

MEDICAL EVACUATION

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Medical evacuation refers to the movement and en route care of casualties within a conflict zone. The evacuation may be the initial movement from a battlefield or between other more sophisticated echelons of care, up to and including repatriation to a home nation. Aeromedical evacuation using either fixed or rotary wing - aircraft has had a major impact on evacuation timelines. Certain considerations must be made prior to and during aeromedical evacuation: /uni25CF the patient should be sufficiently stabilised for the anticipated mode and duration of travel; /uni25CF the patient's airway and breathing are adequate for movement; /uni25CF intravenous access, surgical drains, urinary catheters and any other tubes should be firmly secured; - /uni25CF patients at high risk for thoracic barotrauma should be considered for prophylactic chest tube placement before prolonged aeromedical evacuation; - /uni25CF blankets and/or warmers should cover the patient securely to mitigate against hypothermia. The capability of different evacuation platforms may vary - from highly sophisticated mobile critical care units to the simple transportation of casualties by non-medical personnel. These capabilities, along with the timelines and distances involved in casualty movement, should be major considerations for the planning of medical support operations. The 'golden hour' is an oft-quoted principle in trauma medicine and refers to the initial time period following injury during which a life is most likely lost or saved. Although the origins and applicability of the term are disputed, the principle is ubiquitously understood. Within the military setting, death is certainly seen to occur most commonly within the prehospital environment and within a short period after injury, with better outcomes seen after rapid transport to surgical care. Improvement in outcomes from severe deployed trauma may rely upon either the shortening of time to damage control care or lengthening of the 'golden hour'. Shortening of timelines may be achieved with change in transport systems or deployment of surgical teams further 'forward', or even the use of telemedical technology to utilise remote expertise. Lengthening of the golden hour may perhaps be achieved by the use of novel prehospital haemorrhage control techniques or an 5-8 increase in the availability of prehospital blood products. MEDICAL EVACUATION

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