Opinion

Aeromedical evacuation: a personal outlook

Abstract

Aeromedical Evacuation is relatively new In Nigeria. Here is a personal outlook

Opinion

Medical Evacuation often shortened to Medevac is the timely, efficient movement and en route care provided by highly trained medical personnel to ill, wounded patients, neonates and infants from an area with inadequate medical facility to one with better equipped facility. The United States Army is arguably the first set of people to use this lifesaving technique in Burma towards the end of the World War II using the Sikorsky R-4B helicopter. The British also used it in Sinai Peninsula when a Royal Aircraft Factory BE2 flew out a soldier in the Imperial Camel Corp who had been shot in the ankle.

In modern times, aeromedical evacuation has gone way beyond just evacuation in times of war and conflict to evacuation from construction sites, remote sites, oil rigs, drills and mining sites to even neonatal and infant transport for better medical specialist care. In Nigeria, aeromedical evacuation is very new. Initially it was exclusive to expatriates in the Oil and Gas sector to repatriate them to their home countries for better medical care and attention. However, today such services are available and accessible commercially. I was privileged to be on one in my home country.

The patient to be evacuated, Mr. I.I, a 45year old Nigerian male with a background history of hypertension and type II diabetes mellitus not regular on medications who had presented with a recent history of right side hemispheric stroke possibly ischemic and was stabilized in a hospital in his country home. His vitals as at the time of contacting the aeromedical evacuation team was a blood pressure of 150/90mmHg, temperature of 37.1 C, Pulse of 90/minute regular, synchronous with no radio-radial or radio-femoral delays, respiratory rate of 18cycles/min and a SpO2 of 96-100%. The patient was conscious, alert oriented in time place and person with a Glasgow Coma Score of 15/15. He was to be airlifted from Port Harcourt to Lagos for specialist care. The first thing that caught my attention was the high level of commitment of the flight physicians on call. It was an early morning evacuation but the response time was 23minutes. The team comprised an anesthetist, a senior flight physician, me, the paramedics, the pilot, co-pilot and the cabin crew. The anesthetist was given a clear role as the lead physician. He read out the medical history of the patient to be evacuated, possible an etiology, various modes by which such patients could present, the complications, risks of flying such patients at various altitudes, safety precautions to be taken and look-out signs on such patients. He stated that all such details have been explained to the relatives of the patients and they have signed a consent form with the legal team before we proceeded with this evacuation.

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Olutomiwa Ogunbona
Flying Doctors Nigeria, Nigeria

Correspondence: Olutomiwa Ogunbona, Flying Doctors Nigeria, 2nd Floor, EAN Hanger Jet Centre, FAAN Transit Camp Road, Nigeria, Tel +2348034330784, Email tommyogunbona@gmail.com

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Simultaneously, I could see the flight engineers on the aircraft. I later found out that they were checking all the medical equipments were fully functional, the batteries fully charged and that the Air Transport Stretchers were comfortable for a non-ambulant patient. Just as we boarded, the lead physician took a few minutes off to repeat a summary of the patient to the pilot, co-pilot and cabin crew. Then we were cleared for take-off. Aboard, we took turns to refresh one another on various topics in Advanced Cardiac Life Support. It was a 45minutes flight. On ground at the Port Harcourt Airport, the patients was at the tarmac with a land ambulance, had an anesthetist, 2 physicians and a few paramedics. The lead physician again lead us to the patient, introduced us one after the other to the team on ground, I was asked to do a Pre-flight assessment of the patient. This included documenting the vital signs of the patient, performing and documenting general physical examination as well as systemic examination. Then the lead physician who was discussing with the on ground physicians and relatives came over to do a run through of yet another general physical examination but picked out only the affected systems for examinations. He then explained to the patient the risk associated with flying him, possible complications that could arise and the steps that have been taken but to forestall and control.

He was then loaded into the air ambulance using a vacuum stretcher. He had his face mask connected; Intravenous fluid was set at 15drops/minute. One of paramedics was assigned to monitor the vitals of the patient every 10minutes. On ground at the Lagos airport, the receiving hospital had sent a land ambulance with paramedics to transport the patient over. The lead physician again briefed them on the clinical state of the patient after doing his Post-flight assessment. We were then ushered to the airport lounge for a debrief and brunch.

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Conflict of interest

The author declares no conflict of interest.