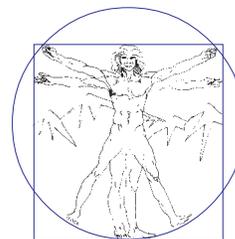


the Wilderness Medicine Training Center

www.WildMedCenter.com



Institutional Guidelines for Establishing Wilderness Protocols

For the purpose of this document “Wilderness Protocols” are defined as any protocols outside the traditional EMS curriculum but supported by position papers published by the National Association of EMS Physicians (NAEMSP)^{1,4,5} and the practice guidelines published by the Wilderness Medical Society (WMS)². They will likely include but are not limited to:

- use of prescription drugs, herbs, and OTC drugs
- field management and clearing of spine injuries
- wound cleaning
- treatment of impaled objects
- field management and evacuation guidelines for specific environmental injuries
- field management and evacuation guidelines for specific traumatic injuries
- field management and evacuation guidelines for specific medical problems
- CPR protocols
- specific treatment of preexisting conditions (e.g.: asthma, diabetes, etc.)

In conjunction with their physician advisor each institution should establish written wilderness protocols to act as guidelines for the field management of trauma, environmental, and medical problems. The protocols should define when they should be used based on the timeliness of conventional EMS response. Wilderness Protocols are usually in effect when a group is longer than one hour from definitive care (with the exception of immediately life-threatening situations: e.g.: severe asthma, anaphylaxis, etc.) Institutions should also develop a first aid kit designed to support their guidelines and staff should be trained in the use of the kit contents on a regular basis. The use of weatherproof Patient SOAP Notes for documentation is highly encouraged.

We recommend that institutions and their physician advisors review the NAEMSP position papers and the WMS practice guidelines and amend them to the needs of their program(s). Institutions should consider adopting the following general guidelines for staff trained to the Wilderness First Responder Level (WFR):

- administration of 0.3 cc 1/1000 epinephrine by SQ/IM injection (Rx) and subsequent oral antihistamine at the first sign of a systemic allergic reaction in an adult (standard pediatric dose is 0.15 cc or 0.01 mg/kg) Subsequent injections are indicated if: the S/Sx increase after the last injection or S/Sx do not resolve within fifteen minutes of the last injection. Oral antihistamines should be kept current for 24 hours.¹
- field management and clearing of spine injuries as described by Peter Goth, MD and George Garnett, MD in: Spine Injury: Clinical Criteria for Assessment and Management, WMS, and NAEMSP guidelines.^{1,3,5}

- aggressive pressure flushing of full thickness wounds with “drinkable” water followed by protection with a dry dressing. Wounds at high risk of developing an infection may also be flushed with an antimicrobial solution depending on physician advisor preferences. Deep, highly contaminated wounds may be wet packed with the same solution, splinted, and evacuated; do NOT close high risk wounds. Evacuate all wounds with underlying damage to deep structures (bone, tendons, ligaments, cartilage).^{1,2}
- impaled objects should be removed in the field if they will interfere with safe transport and will cause additional damage if left in place. Removal should be easily accomplished and safe (e.g.: will not cause undue additional damage). The wound should then be cleaned as above.¹
- simple dislocations of the shoulder, patella, and digits (resulting from indirect trauma) should be reduced in the field according to NAEMSP and WMS guidelines.^{1,2}
- CPR should NOT be started in the field according to NAEMSP & WMS guidelines.^{1,4} CPR may be discontinued if the patient remains pulseless for 30 minutes.^{1,2} Hypothermia protocols should be clearly spelled out.
- as per the 1997 Guidelines for the Diagnosis and Management of Asthma: Expert Panel Report II severe asthma should be treated with 0.3 cc 1/1000 epinephrine by SQ/IM injection (Rx) and oral corticosteroid (e.g.: 40-60 mg prednisone PO). Repeat prn q 15-20 minutes for a total of three doses.

Authorization should be in the form of a written document that clearly identifies:

1. the sponsoring organization (e.g.: outfitter, schools, institution, club, etc. name).
2. brief summary of the purpose: standard EMS training is based on immediate access, assessment, and transport via 911 communications. This level of training and subsequent scope of practice does not address the special considerations required in a wilderness/remote environment where delayed transport, prolonged exposure to severe environments, and limited medical equipment are the norm.
3. who is authorized to use the protocols (currently certified WEMT, WFR, WAFA, etc.) and from what providers
4. each individual protocol (e.g.: acute allergic reactions, spine clearing, etc.). Each protocol should briefly identify the problem and specify signs, symptoms, and treatment (including evacuation). Ideally the protocols should be referenced to the providers original course text, handbook, etc.
5. the medical director/consulting physician who is authorizing the treatment, their license number, and date.

References

1. Forgey, W.W.: **Wilderness Medical Society Practice Guidelines**, Merrillville, ICS Books, c1995, 2001.
2. Goth, Peter and Garnett, George: **Clinical Guidelines for Delayed or Prolonged Transport**, Lenexa, National Association of EMS Physicians, c1991-1993
3. Goth, Peter: **Spine Injury: Clinical Criteria for Assessment and Management**, Augusta, Medical Care Development, Inc., c1994.
4. Hopson, Laura R. et al: **Guidelines for Withholding or Termination of Resuscitation in Prehospital Traumatic Cardiopulmonary Arrest**, NAEMSP Position Paper, c2002
5. Domeier, Robert M., **Indications for Prehospital Spinal Immobilization**, NAEMSP Position Paper, c1999