

- b. relatively low for those with 1 or 2 coronary vessel disease
- c. is significantly less in those who have first undergone and survived CABG compared with those with similar CAD who have not undergone CABG.

INTENSIVE CARE SERVICE IN N.S.W. AMBULANCE

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An intensive care ambulance service was introduced in November 1976 to incorporate the coronary ambulance service which had functioned in the eastern suburbs of Sydney since 1969. This intensive care service now covers the inner metropolitan area of Sydney with three specially equipped vehicles and the cities of Newcastle and Wollongong with one each. Vehicles are staffed by 37 ambulance officers who work in pairs and whose initial training was based on the Los Angeles paramedic system.

Since initiated and up till March 1978, there have been 8875 calls for the intensive care ambulance service. This comprised just over 1% of all ambulance calls during the same period in N.S.W., where 1200 officers in 783 ambulances attended over 800,000 calls.

We reviewed in detail experience of the intensive care ambulance service from July 1, 1977 to March 31, 1978 in the Sydney metropolitan area. During this 9 month period there were 5661 calls. Detailed information from case sheets was available in 3898 (68%) of these. Case sheets appear to be representative. Calls comprised Primary transport (2976 calls) and Secondary or inter-hospital transport (922). Classification of primary calls was: loss of consciousness or collapse, but non-cardiac, 528; cardiac including chest pain, cardiac failure, cardiac arrest or arrhythmia, 684; industrial or domestic trauma, 469; motor vehicle accidents, 270; abdominal pain, 191; overdose, 151; dyspnoea, 125 and miscellaneous, 206. In 352 calls, services were not required.

Inter-hospital transfers were principally for cardiac problems in adults (97 of 519 patients) and for respiratory distress (162 of 403) in children. Though most inter-hospital transfers warranted an intensive care ambulance, this was also used for transfer to radiotherapy facilities, to a C.A.T. scanner, to a referring hospital or terminal care institution on 179 occasions (19% of all secondary calls).

Of the 684 primary cardiac calls there were 98 patients in cardiac arrest. Another two arrested after arrival of the ambulance. No attempt at resuscitation was made in 27 patients who were clearly dead. Attempts at resuscitation (including ventilation, external cardiac massage and defibrillation) were made in 73 patients, 13 of whom were in asystole and 60 in ventricular fibrillation or tachycardia. Stable cardiac rhythm was restored in only 17 patients (one with asystole). Only three patients (none with asystole) left hospital alive.

Data indicate unusual use of the intensive care ambulance with a high proportion of unwarranted secondary calls, a low proportion of primary calls to cardiac emergencies, and a high incidence of cardiac arrest in cardiac patients, with poor long term survival in these.

CARDIOVASCULAR EMERGENCIES IN THE COMMUNITY - VICTORIAN EXPERIENCE

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In 1968 the Victorian Hospitals and Charities Commission invited representatives from the Royal Australasian College of Surgeons, The Royal Melbourne Hospital and the Ambulance Service - Melbourne to meet and advise on the development of a service to handle emergency situations in the Community. As a result, five Mobile Intensive Care Ambulances (MICA) were progressively brought into use. By 1978 these ambulances were providing a specialised service for an urban and suburban population of 1.5 million people. The service was on call for all community members as well as for medical practitioners and paramedical personnel.

The specialised ambulances were manned by specially trained ambulance officers whose basic training was carried out at the Ambulance Officers School and in the Department of Cardiology, The Royal Melbourne Hospital. Selected ambulance officers underwent a 6 week classroom instruction course and this was followed by a 3 month inservice apprenticeship type training.

The MICA service was backed by community training in heart lung resuscitation co-ordinated by the National Heart Foundation.

During 1977, 7,200 patients were transported by the MICA service. During the first 3 months of 1978, the service was carrying patients at the rate of 8,000 annually. Calls for help were initiated by dialing 000 and analysis of the calls indicated that the majority related to cardiovascular emergencies. A current review of all admissions through the Coronary Care Unit at the Royal Melbourne Hospital found that 45% of all patients admitted were transported by MICA.

During the first 8 months of 1977, 75 subjects were successfully resuscitated from cardiac arrest and admitted to hospital. Forty of those patients were discharged from hospital well. During this period of time treatment judged as being life saving was administered to 92 additional subjects who arrived in hospital alive.

DISPOSITION AND CLINICAL EFFICIENCY OF LORCAINIDE (R 15889)

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Pharmacokinetics, clinical efficiency in ventricular premature beats (VPB) and electrophysiological parameters (PR-, QRS-, and QT- intervals, His bundle electrogram) have been investigated in 65 patients after administration of lorcaïnide (L). Single dose studies (100, 200 mg. p.o. and 100 mg, 2 mg/kg i.v.) as well as steady state dosage regimens (2 or 3 x 100 mg/day) have been performed. Lorcaïnide and a deacylated metabolite have been measured by a sensitive and specific gaschromatographic assay.