



Sistema Socio Sanitario



ORDINE DEI MEDICI CHIRURGHI E DEGLI ODONTOIATRI  
DELLA PROVINCIA DI BERGAMO

«FILIPPO LUSSANA MEDICO CHIRURGO (1820 - 1897)»

# Le Maxi-Emergenze

## 18.10.2025

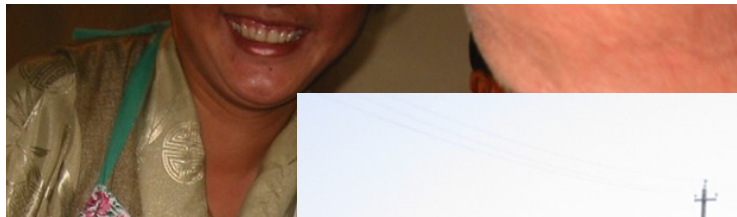


# Formazione integrata extra ed intra-ospedaliera



## Roberto Faccincani

### SSD Maxiemergenze



**Strategic Management Board:**

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To whom

This is to

Has succeeded

During the course completed in the e-learning Hospital Acute Care Threshold (MCI) acute care (MCI). Ex

The official Emergency

On behalf

Prof. Franco  
 Chair, Dept  
 Master of  
 Azienda I  
 Viale Maz

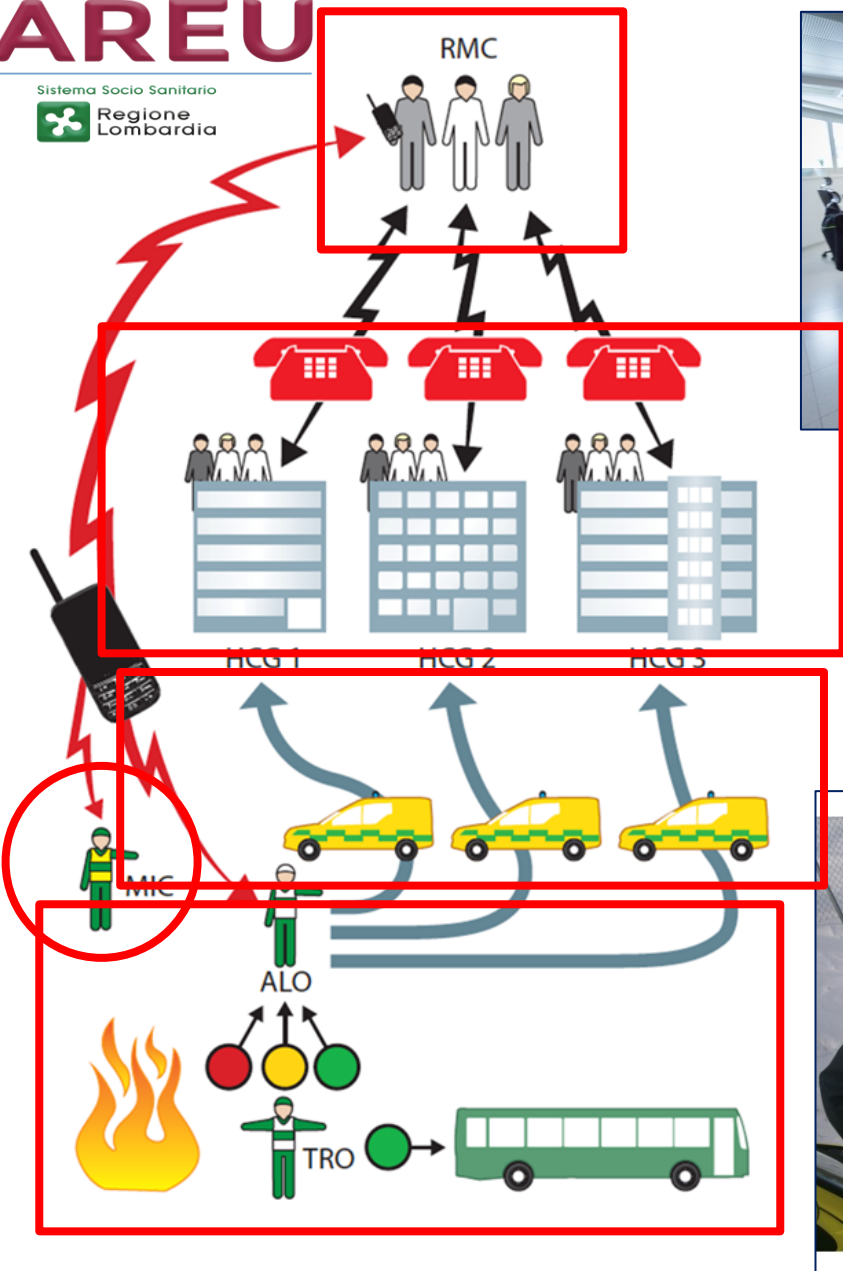
**Organizing Universities**

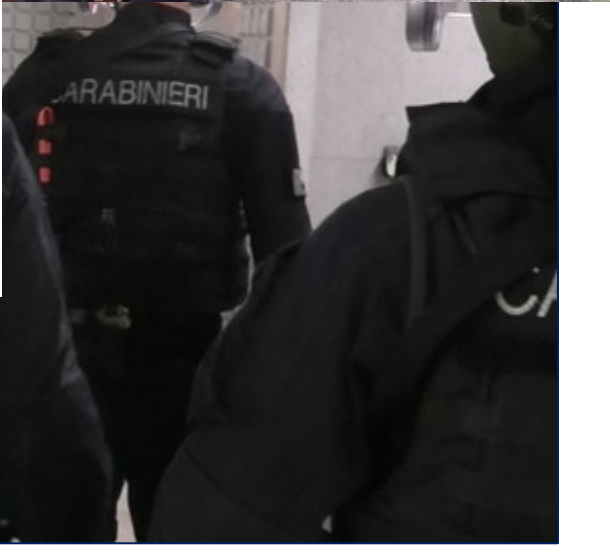
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 Vrije Universiteit Brussel, Belgium

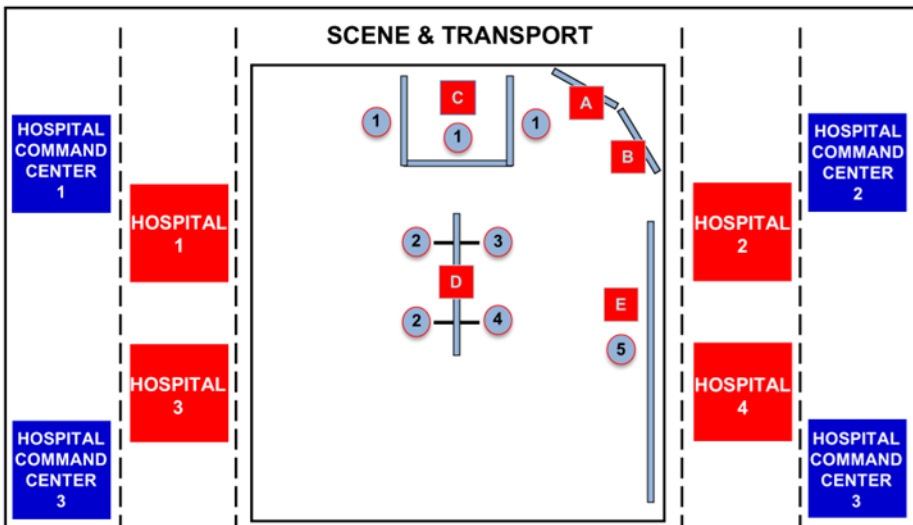


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(d) How capable would you be to perform primary (first) triage of arriving casualties in the hospital in a major incident today?

25



www.estesonline.org

# ESTES

EUROPEAN SOCIETY FOR TRAUMA AND EMERGENCY SURGERY

- A = City map
- B = Command on scene
- C = Site of incident
- D = Triage-lines
- E = Transport
- 1. Primary triage
- 2. Secondary triage
- 3. Secondary triage
- 4. Waiting for transport
- 5. Ambulances & transport

MEDICAL

STERS




**ASU**  
Azienda Sanitaria Universitaria  
Giuliano Isontina



GESTIONE SANITARIA DI UNA  
MAXI-EMERGENZA  
TRAUMATICA SECONDO  
IL MODELLO MRMI

**Asl2**

Sistema Sanitario Regione Liguria



REGIONE AUTONOMA FRIULI VENEZIA GIULIA

AGENZIA REGIONALE E



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Milano, 14 luglio 2025

Prot. n. 24161/25

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Direttore Sanitario  
AREU - Agenzia Regionale Emergenza Urgenza  
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**Oggetto: programma formativo ed esercitativo congiunto AREU – ASST GOM Niguarda per la gestione delle maxiemergenze in Regione Lombardia – proposta partnership\_RISCONTRO**

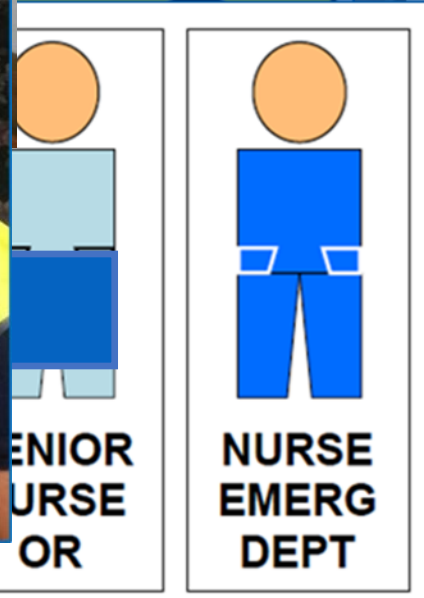
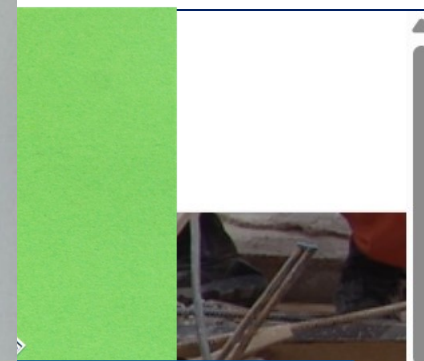
Nel prendere atto della richiesta che si valuta pertinente agli obiettivi del progetto olimpico approvato con DGR n. XII/2931 del 05/08/2024, al fine di valutare la capienza del finanziamento complessivo assegnato dalla sopra citata DGR alla scrivente ASST, si richiede di acquisire preliminarmente un programma dei corsi di formazione correlati all'evento Olimpico/Paraolimpico, con i relativi costi, che AREU o ha già condotto nel 2025 o intende realizzare nel 2025 e 2026.

Cordiali saluti.





- 1)
- 2)
- 3)
- 4) an
- 5)
- 6)



Training Speciale n

1) Low costs

2) Low complexity

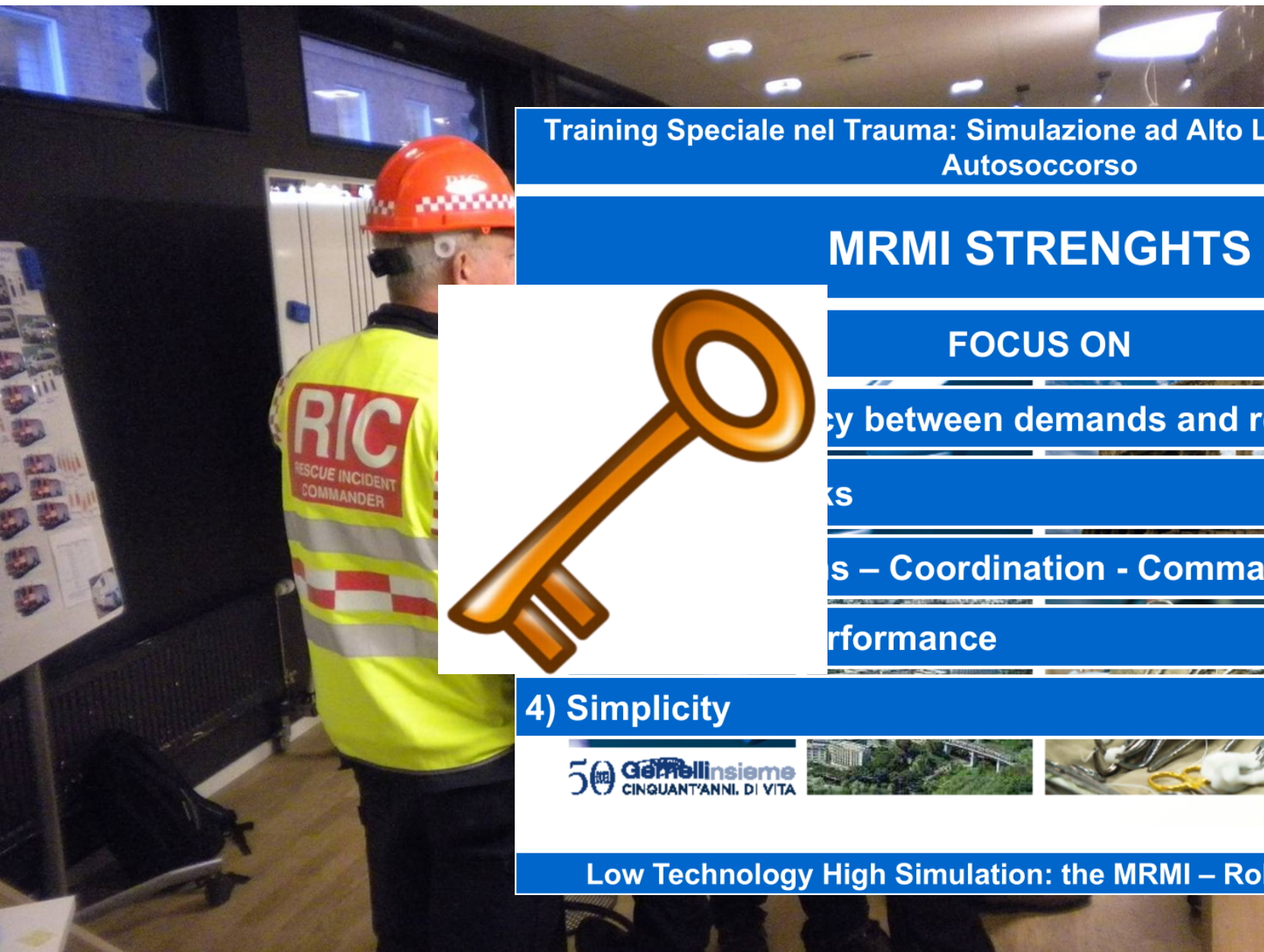
3) Portability

4) Fisical interact



50 **Gemelliinsieme**  
CINQUANT'ANNI DI VITA

Low Technology



Training Speciale nel Trauma: Simulazione ad Alto Livello e Tecniche di Autosoccorso

# MRMI STRENGTHS

FOCUS ON

...y between demands and resources

...ks

...s – Coordination - Command chain

...formance



4) Simplicity

50 **Gemelliinsieme**  
CINQUANT'ANNI DI VITA



TRAUMIA OGGI

Low Technology High Simulation: the MRMI – Roberto Faccincani

## STAFF OSPEDALIERO

ENTRANCE HALL

**NON-DANGER PATIENT**

Blue in color  
No red or yellow  
No oxygen or suction  
No IV or blood  
No incontinent

**NON-DANGER PATIENT**

Blue in color  
No red or yellow  
No oxygen or suction  
No IV or blood  
No incontinent

**NURSE EMERGENCY**

Blue in color  
No red or yellow  
No oxygen or suction  
No IV or blood  
No incontinent

Blue in color  
No red or yellow  
No oxygen or suction  
No IV or blood  
No incontinent

Blue in color  
No red or yellow  
No oxygen or suction  
No IV or blood  
No incontinent

Blue in color  
No red or yellow  
No oxygen or suction  
No IV or blood  
No incontinent

### Harbor City Hospital

ENTRANCE HALL

MOC
AOC
STAFF
SECR

### HCG STAFF

MOC
AOC
STAFF
SECR

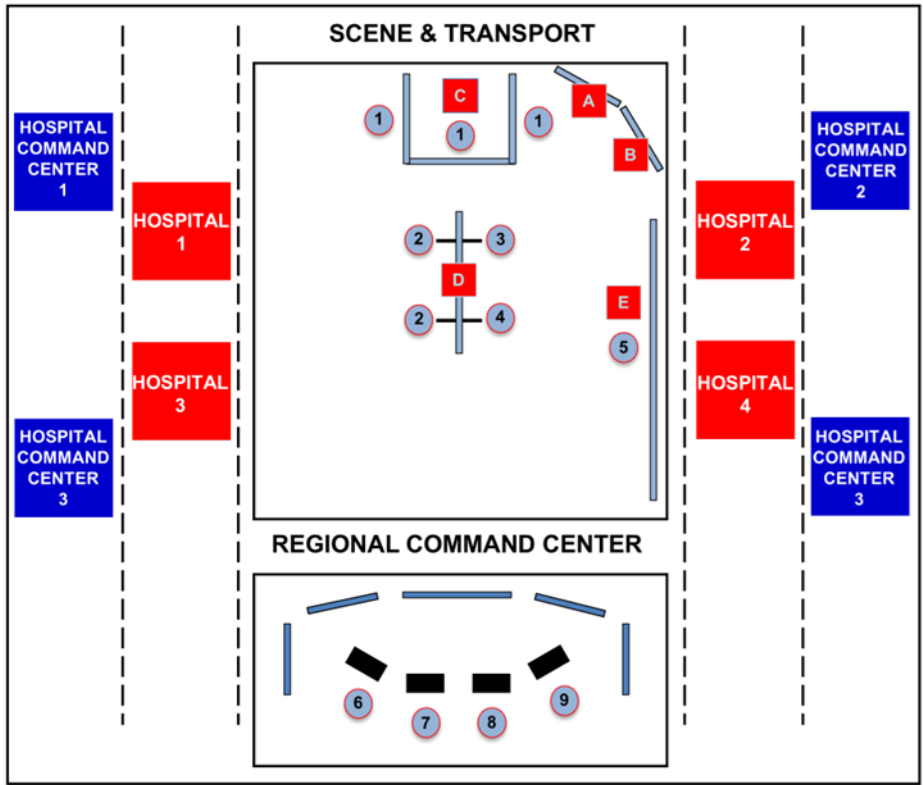
### HCG SUPPORT GROUP

MANAGER TECHN SUPPORT	MANAGER INFO
MANAGER IT SUPPORT	COORDIN NURSING STAFF
MANAGER SECURITY	COORDIN ADM STAFF
MANAGER SUPPLIES	COORDIN PSYCHO SOCIAL STAFF
MANAGER TRANSP	MANAGER CATERING

### AREA VERDE

STAFF SENT HOME FOR STAND-BY ON TELEPHONE

POSTOP					
STAFF	PATIENT	STAFF	PATIENT	STAFF	PATIENT



- A = City map
- 1. Primary triage
- 6. Ambulance Dispatch
- B = Command on scene
- 2. Secondary triage T1, T2
- 7. Regional Medical Command
- C = Site of incident
- 3. Secondary triage T3
- 8. Rescue Command
- D = Triage-lines
- 4. Waiting for transport, re-triage
- 9. Police Command
- E = Transport
- 5. Ambulances & helicopters

NEEDING VENTILATOR		
NEEDING IN-HOSPITAL TREATMENT		
AMBULATORY		
DEAD		

If need to continue = Take photo before deleting and then restart



### MAPS OF HOSPITALS

**NON-DANGER PATIENT**

Blue in color  
No red or yellow  
No oxygen or suction  
No IV or blood  
No incontinent

**NON-DANGER PATIENT**

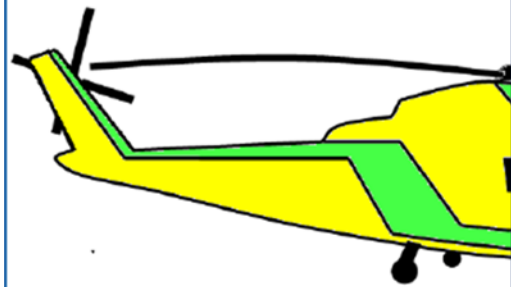
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**NON-DANGER PATIENT**

Blue in color  
No red or yellow  
No oxygen or suction  
No IV or blood  
No incontinent

**NON-DANGER PATIENT**

Blue in color  
No red or yellow  
No oxygen or suction  
No IV or blood  
No incontinent



1. Cerebral contusion with bleeding and (intracranial pressure),  
 (scapnel) right  
 ries  
 ft thigh, right arm  
 , IX left, small  
 V (organ injury)



	AMPIA LACERAZIONE
	AMPUTAZIONE TRAUMATICA
	È / È STATO BLOCCATO/ INCARCERATO

SUPINO IN SILENZIO	SUPINO CHIEDE AIUTO	A TERRA IN SILENZIO	A TERRA CHIEDE AIUTO

**SURG**

**SPEC**

**RESID**

**PHYS ON CALL**

**SENIOR NURSE OR**

**NURSE EMERG DEPT**

# Primary Treatment Scene

1. Triage
2. Basic life-saving procedures
  - A - Secure the airway
  - B - Chest decompress
  - C - Stop

“Exsanguination remains a major problem in attacks using high-velocity war weapons. Education of all rescuers with tourniquet and haemostatic dressing might be a simple and efficient solution for some patients and a rapid transfer to hospital.”

The French emergency medical services after the Nice terrorist attacks: what have we learnt?

On Nov 15, 2015, Paris was the scene of multiple mass casualty terrorist attacks that were the most lethal and devastating in the history of France since World War II, resulting in the deaths of 197 people and injuring 3,417. On July 14, 2016, France was targeted again by the attack on Nice in which a truck was deliberately driven through a pedestrian promenade, resulting in the deaths of 41 people and injuring 203. Since the attack on Nice, several further terrorist attacks have occurred in Europe (Figure 1) providing the real proof that the threat has spread to many countries.

The remaining conflict in Iraq, Libya, and Syria indicate that many countries will face such incidents for many years. Preparing and adapting our emergency plans to face this modernized threat is crucial. The medical response to terrorist attacks does not have a routine working flow. This is also evident as a message to our people: we shall never surrender to terrorism. In this respect, we present a synopsis of the measures taken to prevent or improve our medical capacity to face the unexpected



# Primary In-hospital

Precision of In-Hospital Triage in Mass-Casualty Incidents after Terror Attacks. *Prehospital and Disaster Medicine, 21(1), 20-23*  
 Ashkenazi, I., Kessel, B., Khashan, T., Haspel, J., Oren, M., Olsha, O., & Alfici, R. (2006).

**Chapter Statement**

The diagnosis of shock is based on clinical recognition of the presence of inadequate tissue perfusion and oxygenation; the first step in the initial management of shock is to recognize its presence.

Indicazioni per un Piano di risposta ospedaliera ad una Maxi-emergenza di carattere traumatico

A cura della SCUT  
 Società Italiana di Chirurgia d'Urgenza e del Trauma

# Scene



# Primary Treatment In-hospital

The MAC strategy in the ED, with limited use of imaging, emphasis on plain film examinations, and CT reserved for potentially severe head injuries, was successful in preventing the ED from becoming a bottleneck.

Emergency Radiology

Radiology response in the emergency department during a mass casualty incident: a retrospective study of the two terrorist attacks on 22 July 2011 in Norway

Marcus Nohoy Young<sup>1</sup>, Steinhilber B. Eggseth<sup>2</sup>, Christian Gundersen<sup>3</sup>, Per Arne Naess<sup>4,5</sup>, Svein Tvedes<sup>6</sup>

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**Abstract**  
 Objectives To describe the use of radiology in the emergency department (ED) in a trauma center during a mass casualty incident, using a mass casualty care (MAC) strategy in which CT was restricted to potentially severe head injuries. Methods We retrospectively studied the initial use of imaging on patients triaged to the trauma center following the twin terrorist attacks in Norway on 22 July 2011. Results Most patients from the explosion and 15 from the shooting were included. Fracture patients had an Injury Severity Score  $\geq 15$ . During the first 15 h, 2234 patients underwent imaging in the ED. All 15 gunshot patients had plain film taken in the ED, compared to three from the explosion. A CT was performed in 1524 patients; ten of these were completed in the ED and included five non-head CTs, the latter representing deviations from the MAC strategy. Six CT referrals were delayed or declined. Mobilization of radiology personnel resulted in a saving of the wait.

**Conclusions** Plain film and CT capacity was never exceeded despite deviations from the MAC strategy. An optimized disaster management plan will require the radiologist to cancel non-head CTs performed in the ED until no additional MCI patients are expected.

**Key points**

- Minimum acceptable care (MAC) should replace normal numbers in mass casualty incidents.
- MAC applied reduced use of imaging in the emergency department (ED).
- CT in ED was restricted to suspected severe head injuries during MCI.
- The radiologist should cancel all non-head CTs in the ED during MCI.

**Keywords** Mass casualty incident · Emergency radiology · Radiology department · Disaster planning · Trauma

**Introduction**

In a mass casualty incident (MCI), the capacity to provide rapid and trauma care is challenged and will be challenged [1–6]. Consequently, normal routines are replaced by a minimum acceptable care (MAC) strategy aimed at rapid assessment and limited triaging procedures using minimal resources, including imaging, followed by movement of patients to open definite diagnosis and management [1, 5, 7]. Whether during an MCI or any trauma triaging in the emergency department (ED) should include plain X-rays of chest and pelvis, and focused assessment with ultrasound for trauma (FAST) as a screening tool for the abdomen [8]. When applying a MAC strategy, the use of computed tomography (CT) in the ED is restricted to the assessment of severe head injuries. This is different from the routine initial diagnostic work-up of potentially severely injured patients with frequent use of head and body CT combined, as is with the Advanced Trauma Life Support (ATLS) radiological guidelines [1, 5, 9].

**Editor**

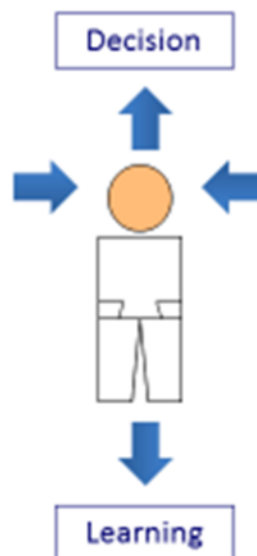
# Training ~~X~~ on job



## Training of decision making

Access to **all** information on which the decision should be based:

- Patients' injuries
- Patients' condition (dynamic, not static!)
- Available resources
- Estimated total casualty-load
- Geography, climate



Feedback on **all** consequences of the decision

- Consumption of time
- Consumption of resources
- Preventable mortality/complications related to injury severity
- Efficiency in utilization of resources (accuracy of alert, accuracy in triage)





It does  
Medi

**CENTRO CONGRES**



azione ad  
corso

the MRMI  
dents

novembre 2013  
 REGNO  
 NAZIONALE  
 IUMA OGGI

erto Faccincani  
 Raffaele, Milano  
 MRMI Italia

# GRAZIE PER L'ATTENZIONE

# AREU

Sistema Socio Sanitario



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