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SPARK OF LIFE CONFERENCE 2005
“UPDATE”

Council is pleased to announce that the three keynote invited speakers have indicated that they would be honoured to accept Council’s invitation to attend. They are:

- Pierre Carli (France)
- Tony Handley (UK)
- Vinay Nadkarni (USA)

Council is sure that the papers presented by these speakers, together with other invited speakers and free paper presentations will make way for a very interesting and informative scientific program.

The “Australian Visitor” will be Dr Frank Archer from Victoria. Dr Archer has contributed to all past conferences and his presentations are always of a very high standard.

Dr John Williamson from Adelaide has accepted Council’s invitation to present the “Ian Mackie Memorial Lecture”.

The countdown begins. By the time you receive this Newsletter there will only be 19+ months to go!

ILCOR

Three ARC representatives, along with our colleagues from the New Zealand Resuscitation Council, attended the most recent ILCOR meeting in April 2003. The main purpose of these meetings is to establish the framework and processes by which the evidence based evaluations of the science of resuscitation will be undertaken. The outcome of this will be the publication of the 2005 / 2006 Resuscitation Guidelines – International Consensus of Science. The BLS, ALS and PALS will be finalised shortly.

This is very much an international process to which the ARC is significant contributors. Such is the level of the ARC’s involvement that Dr Peter Morley – Chair of our ALS Sub-Committee – has been appointed as one of the two worksheet editors for the guidelines process. Congratulations Peter!! The next meeting will be held in September 2003 and Council will once again be sending three representatives.
CONGRATULATIONS
The following ARC representatives have served 10 or more years on Council:

A/Professor Vic Callanan (14 years)
A/Professor Ian Jacobs (14 years)
Dr Peter Morley (10 years)
Mr John Hall (10 years)

Mrs Carol Carey (Administrative Officer) has also been with the ARC for 14 years.

RENamING “BASIC LIFE SUPPORT”?

At the last Council meeting consideration was given to a request from an Educator who has been teaching Basic Life Support (BLS) for many years, both in-hospital and out of hospital. He wrote:

“Learners in hospital environments have, by and large, the paradigm that BLS is a skill that is really “marking time” prior to arrival of staff trained in advanced life support techniques. The community, too, believe that their role is relatively unimportant in comparison to that of the paramedic on arrival. As a teacher of BLS skills, I find I am frequently attempting to shift paradigms. A lot of the problem by be generated by the use of “basic” in the term “basic life support”. This word actually means “primitive” which does not describe the skills required and the desired outcomes of BLS well. There are many alternative words to basic, a key word is “essential”. In dictionary terms, essential is described as “fundamental, indispensable, vital, crucial, central and critical”. The public may equate “basic” with being a poor relation of “advanced” and many underemphasise its relative importance. Renaming BLS may reiterate its role in combination with early defibrillation. After all, without the essential first responder skills, advanced life support may be ineffective.”

Council discussed the letter in detail and believed that there were a number of valid points. However, Council did not believe that the confusion such a change would cause could be justified in terms of beneficial outcomes. However, Council did feel that CPR trainers should continue to emphasise the importance of BLS in their training programs and that word Basic does not imply unimportant.

“ANY ATTEMPT AT RESUSCITATION IS BETTER THAN NO ATTEMPT”

At the most recent Council meeting, compression rates were discussed once again. Issues such as ease of teaching; effective CPR in a real life situation and rescuers feeling comfortable to have a go without being stressed were considered. It was agreed that Council must endeavour to put their philosophical message forward that “any attempt at resuscitation is better than no attempt”.

Rates have been debated worldwide and are under constant review. Unfortunately, there is little experimental evidence to guide recommendations. The ARC guideline for infants and children changed from 15:2 to 5:1 because of some evidence which suggested that more ventilation can be given with the 5:1 ratio than with 15:2 and it is known that problems with breathing rather than heart problems are more likely to occur in the child age group. There is no problem teaching 15:2 for older children. ARC Guideline 7.1.2 categorises children into infants (< 1 yr), young children (aged 1-8 yrs) and older children (aged 9-14 yrs). The ratio is 5:1 for infants and young children, but older children may be managed as per adults ie ARC Guideline 7.1.1 which states that either ratio may be used for 1 or 2 rescuers.

The formulation of guidelines must necessarily be a union of what is most desirable from the victim’s viewpoint and what is possible and practical from a rescuer’s point of view.
Obviously, from a lay-person’s perspective, it is important to make guidelines as simple as possible so that a potential rescuer can remember what has been taught and can perform it. The ARC has specified guidelines but it also wants rescuers to ‘have a go’ even if the exact guideline cannot be adhered to or achieved. Remember;

“Any attempt at resuscitation is better than no attempt”

PUBLIC ACCESS DEFIBRILLATION

The ARC National Chairman attended a workshop on Public Access Defibrillation (PAD) in Canberra in December 2002. The workshop was organised by the Commonwealth Department of Health to discuss the issue of developing a strategy for Public Assess Defibrillation. A follow up meeting was held in May this year in Melbourne. From these meetings a statement (to be known as the “Eclipse Statement”) in support of PAD as previously discussed by Council was accepted. The eclipse statement has been forwarded to NHPAC (a National Health Priority Action Committee) requesting an out of session endorsement. Once the statement is endorsed it will be disseminated widely within the community and posted on the ARC website. The ARC looks forward to working with the Commonwealth Department of Health on further developing a national PAD strategy.

LOCATING THE COMPRESSION POINT

The ARC is always interested in new research and maintains a watching brief in many areas of resuscitation. One such area is the method/s used to obtain correct hand placement on the chest for external cardiac compression. Policy Statement 6.3.1 outlines the two common methods taught for locating the site for external cardiac compression - the caliper method and the index finger technique. Both these methods are taught widely both in Australia and overseas.

The ARC notes with interest a recent article published in Resuscitation 57 (2003) 187-191 regarding the use of the caliper method. ARC has reviewed this research and awaits the findings of other similar studies with interest.

CPR ASSESSMENT

Emerging technologies of computerised education are interesting and have their place however, Council believes that to assess CPR competencies a recognised training program with hands on practice is an essential part of this competency assessment.

BABY UPDATE

Congratulations to Karen (Theobald) and Alan on the safe arrival of their bouncing baby boy Samuel Royse Marlow, born 2nd May 2003 all 9lb 6oz of him!

Karen will now have to share her duties of motherhood and Chairperson of the ARC Qld Branch. Not hard to guess which one will come first!

NEW AND/OR UPDATED GUIDELINES

Which accompany this Newsletter

Red Border
Guideline 11.6.1 Post-Resuscitation Therapy in Adult Advanced Life Support
Guideline 11.6.2 Therapeutic Hypothermia After Cardiac Arrest
The following Guidelines have been issued to member organisations and State Branches, as drafts, for consideration at the next meeting of Council.

- Guideline 3.1 Unconsciousness
- Guideline 4.3.1 Airway Management
- Guideline 4.3.5 Clearance of the Airway
- Guideline 5.4 Expired Air Resuscitation in Children & Infants
- Guideline 8.1 Principles of Control of Bleeding for First Aiders
- Guideline 8.23 Anaphylaxis – First Aid Management
- Guideline 8.9.6 First Aid Treatment for Marine Envenomation
- Guideline 9.1.1 CPR Training Course Objectives, Content and Criteria for Evaluation
- Guideline 12.7 Techniques in Paediatric Advanced Life Support

The new CPR: flip the patient
By Ben Wyld
June 28 2003

Flipping a patient over and performing heart massage on their back could be a better way of restoring blood flow than the standard resuscitation method, according to research that may challenge decades-old orthodoxy.

A study of reverse cardiopulmonary resuscitation (CPR) on six critically ill intensive care patients found significant increases in their blood pressure. The patients' hearts had stopped and they had failed to respond to standard resuscitation.

After 45 minutes of standard CPR without response, doctors at New York's Columbia Presbyterian Medical Centre turned the patients on to their stomachs and gave them a further 15 minutes of CPR applied to their backs. They found the systolic blood pressure improved dramatically, compared to that measured in the final 15 minutes of the standard technique. Blood flow through the arteries also increased.

None of the patients survived, but the researchers claim the results demonstrate, for the first time, that CPR applied to the back may have distinct benefits. The technique is already used when patients suffer an arrest while they are face down for surgery. But it has never been directly compared to standard CPR.

"This is not a mandate to change current CPR practice, but it does raise interesting possibilities for continuing research," said a Baltimore cardiologist, Myron Weisfeldt, a co-author of the study, published in the journal Resuscitation.

Dr Weisfeldt believes the technique allows for firmer compression of the heart muscle. This is because the spine is less easily damaged than the sternum and ribcage. Peter Mckie, the chairman of the Australian Resuscitation Council's NSW branch, said the technique deserved further study, but the benefits of reverse CPR would need to be clearly established before initiating such a radical change in technique.