SHORT REPORT

ABCDEs

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It is generally accepted that the priorities, when resuscitating an ill patient are ABC, to which one can add D and E for the injured patient. I have been practising emergency medicine for over 20 years both in hospital and, occasionally, out of hospital and I am sure that I am not alone in still finding it helpful to say to myself "A.... B.... C...." etc, as I assess and treat a severely ill or injured patient.

A few years ago I was asked to give a guest lecture on a first aid course and made the above two points. The lecture seemed to be well received but at question time one of the participants commented that whereas everyone seemed to agree that the priorities were ABC, nobody could agree on what ABC stood for. It turned out that I had been teaching the Advanced Trauma Life Support (ATLS) system of **A**irway with cervical spine protection, **B**reathing, **C**irculation, **D**isability and **E**xposure and **E**nvironment¹ whereas they, on an officially recognised first aid course, were being taught **A**ssess and **A**irway, **B**reathing, **C**irculation, **D**eformities and **E**motions and **E**nsure (that is, recheck all that you have previously done). Since then I have also discovered **A**ssess, **B**reathing and **B**leeding, **C**onsciousness; **A**irway, **B**leeding, **C**irculation; **A**irway, **B**reathing, **C**ervical spine; **A**irway, **B**reathing, **C**irculation, **D**rugs (for neonatal resuscitation)² and **A**irway, **B**reathing, **C**irculation, **D**ecompression (of the stomach—that is, gastric tube), **E**limination (catheterisation) and **F**luids.³ **E** seems a particular problem: in the original ATLS protocol⁴ **E** stood for **E**xposure (expose the patient) but this was of no relevance and was possibly even wrong advice for prehospital care and **E** now stands for **E**xposure and **E**nvironment.¹ In the APLS protocol⁵ **E** still stands for **E**xposure. I have also seen **E** standing for **E**xamine (that is, to start the secondary survey) and, more than once, **E**valuate and **E**nvironment.

Many of these ABCs have not been in published documents but have rather been in handouts or aide memoires given out at first aid lectures though one was a draft document that I was asked to review with a view to it becoming a national protocol for the ambulance service.

When dealing with special situations you may need to add additional priorities. The TOXALS system for advanced life support for contaminated patients recommends **A**ssess and **A**irway, **B**reathing, **C**irculation, **D**econtaminate and **D**isability but **E** stands for **E**vacuation⁶ or **E**vacuation and **E**valuation.⁷

No guideline should be set in stone, as treatment may change with advancing medical knowledge but just as in cardiac arrest, any cardiopulmonary resuscitation (CPR) is better

than no CPR,⁸ so in trauma, any system of assessing and treating patients is better than no system. There is a value to simplicity in helping people to learn and retain knowledge and a system based on a simple ABCDE mnemonic has much to commend it.⁸ However, for different people to use the same mnemonic but with the letters standing for different things is confusing, particularly for lay people. Prehospital and in-hospital staff should speak the same "language".¹

I do not wish to stifle novel alphabetical mnemonics and I particularly like the advice of an experienced mountain rescue leader that casualties should try to **A**mbulate **B**efore **C**arry and the recommendation for sick children that after **A**BC, **D**on't **E**ver **F**orget **G**lucose. It is also sensible to **A**nticipate **B**efore **C**omplications. However, when teaching the assessment and resuscitation of ill and injured patients, particularly to lay people, we should stick to one ABCDE (with additions, if necessary, for special circumstances). Different organisations involved with teaching resuscitation and first aid should agree a common use of ABCDE. To do otherwise causes confusion that may lead to error and it should never be forgotten that the results of error are often **A**ccusation, **B**lame and **C**omplaint with demand for **C**ompensation.

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REFERENCES

- 1 **Committee on Trauma**, American College of Surgeons. *Advanced trauma life support course*. 6th edn. Chicago: American College of Surgeons, 1997.
- 2 **McKlveen RE**, Ostheimer GW. Resuscitation of the newborn. *Clin Obstet Gynecol* 1987;**30**:611–20.
- 3 **Livingston EH**, Passaro EP. Resuscitation, revival should be the first priority. *Postgrad Med* 1991;**89**:117–22.
- 4 **Committee on Trauma**, American College of Surgeons. *Advanced trauma life support course* 1988. Chicago: American College of Surgeons, 1989.
- 5 **Advanced Life Support Group**. *Advanced paediatric life support*. 3rd edn. London: BMJ Books, 2001.
- 6 **Baker DJ**. Management of respiratory failure in toxic disaster. *Resuscitation* 1999;**42**:125–31.
- 7 **Baker DJ**. Advanced life support for acute toxic injury. *European Journal of Emergency Medicine* 1996;**3**:256–62.
- 8 **Handley AJ**, Becker LB, Allen M, et al. Single rescuer adult basic life support. *Resuscitation* 1997;**34**:101–8.