As the winter months approach, the community has expanded the offerings in regard to Prolonged Field Care (PFC) submissions. This issue marks a landmark for the PFC Working Group (WG), with submissions from multiple unique efforts that sprung from the original PFC WG analysis of PFC capabilities and knowledge gaps in the force. By communicating the needs of Special Operations Forces (SOF) to the greater Department of Defense medical infrastructure, USSOCOM was able to harness the talents of medical subspecialists to directly support and, ultimately, enhance the resources for SOF Medics in the field.

Included in this edition is a second Clinical Practice Guideline (CPG), authored by the Joint Trauma System medical experts, in conjunction with operational SOF authors, for the practical management of burn casualties in austere environments. Based on the expertise and framework of the original surgical CPG for burn management, this CPG blends best practices from the Institute of Surgical Research Burn Unit, with other PFC CPGs and guideline papers, to provide practical, realistic tools to SOF medics. We hope it will inform current protocols and teaching in the community.

Additionally, we have the beginning of a relevant series from our first “Sub-Working Group” in telemedicine, with an introduction to the Virtual Critical Care Consultation (VC3) service. This educational case series highlights actual cases managed in the field and the benefit of clinical consultation from SOF Operators to the expert consultation staff at military medical centers. By informing the community of the practical application of teleconsultation, we hope to not only advertise the service but also highlight the utility of this powerful capability.

We also have a case report from the field of a presentation of combat trauma that morphed from a “typical” TCCC scenario into a complex case involving PFC. This case adroitly illustrates the operational constraints and challenges of direct combat on patient management and serves as a reminder of the realities of combat.

We hope that you find these articles informative and useful, as both teaching tools and reference documents. If you have clinical cases that demonstrate the complexities of a PFC environment or highlight the advanced application of SOF medicine, please submit them to the Editor to include in future editions of the Journal.

Thank you for your continued interest, and joining us in this exciting effort to advance SOF medicine!
Management of Burn Wounds Under Prolonged Field Care

Leopoldo C. Cancio, MD; Doug Powell, MD; Britton Adams, NREMT-P, ATP; Kenneth Bull, MD; Alexander Keller, MD; Jennifer Gurney, MD; Jeremy Pamplin, MD; Stacy Shackelford, MD; Sean Keenan, MD

This Role 1, prolonged field care (PFC) guideline is intended to be used after Tactical Combat Casualty Care (TCCC) Guidelines, when evacuation to higher level of care is not immediately possible. A provider of PFC must first and foremost be an expert in TCCC. This Clinical Practice Guideline (CPG) is meant to provide medical professionals who encounter burns in austere environments with evidence-based guidance. Recommendations follow a “best,” “better,” “minimum” format that provides alternate or improvised methods when optimal hospital options are unavailable. A more comprehensive guideline for burn care is available in the Joint Theater Trauma System Clinical Practice Guideline (JTS CPG) for Burn Care at http://www.usaisr.amedd.army.mil/cpgs.html.

**Airway management:**

➤ **Goal:** Avoid airway obstruction due to inhalation injury or burn-induced swelling.

- Patients with smoke inhalation injury may present with a range of symptoms in terms of severity.
- Patients with severely symptomatic smoke inhalation injury (e.g., respiratory distress, stridor) require immediate definitive airway (cuffed tube in trachea) because they are at risk of immediate airway loss. Oxygenate and ventilate.
- All patients with burns covering >40% TBSA should be intubated because total-body swelling will tend to obstruct the airway. Patients with facial burns around the mouth may require intubation (Figure 1).

**Figure 1** Severe facial burns with airway secured.

- **Best:** Rapid-sequence intubation by skilled provider, followed by continuous sedation and airway maintenance, supplemental oxygen, portable ventilator.
- **Better:** Cricothyroidotomy followed by continuous sedation and airway maintenance, supplemental oxygen via an oxygen concentrator, portable ventilator.
- **Minimum:** Cricothyroidotomy, ketamine, ambu bag with positive end-expiratory pressure (PEEP) valve.

**Notes:**

- Patients with mild symptoms of smoke inhalation injury (e.g., some cough, no respiratory distress) can be observed.
• Burns or explosions in a closed space are associated with higher risk of inhalation injury than burns occurring in open areas.

• Supraglottic airway (e.g., laryngeal mask airway [LMA], King LT [Ambu, http://www.ambuusa.com/], or Combitube [Medtronic Minimally Invasive Therapies, http://www.medtronic.com/covidien]) is not appropriate because edema will continue to increase over 48 hours and these tubes do not overcome vocal-cord edema.

• Endotracheal tube must be secured circumferentially around the neck using cotton ties or similar. Tape does not stick to the face well enough in burn patients.

• Place nasogastric (or orogastric) tube to decompress stomach in intubated patients.

• Perform frequent endotracheal suction of intubated patients to ensure tube patency and remove mucus/debris (approximately once an hour or more frequently if oxygen saturation [SpO2] drops).

• If there is evidence of inhalation injury, use 3–5mL of endotracheal saline to facilitate suctioning and prevent tube insipiation and obstruction.

• Monitoring end-tidal CO₂ is an important capability for all intubated patients. A rising end-tidal CO₂ could indicate clogging of endotracheal tube or poor ventilation from another cause (e.g., bronchospasm, tight eschar across chest).

• Use PEEP on all intubated patients.

• Perform a surgical escharotomy of the chest for tight, circumferential, full-thickness burns that impair breathing. Incision goes through the full thickness of the burn and into the fat (Appendix A). Expect some pain and bleeding.

• Use bronchodilators (e.g., albuterol inhaler) for intubated patients with inhalation injury, if available.

Ventilator management of burn patients can be complicated and evolve as pulmonary conditions change due to volume overload/edema and acute respiratory distress syndrome (ARDS). Telemedicine consultation with skilled providers is recommended.

◆ Assess Burn Size:
  ➤ Goal: Accurately identify burn wound size to identify appropriate fluid resuscitation needs.

Estimating burn wound size may be difficult. Engage remote specialty consultants early. If possible, send pictures of wounds that have been cleaned and debrided.

Note: Significant over- or underestimation of burn wound size (by more than 10%) may lead to significant morbidity. Underestimation may lead to under-resuscitation and organ failure (i.e., renal failure, shock); overestimation may lead to resuscitation morbidity (i.e., respiratory failure, compartment syndromes).

• “1st degree” (superficial) burns look like a mild-moderate sunburn. They appear red, blanch readily, do not blister, and hurt when touched. Do NOT include these wounds in the estimation of TBSA used for fluid resuscitation (Figure 2).

• “2nd degree” (partial thickness) burns are moist, blister, blanch, and hurt. Include these wounds in the TBSA estimation (Figure 3).

• “3rd degree” (full thickness) burns appear leathery, dry, nonblanching, do not hurt, and often contain thrombosed vessels that are visible. Include these wounds in the TBSA estimation (Figure 4).

■ Best: When wounds are cleaned/debrided, re-calculate TBSA using the Lund-Browder chart (Appendix B).

■ Better: Same as minimum.

■ Minimum: For small wounds, calculate the size of the wound by using the patient’s hand size (including fingers) to represent a 1% TBSA. For larger wounds, calculate the patient’s initial burn size using the Rule of Nines (Appendix C).

◆ Fluid Resuscitation:
  ➤ Goal: Over the first 24–48 hours postburn, plasma is lost into the burned and unburned tissues, causing hypovolemic shock (when burn size is >20%). The goal of burn-shock resuscitation is to replace these ongoing losses while avoiding over-resuscitation.

■ Best: Isotonic crystalloids (e.g., lactated Ringer’s, Plasma-Lyte IV [Baxter, http://www.baxter.com/]);
  • Start intravenous (IV) or intraosseous (IO) administration IMMEDIATELY
  • IV/IO can be placed through burned skin if necessary.
  • NO bolus (unless hypotensive, in which case, bolus only until palpable pulses are restored)
  • Initial IV rate 500mL/h; start while completing initial assessment
  • Adults: measure burn size (TBSA) and multiply by 10. This is your IV fluid rate. For
example, if the burn size is 30%: $30 \times 10 = 300$. Starting rate is 300mL/h.

❖ For patients with weight >80kg, add an extra 100mL/h for each 10kg. For example, for a 100kg patient with 30% burns, the starting rate is $300\text{mL/h} + 200\text{mL/h} = 500\text{mL/h}$.

❖ If resuscitation is delayed, DO NOT try to “catch up” by giving extra fluids.

❖ For children, $3 \times \text{TBSA} \times \text{body weight in kg}$ gives the volume for the first 24 hours.

■ Better: enteral (oral or gastric) intake of electrolyte solution

- Sufficient volume replacement will require “coached” drinking on a schedule using approximately the same amount of fluids that would be given IV/IO (see above).
- Oral resuscitation of patients with burns up to about 30% TBSA is possible (see Hydration box below).
- If a nasogastric tube (NGT) is available, it is preferable to resuscitate with infusion of electrolyte solution via NGT (e.g., 300–500mL/h). But watch for nausea/vomiting.

■ Minimum: rectal infusion of electrolyte solution

- Rectal infusion of up to 500mL/h can be supplemented with oral hydration (see Hydration box below).

❖ Monitoring:

- Goal: maintain adequate oxygenation and ventilation, avoid hypotension, trend response to resuscitation. Document blood pressure (BP), heart rate (HR), urine output (UO), mental status, pain, pulse oximetry, and temperature, and record data on a flowsheet (Appendix D).

**Hydration**

Plain water is ineffective for shock resuscitation and can cause hyponatremia. If using oral or rectal fluids, they must be in the form of a premixed or improvised electrolyte solution to reduce this risk. Examples:

- World Health Organization (WHO) Oral Rehydration Solution (per package instructions or 1L of potable water with 6 level teaspoons sugar, 0.5 level teaspoon salt)
- Mix 1L of D5W solution with 2L of Plasma-Lyte
- Per 1L water: add 8 tsp sugar, 0.5 tsp salt, 0.5 tsp baking soda
- Per quart of Gatorade (Stokely-Van Camp Inc., http://www.gatorade.com/): add 0.25 tsp salt, 0.25 tsp baking soda (If no baking soda, double the amount of salt in the recipe.)

### Figure 2

First-degree burns. (Do not include these wounds in the TBSA estimate!)

(A) Sunburn.

(B) Mostly first-degree burns with small area of superficial second degree.

⚠️ The principles of hypotensive resuscitation according to TCCC DO NOT apply in the setting of burns (without severe bleeding).

HOWEVER

📞 In the unusual setting of burns associated with noncompressible (e.g., thoracic, abdominal, pelvic) hemorrhage, aggressive fluid resuscitation may result in increased hemorrhage. Balancing the risk of uncontrolled hemorrhage against the risk of worsening burn shock from under-resuscitation should be guided by expert medical advice (in-person or telemedicine). Be prepared for blood transfusion.
Vital signs
- **Best**: Portable monitor providing continuous vital-signs display; capnography if intubated; document vital-signs trends frequently (every 15 minutes initially, then every 30–60 minutes once stable for more than 2 hours).
- **Better**: Capnometry in addition to minimum requirements (if intubated).
- **Minimum**: blood-pressure cuff, stethoscope, pulse oximetry, document vital-signs trends frequently.

Urine output
Urine output is the main indicator of resuscitation adequacy in burn shock.
▶ **Goal**: adjust IV (or oral/rectal intake) rate to UO goal of 30–50mL/h. For children, titrate infusion rate for a goal UO 0.5–1 mL/kg/hr.
- **Best**: place Foley catheter
  - If UO too low, increase IV rate by 25% every 1–2 hours (e.g., if UO = 20mL/h and IV rate =
Extremity Burns:
Burned extremities are vulnerable to injury from postburn swelling.

- **Goal:** Prevent and manage swelling (edema) of burned extremities to prevent long-term damage.
- **Best:** Elevate burned extremities above heart level. Encourage patient to exercise burned extremities to decrease edema. Monitor peripheral pulses on all burned extremities hourly, using a Doppler flowmeter if available. Perform escharotomies of circumferential burns to restore blood flow (Appendix A). Anticipate blood loss and prepare for blood transfusion.

Obtain teleconsultation.

- **Better:** Consider doing escharotomies for circumferential full thickness (3rd degree) burns of an extremity if extremity is edematous, you are unable to palpate distal pulses, and evacuation will be delayed. Anticipate blood loss and prepare for blood transfusion.

Obtain teleconsultation.

- **Minimum:** Triage patient to more rapid evacuation if extremity is edematous and you are unable to palpate distal pulses. Elevate burned extremities above heart level and have patient exercise or provide passive range of motion (PROM) to burned extremities to mobilize edema. Provide pain control to enable PROM.

Pain Management:
Refer to Analgesia and Sedation CPG.

- **Burns can be painful and can cause hypovolemia.** Thus, **frequent, smaller doses** of an IV opioid or ketamine are preferred.

- In hypovolemic burn patients, ketamine can be used for severe pain or for painful procedures, but less than the full anesthetic dose is safer (e.g., 0.1–0.2mg/kg IV push, assess response and redose ketamine as needed every 5–10 minutes).

- For prolonged care of burn patients, a ketamine infusion may provide more consistent analgesia and help conserve supplies of analgesic medications.

- Burn wound care is extremely painful. Ensure an adequate supply of analgesic agents is available before starting wound cleaning, debridement, escharotomy, or dressing change. Refer to Analgesia and Sedation CPG or obtain telemedicine advice for adequate dosing of procedural analgesia for burn care.

- Consider administering an oral or IV benzodiazepine for anxiety (common with repeated painful wound care).

Infection:
Burn wounds are easily infected.

- **Goal:** Prevent burn wound infection through wound care. If evacuation to higher level of care is anticipated within 24 hours, simply cover burns with clean, dry gauze and leave intact blisters in place. Always avoid wet dressings, because of the risk of hypothermia. If evacuation is not anticipated for more than 24 hours, and time, medication, and human resources permit, provide wound care as soon as possible after the injury (within the first 24 hours). If resources are not available initially, provide wound care as soon as possible.

- **Best:** Clean wounds and debride loose dead skin by scrubbing gently with gauze and chlorhexidine gluconate solution (e.g., Hibiclens, Mölnlycke Health Care, http://www.hibiclens.com/) in clean water; apply topical antimicrobial cream (silver sulfadiazine [Silvadene, Pfizer Inc., http://www.pfizer.com/ or mafenide acetate [Sulfamylon, Mylan, http://www.mylan.com/]), followed by gauze dressing. Repeat daily.

- Silverlon can be left in place for 3–5 days as long as the wound is clean when the Silverlon is applied.
- The outer gauze dressings (e.g., Kerlix [Covidien]) should be moistened (not soaked) at least daily. Use sterile (or at least clean, uncontaminated) water or normal saline.
- The outer gauze dressings should be changed, leaving the Silverlon in place, sooner than 3 days if they become saturated with exudate or otherwise dirty.
- If the patient develops any evidence of infection, the Silverlon must be removed and the wound inspected sooner than 3–5 days.
- The Silverlon can be removed and cleaned in sterile, or at least clean uncontaminated, water and reused for up to 5 days.

■ Better: Clean wounds and debride loose dead skin by washing with any antibacterial soap in clean water, dress wounds with any available dressings; optimize wound and patient hygiene to the extent possible given environment.

■ Minimum: Cover with clean sheet or dry gauze. Leave blisters intact. Avoid wet dressings.

Antibiotics

- IV or oral antibiotics are not normally used for prophylaxis in burn patients in the absence of other open wounds requiring them (e.g., open fractures.)
- After several days, if patient develops cellulitis (spreading erythema around edges of burn), treat for gram-positive organisms, (e.g., cefazolin or clindamycin).
- If patient develops invasive burn wound infection (signs: sepsis/septic shock, changes in color of wound, possible foul smell of wound), treat with broad-spectrum antibiotics to include gram-positive and gram-negative coverage that ideally includes coverage for *Pseudomonas aeruginosa* (e.g., ertapenem + ciprofloxacin).

Fluid and equipment planning considerations. See Appendix E.

Summary Table. See Appendix F.

COL (Ret) Cancio, MC, USA, is the senior burn surgeon at the US Army Burn Center. He directs the Multi-Organ Support Task area. He deployed as 504 Parachute Infantry Regiment Surgeon, 82d Airborne Division, Operation Just Cause and Desert Storm; with SOCCENT and 86th Combat Support Hospital during Operation Iraqi Freedom; and with a Forward Surgical Team during Operation Enduring Freedom.

Maj Powell, MC, USA, is an intensive care physician currently serving as the 4th Battalion 3rd Special Forces Group (Airborne) Surgeon and a staff intensivist at Womack Army Medical Center.

MSgt Adams, USAF, is an IDMTP, FP-C, ATP, and Combat Aviation Advisor with the Air Force Special Operations Air Warfare Center (AFSOAWC)/Irregular Warfare Directorate, where he directs/coordinates Aviation Foreign Internal Defense/Global Health Engagement missions in Special Operations Command Africa (SOCAF). He has served multiple deployments to Iraq/Afghanistan and Africa supporting Base Support Operations, casualty evacuations (CASEVAC) and the CAA TCCC/CASEVAC missions. He also works part-time as a civilian critical care flight paramedic.

LT Bull, MC, USN, formerly the Battalion Surgeon for 3d Marine Raider Battalion, Marine Special Operations Command, is a family medicine resident at Naval Hospital Camp Lejeune. He is also a Navy Undersea Medical Officer.

Maj Keller, MC, USAF, is an emergency medicine physician serving as the group surgeon for the 720th Special Tactics Group (AFSOC). He previously served as a CSAR flight surgeon with multiple deployments to Iraq and Afghanistan supporting rescue forces. Maj Keller is also an experienced tactical EMS provider having provided support to multiple law enforcement agencies to include the Dayton Police Department SWAT and Vice Squad, as well as the FBI.

LTC Gurney, MC USA, is a general, trauma, and burn surgeon and currently works as the Chief of Trauma Systems Development, Joint Trauma System, and the Deputy Director of the Burn Center in San Antonio, Texas. She has multiple deployments to Iraq and Afghanistan as part of Combat Support Hospitals and Forward Surgical Teams.

LTC Pamplin, MC, USA, is a board-certified intensivist and is currently the Director of Virtual Critical Care at Madigan Army Medical Center, Joint Base Lewis-McChord, Washington. Previously, he was the Director of the US Army Burn Intensive Care Unit and Chief of Clinical Trials in Burns and Trauma at the US Army Institute of Surgical Research, San Antonio, Texas, and has served as the Simulation and Training Director for the Extracorporeal Membrane Oxygenation Program, San Antonio Military Medical Center, and the Director of the Surgical Intensive Care Unit, Brooke Army Medical Center.

Col Shackelford, MC, USAF, is a trauma surgeon, currently serving as the Chief of Performance Improvement, Joint Trauma System, San Antonio, Texas. She is a member of the Committee on TCCC and has previously deployed as the director of the Joint Theater Trauma System.

COL Keenan, MC, USA, is a board-certified emergency medicine physician, and is currently serving as Command Surgeon, Special Operations Command, Europe. He has previously served as Battalion Surgeon in both 1st and 3rd SF(G)(A), and as Group Surgeon, 10th SF(G)(A). He is the coordinator for the SOMA Prolonged Field Care Working Group. E-mail: sean.keenan1.mil@mail.mil.
Appendix A  Escharotomy incisions

The incisions on the extremities are placed along the mid-medial and/or mid-lateral joint lines. The bold lines indicate the importance of always carrying the incisions across any involved joints. The incisions on the chest are intended to free up a mobile “plate” of tissue to restore adequate chest movement with breathing. Source: Figure 26.1, p. 379, Chapter 26 (Burns). In: Anonymous, Emergency War Surgery, 4th United States Revision. Fort Sam Houston, TX: Office of the Surgeon General, Borden Institute, 2013.

**Figure A1**  *Photograph of a patient undergoing escharotomy of the leg, using electrocautery. The goal is to go through the burned skin into viable tissue (i.e., subcutaneous fat).*

**Figure A2**  *Photograph of a patient undergoing escharotomy of the leg and foot, using a scalpel. When using a scalpel, there may be increased blood loss compared to electrocautery, as shown here.*
Appendix B  Lund and Browder Burn Wound Calculation Worksheet

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<th>1 - 4 years</th>
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Appendix C  Rule of Nines Burn Wound Calculation

Use this image to calculate the percent of total body surface area (%TBSA) involved by second and third degree burn wounds (do NOT include first degree wounds in this assessment). Example: Second and third degree wounds involving the entire anterior torso and right upper extremity, front and back, would be cover 27% TBSA. If this wound had scattered areas of unburned skin and/or first degree burns, adjust the %TBSA downward. %TBSA is an estimate. Both over- and underestimates have potential negative impacts on a patient’s resuscitation.

![Burn Diagram Image]

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**Appendix D  Joint Trauma System (JTS) Burn Resuscitation Flow Sheet**

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<tbody>
<tr>
<td>Name</td>
<td>SSN</td>
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<tr>
<td>Preburn est. wt (kg)</td>
<td>%TBSA (Do not include superficial 1st degree burn)</td>
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<tr>
<td></td>
<td>Calculate Rule of Tens (if &gt;40&lt;80kg, %TBSA × 10 = starting rate for LR)</td>
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<tr>
<td></td>
<td>Calculate max 24hr volume (250mL × kg) Avoid overresuscitation, use adjuncts if necessary</td>
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</table>

<table>
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<th>Date and Time of Injury</th>
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<tr>
<td>Tx Site/ Team HR from burn Local Time Crystalloid* (LR) / Colloid Total UOP (Target 30-50mL/hr) Base Deficit / Lactate Heart Rate MAP (&gt;55) / CVP (6-8mmHg) Pressors (Vasopressin 0.04 U/min) Bladder Pressure (Q4)</td>
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**Total Fluids:** (Use adjuncts if >24hr max)

*Titrate LR hourly to maintain adequate UOP (30-50mL/hr) and tissue perfusion

BAMC/ISR, Brooke Army Medical Center/Institute of Surgical Research; CVP, central venous pressure; est wt, estimated weight; HR, heart rate; LR, lactated Ringer's solution; MAP, mean arterial pressure; max, maximum; Tx, therapy; UOP, urine output.
Appendix E  Fluid and equipment planning considerations

Assumptions: one patient with a 50% total body surface area (TBSA) burn, weighing 80kg, and requiring 4mL/kg/%TBSA for resuscitation the first day (16L), half that the second day (8L), and half that the third day (4L). Note: For planning purposes only, the Parkland formula of 4mL/kg/%TBSA provides an estimate for the first 24-hour fluid requirements; however, hourly fluid resuscitation should start with the rule of 10s.

Best:
- Fluids: IV fluid (lactated Ringer’s solution or Plasma-Lyte) to provide resuscitation for 72 hours (28L)
- Equipment: Portable monitor with capnography; lab capability for serum electrolytes, arterial blood gases, and lactate; Foley catheter with graduated collection system; portable ventilator; portable suction; electrocautery or scalpel; oxygen or oxygen concentrator; airway management kit to include endotracheal suction catheter
- Medications: pain medications (refer to Analgesia, Sedation CPG)
- Burn-specific dressings: Hibiclens to clean wounds, Silvadene and/or Sulfamylon cream (two 400g jars per patient per day), or silver nylon (Silverlon) dressings
- Nonspecific dressings: roller gauze, torso dressings, tape or stapler
- Hypothermia prevention: sleeping bag/HPMK/Blizzard Blanket (Blizzard Protection Systems Ltd., http://www.blizzardsurvival.com/)
- Monitoring: Frequent vital signs, examination, fluid input, urine output, flowsheet to document
- Communications: telephone; e-mail digital photos

Better:
- Fluids: IV fluid (lactated Ringer’s solution or Plasma-Lyte) to provide resuscitation for 24 hours (16L); oral electrolyte replacement
- Equipment: Blood pressure cuff, stethoscope, pulse oximeter, capnometry, portable ventilator, oxygen or oxygen concentrator, airway management kit to include endotracheal suction catheter
- Graduated container to monitor urine output
- Pain medications
- Nonspecific dressings: roller gauze, torso dressings, tape or stapler
- Hypothermia prevention: sleeping bag/HPMK/Blizzard Blanket (Blizzard Protection Systems Ltd., http://www.blizzardsurvival.com/)
- Monitoring: Frequent vital signs, examination, fluid input, urine output, flowsheet to document
- Communications: telephone; e-mail digital photos

Minimum:
- Fluids: Resuscitation with commercial or improvised electrolyte solution (oral, enteral, rectal)
- Equipment: Blood pressure cuff, stethoscope, pulse oximeter, bag-valve mask with positive end-expiratory pressure (PEEP) valve, airway management kit
- Graduated or improvised graduated container to monitor urine output
- Pain medications
- Clean sheet, any available trauma dressings
- Hypothermia prevention: sleeping bag/emergency blanket/blankets
- Monitoring: Frequent vital signs, examination, fluid input, urine output documented on pre-printed or improvised flowsheet
- Communications: telephone
Appendix F  Summary Table

<table>
<thead>
<tr>
<th>Section</th>
<th>Best</th>
<th>Better</th>
<th>Minimum</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Airway</strong></td>
<td>• Rapid-sequence intubation</td>
<td>• Cricothyroidotomy</td>
<td>• Cricothyroidotomy</td>
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<tr>
<td></td>
<td>• Continuous sedation + airway maintenance and suctioning</td>
<td>• Continuous sedation + airway suctioning</td>
<td>• Ketamine</td>
</tr>
<tr>
<td></td>
<td>• O₂ and portable ventilator</td>
<td>• O₂ concentrator and portable ventilator</td>
<td>• Bag-valve mask with PEEP valve</td>
</tr>
<tr>
<td><strong>Assess Burn Size</strong></td>
<td>• For initial estimate: Rule of 9s</td>
<td>• Same as minimum</td>
<td>• For large burns: Rule of 9s</td>
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<td></td>
<td>• After wounds are cleaned/debrided: recalculate burn size using Lund-Browder chart</td>
<td></td>
<td>• For small burns: Patient’s hand = 1% TBSA</td>
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<tr>
<td><strong>Fluid Resuscitation</strong></td>
<td>• Use isotonic crystalloid (lactated Ringer’s or Plasma-Lyte)</td>
<td>• Oral resuscitation with electrolyte solution (avoid plain water)</td>
<td>• Rectal infusion of electrolyte solution</td>
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<td>• Starting fluid rate calculated by Rule of 10s (TBSA × 10; +100mL/h for each 10kg over 80kg)</td>
<td>• Possible for up to 30% TBSA burns</td>
<td>• Can infuse up to 500mL/h</td>
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<td>• “Coached” drinking on a schedule to meet target fluid rate</td>
<td>• May use to supplement oral hydration</td>
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<tr>
<td><strong>Teleconsultation</strong></td>
<td>• Establish contact early</td>
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<td>• Burn &gt;20% TBSA</td>
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<td></td>
<td>• Ventilator management</td>
<td></td>
<td>• Electrical burn</td>
</tr>
<tr>
<td></td>
<td>• Measuring burn size</td>
<td></td>
<td>• Escharotomy needed</td>
</tr>
<tr>
<td></td>
<td>• Hemorrhagic shock + burns</td>
<td></td>
<td>• Infection</td>
</tr>
<tr>
<td><strong>Monitoring</strong></td>
<td></td>
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<tr>
<td><strong>Vital Signs</strong></td>
<td>• Portable monitor</td>
<td>• Blood pressure (BP) cuff, stethoscope</td>
<td>• BP cuff, stethoscope</td>
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<tr>
<td></td>
<td>• Capnography</td>
<td>• Pulse oximetry, capnometry</td>
<td>• Pulse oximetry</td>
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<td>• Document vital signs (VS) and intake/output (I/O) on flow sheet</td>
<td>• Document VS and I/O on flow sheet</td>
<td>• Document VS on flow sheet</td>
</tr>
<tr>
<td><strong>Urine Output</strong></td>
<td>• Foley catheter, titrate fluids to keep urine output (UO) 30–50mL/h</td>
<td>• Collect urine in graduated container</td>
<td>• If unable to measure UO, adjust fluids to maintain HR &lt;140, good capillary refill, intact mental status</td>
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<td>• Increase or decrease fluid rate by 25% each hour if UO not at goal</td>
<td>• &gt;180mL every 6 hours is adequate</td>
<td>• Treat hypotension if needed, but this is a late sign of hypovolemia</td>
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### Appendix F  Summary Table (cont.)

#### Extremity Burns

<table>
<thead>
<tr>
<th>Level</th>
<th>Recommendations</th>
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</table>
| **Best** | • Elevate, exercise  
  • Monitor pulses hourly, Doppler flowmeter  
  • Escharotomy if circumferential third degree burn |
| **Better** | • Elevate, exercise  
  • Monitor pulses hourly  
  • Escharotomy only if unable to palpate distal pulses and evacuation delayed |
| **Minimum** | • Elevate, exercise  
  • Monitor pulses hourly |

#### Pain Management

<table>
<thead>
<tr>
<th>Level</th>
<th>Recommendations</th>
</tr>
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</table>
| **Best** | • Ketamine infusion  
  • Supplement with IV opioids and midazolam (e.g., Versed), frequent small doses |
| **Better** | • Ketamine IV  
  • Supplement with IV opioids and midazolam, frequent small doses |
| **Minimum** | • Fentanyl lozenge  
  • Oral acetaminophen/oxycodone (e.g., Percocet, Endo Pharmaceuticals, http://www.endo.com/) |

#### Infection

##### Prevent Infection

<table>
<thead>
<tr>
<th>Level</th>
<th>Recommendations</th>
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| **Best** | • Clean wound and debride loose dead skin using gauze and Hibiclens in clean water  
  • Apply antimicrobial cream (Silvadene or Sulfamylon, cover with gauze)  
  • Alternative: Apply Silverlon dressings to clean wounds, cover with gauze |
| **Better** | • Clean wound and debride loose dead skin using any antibacterial soap in clean water  
  • Apply any available dressing  
  • Optimize wound care and hygiene to extent possible |
| **Minimum** | • Cover with clean sheet or dry gauze  
  • Leave blisters intact |

##### Treat Infection

<table>
<thead>
<tr>
<th>Level</th>
<th>Recommendations</th>
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| **Best** | • If cellulitis (spreading erythema around edge of burn), treat with IV antibiotics (e.g., cefazolin or clindamycin)  
  • If invasive infection with sepsis, foul smell, or burn wound color change, cover gram-positive, gram-negative, and Pseudomonas bacteria (e.g., ertapenem + ciprofloxacin) |
| **Better** | • Same as minimum |
| **Minimum** | • If cellulitis (spreading erythema around edge of burn) or invasive infection, treat with any available antibiotic |
Inside this Issue:

- Case Report: Unilateral Renal Cystic Disease
- Learning Curves of Emergency Tourniquet Use
- Tourniquet Pressure Loss
- SWCC Postural Stability With Gear
- Trigger-Point Dry Needling
- Physiological Effects of Kettlebell Swing Training
- Rice-Based Rehydration Drink
- Comparison of Red-Green Versus Blue Tactical Light
- Editorial: Pretrauma Interventions: Preventing Battlefield Injuries
- Ongoing Series: Human Performance Optimization, Infectious Diseases, Injury Prevention, Picture This, Preventive Medicine, Prolonged Field Care, SOFsono Ultrasound Series, Special Talk, The World of Special Operations Medicine, Book Reviews, From the NATO Surgeon, TCCC Updates, TacMed Updates, and more!  

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