Force of Nature

A growing number of adventure-seekers are departing their urban confines to explore the great outdoors. As such, clinicians must be prepared to initiate life- and limb-saving treatment for wilderness-related injuries, even in the most challenging of environments. Proper planning and appropriate interventions can greatly affect the outcomes of these patients, both in the field and in the emergency department.

Buckled Up

While there’s no question that seat belts save lives and reduce the severity of trauma caused by motor vehicle accidents, there are a number of serious injuries that can be inflicted by the restraint itself. Despite the ever-increasing number of safety features used by modern car manufacturers, children remain at particular risk for seat belt-associated trauma, including unique injuries to the abdomen and spine.
A growing number of adventure-seekers are departing their urban confines to explore the great outdoors. As such, clinicians must be prepared to initiate life- and limb-saving treatments for wilderness-related injuries, even in the most austere environments and with limited resources and manpower.1,2 Proper planning and appropriate interventions can greatly affect outcomes, both in the field and in the emergency department. In light of the rising global interest in outdoor activities, it is increasingly important for clinicians to understand how to prevent, evaluate, and manage the traumatic injuries they are most likely to encounter as expedition medical officers, guides, trip leaders, or participants.
The distribution of death from trauma is trimodal in nature. The first fatalities, which occur within the first few minutes of the event, usually arise from catastrophic injuries (eg, aortic rupture, high spinal cord injuries). The second peak of fatalities occurs in the first few hours and is usually associated with intracranial injuries, pneumothoraces, and hemorrhagic anemia. The third peak is delayed for days to weeks, likely secondary to infection or other complications. The term “golden hour” in trauma literature is used to describe the second peak of fatalities, which can be greatly reduced with proper assessment and treatment. In the wilderness setting, however, it is unlikely that the victim will arrive at a trauma center within the “golden hour.”

From 2007 to 2011, the US National Park System reported an average of 280 million annual visits. An estimated 32.5 out of every 1 million visitors require a trauma or first-aid evaluation. Although this frequency is low, it equates to 9,076 annual incidents. One study suggests that as many as 80% of these fatalities occur prior to evacuation.

Researchers have described applying the “golden principles” of prehospital trauma care in the urban setting. Although these guidelines were not intended for use in wilderness medicine, several key components are applicable to outdoor settings. Rescuers should continually evaluate the safety of both the patient and the provider; employ primary and secondary surveys; ensure...
cervical spine immobilization (Figure 1); address external hemorrhage; keep the patient warm; initiate early evacuation; and, above all, do no harm. 1

Once the patient is in the safest, most stable environment possible, the Advanced Trauma Life Support (ATLS)–based steps of trauma management should be implemented, as adapted for the outdoors: 2

1. Primary survey
2. Resuscitation
3. Secondary survey
4. Definitive plan
5. Packaging and transfer preparation

Even in the wilderness, the primary survey should employ the ABCDEs of any trauma evaluation: 3

- Airway maintenance and cervical spine stabilization
- Breathing
- Circulation and control of significant external hemorrhage
- Disability: neurological status
- Exposure/environmental control

Following the primary survey, the patient should be resuscitated with the available equipment and supplies.

Next, a secondary survey should be performed to evaluate the patient from head to toe. When appropriate, it is important to completely undress the patient and examine all aspects of the body for signs of injury. In some environments, however, full exposure can lead to hypothermia and further complications. In potentially dangerous locations, a full examination may be impossible. In such cases, physicians should minimize exposure to the elements and use auscultation and palpation to evaluate the patient.

A thorough medical history should also be taken, using the AMPLE pneumatic (Allergies, Medications, Past medical history, Last meal, Events leading to injury) from the ATLS guidelines. 4 The history and physical examination can be used to generate a list of injuries and discern which, if any, require immediate intervention or evacuation. In addition, factors such as the severity of the trauma, possible methods of evacuation, and potential routes must be weighed.

When managing chest trauma, for example, the most serious complications should be considered first, including pneumothorax, tension pneumothorax, flail chest, and cardiac tamponade. A traumatic aortic dissection or rupture is likely to be fatal before interventions can be employed. A patient with chest trauma also must be evaluated for shortness of breath, tachycardia, and altered mental status, which can signal hypoxia. In these situations, a handheld pulse oximeter can be invaluable.

The chest should then be examined for major deformities, symmetry, and other signs of trauma, including tenderness with palpation and skin damage or changes. An uneven chest wall rise, however subtle, is a pathognomonic sign of flail chest secondary to multiple rib fractures. A deviated trachea away from the side of injury, tachycardia, distended neck veins, and increased work of breathing or hypoxia are all signs of a tension pneumothorax. Altered mental status may be present in cases of severe or prolonged hypoxia or significant blood loss from severe chest trauma, with or without concomitant injuries.

### Critical Decision

When should needle decompression of the chest be performed in the field?

Patients with severe symptoms following chest trauma must be evaluated for life-threatening injuries, including a pneumothorax or tension pneumothorax. Patients with a suspected pneumothorax should be transported as quickly as possible to the nearest medical facility for further evaluation and definitive treatment. Any patient without severe symptoms should be monitored for signs and symptoms of an expanding pneumothorax and a subsequent tension pneumothorax.

The pathophysiology of a tension pneumothorax includes the development of a one-way valve secondary to the injured lung tissue, which allows air to enter and expand the pleural space. Because the air is unable to escape and volume expansion is limited, the pressure in
the injured hemithorax increases. The lung on the affected side collapses, and the increased pressure displaces the mediastinum contralaterally, resulting in compression of the superior and inferior venae cavae. These events subsequently affect venous return and reduce preload, prompting signs and symptoms of shock. Indications for immediate needle decompression in a patient with chest trauma in the wilderness include:

- Significant shortness of breath
- Hypoxia or cyanosis
- Distended neck veins
- Tracheal deviation
- Altered mental status

Once a tension pneumothorax has been identified, the severity of the injury and the next steps should be discussed. If help is available, someone else should arrange for emergent evacuation while the physician explains the importance of needle decompression to the patient. It is important to emphasize that the procedure is a potentially lifesaving therapy for a tension pneumothorax, a condition that can rapidly lead to cardiovascular collapse and death if left untreated.

When managing a patient in the wilderness setting, it is always important to minimize exposure and alleviate pain as much as possible (Figure 2). As in the hospital setting, once the needle decompression has been performed, the catheter should be secured in place. While preventing entanglement, the patient should be reclothed to prevent further exposure. Frequent reassessments should be performed to look for signs of decompensation and reaccumulation of the pneumothorax.

CRITICAL DECISION
When should a patient be treated in place versus being evacuated to definitive care?

Patients who become sick or injured in the wilderness must be quickly evaluated, and a determination must be made as to whether they can be managed on-site or must be evacuated for definitive treatment (Figure 3). Patients who are at risk of significant complications or death require urgent evacuation. Nonurgent evacuation can be considered for those who need further evaluation and treatment but are at low risk of rapid decompensation or death.

This determination should be made with the help of everyone in the group, including the patient, if possible. It is imperative for medical or rescue leaders to:

- understand the capability of the group and the experience of its members;
- know the capability of any local rescue organizations and how to contact them; and
- consider the geographical area and the timing necessary for an evacuation.

Rescue leaders should also develop a coordinated plan that is communicated to at least one person not involved in the trip. An awareness of these limitations can help to more clearly define when such decisions must be made.

After a trauma evaluation, the clinician must determine whether the patient’s injury can be definitively treated in the field with the supplies available or whether the injury, if not managed urgently, could worsen significantly. These decisions can be much easier to make when assessing injuries at each end of the severity spectrum. For example, patients with minor wounds can often be treated in the field and released to continue their journey.

Paul Auerbach’s authoritative Wilderness Medicine describes which patients require evacuation, including:

1. Those who do not improve or deteriorate after treatment
2. Those with debilitating pain
3. Those with an inability to sustain travel at a reasonable pace due to a medical problem
4. Those with persistent abdominal pain
5. Those with signs and symptoms of serious high-altitude illness
6. Those with infections that do not improve after 24 hours of treatment
7. Those with chest pain not clearly from a minor musculoskeletal injury
8. Those who develop a psychiatric issue that puts the patient or the group at risk.
9. Those with large or serious injuries or wounds with complications (e.g., an open fracture, fractures with deformity, fractures with impaired neurovascular status, gunshot wounds, a suspected spinal cord injury, and certain burns).

Travel toward definitive medical care can continue in scenarios 3, 4, and 8, or when descending in scenario 5. Evacuating a patient from a wilderness setting requires relaying important factors to EMS and search and rescue (SAR) personnel, including a description of the patient’s injuries, the treatment given, the environmental conditions, and the type of evacuation required. Evacuation is a time- and personnel-intensive task that often moves more slowly than 1 mile per hour, depending on the injury, terrain, and supplies.

Patients who are severely ill or have sustained an injury with a high risk of morbidity or mortality necessitate both on-site treatment and timely evacuation. Any urgent medical needs must be addressed on-site while evacuation is simultaneously arranged.

**CRITICAL DECISION**

**When should an orthopedic fracture or dislocation be reduced in the wilderness?**

Musculoskeletal trauma accounts for approximately 80% of wilderness-related accidents. Ankle fractures are the most commonly encountered injuries in the outdoor setting. Without immediate access to radiographs, a detailed history can help properly diagnose orthopedic trauma. The patient may be able to describe force vectors that led to the injury or state whether a “pop” was heard. After the primary survey and a focused evaluation of the spine and pelvis, the clinician should concentrate on focal extremity injuries. It is paramount to evaluate for deformities, crepitus, swelling, skin changes, and neurovascular function. When uncertain, the injured limb should be compared to the unaffected side.

Any dislocation that appears to be an isolated injury can and should be reduced on scene if the procedure can be accomplished safely. Early reductions are usually easier, when swelling and muscle spasms are less severe. In addition, early intervention can significantly reduce pain and mitigate the need for evacuation. If a fracture is associated with the dislocation, a reduction is less likely to be successful and is therefore discouraged. Techniques for reduction depend on the treating clinician, affected joint, and medicines available. Reductions of the fingers and patellae can often be completed without any anesthesia. Ankles and shoulders can benefit from intra-articular, intramuscular, or oral pain control or anesthesia. A dislocated hip or knee is a major injury that may not be reducible without sedation; in such cases, transport may be required.

As in the emergency department, patients who require an urgent reduction in the wilderness include those with decreased perfusion distally, those with reduced neurological function distally, and those at risk of developing compartment syndrome. Traditionally, large deformities without these concerns were reduced and placed in external traction splints; however, this approach is no longer recommended. The Wilderness Medical Society practice guidelines discourage the routine use of traction splints on long-bone fractures (stereotypically femurs). Initially, in-line traction can provide relief; however, prolonged external traction devices or improvisations can lead to skin necrosis and reduced circulation, and have no proven benefit.

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**FIGURE 3. Evacuation Plan Flowchart**

- Is the injury or illness severe enough to require additional medical treatment? Make this assessment in a timely manner.
  - **NO**
  - **YES**

- Can the patient walk out on their own without aggravating the condition?
  - **NO**
  - **YES**

- Can the available evacuation routes be safely traveled by the patient?
  - **NO**
  - **YES**

- Will walking out and carrying gear create additional accident potential for the patient or the group?
  - **NO**
  - **YES**

- Allow the person to hike out with appropriate group support, but do not let them carry gear.
  - **YES**

- Is the person unable to continue with the trip?
  - **NO**
  - **YES**

- This person needs a litter evacuation. Does the group have the skills, people, and equipment to safely evacuate the person?
  - **NO**
  - **YES**

- Send appropriate members of the group out to secure professional help.

- Prepare for evacuation.

- Allow the patient to hike out with appropriate group support and with gear.
  - **YES**

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MARCH mnemonic to direct the initial assessment of soldiers injured during combat operations:

- Massive hemorrhage
- Airway
- Respiration
- Circulation
- Head injuries/hypothermia

Tourniquets are a safe and effective way to treat wounds with significant bleeding. If direct pressure is ineffective, the next step should be the application of a tourniquet proximal to the wound, which should be tightened as quickly as possible.

Hemorrhagic shock is the leading cause of death on the military battlefield and is the second leading cause of traumatic deaths in the civilian sector. Because of this risk — which is inherent in any low-resource environment, including the wilderness — the United States Armed Forces developed the MARCH mnemonic to direct the initial assessment of soldiers injured during combat operations:

- Massive hemorrhage
- Airway
- Respiration
- Circulation
- Head injuries/hypothermia

This battlefield protocol has been successfully employed in wilderness settings. Applying a tourniquet before a victim goes into shock appears to provide a profound survival benefit (96% vs 4%). Prehospital application vs hospital application also appears to improve the likelihood of survival (89% vs 78%, p <0.05).9

There appears to be no correlation between morbidity and the time a tourniquet stays in place, and no increase in thromboembolic events, necrosis, amputation, or renal failure. Research also shows a slight, but statistically significant, increase in the need for a fasciotomy if the tourniquet remains in place for more than 2 hours; however, 91% of tourniquets in the referenced study were removed prior to the 2-hour mark.10

One of the biggest mistakes a clinician can make when applying a tourniquet in the prehospital setting is failing to tighten it enough. An estimated 83% of extremities have palpable distal pulses upon hospital arrival, which can lead to a “venous tourniquet” that increases the risk of compartment syndrome or increased blood loss by allowing inflow while precluding a return to systemic circulation from the injured limb.11,12

Summary

- Failing to prepare for the most common injuries encountered in the wilderness or for specific types of travel, an oversight that can adversely impact a physician’s ability to effectively respond to emergencies in the field.
- Waiting too long to reduce a fracture or dislocation. Delays can make the reduction of the affected limb more difficult due to increased muscle spasms and swelling around the wound. Delaying reduction can also adversely affect the tissue distally.
- Using improper techniques or equipment, including external traction splints, which are no longer recommended.
- Failing to adapt emergency procedures to the outdoor setting, which can lead to complications and death.
- Neglecting to recognize when an emergent evacuation is warranted, a mistake that can increase morbidity and mortality.

REFERENCES

CASE RESOLUTIONS

■ CASE ONE

Within minutes, the musher became tachycardic and dyspneic. The initial trauma survey revealed a chest wound accompanied by shortness of breath and absent breath sounds on the right side. Because the musher also had distended neck veins and a tracheal deviation to the left, the physician suspected a tension pneumothorax, a life-threatening injury that requires immediate needle decompression to prevent further cardiovascular decompensation and death. As the patient’s symptoms worsened, treating the tension pneumothorax became paramount.

While the physician discussed the urgency of the injuries with the patient, the friend called for immediate evacuation to the nearest medical facility and provided their coordinates. The physician performed a needle decompression of the chest and heard a rush of air from the musher’s chest. Pain medicine was administered (800 mg of ibuprofen and 1 g of acetaminophen by mouth), and the patient was re-evaluated frequently to assess for pain, clinical stability, and comfort. The physician instructed the musher to slide into his sled to stay out of the wind, as the group sheltered in the wooded area.

Approximately 45 minutes later, a rescue helicopter landed on the frozen river, and the flight medic signaled that he was ready for the patient. The physician relayed to the flight crew that the cather used to decompress the patient’s chest was still in place. The pilot stated he would fly low to reduce the chance of re-expansion secondary to decreased barometric pressure at higher altitude. On arrival at the medical center, a chest tube was placed, and the patient was admitted for further observation.

■ CASE TWO

The physician suspected that the fallen rock climber had sustained a right hip fracture and/or dislocation and a left distal femur fracture with significant displacement, which was contributing to vascular compromise distally. No additional injuries were found. The skin was intact, and no signs of external hemorrhage existed.

Because of decreased perfusion, the physician focused on the left leg first. He administered ibuprofen (800 mg) and acetaminophen (1 g) orally and applied gentle in-line traction, which initially caused significant pain but led to improved comfort. Reassessment of the leg revealed improvement in the visible deformity and a 2/4 dorsalis pedis pulse. The warmth and color of the leg improved.

The physician was unsure if the woman’s right leg was fractured or dislocated but did not believe she had an open-book pelvic fracture. Concerned about how painful a reduction attempt would be given the lack of pharmacological supplies and the inability to determine concomitant pelvic or femur fractures, he deferred intervention; splinted the legs together with padding between the thighs and a sturdy branch, which was placed 4 inches proximal to the cyclist’s wound. Twisting the branch increased the tension and eventually occluded the radial pulse. When the bleeding abated, the physician changed the dressing and applied a pressure dressing directly to the wound.

Pain medication and oral fluids were given. With assistance, the patient ambulated slowly toward the trailhead. The group was met by EMS, who established an IV and transferred the patient to the local hospital. CT angiography showed a laceration to the proximal ulnar artery. The patient underwent urgent vascular repair and was discharged in stable condition a few days later.

The physician indicated an emergency on the GPS locator, and the group waited nearly 4 hours for the SAR team to appear. A paramedic administered fentanyl intramuscularly (100 mcg). The patient was then placed in a vacuum litter, fitted with a cervical collar, and packaged into a one-wheeled litter. It took 8 hours to reach the ambulance at the trailhead.

At the local hospital, the patient was diagnosed with a right hip dislocation and a left distal femur fracture. With procedural sedation, the hip was reduced, and she was admitted for surgical repair of the left femur.

■ CASE THREE

The physician fashioned a wide tourniquet from a spare bike tube and a sturdy branch, which was placed 4 inches proximal to the cyclist’s wound. The patient was admitted for surgical repair of the left femur. The physician was unsure if the woman’s right leg was fractured or dislocated but did not believe she had an open-book pelvic fracture.

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