Talking Points

- What is your current tactical Casualty Collection Point (CCP) SOP?
- Does this SOP include a “rolling CCP” SOP?
- What is your plan on the ground for cross loading equipment between your assault force after casualties are sustained?
- What is your SOP on triaging (i.e., IDME or UPR)?
- What is your SOP for labeling casualties as they enter the CCP and as they exit for EVAC (i.e., numerically when entering and alphabetically when exiting)?
- Perform an early finger thoracostomy…it works!!!!

CASUALTY OVERVIEW

- There were 7 casualties total, with 2 evacuated on MEDEVAC, 3 on CASEVAC, and 2 EXFIL’d with the force.
- Discussion will focus on casualties #1, #3, and #5 due to severity.
- The other casualties will be briefly discussed due to limited information to discuss based on severity of injuries.
- Casualties will be discussed in order of occurrence.
CASUALTY #1

- Demographic: Afghan Partner Force
- Uniform: Body Armor (Front and Back plates only) and Helmet
- Scenario: Casualty was shot while clearing a compound and was trapped in the compound due to enemy engagement for ~8 minutes before I was able to get to him inside the breech. I drug the casualty outside the breech with the other medic at POI.

POI Assessment:
- Small entrance GSW to R anterior thorax and large exit wound to R posterior thorax that had excessive hemorrhage. GSW to R bicep. Casualty was alert and in obvious distress. No interpreter was present so communication was minimal.

Treatment:
- CAT Gen 7 was placed on R arm.
- HALO (Non-vented) Occlusive Dressing applied to anterior and posterior wounds. The posterior wound was bleeding excessively and multiple occlusive dressings were applied. Combat gauze was applied to the tissue and HALO reapplied with hemorrhage control achieved.
- Casualty was placed in a HPMK and Talon II litter after several minutes.

CASUALTY #1 CASUALTY CARD

POI Treatment:

- 1 Unit CWB IO
- 200 mg Ketamine IM
- 1 gram TXA IO
- Combat Gauze
- H&H x4
- HALO Finger
- Thoracostomy CAT
- 2042Z HPMK
- TALON II Litter 2049Z 2057Z

KE/ETC 02
80/P
Rapid
UNK
UNK
UNK
UNK
120
70/P
40
50
U
140
70/P
30
U
110
80/P
20
40
U
CASUALTY #1

Treatment Continued:
- Obvious tension pneumothorax on R thorax noted. Corrected with Finger Thoracostomy. Approximately ~100 cc of blood evacuated and immediate relief of tension pneumothorax and breathing effort. No NCD’s were given and the finger thoracostomy was burped 10 times prior to Dustoff arriving.
- Casualty was moved several times due to enemy engagement and in preparation of preplanned HLZ location.
- I determined that due to absent Radial pulse and weak femoral pulse, TXA and CWB was needed. A 18g IV was placed and 1 unit of CWB was infused via a Buddy site.

CASUALTY #1

Treatment Continued:
- Casualty was given 200 mg Ketamine IM and nystagmus achieved, as well as, a “K-Hole” state.
- Casualty was reported as apneic by the other medic after the CWB transfusion began and a KING LT (Unknown size) was attempted by the other medic. After one failed attempt, a second attempt was tried and the casualty gagged and bit the finger of an Afghan medic assisting. I performed a cricothyroidotomy using a (H&H Cric Kit with bougie) without complications and secured hastily with a HALO. Spontaneous respirations occurred after giving a few breaths with a BVM and I placed an EMMA with an average ETCO2 reading of ~35 mmHg.

CASUALTY #1

Treatment Continued:
- A Tactical FAST-1 was given and flushed with 1 g TXA.
- A weak radial pulse was obtained shortly before Dustoff arrived. The casualty was reassessed, finger thoracostomy burped, and handoff was conducted with Dustoff; the casualty was stable at time of handoff.
ARRIVAL AT FST

DUSTOFF:
- Dustoff medic never reassessed the casualty properly.
- Casualty was hooked up to a BVM and supplemental oxygen during flight.
- Casualty was never given a NCD nor was the finger thoracostomy ever burped due to this procedure outside of the flight medic's skillset.
- The cric was ripped out upon landing at the FST and the dustoff medic was able to replace the cric in the initial incision.
- After talking to the dustoff medic at the FST, he was aware of all injuries and treatments that were passed up over the radio.

CASUALTY #2
- Casualty #2 (Afghan Partner Force) was IVO of Casualty #1. Abrasions occurred due to grenade fragmentation. Casualty was evacuated on Dustoff along with casualty #1.

CASUALTY #3
- Demographic: U.S. Soldier
- Uniform: Body Armor (Front, Back, and Side Plates) and OPS Core
- Scenario: Casualty was shot in the posterior thorax while engaging a compound to his front. I was running up to engage the compound when casualty #3 fell to the ground in front of me. I dragged the casualty behind cover while asking where he was hit and he told me his neck. I directed him to apply direct pressure and not to let go until I directed him to do so.
POI Assessment:
- Large exit GSW to the R anterior neck and subsequent small entrance GSW on upper R posterior thorax. Casualty was stable the entire time and walked to the preplanned CASEVAC HLZ with assistance.

Treatment:
- The R anterior neck GSW had venous hemorrhaging and combat gauze was initially applied to inspect the wound. A curved Kelly was used to arrest the hemorrhaging vessel and a HALO (non-vented) was applied on top.
- HALO (non-vented) Occlusive Dressing was applied to the posterior GSW wound.
- Casualty was given Actiq 800 mcg transbuccal.
- I handed off this casualty to the other medic and responded to 2 additional casualties that were reported on the radio.
ARRIVAL AT FST

CASUALTY #4
- Demographic: Afghan Partner Force
- Uniform: Body Armor (Front and Back plates only) and Helmet
- Scenario: Casualty was shot in the R Humerus and was pulled to cover by fellow Afghan Soldiers before I arrived.

CASUALTY #5
- Demographic: U.S. Advisor
- Uniform: Body Armor (Front, Back, and side plates) and Helmet
- Scenario: Casualty was shot in the R forearm and two improperly placed tourniquets were placed, which did not control hemorrhage. After several minutes of uncontrolled hemorrhage, I correctly tightened a TQ and controlled hemorrhage. Due to the casualty's status, I determined the need for CWB transfusion and TXA.
CASUALTY #5 CASUALTY CARD

The R arm was grossly soaked in blood and upon assessing the extremity the 2x CAT's slid down when I assessed them. I tightened the proximal CAT and hemorrhage was controlled. Casualty was ambubed the entire time and complained of being lightheaded so myself and another U.S. Advisor assisted him while we walked to the preplanned CASEVAC HZ.

I obtained an IV in the L AC and gave 1g TXA then started a unit of CWB and during exfil on CASEVAC the unit of blood stopped flowing for an unknown reason.

The need for CWB and TXA could have been prevented entirely with proper TQ use!!!

CASUALTY #6

Demographic: U.S. Advisor

Uniform: Body Armor (Front and Back plates only) and Helmet

Scenario: Casualty took shrapnel to the R side of his forehead. NSTR and a MACE was conducted at the FST with a duration of symptoms < 72 hour.
CASUALTY #7

- Demographic: U.S. Soldier
- Uniform: Body Armor (front, back, and side plates) and OPS Core
- Scenario: Casualty was next to casualty #3 and sustained a GSW to the NVG mount, which knocked him to the ground. NSTR and SM followed up at FST for MACE with a duration of symptoms < 72 hours.

QUESTIONS / COMMENTS?