

PO Box 07490
Fort Myers, FL 33919
Phone & Fax
239-482-2162

POINTS OF INTEREST:

SAPA Election Results

SAPA Survey

Preventable Causes of
Death

Fresh Whole Blood
Transfusion

MC4 Update

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SAPA JOURNAL

The Society of Army Physician Assistants
A Civilian Organization Representing Army PAs

Vol. 24, NO. 7 A

AUG / SEP / 2011

Newest SAPA Officers Announced

FROM: STEVEN BRIGGS, SAPA PRESIDENT ELECT

Below are the results of the 2011-2012 SAPA Election. Congratulations to all new or not so new Officers.

As the President Elect, one of my inherited duties is to announce the Society of Army Physician Assistant election results. It is with great pleasure to announce the following results.

President Elect: Frank Piper

Active Duty Director: Pauline Gross

Retired Army PA Director: Casey Bond

Secretary: Karen McMillan

Treasurer: Jim Miller

Army Reserve Director: Tanya Moore

Army National Guard Director: Nolan A. Wright

Alternate Delegates to AAPA: Hal Slusher (Primary), Orié (Bob) Potter (Secondary) and Stephen Ward (Tertiary).

I would like to thank all individuals who have volunteered their time to run for office and those who participated in the voting process.

Duty position will take affect 01 July 2011.

If any SAPA member would like to know the actual vote count it is a matter of record and can be obtained by contacting the Secretary.

Respectfully Submitted,
Steven Briggs, President Elect

“ There is no other organization like SAPA that can and will speak out for Army PAs. I want to grow our membership to include ALL Current Active Duty, Guard and Reserve Physician Assistants as well as keep those who have been faithful to SAPA.”

SAPA SURVEY

From the editor: Below is a letter and survey from the officers of SAPA. The goal of this survey is to gather data to better serve our fellow members and to find ways to attract new members especially those on active/reserve/guard duty. The survey can be found at the SAPA website and results sent to the editor at john.f.detro@us.army.mil.

The Society of Army Physician Assistance (SAPA) is a Chapter of the American Academy of Physician Assistance (AAPA). The SAPA Board of Directors (BOD) has been elected to run the day-to-day business operations of the Society. The business activity includes monitoring and voicing to the AAPA and to Capitol Hill any concerns with regards to the business practices and direction that they pursue. We not only have a duty to advocate any and all concern on behalf of its members to the AAPA and Capitol Hill, but we also conduct our annual SAPA refresher conference and I have only three goals in carrying out my responsibilities as your elected member of the BOD. First, I want to make sure we are advocating on the behalf of the majority of the SAPA Constituency. So, I need to know what your concerns are. Secondly, I want to make sure that our annual CME/Conference is truly the “Biggest Bang for the Buck”. In order to this, I need to ensure that it is not only cost affective and convenient, but relevant! Last and most important, is maintaining the continued legacy/lineage of SAPA and to grow our membership, so that we have a strong voice both as a chapter of AAPA and on Capitol Hill.

There is no other organization like SAPA that can and will speak out for Army PAs. I want to grow our membership to include ALL Current Active Duty, Guard and Reserve Physician Assistants as well as keep those who have been faithful to SAPA. If I am correct and we are successful in the first two goals, the third will come in time. So, I ask you to please take a few minutes to fill out this brief survey of only 20 questions. As an advocate of the Society of “Army” Physician Assistants (Your Advocate), I and the other Board Members want to make sure that our services are fulfilling the requirements of our current, past and future constituency.

This Survey is broken up into 3 short sections; Demographics, The Conference Venue/ Continued Medical Education (CME) and a Miscellaneous Section to solicit your willingness and ideas to enhance our overall business strategy. No personal information is being petitioned. I want your sincere honesty and concerns! Sincerely, Steve Briggs

SAPA SURVEY

DEMOGRAPHICS:

I am...

- A male
- A Female

My Current age is...

- 18-25 years old.
- 26-35 years old.
- 36-45 years old.
- 46-55 years young.
- 56-? Years and getting younger!

Marital/ Family Status

- Single (Never Married)
- Married or in a long term relationship (no children living at home)
- Married or in a long term relationship (1-2 children living at home)
- Married or in a long term relationship (3 or more children living at home)

I am ...

- Currently an Active Duty Member of the Armed Services (not retired).
- Currently in the National Guard (not retired).
- Currently a Reservist (not retired)
- Currently a Retired Active Duty Member of the Armed Services (Any and All services or Status).
- A civilian.

My Status as a PA is best described as:

- I am a PA Student or I have not passed/obtained my NCCPA or State licensure.
- I am currently practicing as a PA.
- I am no longer practicing as a PA.
- I have retired from practicing as a PA.
- N/A. I am not a PA

I am a Physician Assistant...

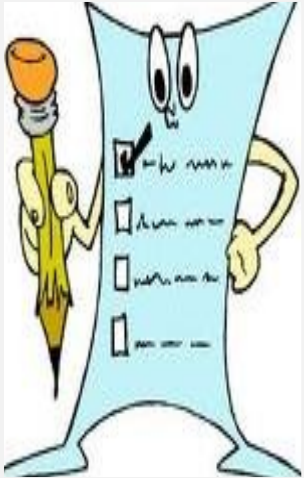
- Student or I have less than 5 years' experience as a PA.
- With 5-10 years' experience.
- With 11-15 years' experience.
- With greater than 15 years' experience.
- I'm not a PA. (Please, someone help me)!

SAPA Membership.

- I am not a SAPA Member.
- I am a current Member of SAPA
- My Membership expired last year but I plan on renewing it in the next year.
- My Membership expired last year and I do not have any plans on renewing it.
- My Membership expired over 2years ago and I do not have any plans on renewing it.

AAPA Membership.

- I am a current AAPA member.
- Not current or previous AAPA member.



SAPA SURVEY

SAPA CONFERENCE CME/VENUE

I have attended _____ SAPA Conference (s).

- only 1 (one)
- less than 5 (five)
- 6-10
- 10-15
- greater than 15

My overall SAPA Conference Experience (s) was/were.

- Very Poor.
- Poor.
- Average
- Positive
- Excellent

My above answer was based on

- Venue City Location (Fayetteville, NC) proximity to Fort Bragg and or home.
- Venue Hotel Accommodations (Holiday Inn and surrounding Hotels/establishments)
- Cheap overall cost of Accommodations and CMEs
- Quality and relevance of CME and presenters.
- Social and family accommodations (i.e., meeting old friends, Golfing, night life and other attractions).

I would like to see the venue location of the SAPA conference changed to:

- San Antonio, Tx
- Tampa, FL
- Charlotte, NC
- Another big city with a major airport and close proximity to a military installation.
- I don't want it changed. I think Fayetteville is the right location.

If the venue location were to change, I would be willing to spend _____ more for conference registration fee.

- \$25-\$50 dollars more
- \$100 (one hundred dollar)
- Up to \$150 (one-hundred and fifty dollars)
- More than \$150 (one-hundred and fifty dollars) if there were more social and family attractions available.
- I would not be willing or cannot afford an increase in registration fee to change location.

How would you best describe the quality of the CME and presenters of past Conferences?

- I like them the way they have been in the past, make no changes.
- I would like to see more relevant Active Duty presentations and presenters.
- I would like to see more break-out sessions (by specialties) or have multiple choices each hour.
- I would like a break from the usual presenters and presentations that continue to show up each year.
- I agree with some or all of "b", "c" and "d" above.
- I can't say, I come for the golfing, and social aspects or I've never attended.



SAPA SURVEY

SAPA CONFERENCE CME/VENUE (cont.)

The best reason I attend the SAPA Conference each year is because of...

- Location and proximity of Fayetteville to Fort Bragg and all the local attractions/accommodations.
- Cheap CMEs
- To Meet with HRC representatives.
- Golf and Social reasons
- I don't for all or some of the above reasons.

The following statement best describes my attitude, belief and willingness to participate in SAPA and attend the annual Conference. (please choose all that apply)

- I would attend the SAPA Conference if there were more family attractions available at the location and where I could tie the CME/Conference into an experience/vacation for my entire family.
- I have a set CME budget and this greatly influences my choice of where I go for CMEs.
- I would not get any funding if it were perceived as a vacation/ "boon-doggle" from my employer.
- I would participate in SAPA and join as a member if I felt that the CME/Conference and being a member benefitted me and the profession; currently I do not share these beliefs.
- I strongly agree with "b" and "c" above and for that reason I favor keeping the conference at its current location.
- I strongly agree with "a" and "d" and feel that there needs to be some major changes in the SAPA organization.



Miscellaneous Information and Request

The SAPA organization needs some assistance in the following areas and would like your assistance. Please mark any areas that you would be willing to assist us in. (Note: if willing, please give name and contact information in Comments section.)

- Webmaster
- Soliciting for donations and sponsors
- Public Relationship
- SAPA Interns (Looking for motivated students and other active Duty PAs)
- Thanks, but I'm not interested at this time

Please let us know what your concerns or interests are.

What changes in the overall organization would you like to see?

What did we forget?

Comments:

TRUNCAL TRAUMA -Fourth Preventable Cause of Combat Death

By Major John Detro, SAPA Editor

During the Global War on Terrorism, Died of Wounds (DOW) rates (%) have been the lowest in recorded military history. There are many reasons for this fact to include improved body armor, advanced technology, decreased medical evacuation times, damage control resuscitation, damage control surgery and most importantly in my opinion— training of all first responders in Tactical Combat Casualty Care (TC3), improved training of combat medical providers in TC3 methodology, and training of tactical leaders in casualty response drills.

The original impetus for this change in the training paradigm of military medics was an article written by John Haggmann and Frank Butler titled, “Combat Casualty Care in Special Operations.” This article was published as a supplement to *Military Medicine* (1996) and was written based on the findings of medical care rendered by special operations medical providers during the Battle of the Black Sea during Operation Restore Hope (Somalia). The authors were critical of the care rendered by medical personnel present during the battle but most critical of the training path utilized for deploying medical providers versus their individual actions. Butler and Haggmann’s contribution was an article that provided guidance on ways to improve this inadequate training. Their article advocated focusing on the three preventable causes of death as first described by Ron Bellamy— airway compromise (1%), breathing compromise caused by tension pneumothorax (5%), and extremity hemorrhage (9%). This represents 6%, 33%, and 60% of preventable combat deaths respectively. However, based on these statistics only 15% of combat deaths were considered amenable to survival based on then current presurgical intervention.

Along with advocating treatment of preventable causes of death, the authors also prescribed a change in the tactical principles employed by medics leading to the three phases of care— Care Under Fire, Tactical Field Care, and Casualty Evacuation Care (CASEVAC). These phases described the recommended care during each period. For example, during Care Under Fire, the medic is still under effective enemy fire and medical care should be limited and include use of tourniquets, movement of casualties to a more secure location, and most importantly medics practicing restraint to ensure they do not become a casualty through poor tactics.

In 1997, the 3rd Ranger Battalion (author fortunate to be there) began to employ the principles of this article and soon Regular Army, Marine Corps, Foreign medical units, and Special Operations forces started to train employing the principles of TC3. Since the employment of TC3 principles, LTC Russ Kotwal, former 75th Ranger Regimental Surgeon, has reported no preventable causes of death despite the Rangers sustaining 400 battle injuries including 28 killed in actions (KIA) and 3 who died of wounds (DOW).

Belatedly, the Army Medical Department (AMEDD) came on board and the principles of TC3 were incorporated into the AMEDD’s combat medical care courses to include the Department of Combat Medic Training (DCMT) and Center for Predeployment Medicine (CPDM).

“In 1997, the 3rd Ranger Battalion (author fortunate to be there) began to employ the principles of this article and soon Regular Army, Marine Corps, Foreign medical units, and Special Operations forces started to train employing their principles of TC3.”

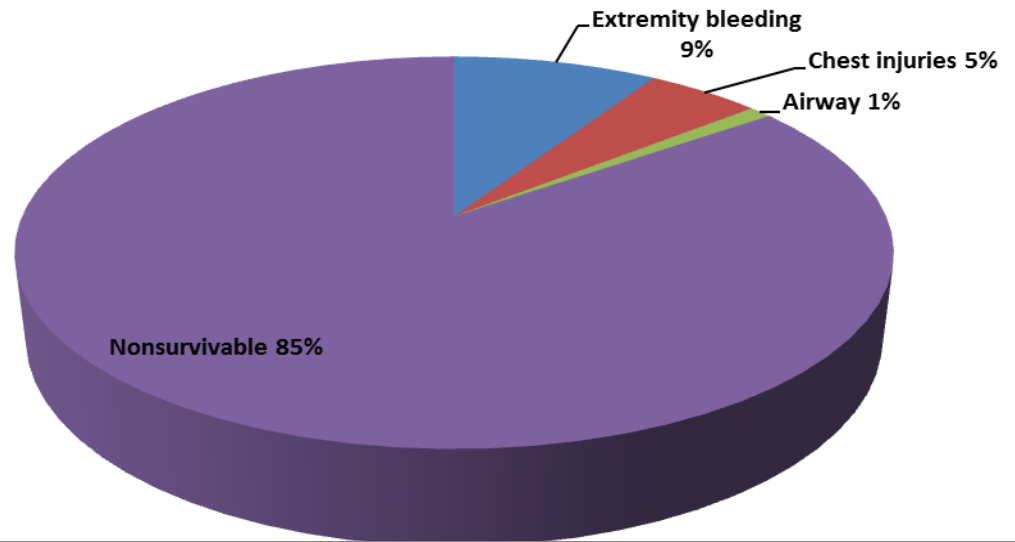
TRUNCAL TRAUMA -Fourth Preventable Cause of Combat Death

Tactical Combat Casualty Care: Principles

- Phased care in combat based on tactical situation

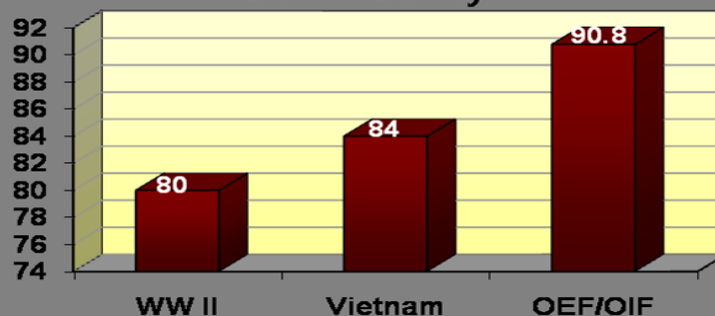


2011 Army
Medical
Department
Tactical Medical
Training Strategy



	World War II	Vietnam War	OIF/OEF
% Case Fatality Rate	19.1%	15.8%	9.4%

Survivability



TRUNCAL TRAUMA -Fourth Preventable Cause of Combat Death

DCMT is responsible for Advanced Individual Training (AIT) of newly assigned combat medical care specialists (Combat Medics). CPDM is responsible for training deploying medical providers to include medics, nurses, physician assistants, and physicians through its four courses to include the Tactical Combat Medical Care (TCMC) Course, Brigade Combat Team Trauma Training (BCT3) Course, Military Transition Team (MiTT) Medical NCO Course, and Joint Forces Combat Trauma Management (JFCTMC) Course.

Where should the United States military medical community focus its future combat trauma training, equipment development, doctrine, and research? Currently, DCMT, CPDM and the majority of military medical training programs focus on treating all forms of combat trauma but have a main emphasis of decreasing the three most common causes of preventable battlefield death- airway compromise, extremity hemorrhage, and tension pneumothorax. Due to the efforts of the Naval Special Warfare Medical Community (NSW), Committee on Tactical Combat Casualty Care (CoTCCC), Special Operations Medical Community, US Army Institute of Surgical Research (USAISR), multiple commercial entities, and the ingenuity of medical personnel the casualty fatality rates are the lowest in warfare history (9.4%). In the past, in most cases truncal and junctional injuries (axilla/inguinal region) were not amenable to presurgical treatment. However, based on the results of TC3, improved medical technologies, decreased evacuation times, damage control resuscitation, and damage control surgery, deaths from these injuries may in some cases now be preventable. Therefore, the time is ripe for another transformation in TC3 methodology and therefore trauma training. Trauma training programs such as DCMT and CPDM should focus on the fourth preventable cause of death— truncal and junctional trauma.

Despite decreased case fatalities rates airway compromise, tension pneumothorax, and extremity hemorrhage remain the 3 leading causes of preventable death— largely unchanged. These findings are despite increased training, improved technology, shorter evacuation times, etc. During the current conflict, airway compromise has been addressed by blindly applied airway devices (King LT, Combitube), nasopharyngeal airways, surgical cricothyroidotomies, and intubation. Chest injuries have been addressed by improved body armor, more robust use of needle decompression, chest tube insertions, and multiple forms of chest sealants to include improvised or commercially available products. Despite the widespread use of tourniquets, percentage of extremity hemorrhage deaths remain largely unchanged. Various reports cite potentially survivable non compressible truncal hemorrhage (NCTH) rates of roughly 10%. In addition, many casualties with inguinal or axillary injuries may now have survivable wounds. In the past, these casualties would have likely been considered expectant or would have died of their wounds. However, today this may not be the fact.

“Trauma training programs such as DCMT and CPDM should focus on the fourth preventable cause of death— truncal and Junctional trauma.”

TRUNCAL TRAUMA -Fourth Preventable Cause of Combat Death

“ In other words, practices and procedures generally performed by surgeons in fixed facilities may be implemented by medics and medical providers during both the tactical field care and CASEVAC (now known as TACEVAC) stages of trauma care.”

According to LTC Robert Gerhardt (USAISR), both truncal and Junctional trauma may be amendable to lifesaving interventions through the use of Remote Damage Control Resuscitation (RDCR). Remote Damage Control Resuscitation is the implementation of DCR forward of traditional locations such as Role-II (forward surgical facility) and role III (theatre hospitals). In other words, practices and procedures generally performed by surgeons in fixed facilities may be implemented by medics and medical providers during both the tactical field care and CASEVAC (now known as TACEVAC) stages of trauma care.

This premise is based on multiple factors to include better trained medics; an improvement of hemostatic agents; use of Advanced Therapeutic Agents (ATA) such as freeze dried plasma, transexemic acid, or recombinant Factor VIIa; fresh whole blood transfusions (buddy transfusions); junctional tourniquets; improved chest sealants; employment of hypotensive resuscitation; and early medical intervention following rapid diagnosis with equipment such as the Focused Assessment with Sonography for Trauma (FAST) ultrasound. The goal is to provide advanced interventions earlier to prevent the onset of the “lethal triad” of coagulopathy, acidosis, and hypothermia. These interventions may become even more important as the US military moves away from traditional Full Spectrum Operations (FSO) toward a doctrine of Unconventional Warfare (UW). This change in doctrine will lead to forces deployed to remote areas surely leading to increased evacuation times necessitating improved pre-surgical intervention.

Based on these improvements and the success in addressing the traditional three forms of preventable combat death, it is now possible to increase training in treating and preventing what may become the fourth preventable cause of death-truncal trauma. The author proposes an increased emphasis on training and equipping medical providers to more aggressively address truncal and junctional injuries. This training in Remote Damage Control Resuscitation (RDCR) could potentially decrease preventable combat deaths.

Bellamy RF. The Causes of Death in Conventional Land Warfare: Implications for Combat Casualty Care Research. *Mil Med* 149: 55-62, 1984.

Butler FK, Hagmann JH. Tactical Combat Casualty Care in Special Operations. *Mil Med*. 1996; 161 (suppl): 1-16.

Butler FK, Hagmann JH. Tactical Management of Urban Warfare Casualties in Special Operations. *Mil Med*. 2000; 165 (suppl): 1-48.

Gerhardt RT. *Prehospital and Emergency Care Research at the US Army Institute of Surgical Research: Enabling the Next Great Leap in Combat Casualty Survival*. The United States Army Medical Journal. April 2011;82-86.

Kotwal RS, Montgomery H, Veliz C. *Ranger First Responder and the Evolution of Tactical Combat Casualty Care*. *Infantry Magazine*. May 2010; 47-48.

Three Earn "9A" Identifier

Congratulations to the following Army Physician Assistants selected for the Army Medical Department Award of the "A" Proficiency Designator (9A):

LTC James Schumacher 65D

LTC Richard Villarreal 65D

MAJ Pamela Roof 65D

The "A" proficiency designator is the highest recognition for professional excellence in the Army Medical Department (AMEDD). Candidates for the honor must be eminently qualified to chair a department, division or service, or have attained full professional status and national prominence in their field. This award includes all AMEDD AC, ARNG, and USAR (RC).

2011 LTHET Selectees Announced

The following active duty Army physician assistants have been selected for Long Term Health Education Training for the 2011 academic year.

CPT Armando Burguete - Emergency Medicine

CPT Zakiya Dixon - General Surgery (Intensivist)

CPT Jeremy Fisher - Orthopedic Surgery

CPT John King - Orthopedic Surgery

CPT Ben Kocher - Orthopedic Surgery

CPT Richard Gieck - Emergency Medicine

MAJ Adam McGarry- Emergency Medicine

CPT Brian Panganiban - Emergency Medicine

CPT James Ruley - Emergency Medicine

CPT Shawn Thompson - Emergency Medicine

CPT Gary Tocci - Emergency Medicine

CPT Kerri VanArnem - Emergency Medicine

CPT Thomas Weissenberger - General Surgery (Intensivist)

CPT David Zeller - Orthopedic Surgery



Intermediate Level Education (ILE) Selectees

Congratulations to the following Army PAs who have been selected to attend the FY 2011 Intermediate Level Education (ILE) Course (AY2012-2013):

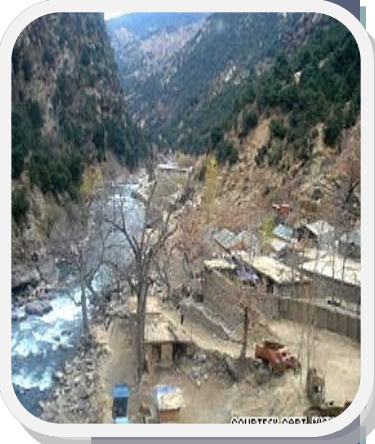
MAJ Auck, Michell	MAJ Foster, Douglas	MAJ Sharp, Dale
MAJ Baker, Bert	MAJ Gann, David	MAJ Smith, Kenneth
MAJ Baldwin III, Edward	MAJ Geise, John	MAJ Starr, Jerry
MAJ Barnett, John	MAJ Georgiana, Christopher	MAJ Staton, Tom
MAJ Bigham, Ronny	MAJ Godwin, Jeffrey	MAJ Swee, Derik
MAJ Black, Michael	MAJ Gurrola, Terri	MAJ Sylvester, Cleve
CPT Bohl, Anthony	MAJ Hairston, Edward	MAJ Thomas, Michael
MAJ Bowman, William	MAJ Hendricks, John	MAJ Treadway, Quintin
MAJ Carney, Avery	MAJ Martin, Dustin	MAJ Warr, Bradley
MAJ Casmaer, Monica	CPT McCrum, Gregory	MAJ Way, Michael
MAJ Christensen, Jon	MAJ McPherson, Cynthia	MAJ Welch, Connie
MAJ Couly, Louis	MAJ Midla, George	MAJ Wenninger, Jerome
MAJ Cranston, William	MAJ Miller, Stewart	MAJ Wyatt, Larry
CPT Cronin, Aaron	MAJ Mohr, K Scot	MAJ Zeller, David
MAJ Curtis, Ryan	MAJ Montano, Danie	
MAJ Day, Charles	MAJ Naylor, Jason	
MAJ Deck, Margie	MAJ Nelson, Dwayne	
MAJ Decker, Justin	MAJ Norton, Jessie	
MAJ DelGrego, Sean	MAJ Pagel, Michael	
MAJ Depold, Gerald	MAJ Patterson, Paul	
MAJ Dominguez, Joseph	MAJ Paul, Johnny	
MAJ Douglas, Matthew	MAJ Robinson, Lawrence	
MAJ Downs, Earl	MAJ Rosser, Sharon	
MAJ Duran-Stanton, Amelia	MAJ Schmid, James	
CPT Engle, Walter	MAJ Setka, Nathan	



Fresh Whole Blood Transfusion

From the Joint Theatre Trauma System (JTTS)

During recent fighting in Afghanistan, several medical providers have performed Fresh Whole Blood (FWB) Transfusions. These providers were faced with a delay in evacuation to surgical care and employed the Clinical Practice Guidelines (CPGs) of the Joint Theatre Trauma System. In May 2009, CPT Chris Cordova (Army PA) performed the procedures when Combat Outpost (COP) Keating was attacked. For his heroism and medical expertise, CPT Cordova was presented the Silver Star, the nations third highest award for valor. Several predeployment courses train in this technique to include the Tactical Combat Medical Care Course (TCMC). Below are the CPGs for FWB transfusion provided by the JTTS.



FOB Keating

FRESH WHOLE BLOOD (FWB) TRANSFUSION

Original Release/Approval	Oct 2006	Note: This CPG requires an annual review.	
Reviewed:	Feb 2011	Approved:	18 Mar 2011
Supersedes:	Fresh Whole Blood (FWB) Transfusion, updated 19 Nov 08		
<input type="checkbox"/> Minor Changes (or)	<input checked="" type="checkbox"/> Changes are substantial and require a thorough reading of this CPG (or)		
Significant Changes:			

- 1. Goal.** Provide the rationale and guidelines for FWB transfusion, including but not limited to indications, collection, testing, transfusion, and documentation.
- 2. Background.** Whole blood has been used extensively to resuscitate casualties in military conflicts since World War I. Its use in civilian settings is limited due to the wide availability of fractionated components derived from whole blood and provided for specific deficits (e.g., pRBCs for anemia, fresh frozen plasma (FFP) to replace lost/consumed clotting factors, platelets (PLTS) for thrombocytopenia, cryoprecipitate (Cryo) for hypofibrinogenemia.) However, in austere conditions, fractionated blood products are often in limited supply or unavailable. In these settings, FWB may be the only source of blood components available for the management of hemorrhagic shock and its associated coagulopathy in casualties (Appendix A).

Massively transfused casualties (≥ 10 units RBCs in 24 hours) have a high mortality rate (33%) and have the greatest potential to benefit from appropriate transfusion strategies. Large retrospective cohort studies of casualties requiring massive transfusions during Operations IRAQI FREEDOM (OIF) and ENDURING FREEDOM (OEF) demonstrate a significant survival benefit for the massively transfused casualty when RBCs, fresh frozen plasma, and platelets are transfused at a 1:1:1 ratio.

Fresh Whole Blood Transfusion

Advantages to FWB: FWB provides FFP:RBC:PLTs in a 1:1:1 ratio. For US casualties presenting in hemorrhagic shock, a transfusion strategy that included FWB with RBCs and plasma has an improved survival compared to the use of stored components only (FFP, RBCs, and PLTs). Additionally, FWB is readily available in austere conditions, has no loss of clotting factor or platelet activity that is often associated with cold storage, and has no red blood cell “storage lesion”.

Disadvantages to FWB: Since FWB has both RBCs and plasma, it must be ABO type specific. There are risks associated with the use of FWB, including but not limited to increased risk of transmitted blood-borne diseases (e.g., HIV, hepatitis B/C, syphilis), a period of decreased exercise tolerance in donors (who are often members in the casualty's unit), and an increased risk of clerical errors (e.g., ABO typing) due to the frequently chaotic activity during which FWB is requested. Additionally, field conditions are inherently unsanitary and are presumed to increase the risk of bacterial contamination of the blood. Recent history with >4000 FWB transfusions during OIF/OEF have resulted in one Hepatitis C seroconversion. Fresh whole blood is not FDA-approved and is not intended or indicated for routine use. **It is NOT appropriate, as a matter of convenience, to use FWB as an alternative to more stringently controlled blood products for patients who do not have severe, immediately life-threatening injuries. FWB is to be used only when other blood products are unable to be delivered at an acceptable rate to sustain the resuscitation of an actively bleeding patient, when specific stored components are not available (e.g., pRBCs, PLTs, Cryo, FFP), or when stored components are not adequately resuscitating a patient with an immediately life-threatening injury.**

3. Recommendations. The use of FWB should be reserved for casualties who are anticipated to require massive transfusion (10 or more units pRBCs in 24 hours), for those with clinically significant shock or coagulopathy (e.g. bleeding with associated metabolic acidosis, thrombocytopenia or INR>1.5) when optimal component therapy (e.g., apheresis platelets and FFP) are unavailable or stored component therapy is not adequately resuscitating a patient with immediately life-threatening injuries.

a. Facilities where full component therapy is available (e.g. Level III facilities): Due to infectious concerns the risk: benefit ratio does not justify the routine use of FWB over banked blood products in non life-threatening severe trauma. Conversely, when platelets and FFP Inventories are depleted, or in contingencies such as mass casualty (MASCAL) situation where the blood inventory may be exhausted, the use of FWB remains an appropriate life-saving option.

b. Surgical Facilities where component therapy is limited (e.g. no availability of apheresis platelets): Due to risks inherent with the use of FWB it should only be used for patients with immediate life-threatening injuries.



Defending FOB Keating

Fresh Whole Blood Transfusion

c. *Facilities where full component therapy is not available (i.e., Level I and II facilities):*

FWB should only be used when there is a threat to loss of life, limb or eye-sight. A walking blood bank program will be established based on a risk assessment and the potential for casualties. Coordination with the Area Joint Blood Program Officer is required to establish a walking blood bank.

4. Guidelines. The decision to use FWB is a medical decision that must be made by a physician who has full knowledge of both the clinical situation and the availability of compatible blood components.

a. In general, the use of FWB should be limited to casualties who are anticipated to require a massive transfusion when the physician determines that optimal component therapy is unavailable or in limited supply, or in patients that are not responding to stored component therapy.

b. The decision to initiate a FWB drive should be made in consultation with the appropriate MTF medical authority (e.g., DCCS, Trauma Director) and Laboratory/Blood Bank OIC.

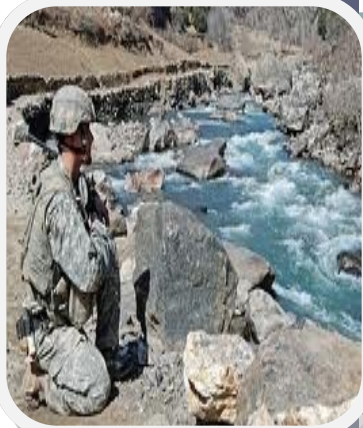
c. *Donor FWB must be an ABO type-specific match to the casualty.* If not matched, a fatal hemolytic reaction may occur. TYPE O whole blood is NOT universal.

d. The decision to use FWB that has not been completely screened for infectious agents is a medical decision that must be made after thorough consideration of risks and benefits.

Decision-making should be adequately documented in the casualty record.

5. Precautions. Transfusion of FWB in the field may be dangerous for several reasons:

a. There is no universally compatible FWB type. Transfusions of FWB must be an ABO match. For female casualties of child-bearing potential, there must also be an Rh match. Service members' blood types are not always known with certainty. The blood type on Identification tags is occasionally incorrect (last correlated data equated to about 4%) and must not be relied upon routinely to determine blood type for either donors or recipients. Identification tags for ABO/Rh verification should be utilized as a last resort only.



On Patrol Near
FOB Keating

Fresh Whole Blood Transfusion

b. Because it is not subject to the same infectious disease testing and strict quality controls as banked blood, FWB does not meet FDA standards and has an increased risk of blood borne disease transmission (e.g., HIV, hepatitis B/C, syphilis).

c. In MASCAL situations, particularly when more than one blood type is being collected, there is an increased risk of a clerical error leading to a life-threatening transfusion reaction.

d. Field conditions are inherently unsanitary and increase the risk of bacterial contamination of the blood.

e. Use of non-standard transfusion equipment may lead to coagulation during the transfusion process; therefore only authorized equipment will be utilized (Appendix B enclosure 6).

6. Planning. Since the need for FWB cannot be predicted, a robust contingency operational plan should be developed by the MTF staff to include the Laboratory/Blood Bank and surgical and anesthesia providers in coordination with the Area Joint Blood Program Officer. The plan should be reviewed and rehearsed regularly.

a. Establish a pre-screened donor pool using the Blood Donation Questionnaire (DD Form 572 or MS Word version), preferably composed of active duty, active reserve, active National Guard, and other DoD beneficiaries. Testing of the potential donor pool for transfusion-transmitted diseases should be also be performed. Coalition and Foreign Nationals will not be routinely utilized as donors, only by exception. Recent laboratory confirmation of blood group/type and non-reactive status for transfusion-transmissible disease tests is ideal, but does not obviate the need for confirmatory testing. The donor file must be maintained and updated frequently.

b. In an emergency, rapidly establish ABO/Rh status of donors and casualties on-site using appropriate reagents/tests in conjunction with previous blood donor history records, if available.

c. Every effort should be made to adhere to the same screening, drawing, labeling, and Issuing standards required for US FDA-approved blood products.



**Resting Following
the Battle**

Fresh Whole Blood Transfusion

d. The physical donation site should be organized in such a way as to maintain the integrity of the screening and donation process, and to minimize the possibility of clerical errors.

This is especially important in emergency situations.

e. It is highly recommended, to perform on-site testing of potential blood donors using rapid screening immunoassays for infectious diseases (i.e., HIV, HBV, HCV) before FWB is transfused. Regardless whether the local testing is performed pre- or post-transfusion, these tests are not licensed for donor testing and samples must be sent to a reference lab for FDA-approved testing. A mechanism must be in place to ensure that both the recipient and donor can be notified should the results be positive for infectious disease.

f. A contingency plan should be developed for collecting, storing, and transfusing FWB in MASCAL situations or when it may be deemed the current blood inventory will be exhausted prior to re-supply (e.g., when multiple type-O trauma casualties are exhausting the type-O RBC inventory).

g. **Procedure.** See Appendix B for Emergency Fresh Whole Blood Donation.

7. References:

1. Massive transfusion in trauma patients: tissue hemoglobin oxygen saturation predicts poor outcome. Moore FA, Nelson T, McKinley BA, Moore EE, Nathens AB, Rhee P, Puyana JC, Beilman GJ, Cohn SM; StO2 Study Group. *J Trauma*. 2008 Apr;64(4):1010-23.
2. CENTCOM FRAGO 09-1222: Joint Theater Blood Program Update: 4 May 2007
3. Emergency War Surgery, 2004, Third US Revision, Chap 7: Shock and Resuscitation
4. Theater MTF-specific Standard Operating Procedures (SOPs)
5. Technical Manual, AABB, Bethesda Maryland, 16th Edition, 2008
6. Standards for Blood Banks & Transfusion Services, AABB, 25th Ed, February 2008

For more specifics visit the JTTS. The site provides instructions on FWB transfusions to include needed equipment, blood collection techniques, transfusion procedures, and required documentation.



Remains of FOB
Keating

Army to field tablets to manage medical records on battlefield

By NICOLE BLAKE JOHNSON | Last Updated: August 12, 2011

The following article (Federal Times) is provided by MAJ (retired) Ray Sterling, Chief, Operational Medicine Branch, Clinical Operations Office Medical Communications for Combat Casualty Care (MC4) Product Management Office Headquarters

Army medics could soon be accessing an injured soldier's medical data using tablet computers.

Currently, medics use bulky Motorola hand-held devices to document administered care, injuries and illnesses to soldiers in combat zones, ranging from battlefield wounds to a stomach virus. But this technology, fielded four years ago, can only support a limited version of the military's electronic outpatient medical record. And medics complain that the device's keypad is a sand magnet.

Mobile technologies like the iPad, iPhone and Android smartphones can run a more robust version of outpatient and inpatient medical records, with features that alert users to potentially harmful impacts of certain drug interactions and a list of patient allergies. Although medics usually do not administer prescription drugs, these additional capabilities would give them greater insight into a soldier's medical history.

"It's enabling the soldier to have the benefits of all the modern technology that we've got," said Lt. Col. William Geesey, who oversees the integration, training and distribution of the Army's health IT hardware and software program, called the Medical Communications for Combat Casualty Care (MC4) system.

Geesey has already tested some military electronic medical record applications on the iPad, iPod Touch, iPhone and Android smartphones. The 2010 tests were not conducted in theater, but demonstrated that the applications can run on mobile devices. Geesey and a small team of government workers spent about three months configuring the applications to run on the Apple and Android operating systems.

Mike Jones, chief of emerging technologies within the Army's chief information officer's office, said he expects some tablets will be approved for Army use by December. Jones said the Army is also reviewing how it will manage mobile devices and provide patch updates and the ability to remotely wipe information from lost or stolen devices.

“Currently, medics use bulky Motorola hand-held devices to document administered care, injuries and illnesses to soldiers in combat zones, ranging from battlefield wounds to a stomach virus.”

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Smaller devices have less computing power, and the Motorola handheld devices used today weren't designed to browse the Internet, Geesey said. DoD also hasn't signed off on soldiers using wireless capabilities on the Motorola handheld for fear that an enemy could hack into the network and eavesdrop.

Once medics document a soldier's injuries, the data is stored on the hand-held device until it can be electronically transferred onto a laptop and into the patient's permanent record. There, it can be viewed by DoD and VA physicians.

Army Sgt. 1st Class Matthew Sims, who assists medics in gathering and storing health data with the Army's health IT system, says technological developments have done much to improve how health records are managed and used, both on the battlefield and off.

"Prior to digital documentation in 2003, during deployments all the medical records were paper and most of those paper documents never actually made it to the patient's medical records," Sims said.

As a staff sergeant in Iraq, Sims battled through several injuries -including a punctured left lung, a fractured skull and broken vertebrae. Doctors could easily track his medical history electronically as opposed to hunting for paper records, Sims said.

The challenge for today's medics, he said, is recording data with aging hand-held devices. They also have a laptop, but that is too bulky for the battlefield. Between his combat gear and medical aid bag, Sims' load is between 80 and 100 pounds.

Being able to use tablets in the battlefield to manage medical records offers many advantages, say Sims and other experts, such as:

The screen is larger and medics can zoom in using the tap-and-stretch feature versus a stylus.

Users can access basic laboratory, radiology and pharmacy applications on the battlefield.

The likelihood of entering incorrect patient information decreases because users can scan a patient's Common Access Card to input demographic data rather than entering the information.

"Having it on the tablet or [a more modern] hand-held device would definitely benefit," Sims said.

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THE GATEWAY
ARMY TACTICAL HEALTH INFORMATION SYSTEMS RESOURCE



Senior Leader Forum

On 14 September, the Army Medical Specialist Corps will conduct another Senior Leader Forum. These forums have been very informative and provide senior leaders the ability to communicate with their field grade constituency.

Below is the information for the next forum:

Who: Field Grade SP officers

What: Topic: TBD

When: Wednesday, 14 September 2011; 1300 - 1430 CST, 1400 ? 1530 EST

Where: Defense Connect Online (DCO) at <https://www.dco.dod.mil>

To register. Send an email to amedd.sp.corps@amedd.army.mil and let the SP Corps Office know you have registered so we can add you to the meeting. Ensure you log-in approximately 30 minutes prior to the meeting to check your microphone.

Why: The Senior Leader Forum is a leader-development platform designed to educate our officers for key leadership positions in the future.

Hosted by your Corps Office.



Senior Discount!

From Paul Lowe, SAPA Membership Director

SAPA desires to honor our “more seasoned” military veterans with reduced membership dues or the ability to purchase an “Indefinite” membership. This benefit is for Federal Service PA’s age 65 or above. For this category of PA’s, annual dues will be reduced to \$15.00 or you can purchase an indefinite membership for \$100.00. This change will take effect 31 July, 2010. Any dues paid at the regular rate of \$25.00 after this date will be credited toward “future dues” or your “indefinite” membership status. Please email or write at the below listed address to update your membership status. Signed, Paul W. Lowe, Membership Director.

SAPA

ATTN: Membership Update

P.O. Box 07490

Ft. Myers , Florida 33919

Or EMAIL: lowepw@earthlink.net



This is an outstanding opportunity for senior PAs to remain active in SAPA even after retiring from practice.



SAPA Membership News

Retirements/ETS

The SAPA Leadership would like to thank the following PAs for their service to the US Army and our Nation. They will leave the military in the next several months. Please wish them luck with their new endeavors.

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SAPA OFFICERS

SOCIETY OF ARMY PHYSICIAN ASSISTANTS

P O Box 07490, FT. MYERS, FL 33919-6402

Phone and Fax - 239-482-2162

EXECUTIVE DIRECTOR:

Harold E. Slusher, PA-C

Address and phone as above, e-mail - hal.slusher@juno.com

SAPA Web Page: <http://www.sapa.org>

(Webmaster: **Orie Potter**)

PRESIDENT

Sherry L. Womack, Lieutenant Colonel, SP, PA-C

E-mail: womachj@wave-net.net

PRESIDENT ELECT

Steven L. Briggs, Major, SP, PA-C

E-mail: steven.briggs@us.army.mil

IMMEDIATE PAST PRESIDENT

Steven W. Ward, PA-C

E-mail: swardpac@ctvea.net

SECRETARY

Karen McMillan, PA-C

E-mail: kl4u@comcast.net

TREASURER

James L.C. Miller, PA-C

E-mail - jmillx2@earthlink.net

DIRECTOR, ACTIVE DUTY ARMY PAS

Pauline Gross, COL, SP, U.S. Army

E-mail: pauline.gross@us.army.mil

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Nolan Wright, CPT, PA-C Texas Army National Guard

E-mail: nolan.wright@us.army.mil

DIRECTOR, US ARMY RESERVE PAS

Tonya Moore, LTC, PA-C

E-Mail: tfmoore60@gmail.com

MEMBERSHIP DIRECTOR

Paul W. Lowe, PA-C

E-mail: lowepw@earthlink.net

RETIRED COMPONENT DIRECTOR

Jan (Casey) Bond, PA-C

E-Mail: jan.bond@AMEDD.army.mil/caseybond@earthlink.net

SAPA CONFERENCE STAFF

CONFERENCE COORDINATOR: **Bob Potter, PA-C**

PO Box 623

2Monmouth, IL 61462

SAPA Voice Line: 309-734-5446

Fax: 309-734-4489

E-mail: orpotter@aol.com

CONFERENCE REGISTRAR: **Bob Potter, PA-C**

Info for Bob Potter same as immediately above

ASST. CONFERENCE COORDINATOR:

Pat Malone, PA-C

E-mail: sapamed@aol.com

Dave Paulson

E-mail: DNORSK3@aol.com

CO-REGISTRAR: **Judy Potter**

DECORUM AND MORALE: **Nicole Potter**

E-mail: pottercats@aol.com

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SAPA JOURNAL STAFF

Editor: **Major John F. Detro, MPAS, PA-C**

E-mail: john.f.detro@us.army.mil

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