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GU Eye Unit Joins Part of Md. Emergency System

By R. D. Cole

No longer will a farmer jabbed in the eye by a pitchfork in Garrett County or a youngster shot in the eye with a BB gun in St. Mary's County have to be transported clear across Maryland to Baltimore for specialized emergency medical care.

Instead, those emergencies, as well as similar emergencies in Washington, Allegany, Frederick, Montgomery, Prince George's, Calvert and Charles counties, will now be handled by an eye trauma service established at Georgetown University Medical Center in Washington as an official part of the Maryland state emergency medical services system.

The new eye service has been developed as a cooperative venture involving Georgetown on the Washington end and Johns Hopkins Hospital in Baltimore on the Maryland end. Patients in those areas of Maryland not served by the Georgetown unit will be taken care of at Hopkins.

While the need for such a service may not seem great, eye trauma is indeed a major medical problem.

There are about 198,000 penetrating eye injuries every year in the U.S., said Dr. Leonard Parver, director of the new service at Georgetown, "and such injuries are the fourth leading indication for the admission of an eye patient to a hospital."

According to Parver, "what we offer is a regional cooperative effort to deliver eye care in a hospitalized area."

The service, he said, will care for "any severe ocular injury," including penetration of the eye by a foreign object, an accident in which an object is lodged within the eye and other problems such as detached retinas.

The service includes the establishment of a special telephone number at Georgetown—625-EYES—by which individuals or officials in outlying jurisdictions can alert the service that an emergency is coming in.

Parver said there will always be two or three ophthalmologic surgeons on call 24 hours a day, one of whom is a specialist in injuries to the front of the eye, another of whom specializes in the back area of the eye and one who is a specialist in ocular plastic surgery, the repair of the eye lids and the tissue around the eye.

The announcement of the service's establishment—and the willingness of Maryland authorities to have Maryland residents taken to Georgetown by Maryland State Police medivac helicopter—comes at a time when officials in Maryland and the District are apparently at loggerheads over how to deal with other types of trauma victims.

Maryland authorities have insisted, for example, that their helicopters bypass the trauma center at the Washington Hospital Center to take accident victims in Montgomery and Prince George's

Shock-Trauma Unit at University Hospital in Baltimore.

Sources have said that the reason Parver and his Johns Hopkins collaborators had no trouble selling the idea of their service to the leaders of Maryland's state system is that it is noncompetitive—it does not threaten to empty beds in the Shock-Trauma Unit—just as a hand trauma service at Baltimore's Union Memorial Hospital, a burn unit at the Washington Hospital Center and several other specialty units are noncompetitive.

A spokeswoman for the Maryland system said the eye trauma service was included in the state program because it was needed. She said competition has nothing to do with the criteria by which services are judged.

Although the helicopter service will be available for the service—Georgetown is one of two hospitals in Washington with a helicopter pad; the Washington Hospital Center is the

probably be brought to Georgetown and Hopkins by ambulance or private automobile.

Only if the injury is one that threatens permanent loss of vision if not attended to within minutes, will the helicopters be used, he said.

The concept of creating such a service "started out as an academic interest," said Parver. "We saw the need and we're trying to fill it." He said he hopes the service will be a "prototype for a national eye trauma service."

Parver said the services at Hopkins and Georgetown will, for the first time, allow for the uniform gathering of data about types and treatments of serious eye injuries.

Because of the cooperation between the two services, he said, physicians will be able to study about 300 trauma cases a year, all of which will be documented and filed in a like manner, allowing an accurate comparison of dif-

Treating Wounds

By Sue Miller

The 18-year-old is wheeled into the Wilmer Eye Institute Emergency Room. Bloody tears are streaming down his face.

He has an irregular pupil and some of his iris (the colored part of the eye) is coming out through a cut in the cornea. A sharp knife had flicked into his eye while he was making a model plane.

The eye specialists who crowd about him find that he can only see shadows in his injured eye.

He is hooked up to ultrasound equipment to see the back of the eye, which has been covered by a dense cataract (a clouding of the lens). X-rays are taken to pick up any foreign objects in the eye.

Within three to four hours, the injured eye has been reformed under the skilled fingers of the surgeon working under a microscope and taking stitches with material that is one third as thick as a strand of human hair.

The cataract is sucked out and this reveals a retinal detachment in the back of the eye. It is then reattached. In 10 days, the patient leaves the hospital. In two months, he is given a hard, contact lens, and he's able to see 20/30 in his wounded eye.

But without this kind of attention, this young man would most likely have been blind in one eye.

The right kind of care—swiftly—is at the heart of the human dramas unfolding at the newly opened Johns Hopkins Eye Trauma Center when the special red phone—955-8400—rings.

The center is delivering 24-hour, seven-day-a-week care. With its counterpart, the Georgetown University Eye Trauma Center, it is part of the Maryland Emergency Medical Services System. The centers are the first two of what is hoped will become a national network to be connected with state emergency systems.

The center has been established to care for those who do not have their own ophthalmologist (a medical doctor who specializes in eye care) or for the ophthalmologist who wishes to refer a patient for specialized treatment that only a center can offer.

"There are roughly a half a million people hospitalized each year for severe eye trauma," says Dr. Lawrence W. Hirst, an eye surgeon who is serving as the center's director. "And the goal is to cut down significantly on the loss of sight because of these injuries."

There are other goals, too, says the specialist in corneal and cataract surgery. The center will collect data on the incidence of various sorts of trauma, the long-range effects of trauma on vision and evaluate treatment procedures.

The potential for eye trauma is all about us, he says. It's in the house, on the tennis court, in the car, on the job. The dangerous objects are used in everyday life—the oven cleaner, the screw driver, the scissors, cables to jump car batteries.

At home, someone can inadvertently spray eyes with a caustic cleaner. In an industrial setting, a person is hammering metal on metal and a small fragment of the metal can ricochet into the eye. In sports, someone is hit a direct blow with a tennis ball.

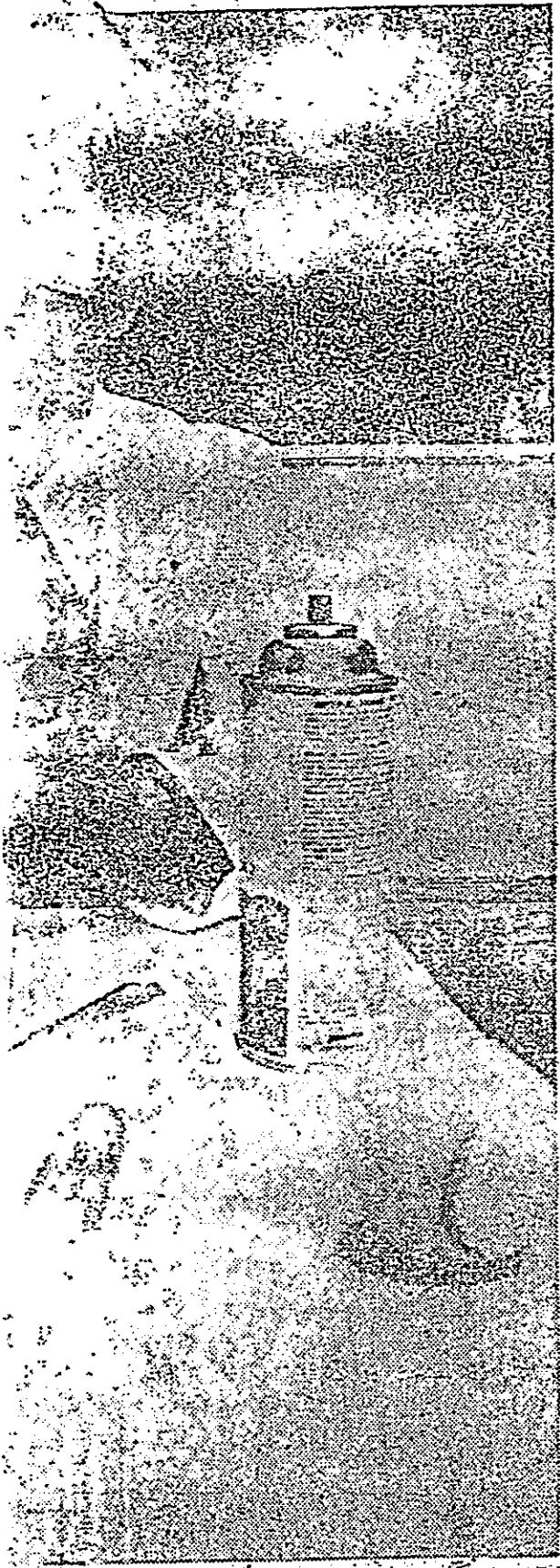
"You cannot avoid exposure to the problem," Dr. Hirst says, "but you can become aware of the problem."

He recommends wearing protective sports glasses when playing ball sports, using seat belts or restraining lap sash belts in motor vehicles, strapping children into portable car seats, wearing protective goggles for all those in an industrial environment and avoiding caustic materials or handling them with extreme caution.

He stresses the need for parents to be aware of the danger of their children running with sharp instruments in their hands.

The specialist has some tips, too, in case an emergency does arise:

- If there is a chemical injury to the eye, the eye should be flushed immediately with the closest available fluid, preferably water. Speed is of the essence. The flushing should be within seconds and should be continued for three to five minutes.
- If there is injury with a sharp object, the eye should be protected from external pressure (so contents of the eye will not come out) and the patient should avoid straining.
- In every situation, the victim needs swift medical attention and expert ophthalmological attention.



Evening Sun Photo—Lloyd Pearson

ter shows a few of the everyday articles found at home or work that can be hazardous to eyes.

New Film Illustrates Prevention and Treatment Of Eye Emergencies

A new film entitled *Eye Emergency*, which illustrates six types of eye injuries and how to prevent and treat them, has recently been released by Pyramid Films. The film uses actual workers and rescue personnel to demonstrate step-by-step treatment for a foreign body in the eye including sharp, penetrating, and blunt injuries and chemical and welding arc burns. Locations such as factories, home, and outdoor situations are used to dramatize the accidents. Real case histories are also included to emphasize the fact that 95 percent of all eye injuries could have been prevented.

For better viewer understanding, animation shows how the eye is structured and a review is given at the end which includes all treatment techniques. According to Pyramid Films, Hollywood special effects experts were used to produce a film that should hold the attention of workers, trainees, and students "from first minute to last."

The strength of the film lies in its outlining of the six causes and types of injuries to the eye. The viewer is reminded of the preventive measures that should be taken in high risk activities, such as proper caution and wearing protective glasses or goggles. The likelihood of multiple injuries in accidents is also mentioned, cautioning the rescuer to establish priorities and not concentrate solely on the more obvious wounds.

The importance of transporting the patient on his back was not stressed, however, nor was covering the uninjured eye addressed. Two major EMT texts and the American Red Cross Advanced First Aid Manual, upon consultation by the editors, all concurred on the necessity of covering the uninjured eye to prevent additional movement. These points probably should be mentioned to students upon viewing.

The color film, No. 1201, is 24 minutes in length. Purchase price

for 16mm is \$350, and \$265 for video. Rental fee is \$35. For more details contact Pyramid Films, P.O. Box 1048, Santa Monica, Calif. 90406.

Formal Recognition of Emergency Medicine as a Specialty Due This Fall

A resolution has been adopted by the American Board of Medical Specialties (ABMS) authorizing the American Board of Emergency Medicine (ABEM) to begin formation and planning for the administration of a certifying examination. The single-spaced, one-page document is the outcome of the March 15 meeting of ABMS in Chicago. A formal vote remains as the final hurdle for the newest recognized medical specialty which will be held in September to comply with provisions in the ABMS bylaws. The March decision is the breakthrough that emergency medicine has been seeking, according to a spokesman for the American College of Emergency Physicians (ACEP).

"This resolution demonstrates peer recognition of the specialty of emergency medicine," explained Dr. George Podgorny, president of ACEP. The application for specialty status, and therefore the existence of ABEM, was sponsored by ACEP as well as the University Association for Emergency Medicine (UA/EM) and the AMA's Section on Emergency Medicine.

The effort to create a board has been ongoing since the inception of ACEP in 1968. Three years of planning and study by the young organization culminated in a motion anticipating the formation of a certifying Board and stating their position that certification be by examination only. A letter of application was sent to the AMA in June 1973 and approved in 1975, and a committee was formed to help guide board establishment and exam development which proposed bylaws for an American Board of Emergency Medicine and formed liaisons with other organizations.

The articles of incorporation were agreed upon in 1977 by the ACEP Board of Directors and Dr. Podgorny was elected first president of the fledgling board. Approval was postponed by ABMS, however, until emergency medicine was recognized as a conjoint board. The American Boards of Family Practice, Internal Medicine, Obstetrics and Gynecology, Otolaryngology, Pediatrics, and Psychiatry and Neurology thus joined with ACEP, the UA/EM, and the AMA's Section on Emergency Medicine in support of the proposed emergency medicine Board.

The conjoint application was approved on February 16 by the Liaison Committee of Specialty Boards and on March 2 by the AMA/Council on Medical Education (AMA/CME). The March 15 ABMS vote on principle therefore sets the stage for final approval in September 1979. According to Dr. Podgorny, "the standards set by ABEM are expected to ensure that board certified emergency physicians will be able to meet the highest specifications for the provision of emergency care."

Physician Offers Advice On Emergency Treatment of Jehovah's Witnesses

To administer blood to a Jehovah's Witness without informing him is unethical as well as illegal. Considerable emergency and surgical care can be given to Jehovah's Witnesses, however, without infringing upon their religious principles, explained Dr. Horace Herbsman at a trauma seminar sponsored by the American College of Surgeons. Unacceptable treatment would involve any form of blood or blood components, such as albumin, he said, but careful techniques with the patient's own whole blood can treat cases of blood loss even as complicated as open heart surgery.

Autotransfusion using a continuous system, such as the Bentley apparatus, is admissible and reportedly has proven to be life saving in

(Continued on page 4)