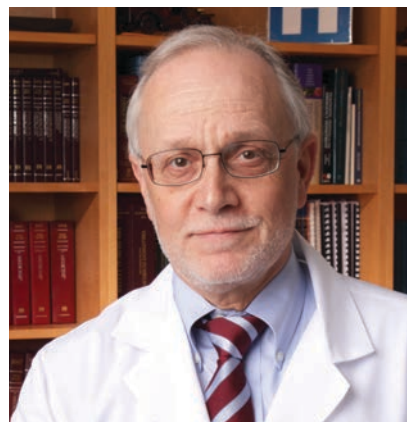


# Emergency Care When the Music Stops



In this issue of *Emergency Medicine (EM)*, emergency physician (EP) Christopher Hunter, MD, and his colleagues from Orlando Regional Medical Center (ORMC) share their first-person experiences planning for and dealing with the medical issues presented by an estimated 40,000 people attending an annual outdoor electronic dance music festival on each of 2 days in November 2016. Reacting to the overwhelming burden that had been placed on their ED and hospital by the same event the year before, the ORMC EPs demonstrate how a coordinated approach to planning and execution by EPs, the local emergency medical services system, festival organizers, and disaster response groups can accurately anticipate and effectively deal with the myriad of urgent and emergent needs presented by this type of event. In recent years, the number of such events throughout the country has been increasing rapidly.

This same group of skilled and dedicated ORMC EPs authored a first-person account in the August 2016 issue of *EM* (*The Orlando Nightclub Shooting: Firsthand Accounts and Lessons Learned. Emerg Med. 2016;48(8):348-356*), describing how they handled the aftermath of the Pulse Nightclub mass casualty incident (MCI), which also occurred in close proximity to ORMC.

Tragically, as this issue of *EM* was

going to press, the world was shocked by yet another terrorist MCI, this time at a concert venue in Manchester, England. The lethal explosives were detonated in Manchester by a suicide bomber just outside the arena as the exiting crowd was heading to the nearby railroad station. This latest MCI claimed the lives of at least 22 children, parents, and young adults, and is of great concern to all who participate in concerts and large outdoor events: We must now consider the possibility of incidents combining the problems described in both of the first-person accounts mentioned above.

The most recent wave of terrorist MCIs, including the 2016 Orlando Pulse Nightclub shootings (49 deaths, 53 injuries, all but four victims were under the age of 40 years); the November 2015 terrorist incidents in Paris, including the Bataclan theatre rock concert massacre (89 deaths); and the April 15, 2013 Boston Marathon bombing (three deaths—ages 8, 23, 29 years—and 264 injuries), have all targeted mostly children and young adults.

In contrast, the victims of previous terrorist MCIs were mostly working adults. Of the almost 3,000 people who died in the 9/11 World Trade Center (WTC) and Pentagon attacks, almost all were between 35 and 39 years old, with the youngest WTC tower victim 18 years of age and the

oldest 79. Terrorist activities in trains such as the March 11, 2004 Madrid commuter train bombings (192 deaths, about 2,000 injuries), and the March 20, 1995 Tokyo subway sarin gas release (12 deaths, over 1,000 severe injuries) also appeared to have targeted adults traveling to work during rush hours.

Clearly, EPs have an important role to play in providing urgent and emergent care at large outdoor gatherings, and emergent care and resuscitation of victims after natural and man-made MCIs. But the prospect of both types of events occurring in rapid succession at the same venue underlines the importance of preserving hospital-based ED resources during large gatherings by treating and releasing the majority of patients with festival-related illnesses and minor injuries on-site, as described in this month's cover article.

The proliferation of EP-staffed urgent care centers and freestanding EDs (FSEDs) in recent years has demonstrated the ability of EPs to provide expert, needed emergency care *outside of the walls of traditional, hospital-based EDs*—a healthy trend for the future of emergency medicine. Like “pop-up” seasonal retail stores, the “pop-up FSED” described here by the ORMC EPs will become an increasingly important means of delivering urgent and emergent care in the future. ■