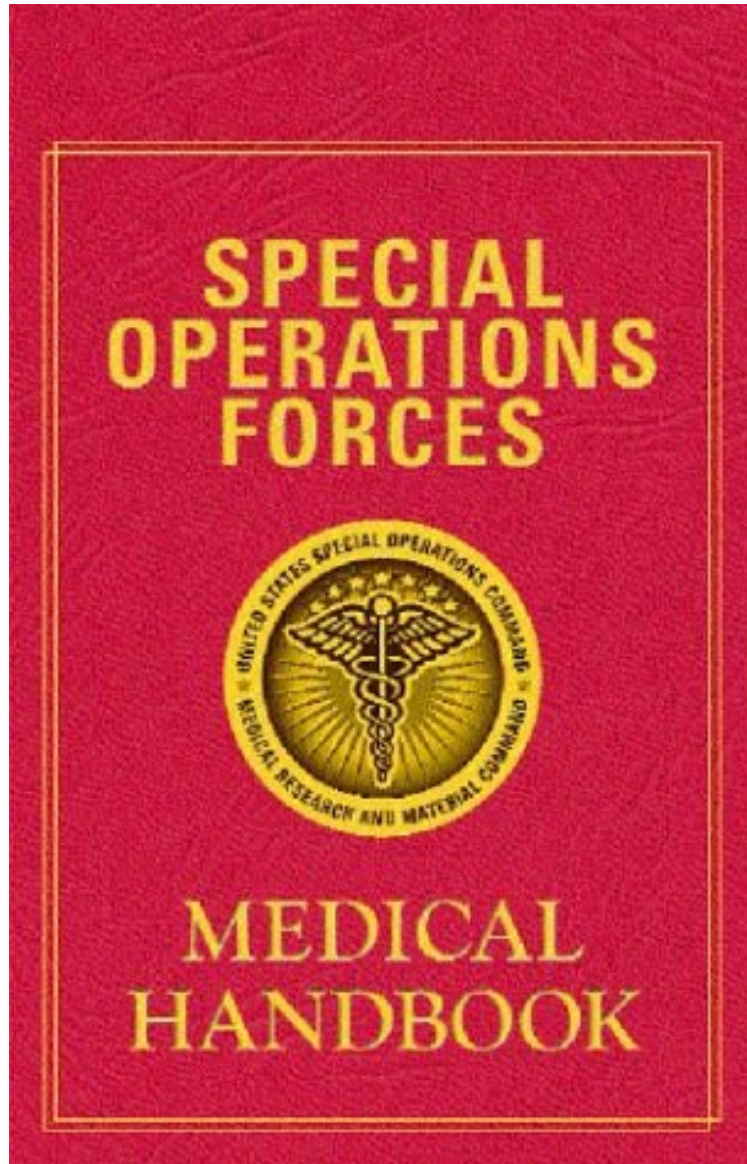


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Steve Yevich, Warren Whitlock, Richard Broadhurst, Gay Thompson, Pete Redmond

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Steve Yevich, Warren Whitlock, Richard Broadhurst, Gay Thompson, Pete Redmond : Special Operations Forces Medical Handbook (Book Only Edition) before purchasing it in order to gauge whether or not it would be worth my time, and all praised Special Operations Forces Medical Handbook (Book Only Edition):

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cover anything you run into and (hopefully) a whole lot more. If you are getting this for use in an aid station you might want to supplement it with Tintinali's Emergency Medicine Text Book, HUGE book, but tons of in-depth info that they couldn't possibly cram into that already full flip book. If you are deploying, or know someone who is and is in the medical field this is THE book to get them. 6 of 6 people found the following review helpful. A MUST HAVE FOR ANY CORPSMAN OR MEDIC. By A Customer IF I COULD HAVE ONLY HAD THIS BOOK 3 YEARS AGO MY LIFE WOULD HAVE BEEN SO MUCH EASIER. THIS BOOK IS ORGANIZED, COMPACT AND FULL OF DIAGRAMS AND CHARTS. EVERY DISORDER OR DISEASE THAT YOU COULD IMAGINE IS COVERED IN THIS BOOK AND IS WRITTEN OUT IN SOAP FORMAT TO MAKE YOUR JOB EVEN EASIER WHEN IT COMES TIME TO DOCUMENT. DO YOURSELF A FAVOR, PAY THE 70 DOLLARS AND GET THIS BOOK. I USE IT DAY IN AND DAY OUT. I HAVE LEARNED MORE FROM IT THAN ANY SCHOOL THE MILITARY HAS SENT ME. 1 of 2 people found the following review helpful. RIP OFF. By UNHAPPY MEDIC HUGE HUGE RIP OFF. DON'T WASTE YOUR MONEY. THIS BOOK IS NOT TEAR RESISTANT OR WATER RESISTANT. PAGES ARE STUCK TOGETHER. DON'T BE HAD. INFO INSIDE IS GOOD BUT YOU CAN PRINT THE SAME OFF THE INTERNET AND MAKE YOUR OWN BOOK FOR CHEAPER. PLEASE DON'T THROW AWAY YOUR MONEY ON A CHEAP COPY CAT MANUAL.

This single-source reference provides many revolutionary approaches to accessing medical information, such as treatment hierarchy based on available medical resources and mission circumstances commonly facing the soft medic.

From the Publisher Special Operations Forces Medical Handbook provides step-by-step illustrated procedures for performance of surgical procedures under hostile and/or primitive conditions. It offers alternatives to conventional procedures for management of a given problem that can be used under less than optimal circumstances. The physical presentation is designed to hold up under adverse conditions. It is waterproof, tear resistant and ring bound so that updated material can be added at will. It is in a small trim size for ease of carrying and printed on a special stock to aid with reading under poor light conditions. About the Author Created by the Editorial Staff of the United States Special Operations Command, Office of the Command Surgeon, and over 80 medical specialists from all branches of the military. Excerpt. Reprinted by permission. All rights reserved. PART 1: OPERATIONAL ISSUES Operational Issues: Care Under Fire Lt Col John Wightman, USAF, MC Introduction: The primary types of injuries caused by weapons are penetrating, blast, and thermal trauma. Penetrating injuries from bullets, fragments, shrapnel, and secondary debris are the most common and easily identified injuries. Thermal injuries are likewise easily noticed. Blunt injury can be caused by blast winds propelling a casualty, causing them to tumble or hit objects. Injuries from blunt and blast trauma may not be immediately apparent. Attending to or retrieving the casualty is important, but may not be worth drawing fire or exposing others to risk. Predetermined hand signals should be used to communicate with conscious casualties. Binoculars may help assess unconscious casualties from a concealed site. The best medicine on the battlefield is fire superiority. Subjective: Symptoms Focused History (if attending casualty): Where does it hurt? (may help identify location of wounds with potentially exsanguinating hemorrhage) Can you breathe OK? (may help decide urgency of movement to cover) Can you shoot back or make it to cover? (determines whether the casualty will be operationally useful, or be able to assist in his own rescue) Objective: Signs Using Basic Tools: General: Altered mental status (AMS) may range from confusion to coma. Seizures may occur. However, airway problems are rare on the battlefield and intervention, beyond placing casualty in coma position if the casualty is unable to move, is not worth the risk while under fire. Altered mental status is most likely due to penetrating or blunt head trauma or shock from bleeding, but two unique features of blast injury are less common causes: blast overpressure on lungs can cause vasovagal syncope with bradycardia and hypotension, lasting minutes to hours even with conventional treatment; and stress-induced tears in lung tissue allowing air into pulmonary veins, which can then be ejected to brain (stroke) or heart (heart attack). Inspection: Identify sites of life-threatening external hemorrhage first. The volume of bleeding is the critical parameter exsanguinating hemorrhage from penetrated extremities is the #1 cause of preventable death on battlefield. Traumatic amputation, ranging from tips of digits to entire limbs, and penetrating vascular injury are common in casualties close to explosions. Auscultation: Not necessary while under fire. Palpation: Rapidly touching all body surfaces may help identify wounds with significant bleeding. Rapid palpation of spine or extremities may be appropriate to decide if casualty can move under own power. Assessment: Make Decision Rapidly: Significant external hemorrhage and respiratory distress are the only medical reasons for attending a casualty under fire. But the benefit of rescue must outweigh the cost to the mission from losing more personnel in the rescue. The casualty and potential rescuers may continue to be targets due to exposure and movement. Unconsciousness alone is not reason to expose additional personnel to danger. Without respiratory distress or arrest, the casualty's airway can be considered intact. Blast-induced vasovagal syncope will resolve on its own. Penetrating head and torso trauma, arterial gas embolism (AGE), and seizures cannot be managed under fire. Differential Diagnosis Loss of consciousness or seizures manifesting after detonation may indicate release of chemical nerve agent or cyanide. Plan: Treatment 1. Have casualty return fire (if capable) as directed or required, take cover or otherwise prevent additional injury and don

chemical-biological-radiological (CBR) protection, if appropriate.2. If conscious but unable to assist in firefight, direct casualty to move to cover. If unable to move, direct casualty to lay motionless in order to avoid drawing hostile fire. Make tactical decision whether or not to have other personnel attempt rescue.3. Stop exsanguinating external hemorrhage with tourniquet on any bleeding extremity. Ignore non-life-threatening hemorrhage. 4. Move casualty to cover so direct pressure can be applied to bleeding wounds in other locations. Potential hazards of time and exposure do not warrant immobilization of cervical spine before movement.If airway can be managed by gravity, or AGE is suspected, place casualty in coma position: left side down (halfway between left-lateral decubitus and prone) and head at same level as heart (Figure 1-1).