War Time Medicine on a Peace Time Mission

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ABSTRACT

As we realized the MEDEVAC from JTF-B was not going to happen, the words of instructors from the Joint Special Operations Medical Training Center (JSOMTC) echoed through my head, "Men, pay attention to this. There will be a day when you, as Deltas, will have to sustain a patient for hours, possibly days; this is what separates you from any other medical professional in the military, so shut up and stay awake." We had heard those words every time we started a new section of Special Forces Medical Sergeants (SFMS) course. Now those words were staring right back at us in the form of the patient's friends and family. We looked at our patient in the back of that beat up truck and knew we could keep our patient alive. We had the knowledge and the equipment; we just didn't know how much longer we would have to sustain him.

In January of 2012, Operational Detachment-Alpha (ODA) 2323 began preparations for our Counter Narcotics and Terrorism (CNT) mission to Central America (CENTAM). Moving through Camp Shelby, MS, and then to 7th Special Forces Group at Eglin Air Force Base, FL, our team began its planning phase of the operation. After a few days building pallets and preparing to go to CENTAM, the team was in good spirits as we flew to Soto Cano Air Base near, Comayaqua, Honduras. Soto Cano is a Honduran air base and is also the home to the Honduran Air Force Academy. Soto Cano also shares its gates with Joint Task Force-Bravo (JTF-B), a joint military compound. JTF-B's mission states:

Joint Task Force-Bravo, as guests of our Honduran host-nation partners and the senior representative for USSOUTHCOM at Soto Cano Air Base, conducts and supports joint operations, actions, and activities throughout the joint operations area maintaining a forward presence in order to enhance regional security, stability, and cooperation.

After a few days at Soto Cano, our team moved out and to our respective locations. Our ODA was to be a split team between the two Special Forces battalions of our partner nation. One half would be with the 1st Battalion, in the southern part of the country, and the other half would be with the 15th Battalion in the north. Problems arose quickly as we were splitting up when the senior 18C (Special Forces Engineer), and Senior Non-Commissioned Officer (NCO) for the southern split, had a family emergency back home and was to be flown home, not to return to CENTAM. This meant that our split in the north was to lose a senior NCO. My senior 18D (Special Forces Medical Sergeant) and another junior 18C went to the 1st Battalion with my senior 18D to be the new senior NCO for that split. This meant that I was now the only Delta (18D) on the team, straight out of the Q-course, and with no experience other than civilian medicine. Luckily, I had knowledgeable and experienced Operators with me to answer my questions and to guide me along with team specific tasks. This, along with my training, eased my mind.

The training calendar wasn't too hectic the first month of getting to our battalion. I had run a simple Combat Life Saver (CLS) class for some of the partner nation guys to prepare them to be first-responders to accidents in the area during Semana Santa, the holy week during the time of Easter. Aside from occasional ranges and waiting on the partner nation's command to start the next *Comando* course (their Ranger school), the team was trying to find a way to get to our real training objective. The remote Central American village was inaccessible by roads, but our battalion was sending soldiers there by helicopter to support their mission. We knew this village could be an incredible opportunity to get out into the country with the soldiers and conduct training that hadn't been attempted since the 1980s.

We received our other Delta in April. SSG Squires had just completed a Joint Combined Exchange Training (JCET) with 2/20th Group and wanted another run in CENTAM. We already knew each other from the 18D course where we met on Saint Mere drop zone, Fort Bragg, NC, on one of the jumps Deltas performed every two months. There, we also found out we were in the

same company back in Mississippi. For the next month, we ran medical coverage for the 15th, instructed a two-week Tactical Combat Casualty Care (TCCC) course for the medics of the base, and got equipment and supplies ready for our Field Training Exercise (FTX) to our remote village. Squires would be going out before me to set up the house and assess the area's medical capabilities. I'd be lying if I didn't say I was a little upset that he got to go before me, but I placed my mild jealousy aside and knew I'd be out there soon enough.

On 11 May the team sat down in the team room to listen to a brief from a LTC about the events in Colombia and to receive our new 180A (Assistant ODA Commander). We hadn't heard much about him, but SFC Underwood knew him, and that was all we needed to know about this man. We quickly realized we would enjoy CW2 Jett. Unfortunately for Chief, the pleasantries of handshakes and names would have to wait. The team of SSG Hare, SSG Squires, and SSG Francis were ready to load the plane and get into the remote village to start the FTX. Immediately after they jumped into the pre-packed truck and drove to the airfield to meet the State Department pilot. We had coordinated with them to use their PC-6 (a 6–10 passenger, single engine, Short Take Off and Landing) to get our three men and equipment to the village's tiny airfield. Upon infiltration into our area of training, the team linked up with the Soldiers from the 15th battalion, and the training began. SSG Squires would have the next few weeks to assess the medical capabilities of the area, the school system, and sanitation of the house where the ODA and Honduran soldiers would be living. Assessing the medical capabilities was a task that any Delta would want to know about the area where he was working; however, the school and sanitation assessments would be sent to higher headquarters so a Civil Affairs team could be sent to the location with different supplies. These actions could possibly improve the quality of living in the area. SSG Squires would have his hands full with patients in the area hearing of the "new American doctor" who had medication and knowledge. Some days he would see no patients, and the next day, he would see 15 patients with anything from rashes to muscle aches. Day to day, he was winning the hearts and minds of the locals.

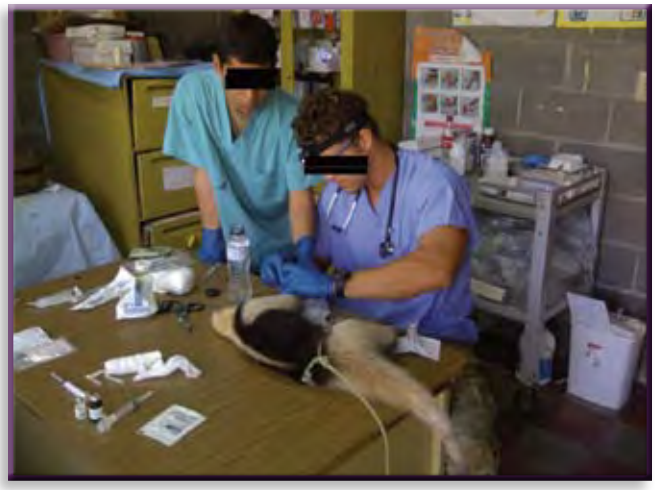
While the rest of the team was in conducting the FTX, day-to-day operations were still going on at the 15th Battalion base. We had rifle and pistol ranges, classes, and hopes of starting a new Comando Course loomed in the future. It was just another day before a local stopped SFC Underwood and myself about an animal he had trapped. Well, curiosity got the best of us, and we wanted to see the animal. It was quite the sight at 0700 in the morning to see an anteater tied to a rope, clearly suffering and in pain. We weren't going to negotiate over a price with the local; we just left and made a phone call to 15th Battalion Logistics Officer (S-4). They had the authority to take animals in distress or endangered animals from the local populace if they were in danger of hurting others or being hurt. It just so happened that this anteater had the padding of her hands torn off from a trap or neglect. So the CPT and some of his men went to the gentleman in town and commandeered the animal from him with no incident. As they brought it back to the base, I was making plans to sedate the animal and clean its paws to be released back into the jungle somewhere in the area. The 15th Battalion has quite the abundance of jungle that would make for an exceptional home to the anteater. I researched anteaters and found that 10–20mg/kg of Ketamine with an additional 0.1mg/kg of Diazapam is used for the animal in a zoo environment. The following day, this was what I used on the 2kg anteater the next day for the cleaning.

Case 1

I was trying to get some rest for the next day when knocking at the door woke me at 2230. We always had a person at the Operations Center (OpCen) over night to watch sensitive items and monitor the radios for traffic. There stood the CPT and the Base Commander with his jaw in his hand, in apparent pain. A Honduran colonel had a cleaning that afternoon from his usual dentist and complained of radiating pain along his jaw that originated from tooth #31. He also had an amalgam filling placed inside the tooth that afternoon, but did not have pain when he left the dentist's office. The skin around his jaw and face had no significant findings and he denied any pain originating from his cheek or muscles. He also denied having sensitive gums around the tooth. He described the pain as "electric and radiating" from the tooth. He also denied pain from pressure and percussion applied to the mandible/maxilla. He also had no pain upon palpation of his submandibular, anterior, and posterior lymph nodes. I decided to treat his symptoms with an inferior alveolar nerve block and a buccal nerve block (Figure 1). Using an injection of Xylocaine with Epinephrine 2% at the appropriate sites, the colonel's pain began to subside. I monitored the colonel for any reactions to the medication, and I also gave him five pills of Tylenol 3 with instructions to take one pill with food every four hours, in order to continue pain management. I then made it clear to make arrangements to see his primary dentist as soon as possible to follow up. He understood all of my instructions and insisted that he would comply. I also asked him to only eat soft foods until his pain subsided or his dentist approved another plan of treatment. He returned two days later saying he was out of pain medication, and he was seeing his dentist that afternoon. I then gave him three Percocet with instructions to take one pill with food every four hours, in order to continue pain management. He saw his regular dentist

Figure 1 *Reynolds treating the COL's pain by performing an Inferior Alveolar Nerve Block.*

Figure 2 *Reynolds and PN medical assistant cleaning Renee's wounds sustained from the trap.*



that afternoon and was prescribed another medication. We spoke that evening about his unexpected visit to our OPCEN and how he never knew that Deltas could perform dental procedures. The colonel was only a year old to the battlion and had worked with U.S. SF before, but had never been a patient. Treating the colonel that evening was nothing short of ordinary for a Delta, but the trust and faith in our capabilities he had now would stay with him the rest of our time in CENTAM.

Case 2

After we got the tooth difficulty under control, we were able to turn our attention back to the distressed animal we had commandeered earlier. We sedated the 2kg female anteater using 30mg IM of Ketamine (15mg/kg) and 0.2mg IM of Diazepam (0.1mg/kg). I had one of the partner nation soldiers, who was a part of the medic class we had taught earlier, assist me during the cleaning of the animal's claws. After the animal was sedated, we began using gauze and clean water to remove gross contaminants and debris (Figure 2). Once we had removed all we could, I started soaking the wounds in a 10:1 solution of water and Betadine for approximately 15 minutes. Once completed, the wounds were scrubbed gently with Betadine and water and then wrapped with non-adherent pads and wrapped in gauze (Figure 3). The partner nation medic and myself monitored the patient every 15–20 minutes during the procedure for heart rate (HR) and respiratory rate (RR) (Figure 4). Monitoring HR and RR proved interesting as my pulse ox wouldn't fit over her claws. My assistant and I found that using my stethoscope was the best method to record vitals. After both wounds were cleaned and wrapped, I looked through the patient's coat for other signs of trauma, infections, and parasites. None were found, and the patient was placed outside in sunlight until alert and able to

Figure 3 *One of the injuries before cleaning.*

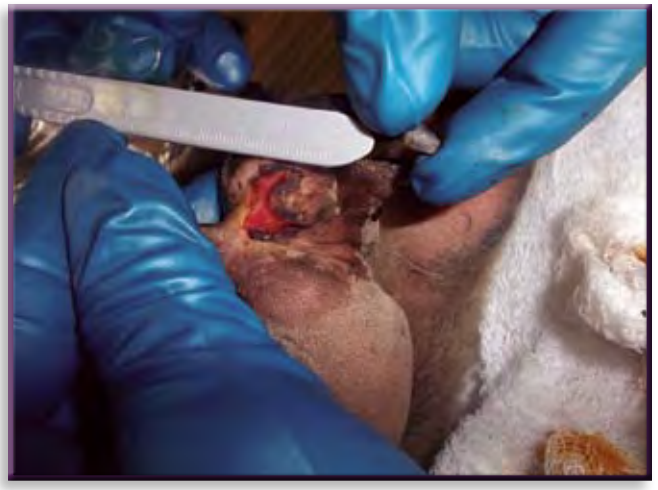


Figure 4 *Reynolds helping the PN medic to find Renee's heartbeat.*

walk. About two hours after the initial sedation, she was alert and walking around the base. She stayed in a tree outside of our team room, still attached to the leash, for the duration of the night and then was retrieved the next morning. The patient had normal behavior and seemed unaffected by the anesthesia. We then removed the gauze and let the patient off the leash. She found a large tree on the compound where she still lives today. Renee has been named an unofficial *mascota,* or pet, by the base.

Case 3

The ODA members on the FTX had been in the village for almost a month when SSG Squires had his first trauma. A 13-year old male presented with excruciating pain in his lower right leg to the shotgun house, where three ODA members and fifteen Honduran soldiers where living during the FTX. SSG Squires had the boy brought in the fenced area and placed onto a table. He then asked that only one of the people who helped bring the boy remain, as the rest would need to stand outside the fence for security reasons. SSG Squires asked the boy to tell him what happened to cause so much pain. The boy described that he had been playing soccer when another player tackled him. He heard a loud pop, and he immediately couldn't move his leg. He said it was the worst pain he ever had in his life. Squires then made a full assessment of the boy, finding nothing else to be affected other that the right leg. On closer inspection of the point of impact on the leg, audible crepitus was heard and Squires immediately checked for distal pulse. He couldn't feel a pedal pulse initially, and he attempted to reduce the fracture with steady traction. He then tried to palpate the pedal pulse again and found the pulse this time. The boy's leg was then splinted in a position of function, and pulse was again reassessed. SSG Squires began telling the Honduran soldiers to bring him the hard litter for transport to the clinic as he thought about pain management. The boy's vitals were elevated from the pain, but he was in stable condition. His blood pressure (BP) was 128/84 with a heart rate (HR) of 90bpm. SSG Squires then injected Promthazine 25mg IM and taped one 800mcg Transmucosal Fentanyl applicator to the boy's right index finger. The litter was brought to table, and the patient was secured to it with extra padding and support around the broken leg. Once secured, Squires removed the Fentanyl from the patient and discarded the rest. After monitoring him for 15 minutes to ensure respiration rate was unaffected, Honduran soldiers then moved the patient to the nearest clinic about two miles away. The Honduran soldiers would take turns carrying the litter through the heat and humidity. Luckily, the clinic had a doctor this particular week that could further help the boy. The doctor received the flow sheet with all interventions written on it and was briefed on what occurred with the patient.

It's easy to forget that a Delta for most remote CENTAM villages is the only medical professional for miles around. This particular patient could have easily permanently lost blood flow to the leg affected and it may have become gangrenous. Amputation is a life-changing event in any country; it's amplified when you rely on walking as much as the locals in these villages do. With one medically trained person across the road, this patient kept his leg. I remembered hearing these events for the first time and thinking he is extremely lucky to have a Delta right there and a doctor at the clinic. In just a few days, we would meet another very lucky patient who would have two Deltas just a 4-wheeler ride away.

I had finally gotten the green light to go to the FTX in our village about the same time Squires was handling the young man's leg. I had been fighting to get out there for weeks, but the situation wasn't right back at the 15th Battalion. The battalion needed the medical coverage of a Delta there to support them during ranges and other training. Chief Jett fought to get me out there and fixed the medical situation by having another Delta come to the 15th Battalion to cover in my absence. As soon as I was told I was heading out, I starting packing and planning. Our 18-E (Special Forces Communications Sergeant), SSG Francis, had just switched with SSG Braun as the 18E at the FTX and Francis was back at the 15th. With SSG Francis feeding me information about the conditions, I was able to get an idea of what I could do as another Delta in the area. Day-to-day talks with SSG Squires about what they needed and what I could bring made packing easy as well. My own equipment, more medical supplies, more building supplies, and diet colas were needed to accomplish the mission.

On 5 June, I loaded the CH-47 Chinook helicopter with building supplies, medical supplies, and a few diet colas for the ODA. When we landed, I was greeted by my teammates on ATV's and Honduran soldiers guarding the helicopter-landing zone (HLZ). The HLZ was no more than a borrowed soccer field in front of the house where we would be staying. We unloaded the helicopter, secured the supplies to the ATVs, and drove across a dirt road to our home for the next few weeks. The building was a lifted wooden shotgun house with rooms that were meant for one person, but each had two or more people in them. Everyone had cots that the ODA obtained before the initial push into the village. The partner nation soldiers usually slept on the floor on sheets or whatever they could find on these types of missions and were extremely grateful to be off of the ground. The variety of food choices was limited, with beans and rice being the staple to every meal. Meat was a luxury and in short supply after the ODA and partner nation soldiers had finished off most the water buffalo they killed earlier. The water was being hand pumped from a natural well

on the property and purified using an Aspen Purification System. The Aspen provided clean and potable water for all the Soldiers in the house with plenty to spare for the Honduran soldiers who cooked. We stored the water in six to seven 5-gallon containers in the kitchen with a simple wash station and small table for storing utensils and plates. The kitchen/eating area was a circular hut outside and away from the house that kept the partner nation soldiers from carrying their food into house and attracting even more creatures from nature. Along with the rest of the supplies, I had brought a water pump for the well and piping to build an outdoor shower for the men that would provide a much needed boost for moral and hygiene for an already sweaty and mildly odoriferous group of men. The land around the house was not much over a half acre with a handmade barbwire fence around the perimeter. The ODA had built sandbag watch points for the guards and placed sandbags against the wall facing the only road in the area to increase the Force Protection (ForcePro) of the "compound." When the Soldiers weren't conducting training, they were enjoying themselves as anyone does in CENTAM, by playing *fútbol*. Soccer was a staple of any Latin culture, and the soldiers in the army took it just as seriously. After I got my equipment in order, I was spun up on the current events and training that was being conducted. SSG Squires briefed me on the medical capabilities of the area and possibilities to improve the situation in the future. We were hindered by the fact that no roads led to where we were training and the only infiltration platform was by air assets. After chow, the ODA sat down put out the training schedule with the Honduran Capitan, and they discussed ideas. We had planned events that would take up our week, but our FTX was about to turn into a real scenario in which every person, ODA and partner nation soldier, would execute their role without hesitation or question.

Case 4

On 9 June our day started with an uneventful buffalo hunt through knee-deep swampland and almost ended the same way. We were tired, wet, and hungry from trudging through difficult terrain, but we were somehow still in high spirits. We had left that morning with the sun coming up and returned to see it set. Food awaited us as we grabbed our plates to discuss the day's events and tomorrow's plans. We always had a short team meeting every night to make sure the training schedule was being met and everyone was on the same page. After the meeting, SSG Hare would call SFC Underwood to talk about the schedule and keep the team command in the know on a daily basis. It wasn't much longer after the evening phone call that we decided to crawl underneath our mosquito nets and listen to a symphony of insects. Silence was a luxury in our house as the walls crawled with natural fauna of the area. Everyone had mosquito nets with their cots, but the netting was no match for some of the mosquitoes. I had just gotten to sleep when I heard a phone ringing in the next room. Such things were normal, and I easily fell back into a deep sleep.

"Wake up Deltas! Get it on! We got a soldier shot up in town!"

2300: SSG Hare shouted from the room across the hall to alert the med shed, and we began donning our gear. Hare was woken by our partner nation capitan with an initial report that a Honduran naval sailor or soldier had been shot by a local in town. The Captain had made contacts and friends in the town to alert him in case of this type of situation. Quickly, the soldiers and ODA dressed and armed themselves, and separated into groups. SSG Braun had two Honduran soldiers on his ATV and would be the lead element into the town. Following closely behind were Hare and Squires with one partner nation soldier on another ATV. The last ATV had our captain and two other partner nation soldiers acting as security. Two partner nation soldiers and I remained at the house as a reserve element to receive casualties in the event that there was more than one.

2315: All three ATVs left the fence in a cloud of dust, and I began giving instructions to the Honduran soldiers on how we would conduct triage if the situation arose. I showed them the choke point where I would classify the patients, the different areas for the patients, and how to assist me if needed. We also discussed how to maintain security of the area in case civilians started approaching the wire to get a look at what was going on at our house. All of the information would prove moot for the moment as I started to hear an ATV coming down the road.

"LETS GO!!"

2335: SSG Braun found the injured individual lying in a village street with wounds sustained from the Honduran navy. While Braun began rendering care, Hare had returned to the compound to grab me to assist with the only casualty they found during the search. I jumped on the back of the ATV with Hare driving and telling me that at 2330, Braun found a 28-year old Hispanic male lying in the road with two other locals around the male. He then started working on the patient as he called for Squires on the radio to come to his position. SSG Braun, an 18E, was an EMT Intermediate as a civilian and had also received cross training from Deltas in Combat Lifesaver (CLS) and some TCCC. After ensuring security around him and donning gloves, Braun applied a Combat Application Tourniquet (CAT) to the left arm to stop the bleeding from one gunshot wound (GSW) near the brachial artery. He then applied a HyFin Chest Seal

to the left pectoral GSW and checked for a good seal. After doing this, he noticed blood from the abdomen and directed a Honduran soldier to apply direct pressure until one of the Deltas arrived with a proper abdominal dressing.

Figure 5 *Squires assesses airway while Reynolds preps to start IV*

2344: While I was still on the back of the ATV headed towards the action, Squires arrived and took over from Braun. SSG Squires put on gloves and began his assessment of the patient while Braun began pushing partner nation soldiers further out to ensure a greater security perimeter. SSG Squires began looking for life threatening hemorrhaging and found that the GSW to the left ring finger, left forearm GSW just distal and medial to the antecubital fossa (entrance), and a GSW distal to olecranon process (exit) were still slightly bleeding. He then applied another CAT more proximal to the previous tourniquet until all bleeding stopped. After this, he then marked on the patient's forehead and on the tourniquet the time of 2346. Checking for further signs of hemorrhage, Squires found the abdominal GSW in the left upper quadrant was not being adequately controlled with just the partner nation soldier's hands. He then applied an abdominal dressing to control the bleeding and continued his assessment. During this time, the patient's airway was not compromised as evidenced by the fact that the patient had been talking to the partner nation soldier and Squires. At this time, the decision was made to secure the patient to the Talon litter and move the patient. Utilizing an ODA trained medical assistant, Squires rolled the patient onto his side while the partner nation soldier maintained C-spine control. SSG Squires checked for downside wounds and rolled the patient back onto the litter. After assessing all interventions, they moved to patient on ATVs to the nearest clinic. After arriving, the patient was removed from the ATV and placed on the ground with the litter. The local doctor was called by the Honduran Capitan to come and open the clinic, but we would have to wait 20 minutes before he could arrive and open the doors of the clinic. This was about the time when Hare and I arrived on our ATV.

"Get these people back! Get the patient *inside!"*

0005: SSG Hare began asking the Delta for a status on the patient to be able to plan for transport. SSG Squires and I decided without surgical intervention, the patient would only have a few hours. The family's plan was to take a small boat down swamp and creeks at night, to a clinic five hours away. A family member was sent to the boat and found that the motor on the boat wasn't working. SSG Hare then told the Deltas he would arrange for medical evacuation (MEDEVAC) thru JTF-B. As I started exposing the patient and examining the extremities, Squires found the patient to be awake and oriented but complained of difficulty breathing. The language barrier was a challenge in itself. The language was something to Spanish like Cajun is to French. We could communicate efficiently but we had to use different words than we were taught in the classrooms. With the patient having difficulty breathing, SSG Squires gave the Honduran medic a bag valve mask and instructed the soldier how to clamp and assist breathing correctly. SSG Squires then began his head to toe assessment. He found nothing significant until the chest. He heard diminished breath sounds on the left with hyper resonance and unequal rise and fall. He then performed needle decompression at the second intercostal space, left mid-clavicular line with a 14-gauge needle (Figure 7). After 30–40 seconds, the patient said he felt better breathing for the time being. Vitals at this time were HR 85, RR 12 with assistance, BP 90/palp, with pulses slightly weakened, yet equal. I then started an IV with a 16-gauge cathlon and 1L 0.9% normal saline (NS) bolus wide open to stabilize his blood pressure (Figure 6). Immediately after I secured the IV, the clinic doors opened, and we moved the patient inside off of the street. We knew the clinic didn't have a lot as far as supplies go, and we would mainly be working out of our aid bags, but any little bit would help.

Both of us wanted to use Hextend to help stabilize our patient. *We had packed it in a separate truck back for the ATV's, but the bag was left at our house. Neither of us had Hextend in our personal bags so we continued using NS.*

0015: After placing the litter onto the table in the clinic, we immediately started reassessing all of our interventions. At this time, the ABD dressing was starting to show blood on the outer edges of the bandage and had shifted during transport. We removed the dressing and

Figure 6 *Squires continues assessment, Reynolds starts IV. It's important to remember that this total darkness without our head lamps, the flash of the camera gives a false sense of light around us.*

Figure 7 *Squires administering needle decompression inside the clinic.*

applied a new dressing while observing mild oozing of blood from the wound. Most likely, the patient's BP was rising to normal during fluid resuscitation, which would definitely be a positive sign for the patient.

0020: SSG Hare informed us that JTF-B was to awaken the MEDEVAC crew to possibly fly out and assist the ODA. The bird would arrive in 2.5 hours, so the decision was made to reduce the tourniquet to only a pressure dressing. We applied Combat Gauze™ to the wound and wrap an ACE™ bandage tightly around the gauze to maintain pressure. After assuring the pressure dressing on the left arm was in the correct position, the tourniquet was released and I slowly spun the dowel, relieving pressure, one quarter turn every 20 seconds. Not noticing any bleeding through the pressure dressing, the tourniquet was released and successfully converted. The bolus IV was changed to a 500cc 0.9% NS TKO, and a Foley Catheter was placed to monitor urine output. We received 150cc on the initial output, which was sufficient to let us know that his kidneys were still functioning. Vitals were stable, and we started pain management with Tramadol 100mg IM in the left hip at 0030 given by the doctor of the clinic.

Figure 8 *Hare coordinating air assets for MEDEVAC.*

"Where's our air?!"

0040–0300 hrs: Vitals were taken every 15 minutes by Squires or myself during our 30 minute rotations with the patient inside the clinic. At 0300, the patient began to have growing pain in his abdomen. We wanted to give the patient a longer lasting effect of pain management with 25mg promethazine IV from the bag, 15mg morphine IM, and 5mg diazepam IV from the bag. The pain resided, and the waiting game continued with JTF-B and our helicopter. SSG Hare was busy making sure we had a backup plan with State Department assets in case we needed them.

0315: We moved the patient from the clinic to a local's truck to transport to the HLZ in anticipation of our MEDEVAC landing soon. Right as we started to pull away from the clinic, Hare received word from JTF-B that they would not be flying to our location for numerous reasons. As we realized the MEDEVAC was not going to happen, the words of instructors from the Joint Special Operations Medical Training Center (JSOMTC) echoed through my head, "Men, pay attention to this. There will be a day when you, as Deltas, will have to sustain a patient for hours, possibly days; this is what separates you from any other medical professional in the military, so shut up and stay awake." We had heard

those words every time we started a new section of the Special Forces Medial Sergeants (SFMS) course. Now those words were staring right back at us in the form of the patient's friends and family. We looked at our patient in the back of that beat up truck and knew we could keep our patient alive. We had the knowledge and the equipment; we just didn't know how much longer we would have to sustain him. The ODA then received word from the State Department assets that they could support or MEDEVAC and would be landing at our location in two hours. We moved our patient to our compound and set up a secure perimeter around the HLZ (Figure 9).

Figure 9 *Squires assesses patient at our house, while Braun assists.*

0350: We changed IV fluid for another 500cc 0.9% NS TKO while monitoring urine output. With the fluid change and the patient's kidneys functioning, we then mixed and gave 1g cefazolin into the IV bag for preventive medicine. While the patient rested as much as he could, Squires continued to monitor and record vitals every 15 minutes while I prepped my bag to ride the bird with the patient.

"POP SMOKE!"

0530: SSG Braun and Hare had been running all night ensuring security and communications with higher. SSG Hare always seemed to be talking to someone at JTF-B, State Department, or Chief Jett. SSG Braun ensured communications never failed and made sure the Deltas had plenty of security around us at all times. Now we could start to relax and wait on the helicopters to land. The HLZ was fully secured and the family was saying goodbye to the patient before we pushed all civilians back another 50 meters from the soccer field. We received word that the bird was less than 10 minutes away as we finished final rehearsals with the partner nation soldiers. At 0540, we heard the bird over the horizon, which signaled Braun to throw red smoke so the pilots could confirm our HLZ. When the bird landed, I had the partner nation soldiers carry the litter to the helicopter and help me properly secure it. As we gained altitude, the patient's abdomen became painful again. To alleviate the pain, I taped one 800mcg transmucosal fentanyl applicator to the patient's right index finger, which reduced any pain the patient would have for the duration of the one hour flight. With the patient resting comfortably, I continued to monitor vitals every 15 minutes until we landed (Figure 10, 11).

Figure 10 *Securing patient to the helicopter.*

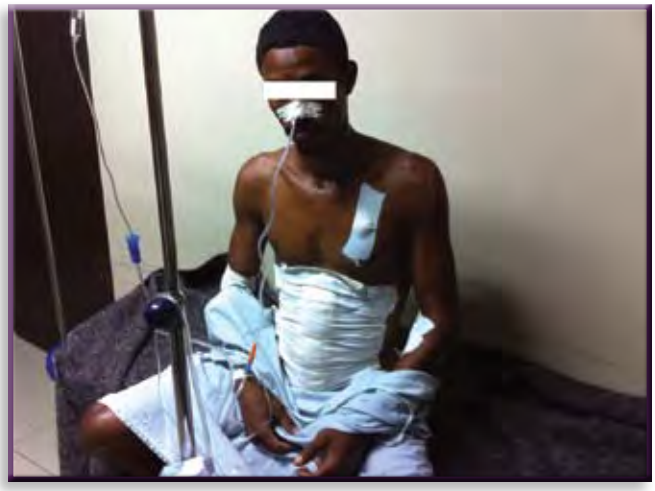
Figure 11 *Reynolds arrives at base to transport patient by partner nation military ambulance to local hospital.*

0640: We landed at the Honduran air base where there was a military ambulance and paramedic ready to take over with transportation. I then quickly briefed the paramedic on what had been done and handed over the

patient's flow sheet and personal information. As the ambulance drove off, the local command for the State Department and a member of JTF-B greeted me and offered me breakfast. I'll call that a good ending to a not-so-good night in the middle of the jungle.

The next morning, Chief Jett traveled to my location so we could both go visit the patient and see how his recovery was going. After tracking the patient down in the recovery room, we spoke to him about the night and its events. After hearing his story, I let him call his family from my phone to tell them he was doing well. Considering he had just had abdominal exploratory surgery and was able to walk, I'd say he was doing a lot better than the previous night. At the end of our conversation, he thanked the team and me for help we provided the previous night. He was extremely fortunate to have two 18Ds, experienced Operators, and Honduran soldiers that worked together to save his life (Figure 12).

Figure 12 *Patient after surgery*



After visiting with the patient and allowing him to talk to his family, I was flown back to our FTX to finish the exercise. Twelve days later the team left the FTX, on our own accord, by local supply barge from the town's dock at first light of day (Figure 13). What would have been a quick 8-hour ride was a 23-hour movement due to the ship stopping at every town along the coastline to drop off supplies to the people that needed them. We made the best out of the ride and enjoyed an occasional nap and took in the beautiful scenery around us. Upon arriving at the dock in the town near our battalion, we unloaded all of our equipment and personnel in the hours before dawn tired and wore down from the tossing ocean. After an amazing sleep it was back to work at the battalion. More training and work was to be done and no one expected a break. We did, after all, volunteer for our job.

Figure 13 *Boat training with Hare, Francis, Squires and partner nation soldiers and sailors.*

After arriving back at the 15th Battalion, we lost contact with the patient and his family. Unfortunately, I cannot give an accurate update on his health or quality of life. We hope for a speedy recovery for him.

The MEDEVAC that transpired in this story was not a glorification of 18Ds, but a timeline of an ODA and partner nation soldiers that worked together to accomplish something phenomenal. SSG Braun, an 18E Communications Sergeant, was the first person to apply life-saving interventions on the patient. By simply placing a tourniquet, he prevented life-sustaining red blood cells from being lost. By applying a chest seal, and ensuring it was correctly applied, he prevented a sucking chest wound. SSG Braun's willingness to learn, and his civilian medical training played a vital role in the saving of this patient's life. SSG Hare, an 18B Weapons Sergeant and NCOIC during the FTX, performed command and control (C2) like an experienced officer. It may have to do with the fact that he was once an Army Captain with the Transportation Corp before resigning his commission to become a Special Forces Operator. It was his coordination that led to a successful MEDEVAC, so the Deltas could focus on medicine and not logistics. The Honduran soldiers provided security, support, and translations when needed. They were happy to help save a life of a fellow Honduran, and we still hear the stories about how they did. The people involved at the State Department that allowed us to use their helicopters to evacuate our patient also saved a life. Sending the patient on a boat ride with zero medical support was the next option had the State Department not come through. Overall, this was a collaborative effort from everyone there, not just the Deltas. Honestly, it would've been a lot harder to accomplish without the help of my teammates (Figure 14).

Figure 14 *Exfil Day from our FTX*

Figure 15 *Assessment of Paraquidista on the drop zone.*

Case 5

On 17 July Squires and I were staged at Soto Cano for an airborne operation with Honduran *Paraquidistas* for a wing exchange. The day before and the day of the operation were your standard airborne days of fun, with weather briefs, refreshers, jumpers hit it, operational orders, and parachute landing falls. On 18 July the day of the jump, after Squires and myself had made our jump, we rallied with Chief Jett, who was the DZSO (Drop Zone Safety Officer), to help pull medical coverage with the Air Force medical personnel, TSgt Stanfield and SSgt Canfield. The next stick to jump came out of the CH-47 Chinook, chutes deployed, and we waited for them to land. Not 15 minutes after we jumped from the helicopter, we had a barely conscious 20-year old Honduran male being drug across the drop zone (DZ) by his parachute. We didn't know we had a patient until the Honduran soldiers around him start screaming, "Auxilio! Medico!" Squires and I jumped in a Gator ATV with the Air Force medics and our aid bags, which we had staged in the DZSO's truck, and headed to the patient donning our gloves enroute.

0910: We pulled up to the patient, saw no helicopters or jumpers overhead, no immediate life-threatening bleeding, and then assessed his level of consciousness and airway. We then asked one of the Air Force medics to maintain C-Spine control while we started our assessment. The patient was moaning slightly, but only responded to a sternum rub. He was breathing well on his own, but the decision was made to emplace nasopharyngeal airway (NPA). After no LaForte fractures were found, the NPA was measured and a attempt was made to insert it; however, the patient fought the two of us off. After a few attempts, we ceased and the rest of the assessment was conducted (Figure 15). Blood was found in the mouth with no threat to the airway. With the patient protecting his own airway, a C-Collar was placed on the patient with Canfield still maintaining C-spine control. I then began a head to toe assessment of the patient while Squires drew 15mg of diazepam to be given IM to calm the patient from struggling and possibly hurting himself or us. In order to properly restrain the patient from moving too much, three or four people at a time were holding his extremities. Abrasions were found on his head, most notably on his left temple. No battle signs or raccoon eyes were found, pupils were equal and reactive to light, and we continued to watch the blood in his mouth, but there seemed to be no active bleeding. Examining his ear canals, I saw no bleeding or bulging tympanic membranes.

0916: The diazepam was injected into the patient's right deltoid. His breath sounds were strong and clear. I found a possible rib fracture, but no flail chest. I assessed his abdomen while Squires was assessing the extremities and found no crepitus or grimace. We then had a third Delta come on scene to assist. SGT Wright immediately helped the ambulance back up safely to the patient and came with the backboard and straps for the patient. SGT Wright laid the equipment next to the patient and controlled the patient's legs while Canfield counted down to roll the patient. With the patient on his side, Squires and Wright moved the backboard into position. I then assessed the patient's back for obvious deformities, fractures, or blood. With no wounds found, we rolled the patient onto the backboard and immediately reassessed his airway and C-Collar (Figure 16).

0924: After being strapped to the board we lifted the patient into the ambulance and Canfield and Stanfield drove the patient to the Medical Element Station where the staff intubated the patient using rapid sequence

Figure 16 *Checking for injuries while rolling to backboard.*

intubation technique and took X-rays before preparing him to be flown to the hospital. He was flown to the city's Level One hospital for further treatment shortly afterwards. Our thoughts stay with the soldier and his family during what will be an intensive therapy and recovery period. His road ahead will be arduous and compounded greatly by his living conditions. We hope for the best in his days ahead.

I've heard that the patient was starting to recover at the hospital, but specifics on his condition were not made know. The Honduran officer that I spoke to seemed confident he would return to duty after the patient took time to properly recover and heal.

In closing, I'd like to add a few personal notes. The preceding accounts of ODA 2323 were a joint effort and I hope they have read as such. Nothing that the Deltas performed and accomplished would have been possible without the rest of the team and the Honduran soldiers. These were just a few of the stories that were note-worthy for publication during our CNT mission to CENTAM. Along with these stories, Squires and I performed many debridement of abscesses, stabilized and transported severe knee injuries, acted as first-responders to car accidents we saw while driving in country, sutured countless lacerations, treated local domesticated animals, and assisted the Honduran Air Force during their mass medical evaluations to impoverished towns. These were looked at as simply day-to-day tasks for Deltas. If any 18D read these stories, they should feel proud that the training conducted at the JSOMTC is still and will continue to be one of the best trauma schools in the world. I had the opportunity to meet and work with an extremely experienced and decorated Delta working with the State Department who jokingly called me a "glory hound" for having the chance to tell our story in this journal. He would say, "Hell man, all you did was the job you were trained to do," and in that regard, he was absolutely correct. I would never seek glory or accolades from my time here. No Special Forces Operator would ever want something for doing his job the way he was trained to do it. I only took this opportunity originally, to tell others of the great work of an entire ODA and partner nation soldiers that came together to accomplish something during our FTX that no one dared attempt since the 1980s. But with time, more work arose for us and I felt it would be a great addition to the FTX story. So yes, this is my way of getting the message out that other SF guys are working together in other areas of operations (AO) of the world and we're doing great things. Also, it is important to know that different agencies are working together to accomplish a common mission in an AO that is taken lightly as a deployment in the wake of two wars. I honestly feel like this team came to CENTAM and performed a classic Special Forces mission. The ODA members came together with a dozen Honduran Soldiers on many occasions and acted as a force multiplier. I can't wait to see what my future deployments and training opportunities have in store for me. Even though I'm still a new guy to the Special Forces culture and way of life, I know that with future teammates like I had on this team, I will learn so much more and take those experiences with me to hopefully become an even better Operator.

Special Thanks to ODA 2323

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SSG Steven Reynolds enlisted in the U.S. Army Reserves as a 92F Petroleum Supply Specialist and attended Basic Training at Fort Jackson, SC and AIT at Fort Lee, VA. In 2007, he transferred to Charlie Company, 2nd Battalion, 20th Special Forces Group (Airborne) for Special Forces Assessment and Selection (SFAS). He was selected from SFAS in November of 2008 and then graduated Airborne School in February of 2009. He graduated the Special Forces Qualification course in August 2011 and was attached to Charlie Company, 2nd Battalion, 20th Special Forces Group (Airborne) where he is still assigned. His first assignment was working with the Reserve Officer Training Corp (ROTC) at Mississippi State University as an assistant instructor until Jan 2012. He first deployment was to CENTAM with ODA 2323 as a Junior Special Forces Medical Sergeant.

SSG Austin Squires enlisted in the U.S. Army as a 68W Combat Medic and attended basic training at Fort Jackson SC, and AIT at Fort Sam Houston TX. He then attended Airborne school at Fort Benning, GA in 2007, and then went on for Special Forces Training. After graduation from the Special Forces Qualification Course SSG Squires went to 20th Special Forces Group 2nd Battalion (C) Company. His First SF assignment was as a Junior Special Forces Medical Sergeant for ODA 2235 that deployed to CENTAM. His second was as a Senior Special Forces Medical Sergeant for ODA 2323 deployed to CENTAM.