

EDITORIAL

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Lack of transport is an important barrier to good health service provision. Triage, resuscitation and stabilisation of paediatric emergencies will assume greater meaning if children can be transported in time to health care facilities. Transport medicine is not just about logistics and planning. It must have an inbuilt clinical governance. Clinical governance is essentially a continuous process of improving quality and controlling risk through an evidence-based approach. Transport Medicine is indeed combining profession with a passion for speed and prompt action.

It is common practice to use the resuscitation bag if the victim stops breathing. If respiratory failure occurs due to flaccid paralysis and there is a strong likelihood that the tongue will fall back and obstruct the airway, the effective functioning of a resuscitation bag in these circumstances will be highly limited. Nasopharyngeal airway (NPA) support is an excellent emergency measure in these situations (1,2). If available, NPAs should be inserted before transportation to the referral hospital, which will dramatically increase the probability of effective respiratory support during the journey. It is possible however to improvise nasopharyngeal tubes (NT) from endotracheal tubes (ET), which are usually readily available or can be obtained easily. Two rubber or plastic size 6.5 ET tubes for females, size 7 for males or size 5 for either can be adapted to provide NT. The tubes are cut to the distance between the nostril and the tragus, lubricated and inserted into the nostrils of a conscious or unconscious patient. Cut to the correct length, they will not trigger the gagging reflex and thus can be used when a patient is conscious. In the event that a patient cannot perform a neck lift and is to

be transferred to a better-equipped hospital, the tubes can be inserted and the individuals accompanying the victim instructed to use the resuscitation bag if the victim stops breathing (3).

Substantial funding dependant on donor provision is important while planning the Children's Acute Transport Services (CATS). Competent transport facilities are costly affairs with one time as well as recurring maintenance costs. Though significant additional cost is incurred in the form of team training and quality assurance measures, they form the backbone in maintaining the quality of service provided. Creatively utilising this specialised team in other areas of similar medical activity will both further improve the hospital services apart from being more cost effective (4).

The Three Aces Concept of Thornicroft and Tansella (2001) can be adapted while planning these services. "Autonomy, Continuity, Effectiveness / Accessibility, Comprehensiveness, Equity / Accountability, Coordination, Efficiency" (5). When users of services and carers are involved in planning, quality of transport medicine will improve and people will have more confidence in them.

The special article on CATS in UK and the Indian perspective of EMRI 108 in this issue of our Journal highlight the delicate balance to be struck between good performance and trained manpower on a continuing basis. There is a gap between the current situation in many hospitals i.e. poor referral and transport processes and the EMRI 108 style ambulance. This gap can only be covered by understanding and managing respiratory failure prior to or during transport through the improvised solutions such as those

recommended in the National protocol on Snakebite management i.e cut down ET Tubes, Nasopharyngeal airway support (6,7). Also we need more research on the benefits of Laryngeal Tubes over LMAs (Laryngeal Mask Airways) in rough road environments.

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