Senior Visiting Surgeon Program: AAST/ACS 2006-2007
Overview: Summer 2006
C. William Schwab, M.D.

Key Phone numbers (cells):

Warren Dorlac, Chief: 0162 271 0857

Ray Fang, MD. Major, MC, USAF: 0162 297 1132

Landstuhl Regional Medical Center (LRMC): Largest military hospital outside US. It is an ARMY hospital staffed jointly by the Air Force and Army with doctors and nurses. It sits on the top of a hill and is a beautiful campus about two miles from Ramstein AF base, a huge and critical American base.

The hospital has all specialties except some of the ultra specialists. No CT or vascular surgeons at present but covered by Tra and SCC group. Has one NS for three months, reservist from Houston. Great orthopaedic group and all others, ENT, GU, ophthalmology, plastic, etc. Has all medical specialists, including Pul/Crit care that are your partners in the critical care unit. One large ICU that is multidisciplinary and quite good in all dimensions. Good nursing and tech support. Good lab and radiology. NO IR capability. Computers everywhere, but you need security card log on, which I did not have. (A must in the future.) OR good, very accessible and well equipped. People are pleasant, dedicated and know the mission. They are very good at receiving, stabilizing, and transiently managing many hideous wounds, blast injury, and fragmentation injury.

Main thrust and mission is to stabilize and begin definitive care on all troops coming from Iraq and Afghanistan. They come in waves and it varies from zero to a dozen a day. Some very severely wounded.

Most have been operated on "in country" or "down range" by various forward surgical teams and these teams are US and NATO surgeons, who are well trained and equipped. The FAS or CAS (forward surgical teams) do damage control or minimal acceptable care type surgery. Patients then transferred to Balah and have more definitive surgical procedures a day (or two) of critical care and then evacuated to LRMC. Balah has vascular surgeons, neurosurgeons, and critical care teams. All appear excellent. Most on arrival at LRMC get redebridement and ortho stabilization. The surgeons at LRMC are excellent at this and show great judgment in who needs what and when. The patients are in LRMC for 3-5 days before flying home to large military medical centers at Walter Reed, Bethesda, Wilford Hall, etc. They are flown in and out by the CCATC or critical care transport teams. These are ICU doctor, nurse, RT and medics…superb and a great concept. The can fly many patients and up to three on full ventilation with drips, etc. During the phase from Iraq, these patients can be unstable and literally hours from wounding and operation (but most are in Balad for a day).

Information from the various forward medical units and teams is better coordinated than ever and comes via computer system (JEPTA) and conventional copies of charts. Some info is complete

and very detailed. Some is not. X-rays', including CT scans can be acquired from down range but requires radiology to do this if not initiated by Balad or the hospital in Baghdad. This acquisition of info and x-rays is frustrating for all, but the docs, nurses and techs work hard (and at times long) to get it. With two or three previous major interventions at different sites prior to arrival at LRMC you can imagine how difficult but necessary this becomes. I gave the analogy that the surgeons at LRMC must solve a very complex jigsaw puzzle quickly and be ready to proceed with their part. The surgeons who have been at Landstuhl for a while get good at this and the senior staff is excellent with knowing the environments and capabilities of the forward areas and appear to be very accurate at their solving the individual patient's "puzzle."

Care is comprehensive. Many patients, dominantly US, but all NATO troops, with illnesses or wounds come through Landstuhl. Besides the physical care, there is great emphasis put on hygiene, family communication, planning and coordination with the home unit, the transport teams and receiving medical center in the US. In general, all this is done in less than 24 hours and occurs 7 days a week. The compassion for these soldiers is truly amazing. Most stay 48-72 hours but some are too sick to move, so they require intensive care, multiple operations, etc. At each step, families are informed and if the patient must stay longer than 72 hours, the family is flown over and there are two "McDonald Houses" on base for them. Great system.

Cleanliness, cleaning, neatness is the SOP, and they are serious about it everywhere. Not just the military thing, but the hospital, staff and patients are spotless. Hand washing and protective gear is enforced. This is good as the troops are colonized with Actinobactor in country and that bug is the most common pulmonary and systemic infection seen. It is virulent and aggressive.

1. <u>Medical Center:</u>

Large full service hospital functions as an excellent American "Level II trauma center" with the key surgeons being GS/Tra and SCC trained team of 5-7 surgeons. Total complement is 9, but never have the full number. When busy, this low number hurts them.

Lots of turnover and some come for short rotations. It takes some experience to get good at this unique job of providing critical, surgical and intensive care for a short but crucial period on their way to definitive and reconstructive care in the US.

<u>Staff</u>: (SEE ATTACHMENT (D) FOR PHONE NUMBERS)

- Warren Dorlac, LTC: Chief of Trauma -- has been at LRMC for two years. Tra and SCC; Wife, Gina, a Pul/Crit Care doc, and the med director of the ICU.
- Bob Benjamin, Major: Vice Chief, USA -- due to rotate to USA in September, Tra and SCC
- Ray Fang, Major: your host, Tra and SCC.
- Valerie Pruitt, Major: Tra and SCC.
- Richard Standdaerd, LTC: Head of Gen Surgery.

- Steve Flaratey, Tra and SCC trained – new, arriving in Aug/Sept?

- Richard Wigle, gen surg, does clinic a great deal.

- *The above group covers all trauma and ICU gen surg and trauma admits, ops, care and disposition. ICU covered daily with in house 24hrs call. These surgeons do 3 days, fourth day, Pulmonary (below) in house with surgeon on backup.*

- Pulmonary Partners: *Kevin Kumke, Dorlac G, Marco and Vazquez-Torres: all very good in unit 7 days at a time, from Wed-Wed, present daily and in house q 4, with surgeon as back up (see above).*

Nurses: many including military, civilian contractors and German contractors. In the ICU and OR they appear excellent. Lots of turnover.

2. **Landstuhl-The hospital**: Cafeteria, bank, Internet café, Burger King, Subway, Dry cleaners, and small store like a 7-11. Dollars work through out all military bases. Prices on base are cheap. Be careful of the times these things are open as once they're closed in the early evening, there is nothing.

3. **Living Quarters:** Ramstein Inn about 250 feet from front door of hospital. Clean and has a kitchenette, private bath. Front desk has everything and lots of info. Room has TV and supposed to have DVD, mine did not.

Dress: everything is informal, and I wore scrubs and lab coat daily. New scrubs from OR, men's locker room are available and switch out daily as there is little air-conditioning and you sweat. After hospital, very informal and folks in restaurants have open color shirts and shorts. Better restaurants: long pants, chinos, jeans, etc. Never saw a tie or sports coat. Suggest informal clothes, most days wear scrubs. Bring lab coats.

Great gym about a quarter mile walk from INN and hospital; great hiking and running paths in area, ask desk.

4. **Patients:**

TYPES AND LOAD: Trauma Registry for 2006 to mid July shows:

760 admits from down range (air evacs).

220 ICU and critical, almost all require an operation within 12-24 hours.

Burns: usually huge BSA and inhalation will turn out to be the sickest patients due to explosive nature lung injury and BSB.

Registry is more demographic than traditional trauma data set (home grown in origin) but reveals:

Key complications from down range are: compartment syndromes (extremity), most released in country but continue to swell in air-evac. Fasciotomy extensions and new fasciotomies are frequent.

Wound "infections": SOP is to redebride and irrigate all wounds coming out of Iraq.

Actinobacter is principle pathogen, all sites, especially VAP.

5. Staffing:

Planes arrive daily and most days the surgeons get 3-6 for ICU and the same for admission to surgical wards. Some days nothing comes in. It all depends on the action down range.

General and Trauma/SCC surgeons rotate staffing the general surgical wards with ICU/trauma coverage surgeon assigned per seven-day period to manage all the non-ICU general surgery patients This can be huge and this surgeon is very busy with all surgical emergencies, admissions, etc. NO resident, one PA, Kelley she is good.

The Trauma/SCC surgeons and Pulmonary Critical Care physicians co-staff the ICU service on a daily 24-hour basis. One each per 24 hours. The division of labor and who does what is understood and the surgeons are in charge of patient care ultimately, but this issue never came up. When multiples came in, they divided up the patients using previous information and rapid on site triage. Surgical issues were identified by the pulmonary specialist and rapidly brought to everyone's attention. The specialists in surgery are in and consulting as soon as you ask them and the OR is available as needed, 24/7. Good system.

Residents from Brook Army Hospital are on the ICU for a one-month rotation. They are senior INT Medicine residents and are very motivated and good. Teach them as they are sponges and most took the rotation to learn about trauma and intensive care of the trauma patient. They do all or most of the paper work.

6. Orientation:

a. Getting Started: Everyone is busy and the surgeons have little to no support staff. One PA for the non-ICU services. No secretary. Trauma support people, like TPC do your orders and disbursements. This needs to be overseen and assured by SVS.

b. Pre-Arrival: It is important and vital to send Ray Fang a copy of your passport and accurate dates of your stay. He will get you on a list of civilians that can come on and off base with a valid passport. In addition, Ray will oversee the process to get you two IDs. One hospital (easy), and the other, Military, and this can only be obtained at a neighboring base with limited hours. You will need your orders, provided by Landstuhl and you should receive before traveling.

You need a list of key phone numbers, and they need yours. I would strongly suggest an American cell with European coverage or global cell. My Cingular

system with global coverage worked fine. Once at Landstuhl, they should provide a "local" cell phone, so you can easily communicate with all. They did not have this for me.

c. Arrival:

Fly into Frankfort and arrange a ride to LRMC, about 90 minutes. A surgeon from LRMC may pick you up, but there are shuttles directly to the base that can be arranged and be waiting for you as you clear customs. DECIDE before leaving and arrange through Ray Fang.

You will need a passport for everything.

On BASE: Need an ID for hospital and another for the base, and as neither is military ID, you are still at a disadvantage. For example, hospital Bank will convert dollars to Euros but will not cash even a traveler's check without a military ID. If you are there any longer than 2 weeks push them to get you computer security clearance.

You need to learn a few things fast: how to come into hospital; front door has elevators to ICU and OR and they are key for 90% plus of your time and activity are there. ED is close to front door, but almost all patients arrive from air-evac to ICU. Cafeteria and fast food, Internet café on first or ground floor, but hospital is sprawling, so check a map (See Attachments). Hours of cafeteria are limited, so pay attention and on weekends everything is more limited.

d. Daily Rhythm:

Each morning before 7:00 am, the ICU and hospital get a complete manifest of the arriving patients from all sites, most commonly Balah, but at times from Afghanistan, etc. Arriving patients have a description form and the computer system for info (JEPTA) is accessed and summaries created. IF there are residents from the states, they do this. These are reviewed and plans made. Rounds start at 8am M-F, 9am S,S. Rounds can take 60-90 minutes and can be as academic as you make them. The staff wants this and need it. Post rounds work in ICU, cases, find the surgeon covering floor service and check with them to see if they need or want help.

Working with staff surgeons and Trauma support people individually was a daily thing and they seek your input.

I suggested weekly seminar type meetings for PI reviews, review and discussions of topics and controversies. They need this.

The difficult cases and deaths are very tough on all hospital staff as these are young healthy people in the service of our country. The staff and surgeons always feel inadequate and at fault when a death occurs (they are frequent secondary to

the extensive injury and wounds) and they can use our help to validate their good care and approach.

Evenings are up to you and if there are things going on, it is best to stay and help, especially if they have received multiple ICU wounded as these will need trips to OR and things we don't normally see or do at a civilian TC.

City of Landstuhl:

The town of Landstuhl is about a mile down the hill walk and is beautiful. Because of the long and big presence of the American military, almost everyone speaks English, and is not annoyed by American behavior, though Americans really respect the German culture and way of life when in the country. Good restaurants and shops.

Landstuhl the city, is about a mile walk down the hill, exited by gate at front of hospital. Walk up is great cardiovascular workout. Learn how as this is your passage to the civilian world if you don't have a car. Cabs are usually at this gate to take you down and easy to get in town as most restaurants will call and they are prompt. Have Euros.

ATTACHMENTS

A – Hospital Map

B - Base Map

C – Airport Shuttle Services

D – Mock Call Schedule Phone Numbers