Tactical Combat Casualty Care Guidelines

for All Combatants

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These recommendations are intended to be guidelines only and are not a substitute for clinical judgment.

**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. Airway management is generally best deferred until the Tactical Field Care phase.
7. Stop *life-threatening* external hemorrhage if tactically feasible:
* Direct casualty to control hemorrhage by self-aid if able.
* Use a CoTCCC-recommendedlimb tourniquet for hemorrhage that is anatomically amenable to tourniquet use.
* 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.

**Basic Management Plan for Tactical Field Care**

1. Casualties with an altered mental status should be disarmed immediately.
2. Airway Management
	1. Unconscious casualty without airway obstruction:
		* Chin lift or jaw thrust maneuver
		* Nasopharyngeal airway
		* Place the casualty in the recovery position
	2. Casualty with airway obstruction or impending airway obstruction:
		* Chin lift or jaw thrust maneuver
		* Nasopharyngeal airway
		* Allow a conscious casualty to assume any position that best protects the airway, to include sitting up.
		* Place an unconscious casualty in the recovery position.
		* If the previous measures are unsuccessful, refer to a medic immediately.
3. Breathing

a. In a casualty with progressive respiratory distress and known or suspected torso trauma, consider a tension pneumothorax and refer to a medic as soon as possible.

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 respiratory distress. If it develops, you should suspect a tension pneumothorax. Treat this by burping or temporarily removing the dressing. If that doesn’t relieve the respiratory distress, refer to a medic.

4. Bleeding

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 it directly to the skin 2-3 inches above wound. If bleeding is not controlled with the first tourniquet, apply a second tourniquet side-by-side with the first.

b. For compressible hemorrhage not amenable to limb tourniquet use, use Combat Gauze as the CoTCCC hemostatic dressing of choice. Celox Gauze and ChitoGauzemay also be used if Combat Gauze is not available. Hemostatic dressings should be applied with at least 3 minutes of direct pressure.

c. Reassess every tourniquet that was applied earlier. Expose the wound and determine if the tourniquet is controlling the bleeding. Any tourniquet that was applied over the casualty’s uniform should be replaced by medical personnel with another tourniquet applied directly to the skin 2-3 inches above the wound, if possible.

d. When time and the tactical situation permit, check for further bleeding and for pulses further out on the limb than the tourniquet. If bleeding persists **o**r a pulse is still present distal to the tourniquet, consider additional tightening of the tourniquet or the use of a second tourniquet, side-by-side and proximal to the first, to eliminate any bleeding and any distal pulse.

e. Expose and clearly mark all tourniquet sites with the time of tourniquet application. Use an indelible marker.

5. Assess for hemorrhagic shock (altered mental status in the absence of brain injury and/or weak or absent radial pulse).

1. If the casualty is not in shock:

- No IV fluids are immediately necessary.

- Fluids by mouth are permissible if the casualty is conscious and can swallow.

- Reassess the casualty frequently for the onset of shock.

2. If the casualty is in shock or develops shock, refer to a medic.

6. Prevention of Hypothermia

a. Minimize the 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.

7. Penetrating Eye Trauma

a. If a penetrating eye injury is noted or suspected:

 1. Perform a rapid field test of visual acuity.

2. Cover the eye with a rigid eye shield (NOT a pressure patch.)

3. Ensure that the 400 mg moxifloxacin tablet in the combat pill pack is taken if the casualty can swallow. If she can’t, refer to a medic for IV or IM antibiotics.

8. Inspect and dress known wounds.

9. Check for additional wounds.

10. Pain relief on the battlefield:

 For mild to moderate pain that will not keep the casualty out of the fight:

- TCCC Combat pill pack:

- Tylenol - 650-mg bilayer caplet, 2 PO every 8 hours

- Meloxicam - 15 mg PO once a day

If the casualty’s pain is severe enough to interfere with his ability to fight, refer him to a medic for treatment.

11. Splint fractures and re-check pulses.

12. Antibiotics: recommended for all open combat wounds

a. If the casualty can swallow:

Moxifloxacin, 400 mg PO one a day

b. If the casualty can’t swallow (shock, unconsciousness):

Refer to a medic for treatment.

13. Burns

a. Facial burns, especially those that occur in closed spaces, may be associated with toxic or thermal injury to the airways or lungs. Aggressively monitor the casualty’s airway status and refer to a medic as soon as possible.

b. Cover the burn area with dry, sterile dressings. For extensive burns (>20%TBSA), 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.

c. Refer any casualty with extensive or severe burns to a medic as soon as possible.

14. Communicate with the casualty if possible.

a. Encouragement and reassurance are helpful.

b. Explain the care you have given.

15. Cardiopulmonary Resuscitation (CPR)

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.

16. Documentation of Care

Document any care given and changes in the casualty’s status on a TCCC Casualty Card (DD Form 1380). Forward this information with the casualty to the next level of care.

**Basic Management Plan for Tactical Evacuation Care**

1. The care you can give a casualty during evacuation is the same as Tactical Field Care.

2. For casualties with chest and abdominal trauma watch closely for tension pneumothorax, especially if evacuating by air or crossing mountainous terrain.

3. Watch for renewed bleeding from any wound. If it occurs, control it.

4. Keep the casualty warm.

5. Document the care you give.