

Tactical Combat Casualty Care

Introduction

For US military men and women wounded on the battlefield, the most critical phase of care is the period from the time of injury until the time that they arrive at a medical treatment facility (MTF) capable of providing surgical care. If a casualty survives long enough to reach the care of a combat trauma surgeon, the likelihood is very high that he or she will survive. Almost 90% of US service men and women who die from combat wounds do so before they arrive at an MTF.¹ This fact highlights the importance of the battlefield trauma care provided by combat medics, corpsmen, and pararescuemen (PJs), as well as non-medical unit members, in improving the survival of the country's combat wounded.

Prehospital trauma care in the US military has undergone an unprecedented transformation in the last 2 decades with the advent of Tactical Combat Casualty Care (TCCC). TCCC is a set of evidence-based, best-practice prehospital trauma care guidelines customized for use on the battlefield. DoD Instruction 1322.24, Medical Readiness Training (MRT), effective 16 March 2018, provides added guidance.

The need for reconsideration of prehospital trauma care guidelines in the tactical setting has long been recognized, but had not been accomplished as of 1992, when a research project was undertaken as a combined effort of the US Special Operations Command and the Uniformed Services University of the Health Sciences. This effort resulted in the publication of the original TCCC Guidelines in 1996.²

After 10 years of intense combat operations in Iraq and Afghanistan by the Ranger Regiment, Kotwal and colleagues reported that the incidence of preventable deaths among 419

combat casualties sustained by the 75th Rangers was 3%,³ and that the single death that was deemed preventable occurred in the hospital, not the prehospital, setting. This finding stands in stark contrast to the 15% to 28% reported in other studies of preventable deaths among US casualties in these conflicts.^{1,4,5} Considering the prehospital phase only, the incidence of preventable deaths among fatalities in the 75th Rangers was zero, as compared to 24% in a study by Eastridge et al.¹ The remarkable disparity in the incidence of preventable deaths between early adopters of TCCC and the rest of the US military was not widely known until the Kotwal study was published in 2011,³ followed by the Eastridge study in 2012.¹

After 16 years of conflict in the Middle East, US military units that have trained their members in TCCC have documented the lowest incidence of preventable deaths among their casualties in the history of modern warfare. The accumulated published evidence and battlefield experience has resulted in all services in the US military, and many allied nations, using TCCC concepts to care for their combat wounded. TCCC-based prehospital trauma training is now widespread in the US civilian sector as well. Although observed differences in potentially preventable deaths may be due to differences in the methodology of determining which deaths are considered potentially preventable, in 2017 there is little disagreement that the interventions pioneered by TCCC do clearly reduce preventable deaths during the phase of care when they are most likely to occur.⁶⁻⁸ As a result of the TCCC's success at saving lives on the battlefield, on 16 March 2018, the Department of Defense mandated TCCC training for everyone in the US military.⁹

References

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The guidelines printed below were updated in August 2017. They are divided into three sections: care under fire, tactical field care, and tactical evacuation care.

TCCC Guidelines for Medical Personnel

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Basic Management Plan for Care Under Fire

1. Return fire and take cover.
2. Direct or expect casualty to remain engaged as a combatant if appropriate.
3. Direct casualty to move to cover and apply self-aid if able.
4. Try to keep the casualty from sustaining additional wounds.
5. Casualties should be extricated from burning vehicles or buildings and moved to places of relative safety. Do what is necessary to stop the burning process.
6. Stop life-threatening external hemorrhage if tactically feasible:
 - a. Direct casualty to control hemorrhage by self-aid if able.
 - b. Use a CoTCCC-recommended limb tourniquet for hemorrhage that is anatomically amenable to tourniquet use.
 - c. Apply the limb tourniquet over the uniform clearly proximal to the bleeding site(s). If the site of the life-threatening bleeding is not readily apparent, place the tourniquet "high and tight" (as proximal as possible) on the injured limb and move the casualty to cover.
7. Airway management is generally best deferred until the Tactical Field Care phase.

Basic Management Plan for Tactical Field Care

1. Establish a security perimeter in accordance with unit tactical standard operating procedures and/or battle drills. Maintain tactical situational awareness.
2. Triage casualties as required. Casualties with an altered mental status should have weapons and communications equipment taken away immediately.
3. Massive Hemorrhage
 - a. Assess for unrecognized hemorrhage and control all sources of bleeding. If not already done, use a CoTCCC-recommended limb tourniquet to control life-threatening external hemorrhage that is anatomically amenable to tourniquet use or for any traumatic amputation. Apply directly to the skin 2–3 inches above the bleeding site. If bleeding is not controlled with the first tourniquet, apply a second tourniquet side-by-side with the first.
 - b. For compressible (external) hemorrhage not amenable to limb tourniquet use or as an adjunct to tourniquet removal, use Combat Gauze as the CoTCCC hemostatic dressing of choice.
 - Alternative hemostatic adjuncts:
 - Celox Gauze or
 - ChitoGauze or
 - XStat (Best for deep, narrow-tract junctional wounds)
 - Hemostatic dressings should be applied with at least 3 minutes of direct pressure (optional for XStat). Each dressing works differently, so if one fails to control bleeding, it may be removed and a fresh dressing of the same type or a different type applied. (Note: XStat is not to be removed in the field, but additional XStat, other hemostatic adjuncts, or trauma dressings may be applied over it.)
 - If the bleeding site is amenable to use of a junctional tourniquet, immediately apply a CoTCCC-recommended junctional tourniquet. Do not delay in the application of the junctional tourniquet once it is ready for use. Apply hemostatic dressings with direct pressure if a junctional tourniquet is not available or while the junctional tourniquet is being readied for use.

4. Airway Management

- a. Conscious casualty with no airway problem identified:
 - No airway intervention required
 - b. Unconscious casualty without airway obstruction:
 - Place casualty in the recovery position
 - Chin lift or jaw thrust maneuver or
 - Nasopharyngeal airway or
 - Extraglottic airway
 - c. Casualty with airway obstruction or impending airway obstruction:
 - Allow a conscious casualty to assume any position that best protects the airway, to include sitting up.
 - Use a chin lift or jaw thrust maneuver
 - Use suction if available and appropriate
 - Nasopharyngeal airway or
 - Extraglottic airway (if the casualty is unconscious)
 - Place an unconscious casualty in the recovery position.
 - d. If the previous measures are unsuccessful, perform a surgical cricothyroidotomy using one of the following:
 - Cric-Key technique (preferred option)
 - Bougie-aided open surgical technique using a flanged and cuffed airway cannula of less than 10 mm outer diameter, 6–7 mm internal diameter, and 5–8 cm of intratracheal length
 - Standard open surgical technique using a flanged and cuffed airway cannula of less than 10 mm outer diameter, 6–7 mm internal diameter, and 5–8 cm of intra-tracheal length (least desirable option)
 - Use lidocaine if the casualty is conscious.
 - e. Cervical spine stabilization is not necessary for casualties who have sustained only penetrating trauma.
 - f. Monitor the hemoglobin oxygen saturation in casualties to help assess airway patency.
 - g. Always remember that the casualty's airway status may change over time and requires frequent reassessment.
- * The i-gel is the preferred extraglottic airway because its gel-filled cuff makes it simpler to use and avoids the need for cuff inflation and monitoring. If an extraglottic airway with an air-filled cuff is used, the cuff pressure must be monitored

to avoid overpressurization, especially during TACEVAC on an aircraft with the accompanying pressure changes.

- * Extraglottic airways will not be tolerated by a casualty who is not deeply unconscious. If an unconscious casualty without direct airway trauma needs an airway intervention, but does not tolerate an extraglottic airway, consider the use of a nasopharyngeal airway.
- * For casualties with trauma to the face and mouth, or facial burns with suspected inhalation injury, nasopharyngeal airways and extraglottic airways may not suffice and a surgical cricothyroidotomy may be required.
- * Surgical cricothyroidotomies should not be performed on unconscious casualties who have no direct airway trauma unless use of a nasopharyngeal airway and/or an extraglottic airway have been unsuccessful in opening the airway.

5. Respiration/Breathing

- a. In a casualty with progressive respiratory distress and known or suspected torso trauma, consider a tension pneumothorax and decompress the chest on the side of the injury with a 14-gauge, 3.25 inch needle/catheter unit inserted in the second intercostal space at the midclavicular line. Ensure that the needle entry into the chest is not medial to the nipple line and is not directed towards the heart. An acceptable alternate site is the 4th or 5th intercostal space at the anterior axillary line (AAL).
- b. All open and/or sucking chest wounds should be treated by immediately applying a vented chest seal to cover the defect. If a vented chest seal is not available, use a non-vented chest seal. Monitor the casualty for the potential development of a subsequent tension pneumothorax. If the casualty develops increasing hypoxia, respiratory distress, or hypotension and a tension pneumothorax is suspected, treat by burping or removing the dressing or by needle decompression.
- c. Initiate pulse oximetry. All individuals with moderate/severe TBI should be monitored with pulse oximetry. Readings may be misleading in the settings of shock or marked hypothermia.

d. Casualties with moderate/severe TBI should be given supplemental oxygen when available to maintain an oxygen saturation > 90%.

6. Circulation

a. Bleeding

- A pelvic binder should be applied for cases of suspected pelvic fracture:
 - Severe blunt force or blast injury with one or more of the following indications:
 - Pelvic pain
 - Any major lower limb amputation or near amputation
 - Physical exam findings suggestive of a pelvic fracture
 - Unconsciousness
 - Shock
- Reassess prior tourniquet application. Expose the wound and determine if a tourniquet is needed. If it is needed, replace any limb tourniquet placed over the uniform with one applied directly to the skin 2–3 inches above the bleeding site. Ensure that bleeding is stopped. If there is no traumatic amputation, a distal pulse should be checked. If bleeding persists or a distal pulse is still present, consider additional tightening of the tourniquet or the use of a second tourniquet side-by-side with the first to eliminate both bleeding and the distal pulse. If the reassessment determines that the prior tourniquet was not needed, then remove the tourniquet and note time of removal on the TCCC Casualty Card.
- Limb tourniquets and junctional tourniquets should be converted to hemostatic or pressure dressings as soon as possible if three criteria are met: the casualty is not in shock; it is possible to monitor the wound closely for bleeding; and the tourniquet is not being used to control bleeding from an amputated extremity. Every effort should be made to convert tourniquets in less than 2 hours if bleeding can be controlled with other means. Do not remove a tourniquet that has been in place more than 6 hours unless close monitoring and lab capability are available.

- Expose and clearly mark all tourniquets with the time of tourniquet application. Note tourniquets applied and time of application; time of re-application; time of conversion; and time of removal on the TCCC Casualty Card. Use a permanent marker to mark on the tourniquet and the casualty card.
- b. IV Access
- Intravenous (IV) or intraosseous (IO) access is indicated if the casualty is in hemorrhagic shock or at significant risk of shock (and may therefore need fluid resuscitation), or if the casualty needs medications, but cannot take them by mouth.
 - An 18-gauge IV or saline lock is preferred.
 - If vascular access is needed but not quickly obtainable via the IV route, use the IO route.
- c. Tranexamic Acid (TXA)
- If a casualty is anticipated to need significant blood transfusion (for example: presents with hemorrhagic shock, one or more major amputations, penetrating torso trauma, or evidence of severe bleeding):
 - Administer 1 g of tranexamic acid in 100 mL Normal Saline or Lactated Ringer's as soon as possible but NOT later than 3 hours after injury. When given, TXA should be administered over 10 minutes by IV infusion.
 - Begin the second infusion of 1 g TXA after initial fluid resuscitation has been completed.
- d. Fluid Resuscitation
- Assess for hemorrhagic shock (altered mental status in the absence of brain injury and/or weak or absent radial pulse).
 - The resuscitation fluids of choice for casualties in hemorrhagic shock, listed from most to least preferred, are: whole blood*; plasma, red blood cells (RBCs) and platelets in a 1:1:1 ratio*; plasma and RBCs in a 1:1 ratio; plasma or RBCs alone; Hextend; and crystalloid (Lactated Ringer's or Plasma-Lyte A). (NOTE: Hypothermia prevention measures [Section 7] should be initiated while fluid resuscitation is being accomplished.)

- If not in shock:
 - No IV fluids are immediately necessary.
 - Fluids by mouth are permissible if the casualty is conscious and can swallow.
- If in shock and blood products are available under an approved command or theater blood product administration protocol:
 - Resuscitate with whole blood*, or, if not available
 - Plasma, RBCs and platelets in a 1:1:1 ratio*, or, if not available
 - Plasma and RBCs in a 1:1 ratio, or, if not available
 - Reconstituted dried plasma, liquid plasma or thawed plasma alone or RBCs alone
 - Reassess the casualty after each unit. Continue resuscitation until a palpable radial pulse, improved mental status or systolic BP of 80–90 is present.
- If in shock and blood products are not available under an approved command or theater blood product administration protocol due to tactical or logistical constraints:
 - Resuscitate with Hextend, or if not available
 - Lactated Ringer's or Plasma-Lyte A
 - Reassess the casualty after each 500 mL IV bolus.
 - Continue resuscitation until a palpable radial pulse, improved mental status, or systolic BP of 80–90 mmHg is present.
 - Discontinue fluid administration when one or more of the above end points has been achieved.
- If a casualty with an altered mental status due to suspected TBI has a weak or absent radial pulse, resuscitate as necessary to restore and maintain a normal radial pulse. If BP monitoring is available, maintain a target systolic BP of at least 90 mmHg.
- Reassess the casualty frequently to check for recurrence of shock. If shock recurs, re-check all external hemorrhage control measures to ensure that they are still effective and repeat the fluid resuscitation as outlined above.

- * Currently, neither whole blood nor apheresis platelets collected in theater are FDA-compliant because of the way they are collected. Consequently, whole blood and 1:1:1 resuscitation using apheresis platelets should be used only if all of the FDA-compliant blood products needed to support 1:1:1 resuscitation are not available, or if 1:1:1 resuscitation is not producing the desired clinical effect.
- 7. Hypothermia Prevention
 - a. Minimize casualty's exposure to the elements. Keep protective gear on or with the casualty if feasible.
 - b. Replace wet clothing with dry if possible. Get the casualty onto an insulated surface as soon as possible.
 - c. Apply the Ready-Heat Blanket from the Hypothermia Prevention and Management Kit (HPMK) to the casualty's torso (not directly on the skin) and cover the casualty with the Heat-Reflective Shell (HRS).
 - d. If an HRS is not available, the previously recommended combination of the Blizzard Survival Blanket and the Ready Heat blanket may also be used.
 - e. If the items mentioned above are not available, use dry blankets, poncho liners, sleeping bags, or anything that will retain heat and keep the casualty dry.
 - f. Warm fluids are preferred if IV fluids are required.
- 8. Penetrating Eye Trauma
 - a. If a penetrating eye injury is noted or suspected:
 - Perform a rapid field test of visual acuity and document findings.
 - Cover the eye with a rigid eye shield (NOT a pressure patch.)
 - Ensure that the 400 mg moxifloxacin tablet in the Combat Wound Medication Pack (CWMP) is taken if possible and that IV/IM antibiotics are given as outlined below if oral moxifloxacin cannot be taken.
- 9. Monitoring
 - a. Initiate advanced electronic monitoring if indicated and if monitoring equipment is available.
- 10. Analgesia
 - a. Analgesia on the battlefield should generally be achieved using one of three options:

- Option 1
 - Mild to Moderate Pain
Casualty is still able to fight
 - TCCC Combat Wound Medication Pack (CWMP)
 - * Tylenol - 650 mg bilayer caplet, 2 PO every 8 hours
 - * Meloxicam - 15 mg PO once a day
- Option 2
 - Moderate to Severe Pain
Casualty IS NOT in shock or respiratory distress AND
Casualty IS NOT at significant risk of developing either condition
 - Oral transmucosal fentanyl citrate (OTFC) 800 µg
 - * Place lozenge between the cheek and the gum
 - * Do not chew the lozenge
- Option 3
 - Moderate to Severe Pain
Casualty IS in hemorrhagic shock or respiratory distress OR
Casualty IS at significant risk of developing either condition
 - Ketamine 50 mg IM or IV
Or
 - Ketamine 20 mg slow IV or IO
 - * Repeat doses q30min prn for IM or IN
 - * Repeat doses q20min prn for IV or IO
 - * End points: Control of pain or development of nystagmus (rhythmic back-and-forth movement of the eyes)

Analgesia notes:

- a. Casualties may need to be disarmed after being given OTFC or ketamine.
- b. Document a mental status exam using the AVPU method prior to administering opioids or ketamine.
- c. For all casualties given opioids or ketamine – monitor airway, breathing, and circulation closely
- d. Directions for administering OTFC:
 - Recommend taping lozenge-on-a-stick to casualty's finger as an added safety measure OR utilizing a safety

- pin and rubber band to attach the lozenge (under tension) to the patient's uniform or plate carrier.
- Reassess in 15 minutes
 - Add second lozenge, in other cheek, as necessary to control severe pain
 - Monitor for respiratory depression
- e. IV Morphine is an alternative to OTFC if IV access has been obtained
- 5 mg IV/IO
 - Reassess in 10 minutes.
 - Repeat dose every 10 minutes as necessary to control severe pain.
 - Monitor for respiratory depression.
- f. Naloxone (0.4 mg IV or IM) should be available when using opioid analgesics.
- g. Both ketamine and OTFC have the potential to worsen severe TBI. The combat medic, corpsman, or PJ must consider this fact in his or her analgesic decision, but if the casualty is able to complain of pain, then the TBI is likely not severe enough to preclude the use of ketamine or OTFC.
- h. Eye injury does not preclude the use of ketamine. The risk of additional damage to the eye from using ketamine is low and maximizing the casualty's chance for survival takes precedence if the casualty is in shock or respiratory distress or at significant risk for either.
- i. Ketamine may be a useful adjunct to reduce the amount of opioids required to provide effective pain relief. It is safe to give ketamine to a casualty who has previously received morphine or OTFC. IV Ketamine should be given over 1 minute.
- j. If respirations are noted to be reduced after using opioids or ketamine, provide ventilatory support with a bag-valve-mask or mouth-to-mask ventilations.
- k. Ondansetron, 4 mg Orally Dissolving Tablet (ODT)/IV/IO/IM, every 8 hours as needed for nausea or vomiting. Each 8-hour dose can be repeated once at 15 minutes if nausea and vomiting are not improved. Do not give more than 8 mg in any 8-hour interval. Oral ondansetron is NOT an acceptable alternative to the ODT formulation.
- l. Reassess – reassess – reassess!

11. Antibiotics: recommended for all open combat wounds
 - a. If able to take PO meds:
 - Moxifloxacin (from the CWMP), 400 mg PO once a day
 - b. If unable to take PO meds (shock, unconsciousness):
 - Ertapenem, 1 g IV/IM once a day
12. Inspect and dress known wounds.
13. Check for additional wounds.
14. Burns
 - a. Facial burns, especially those that occur in closed spaces, may be associated with inhalation injury. Aggressively monitor airway status and oxygen saturation in such patients and consider early surgical airway for respiratory distress or oxygen desaturation.
 - b. Estimate total body surface area (TBSA) burned to the nearest 10% using the Rule of Nines.
 - c. Cover the burn area with dry, sterile dressings. For extensive burns (>20%), consider placing the casualty in the Heat-Reflective Shell or Blizzard Survival Blanket from the Hypothermia Prevention Kit in order to both cover the burned areas and prevent hypothermia.
 - d. Fluid resuscitation (USAISR Rule of Ten)
 - If burns are greater than 20% of TBSA, fluid resuscitation should be initiated as soon as IV/IO access is established. Resuscitation should be initiated with Lactated Ringer's, normal saline, or Hextend. If Hextend is used, no more than 1000 mL should be given, followed by Lactated Ringer's or normal saline as needed.
 - Initial IV/IO fluid rate is calculated as %TBSA x 10 mL/hr for adults weighing 40–80 kg.
 - For every 10 kg ABOVE 80 kg, increase initial rate by 100 ml/hr.
 - If hemorrhagic shock is also present, resuscitation for hemorrhagic shock takes precedence over resuscitation for burn shock. Administer IV/IO fluids per the TCCC Guidelines in Section (6).
 - e. Analgesia in accordance with the TCCC Guidelines in Section (10) may be administered to treat burn pain.
 - f. Prehospital antibiotic therapy is not indicated solely for burns, but antibiotics should be given per the TCCC

- guidelines in Section (11) if indicated to prevent infection in penetrating wounds.
- g. All TCCC interventions can be performed on or through burned skin in a burn casualty.
 - h. Burn patients are particularly susceptible to hypothermia. Extra emphasis should be placed on barrier heat loss prevention methods.
15. Splint fractures and recheck pulses.
16. Communication
- a. Communicate with the casualty if possible. Encourage, reassure and explain care.
 - b. Communicate with tactical leadership as soon as possible and throughout casualty treatment as needed. Provide leadership with casualty status and evacuation requirements to assist with coordination of evacuation assets.
 - c. Communicate with the evacuation system (the Patient Evacuation Coordination Cell) to arrange for TACEVAC. Communicate with medical providers on the evacuation asset if possible and relay mechanism of injury, injuries sustained, signs/symptoms, and treatments rendered. Provide additional information as appropriate.
17. Cardiopulmonary Resuscitation (CPR)
- a. Resuscitation on the battlefield for victims of blast or penetrating trauma who have no pulse, no ventilations, and no other signs of life will not be successful and should not be attempted. However, casualties with torso trauma or polytrauma who have no pulse or respirations during TFC should have bilateral needle decompression performed to ensure they do not have a tension pneumothorax prior to discontinuation of care. The procedure is the same as described in section (5a) above.
18. Documentation of Care
- a. Document clinical assessments, treatments rendered, and changes in the casualty's status on a TCCC Card (DD Form 1380). Forward this information with the casualty to the next level of care.
19. Prepare for Evacuation.
- a. Complete and secure the TCCC Card (DD 1380) to the casualty.

- b. Secure all loose ends of bandages and wraps.
- c. Secure hypothermia prevention wraps/blankets/straps.
- d. Secure litter straps as required. Consider additional padding for long evacuations.
- e. Provide instructions to ambulatory patients as needed.
- f. Stage casualties for evacuation in accordance with unit standard operating procedures.
- g. Maintain security at the evacuation point in accordance with unit standard operating procedures.

Basic Management Plan for Tactical Evacuation Care

- * The term “Tactical Evacuation” includes both Casualty Evacuation (CASEVAC) and Medical Evacuation (MEDEVAC) as defined in Joint Publication 4-02.
- 1. Transition of Care
 - a. Tactical force personnel should establish evacuation point security and stage casualties for evacuation.
 - b. Tactical force personnel or the medic should communicate patient information and status to TACEVAC personnel as clearly as possible. The minimum information communicated should include stable or unstable, injuries identified, and treatments rendered.
 - c. TACEVAC personnel should stage casualties on evacuation platforms as required.
 - d. Secure casualties in the evacuation platform in accordance with unit policies, platform configurations and safety requirements.
 - e. TACEVAC medical personnel should re-assess casualties and re-evaluate all injuries and previous interventions.
- 2. Massive Hemorrhage
 - a. Assess for unrecognized hemorrhage and control all sources of bleeding. If not already done, use a CoTCCC-recommended limb tourniquet to control life-threatening external hemorrhage that is anatomically amenable to tourniquet use or for any traumatic amputation. Apply directly to the skin 2–3 inches above the bleeding site. If bleeding is not controlled with the first tourniquet, apply a second tourniquet side-by-side with the first.
 - b. For compressible (external) hemorrhage not amenable to limb tourniquet use or as an adjunct to tourniquet removal, use Combat Gauze as the CoTCCC hemostatic dressing of choice.
 - Alternative hemostatic adjuncts:
 - Celox Gauze or
 - ChitoGauze or
 - XStat (Best for deep, narrow-tract junctional wounds)

- Hemostatic dressings should be applied with at least 3 minutes of direct pressure (optional for XStat). Each dressing works differently, so if one fails to control bleeding, it may be removed and a fresh dressing of the same type or a different type applied. (Note: XStat is not to be removed in the field, but additional XStat, other hemostatic adjuncts, or trauma dressings may be applied over it.)
- If the bleeding site is amenable to use of a junctional tourniquet, immediately apply a CoTCCC-recommended junctional tourniquet. Do not delay in the application of the junctional tourniquet once it is ready for use. Apply hemostatic dressings with direct pressure if a junctional tourniquet is not available or while the junctional tourniquet is being readied for use.

3. Airway Management

- a. Conscious casualty with no airway problem identified:
 - No airway intervention required
- b. Unconscious casualty without airway obstruction:
 - Place casualty in the recovery position
 - Chin lift or jaw thrust maneuver or
 - Nasopharyngeal airway or
 - Extraglottic airway
- c. Casualty with airway obstruction or impending airway obstruction:
 - Allow a conscious casualty to assume any position that best protects the airway, to include sitting up.
 - Use a chin lift or jaw thrust maneuver
 - Use suction if available and appropriate
 - Nasopharyngeal airway or
 - Extraglottic airway (if the casualty is unconscious)
 - Place an unconscious casualty in the recovery position.
- d. If the previous measures are unsuccessful, assess the tactical and clinical situations, the equipment at hand, and the skills and experience of the person providing care, and then select one of the following airway interventions:
 - Endotracheal intubation or
 - Perform a surgical cricothyroidotomy using one of the following:

- Cric-Key technique (Preferred option)
 - Bougie-aided open surgical technique using a flanged and cuffed airway cannula of less than 10 mm outer diameter, 6–7 mm internal diameter, and 5–8 cm of intra-tracheal length
 - Standard open surgical technique using a flanged and cuffed airway cannula of less than 10 mm outer diameter, 6–7 mm internal diameter and 5–8 cm of intra-tracheal length (Least desirable option)
 - Use lidocaine if the casualty is conscious.
 - e. Cervical spine stabilization is not necessary for casualties who have sustained only penetrating trauma.
 - f. Monitor the hemoglobin oxygen saturation in casualties to help assess airway patency. Use capnography monitoring in this phase of care if available.
 - g. Always remember that the casualty's airway status may change over time and requires frequent reassessment.
 - * The i-gel is the preferred extraglottic airway because its gel-filled cuff makes it simpler to use and avoids the need for cuff inflation and monitoring. If an extraglottic airway with an air-filled cuff is used, the cuff pressure must be monitored to avoid overpressurization, especially during TACEVAC on an aircraft with the accompanying pressure changes.
 - * Extraglottic airways will not be tolerated by a casualty who is not deeply unconscious. If an unconscious casualty without direct airway trauma needs an airway intervention, but does not tolerate an extraglottic airway, consider the use of a nasopharyngeal airway.
 - * For casualties with trauma to the face and mouth, or facial burns with suspected inhalation injury, nasopharyngeal airways and extraglottic airways may not suffice and a surgical cricothyroidotomy may be required.
 - * Surgical cricothyroidotomies should not be performed on unconscious casualties who have no direct airway trauma unless use of a nasopharyngeal airway and/or an extraglottic airway have been unsuccessful in opening the airway.
4. Respiration/Breathing
- a. In a casualty with progressive respiratory distress and known or suspected torso trauma, consider a tension

pneumothorax and decompress the chest on the side of the injury with a 14-gauge, 3.25 inch needle/catheter unit inserted in the second intercostal space at the midclavicular line. Ensure that the needle entry into the chest is not medial to the nipple line and is not directed towards the heart. An acceptable alternate site is the 4th or 5th intercostal space at the anterior axillary line (AAL).

- b. Consider chest tube insertion if no improvement and/or long transport is anticipated.
 - c. Initiate pulse oximetry if not previously done. All individuals with moderate/severe TBI should be monitored with pulse oximetry. Readings may be misleading in the settings of shock or marked hypothermia.
 - d. Most combat casualties do not require supplemental oxygen, but administration of oxygen may be of benefit for the following types of casualties:
 - Low oxygen saturation by pulse oximetry
 - Injuries associated with impaired oxygenation
 - Unconscious casualty
 - Casualty with TBI (maintain oxygen saturation > 90%)
 - Casualty in shock
 - Casualty at altitude
 - Known or suspected smoke inhalation
 - e. All open and/or sucking chest wounds should be treated by immediately applying a vented chest seal to cover the defect. If a vented chest seal is not available, use a non-vented chest seal. Monitor the casualty for the potential development of a subsequent tension pneumothorax. If the casualty develops increasing hypoxia, respiratory distress, or hypotension and a tension pneumothorax is suspected, treat by burping or removing the dressing or by needle decompression.
5. Circulation
- a. Bleeding
 - A pelvic binder should be applied for cases of suspected pelvic fracture:
 - Severe blunt force or blast injury with one or more of the following indications:
 - Pelvic pain

- Any major lower limb amputation or near amputation
 - Physical exam findings suggestive of a pelvic fracture
 - Unconsciousness
 - Shock
 - Reassess prior tourniquet application. Expose the wound and determine if a tourniquet is needed. If it is needed, replace any limb tourniquet placed over the uniform with one applied directly to the skin 2–3 inches above the bleeding site. Ensure that bleeding is stopped. If there is no traumatic amputation, a distal pulse should be checked. If bleeding persists or a distal pulse is still present, consider additional tightening of the tourniquet or the use of a second tourniquet side-by-side with the first to eliminate both bleeding and the distal pulse. If the reassessment determines that the prior tourniquet was not needed, then remove the tourniquet and note time of removal on the TCCC Casualty Card.
 - Limb tourniquets and junctional tourniquets should be converted to hemostatic or pressure dressings as soon as possible if three criteria are met: the casualty is not in shock; it is possible to monitor the wound closely for bleeding; and the tourniquet is not being used to control bleeding from an amputated extremity. Every effort should be made to convert tourniquets in less than 2 hours if bleeding can be controlled with other means. Do not remove a tourniquet that has been in place more than 6 hours unless close monitoring and lab capability are available.
 - Expose and clearly mark all tourniquets with the time of tourniquet application. Note tourniquets applied and time of application; time of re-application; time of conversion; and time of removal on the TCCC Casualty Card. Use a permanent marker to mark on the tourniquet and the casualty card.
- b. IV Access
- Reassess need for IV access.
 - IV or IO access is indicated if the casualty is in

hemorrhagic shock or at significant risk of shock (and may therefore need fluid resuscitation), or if the casualty needs medications, but cannot take them by mouth.

- An 18-gauge IV or saline lock is preferred.
- If vascular access is needed but not quickly obtainable via the IV route, use the IO route.

c. Tranexamic Acid (TXA)

- If a casualty is anticipated to need significant blood transfusion (for example: presents with hemorrhagic shock, one or more major amputations, penetrating torso trauma, or evidence of severe bleeding):
 - Administer 1 g of tranexamic acid in 100 mL Normal Saline or Lactated Ringers as soon as possible but NOT later than 3 hours after injury. When given, TXA should be administered over 10 minutes by IV infusion.
 - Begin second infusion of 1 g TXA after initial fluid resuscitation has been completed.

d. Fluid Resuscitation

- Assess for hemorrhagic shock (altered mental status in the absence of brain injury and/or weak or absent radial pulse).
- The resuscitation fluids of choice for casualties in hemorrhagic shock, listed from most to least preferred, are: whole blood*; plasma, RBCs and platelets in a 1:1:1 ratio*; plasma and RBCs in a 1:1 ratio; plasma or RBCs alone; Hextend; and crystalloid (Lactated Ringer's or Plasma-Lyte A). (NOTE: Hypothermia prevention measures [Section 7] should be initiated while fluid resuscitation is being accomplished.)
 - If not in shock:
 - No IV fluids are immediately necessary.
 - Fluids by mouth are permissible if the casualty is conscious and can swallow.
 - If in shock and blood products are available under an approved command or theater blood product administration protocol:
 - Resuscitate with whole blood*, or, if not available

- Plasma, RBCs and platelets in a 1:1:1 ratio*, or, if not available
 - Plasma and RBCs in a 1:1 ratio, or, if not available
 - Reconstituted dried plasma, liquid plasma or thawed plasma alone or RBCs alone
 - Reassess the casualty after each unit. Continue resuscitation until a palpable radial pulse, improved mental status or systolic BP of 80–90 is present.
 - If in shock and blood products are not available under an approved command or theater blood product administration protocol due to tactical or logistical constraints:
 - Resuscitate with Hextend, or if not available
 - Lactated Ringer's or Plasma-Lyte A
 - Reassess the casualty after each 500 mL IV bolus.
 - Continue resuscitation until a palpable radial pulse, improved mental status, or systolic BP of 80–90 mmHg is present.
 - Discontinue fluid administration when one or more of the above end points has been achieved.
 - If a casualty with an altered mental status due to suspected TBI has a weak or absent radial pulse, resuscitate as necessary to restore and maintain a normal radial pulse. If BP monitoring is available, maintain a target systolic BP of at least 90 mmHg.
 - Reassess the casualty frequently to check for recurrence of shock. If shock recurs, recheck all external hemorrhage control measures to ensure that they are still effective and repeat the fluid resuscitation as outlined above.
- * Currently, neither whole blood nor apheresis platelets collected in theater are FDA-compliant because of the way they are collected. Consequently, whole blood and 1:1:1 resuscitation using apheresis platelets should be used only if all the FDA-compliant blood products needed to support 1:1:1 resuscitation are not available, or if 1:1:1 resuscitation is not producing the desired clinical effect.

6. Traumatic Brain Injury

a. Casualties with moderate/severe TBI should be monitored for:

- Decreases in level of consciousness
- Pupillary dilation
- SBP should be >90 mmHg
- O₂ sat > 90
- Hypothermia
- Pco₂ (If capnography is available, maintain between 35–40 mmHg)
- Penetrating head trauma (if present, administer antibiotics)
- Assume a spinal (neck) injury until cleared.

b. Unilateral pupillary dilation accompanied by a decreased level of consciousness may signify impending cerebral herniation; if these signs occur, take the following actions to decrease intracranial pressure:

- Administer 250 mL of 3% or 5% hypertonic saline bolus.
- Elevate the casualty's head 30 degrees.
- Hyperventilate the casualty.
 - Respiratory rate 20
 - Capnography should be used to maintain the end-tidal CO₂ between 30–35 mmHg
 - The highest oxygen concentration (FIO₂) possible should be used for hyperventilation.

* Notes:

Do not hyperventilate the casualty unless signs of impending herniation are present.

Casualties may be hyperventilated with oxygen using the bag-valve-mask technique.

7. Hypothermia Prevention

a. Minimize casualty's exposure to the elements. Keep protective gear on or with the casualty if feasible.

b. Replace wet clothing with dry if possible. Get the casualty onto an insulated surface as soon as possible.

c. Apply the Ready-Heat Blanket from the Hypothermia Prevention and Management Kit (HPMK) to the casualty's torso (not directly on the skin) and cover the casualty with the Heat-Reflective Shell (HRS).

- d. If an HRS is not available, the previously recommended combination of the Blizzard Survival Blanket and the Ready Heat blanket may also be used.
 - e. If the items mentioned above are not available, use poncho liners, sleeping bags, or anything that will retain heat and keep the casualty dry.
 - f. Use a portable fluid warmer capable of warming all IV fluids including blood products.
 - g. Protect the casualty from wind if doors must be kept open.
8. Penetrating Eye Trauma
- a. If a penetrating eye injury is noted or suspected:
 - Perform a rapid field test of visual acuity and document findings.
 - Cover the eye with a rigid eye shield (NOT a pressure patch.)
 - Ensure that the 400 mg moxifloxacin tablet in the Combat Wound Medication Pack (CWMP) is taken if possible and that IV/IM antibiotics are given as outlined below if oral moxifloxacin cannot be taken.
9. Monitoring
- a. Initiate advanced electronic monitoring if indicated and if monitoring equipment is available.
10. Analgesia
- a. Analgesia on the battlefield should generally be achieved using one of three options:
 - Option 1
 - Mild to Moderate Pain
Casualty is still able to fight
 - TCCC CWMP
 - * Tylenol – 650 mg bilayer caplet, 2 PO every 8 hours
 - * Meloxicam – 15 mg PO once a day
 - Option 2
 - Moderate to Severe Pain
Casualty IS NOT in shock or respiratory distress AND
Casualty IS NOT at significant risk of developing either condition
 - Oral transmucosal fentanyl citrate (OTFC) 800 µg
 - * Place lozenge between the cheek and the gum
 - * Do not chew the lozenge

- Option 3
 - Moderate to Severe Pain
Casualty IS in hemorrhagic shock or respiratory distress OR
Casualty IS at significant risk of developing either condition
 - Ketamine 50 mg IM or IN
Or
 - Ketamine 20 mg slow IV or IO
 - * Repeat doses q30min prn for IM or IN
 - * Repeat doses q20min prn for IV or IO
 - * End points: Control of pain or development of nystagmus (rhythmic back-and-forth movement of the eyes)

Analgesia notes:

- a. Casualties may need to be disarmed after being given OTFC or ketamine.
- b. Document a mental status exam using the AVPU method prior to administering opioids or ketamine.
- c. For all casualties given opioids or ketamine – monitor airway, breathing, and circulation closely
- d. Directions for administering OTFC:
 - Recommend taping lozenge-on-a-stick to casualty's finger as an added safety measure OR utilizing a safety pin and rubber band to attach the lozenge (under tension) to the patient's uniform or plate carrier.
 - Reassess in 15 minutes
 - Add second lozenge, in other cheek, as necessary to control severe pain
 - Monitor for respiratory depression
- e. IV Morphine is an alternative to OTFC if IV access has been obtained
 - 5 mg IV/IO
 - Reassess in 10 minutes.
 - Repeat dose every 10 minutes as necessary to control severe pain.
 - Monitor for respiratory depression.
- f. Naloxone (0.4 mg IV or IM) should be available when using opioid analgesics.

- g. Both ketamine and OTFC have the potential to worsen severe TBI. The combat medic, corpsman, or PJ must consider this fact in his or her analgesic decision, but if the casualty can complain of pain, then the TBI is likely not severe enough to preclude the use of ketamine or OTFC.
 - h. Eye injury does not preclude the use of ketamine. The risk of additional damage to the eye from using ketamine is low and maximizing the casualty's chance for survival takes precedence if the casualty is in shock or respiratory distress or at significant risk for either.
 - i. Ketamine may be a useful adjunct to reduce the amount of opioids required to provide effective pain relief. It is safe to give ketamine to a casualty who has previously received morphine or OTFC. IV Ketamine should be given over 1 minute.
 - j. If respirations are noted to be reduced after using opioids or ketamine, provide ventilatory support with a bag-valve-mask or mouth-to-mask ventilations.
 - k. Ondansetron, 4 mg ODT/IV/IO/IM, every 8 hours as needed for nausea or vomiting. Each 8-hour dose can be repeated once at 15 minutes if nausea and vomiting are not improved. Do not give more than 8 mg in any 8-hour interval. Oral ondansetron is NOT an acceptable alternative to the ODT formulation.
 - l. Reassess – reassess – reassess!
11. Antibiotics: recommended for all open combat wounds
- a. If able to take PO meds:
 - Moxifloxacin (from CWMP), 400 mg PO once a day
 - b. If unable to take PO meds (shock, unconsciousness):
 - Ertapenem, 1 g IV/IM once a day
12. Inspect and dress known wounds.
13. Check for additional wounds.
14. Burns
- a. Facial burns, especially those that occur in closed spaces, may be associated with inhalation injury. Aggressively monitor airway status and oxygen saturation in such patients and consider early surgical airway for respiratory distress or oxygen desaturation.

- b. Estimate total body surface area (TBSA) burned to the nearest 10% using the Rule of Nines.
 - c. Cover the burn area with dry, sterile dressings. For extensive burns (>20%), consider placing the casualty in the Heat-Reflective Shell or Blizzard Survival Blanket from the Hypothermia Prevention Kit to both cover the burned areas and prevent hypothermia.
 - d. Fluid resuscitation (USAISR Rule of Ten)
 - If burns are greater than 20% of TBSA, fluid resuscitation should be initiated as soon as IV/IO access is established. Resuscitation should be initiated with Lactated Ringer's, normal saline, or Hextend. If Hextend is used, no more than 1000 mL should be given, followed by Lactated Ringer's or normal saline as needed.
 - Initial IV/IO fluid rate is calculated as %TBSA x 10 mL/hr for adults weighing 40–80 kg.
 - For every 10 kg ABOVE 80 kg, increase initial rate by 100 mL/hr.
 - If hemorrhagic shock is also present, resuscitation for hemorrhagic shock takes precedence over resuscitation for burn shock. Administer IV/IO fluids per the TCCC Guidelines in Section (6).
 - e. Analgesia in accordance with the TCCC Guidelines in Section (10) may be administered to treat burn pain.
 - f. Prehospital antibiotic therapy is not indicated solely for burns, but antibiotics should be given per the TCCC guidelines in Section (11) if indicated to prevent infection in penetrating wounds.
 - g. All TCCC interventions can be performed on or through burned skin in a burn casualty.
 - h. Burn patients are particularly susceptible to hypothermia. Extra emphasis should be placed on barrier heat loss prevention methods and IV fluid warming in this phase.
15. Reassess fractures and recheck pulses.
16. Communication
- a. Communicate with the casualty if possible. Encourage, reassure and explain care.

- b. Communicate with medical providers at the next level of care as feasible and relay mechanism of injury, injuries sustained, signs/symptoms, and treatments rendered. Provide additional information as appropriate.
17. CPR in TACEVAC Care
 - a. Casualties with torso trauma or polytrauma who have no pulse or respirations during TACEVAC should have bilateral needle decompression performed to ensure they do not have a tension pneumothorax. The procedure is the same as described in Section (4a) above.
 - b. CPR may be attempted during this phase of care if the casualty does not have obviously fatal wounds and will be arriving at a facility with a surgical capability within a short period of time. CPR should not be done at the expense of compromising the mission or denying lifesaving care to other casualties.
18. Documentation of Care
 - a. Document clinical assessments, treatments rendered, and changes in the casualty's status on a TCCC Card (DD Form 1380). Forward this information with the casualty to the next level of care.



I remember preparing to go to Afghanistan a couple of months post 9/11. Part of my preparation was packing a chest with reference materials and books (just in case we were without power). One of those books was the Emergency War Surgery handbook (EWS). As I grabbed the book, I took the time to look at its contents because this was the first time I was going to war and I wanted to be able to take care of my people if I got dislocated from higher medical care. The Special Operations Combat Medic Course taught me advanced interventions and it was nice to refresh on things I had not looked at recently.

This new edition of EWS includes for the first time Tactical Combat Casualty Care (TCCC), which is the basis for military prehospital medical providers at all levels. The lives of many have been saved by applying TCCC. Morbidity rates have declined over the last decades of combat. As the beginning of the medical process, a well-informed and trained medic on the frontline is key to patient survival. This update to the EWS will enhance our capability to address many diverse and challenging situations not encountered in garrison environments.

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