ALL IN THE NIGHT'S WORK— PEACETIME MILITARY SURGERY

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Introduction

IN the late summer of 1962 the 16th Independent Parachute Brigade Group spent eight weeks on Exercises in Greece culminating in the N.A.T.O. Exercise of FALL TRAP. By this time, the blissful summer weather had changed to unpredictable winds and dramatic downpours of rain. Despite this, the major part of the Brigade parachute-landed on a Dropping Zone (D.Z.) in the Strimon Valley. The Brigade Administrative Area was positioned about five miles from this D.Z. and the Advanced Dressing Station (A.D.S.) of 23 Parachute Field Ambulance was set up to deal with casualties. The Battalions, followed by Brigade Headquarters, moved on fast and were about 25 miles south of the A.D.S. 24 hours later.

With a far greater foresight that he can possibly have realised a Senior Staff Officer of Brigade Headquarters then called 23 Parachute Field Ambulance forward to a position just vacated by Brigade Headquarters. They arrived as dark was falling, at 19.30 hours approximately.

The Senior Staff Officer with a Staff Captain, some signallers, and driver, had just started to move forward to their new location. Having castigated an Umpire who was showing lights, they promptly drove off the track into a ravine about 10 feet deep. The Staff Captain clearly remembered hitting the ground and congratulating himself that he wasn't badly hurt when the Landrover crashed down on him and he momentarily lost consciousness. It also crushed the Senior Staff Officer but the signallers and driver were thrown clear.

In response to an urgent call for help, a Stretcher Landrover Team was sent from 23 Parachute Field Ambulance to the accident and with some considerable difficulty managed to get the Landrover off the injured.

Case Details

When they arrived at the A.D.S., where an Airborne shelter had quickly been set up for the Field Surgical Team and the back of a 3-tonner utilised as a Reception Ward, the patients were examined. The driver was found to be mildly concussed, and merely required bedding down for the night and reassuring. The Staff Captain, a big man, was moderately shocked and appeared to have a fractured clavicle, fractured ribs and possible injury of the cervical spine. The Senior Staff Officer was deeply shocked, with unrecordable pulse and blood pressure. He had pain in the lower part of his chest on the left side and the upper left abdomen, which was guarded. Bowel sounds could be heard in the chest and the heart sounds were almost inaudible.

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Provisional diagnosis of rupture of spleen or kidney and traumatic rupture of the diaphragm was made, and it was obvious that blood was needed in large quantities as quickly as possible.

In view of the need for a Transfusion Orderly, a Dental Coporal had been sent one year before to the Army Blood Transfusion Centre on a six-weeks course, as there is at present no official training course for Transfusion Orderlies. Here he learned the technique of cross-matching and had plenty of practice in taking and giving blood. He then went to the Birmingham Accident Hospital where he gained further experience. He was chosen because it was unlikely that he would be busy in the early part of an airborne action. All the men of the 16th Parachute Brigade Group wear identity tags on which their name and blood group are recorded; that is to say, all except the Senior Staff Officer who, being a Staff Officer, was not wearing a tag. (In all fairness it must be admitted that one of the authors, having complained about patients not wearing identity tags, found that he too had forgotten his). It speaks highly of the Dental Corporal that he had grouped the patient, found and bled a donor and cross-matched the blood within 30 minutes. In all, he produced a total of 7 pints which were given without transfusion reaction (Fig. 1).

The decision on where to operate on the patient presented an urgent and difficult problem. The alternatives were to operate with the Field Surgical Team equipment on the spot, or in the nearest suitable building; secondly, to get him to the Greek Military Hospital in Thessaloniki in the dark, either by air or by Landrover across the appalling mountain tracks, a total distance of about 50 miles; or, thirdly, to keep him in the A.D.S. until morning and then fly him by helicopter to Thessaloniki. The time was now 20.30 hours.

Because of the gravity of the injuries, it was decided to get him to Thessaloniki where the post-operative care could be more easily carried out. The S.M.O. therefore went to Brigade Headquarters to ascertain the possibility of air transport. Unfortunately, the helicopters were unable to cross the mountain ranges in the dark, but the Army Air Corps thought it was just possible that they could get a Beaver Light Aircraft off if the runway was lengthened. In a very short space of time 9 Independent Parachute Squadron, Royal Engineers, had begun to bulldoze the end of the landing strip. At the same time another Staff Captain with a Greek interpreter went to Rendina (Fig. 2) to phone Thessaloniki to warn them of the arrival of the patient and to arrange that a Greek ambulance should come to Rendina to meet the Stretcher Landrover if air transport should prove impossible.

As the air strip was in the opposite direction to Thessaloniki over difficult roads, the patient was kept at the A.D.S. pending a firm decision. When the pilot of the Beaver had decided that he could take the chance, fog came down from a nearby lake and made take-off impossible. As there was no guarantee that fog or bad weather would not ground all aircraft the following morning, if the patient was held until then, it was decided to press on by Landrover. As the facilities at the Greek Military Hospital were unknown, a convoy was made. The S.M.O., a Theatre Technician, two Nursing Orderlies and the Blood Transfusion Orderly travelled in the first Landrover; the patient and the Brigade Surgeon went in the second, and in the third were a further six blood donors. The 15 miles to Rendina were a nightmare—5 miles per hour

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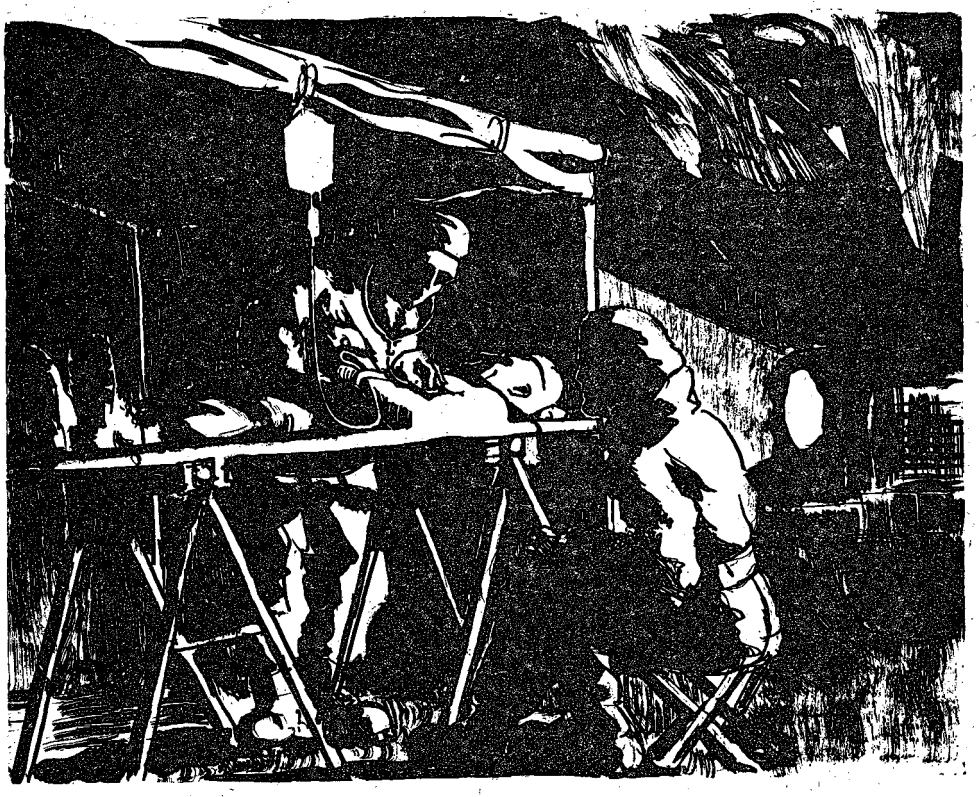

Figure 1.

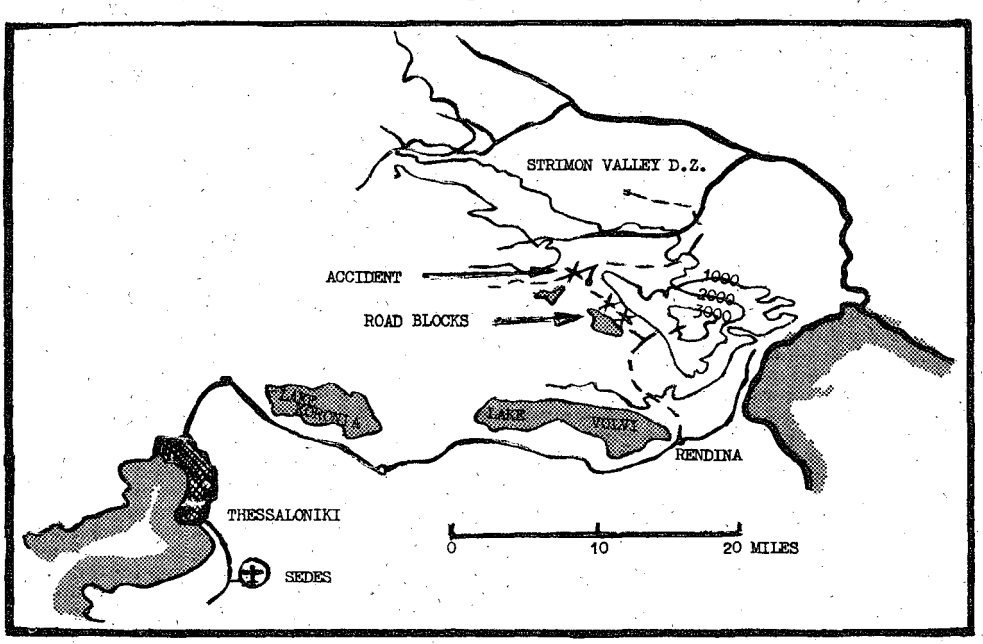

Figure 2.

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proved to be an absolute maximum for the patient, and stops had to be made to give further injections of morphia and to change the drip. It was therefore a great relief to be met by the Greek Army Ambulance a few miles before Rendina. After transferring the patient it was found that we could make about 15 miles an hour.

We then had a further problem of convincing the N.A.T.O. Exercise "enemy" that this was not a ruse to pass their road blocks, and on arrival at Rendina the Greek interpreter came on with us in the ambulance. The road from there was a good deal better and we were able to travel at 30 miles an hour. Conditions in the ambulance were very reasonable, but the open Landrover was bitterly cold and the occupants kept on falling asleep, including the driver, who several times nearly managed to reproduce the original accident.

The party arrived in the Greek Military Hospital at 06.30 hours to find that the Theatre Staff had been waiting since midnight. We were taken directly to the operating theatre suite where we were invited to start operating forthwith. However, once they realised that we wanted an opportunity for further examination and to plan what was required, we had our first experience of the almost unbelievable helpfulness of the Greek Medical Services.

The patient had travelled very well, but was obviously going to need more blood and the Transfusion Orderly got to work.

The guarding under the patient's left ribs made a ruptured spleen a strong possibility and when he asked for a urinal he passed almost pure blood, demonstrating also a ruptured kidney. X-rays were taken on an extremely efficient portable machine which can incidentally be packed for two men to carry complete. They showed that the patient had a fractured right clavicle, fractures of the 7th to 11th left ribs, that there were bowel coils in the chest lying in front of the heart, and subsequently an I.V.P. produced by the Senior Radiologist of the Hospital himself in about 20 minutes, demonstrated good function of both kidneys but with some blurring of the outline of the pelvis on the left side.

The Theatre had been put entirely at our disposal and as we were about to go in to start operating, the Senior Surgeon of the Greek Hospital arrived. He was also Commanding Officer of the Hospital. He proved to be a man with enormous experience of trauma from the Second World War, Albanian and Greek Civil War Campaigns. He spoke excellent English, and had spent two years in postgraduate study in England, including six months at the Cambridge Military Hospital. He again made us free of his Theatre, and assisted at the operation. The anaesthetic was given by a Greek anaesthetist.

The sense of unreality as we went into the Theatre came far more from lack of sleep for two nights than it did from the fact that everyone else in the Theatre spoke Greek and that we had never been there before. The Greek interpreter, in fact, was gowned and masked and brought into the Theatre to help out. It was his first experience in a Theatre and he had to leave on a couple of occasions when it got too much for him. But he was quite undefeated at the end, and a great help.

The operation was performed by the S.M.O. assisted by the Greek Surgeon and the Brigade Surgeon. Through a left paramedian incision a copious haemo-peritoneum was found and evacuated after a T-shaped extension of the incision had been made

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The spleen was found to be in three pieces and splenectomy was performed. A large retroperitoneal haematoma obscured the left kidney and the rupture of the diaphragm (5 inches in length) was closed without drainage with interrupted catgut mattress sutures. This tear, in fact, corresponded to the cardiac area of the diaphragm and the heart could be seen beating through the rent. The pleural cavities were not obviously opened. The patient withstood the operation well and was returned to the Ward with a good blood pressure.

At this time the injured Staff Captain arrived by helicopter. X-ray confirmed the fracture of the right collarbone, left acromio clavicular subluxation and fractures of the first four ribs on the right and of the right scapula.

After the operation, the two officers were nursed in the same ward by the Greek Military Nursing Sisters and by the two British Nursing Orderlies. The exceptionally high standard of the the Greek Nurses might have made the British Orderlies superfluous but they were, in fact, of great value in the simple matters of communication and in keeping records that could be understood in English.

It was at this time that we met the Greek Deputy Matron who took personal charge, not only of the patients, but of ourselves as well, insisting on making a room for us to sleep in the Hospital and providing food for us on a very lavish scale in the Nurses Home. She had served with the Americans in Korea, and her command of English was of great value in dealing with prescriptions of dangerous drugs.

The post-operative course of the patient was complicated by five days paralytic ileus, consequent on the retroperitoneal haematoma and other brusing actually in the bowel wall itself. However, once this settled the patient improved very rapidly. During this stage every facility was given to us and when the patient developed a traumatic pericarditis the day after operation, a Cardiologist and E.C.G. machine was immediately made available as also were check X-rays, biochemistry and haematology as often as we wanted.

By the 10th day it was considered that the patient was fit to travel back to the United Kingdom.

In passing, one might say that it should not be imagined that all personnel were crowded around the sick bed 24 hours a day. The Greeks, in fact, extended their hospitality outside duty hours and floods of most kind invitations came in so that we found ourselves entertained to dinner almost every night.

For the return journey, no direct aircraft was available but the R.A.F. arranged that an empty Britannia should fly from the United Kingdom to pick up the patient and medical party and fly from Thessaloniki to Larissa to load men and equipment of the Brigade at Larissa and from there fly to Lyneham. A farewell party from the Greek Military Hospital, including the Commanding Officer, the Matron and the Assistant Matron came the ten miles to the Airport to see us off and insisted on giving us farewell presents in spite of their already quite overpowering hospitality.

The journey was very smooth and the patient experienced no discomfort. At Lyneham the patient was transferred by forklift truck directly from the Britannia to a helicopter, the helicopter landing close to the Cambridge Military Hospital. It might be mentioned here that helicopters were absolutely invaluable for casualty evacuation of some 50 patients during these Exercises.

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Conclusion

The patient was allowed home after two days, convalescence being complicated only by a mild persistent pyrexia which settled in about two weeks. Repeat pyelogram showed normal function of both kidneys; and following two weeks at the R.A.F. Rehabilitation Unit at Headley Court and an indulgence passage to Cyprus for a further two weeks where his wife put him through a rehabilitation course a good deal stiffer than even that of the R.A.F., he has now returned to full duties and has parachuted since.

The Staff Captain also made a good recovery benefitting enormously from his stay at the R.A.F. Rehabilitation Centre at Headly Court, and is now back to full duty.

Summary

Some points arising out of this experience are: firstly, as has already been mentioned and cannot be mentioned too often, the extremely high standard of medical care and co-operation received from the Greek Medical Staff which we would find ourselves hard pressed to emulate if positions were reversed. Secondly, the need for properly trained Transfusion Orderlies for Field Units. Thirdly, the value of having all personnel blood grouped, the blood group on tags which are on the patient and a record of these groups readily available in the Field Ambulance so that donors may be requested. Fourthly, if it had not proved possible to evacuate the patient, the equipment of the Field Surgical Team would have been adequate for the job, but the difficulty of post-operative nursing emphasises the need for fully trained Nursing Orderlies in Field Units, and the advisability of having Q.A. Sisters must be considered even for air-borne units.

Acknowledgments

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