Notes from the Chair
by Jerry A. Focht, RRT, N-REMT

As of this writing in late April, I have just returned from the Critical Care Medical Transport Conference (CCMTC) in Las Vegas with great news! The AARC has officially agreed to participate in the Alliance, which was formed in October of 1999 and includes the Association of Air Medical Services, Air and Surface Transport Nurses Association, Air Medical Physicians Association, National Flight Paramedics Association, National Association of Communications Specialists, and National EMS Pilots Association. The Alliance will act as an avenue for all of us to collaborate and work on mutually beneficial projects on a voluntary basis.

We still have some details to work out regarding our involvement in this important group, but we are making headway. I would like to thank John Hiser, my Board liaison, and Garry Kaufman, AARC president, for all their help with this matter.

The conference was a huge success, with a registration of 230 (270, including exhibitors and faculty). Twelve RRTs were registered, which is the most we have ever had at this meeting. There were many great presentations, and the Transport Section sponsored a booth featuring many great pictures and information. Kathleen Adams, Steven Sittig, and I worked the booth during the breaks and answered questions. One of my favorites was, “Can RTs really do on-scene?”

As we look forward to next fall, everyone needs to be thinking about the AARC International Congress, scheduled for October 7-10 in Cincinnati, OH. The Air Medical Transport Conference will also take place in October in Salt Lake City, UT. The 2001 CCMTC will be held in April in San Antonio, TX. We are currently recruiting speakers for the latter event, so if you have any suggestions, please contact me at the addresses/numbers on page 2.

Notes from the Editor
by Steven E. Sittig, RRT

It is my pleasure to assume the duties of editor of the Transport Bulletin from outgoing editor Peggy Bartram. We all owe Peggy a great deal of thanks for all she has done to promote respiratory therapy in transport and her dedication as editor of this newsletter. I look forward to continuing the tradition of putting out a Bulletin that section members look forward to receiving.

I would like to give all section members a brief summary of my background in respiratory care. I graduated from Dakota State University in 1986 with an Associate of Science degree in respiratory therapy. After graduation I accepted a staff therapist position at Sioux Valley Hospital in Sioux Falls, SD. My duties included shift lead therapist, Level III NICU, PICU, and adult
Motion Sickness: Just Another Part of the Job?

by Steven Sittig RRT, RCP

It is nearly noon and you head for the cafeteria, hoping to get a bite of lunch as you only had a bagel and a glass of orange juice before you ran out the door this morning. Your pager sounds – it’s a pediatric transport via helicopter to a local community hospital. As you run to the helipad, you think, “well, at least it’s a nice sunny day for a flight.” Lifting off the deck, however, you notice that the wind is now blowing quite briskly, and the helicopter is slightly twisting and turning as you gain altitude. As the sun shines overhead, the rotor blades generate a mild strobe effect inside the cabin.

The warm noonday thermals are also causing the helicopter to gently rise and fall as it continues to twist and turn from the strong winds. As you proceed to your destination, your stomach is trying to mimic the motion of the helicopter. You notice a warm, tingly sensation that moves up and down your back. Your colleague mentions that you look about as green as a new bill. You soon feel the need to find the airsickness bag, knowing that your bagel and juice will soon be belching from the stomach producing either fluid or gas, and a feeling of bodily warmth. If the triggering stimulus continues, gastric emptying is inhibited; nausea, pallor, and sweating develop; and, eventually, vomiting and retching occur. The most widely accepted cause of motion sickness is a sensory discrepancy between visual signals sent by the eyes and sensations elicited from the vestibular system.

Indeed, the most critical signals required for the generation of motion sickness come from the vestibular system. The peripheral vestibular system is located in the inner ear, in a structure referred to as the labyrinth. If you remember back to your anatomy and physiology class, you may recall that there are two types of end organs present in the periphery: semicircular canals and otolith organs. Both end organs utilize the
The vomiting center is also directly stimulated by motion and high levels of acetylcholine. Therefore, most pharmacologic management of motion sickness is aimed at preventing or decreasing the impact of these two trigger neurotransmitters. Common motion sickness drugs fall into three classes: antidopaminergics (Phenergan), anticholinergics (Scopolamine), and antihistamines (meclizine). Depending on the type of drug utilized to control motion sickness, one must also be aware of potentially serious side effects, including headache, sedation, dizziness, and equilibrium disturbances. Many times a sympathomimetic such as dextroamphetamine sulfate or ephedrine may be added to avoid the sedative side effect.

There are a lot of nonpharmacologic remedies that have become popular in the treatment of motion sickness. The most popular herbal preparation for nausea is ginger root given in candied form, powdered capsules, or in a ginger tea. However, studies have shown that ginger’s effectiveness is mixed between anecdotal evidence as to ginger’s effectiveness, a controlled trial found no anti-motion sickness activity.

A great deal of interest has been focused on the use of pressure on the P6 acupuncture site, which is just proximal to the wrist and located about 3 cm from the distal palmar crease between the palmaris longus and flexor carpi radialis tendons. Activation of this pressure point has been shown to be beneficial in suppressing nausea and vomiting caused by chemotherapy, pregnancy, or surgical operations. However, a commercially available wristband device (SeaBand) which utilizes this pressure point principal was shown during a study to be ineffective in preventing motion sickness. It was surmised that there was insufficient stimulation of the P6 point to provide relief of motion sickness. Still, most people who have purchased the motion bands feel they benefit from wearing them. A follow-up trial found that continuous vigorous stimulation of the P6 point was required to obtain a significant benefit.

LeBonheur Pedi-Flite Celebrates 30 Years
by Susan Ray, RRT, chief flight therapist, LeBonheur Pedi-Flite, Memphis, TN

The new millennium marks 30 years of interfacility transports for Pedi-Flite, the pediatric transport service of LeBonheur Children’s Medical Center in Memphis, TN. In September of 1970, a call came from Blytheville, AR to transport a critically ill infant. The physician who made the call felt that the patient would not tolerate an ambulance ride and needed advanced care. The patient was transported to LeBonheur by a respiratory therapist on the Memphis Police Department’s Jet Ranger service. Word of this flight spread quickly, and requests to transport children by helicopter increased exponentially.

The basic philosophy of the interfacility transport differs from that of the “swoop and scoop” method often utilized to transport patients from accident scenes to a hospital for treatment. The Pedi-Flite team brings the ICU to the patient at the referring institution. The team literally brings “ICU care” to the patient’s bedside.

The Pedi-Flite team is composed of a pediatric critical care physician, a critical care nurse, and a critical care respiratory therapist. The team is
Pedi-Flite generally covers a 150 mile radius, but in some cases we have gone even further to pick up a patient. We also provide service by ground and fixed wing within Mississippi, Tennessee, Arkansas, Missouri, Kentucky, and Alabama.

Our overall goal is to provide the best quality of care before, during, and after transport of the patient from the referring facility to the receiving hospital.

CAMTS Update
by Thomas J. Cahill, RCP, RRT, NREMT-P

My name is Tom Cahill, and I will be taking Jerry Focht’s place as the AARC Transport Section’s representative to the Commission on Accreditation of Medical Transport Systems (CAMTS). I will be updating you quarterly on the current CAMTS certified agencies throughout the country. But first I wanted to provide a little background information about myself.

I am a Registered Respiratory Therapist licensed in Ohio and Kentucky and a Kentucky-certified paramedic. I work full time at Shriners Hospital for Children-Cincinnati Burns Hospital as the respiratory care manager. I am also a flight therapist for our fixed wing and ground transport service. Our specialty is pediatric burns, and current statistics indicate that we transport approximately 75% of the country’s pediatric burn patients. In my “spare time,” I am the father of two and a half (Alana, Lauren, and ?), and husband to my very patient wife Shannon (who is also an emergency room RN).

I am a graduate of the respiratory care program at Northern Kentucky University and have been a member of the AARC since 1992 and a Transport Section member since 1994. My main interests are in mechanical ventilation, pre-hospital care, and pain control.

I look forward to representing the section in this capacity and corresponding with members about CAMTS-related issues.

New CPR Technique

A new CPR technique using devices developed at the University of Minnesota Medical School has been shown in a clinical trial to maintain near-normal blood pressure in heart attack victims. The method improves on active compression-decompression (ACD) CPR, which has been shown in a previous study to significantly improve long-term survival rates among patients who have cardiac arrest outside the hospital.

The latest study introduced a valve to ACD CPR. The valve has a silicone diaphragm that decreases pressure in the chest during decompression. This results in a greater vacuum effect, which pulls more blood back into the heart and thus improves overall CPR efficacy.

The study involved 21 patients. Ten had ACD CPR without the valve, while 11 had ACD CPR with the valve. More patients returned to spontaneous circulation with (four) than without (two) the valve; those with the valve also returned faster (average 19.8 minutes with versus 26.5 minutes without). With the combination of the valve and the pump, patients in cardiac arrest had near-normal blood pressures for up to 30 minutes or until they were resuscitated. The mean blood pressure in the patients during CPR was 109/56. (Circulation, 3/7/00)
Specialty Practitioner of the Year

Don’t forget to make your nominations for the 2000 Transport Specialty Practitioner of the Year. This honor is given to an outstanding practitioner from this section each year at the AARC’s Annual Convention.

The recipient of this award will be determined by the section chair or a selection committee appointed by the chair. Each nominee must be a member of the AARC and a member of the section.

Use the following form to send in your nominations for this important award:

I would like to nominate ____________________________ for Transport Specialty Practitioner of the Year because

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Nominee                Your Name

Hospital                Hospital

Address                  Address

City                      State,Zip

Phone                     Phone

Mail or FAX your nominee to the section chair at the address/number listed on page 2 of this issue.