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by

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Translated from
Voyennomed. Zh. [J. of Mil. Med.], 1968, no. 5, pp. 19-20

by

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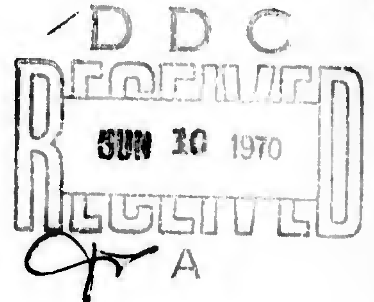

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SOME FEATURES OF THE WORK OF THE FIRST AID POST AND THE MEDICAL BATTALION IN THE RECEPTION OF CHEMICAL WARFARE CASUALTIES

Colonel (Med. Corps) A.V. Teplov and
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Organizing the work of the First Aid Post (FAP) and the Medical Battalion (MB) in the reception of chemical warfare [gas] casualties is a subject that has been repeatedly discussed in the Armed Forces periodical press. As is well known, the effective functioning of the FAP and the MB in the reception of such casualties will in many respects depend on the previous preparation of these bodies for work under conditions of enemy chemical attack. This preparation must above all envisage that timely and reliable military and medical information will be available to the senior medical officers (regimental senior M.O., divisional M.O.). The senior M.O.s, maintaining continuous touch with the commanding officers and with the chiefs of the various service branches, and making use of chemical intelligence and of information received at unit HQ, must keep the FAPs and MBs informed of the time and sector of enemy chemical attack, the nature of the toxic agent employed, the medical losses foreseen, and other data obtained from forecasting and analysis of the chemical warfare situation.

The commanders of FAPs and MBs must also have information on how to employ defensive means at the time of an enemy chemical attack, after that attack, and during subsequent activity in the contaminated areas (timely use of gas-masks, means of skin-protection and so forth).

It is generally accepted that in the organization of the chemical warfare [gas] casualty reception work at FAPs and MBs, one essential is that the stream of casualties who are dangerous to their neighbors should be separated and diverted, at the FAP, to the special treatment area, and at the MB to the special treatment section. The place where the separating is done should be the casualty sorting post. This same opinion is maintained by L.S. Yevlanov and N.V. Kruglikov in a paper of theirs [Voyennomed. Zh. no. 12, 1966]. They, however, indicate that casualties in a grave condition at the FAP are to be transferred to the sorting area *after* receiving special treatment.

It seems to us that there is no need to move such casualties from the special treatment area of the FAP to the sorting area. In the first place, this may cause a mixing of the stream of wounded and sick who have received partial special treatment with the stream of newly arriving wounded and sick, a situation that would considerably hinder the work; in the second place, the wounded in serious condition require immediate measures of medical first aid, which may be carried out either in the bandaging tent (in the case of complex injuries) or in a specially outfitted receiving-sorting tent (for chemical warfare cases) to which all such casualties should be immediately routed, passing up the sorting area. In the special treatment area they will be given partial treatment and certain measures will be taken according to the vital indications (administration of antidotes or cardiac preparations, artificial respiration, etc.).

As regards medical casualty-sorting at the MB, the above authors suggest that from the sorting post and sorting area the chemical warfare casualties should first be routed to the sorting tents for non-postponable first aid, and after that be transferred to the special treatment section. But such an organization of the medical sorting of chemical warfare cases in the MB will cause counter-flows of patients to develop, will

impede the work, and will require considerable personnel for carrying casualties from one section to another. And one must also keep in mind that often the chemical warfare cases will be arriving directly from the locus of the chemical attack, by-passing the FAPs. In this case even more so is it necessary for all casualties to be routed from the sorting post to the special treatment section, since all of them in practice are dangerous to their neighbors, particularly phosphor-organic chemical warfare casualties.

Our view is that when masses of chemical warfare casualties are coming in to the MB, the center for their medical sorting and for rendering them first aid should be the special treatment section, to which the casualties should indeed be routed directly from the sorting post, skipping the sorting tents and the casualty sorting and evacuating section. To this end it is necessary to reinforce the special treatment section with medical personnel (particularly medical officers), with a supply of tents – at the expense of the sorting and evacuating section – and with disinfection and shower facilities – at the expense of the automobilized* epidemic control detachments. A reinforcing of the special treatment section with tents at the expense of the hospital section, as recommended by G.M. Khmara and G.E. Verlinski [Voyennomed. Zh. no. 6, 1967], cannot be accepted as reasonable, for when there is a massive influx of chemical warfare casualties to the MB the hospital section itself will have to be reinforced with tents from the operating and bandaging branch. This necessity arises from the fact that a large percentage of chemical warfare casualties need temporary hospitalization in the MB until they are evacuated to the hospital base.

L.S. Yevlanov and N.V. Kruglikov propose that in the MB there should be separate operating (or bandaging) tables reserved for cases where wounds have been contaminated by chemical warfare agents, and that separate surgical brigades should be designated to work with these cases. Similar views have also been expressed by various authors as regards the organizing of surgical aid to cases with wounds contaminated by radioactive substances. It is hinted in a number of published works that there has been some exaggeration of the danger of absorption of a radioactive substance that gets into a wound, since the greater part of such a substance is segregated with the wound contents and remains on the bandage when the latter is taken off.

As regards the contamination of wounds with chemical warfare agents and the medical tactics of first aid for combined injuries, we must, obviously, start from the following considerations. To *prevent* the contamination of wounds with chemical warfare substances on the field of battle, and also at medical posts in the army area, does not seem to be, as a rule, possible. If a chemical warfare agent gets into a wound on the battle-field before medical aid is given, that is, before the primary bandaging of the wound, neither the patient nor the person applying the dressing will know about the infection of the wound. After arrival of such casualties at the MB, the greater part of the chemical warfare agent contaminating the wound will, within 8 to 12 hours from the time of wounding (or even earlier), have already been absorbed, while part of it will remian on the bandage with the contents of the wound. But if the contaminant just gets onto the bandage after the latter is applied to the wound, then decontamination procedure or changing of the bandage may result in the substance's not getting into the wound at all. It should also be pointed out that when there are massive arrivals of chemical warfare casualties at the FAP or MB no indications of chemical warfare substances in wounds will be forthcoming, except in isolated cases. Thus it does not seem a practical possibility to determine which casualties have wounds contaminated with chemical warfare substances and which have non-contaminated wounds.

From what has been said, there is no necessity of reserving separate bandaging tables and special surgical brigades for giving surgical aid to casualties during massive arrivals of such casualties from the site of a chemical [gas] attack. If casualties' statements and data from the Chemical Warfare Service indicate the use of chemical warfare agents by the enemy, all casualties should be treated as suspected chemical warfare cases and the appropriate prophylactic measures taken.

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* Abbreviation *aspco* = automobilized [?] epidemic control detachments; the word *automobilized* is the translator's conjecture. [Tr.].