



27 APR 2016 Waterfront Meeting

	Speaker	Topic	Time
MRD-SD	LT Hightower	Pretest	5
FST-5 Surgeon	LCDR Donahue	Skin Laceration Repair/Wound Care	45
NMCSO MH	CDR Millegan	Mind Body Medicine	30
NMCSO PT/OT	LCDR Halfpap	SD Physical Therapy Consults	10
Fleet Dental	LCDR Chilcutt	Dental Updates	5
MRD-SD	LT Hightower	Post Test	5
		Total	100



SHIPBOARD FIRST AID AND RESCUE THE NEW FSO-M



SPECIAL ACKNOWLEDGEMENTS



- This project would not have been possible without the expertise and outstanding effort of the following personnel over three years of hard work and determination!***

CMDCM Chris Moore
HMCM Mark Valencia
HMCM Richard Tomlinson
HMCS Ed Purog
HMCS Matt Bauer
HMCS Todd Burkholder
HMCS Tim Bickerton
HMCS Rob Bicanovsky
HMCS Ingrid Phillips
HMCS Jason Adams
HMC Eric Casasflores
HMC Marty Golightly

HMC Justin Viramontes
HMC Corey Miller
HMC Austin Osazuwa
HMC RJ Ronquillo
HMC Phirum Sary
HMC Keren Lemas
HMC Jocelyn Martinez
HMC Patrick Satterfield
HM1 Eben Sanchez
HM1 Steven Price



FSO-M TRAINING



Issue

- ATG FSO-M training is not aligned with current Standards of Care
 - Creates confusion/conflicts with other formal medical training
 - 8 Basic Wounds do not adequately prepare crews for full range of shipboard casualties

Background

- Standards of Care evolution informed by two-theater war & shipboard casualties (COLE)
- AMALs have been updated to meet new Standards of Care guidelines
- Formal medical training COI's updated to reflect changes (RTC, HM "A" & IDC schools)
- ATG conducting differences training to account for gaps in training syllabus

Actions Completed

- Validated DC PQS (105 & 302) against current Standards of Care
- Developed LTGs for use during DC & FSO-M 1.2 training
- Revised FSO-M LOK Test Bank
- Revised FSO-M CE/RE Grade Sheets to reflect current First Aid protocols
- Obtained Approval and funding from BUMED for a Shipboard First Aid and Rescue Training Video (Production is underway).

GOAL

- Update ATG FSO-M governing documents to reflect current Standards of Care
 - Ensures FSO-M medical training requirements align with current Standards of care
- Implement "Shipboard First Aid and Rescue" for FSO-M 1.1 – 1.4 events



FSO-M TRAINING



• OLD STANDARDS

8 Basic Wounds:

- | | |
|---------------------|------------------|
| Compound Fracture | Facial Wound |
| Sucking Chest Wound | Electrical Shock |
| Abdominal Wound | Burns |
| Amputation | Smoke Inhalation |

- No emphasis on watch stander or patient safety
- No focus on basic life support (BLS) standards

• NEW STANDARDS

Shipboard First Aid: (11 wounds/injuries)

- | | |
|---------------------------------|------------------|
| Fractures | Laceration |
| Sucking Chest Wound | Electrical Shock |
| Abdominal Evisceration | Burns |
| Hypothermia | Smoke Inhalation |
| Puncture/Penetrating Wound | Heat Stress |
| Massive Hemorrhage w/Amputation | |

- Stresses safety and recognition of life threats
- Monitor patient's circulation, airway & breathing (CAB)
- Train to perform head-tilt, chin lift & jaw-thrusts
- Aligns with Damage Control PQS 105 and 302
- Aligns with Hospital Corpsman Manual
- Taught at RTC, HM "A" & IDC School
- AMAL supplies support revised Standards of Care (already onboard)



FSO-M TRAINING



• CURRENT GRADESHEETS

- CE-01 Review Administration
- CE-02 Demonstrate LOK (100% of DC-qualified personnel)
- CE-03 Review SOH Programs
- CE-04 Conduct First Aid Drills
- CE-05 Conduct Patient Transport
- CE-06 Conduct BDS Operations
- CE-07 Conduct Mass Casualty Drill

8 Wounds & Injuries

- RE-01 Conduct First Aid Drills
- RE-02 Conduct Patient Transport (1 BDS)
- RE-03 Conduct BDS Operations (1 BDS)
- RE-04 Conduct Mass Casualty Drill

3 Depts & 3 Wounds

• REVISION PROPOSALS

- CE-01 Review Administration
- CE-02 Demonstrate LOK (80% of ship's crew)
- CE-03 Review SOH Programs
- CE-04 Conduct Shipboard First Aid Drills
- CE-05 Conduct Patient Transport
- CE-06 Conduct BDS Operations
- CE-07 Conduct Mass Casualty Drill

11 Wounds & Injuries

- RE-01 Review Administration
- RE-02 Review SOH Programs
- RE-03 Conduct Shipboard First Aid Drills
- RE-04 Conduct Patient Transport (1 BDS)
- RE-05 Conduct BDS Operations (1 BDS)
- RE-06 Conduct Mass Casualty Drill

3 Depts & 4 Wounds



CUMULATIVE IMPACT



Certification Exercises

11 Wounds & Injuries

- FSO-M 1.0: No change
- FSO-M 1.1: No additional time required
 - FSO-M 1.1 & LOA scheduled concurrently
 - FSO-M assessors cover down on both events (saves 3 man days)
- FSO-M 1.2: No additional time required
 - Revised curriculum fits w/in allotted time
 - Heat & cold injuries already being taught
- FSO-M 1.3: No change
 - All events accomplished during the allotted time
- FSO-M 1.4: No change to time requirement
 - Additional 3 wounds accomplished during allotted time
 - new wounds compatible with & can be run in conjunction with established wounds
 - common practice to perform 2 wounds on a single patient

Repetitive Exercises

RE-01 Review Administration } Required in SFTM; lost
 RE-02 Review SOH Programs } in SFRM transition

- RE-01:
- Required every 90 days
 - Should already be accomplished during standard program management
 - If not done concurrently with active program management, adds 2 man hrs / qtr

- RE-02:
- Required every 90 days
 - Should already be accomplished during standard program management
 - If not done concurrently with active program management, adds 2 man hrs / qtr

18 of 26 (69%) recent program reviews were not effective (Jun 14-May 15)



FSO-M TRAINING



- **FSO-M documents & instructions revised to align with current Standards of Care:**
 - COMNAVSURFPACINST 3502.3, Surface Force Readiness Manual Basic Phase Certification / Repetitive Exercises Requirements
 - FSO-M Tab K (ATGPACINST 3502.1)
 - FSO-M SOP (ATGPACINST 3502.2)
 - DC PQS, First Aid & Rescue Fundamentals 105 & 302 (NAVEDTRA 43119-L)
 - FSO-M ASA Check Sheets (aligned w/INSURV check sheets)
 - FSO-M LOK Test Bank (min 100 questions from DC PQS & HM Manual)

Ready to Plug and Play!



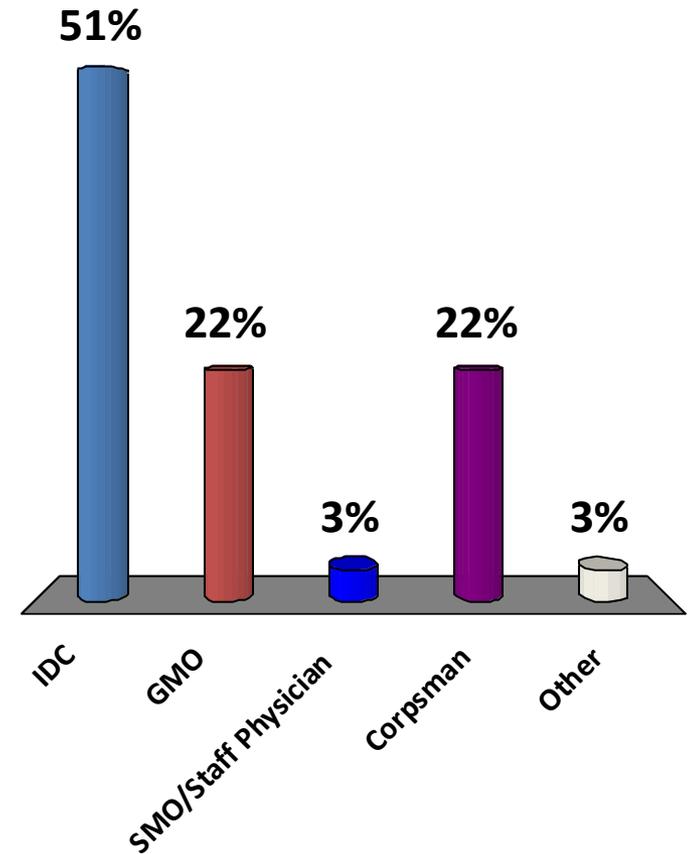
Questions?

Email us:

W_SDNS_ATGSD_MED@navy.mil

I am a (an):

- A. IDC
- B. GMO
- C. SMO/Staff Physician
- D. Corpsman
- E. Other



Surgical closure of a wound refers to
which type of closure?

- A. Primary
- B. Secondary
- C. Tertiary
- D. Quaternary

What is the max dose of lidocaine when administered with epinephrine?

- A. 1 mg/kg
- B. 4 mg/kg
- C. 7 mg/kg
- D. 10 mg/kg

An injured marine is brought to your BAS/BDS in shock with a GCS of 7 and an actively bleeding left thigh after an IED amputated his lower leg. The next best step in management is?

- A. Administer blood products in a 1:1:1 fashion
- B. Administer TXA
- C. Secure airway
- D. Apply tourniquet to left thigh to stop bleeding
- E. Perform a FAST exam

Which of the following suture techniques is particularly good for hemostasis?

- A. Simple, interrupted
- B. Vertical mattress
- C. Horizontal mattress
- D. Running, locking
- E. Baseball stitch

Staples are generally acceptable for all of the following locations except for?

- A. Leg
- B. Arm
- C. Face
- D. Trunk
- E. Scalp

Wound Care/Skin
Closure/Suturing/Local
anesthesia/digital block

LCDR Tim Donahue

Surgeon, FST-5

27 Apr 2016

I have no relevant financial
relationship with any commercial
interests to disclose.

LCDR Tim Donahue

Surgeon, FST-5

27 Apr 2016

Wound basics

- Tissue layers:
 - Skin – epidermis and dermis, strength layer
 - Subcutaneous – adipose, neurovascular structures, hair follicles, glands
 - Fascia – muscle envelope

Healing

- Starts with the injury
 - Coagulation ensues, vessels constrict, platelets activate
 - Inflammation – days 1-10, WBCs accumulate, macrophages (most important cell in wound healing) digest bacteria, debris and necrotic tissue, histamine and cytokines increase vascular permeability and edema/swelling occurs

Healing

- Epithelialization – migration of epithelium across the wound, occurs in about 48 hours for wounds closed primarily
- Proliferation – days 5 – 3 weeks, fibroblasts dominate from day 5 on. They produce the ground substance of the wound and contractile proteins as well as collagen

Healing

- Maturation/remodeling – collagen cross-linking, remodeling and further wound contraction
 - Types I and III collagen are the dominate types in healing, type III eventually replaced by type I
 - Max wound strength is achieved by week 8 but 80% by week 6

Non-healing

Healing process arrests in the inflammatory phase

- Multifactorial
 - PAD, DM, venous insufficiency
 - Age
 - Immunosuppression or compromise
 - Chemo, XRT
 - Spinal cord disease and immobility
 - Malnutrition
 - Smoking
 - infection

Assessment

- History – timing and mechanism, pre-existing RFs for poor wound healing, allergies and tetanus status
- Physical – wound depth and involvement of neurovascular, bone and tendinous structures, presence of foreign material, cosmetic significance
- Plain films to evaluate for fx or foreign body

Treatment of minor wounds

- Achieve hemostasis – direct pressure, epinephrine with the local anesthetic, TQs
- Irrigation and debridement
 - Warm normal saline, water or dilute betadine
 - Pressure should be around 5-8 PSI, use an 18 gauge needle or angiocath and a 60cc syringe
 - volume should be around 100cc per cm of injury
 - Most important principle is removal of foreign material and devitalized tissue, sharply if necessary
- Culture infected wounds

Medical treatment

- Antibiotics – reserved for infected wounds, no role for prophylaxis
- Except:
 - Deep puncture wounds (especially due to cat bites)
 - Moderate to severe wounds with associated crush injury
 - Wounds in areas of underlying venous and/or lymphatic compromise
 - Wounds on the hands, genitalia, face, or in close proximity to a bone or joint
 - Wounds requiring closure
 - Bite wounds in compromised hosts (eg, immunocompromised, absent spleen or splenic dysfunction, and adults with diabetes mellitus)

Antibiotics

- Non bite wounds – keflex, clinda, bactrim, doxy
- Bite wounds:
 - Augmentin for 3-5 days
 - Alternative: doxy or bactrim plus either flagyl or clindamycin for 3-5 days
- Make sure to check wound in about 48 hours
 - Consider parenteral tx if not improving or getting worse
 - Fight bite will close observation and possibly operative washout
- Animal bites – consider source, rabies

Tetanus

- Clean, minor wounds
 - Only give tetanus toxoid vaccine if status unknown, less than 3 doses or >10 years since last booster
- Dirty or major wounds
 - Give tetanus IG and toxoid to all unknowns or < 3 doses
 - If >3 doses but > 5 years since last booster, give toxoid vaccine only

Anesthesia

- Assess need for anesthesia
 - One or two stiches or staples may not require anesthesia
 - Use of steri-strips or skin glue usually does not require anesthesia
 - Some patients may require a sedative in addition to local anesthesia

Local

- Lidocaine – 0.5% or 1% (1% = 10mg/ml)
 - lasts about 3 hours, max dose 4 mg/kg without epi, 7 mg/kg with epi
 - 70 kg man, max dose 1% with epi = 49cc
 - Buffering: add 1 meq/ml of sodium bicarb to every 9cc of lidocaine to decrease pain of injection
- Bupivacaine – 0.25% or 0.5% (0.5% = 5mg/ml)
 - lasts about 8 hours, max dose 2 mg/kg without epi, 3 mg/kg with epi
 - 70 kg man, max dose 0.5% with epi = 42cc
 - Buffering does not work with bupivacaine

Technique

- Sterilize – betadine swabs
- Needle – 25-30 gauge
- Syringe 1-10 ml
- Ways to decrease injection pain
 - Distract
 - Gently pinch or rub overlying skin or adjacent to wound
 - Inject proximally before distally
 - Inject subcutaneous before intradermal
 - Inject slowly
 - Use warm anesthetic
 - Buffer with bicarb
 - Use smaller needles and smaller syringes

Technique

- For lacerations, inject through open wound and along the length of the wound, limit in and out passes of the needle
- Aspirate only if near vessels
- Inject as you advance or as you retreat
- Test the area with forceps
- Pressure and proprioception remain intact

Digital block

- Same agents, same doses
- Web space block
 - Bilateral injection of 1-2 cc in web space just distal to MCP joint on either side of digit, start from dorsal side and advance to palmar. Aspirate here.
- Flexor tendon sheath block
 - Single injection from palmar side into the proximal tendon sheath, site of entry located just distal to palmar crease. 1-2 cc. should flow smoothly.

Digital block



Anesthetic considerations

- Lidocaine and bupivacaine are metabolized by the liver and excreted by the kidneys
- Allergies – rare, tx is supportive
 - If amide allergy, use ester (procaine/novocaine)
- Toxicity – sx are CNS and CV, tx supportive
- Epi is safe to use with digital blocks, caution in those with PVD
- Avoid epi in ears, noes, penis

Wound repair

- Indications for surgical consultation
 - Large defects
 - Severe contamination
 - Deep wounds that penetrate bone, tendons, joints, or other major structures
 - Complex facial lacerations, cosmesis
 - Wounds associated with neurovascular compromise
 - Wounds with complex infections (eg, abscess formation, osteomyelitis, or joint infection)

Wound repair

- **Contraindications to primary repair**
 - Concern for infection
 - Gross contamination
 - Late presentation
- **Other considerations**
 - Patients with RFs for poor wound healing
 - Animal bites and deep puncture wounds
 - Wounds closed under tension
 - Epidermis only injuries
 - Arterial bleeding

Wound repair

- Primary closure
 - Wounds less than 12-18 hours old in absence of RFs
 - Head and neck wounds have up to 24 hours due to rich blood supply
- Delayed primary closure
 - Can be useful for uncomplicated wounds that present later
 - Debride, irrigate, dress
 - Tx with abx for 4-5 days and then close

Skin glue/steristrips

- Can be used for wounds free of active bleeding, tension, away from joints, hair and moist areas like groin/axilla
- Dermabond – lasts for 7-14 days and will slough off
 - Apply in a single swipe along the approximated wound edge, wait 30-40 secs to allow drying and repeat 3-4 times, allow 5 minutes total to set
 - Do not apply petroleum ointment as it will break down the glue
 - Avoid mucosal surfaces and eyes

Staple repair

- Useful for scalp, trunk, extremities
- Prepare wound
- If assistant available, use adson forceps to evert skin edges
- Apply stapler to the skin centered over the middle of the approximated laceration
- Fire the stapler and inspect
- Place staples every 0.5-1 cm

Staple repair

- Wound care
 - Apply antibiotic ointment
 - Non-occlusive, non-adherent dressing
 - Avoid soaking wounds, showers ok
- Removal
 - Scalp – 7-14 days
 - Trunk and upper ext – 7-10 days
 - Lower ext – 10-14 days

Suture repair

- Material

- Absorbable

- Chromic – monofilament, last 10-14 days. Good for oral mucosa or when suture removal is not desired
 - Vicryl – braided, last 3-4 weeks, generally used for subcutaneous structures
 - Monocryl – monofilament, lasts 3 weeks, good for subcuticular suturing

- Non-absorbable

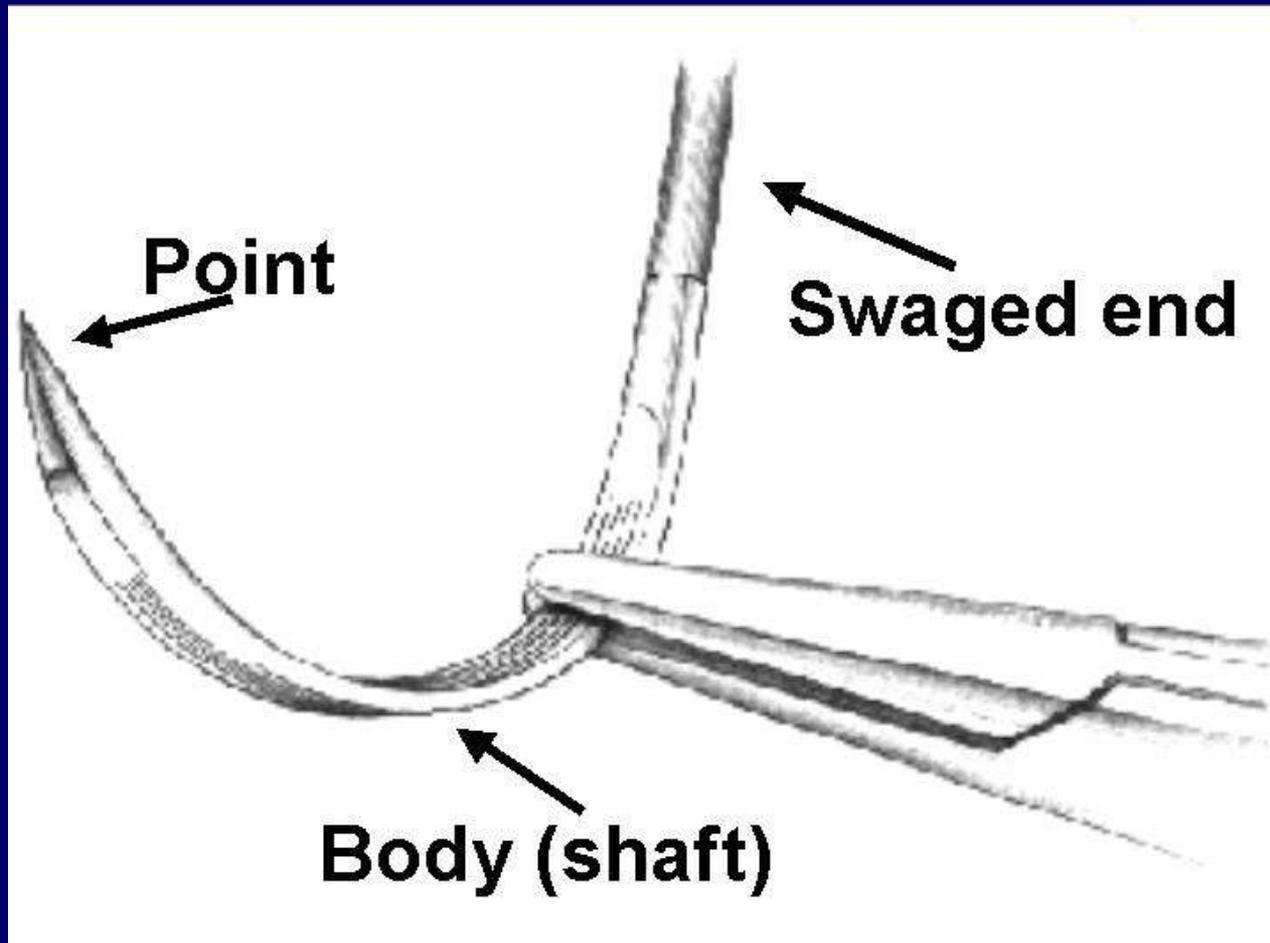
- Silk – braided, low tensile strength, high tissue reactivity
 - Prolene – monofilament, dyed blue, high tensile strength, low reactivity
 - Nylon – monofilament, dyed black
 - Nylon and prolene have high memory and require more knots, 6-8

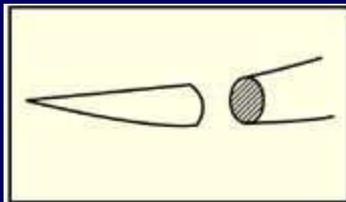
Suture repair

- Size: number of zeros applies to size and strength such that 0 is the largest and strongest, 10-0 is smallest and weakest
- 0 to 2-0 used for heavy repairs, fascia
- 3-0 to 4-0 subcutaneous and skin
- 5-0 to 6-0 finer incisions/lacerations without much tension

Suture repair

- Needle
 - Straight – Keith needle, used for sewing in IV catheters/drains
 - Tapered – good for deep dermal or fascia
 - Cutting – used for skin
 - Swaged or loosely swaged/controlled release (pop offs), come in a pack and good for quick sewing



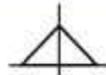
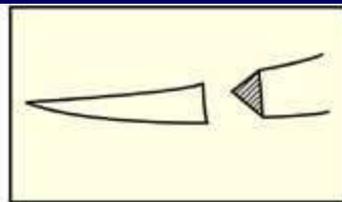


Tip



Body

Round bodied

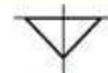
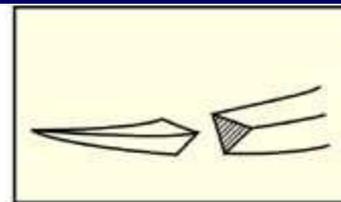


Tip



Body

Curved cutting

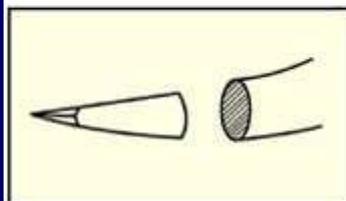


Tip



Body

Reverse cutting

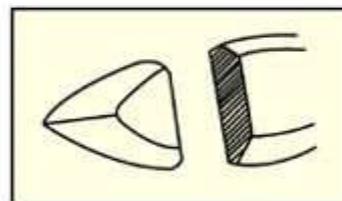


Tip



Body

Tapercut

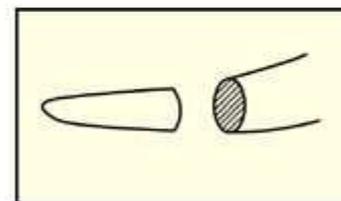


Tip



Body

Micro-point spatula



Tip

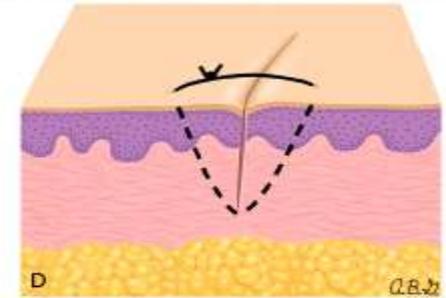
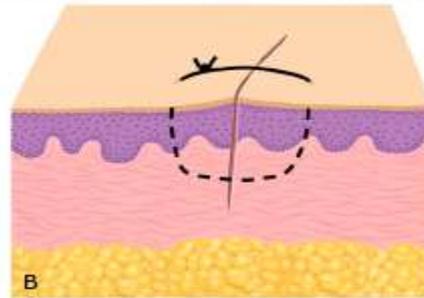
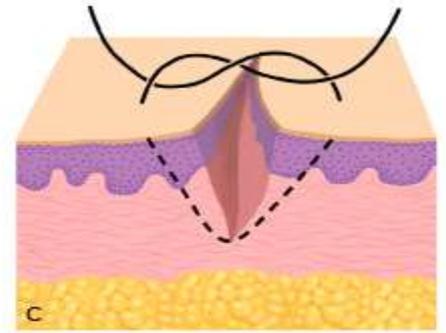
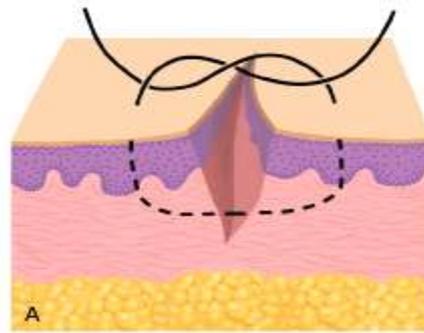
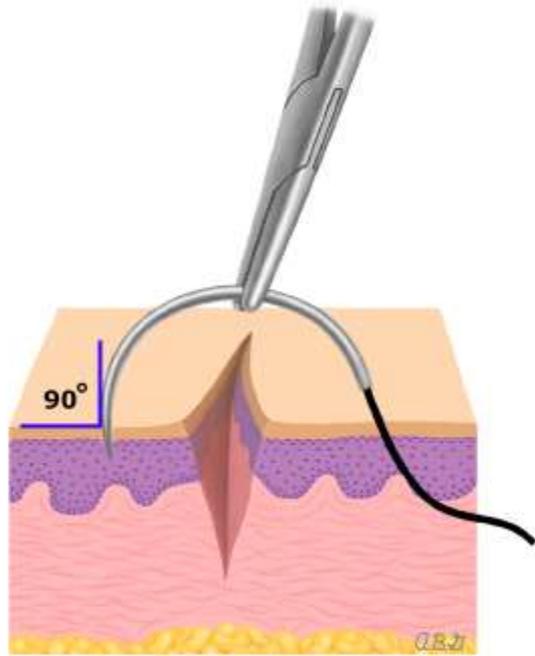


Body

Blunt taper point

Suture repair

- Technique
 - Percutaneous, simple, interrupted
 - Used for most lacerations
 - Enter and exit the skin at 90 angles
 - Evert wound edges
 - Width and depth should be same on both sides of wound
 - Approx 1 cm from edge and 1 cm between sutures

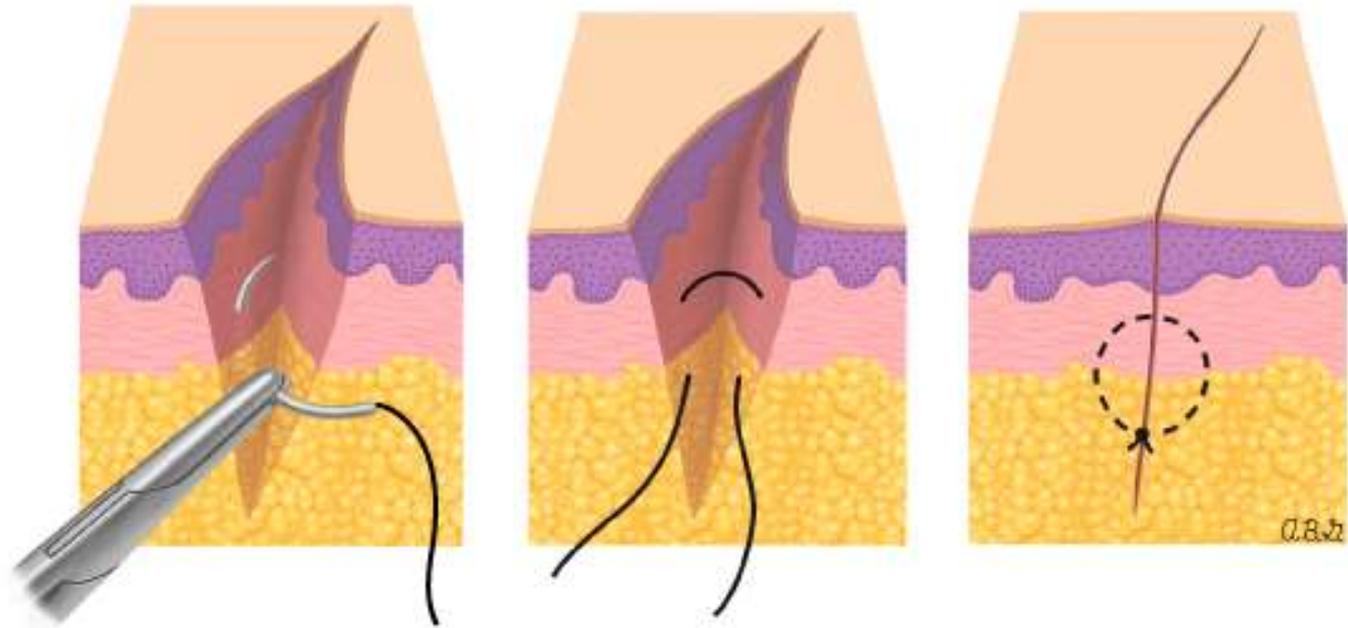


Proper technique

Improper technique

Suture repair

- Dermal repair
 - Re-approximates subQ below dermal-epidermal junction, closes dead space and removes tension from skin – allows skin sutures to be removed sooner
 - Use absorbable suture
 - Bury the knot by starting deep and passing to superficial on one side, then proceed superficial to deep on the other side



Suture repair

- Running – quick for long wounds, spread tension across the length of the wound but will effectively seal wound ie no drainage
 - Best for wounds of low risk for infection and edges that align well
 - Start with a simple interrupted knot at one end and then sequentially pass the needle percutaneously until reaching the other end of the wound and tie

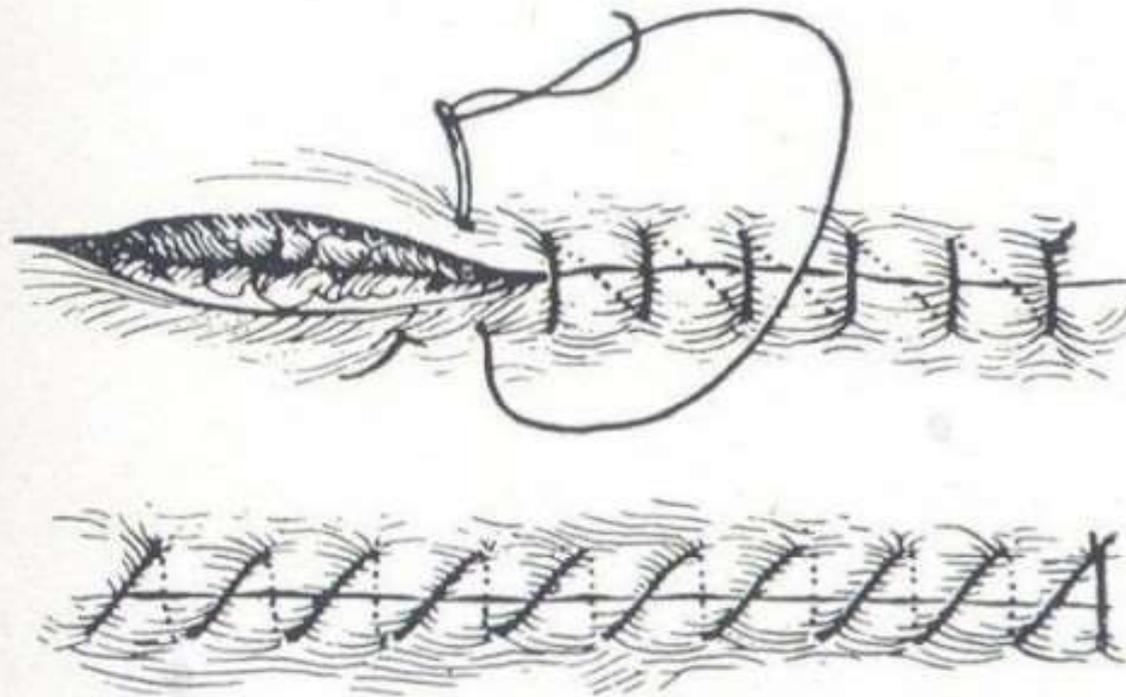
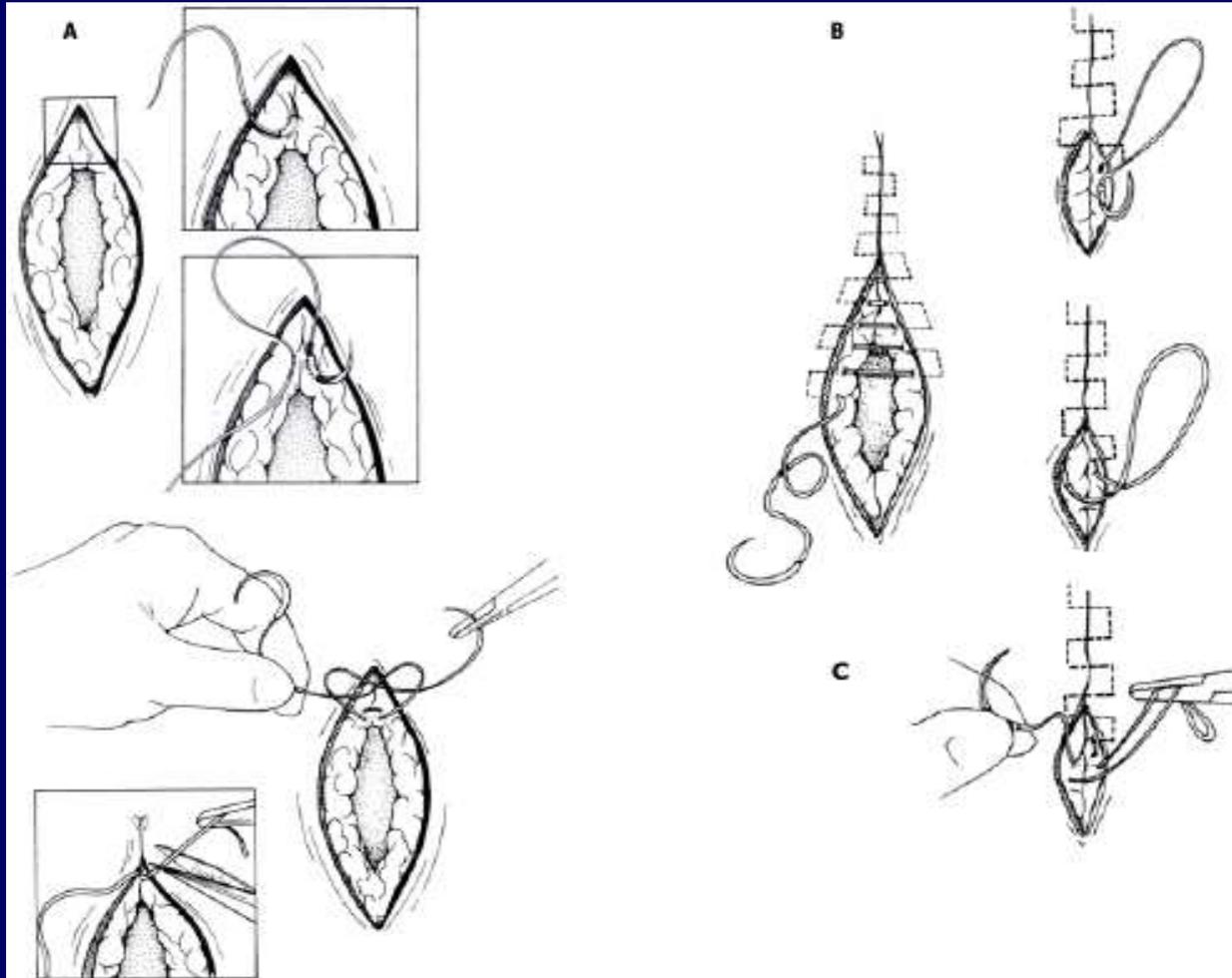


Fig. 94.—Simple continuous suture.

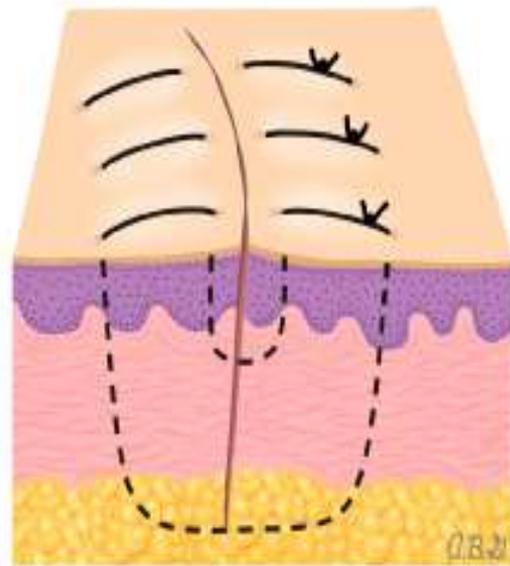
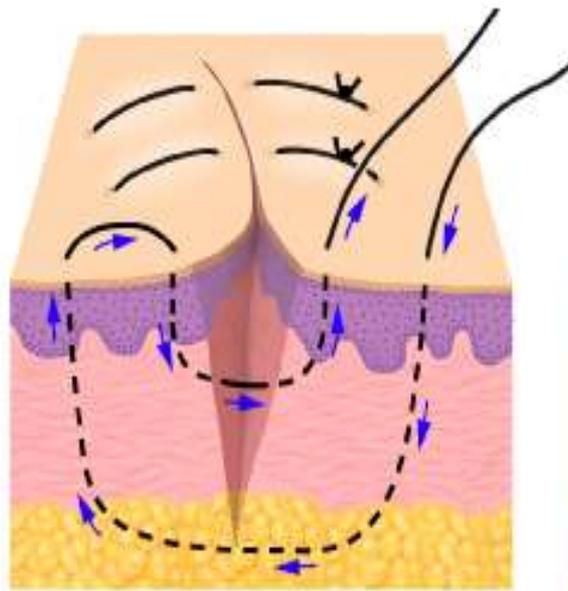
Suture repair

- Subcuticular, running – used mostly for closing surgical incisions but can be used in cosmetically sensitive areas at low risk for infection
 - Use absorbable suture
 - Similar technique to running percutaneous except the needle passes horizontal to wound edges mirroring each side, knots are buried
 - Support with either Steri-strips or Dermabond



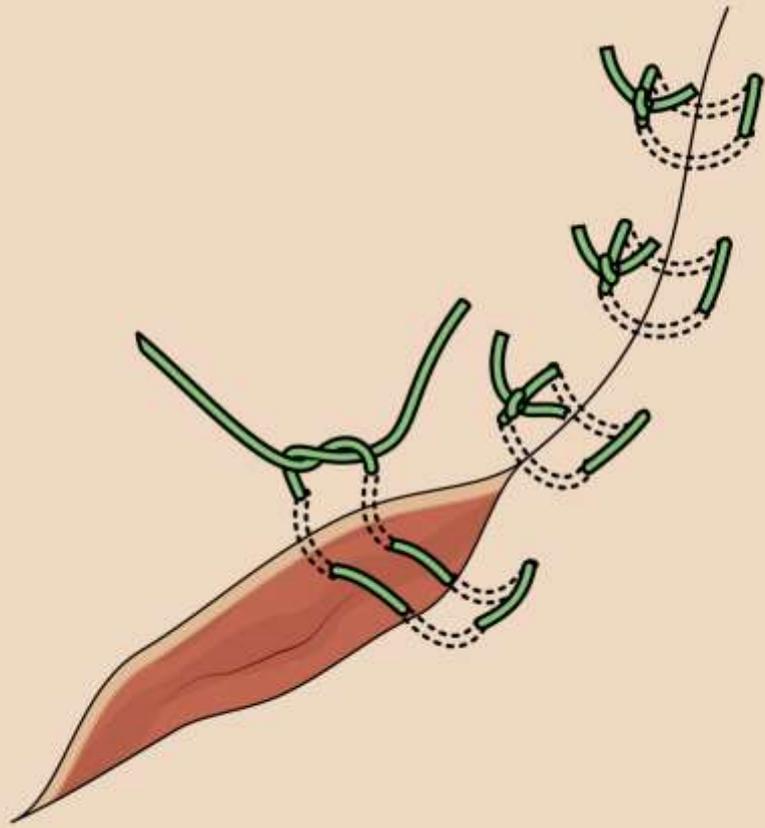
Suture repair

- Vertical mattress
 - For wounds under tension with edges that tend to invert
 - Acts as a superficial and deep suture in one
 - Far to far brings deep tissue together
 - Near to near brings skin together and everts edges



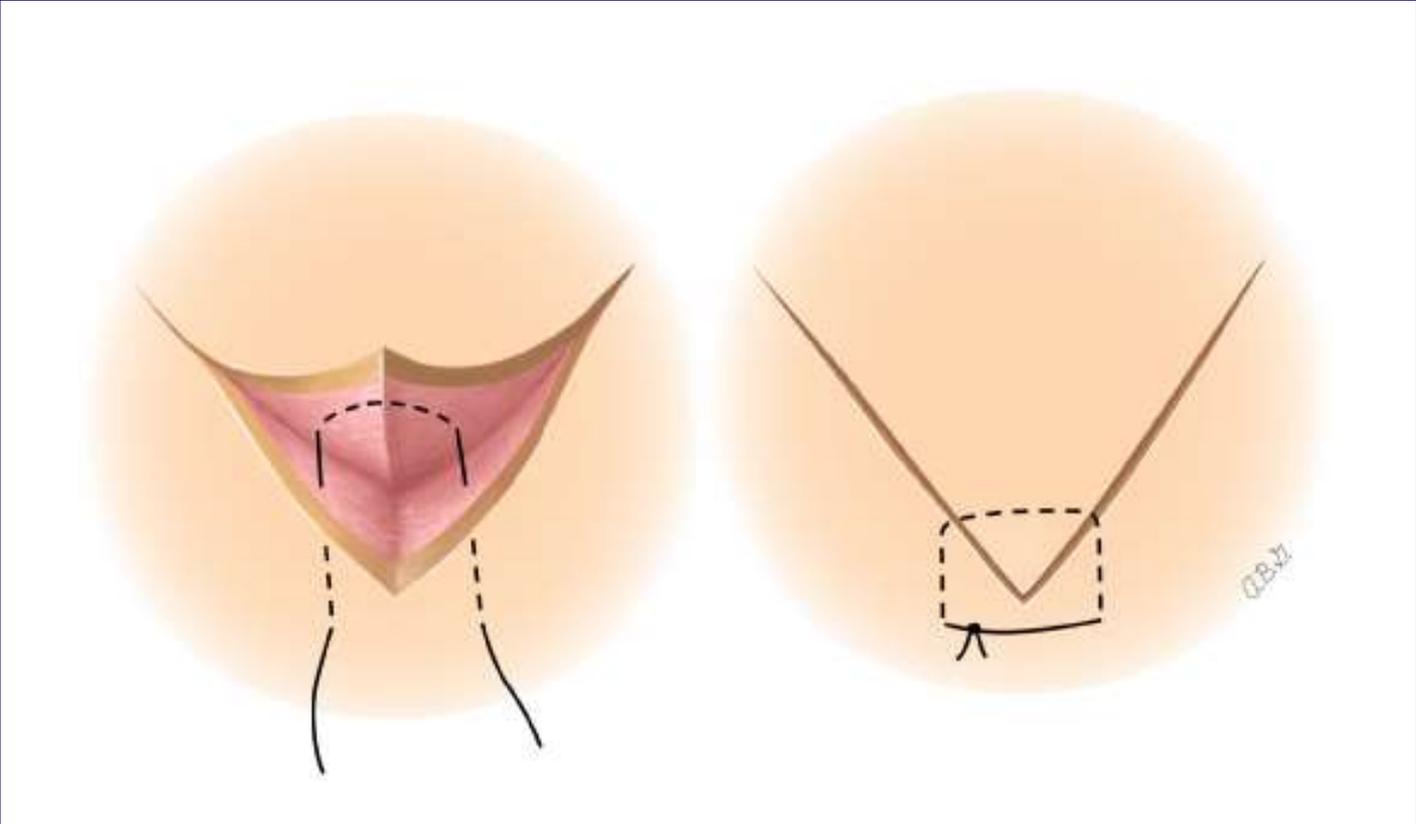
Suture repair

- Horizontal mattress
 - Also for wounds under tension
 - Start with a simple percutaneous throw and travel 0.5 cm and pass back to starting side and tie



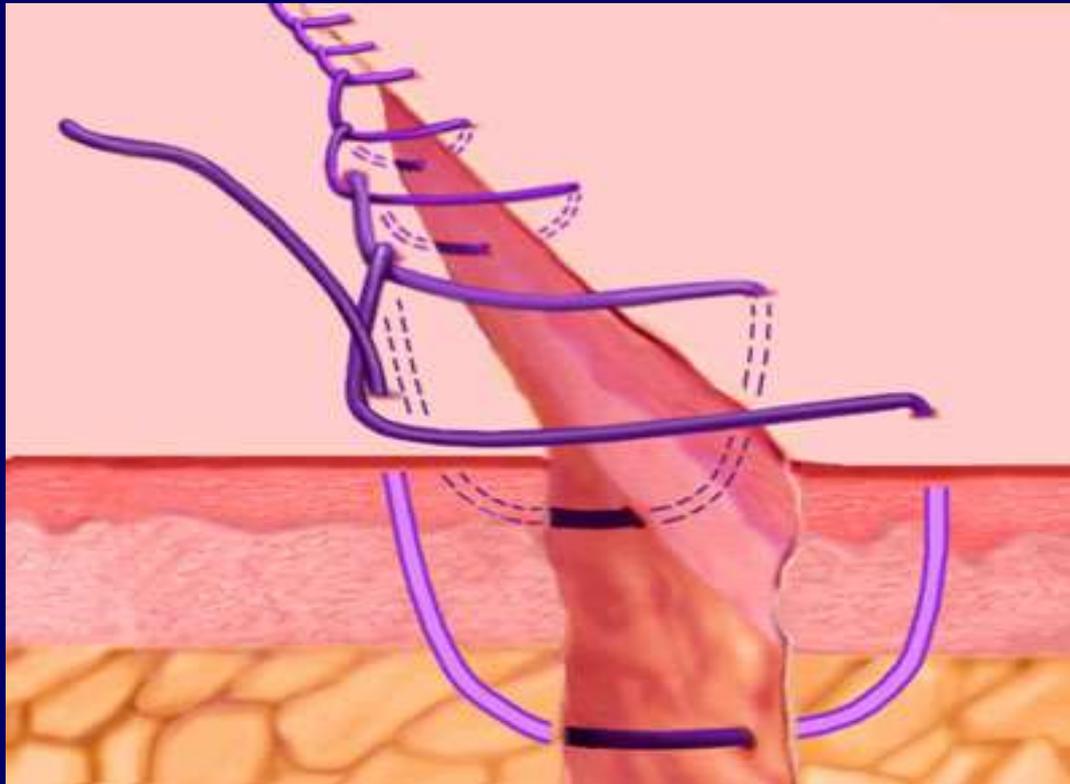
Suture repair

- Half-buried horizontal mattress
 - Good for triangular or irregular lacerations
 - Combines a dermal suture with a horizontal mattress
 - Knot is tied on the non-flap portion



Suture repair

- Running, locking – used for hemostasis, good for scalp lacs, mucosal surfaces



Specific wound sites

- Scalp – use staples for simple lacs; locking suture for bleeding lacs
- Forehead – check for motor and sensation, use 5-0 suture
- Eye brow – avoid shaving eye brows, use 5-0 or 6-0, leave long tails and or blue suture
- Tongue – repair gaps > 1 cm, deep lateral gaps, bleeding gaps
- Oral mucosa – lacs > 2 cm, use chromic
- Ear – cartilage injuries repaired without passing through the cartilage, only perichondrial tissue, use undyed
- Cheek – check for parotid gland or facial nerve injury
- Lip – care to line up vermillion border if involved

Suture removal

- Scalp – 7-10 days
- Face – 5 days
- Neck – 3-4 days
- Trunk and upper extremities – 7 days
- Lower extremities – 10 days

- Can always use steristrips after suture removal if worried about dehiscence

Dressings and care

- open wounds – use wet to dry or dry to dry dressing and change daily or BID until healed
- Stapled or sutured wounds covered with antibiotic ointment, xeroform gauze and then dry plain gauze
- Subcuticular closures need steri-strips or dermabond (no ointment for dermabond)

Questions?

FAST TRACK SPINE CARE CLINIC

Who: Pain \leq 7 days without: *progressive* neurological changes, Loss of Bowel or Bladder function

What: Urgent Care Spine Pain Evaluation and Treatment

Location: Physical Therapy Clinic, Naval Base Dry Side

When: Monday-Friday 0700-0900

(NO CONSULT OR APPOINTMENT REQUIRED)

PURPOSE

Decrease unnecessary ER visits

Increase access to care

Initiate early conservative management and treatment

HOW TO INITIATE

Send patient directly to the following clinics between 0700-0830 (Clinic operating hours are 0700-0900)

NAVSTA (32nd Street dry side clinic) **PHYSICAL THERAPY** Between 0700-0830
Contact: 619-556-8096

NMCSD Physical Therapy Clinic (Bldg 1, Ground Floor): 619-532-7100

North Island Physical Therapy Clinic: 619-545-0462

**EMERGENCY ROOM
URGENT REFERRAL**

INCLUSION/ EXCLUSION SCREENING QUESTIONNAIRE

**Pain Clinic Referral
(Non-Urgent)**

**IPU Intake Metrics
FABQ / VAS**

**Physical Therapy Assessment
Initiate 1st Treatment & Appropriate Secondary Referrals
Initiate Medication and Light Duty Recommendations**

**Symptoms Resolved
Discharge
Return to Full Duty
F/U with PCM**

**Continue Treatment
(Up to 7 Sessions)**

**Symptom Progression
Pain Not Managed
Pain Clinic Referral**

**Unresolved Symptoms
Pain >4/10
Referral to Pain Clinic**

Inclusion Criteria

Pain \leq 7 Days

< 3 Prior Episodes of Acute Low Back Pain/ 3 years

Not currently treated by Physical Therapy, Chiropractor, or Pain Clinic

Exclusion Criteria

Referral to SD Physical Medicine (Dr. Sheu) for Non Urgent Consultation

Pain > 7 Days (Relative Exclusion)

Prior Back Surgery

History of multiple episodes Chronic Back Pain (Relative Exclusion)

Patient on Opioid Medication

Patient with PMH of: RA, Inflammatory Disease, Auto Immune Disease

History of recent Trauma/ or Falls

Referral to ER for Urgent Consultation

Progressive Neurological changes

Loss of bowel or bladder function

Unstable Vital Signs, Fever

Hematuria

REMINDER

Reminder: This is for ACUTE back pain NOT routine referrals

Routine referrals will still be handled through CHCS and patients scheduled per next available visit.

If you have any questions please call 619-556-8096

Primary points of contact:

PT - LCDR Halfpap, joshua.p.halfpap.mil@mail.mil, 619-556-3516

Mind Body Medicine
jeffrey.h.millegan.mil@mail.mil

Jeffrey Millegan, MD MPH FAPA
CDR, MC, USN

Senior Medical Officer, Directorate of Mental Health
Head, Mind Body Medicine
Head, SPRINT West

USU Clinical Associate Professor of Psychiatry
Staff Psychiatrist

Naval Medical Center San Diego

o: 619-532-7065

c: 619-665-1172

Social Work Waterfront Support Initiative



Navy Social Work

- Clinical mental health providers
- Focus on individual and environment
- Advocate for at risk/ under served populations

IDC Manned Ships

- Limited mental health resources
- Mental health situations negatively impact command/ mission readiness
- High prevalence of LIMDU for mental health

Initiative

- Facilitate and support Mind Body Medicine groups

Anticipated Outcomes

- Enhanced resiliency skills
- Decreased stress and anxiety
- Improved sleep hygiene
- Positive impact on mental health and fleet readiness

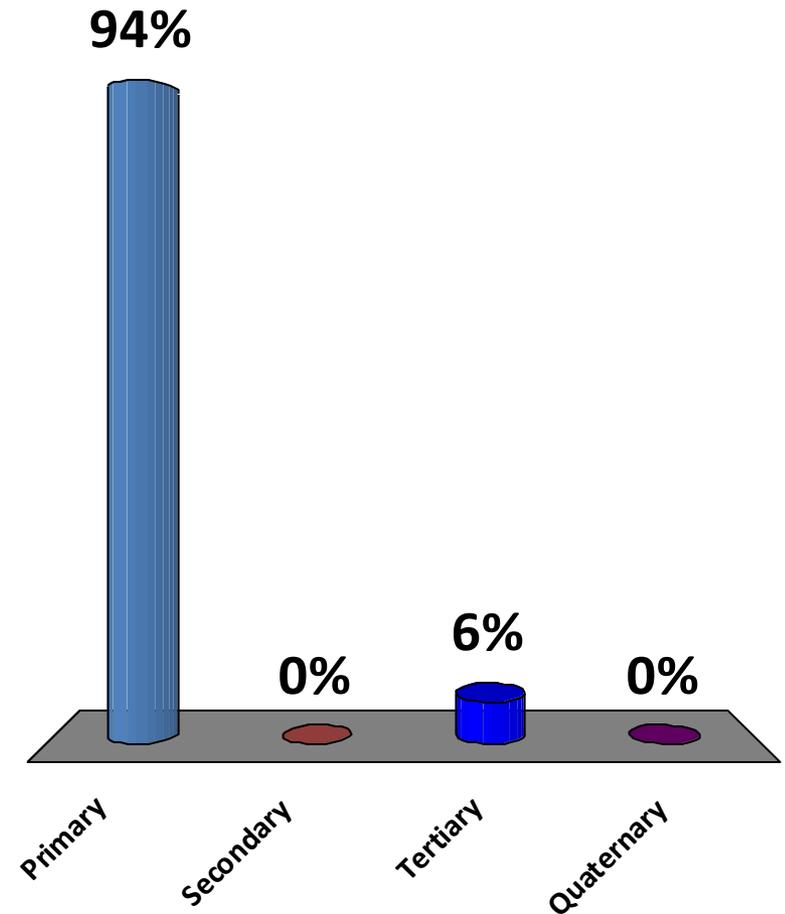
Team

- LCDR Narro: Social Work Department Head
- ENS Stickler
- ENS Henderson
- ENS Zimmer

- POC:
 - LCDR Narro: 619-532-5618
 - ENS Henderson: 619-750-2303

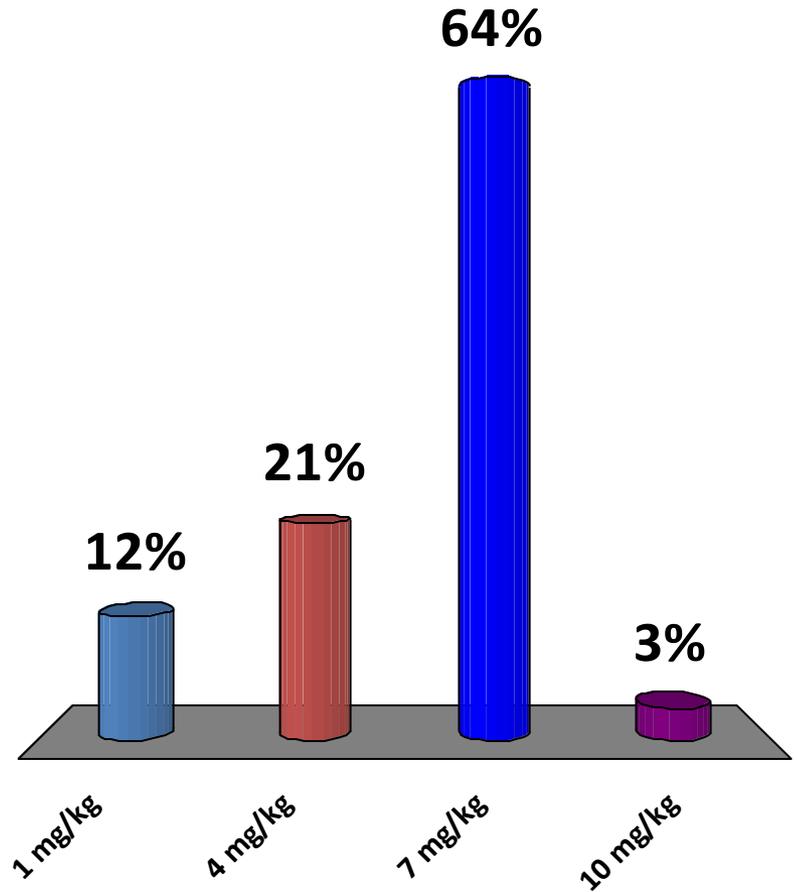
Surgical closure of a wound refers to which type of closure?

- ✓ A. Primary
- B. Secondary
- C. Tertiary
- D. Quaternary



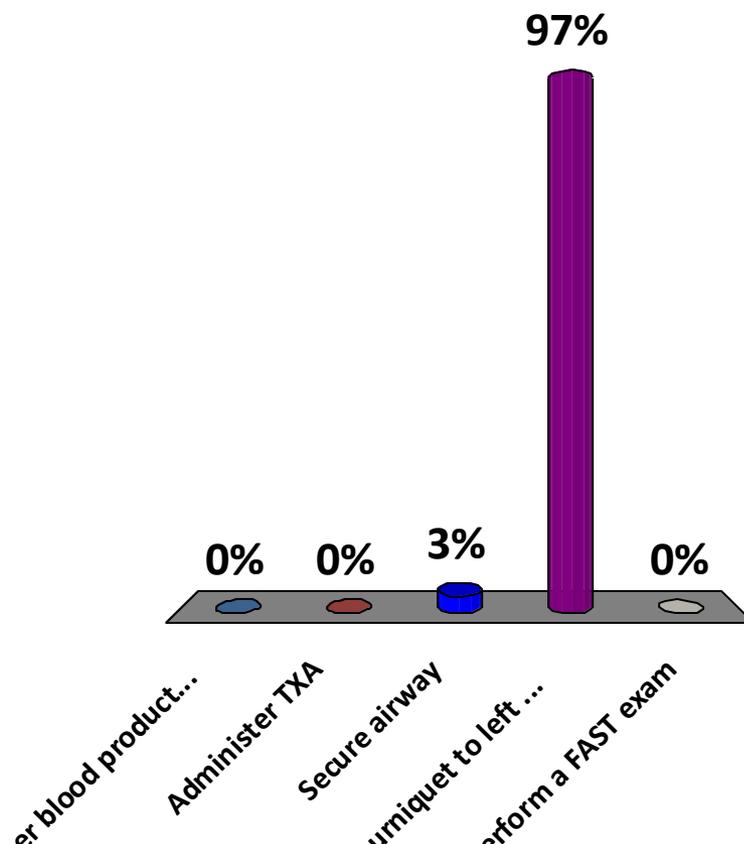
What is the max dose of lidocaine when administered with epinephrine?

- A. 1 mg/kg
- B. 4 mg/kg
- ✓ C. 7 mg/kg
- D. 10 mg/kg



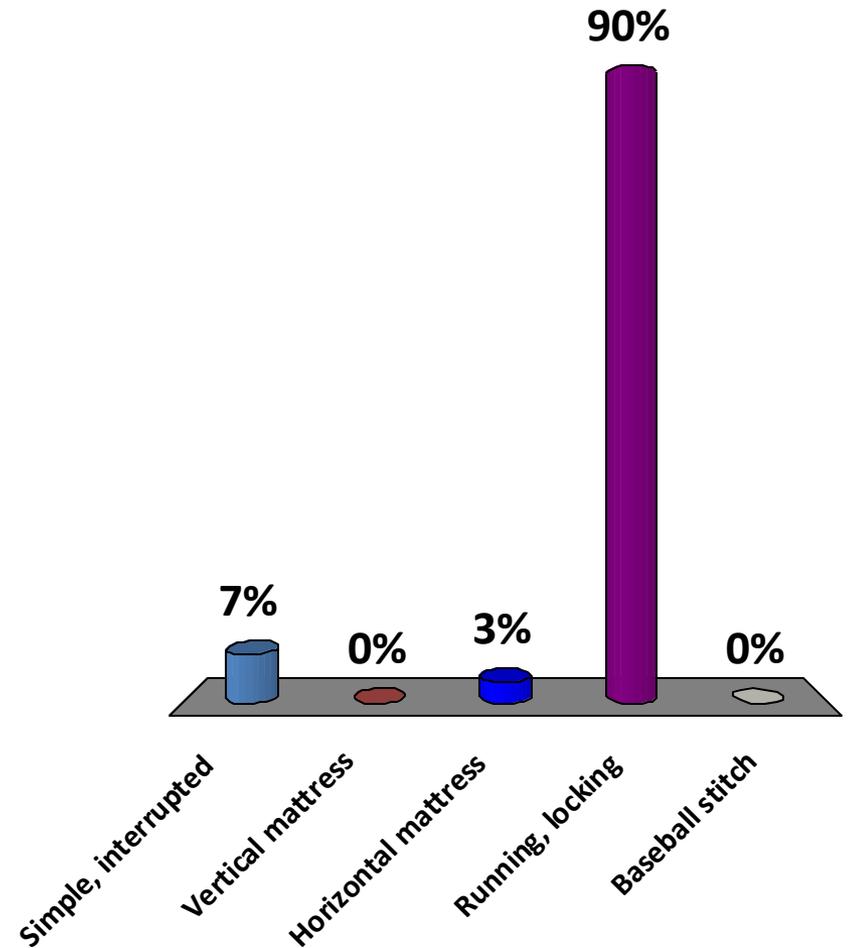
An injured marine is brought to your BAS/BDS in shock with a GCS of 7 and an actively bleeding left thigh after an IED amputated his lower leg. The next best step in management is?

- A. Administer blood products in a 1:1:1 fashion
- B. Administer TXA
- C. Secure airway
- ✓ D. Apply tourniquet to left thigh to stop bleeding
- E. Perform a FAST exam



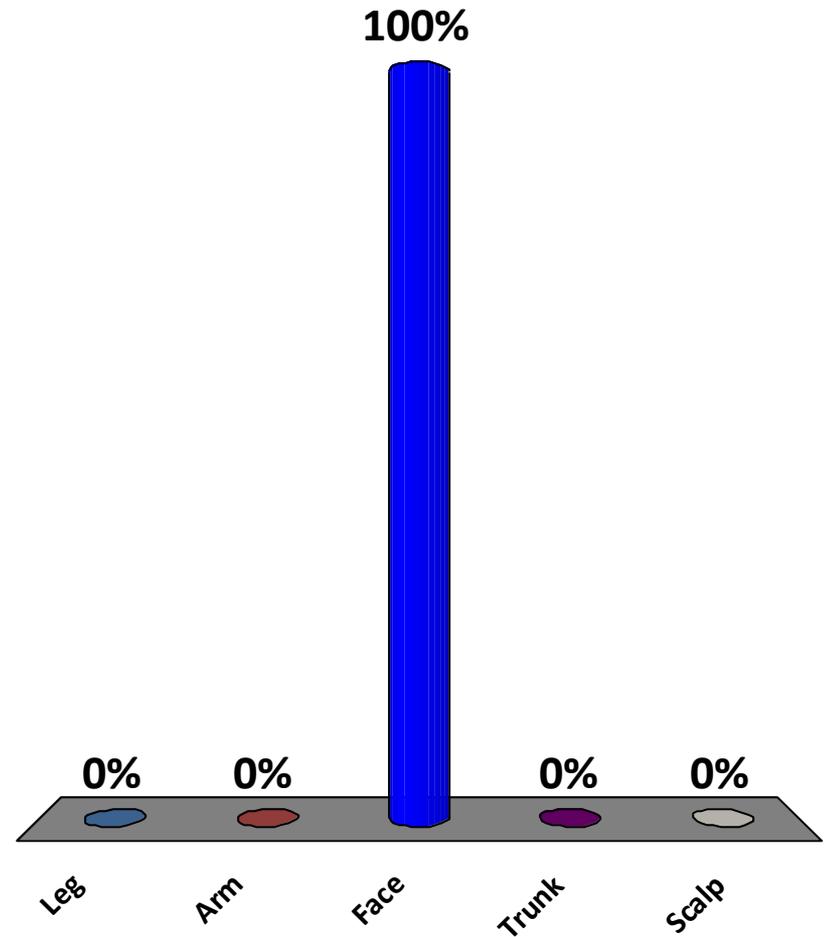
Which of the following suture techniques is particularly good for hemostasis?

- A. Simple, interrupted
- B. Vertical mattress
- C. Horizontal mattress
- ✓ D. Running, locking
- E. Baseball stitch



Staples are generally acceptable for all of the following locations except for?

- A. Leg
- B. Arm
- ✓ C. Face
- D. Trunk
- E. Scalp





DEPARTMENT OF MEDICINE

NAVAL MEDICAL CENTER SAN DIEGO

Primary Care Symposium

Friday May 13, 2016

Cost: Free — VTC available

Time: 0700—1600

Location: NMCSD Auditorium, Bldg 5

Target audience: Primary care providers

Registration: <http://www.med.navy.mil/sites/nmcSD/Pages/Staff/Symposiums/Primary-Care-Symposium.aspx>

7 hours of CME available:

- ◆ **Keynote: Idiopathic Urticaria**
- ◆ **Approach to Vertigo**
- ◆ **Hypertension Update**
- ◆ **Sports Medicine in Primary Care**
- ◆ **Office Dermatology**
- ◆ **“Stump the Specialist”**
- ◆ **NMCSD Resource Fair**

PCM Symposium POC's

Course Director: LCDR Mark P. Tschanz

Contact: mark.p.tschanz.mil@mail.mil

VTC Info: LCDR Debra Coffey

Contact: debra.d.coffey.mil@mail.mil

OPERATION PINC:

A Walk in Clinic for Birth Control

**Process
Improvement for
Non-delayed
Contraception**

WHO: All women and adolescents (active duty & dependents)
in need of birth control services

WHAT: **Same day services for:**

- Birth control pills prescriptions/refills
- IUD insertions
- Nexplanon
- Depo Provera
- Contraception counseling
- Emergency contraception/Plan B

First come, first served; waiting times will vary
NO APPOINTMENT NECESSARY, JUST COME ON IN!

WHERE: Naval Medical Center, San Diego (Balboa)
Department of Obstetrics and Gynecology
Building 3, 1st floor
Phone: (619) 532-7082

WHEN: Monday-Thursday 0830-1530
Fridays 1300-1530



Fleet Dental

Sara A. Chilcutt LCDR DC USN

Fleet Division Officer/ Fleet Liaison Officer

NBHC Naval Base San Diego

Fleet Office: (619) 556-4797

Front Desk: (619) 556-8239/40

sara.a.chilcutt.mil@mail.mil



Medical Readiness Division

MRD_SD_GMO@navy.mil

(619) 556-5191

Bldg 116

San Diego, CA 92136



Active Duty Clinic-Gen Surgery

- Director, MRD CDR Hoang has volunteered to see common general surgery pathology on Fridays at Dept of Surgery, NMCSO to fast track fleet referrals, including:
 - Soft tissue (lipoma, epidermal inclusion cyst, pilonidal cyst);
 - Anal disease (hemorrhoid, anal/rectal abscess);
 - Screening colonoscopy
 - Symptomatic cholelithiasis
 - Hernia (ventral, incisional, inguinal, umbilical)

 - Gen surg matrix referral rules still apply.
- Conditions requiring long term follow up will not be included in active duty clinic, unless discussed with MRD Physician Supervisors.
- Include “forward to Dr. Hoang” in body of the referral.



CME – how to

Commander Naval Surface Force, U.S. Pacific Fleet

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Commander Naval Surface Forces, U.S. Pacific Fleet



Medical Readiness Division San Diego

Clinic: (619) 556-8114 GMO Office: (619) 556-5191 Email Address mrd_sd_gmo@navy.mil
Senior Enlisted Leadership: (619) 556-0662

What's New

- **MRD Clinic has changed locations!**
MRD Clinic is now located in the Patient Treatment Area (PTA)/Acute Care Area (ACA), in the southwest corner of the 32nd st NAVSTA BMC.
Front desk #619-556-8114
- **Dental Clinic 32nd Street**
Contact: (619)556-8240/8239/8233/9545 during the hours of 0645-1515
- **New hernia guidelines - refer to general surgery for workup**
[CAMO General Surgery Matrix - February 2015](#)
- **TMIP Maintenance Guidelines**
- **Infectious Disease: Ebola & MERS information**
[Evaluation and care of patients with possible Ebola](#)
[Ebola Resources/Disinfectant/CDC Guidelines](#)
[MERS Update](#)
NEPMU-5
San Diego, CA
Quarterdeck: (619) 556-7070
CDO: (619) 726-4421
- **STR Tracking Requirements/Separation History & Physicals Instruction**
[SHPE Instruction](#)
[SHPF Guidance](#)

Quick Reference

CME Guidance

- [Athens Access and Up To Date CME Instructions](#)
- [CME Credit Instructions](#)
- [CME Follow-Up Survey](#)

Contact Information

- [CNSRW Ship locator](#)
- [Fleet Liaison Contact Info: Daytime Office Phone #: 619-532-6430, Fax # 619-532-6404, Duty Phone #: 619-302-8944, email: \[fmlo-list@med.navy.mil\]\(mailto:fmlo-list@med.navy.mil\)](#)
- [Phone Directory: Media:INTRANET_PHONE_DIRECTORY_\(pao_approved\).pdf](#)

Consult Guidance

- [Consult Appointment Management Office \(CAMO\) Powerpoint](#)
- [CAMO CT Surgery Matrix](#)
- [CAMO Endocrinology Matrix - December 2013](#)
- [CAMO General Surgery Matrix \(revised - February 2015\)](#)
- [CAMO GYN Matrix - February 2014](#)
- [CAMO MRI Matrix - 6 June 2014](#)



CME – how to



NAVAL MEDICAL CENTER
SAN DIEGO
THE PRIDE OF NAVY MEDICINE

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CME Certificate

Sign In

Welcome!

To evaluate the program and display your certificate, please follow the steps below:

1. Enter your Military Email Address:
2. Please select one of the following:
 - I already have a password, and my password is: [Forgot Password?](#)
 - I am a new user (You'll create a password later)
3. Enter CME Activity Code
4.

(be sure your browser allows pop-ups)

[If you would like to view or print a past certificate, please click here](#)
*Note-Reprint of certificates valid only for certificates received after 10-1-11.



CME Information

- CME Code (To claim credit online): **8326**
- Closing Date (To claim credit online): **04 MAY 2016**
- To complete CME
 - Log onto the MRD IDC website and click on the CME credit link
 - or
 - Go to NMCSD SEAT SharePoint site (via citrix or NMCSD/BMC computer) and click on MRDSD Waterfront Meeting

<http://nmcsd-as-spfe05/sites/dpe/setd/Lists/cmesurvey/Item/newifs.aspx?List=be0f840e%2D0489%2D4b5a%2Db8de%2D9c4cd1a323e5&Web=0901130e%2Dd444%2D45b8%2D8bc7%2D5b9ec10dca77>