

The Use of Pelvic Binders in Tactical Combat Casualty Care

TCCC Guidelines Proposed Change 1602

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Abstract

Proximate Cause for This Change

Blast injuries resulting from improvised explosive device (IED) attacks have been a major cause of combat injury in the Afghanistan conflict.^{1,2} Dismounted IED attacks are frequently associated with pelvic fractures,³ which in turn may result in massive hemorrhage and death.⁴ Pelvic fracture is also frequently caused by penetrating trauma and high-energy blunt trauma such as motor vehicle crash.⁵

The Committee on Tactical Combat Casualty Care (CoTCCC) reviewed the use of pelvic binders in 2008 and decided at the time that there was insufficient evidence of benefit to warrant their addition to the TCCC Guidelines. At the February 2016 meeting of the CoTCCC, CAPT Stephen Bree, the UK Liaison Officer to the US military and an experienced combat medical provider, was asked to present the top three things that he thought needed to be changed about TCCC. One of those three items was to add the use of pelvic binders to the TCCC Guidelines. Col Stacy Shackelford presented a review of this topic for the committee. An extensive review of the literature and consideration by the CoTCCC led the committee to recommend that pelvic binders be reconsidered for addition to the TCCC Guidelines.

Background

Pelvic fractures are common in combat injuries, and may be highly lethal. Twenty-six percent of service members who died during Operations Iraqi and Enduring Freedom had a pelvic fracture. The pelvic fractures resulting from direct combat, to include blast injury and gunshot wounds, had a much higher mortality than those resulting from motor

vehicle crash or fall.⁶ Bleeding pelvic fractures associated with hemodynamic instability may have up to 40% mortality.⁴ Anterior compression injuries (open book fractures) are associated with the highest mortality (48%).⁷ Among military casualties, 76% of fatal pelvic fractures are caused by blast injury, 15% by gunshot wounds, and 4.5% by motor vehicle crash.⁵

Emergent treatment options for pelvic fractures include pelvic binder, external fixation, internal fixation, direct surgical hemostasis, preperitoneal pelvic packing, and pelvic angiography and embolization.⁸ Of these, the only treatment available to prehospital providers is the pelvic binder.

Although definitive evidence demonstrating improved survival with pelvic binder use is lacking, every publication identified in our review addressing the management of pelvic hemorrhage recommends pelvic binder use for initial management of pelvic fracture hemorrhage^{4,9-24} including both civilian²⁵⁻²⁹ and military practice guidelines.³⁰⁻³² In general, the risk:benefit assessment of the intervention and the potentially devastating nature of pelvic hemorrhage have led numerous authors to recommend the use of pelvic binders for initial control of pelvic hemorrhage.

In 2016, the Committee on Tactical Combat Casualty Care considered whether the use of pelvic binders should be included in the TCCC guidelines. Seven specific questions were addressed regarding the prehospital use of pelvic binders:

1. *Does a pelvic binder stabilize the pelvic fracture?*
2. *Does a pelvic binder control bleeding from a fractured pelvis?*
3. *Does a pelvic binder improve survival?*
4. *Who should get a pelvic binder?*
5. *Is there any harm in applying a pelvic binder?*
6. *What is the best type of pelvic binder?*
7. *Where does pelvic binder fit into priorities?*

The PubMed, MEDLINE, and Cochrane databases were searched Jan 1, 1990-Apr 1, 2016 for articles under combinations of the keywords *pelvic fracture*, *pelvic binder*, *pelvic sling*, *pelvic orthotic device*, *pelvic circumferential compression device*, *hemorrhage*, and *prehospital*. A total of 1,984 articles were identified; 114 abstracts were reviewed; 60 articles were identified for full review, and 53 articles selected for final inclusion. The references of selected articles were also reviewed as potential additional sources, identifying an additional 7 articles.

Does a pelvic binder stabilize the pelvic fracture?

The effectiveness of a pelvic binder to stabilize fracture fragments has been assessed in human cadaver studies where various unstable fracture patterns were created and the fracture motion measured after pelvic binder application. Commercial devices (Pelvic BinderTM, T-POD®, and SAM sling®) and circumferential sheeting were compared in various combinations in five separate studies³²⁻³⁶ All devices tested were found to provide

near-anatomic fracture reduction with minimal over reduction. Angular motion was controlled during simulated patient care maneuvers in one study.³³ In general, no significant difference was detected between the various commercial devices and circumferential sheet.

Placement of the binder at the level of the pubic symphysis and greater trochanters was shown to reduce the unstable pelvic fracture most effectively with the least amount of force.³⁵⁻³⁷

Conclusion: There is evidence in cadaver studies that fracture motion is stabilized with a pelvic binder. The binder should be placed at the level of the pubic symphysis/greater trochanters. *Level of evidence: B*

Does a pelvic binder control bleeding from a fractured pelvis?

The primary source of hemorrhage from pelvic fractures is the posterior pelvic venous plexus and bleeding cancellous bone surfaces; however, 10-15% of the time, hemorrhage is arterial and arises from branches of the internal iliac, pudendal, and superior gluteal arteries. Exsanguinating hemorrhage may occur in all fracture patterns, even simple rami fractures, and may be independent of the bony injury pattern to the pelvis altogether.⁴

Conventional teaching indicated that pelvic binders control bleeding by reducing the volume of the pelvis and inducing tamponade. However, the reduction in volume of the true pelvis is much less than expected: a large pubic diastasis of 10 cm only corresponds to a 35% increase in pelvic volume, or 480 cc.^{3,38} Additionally, a tamponade effect may not occur since the retroperitoneum is often disrupted, allowing free bleeding into the peritoneal cavity.⁴ Therefore, it is more likely that splinting of pathologic fracture motion to allow clot formation is the mechanism that aids in hemostasis.

Hemorrhage with stable fracture patterns is unlikely to be controlled with a pelvic binder. However, since it is not possible to differentiate a stable from an unstable fracture pattern in the prehospital environment, all suspected pelvic fractures should have a binder applied.

Several clinical studies have attempted to assess the effect of pelvic binder placement on hemorrhage control. A retrospective review of 585 patients with pelvic fractures requiring transfer to a trauma center showed that those who received a pre-transfer pelvic binder required fewer blood transfusions and had a shorter length of stay.³⁹

In a retrospective study of 183 patients treated with external fixation or pelvic binder after hospital arrival, the binder was associated with lower 24-hour transfusion and shorter length of stay, and with a non-significant decrease in mortality (26% vs 37%). The authors noted that the binder could be applied more quickly compared to external fixation.⁴⁰

A retrospective comparison of 192 civilian trauma patients treated with pelvic compression after hospital arrival showed that lethal hemorrhage was higher when a circumferential sheet was used (23%) compared to a binder or C-clamp (4% and 8%) respectively, although the authors acknowledged that sheets may have been used at the more inexperienced trauma centers, while the experienced centers had binders available.⁴¹

In several case reports, a properly applied binder along with ongoing resuscitation effectively improved hemodynamics for patients with pelvic fracture and hypotension.⁴²⁻
⁴⁴ In a case-series of 15 hemodynamically unstable patients with unstable pelvic fractures, hemodynamics were assessed before and immediately after placement of a T-POD[®] device; mean arterial pressure increased and heart rate declined after the binder was placed.

Conclusion: There is weak clinical evidence that pelvic binder may reduce blood transfusion and lethal hemorrhage compared to other methods. There is likely to have been selection bias in these studies and no studies of prehospital application were identified. Anecdotally, hemodynamics often improve after pelvic binder application.
Level of evidence: B

Does a pelvic binder improve survival?

No high-quality evidence was found that documented improved survival associated with the use of pelvic binders. The results of retrospective studies are mixed.

A German-language publication reported 104 severely injured (ISS>16) patients with isolated pelvic fracture and hemodynamic instability. Those who did receive external pelvic stabilization after hospital arrival had a mortality of 19%, while those treated without external stabilization had a 33% mortality.⁴⁵

In contrast, a retrospective historical control study in the US showed that external mechanical compression, when applied after arrival to the hospital, had no effect on mortality, need for angioembolization, or transfusion in a center that emphasized early treatment with angiography.⁴⁶

Of 135 patients with unstable pelvic fractures transferred to a trauma center, three deaths occurred among those who did not receive a pelvic binder before transfer and none among those who did.³⁹

Conclusion: There is very weak clinical evidence that pelvic binders may improve survival when applied after hospital arrival. Evidence in regard to survival following prehospital application of pelvic binders is lacking. *Level of evidence: C*

Is there any harm in applying a pelvic binder?

In theory, pelvic compression could worsen displacement of certain fracture patterns, particularly lateral compression injuries, or cause injury to internal structures through fracture fragment motion, however there is no actual clinical evidence that significant harm occurs.

In a series of 115 patients with high-energy Tile B and C pelvic ring injuries,⁴⁷ bony alignment of the pelvis improved in 68% after application of a pelvic binder, was unchanged in 11%, and worsened in 11%. The authors noted that in some lateral compression fractures, the radiologic deformity increased with pelvic binder placement, however any association between a pelvic binder and femoral artery, bladder, or rectal injury was determined to be unlikely.⁴⁸

A clinical series of 16 pelvic fracture patients showed that open book fractures were effectively reduced with a controlled tension pelvic binder, while over-reduction of compression type fractures was minimal and no complication observed even with prolonged application (mean 59 hrs).⁴⁹

Pressure injury to the skin is a known complication of pelvic binder; such skin breakdown may interfere with operative fixation of the pelvis.⁵⁰⁻⁵⁴

The radiologic signs of open book pelvic fracture may be masked after pelvic binder is applied, and cases of missed injury due to near-perfect bony alignment after pelvic binder placement have been reported.⁵⁵

Conclusion: applying a pelvic binder is unlikely to increase injury or bleeding. Prolonged use or overtightening may cause pressure ulcerations. *Level of evidence: C*

Who should get a pelvic binder?

Strategies to identify pelvic fracture in the prehospital environment include identification of risk factors for pelvic fracture and physical exam findings.

An analysis of 77 consecutive patients with traumatic lower limb amputation due to dismantled improvised explosive device (IED) from the United Kingdom Joint Theater Trauma Registry demonstrated a high incidence of pelvic fractures in patients with lower limb amputations: overall 22% of these casualties had a pelvic fracture; if bilateral above knee amputations were present, 39% had a pelvic fracture.³ The authors concluded that routine application of pelvic binders was indicated for this injury pattern.

Further analysis of bilateral lower extremity amputations in UK servicemen showed that 14% also had an open pelvic fracture.⁵⁶ Of patients who sustained a perineal injury from IED blast, 53% also had a pelvic fracture; the combination of pelvic fracture and perineal injury had a high mortality rate—41%.⁵⁷

A large study assessing the sensitivity of prehospital physical examination for pelvic fracture showed that about one-third of severe pelvic fractures were not suspected in the

prehospital environment, with brain injury and low GCS independently associated with missed injury. Hypotension and high injury severity score (≥ 25) decreased the risk of missing a pelvic injury.⁵⁸

The Royal London Hospital published their standard criteria for application of a pelvic binder, which included obvious pelvic disruption, severe trauma with pain in the pelvis, pain in lower back, pain in the hip, pelvic deformity on visual inspection, and unconscious patient with high energy blunt mechanism.⁵⁹ They reported that 25% of all prehospital missed injuries were pelvic fractures (8 pelvic fractures were missed on prehospital assessment, 2 of which were severe), however none of the missed pelvic fractures were associated with hypotension; the majority of those that were missed also had distracting injuries to the head or limbs.

The London Faculty of Pre-Hospital Care (FPHC) consensus meeting on prehospital management of pelvic fractures recommended early and liberal application of pelvic binders in high energy blunt trauma. In the presence of high energy blunt trauma, the FPHC recommended that a pelvic binder should be used if any one of four risk factors is present: 1) heart rate > 100 , 2) systolic blood pressure < 90 mmHg, 3) GCS 13 or less, or 4) distracting injury and/or pain on pelvic exam.²⁷

The Royal London Hospital subsequently reported in a retrospective review that had they employed the FPHC criteria, 6 of 8 missed pelvic fractures would have met criteria for a pelvic binder.⁵⁹

Physical exam findings associated with pelvic fracture may include a hematoma above the inguinal ligament, on the proximal thigh, or over the perineum, or echymoses of the flank. Additional findings include pelvic pain or instability, neurologic deficits of the lower extremities, blood at the urethral meatus, rectum, or vagina, high-riding prostate, and unequal leg length.^{4, 20, 21} Pelvic “springing” as a patient assessment technique is a poor predictor of the presence or absence of pelvic fracture and may dislodge adherent clot and further exacerbate hemorrhage, and is painful to a conscious patient.⁶⁰ Physical exam findings are not sensitive for identification of pelvic fracture.²⁰

Conclusion: after consideration by the committee, the indications selected for pelvic binder placement include suspected pelvic fracture based on a mechanism of 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

Level of evidence: C

What is the best type of pelvic binder?

There are three commercial devices that have been evaluated in clinical and cadaveric studies. The Pelvic Binder™ (Pelvic Binder Inc, Dallas, TX, USA, NSN 6515-01-618-9137) is one size fits all, cut-to-fit with Velcro fastener and shoelace cinching mechanism. *Image 1.* The SAM Pelvic Sling® (SAM Medical Products, Newport, OR, USA, NSN 6515-01-509-6866) is made in three standard sizes and contains an “Autostop” buckle that limits the amount of compression applied; the device is narrower, leaving more space to access the abdomen or femoral vessels. The belt mechanism is identical to the belt portion of the SAM junctional tourniquet. The medium size SAM sling fits 96% of adults. *Image 2.* The T-POD® (Bio Cybermetrics International, La Verne, CA, USA, NSN 6515-01-526-2788) is one size fits all, cut-to-fit, with a mechanical advantage pulley lacing system.³² *Image 3.*

Sheet wrapping techniques vary slightly in various studies, and likely in clinical use. In general, this technique involves wrapping a folded sheet around the pelvis and securing the sheet with zip ties or clamps.^{33,42} Other improvised pelvic splints have also been described, but have not been studied.

Cadaver studies

In cadaver studies, the Pelvic Binder™, the SAM Sling®, the T-POD® (Bio Cybermetrics International, La Verne, CA, USA), circumferential sheets, and external fixation have been compared in various combinations.^{32-34,61} All of the devices tested were not different in regard to pelvic ring closure and motion of fracture fragments.

Clinical studies

In the previously described German Trauma Registry study, the use of sheet wrapping was associated with a significantly higher mortality (23% for sheet vs. 4% for binder vs. 8% for C-clamp). The authors commented that higher level and busier trauma centers may have been more likely to use a specialized device rather than a sheet, and that it may have been more likely for a sheet to be applied improperly or removed prematurely to facilitate additional interventions. It is therefore not clear from this study whether the use of the sheet is a marker for less experienced providers, or whether the sheet is less effective at controlling hemorrhage.⁴¹

In an evaluation of application time, ease of use, and user preference in a classroom setting comparing the T-POD® and SAM Pelvic Sling™, both were correctly applied 100% of the time, the SAM was quicker to apply (18 s vs. 31 s), and 78% of users preferred the T-POD.⁶²

A properly applied draw sheet, combined with binding the thighs and ankles loosely together effectively improved hemodynamics in 7 patients.⁴²

Improvised pelvic binder techniques

It is likely that commercial pelvic binders will achieve more consistent results with less

training, and should therefore be encouraged to be packed and utilized whenever the environment and tactical situation allow. Circumferential junctional tourniquets may be utilized as equivalent to a commercial binder.

The constant need to reduce additional gear requirements, has led us to also consider improvised pelvic compression techniques as well.

When properly applied, it has been demonstrated that circumferential sheets are as effective as commercial binders to stabilize pelvic fractures, however in actual practice, it is likely that there is significant variability among users.

The technique of placing the circumferential sheet as described in studies evaluating this intervention^{42,44} involves the combination of manually tightening the sheet to reduce the pelvis and then securing the sheet with clamps or zip ties, generally done with at least two medical personnel. For a single rescuer, it is likely that tension would be lost with this improvised technique due to the need to maintain tension while at the same time securing the sheet. *Image 4.*

Other improvised pelvic compression techniques have been described but have not been formally studied. *Image 5-7.* When considering the use of an improvised technique, it is important to ensure that the same principles are rigidly applied in order to achieve similar results: the improvised pelvic binder must be centered at the level of the greater trochanters and pubic symphysis, the device must be applied tightly enough to reduce the fracture without overtightening, the device must be wide enough to distribute pressure evenly, and the thighs or ankles should be bound loosely together. *Image 8.* Securing the toes also prevents external rotation of the lower extremities, further stabilizing fracture motion. *Image 9.*

Improvised pelvic splints have been described utilizing a combination of SAM splint and CAT tourniquet.⁶³ This technique utilizes a familiar tourniquet in combination with a SAM splint, and in the opinion of the authors appears to achieve adequate tension comparable to a commercial device. *Image 5.* This technique, slightly modified, is also taught at the Special Operations Combat Medic Skill Sustainment Course (SOCMSSC).

An additional improvised technique, also taught at SOCMSSC, involves cutting the trouser legs, using the cut ends to encircle the pelvis, and large stick or pole to tighten as a windlass. *Image 6.*

Techniques that include simply tying a cravat around the pelvis or placing linked tourniquets around the pelvis may not achieve adequate tension or may not be wide enough to achieve the expected result, and should be discouraged.

Improvised techniques, in order to be effective, must be thoroughly trained, practiced, and planned in advance.

Conclusion: There is very weak evidence to suggest that a commercial device is more

effective in controlling hemorrhage than an improvised sheet. *Level of evidence: C.* There is no evidence that any commercial compression device is better than another. *Level of evidence: B.* Other improvised pelvic binders have not been studied.

Overall recommendation

There is consistent evidence in cadaver studies that unstable pelvic fractures are reduced and stabilized by pelvic binder placement. There is clinical evidence supporting pelvic binder placement to reduce hemorrhage, although evidence of improved survival is overall weak and fraught with biases. There is also clinical evidence demonstrating that hemodynamics improve after application of a pelvic binder in hemodynamically unstable patients with severe pelvic fracture. There is no indication of substantial harm, beyond the risk of pressure injury to the skin, associated with pelvic binder use.

A pelvic binder should be converted to external or internal fixation as soon as conditions allow, or removed if found to be unneeded once imaging is obtained. If definitive care is delayed beyond approximately 8-12 hours, the need for a binder should be reassessed and the binder loosened if the patient remains hemodynamically stable.

The CoTCCC recommends the use of pelvic binders for all cases of suspected pelvic fracture. A commercial device is recommended for consistency and ease of training, however improvised compression is acceptable if a suitable commercial device is not available.

Where does pelvic binder fit into priorities?

Prehospital medical interventions are prioritized according to the M-A-R-C-H mnemonic (Massive hemorrhage, Airway, Respiration, Circulation, Head/Hypothermia).

A pelvic binder should be considered in the control of hemorrhage during the “circulation” stage, after control of massive external hemorrhage and addressing airway or respiratory compromise, and before reassessment of tourniquets and intravenous access.

When possible, the pelvis should be immobilized before moving the patient. Care Under Fire precludes pelvic immobilization.

Training

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

The above criteria captures high-risk blast injury patients, those with physical exam concerning for pelvic fracture, those with a compromised physical exam due to unconsciousness, and hemodynamically unstable blunt trauma patients.

A pelvic binder provides the greatest degree of stabilization when applied at the level of the greater trochanters rather than at the level of the anterior superior iliac spine.³³ Improper placement, however, is common—in one study as many as 40% of pelvic binders were placed too high resulting in inadequate reduction of pubic symphysis diastasis.⁶⁴ Ideally, the binder should be placed next to the skin rather than over clothing to allow more accurate positioning and prevent the need to remove the device on arrival to the hospital. In tactical situations, it may not be advisable to remove the clothing, however the pockets should be emptied and gear removed from the belt before placing a pelvic binder.

If a pelvic fracture is suspected, logrolling and unnecessary movement of the patient should be avoided. If possible, the pelvic binder should be placed before moving the patient. Ideally, the patient should be lifted gently onto the litter by two or more people, or a scoop litter utilized if available. In a tactical environment, a rigid litter may not be available, however excess motion should still be avoided when moving the patient to the litter. Since logrolling is a common technique used to place casualties onto a litter, avoidance of such motion in cases of suspected pelvic fracture requires particular training emphasis.

The binder should be passed under the thighs and slid up to the level of the greater trochanters, carefully lifting from behind the back and thighs if needed. If the binder is passed beneath the lumbar spine and slid down, the technique is more likely to result in malpositioning the binder above the greater trochanters and decreased effectiveness of the binder.⁶⁴ If the technique of sliding down from the lumbar spine is used, particular attention must be given to proper positioning over the greater trochanters.

Next the ankles or feet should be loosely strapped or taped together. This will help control external rotation of the lower extremities that is commonly seen in patients with displaced pelvic fractures and reduce the forces acting through the hip joint that contribute to pelvic deformity.⁴² If there is an amputation, the thighs should be bound together.³

Pelvic compression may be effectively accomplished with a commercial device, a sheet or other cloth material such as the trouser legs secured with zip ties, or possibly other combinations of improvised devices (ex. Wilderness Medicine guide to pelvic splints).⁶³

Application techniques are different for each of the three currently available commercial devices, therefore medical personnel must be trained on the specific device to be used. If an improvised device is utilized, it must be incorporated into training. Improvised compression with sheet/clothing is best applied by two personnel—one to pull the cloth tightly and another to secure it.

In addition, currently available circumferential junctional tourniquets (SAM Junctional Tourniquet or Junctional Emergency Treatment Tool) are also effective pelvic compression devices.⁶⁵ Routine use of junctional tourniquets for any suspected pelvic fracture, however, will significantly increase cost.

Pneumatic Antishock Garment (PASG)

The use of PASG has previously been included in the TACEVAC phase of the TCCC guidelines for stabilizing pelvic fractures and controlling pelvic and abdominal bleeding. In recent guideline changes, the addition of junctional tourniquets as well as pelvic binders has replaced the use of PASG for this purpose. Concern for potential harm with lack of proven benefit related to the use of PASG,⁶⁶ as well as the contraindications of thoracic and brain injuries, have led us to recommend removal of the PASG from the TCCC guidelines.

Proposed Change to the TCCC Guidelines

Current wording

Care Under Fire

N/A

Tactical Field Care

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 directly to the skin 2-3 inches above the 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 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.

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.

- c. Reassess prior tourniquet application. Expose the wound and determine if a tourniquet is needed. If it is, replace any limb tourniquet placed over the uniform with one applied directly to the skin 2-3 inches above wound. Ensure that bleeding is stopped. When possible, 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.
- d. 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.
- e. Expose and clearly mark all tourniquet sites with the time of tourniquet application. Use an indelible marker.

TACEVAC Care

3. 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 directly to the skin 2-3 inches above the 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 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.

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.

- c. Reassess prior tourniquet application. Expose the wound and determine if a tourniquet is needed. If it is, replace any limb tourniquet placed over the uniform with one applied directly to the skin 2-3 inches above wound. Ensure that bleeding is stopped. When possible, 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.
- d. 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.
- e. Expose and clearly mark all tourniquet sites with the time of tourniquet application. Use an indelible marker

Proposed New Wording

Care Under Fire

N/A

Tactical Field Care

(Proposed New material in red text)

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 directly to the skin 2-3 inches above the wound. 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.

- 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.
- c. 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**
- d. Reassess prior tourniquet application. Expose the wound and determine if a tourniquet is needed. If it is, replace any limb tourniquet placed over the uniform with one applied directly to the skin 2-3 inches above wound. Ensure that bleeding is stopped. When possible, 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.
- e. 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.
- f. Expose and clearly mark all tourniquet sites with the time of tourniquet application. Use an indelible marker.

TACEVAC Care

3. 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 directly to the skin 2-3 inches above the wound. 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.

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.

- c. 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**
- d. Reassess prior tourniquet application. Expose the wound and determine if a tourniquet is needed. If it is, replace any limb tourniquet placed over the uniform with one applied directly to the skin 2-3 inches above wound. Ensure that bleeding is stopped. When possible, 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.
- e. 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.
- f. Expose and clearly mark all tourniquet sites with the time of tourniquet application. Use an indelible marker

**Remove from guidelines:
TACEVAC Care**

17. The Pneumatic Antishock Garment (PASG) may be useful for stabilizing pelvic fractures and controlling pelvic and abdominal bleeding. Application and extended use must be carefully monitored. The PASG is contraindicated for casualties with thoracic or brain injuries.

Level of evidence: (Tricoci)

The levels of evidence used by the American College of Cardiology and the American Heart Association were outlined by Tricoci in 2009:

- Level A: Evidence from multiple randomized trials or meta-analyses.
- Level B: Evidence from a single randomized trial or nonrandomized studies.
- Level C: Expert opinion, case studies, or standards of care.

Using the taxonomy above, the level of evidence for each statement below is shown:

- *Circumferential pelvic compression devices stabilize pelvic fractures: Level B*
 - *Circumferential pelvic compression devices help to control bleeding from a fractured pelvis: Level B*
 - *Circumferential pelvic compression devices improve survival in individuals with pelvic fractures: Level C*
 - *Circumferential pelvic compression devices are unlikely to cause further injury when applied to individuals with suspected pelvic fractures: Level C*
 - *Circumferential pelvic compression devices should be applied for individuals with suspected pelvic fracture as a result of blast injury with lower extremity amputation or with blunt trauma and any of the following:*
 - *SBP < 100 mm Hg or HR > 100*
 - *Pelvic pain*
 - *Compromised exam (GCS ≤ 13 or distracting injury)*
- Level C*
- *There is no clearly superior device among the three currently available circumferential pelvic compression devices: Level B*

Recommendations for Further Research and Development

1. The Joint Trauma System performance improvement process should be used to identify all future casualties on whom circumferential pelvic compression devices are used and how they performed.
2. Clinical study to evaluate outcomes of prehospital pelvic binder use, both military and civilian.
3. Retrospective review of casualties who would have been good candidates for circumferential pelvic compression devices but for whom these devices were not used.
4. Evaluation of improvised pelvic binders in comparison to commercial devices with particular interest in binders constructed using materials commonly available in combat aid bags.
5. Develop a relevant animal model for pelvic fracture hemorrhage and assess the effect of pelvic binder placement on survival.

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Photos by Lt Col James Wiedenhoefer

Image 1. Pelvic Binder™



Image 2. SAM Pelvic Sling®



Image 3. T-POD®



Image 4. Sheet/Blanket



Image 5. SAM splint + tourniquet



Image 6. Trousers cut with windlass.



Image 7. Cravats



Image 8. Ankles secured.



Image 9. Toes secured to prevent external rotation.

