

Tactical Combat Casualty Care Guidelines

for All Combatants

August 2017

(Based on TCCC Guidelines for Medical Personnel 170131)

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

RED text indicates changes to current wording or new text.

BLUE text indicates unchanged prior wording that was shifted to a different location in the guidelines.

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. *Stop life-threatening external hemorrhage if tactically feasible:*
 - a. Direct the casualty to control his bleeding himself if able.
 - b. Use a CoTCCC-recommended limb tourniquet for hemorrhage that is anatomically amenable to tourniquet use.
 - c. 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.
7. Airway management is generally best deferred until the Tactical Field Care phase.

Basic Management Plan for Tactical Field Care

1. Establish a security perimeter in accordance with unit tactical standard operating procedures and/or battle drills. Maintain tactical situational awareness.
2. Casualties with an altered mental status should have weapons and communications equipment taken away immediately.
3. Massive Hemorrhage
 - 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 the bleeding site. 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, use Combat Gauze as the CoTCCC hemostatic dressing of choice.
 - Alternative hemostatic adjuncts:
 - Celox Gauze or
 - ChitoGauze or
 - Hemostatic dressings should be applied with at least 3 minutes of direct pressure. 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.
4. Airway Management
 - a. Unconscious casualty without airway obstruction:
 - Chin lift or jaw thrust maneuver
 - Nasopharyngeal airway
 - Place casualty in the recovery position
 - b. 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.
 - c. If the previous measures are unsuccessful, refer to a medic immediately.

5. 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.

6. Circulation

a. Bleeding

- 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.
- Ensure that bleeding is stopped. **If there is no traumatic amputation**, check for pulses further out on the limb than the tourniquet. **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.
- Expose and clearly mark all **tourniquets** with the time of tourniquet application. Use a permanent marker to mark on the tourniquet and the casualty card.

b. Hemorrhagic Shock

- Assess for hemorrhagic shock (altered mental status in the absence of brain injury and/or weak or absent radial pulse).
 - 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.
 - If the casualty is in shock or develops shock, refer to a medic.

7. Hypothermia Prevention

- a. Minimize 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 HPMK is not available, use dry blankets, poncho liners, sleeping bags, or anything that will retain heat and keep the casualty dry.

8. Penetrating Eye Trauma

- a. If a penetrating eye injury is noted or suspected:
 - Cover the eye with a rigid eye shield (NOT a pressure patch.)
 - Ensure that the 400-mg moxifloxacin tablet in the **Combat Wound Medication Pack (CWMP)** is taken if the casualty can swallow. If she can't, refer to a medic for IV or IM antibiotics.

9. Pain relief on the battlefield:

- a. For mild to moderate pain that will not keep the casualty out of the fight:
 - **Combat Wound Medication Pack:**
 - Tylenol - 650-mg bilayer caplet, 2 PO every 8 hours
 - Meloxicam - 15 mg PO once a day
- b. If the casualty's pain is severe enough to interfere with his ability to fight, refer him to a medic for treatment.

10. Antibiotics: recommended for all open combat wounds

- a. If the casualty can swallow:
 - Moxifloxacin (**from the CWMP**), 400 mg by mouth once a day
- b. If the casualty can't swallow (shock, unconsciousness):
 - Refer to a medic for treatment.

11. Inspect and dress known wounds.

12. Check for additional wounds.

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, consider placing the casualty in the Heat-Reflective Shell or Blizzard Survival Blanket from the Hypothermia Prevention Kit 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. Splint fractures and re-check pulses.

15. Communicate

- a. Encourage and reassure the casualty.
- b. Explain to the casualty what you are doing to help him/her.
- c. Communicate with tactical leadership as soon as possible and throughout casualty treatment as needed.
- d. Communicate with the evacuation system (the Patient Evacuation Coordination Cell) to arrange for TACEVAC.

16. Cardiopulmonary resuscitation (CPR)

- a. 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.

17. Documentation of Care

- a. Document clinical assessments, treatments rendered, and changes in the casualty's status on a TCCC Card (DD Form 1380). Forward this information with the casualty to the next level of care.

18. Prepare for Evacuation

- a. Complete and secure the TCCC Card (DD 1380) to the casualty.
- b. Secure all loose ends of bandages and wraps.
- c. Secure hypothermia prevention wraps/blankets/straps.
- d. Secure litter straps as required. Consider additional padding for long evacuations.
- e. Provide instructions to ambulatory patients as needed.
- f. Stage casualties for evacuation in accordance with unit standard operating procedures.
- g. Maintain security at the evacuation point in accordance with unit standard operating procedures.

Basic Management Plan for Tactical Evacuation Care

1. Tactical force personnel should establish evacuation point security and stage casualties for evacuation.
2. The care you can give a casualty during evacuation is the same as Tactical Field Care.
3. For casualties with chest and abdominal trauma, watch closely for tension pneumothorax, especially if evacuating by air or crossing mountainous terrain.
4. Watch for renewed bleeding from any wound. If it occurs, control it.
5. Keep the casualty warm.
6. Document the care you give.