



# Transport

## Bulletin

March/April '99

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## Notes from the Chair

by Kathleen Adams RCP, RRT

As this column is being written, the rush to get things done that always occurs as one year ends and another begins is starting to slow. Signs of spring are showing up. For many, spring is considered a time of renewal. As we enter the spring of 1999 I renew my challenge to each of you to recruit new *active* members for the AARC and, of course, for the section.

One duty of the section chair is to act as chair or moderator for lecture sessions at the AARC International Congress. Last November in Atlanta, I was charged with introducing a physician speaker who, when I asked what he wanted mentioned in his introduction, replied that he was a member of the AARC. Then he asked me a question for which I did not have an answer: "Why are so few respiratory therapists members of their own organization?"

If you asked the physicians or nurses who you work with, many would probably say that they belong to at least one of their respective professional organizations. One of our fellow section members sent me an email that brought up a very good point for increasing membership. "Who are the legislators going to listen to – large powerful groups like

the nursing associations, or little groups with low membership ratios?"

Included in this issue is an article by another section member, Bob Fluck, which gives some very good arguments for joining the organization that you can use in your recruitment efforts. Of course, you always have the option, when asked why someone should want to join the AARC, of just saying, "why wouldn't you?"

Now in case you are wondering if your section leadership is doing anything to help with the membership drive – besides heckling you – of course we are. We are planning to include the voting members of the Association of Air Medical Services in the next mailing of the *Bulletin*. We know that there are many respiratory therapists out there who are unaware that our section even exists. We hope to capture some of them by this means. We are also hoping that this mailing will increase industry awareness of the respiratory therapist's level of professionalism and involvement in critical care transports.

On that note, I will sign off so that you may start enjoying this issue of the *Bulletin*. May all your roads be smooth and your landings soft. ■

## Children's Medical Center of Dallas Transport Services

Children's Medical Center began its transport services in March 1989, logging 58 transports in its first year using unit based registered respiratory therapists, registered nurses, and medical staff. Today, using a dedicated staff of RRTs and RNs, it has evolved into one of the busiest pediatric transport services in the country, transporting approximately 2,000 pediatric patients each year by

ground ambulance, helicopter, and fixed wing.

The fact that we have a dedicated transport team with two ambulances at our disposal offers several advantages. First, once the initial phone call is received from the transfer center the team can be in the ambulance and en route within 10 minutes. All

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transport vehicles are outfitted with equipment to handle virtually any pediatric emergency that may arise. Equipment ranges from advanced accessories such as Pro-pac monitors (including end-tidal CO<sub>2</sub> monitors) and nitric oxide to plenty of pacifiers for those not-so-happy passengers.

Three modes of transportation are utilized by our team depending on the patient's location and acuity – ground, helicopter, and a new fixed wing service for longer distances. Children's has access to a Bell 222 for its helicopter flights and uses a King Air E-90 for all fixed wing flights. We also have access to a Lear 35-A for trans-

fers over 500 miles. The transport services program generally covers an area within a 250 mile radius of Dallas. However, we can fly patients in from anywhere in the world. Children from as far away as Ecuador have been transported to Children's Medical Center for treatment. Whenever possible a family member is allowed to accompany the patient to Children's.

To apply for a position on the team, health professionals must have a minimum of two years pediatric ICU or ER experience. Team members must become certified in Pediatric Advanced Life Support and Advanced Cardiac Life Support. In addition to their initial training, crew members

must begin training to become an Emergency Medical Technician. Respiratory therapists on the team have the unique opportunity of using advanced skills such as intubation, interosseous line placement, and ventilator therapy. Practices in pulmonary, trauma, cardiac, neonatal, and burn care are also put to use.

Today, with just one phone call to Children's transport services, physicians and their patients have a direct link to over 50 specialty programs. These programs include critical care, pain management, and the only level I pediatric trauma center in North Texas. ■

### Transport Bulletin

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## Do You Know?

*Editor's Note: The following question was submitted by a member of the section. If you have any information on this topic, please mail or email it to me at the addresses that appear on page two. Your input will be published in an upcoming issue.*

Do state licenses require special addendums to cover flight therapists, or does flight therapy fall into the general state practice for respiratory care? ■

## AARC Provides Travel Resource for Oxygen Dependent Patients

The American Association for Respiratory Care (AARC) is proud to announce the Breathin' Easy Travel Guide. The Guide has been in publication for the past two years, and now, the updated 1999 edition is available. Breathin' Easy founder Jerry Gorby, oxygen dependent himself, developed the Guide to make traveling easier for oxygen dependent patients.

The Breathin' Easy Travel Guide has served as an excellent resource for traveling oxygen users and also for the home care providers and therapists who work with them. Updated annually, this Travel Guide is a "must have" reference book for every oxygen dependent patient. It lists information on oxygen refill sites throughout the United States and also provides helpful travel tips for oxygen patients.

One oxygen dependent patient, John S., recently told us about his 4,172 mile cross-country driving trip. "I had my liquid oxygen tank filled by five different providers, four of which came to my attention in the Guide. The Guide

made planning the trip quite easy, and I'm grateful to you for producing it."

Also, be sure to visit the new Breathin' Easy website, <http://www.breathineasy.com> (or [oxygen4travel.com](http://oxygen4travel.com)). Already visitors like Cheryl V. are singing its praises. "Kudos to the AARC for developing the new website for traveling with oxygen . . . I will be passing it on to all O<sub>2</sub> patients as a way of encouraging them to get moving," she says.

Be the first one in your area to take advantage of promotional opportunities available with the Breathin' Easy website and printed Travel Guide. For more information about getting listed in the Breathin' Easy Travel Guide, contact Jerry Gorby at 707/252-9333, or to purchase a printed guide (\$19.95 + \$4.65 s&h), call 972/406-4663. For more information about promotional opportunities on the Breathin' Easy website, <http://www.breathineasy.com> (or [oxygen4travel.com](http://oxygen4travel.com)), contact Tim Goldsbury by e-mail ([goldsbury@aarc.org](mailto:goldsbury@aarc.org)) or by telephone at 561/745-6793. ■

# Assessment and Emergency Treatment At The Initial Care Facility

by Ronald Mlcak, RRT, Shriners's Hospital for Children Burns Institute, Galveston, TX

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*Editor's Note: This is the second in a series of three articles covering the care of burn victims in the transport setting. The next final segment, "Transport Guidelines, Patient Assessment Prior to Transport to a Specialized Burn Unit, and an International Case Report" will appear in the May-June issue.*

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The assessment of the burn injury patient in the hospital emergency department is essentially the same as that which was outlined for the pre-hospital phase of care in the last issue of the *Bulletin*. The only real difference is the availability of more resources for diagnosis and treatment in the emergency department.

## **Primary survey**

As with other forms of trauma, the primary survey begins with the ABC's and the establishment of an adequate airway. Endotracheal intubation should be accomplished early if impending respiratory failure or ventilatory obstruction is anticipated because it may be impossible with the onset of edema following the initiation of fluid therapy. Not usually thought of, but of equal importance, is how to secure an endotracheal tube, particularly since traditional methods often do not adhere to burned skin. One method of choice includes securing the endotracheal tube with tape under the ears as well as over the ears. (1) While doing assessments and making interventions for life-threatening problems in the primary survey, precautions should be taken to maintain cervical spine immobilization until injury to the spine can be ruled out.

## **Secondary survey**

Following the primary survey, a thorough head-to-toe evaluation of the patient should be done. This includes obtaining a history as thorough as circumstances permit, including an AMPLE history: aller-

gies, medications, pre-existing diseases, last meal, and events of the injury. The history should include the mechanism and time of the injury and description of the surrounding environment, such as injuries incurred in an enclosed space, the presence of noxious chemicals, the possibility of smoke inhalation, and any related trauma. A complete physical exam with a careful neurological exam should be done. Those patients with facial burns should have their corneas examined with fluorescent staining. Routine admission labs should include a CBC, serum electrolytes, glucose, BUN, and creatine. Pulmonary assessment should include arterial blood gases, chest X-rays, and carboxyhemoglobin.

All extremities should be examined for pulses, especially with circumferential burns. Evaluation of pulses can be assisted by use of a Doppler ultrasound flow meter. If pulses are absent the involved limb may need urgent escharotomy. If there is associated respiratory compromise due to a circumferential burn then escharotomies should be done to relieve chest wall constriction and improve ventilation. Escharotomies may be performed at bedside under intravenous sedation. Mid-axial incisions made are through the eschar but not into subcutaneous tissue of the eschar to assure adequate release. Pulses should be monitored for 48 hours.

## **Evaluation of wounds**

After the primary and secondary surveys are completed and resuscitation underway, a more careful evaluation of the burn wound is performed. The wounds are gently cleaned and loose skin and blisters debrided since blister fluid contains high levels of inflammatory mediators that increase burn wound ischemia. The blister fluid is also a rich media for subsequent bacterial growth. Deep blisters of the palms and soles may be aspirated instead of debrided to improve patient comfort.

After burn wound assessment is complete, the wounds are covered with a topical antimicrobial agent or a biological dressing, and an absorbent burn dressing is applied.

An estimate of burn size and depth assists in determination of severity, prognosis, and disposition of the patient. An accurate assessment is important since burn size affects fluid resuscitation, nutritional support, and surgical interventions. The size of the burn wound is most frequently estimated by using the "Rules of Nines" method. A more accurate assessment can be made of the burn injury, especially in children, by using the Lund and Browder chart, which takes into account changes brought about by growth. (2)

The American Burn Association has identified the injuries that usually require a referral to a burn center. Patients with these burns should be treated in a specialized burn facility after initial assessment and treatment at an emergency department. Questions about specific patients should be resolved by consultation with a burn center physician. (2)

## **Fluid resuscitation**

Establishment of intravenous lines for fluid resuscitation is necessary for all patients with major burns, including those with inhalation injury or other associated injuries. These lines are best started in the upper extremity peripherally, and a minimum of two large caliber IV catheters should be established through non-burned tissue if possible, or through burns if no non-burned areas are available. The most critical aspect of the early care of the burn patient is to restore and maintain adequate tissue perfusion and vital organ function. Fluid needs are based on the extent of the burn and should be infused initially as Ringers lactate solution at 2-4 ml/kg%BSA. The two most common

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formulas for estimating fluid needs are the Parkland formula, which is 4ml/kg/%BSA burned, and the modified Brooke formula, which is 2 ml/kg/%BSA burned. These have been combined and presented as the consensus formula of 2-4 ml/kg/%BSA burned. All the formulas call for one-half of the total amount to be given over the first 8 hours from the time of injury and the second half to be given over the following 16 hours.

Taking into account the increased evaporative water loss in the formula for fluid resuscitation for pediatric patients, the Shriner's Hospital for Children Burns Institute formula recommends initial resuscitation with 5000 ml/M<sup>2</sup>/BSA burned/day plus 2000 ml/M<sup>2</sup>/BSA total/day Lactated Ringers. This formula also calls for one-half of the total amount to be given over the first 8 hours and the second half to be given over the following 16 hours.

All resuscitation formulas are designed to serve as a guide only. The response to fluid administration and physiologic tolerance of the patient is most important. Additional fluids are commonly needed with inhalation injury, electrical burns, associated trauma, and delayed resuscitation of patients. The appropriate resuscitation regimen administers the minimal amount of fluid necessary for maintenance of vital organ perfusion, and the subsequent response of the patient over time will dictate if more or less fluids are needed. Inadequate resuscitation can cause diminished perfusion or renal and mesenteric vascular beds. Fluid overload can produce undesired pulmonary or cerebral edema.

### **Urine output requirements**

The single best monitor of fluid replacement is urine output. Acceptable hydration is indicated by a urine output of more than 30 ml/hr in an adult (5 ml/kg/hr) and 1 ml/kg/hr in a child. Diuretics are generally not indicated during the acute resuscitation period. Patients with high voltage electrical burns and crash injuries with myoglobin and/or hemoglobin in the urine have an increased risk of renal tubular obstruction; therefore, in these patients sodium bicarbonate should be added to the IV fluids to alkalinize the urine, and urine output should be maintained at 1-2 ml/kg/hr as long as these pigments are in the urine. The addition of an osmotic diuretic such as Mannitol may be needed to assist in clearing the urine of these pigments.

### **Decompression of stomach**

To combat any regurgitation with an intestinal ileus, a nasogastric tube should be inserted in all patients with major burns to decompress the stomach. This is especially important for all patients being transported in aircraft at high altitudes. Additionally, all patients should be restricted from taking anything by mouth until the transfer has been completed. Decompression of the stomach is usually necessary because the anxious, apprehensive patient will swallow considerable amounts of air and distend the stomach.

### **Temperature control**

The patient must be kept warm and dry since hypothermia is detri-

mental to the trauma patient and can be avoided or at least minimized by the use of blankets or warm solutions. The patient must be kept warm and wet dressings changed, if possible, prior to transfer.

### **Pain control**

The degree of pain experienced initially by the burn victim is inversely proportional to the severity of the injury. No medications for pain relief should be given intramuscularly or subcutaneously, since fluid shifts are from the vascular spaces to the interstitial (third) space, rendering such dosing ineffective and allowing for uncontrolled and unpredictable uptake when fluid resuscitation occurs.

### **Tetanus immunization**

Recommendations for tetanus prophylaxis are based on the condition of the wound and the patient's immunization history. All patients with burns of greater than 10% BSA should receive 0.5 ml tetanus toxoid. If prior immunization is absent or unclear, or the last booster dose was more than ten years ago, 250 units of tetanus immunoglobulin is also given.

### **References**

1. Mlcak, RP, Helvick B: Protocol for securing endotracheal tubes in a pediatric burn unit. *J Burn Care*, 1987; 8:233-237.
2. Nebraska Burn Institute, Advanced burn life support providers manual. Lincoln, 1987.

## **1999 Professor's Rounds Series**

*Professionally Produced, Educational Broadcast Series. Renowned Experts Speak on Each Topic.*

### **Program Schedule**

Ventilators and Their Management - Live Videoconference: April 20, 11:30 AM - 1:00 PM CT

The Role of the Disease Manager - Live Videoconference: May 25, 11:30 AM - 1:00 PM CT

Coping with the Pediatric Respiratory Emergency - Live Videoconference: June 22, 11:30 AM - 1:00 PM CT

The Latest Word in the Treatment of COPD - Live Videoconference: August 24, 11:30 AM - 1:00 PM CT

PEEP: The State of the Art - Live Videoconference: September 28, 11:30 AM - 1:00 PM CT

New Developments in Respiratory Drugs, Medications, and Delivery Devices - Live Videoconference: October 19, 11:30 AM - 1:00 PM CT

*For more information contact the AARC at 972/243-2272.*

# Join the AARC? Make Me!

by Robert R. Fluck, Jr., MS, RRT, EMT-P, SUNYHealth Science Center, Syracuse, NY

*Editor's Note: The AARC Board of Directors recently voted to add a member to the Board from each Specialty Section with at least 1,000 active members. Our section currently falls short of that mark. Therefore, it's up to us to recruit more members from among our colleagues. In the following article, Bob Fluck outlines some of the arguments we can use, not just to get current AARC members to join the section, but also to encourage non-members to sign on as well.*

Join the AARC? Make me! This seems to be the attitude of the 75% or more of practicing respiratory therapists who are not members of the AARC. Perhaps this is why some still have difficulty seeing respiratory care as a profession.

Anyhow, once you get past the initial negativity, people most often ask, "What do I get when I join?" The following laundry list of AARC membership benefits should provide you with enough arrows in your quiver to convince even the most skeptical:

**Flexibility in membership** – You can pay with a credit card, sign up for a three-year membership, and/or choose to receive only one of the journals (*Respiratory Care* and *AARC Times*) to save money. There is also a higher level of membership that provides more benefits and services.

**Respiratory Care Journal** – The only peer-reviewed journal devoted specifically to respiratory care research.

**AARC Times** – Provides news of the

field and important information from agencies that impact our profession (such as the Health Care Financing Administration).

**Professional liability insurance** – Available at very reasonable rates through the Association.

**Credit Card** – Also offering reasonable rates.

**Specialty Sections** – The ability to network with others in your area of specialization (such as transport, for example). They also provide access to people who have already "been there and done that" so you don't have to reinvent the wheel every time you want to implement a new procedure or idea (for instance, rapid sequence intubation).

**Representation in Washington, DC** – The continued existence of the field of respiratory care and the expanding job market are due in large part to the efforts of the AARC to educate those in our nation's capital about the importance of the job we do.

**State government affairs liaison** – Provides information from other states that have already walked the path you're contemplating, again so you don't have to reinvent the wheel.

**Educational opportunities** – Through agreements that the AARC has with educational institutions, you can earn a BS or even an MS.

**A single professional organization** – The greater the numbers, the louder and more effective our voice. (Know anyone in a field that has more than one professional organization? Are they scared right now?)

Beyond addressing tangible bene-

fits with the prospective AARC member, there are intangibles that you can cover as well. One such benefit is the advantage of being a better-informed practitioner. AARC members are literally inundated with information about what is going on at the national and state levels through *AARC Times*, the Specialty Section *Bulletins*, and periodic bulletins from the executive office. Information is also disseminated through chartered affiliate newsletters and meetings. All this provides the practitioner with the knowledge he or she needs to write to his or her senators and representatives and thus help to guide his or her own destiny.

Being a member of the AARC also puts the practitioner in contact with others who are working to benefit the patient and the profession. It's a synergistic relationship in which people encourage each other to be the best they can be. Seeing the personal rewards of active membership can help motivate others to become more involved. Finally, there is the benefit of belonging to a group of people with similar backgrounds, goals, and ideals. This is a part of what being a professional is all about.

I'm going to end here, but I'm sure each member of this section can think of another intangible benefit of membership that is important for him or her. To paraphrase Laubach Literacy's motto, let's "each one reach one" and use what we know and love about the AARC to recruit a new member today. ■

## CAMTS Accredited Transport Services

The following list contains all of the programs that were CAMTS accredited as of 4/1/98.

\* = Reaccredited/RW= Rotorwing/FW= Fixed Wing/G= Ground Critical Care

AeroCare — Lubbock, TX	RW/FW	AIR TREK — Punta Gorda, FL	FW	Allegheny Life Flight — Pittsburgh, PA	RW/FW
*Air 1 — Tyler, TX	RW	*AirEvac for Tulsa — Tulsa, OK	RW/G	Angel Flight — Little Rock, AR	RW
Air Med Team — Modesto, CA	RW	AirLife of Greeley — Greeley, CO	RW	* + Butterworth AeroMed — Grand Rapids, MI	RW
AirMed — Salt Lake City, UT		Airlift Northwest — Seattle, WA	RW/FW	* CareFlight — Dayton, OH	RW

## *Transport Bulletin*

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CAREFLIGHT — Lexington, KY	RW	*LifeGuard— Albuquerque, NM	RW/FW	*Samaritan Air Evac — Phoenix, AZ	RW/FW
*CareFlite Dallas — Dallas, TX	RW/FW	Life Watch— Wichita, KS		San Juan Air Care — Farmington, NM	RW/FW
Conemaugh Med Star — Johnstown, PA	RW	Loyola LIFESTAR— Maywood, CO	RW	Shriners Burns Institute Transport Team — Cincinnati, OH	FW
Critical Air Medicine — San Diego, CA	RW/FW	+Mayo One — Rochester, MN	RW/FW	St. Joseph's Health Systems — Tampa, FL	RW/FW
Eagle Rescue of Arizona — Phoenix, AZ	RW	Med Arizona, Inc. — Show Low, AZ	FW	St. Mary's Air Life— Grand Junction, CO	RW/FW
*EastCare — Greenville, NC	RW/G	+Med Center Air — Charlotte, NC	RW/FW/G	STARS — Edmonton, Alberta, Canada	RW
Flight Care — Saginaw, MI		Med Flight Air — Albuquerque, NM	FW	STAT MedEvac — Pittsburgh, PA	RW/FW
*Flight for Life — Denver, CO	RW/FW	MedJET International— Birmingham, AL	FW	Survival Flight — Ann Arbor, MI	RW/FW/G
Flight For Life — Milwaukee, WI	RW	*Medi-Flight — Modesto, CA	RW	Texas AirLife — San Antonio, TX	RW
Gallup Med Flight - Gallup, NM	FW	Medical Express International, Inc. — Show Low, AZ	FW	Topeka Air Ambulance, Inc. — Topeka, KS	RW
Guardian Air Transport — Flagstaff, AZ	FW	Mercy Air Services, Inc. — Fontana, CA	RW	*UCDMC Life Flight — Sacramento, CA	RW
HealthNet — State of West Virginia		* +Metro Life Flight — Cleveland, OH	RW/FW/G	*UMC Air Care — Tucson, AZ	RW/FW
* INOVA AIRCARE — Falls Church, VA	RW	MidWest MEDFLIGHT — Ypsilanti, MI	RW	University Air Care — Cincinnati, OH	RW
*INTENSIVE AIR — Sioux Falls, SD	RW/FW	Native American Air Ambulance, Inc. Mesa, AZ	RW/FW	University MedEvac — Allentown, PA	RW
Life Air Rescue — Shreveport, LA	RW	North Flight, Inc. — Traverse City, MI	RW/FW	Washington MedSTAR — Washington DC	RW
LifeFlight IHC — Salt Lake City, UT	RW/FW/G	NorthWest MedStar — Spokane, WA	RW/FW	West Michigan AirCare — Kalamazoo, MI	RW/FW/G
*LifeFlight MeritCare— Fargo, ND	RW/FW	*Presbyterian Air — Albuquerque, NM	FW		
Life Flight — Toledo, OH		REACH Mediplane — Santa Rosa, CA	RW / FW		
LIFEFLITE Medical Air Transport — Mesa, AZ	FW	*REACT — Rockford, IL	RW/G		

+ = "Commendation"

## Accreditation Standards

What does it take to become accredited by the Commission on Accreditation of Medical Transport Systems (CAMTS)? According to a posting on the CAMTS web site (<http://camts.org>), the Accreditation Standards include criteria for the following topics:

### General Standards

- Capabilities and resources of the service
- Medical Personnel
- Medical Director
- Medical Control Physician
- Clinical Care Supervisor
- Staffing and Physical Requirements
- Mission Types

- Initial and Continuing Education
- Aircraft/Ambulance section
- Medical Configurations
- Operational issues
- Equipment
- Communications
- Management and Administration
- Management/Policies
- Quality Management
- Safety Committee
- Infection Control

### Rotorwing Standards

- FAA Certificate
- Weather and weather minimums
- Pilot staffing and training
- Maintenance
- Helipad

- Refueling
  - Community outreach
- ### Fixed Wing Standards
- FAA Certificate
  - Aircraft
  - Weather
  - Pilot staffing and training
  - Policies
  - Maintenance
  - Refueling
  - Community outreach

### Ground Interfacility Standards

- Vehicles
- Qualifications of Drivers
- Maintenance and sanitation
- Mechanic
- Policies

## FYI . . .

### Regulators pose fire hazard

The Food and Drug Administration (FDA) is warning rescue squads and other emergency workers about possible fire hazards associated with aluminum regulators on oxygen tanks used during patient transport.

According to the FDA, the regulators, which are more likely to catch on fire than the brass regulators typically used on tanks in the hospital setting, have caused 16 explosions in the last four years resulting in serious burns in 11 people. While the risk of explosion is small – some 200,000 of the tanks are in use around the country – the FDA believes that all aluminum regulators should be taken off the market.

Allied Healthcare Products of St. Louis, which manufactures 60% of the oxygen regulators currently on

the market, has agreed to a voluntary recall of its aluminum regulators. In the meantime, the FDA recommends that emergency personnel minimize the risk of fires from the regulators still in use by cranking the valve slowly to minimize friction that could spark a fire, and scrupulously cleaning tanks and related equipment, particularly when refilling the tanks. (Critical Care Transport News)

### Longer shifts don't lead to cognitive decline

Do longer shifts lead to cognitively impaired medical flight personnel? No, say researchers from Metro Life Flight in Cleveland, OH, who studied 15 flight nurses working 12- and 24-hour shifts.

Each of the nurses was tested on memory, attention, reasoning, motor,

and speed measures, and researchers also evaluated personal journals kept by the nurses to record stress, fatigue, sleep quality, amount of work, and sleep per shift.

Neuropsychologic testing results indicated that performance was not predicted by shift length, time of shift (day or night), amount or quality of sleep before or during shift, or fatigue ratings. Nor were age, gender, or education a factor in mediating shift length/test performance relationships. Some test scores were modestly impacted by uninterrupted sleep, stress ratings, and number of flights per shift.

The researchers conclude that 24-hour shifts do not result in cognitive declines when compared with 12-hour shifts. (Air Medical Journal, Jan.-Mar. 1999) ■

## Resource List Correction

*Please make the following corrections to your Transport Section resource list. The complete list*

*appeared in the Sept./Oct. '98 issue of the Bulletin.*

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### Review of CPGs

The AARC Clinical Practice Guidelines Steering Committee would like your help in revising the Clinical Practice Guidelines (CPGs). We need the respiratory community to identify specific areas of the CPGs for revision. Note that the CPGs are evidence based; therefore, please identify areas for revision, provide suggestions for revision, and cite peer-reviewed literature to support those suggestions.

*Please e-mail your specific comments to the chair of the Steering Committee, Dean Hess, PhD, RRT, FAARC, at [dhess@partners.org](mailto:dhess@partners.org) or fax them to 617/724-4495.*

*You will find copies of all the CPGs published by the AARC at: [http://rcwww.rcjournal.com/online\\_resources/cpgs/cpg\\_index.html](http://rcwww.rcjournal.com/online_resources/cpgs/cpg_index.html)*

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