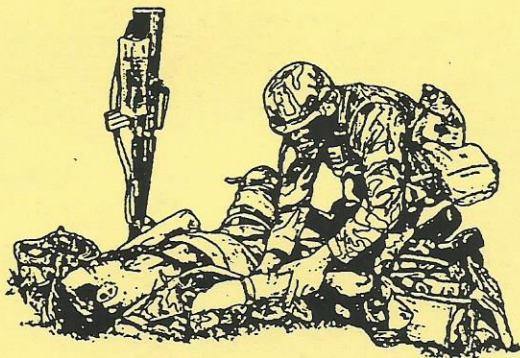


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**91B**

# **COMBAT MEDIC POCKET GUIDE**

**PART I: TRAUMA TREATMENT**



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COMBAT MEDIC POCKET GUIDE  
PART I: TRAUMA TREATMENT

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## PATIENT ASSESSMENT

### NORMAL VITAL SIGNS

- ♦ B/P systolic ↑ 90 ↓ 140  
diastolic ↑ 60 ↓ 90.
- ♦ Pulse rate, 60 - 80.
- ♦ Respiratory rate, 12 - 20.
- ♦ Capillary refill,  
2 seconds or less.
- ♦ Temperature 98.6° F.

### HISTORY (AMPLE SURVEY)

- A = Allergies.
- M = Medications.
- P = Past medical history.
- L = Last meal.
- E = Events.

### NEUROLOGICAL

#### ASSESSMENT (AVPU)

- A = Alert.
- V = Responds to verbal.
- P = Responds to pain.
- U = Unconscious,  
unresponsive.

<b>Eye opening</b>	Spontaneous	4
	To voice	3
	To pain	2
	None	1
Total		_____

<b>Verbal response</b>	Oriented	5
	Confused	4
	Inappropriate words	3
	Incomprehensible wds	2
	None	1
Total		_____

<b>Motor response</b>	Obeys command	6
	Localizes pain	5
	Withdraws from pain	4
	Flexion from pain	3
	Extension from pain	2
	None	1
Total		_____

Glasgow Coma Scale Points: TOTAL = \_\_\_\_\_

Reduction of Glasgow Coma Scale points for use  
in a trauma score:

14 - 15 = 5	5 - 7 = 2
11 - 13 = 4	3 - 4 = 1
8 - 10 = 3	

INJURY LOCATION		INJURY LOCATION	
right	left	left	right
1	16	31	44
2	17	32	45
3	18	36	49
4	19	37	50
8	20	38	61
5	21	39	52
6	22	40	63
7	23	41	54
9	24	42	53
10	25	43	66
11	26		
12	27		
13	28		
14	29		
15	30		



## SHOCK (BLOOD LOSS)

### PATIENT ASSESSMENT

- ◆ Low B/P (late sign).
- ◆ Delayed capillary refill, greater than 2 seconds.
- ◆ ↑ Pulse (weak and thready)
- ◆ (early sign).
- ◆ ↓ Respirations (shallow).
- ◆ Pale, cool, clammy, and diaphoretic skin.
- ◆ Nausea, thirst, weakness.
- ◆ Feeling of impending doom.
- ◆ Changes in level of consciousness.

## NEUROGENIC SHOCK (SPINAL INJURY)

### PATIENT ASSESSMENT

- ◆ Low B/P.
- ◆ Slow or normal pulse.
- ◆ Slow or normal respirations.
- ◆ Skin warm and dry.

## ANAPHYLACTIC SHOCK

### PATIENT ASSESSMENT

- ◆ Low B/P.
- ◆ Changes in level of consciousness.
- ◆ ↑ Pulse.
- ◆ ↑ Respirations with wheezing.
- ◆ Swelling of face, lips, tongue.
- ◆ Skin rash or hives.

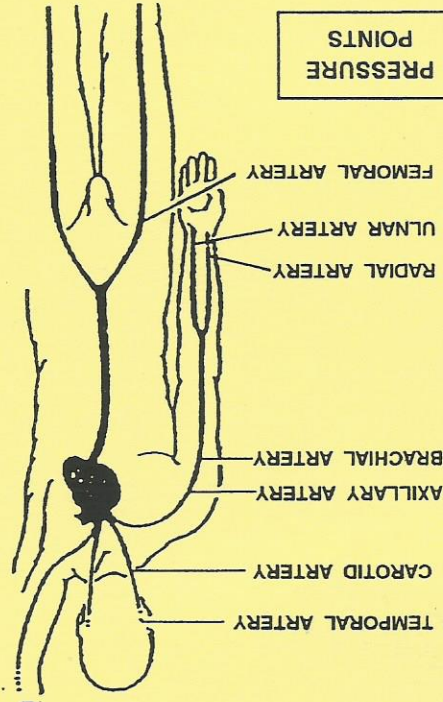
### PATIENT CARE (GENERAL)

- ◆ High concentration of oxygen.
- ◆ Control external bleeding.
- ◆ PASS (if local protocol allows).
- ◆ Spinal immobilization.
- ◆ Splint all suspected fractures.
- ◆ Keep patient warm.
- ◆ Shock position.

## CONTROL EXTERNAL BLEEDING

### PATIENT CARE

- ◆ Direct pressure.
- ◆ Elevation.
- ◆ Pressure Dressing.
- ◆ Pressure points.
- ◆ Applying a tourniquet (last resort).



## SOFT TISSUE INJURIES

### PATIENT ASSESSMENT

- ◆ Contusions - bruises
- ◆ Abrasions - scrapes.
- ◆ Incisions - straight cuts.
- ◆ Avulsions - loose or torn skin flap.
- ◆ Lacerations - jagged edges.
- ◆ Punctures - holes caused by sharp, pointed objects.

### PATIENT CARE

- ◆ Expose the wound.
- ◆ Clear the wound surface.
- ◆ DO NOT remove impaled objects.
- ◆ Control bleeding.
- ◆ Prevent further contamination.
- ◆ Administer high-flow oxygen.
- ◆ Treat for shock.
- ◆ Reassure the patient.
- ◆ Apply MAST pants when appropriate and local protocol permits.
- ◆ Transport as soon as possible.
- ◆ Continue to monitor.

## FRACTURES AND DISLOCATIONS

### PATIENT ASSESSMENT

- ◆ Tenderness and pain.
- ◆ Swelling and discoloration.
- ◆ Crepitus.
- ◆ Loss of function.
- ◆ Loss of distal pulse.
- ◆ Loss of sensation.
- ◆ Exposed bone.
- ◆ An obvious deformity.

### PATIENT CARE

- ◆ Do neurovascular assessment before and after splinting (distal pulse, capillary refill, sensation, and movement).
- ◆ Splint above and below fracture or dislocation site.
- ◆ Splint in position found.
- ◆ Splint fractures of the hand in position of function if possible.
- ◆ Bandage open fractures to control bleeding.
- ◆ DO NOT log roll pelvic fractures.



## SKULL FRACTURES

### PATIENT ASSESSMENT

- ◆ Unconsciousness or change in the level of consciousness.

- ◆ Deep laceration or severe bruise.

- ◆ Pain or swelling.

- ◆ Deformity.

- ◆ "Battle's Sign," "Raccoon's Eyes."

- ◆ Unequal pupils.

- ◆ Bleeding and/or clear fluid from ears or nose.

## BRAIN INJURIES

### PATIENT ASSESSMENT

- ◆ Pain.

- ◆ Decreased level of consciousness.

- ◆ Blood pressure ↑ and pulse rate ↓.

- ◆ Respirations ↑ or ↓.

- ◆ Pupils unequal. Vision disturbances.

### PATIENT CARE OF SKULL FRACTURES

#### AND BRAIN INJURIES

- ◆ Ensure and maintain an open airway.

- ◆ Immobilize the neck and spine.

- ◆ Administer high-flow oxygen

- ◆ (nonrebreather or BVM).

- ◆ Control bleeding. DO NOT use

- pressure dressing.

- ◆ Keep the patient at rest.

- ◆ Monitor vital signs.

- ◆ Manage the patient for shock even if

- shock is not present.

- ◆ Elevate the head of the spine board

- slightly if there is no evidence of shock.

(continued top next column)

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## PATIENT CARE OF SKULL FRACTURES

### AND BRAIN INJURIES (continued)

- ◆ Be prepared for vomiting.

- ◆ Apply light sterile dressing if bleeding

- or if clear fluids flow from ears/nose.

- ◆ If patient is unconscious, hyperventilate

- using BVM.

## FACIAL FRACTURES

### PATIENT ASSESSMENT

- ◆ Blood in the airway.

- ◆ Facial deformities.

- ◆ False face bone movements.

- ◆ Black eyes or discoloration

- below the eyes.

- ◆ Poor jaw function or poor

- alignment of teeth.

- ◆ Loose or knocked out teeth,

- broken dentures.

- ◆ Large facial bruises.

- ◆ Indications of a severe blow

- to the face.

- ◆ Pain, swelling.

### PATIENT CARE

- ◆ Provide spinal immobilization.

- ◆ Ensure and maintain an open airway.

- ◆ Position for drainage.

- ◆ Treat for shock.

- ◆ Administer high-flow oxygen.

- ◆ Be prepared for vomiting.

- ◆ Remove impaled objects in the cheek.

- ◆ Dress any wounds.

## SPINAL INJURIES

### PATIENT ASSESSMENT

- ◆ Pain without movement.
- ◆ Pain with movement.
- ◆ Tenderness, deformity.
- ◆ Impaired breathing.
- ◆ Priapism.
- ◆ Posturing.
- ◆ Loss of bowel or bladder control.
- ◆ Paralysis or nerve impairment of the extremities.
- ◆ Severe shock ( ↓ B/P, normal or slow pulse, warm, dry skin).

### PATIENT CARE

- ◆ Provide manual stabilization for the head/neck.
- ◆ Apply an extrication or rigid collar and continue to maintain manual stabilization.
- ◆ Secure the patient to a long spineboard.
- ◆ Administer high-flow oxygen.
- ◆ Treat for shock.
- ◆ Apply MAST pants if protocol permits.

## CHEST INJURIES

### PATIENT ASSESSMENT

- ◆ An obvious wound.
- ◆ Pain at the injury site.
- ◆ Painful or difficult breathing.
- ◆ Indications of developing shock.
- ◆ Coughing up bright red, frothy blood.
- ◆ Distended neck veins.
- ◆ Tracheal deviation.
- ◆ Unequal air entry.
- ◆ Crepitus.
- ◆ Paradoxical movement.

### PATIENT CARE

- ◆ Seal open chest wound.
- ◆ Administer high-flow oxygen.
- ◆ Stabilize flail segments.
- ◆ Treat for shock.
- ◆ DO NOT remove impaled objects.
- ◆ Immobilize the spine.



## ABDOMINAL INJURIES

### PATIENT ASSESSMENT

- ◆ Bruises, contusions, lacerations, evisceration of abdominal organs.
- ◆ Tenderness.
- ◆ Rigidity.
- ◆ Distention.

### PATIENT CARE

- ◆ Be prepared for vomiting and maintain an open airway.
- ◆ Place the patient on his back, legs flexed at the knees, if possible.
- ◆ Administer high-flow oxygen.
- ◆ Treat for shock.
- ◆ Apply anti-shock garments if indicated and local protocol permits.
- ◆ Give nothing to the patient by mouth.
- ◆ Constantly monitor vital signs.
- ◆ Transport ASAP.
- ◆ Control external bleeding and dress all open wounds.
- ◆ DO NOT replace exposed organs.
- ◆ Cover with sterile dressing and plastic wrap.
- ◆ Immobilize the spine.

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## GENITALIA INJURIES

### PATIENT ASSESSMENT

- ◆ Lacerations.
- ◆ Avulsions.
- ◆ Bruising.
- ◆ Swelling.
- ◆ Amputations.
- ◆ Pain.

### PATIENT CARE

- ◆ Apply a diaper-type dressing or bulky padding.
- ◆ Save all avulsed parts and transport with patient.
- ◆ Follow local protocol in reference to applying ice packs.
- ◆ Administer high concentration oxygen.
- ◆ Treat for shock.
- ◆ Provide emotional support.