

Commentary on Soldiers injured during the Falklands Campaign 1982- sepsis in soft tissue limb wounds

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The major cause of preventable death in war-time has always been infection (1). One of the greatest medical lessons learnt in WW II was the prophylactic use of penicillin in the surgical units closest to the front (2). In the jungles of Burma, soldiers carried their own antibiotic tablets. Medical corpsmen gave antibiotics at point of wounding in Korea (3). In this small but significant series, there were no septic limb complications when antibiotics were administered within 3 hours of wounding. Septic wounds resulted in 7 of 9 cases where antibiotic administration was delayed beyond 6 hours(4).

These simple yet important clinical observations were borne out by later experimental work at Porton Down: Intramuscular administration of Benzylpenicillin, begun within 1 hour of wounding, was effective in preventing streptococcal infections in a pig model of fragment wounds. When this administration was delayed until 6 hours after wounding, the medication was not effective (5).

Two thirds of all war wounds are in the extremities and most are not immediately fatal(6). Yet we repeatedly forget the lessons of history and thus the eminently preventable morbidity and mortality associated with these complex open limb wounds still occurs. The US Military have recently (re)introduced a combat pill pack containing oral Moxifloxacin for pre-hospital

self-administration in the field by the wounded soldier (7). Current UK military practice mandates iv Benzylpenicillin and Flucloxacillin on arrival at Role 2 for extremity wounds and iv Cefuroxime and Metronidazole for cavity wounds (8). These guidelines should still be followed pending a review of the available evidence.

References

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