TCCC Guidelines – May 2026

Summary of 2026 Changes

The 2026 TCCC Guidelines represent a focused update from the 2024 version, with the most significant changes involving traumatic brain injury management, analgesia, antibiotics, penetrating eye trauma, and selected refinements to hemorrhage control for tourniquet repositioning and tourniquet conversion. The Care Under Fire/Threat section is essentially unchanged. Tactical Field Care remains organized around the same major treatment sequence, but several clinical recommendations have been updated or clarified.

2. **Triage** The 2026 guidelines replace the 2024 statement directing removal of weapons and communications equipment from casualties with altered mental status with a reference to **Supplement A – Triage in TCCC** with more refined recommendations for Role 1 triage.

5. **Respiration/Breathing:** The oxygen saturation target for moderate/severe TBI changed from **>90%** to **≥92%**. Ventilatory support language was also updated to include casualties with moderate/severe TBI whose oxygen saturation falls below 92%

6. c. Bleeding Control / Tourniquet Reassessment

Tourniquet reassessment is an absolute requirement in all casualty care. While high & tight or hasty tourniquets may be critical to apply during care under fire/threat for suspected life-threatening bleeding, ALL such tourniquets MUST be reassessed for indicated need and/or proper application.

This update adds an expectation of ASM and CLS personnel to perform tourniquet reposition and tourniquet conversion. This makes the tourniquet section more operationally precise and reflects increasing concern about prolonged tourniquet syndrome, prolonged casualty care, delayed evacuation, and role-based decision authority.

The update now says to **reposition** a previously applied high & tight or over-the-uniform tourniquet by applying a second tourniquet directly to the skin 2–3 inches above the wound, confirm hemorrhage control and then loosening the first, rather than simply "replacing" the first tourniquet.

The previous guidelines already allowed tourniquet conversion when:

- Casualty not in shock
- Wound can be monitored closely

- Tourniquet not controlling an amputation

The update includes an important operational safeguard that TCCC ASM/CLS personnel should generally not attempt conversion beyond 2 hours post-application without higher-level medical direction.

Why this matters:

- Recognizes increased risk of unneeded or inappropriately applied tourniquets, reperfusion injury, recurrent hemorrhage, clot destabilization, and delayed recognition of rebleeding.
- Acknowledges that conversion becomes increasingly complex in prolonged casualty care scenarios.
- Introduces an implicit **scope-of-practice escalation** concept.
- This reflects a maturation of TCCC toward prolonged evacuation realities rather than traditional "golden hour" assumptions

8. **Traumatic Brain Injury**

The 2026 guidelines:

- Separate mild TBI/concussion from moderate/severe TBI.
- Define suspected moderate/severe TBI as inability to follow simple instructions beyond 10 minutes after injury with suspected head injury and no alternative cause.
- Emphasize evacuation to neurosurgical capability, ideally within 5 hours.
- Change the blood pressure target from SBP 100–110 mmHg to **SBP >100 mmHg** or a normal radial pulse when BP cannot be measured.
- Replace crystalloid bolus guidance for isolated TBI with **1–2 units of plasma** when there is no evidence of hemorrhage.
- Update ventilation targets to $EtCO_2$ 35–45 mmHg, or 10 breaths/minute if $EtCO_2$ monitoring is unavailable.
- Add detailed guidance for penetrating TBI/open skull fracture care and clarify that these casualties are not automatically expectant.

9. **Penetrating eye trauma** The antibiotic recommendation changed from moxifloxacin in the CWMP, with IV/IO/IM antibiotics if oral medication cannot be taken, to **ceftriaxone 2g IV/IM or cefadroxil 1g PO** as soon as possible.

11. **Analgesia** The 2026 analgesia section is substantially revised. Major changes include:
    - CWMP acetaminophen changed to **1000–1300 mg every 8 hours**.
    - **Suzetrigine** added to the CWMP regimen.
    - OTFC and fentanyl options from the 2024 guideline are removed for initial management and logistical availability concerns.
    - Ketamine dosing is simplified.
    - Esketamine intranasal (IN) is added.
    - The notes emphasize tolerable pain control while preserving airway, respiratory drive, and mentation.
    - The updated analgesia guidelines reflect a shock-agnostic approach to initial pain control.
    - The procedural sedation text moved to the inspect/dress wounds section of the guidelines.
12. **Antibiotics** The 2026 guidelines replace the 2024 antibiotic regimen:
    - 2024: moxifloxacin PO or ertapenem IV/IO/IM.
    - 2026: cefadroxil PO, cephalexin PO as an alternative, or ceftriaxone IV/IO/IM if unable to take PO medications.