Editor's Response to "Rescuing the Physical Exam"

The message contained in the above letter by Ethan G. Brown and Dr Jay Lemery regarding the enhanced importance of the physical examination of patients in a wilderness setting has been driven home to me. I am now 1 week home after responding as part of an emergency medicine team with the International Medical Corps (along with Dr Paul Auerbach, Dr Anil Menon and other emergency medicine professionals from Stanford University and Columbia University) to earthquake victims in Haiti. We responded to the completely incapacitated Hôpital de l'Université d'État d'Haiti (HUEH) in Port-au-Prince on day 5 after the quake and found ourselves confronted with approximately 800 severely traumatized victims. It was our job to rapidly assess and resuscitate these victims, clean and bandage horrendous wounds, splint shattered extremities, and transport victims by priority of medical necessity to a limited operating room (2 functioning operating tables where dedicated orthopedists performed "battlefield surgery"). We relied solely upon our physical examination skills to make diagnoses—to differentiate crushed and contused extremities from humeral fractures, femur fractures, and pelvic fractures—in the absence of radiographic capabilities for the first week of our stay. We limited administration of tetanus immune globulin to persons with signs and symptoms of early tetanus in order to conserve critically short supplies, and prudently reserved use of precious intravenous fluids and sodium bicarbonate for victims whose exams supported the diagnosis of actual or impending rhabdomyolysis. After several days, when the Mercy class hospital ship, USNS Comfort, anchored offshore, we worked with the Army and the Navy to airlift patients with needs beyond our capabilities to the ship (and to other local medical relief sites). The types of cases these providers sought were precisely defined, which further put our physical diagnosis skills to the test. Anemia was diagnosed by the color of a victim's tongue, conjunctivae, and the soles of his feet; pneumothorax by decreased breath sounds and subcutaneous crepitus; and necrotizing infection by the putrid odor.

For our first week, we used nothing more than physical diagnosis skills to inform critical triage and treatment decisions. Medical students who read Brown and Lemery's letter should take it to heart and pay close attention to the professors teaching "physical diagnosis." You never know when you will be put to the test.

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Morbidity Related to Urban Summer Camp Activities in Scholars, Caracas, Venezuela, 2008

To the Editor:

Summer vacations represent important opportunities for recreation and travel of young people from schools and universities. These students may be involved in many different activities, organized and not. A common source of recreation for such students is participation in summer camps, in the city or outside it. In either case, these activities can result in acute medical problems and exacerbation of pre-existing chronic medical conditions.^{1,2} Here we describe the experience related to the medical needs of students during urban summer camp activities held in Caracas, Venezuela, during school vacation in 2008.

A summer camp organization prepared daily activities for 2 groups of school children during 2 separate weeks and lasting 5 days each during August and September. Different logistical elements were taken in account in planning these activities, including medical care. Resources included 1 medical doctor per group and 1 paramedic per subgroup of 100 children. In the first group of campers, 500 children participated (cared for by 1 medical doctor, 5 paramedics, and 1 trained ambulance driver). In the second group of campers, 300 children participated (cared for by 1 medical doctor, 5 paramedics, and 1 trained ambulance driver). One dedicated ambulance was always with each group during all activities. Children and organizers were transported between the activity locations in comfortable, air-conditioned, 2-level buses. Activities took place in different locations and facilities of the city, including cinemas and theaters, zoo parks, country clubs with swimming pools, beach clubs, and public and private parks (both groups visited the same places during different weeks). We reviewed, and here describe, the medical issues that arose with students, and which were treated and recorded by the medical staff.

In total, 800 children were included in this analysis: 58% girls and 42% boys ($P < .05$) (no significant differences of sex distribution between camper groups, $P > .05$). All were school-age children with a mean age of 7.2 ± 1.7 years ($\pm$ SD) (no significant differences between groups, $P > .05$). From the total, 83 (10.4%) suffered some medical condition during the summer camp (a mean of 8 children per day, 10.38 adverse events per 1000 camper-days), with no significant differences between the first group (10.0%, 7 children per day) and the second group (11.0%, 11 children per day) ($P > .05$). There were no significant differences in incidence according to sex ($P < .05$). Ten children were known with asthma requiring treat-