FORWARD ASSESSMENT OF 79 PREHOSPITAL BATTLEFIELD TOURNIQUETS USED IN CURRENT WAR

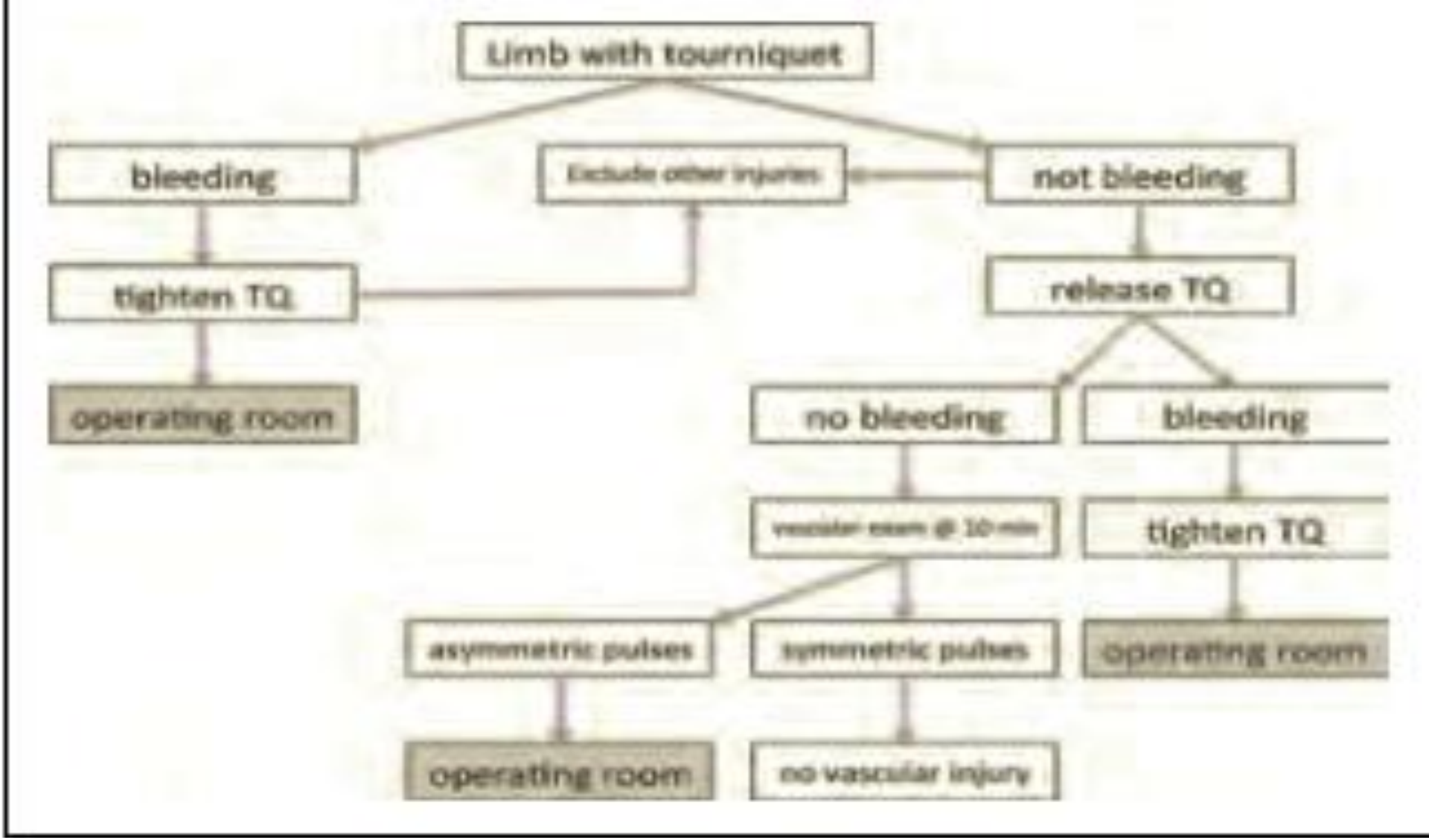

Figure 1 Management Guideline for Limbs with a Tourniquet at Presentation to Level II on the Battlefield. TQ is tourniquet. Vascular examination is conducted at 10 minutes in order to allow for resuscitation, reperfusion, and resolution of vasospasm. “Operating room” entails surgical exploration to identify and repair vascular injury. The guideline concerns emergent exploration for bleeding or ischemia; many limbs have associated skeletal or other injuries beyond the scope of the guideline, but in absence of bleeding and ischemia, such injuries may be triaged so casualties with bleeding may be treated first.

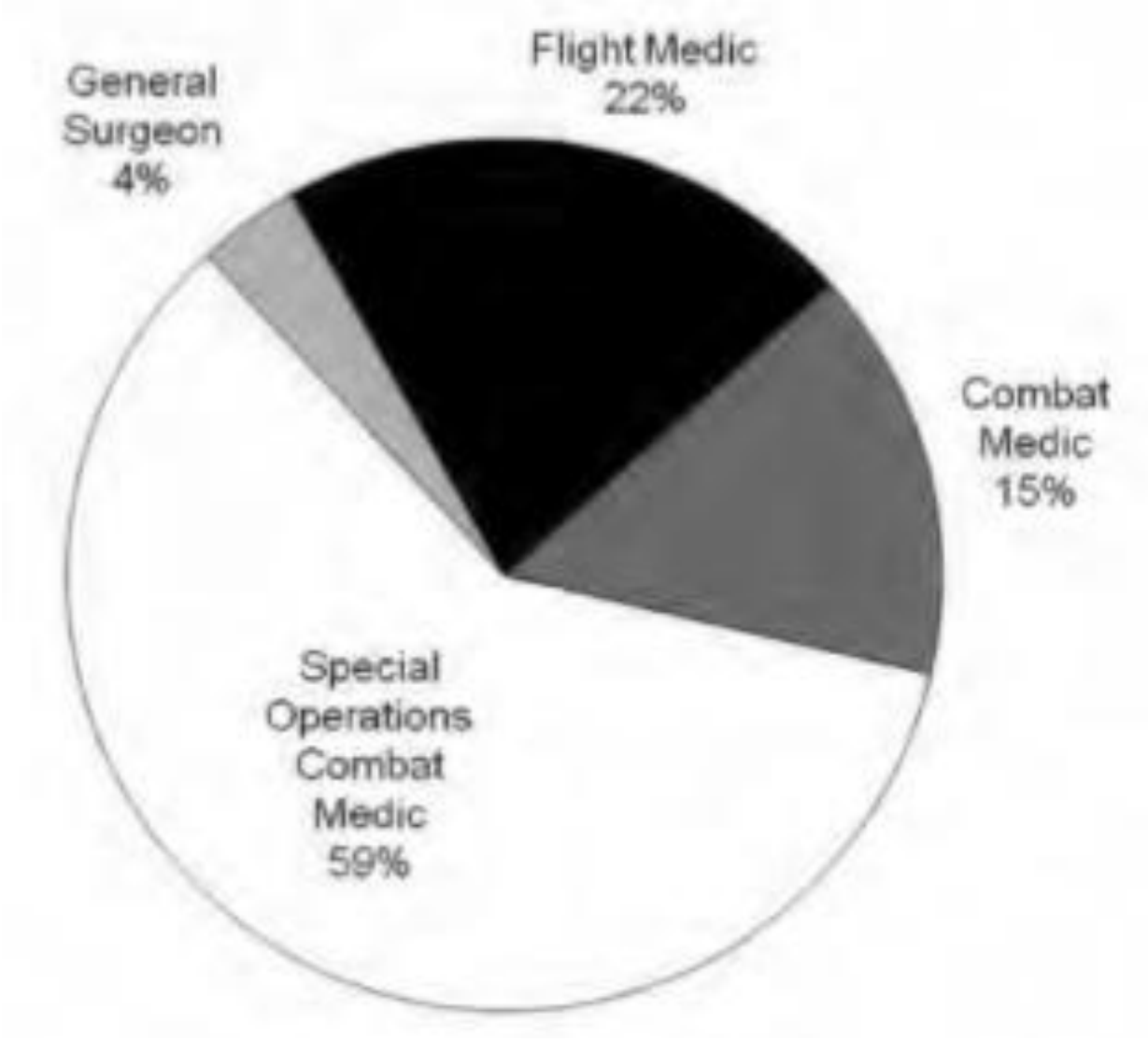

Figure 2 Pie chart of proportions of tourniquet users by job title. Most tourniquets were placed by special operations combat medics (18D, 47 applications, 59%), flight medics (68WF3, 17 applications, 22%), combat medics (military operational specialty [MOS] 68W, 12 applications, 15%), or general surgeons (61J, 3 applications, 4%).

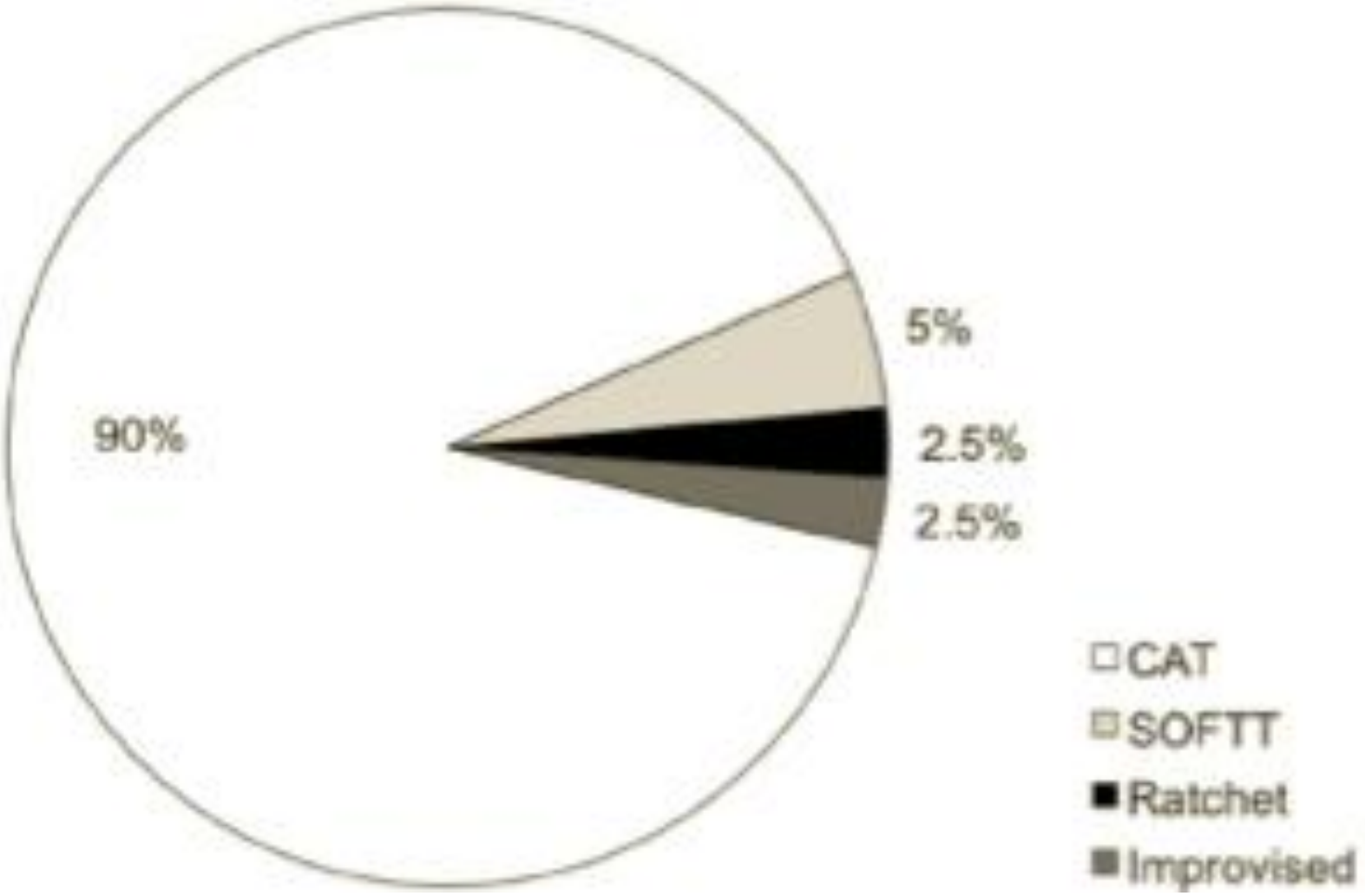

Figure 3 Pie chart of proportions of tourniquets by model. Most tourniquets were the standard issue Combat Application Tourniquet (CAT, 90%). Other included the Special Operations Forces Tactical Tourniquets (SOFTT, 5%), ratchet tourniquets (2.5%), and improvised tourniquets (2.5%).

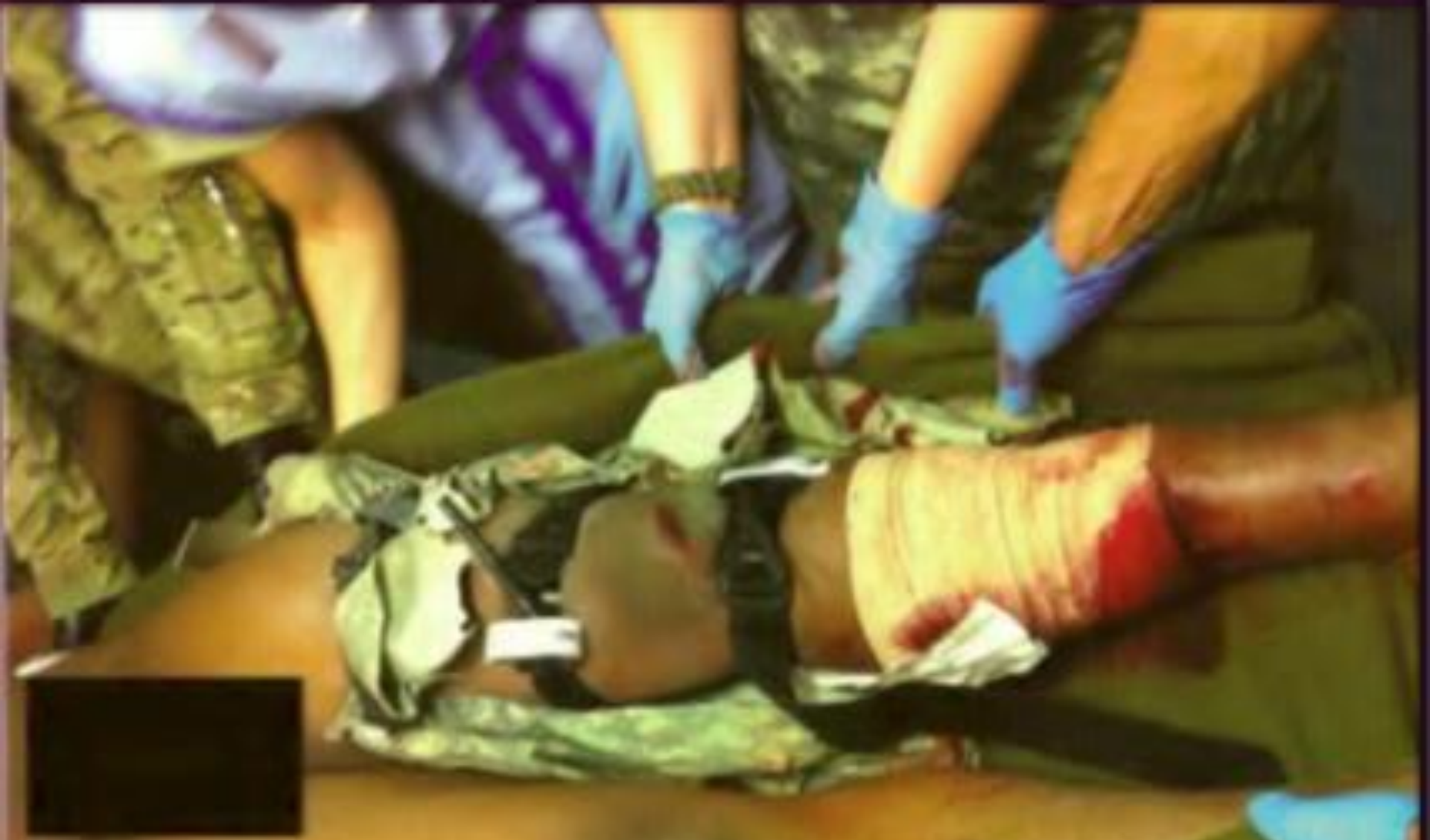

Figure 4 Clinical photograph of a supine casualty with a left lower extremity wound with three tourniquets for combined popliteal artery and venous injuries confirmed later at surgical exploration. The three tourniquets are placed in no coherent plan as they are so far apart as to not be side by side. Side by side, they act as one wide and effective tourniquet. Separately, they add nothing; together, they work well. Tourniquet width is a key design trait for effectiveness.

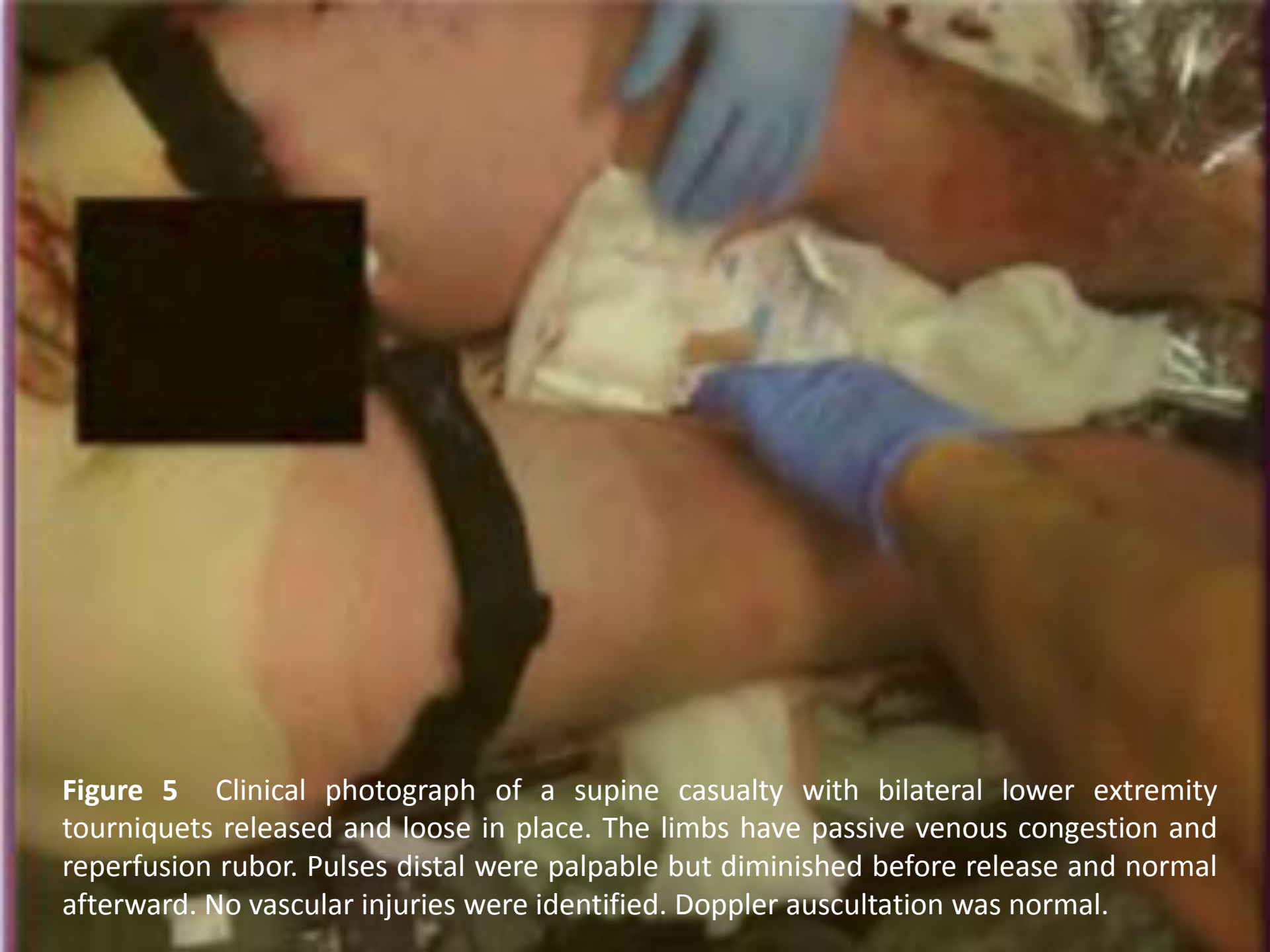

Figure 5 Clinical photograph of a supine casualty with bilateral lower extremity tourniquets released and loose in place. The limbs have passive venous congestion and reperfusion rubor. Pulses distal were palpable but diminished before release and normal afterward. No vascular injuries were identified. Doppler auscultation was normal.

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