called an aneurysm. The result is the same: hemorrhage or "bleeding-out."

- Atherosclerosis, or the buildup of lipids and plaque on the walls of arteries. The debris can either block the vessel entirely (thrombus) or a piece

of it may break off and travel elsewhere in the body (embolus). Either way, the blood flow to the vessel is blocked causing the cells in the organ to become ischemic, or oxygen-starved. When the coronary arteries become blocked, the patient has a heart attack, or myocardial infarction. When the cerebral arteries become blocked, the patient has a stroke, or cerebrovascular accident. When the arteries of the intestines are blocked, the patient experiences unrelenting severe pain and goes into shock.

To understand the dynamics of a blocked intestinal artery, we must first reorient ourselves to the body's circulation system:

If you remember, the aorta is the largest artery in the body. It leaves the heart and makes a 180° left-hand turn into the abdomen. Soon after it branches out into the mesenteric arteries that perfuse the large and small intestines. (See Figure 3)

A blocked (or occluded) mesenteric artery is a common cause of catastrophic abdominal emergencies. The blockage may be caused by a thrombus, an embolus, or even an aneurysm, a weakened arterial wall that ruptures. The pain is mid-abdominal or generalized, severe and unrelenting. It may resemble an infection of the pancreas or a perforated ulcer. The pain is difficult to control. The

patient typically is very ill with nausea and vomiting.

But let's return to our 60-year old male patient with severe, constant abdominal pain. What other condition does he have that might predispose him to a blocked artery? Atrial fibrillation, or A-fib.

A-fib is caused by a malfunctioning of the heart's electrical system. The heart beats rhythmically because of electrical impulses that begin at the atria, the top of the heart, and subsequently travel to the ventricles at the bottom of the heart. The entire chain of events is wonderfully coordinated and leads to the heart muscle rhythmically contracting and pumping blood into circulation. This cycle is repeated billions of times during your lifetime.

Any electrical system can develop problems, and the heart is no exception. Atrial fibrillation is a malfunction that generates multiple electrical impulses within the muscular walls of the atria. These minute discharges compete with the normal pacemaker and eventually override it, leading to an irregular, often rapid pulse.

Because the heart is not contracting rhythmically, blood begins to pool and clot. Sometimes a clot is swept from the heart's chambers to some other part of the body where it may get lodged and cause an obstruction. Patients with chronic A-fib are routinely prescribed Coumadin® (warfarin), a powerful blood thinner that helps prevent the blood from clotting.

In our patient's case, in spite of the Coumadin®, an embolus, or blood clot, has moved from his heart and has circulated to his abdomen where it lodged in the mesenteric artery. Because the underlying intestines are not perfusing – hypoperfusion – they become ischemic which produces severe belly pain. Owing to the hypoperfusion, the patient also experiences signs and symptoms of shock: increased pulse rate and respiratory rate, cold, clammy, pale skin, and finally, a fall in blood pressure. Our highly critical patient dies soon after in the hospital.

Note: Patients with severe abdominal pain typically need surgery to correct the condition. An additional

question you should have asked this patient was whether he has had any past abdominal surgery, e.g., has he had his gallbladder or appendix removed? If the patient is female, has she had her tubes tied or uterus removed (hysterectomy)? Knowing what previous surgeries a patient has helps the physician in making a diagnosis. (If you don't ask, you can also inspect and note any abdominal scars.) For instance, if the man is com-

plaining of severe right lower quadrant abdominal pain, but tells you that he had an appendectomy, obviously the pain is not from his appendix! Therefore, the physician looks to another cause.

An EMS rule of thumb: Pay close attention to the patient with a chief complaint of “**severe** belly pain.” Don't blow it off as something he ate. You'll wish you hadn't.

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Case Study Review #4

What do you think? Your young patient cries for his mother and cannot answer questions. (He's making lots of noise, that's good!) But his vital signs are troubling: systolic blood pressure of 90 mm/Hg, respiratory rate of 34 and a heart rate of 130. Everything points to shock including the mechanism of injury: auto vs. pedestrian. (See *CDC Guidelines for Field Triage of Injured Patients* – Figure 2.)

Hypovolemia, or loss of fluid, is the usual cause of shock in children. This occurs most commonly in blunt trauma and is caused by internal or external blood loss. Signs and symptoms of shock depend upon the nature and extent of injury, and of course, the age and weight of the infant or child. If unchecked, this condition progresses from compensated shock to decompensated shock. Unless reversed, decompensated shock leads to respiratory arrest and then, cardiac arrest.

In compensating for shock, the child's heart rate increases and the skin becomes cool, clammy and pale.

Children have a strong physiologic ability to compensate for shock. In its compensated stage, the child's heart rate increases and the skin becomes cool, clammy and pale. The blood pressure will most likely not be

affected. The child may appear normal, or slightly restless or agitated, or inactive.

When blood loss is significant, the compensatory mechanism becomes less effective. Once the blood pressure begins to drop, usually after 25% blood loss, the child is in decompensated shock. Resuscitation is more difficult in this stage because the child's condition deteriorates rapidly.

Let's look at our five-year old patient. As we said, the initial blood pressure is not a reliable indicator of significant injury. Instead, you should focus on his perfusion: skin color/temperature/condition and capillary refill. The boy is cold/wet/clammy and his capillary refill is four seconds. These critical signs should make you suspicious of hypoperfusion. When the patient sweats – so should you!

Now monitor the boy's vital signs every five minutes. The trend will give you a good indicator of his cardiovascular status. Sustained high heart and respiratory rates should cause you to pay strict attention. When the child begins to tire and those numbers begin to fall, be prepared for respiratory arrest and imminent cardiac arrest.

Also, look closely at the mechanism of his injury. Your rapid trauma assessment has revealed a rigid, bruised belly. Consider: auto vs. pedestrian. The child has been struck by a car and you can surmise the vehicle impacted his belly. (Figure 4) The abdomen is a common site of serious blood loss in pediatric patients; abdominal trauma is the most common cause of unrecognized fatal injury in children. The upper

abdominal cavity holds the liver, spleen and kidneys. These organs are highly vascular, disproportionately larger, and more vulnerable than in an adult because the child's ribs are softer and his abdominal muscles less hardened. Other organs that may be injured in the abdominal cavity include the stomach, small bowel and bladder.

A child's abdominal cavity organs are highly vascular, disproportionately larger, and more vulnerable to injury than an adult's.

With a high index of suspicion, you believe the rigid bruised belly indicates an underlying bleed. The child's poor skin color/temperature/condition and his abnormal capillary refill reconfirm your suspicion that the child is in shock and needs immediate, definitive treatment – surgery.

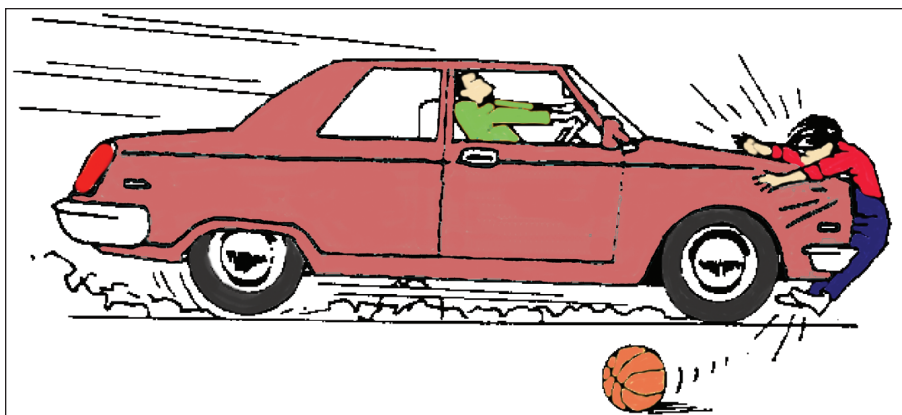
For definitive guidelines to trauma triage, EMTs should annually review the *CDC Guidelines for Field Triage of Injured Patients*. (Note: NJ Department of Health also provides Adult and Pediatric Triage Decision Guidelines to prehospital providers.)

Assume that every child with vital signs, injuries or mechanisms of injury listed in those guidelines is a high priority patient. Also recognize that your youngster may be afraid or have other injuries that distract him and lead him to deny belly pain. The key to determining whether there is pain, rigidity, and bruising is to reassess the young patient's physical exam repeatedly. Be sure and keep him warm: Hypothermia in trauma has been associated with a significantly increased mortality compared to patients with the same body temperature from environmental exposure alone.

Stay and play? Not on your life. This child is a high priority patient and needs immediate transport to the nearest trauma center with pediatric capabilities.

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Figure 4: Mechanism of injury to abdominal cavity.



Case Study Review #5

This patient is obviously stable, but has multiple minor puncture wounds on all four extremities. Her blood pressure is somewhat elevated, but her medical history includes hypertension, therefore, 160/90 is not critical for her.

Is it safe for her to refuse medical care? Should you take the extra time to convince her that she should see a physician?

Absolutely. Although the patient's vital signs are stable, severe infections are associated with animal or human bites if the skin is broken. It is essential that her wounds be cleaned and dead or dirty tissue removed. Tetanus is a *Clostridium tetani* bacteria that can be found in contaminated wounds and may cause an acute infectious disease characterized by convulsions and spasm of voluntary muscles. If untreated, the patient can die.

Your most important job is to convince this woman that she should go to the hospital or see her family

Adults need to get a tetanus booster shot every ten years to stay protected.

physician immediately. Inform her that although she was immunized for tetanus as a child, adults need to get a tetanus booster shot every 10 years to stay protected. It is clear from her medical history that she needs a tetanus booster. If possible, bring all her medications to the hospital as the elderly often forget what it is they are taking, and how much. The emergency department physician needs to know.

Although your patient is stable, she needs clear concise information about animal bites and the high risk of infection and perhaps tetanus, to make an informed decision. It is your job to educate this patient.

What about the dog? It should be quarantined in an animal control unit and observed for at least 10 days

Figure 5: A crush-and-tear type injury resulting from a dog bite.



to confirm that it is not rabid. The state recommends that a dog be vaccinated for rabies at least every two years. By the way, when was the dog's last rabies vaccination? According to the CDC, vaccination of dogs can begin no sooner than three months of age. Some cat vaccines can be given as early as two months of age. (Dogs and cats can be given one-year or three-year vaccines followed by boosters repeated respectively either every one- or three years.)

People who are bitten by, or have had contact with saliva from an animal should notify the local health department having jurisdiction where the animal is located and seek medical care.

Determining Priority Patients

As all EMTs know, we determine whether our patient is low priority or high priority immediately following our ABCs in the first minute of the call. During our primary assessment, we evaluate the patient's level of

responsiveness/orientation, airway, breathing and circulation, provide critical interventions, and then determine: High or low priority? Do we need to immediately get this patient loaded and en route to the hospital or trauma center, or can we stay a few minutes more on scene to complete the rest of the assessment and begin non-critical treatment?

If a trauma patient has experienced one of the mechanisms or "fails" any of the primary assessment – loss of consciousness or lack of responsiveness

or orientation, airway problems, inadequate breathing, poor perfusion, no pulses, or significant bleeding – you immediately know you have a high priority patient.

In four of these scenarios, we deliberately presented unstable patients whose complaints, signs and symptoms, were less obvious. The cases were meant to challenge your assessment skills. Congratulations to those who were able to determine whether the patient was high or low priority. Your assessment skills are sharp! For those who didn't do so well, it's time to pull out your EMT textbook and review.

Remember: When assessing a patient, be keenly suspicious of high priority conditions and keep digging. If you're uncertain – err on the side of the patient.

Julie Aberger is an EMT instructor and an active member of the Pennington First Aid Squad. Julie is also the editor emerita of The Gold Cross.



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