

NOLS WILDERNESS MEDICINE

Curriculum Updates for WFR Recertification Courses

December 2018

Medicine is dynamic. We stay abreast of changes in practices and knowledge, and regularly update our curriculum. These are summaries of recent updates. NOLS Wilderness Medicine Curriculum Updates and resources are available at: <https://www.nols.edu/en/resources/wilderness-medicine-resources/>.

Narcan (June 2018)

We're adding Narcan to the WFR curriculum. The epidemic of opioid overdose should be familiar to all. Reports of incidents in wilderness are rare (but not zero). Narcan, like the AED, is also a valuable skill for us in our urban lives. Narcan, commonly administered via intranasal spray (2.0 - 4.0 mg per spray), is a narcotic antagonist which blocks narcotic effects by occupying, without activating, narcotic receptor sites. The duration of action is 30-90 minutes. It is used for the reversal of narcotic effects such as unresponsiveness/altered mental status, especially respiratory depression, due to known or suspected overdose of narcotic drugs. is used to reverse narcotic effects, especially respiratory depression, due to overdose of narcotic drugs.

All fifty states have passed laws to increase access to Narcan (naloxone) and to legally protect people such as first responders, family and friends, police officers and others who administer it. Narcan remains Rx in the USA, however, you can walk into most pharmacies and request Narcan without a prescription.

Drowning (January 2018)

Drowning is a hypoxic brain problem (requiring oxygenation starting on scene). The focus on treatment is to reverse hypoxia with ABC CPR (not CAB). Use rescue breathing and if available, oxygen. Remove water and vomit from the airway as needed (likely from the stomach). Expect it. Do not spend time removing white foam from the upper airway (likely from the lungs). Ventilate through the foam.

Consider protecting the spine *only* if there is a clear spine injury MOI. Treat for hypothermia. Monitor In a non-fatal drowning, onset of respiratory signs & symptoms is usually within six hours. Monitor for wet lung sounds, productive cough, rapid shallow ventilations, cyanosis, substernal burning, inability to take a deep breath, irregular and/or depressed heart rate, or decreased level of responsiveness

Rhabdomyolysis (January 2019)

Rhabdomyolysis (aka rhabdo) is a breakdown of muscles that dumps cellular contents into the blood and affects, among many organs, the kidneys. It's rare (or at least rarely reported from the wilderness) but people such as endurance athletes and wildland firefighters are more at risk). It has many causes, but for wilderness medicine the context is likely strenuous exercise in heat and with dehydration. It's hard to diagnose as it looks like heat illness, but dark brown urine and muscle soreness should make us suspicious. It's treated with hydration and evacuation.

Thrombolytics in Frostbite (September 2018)

Thrombolytics (clot dissolving medications) have a role in the treatment of severe frostbite in restoring circulation after the injury has been thawed. This hospital based treatment is time sensitive, the sooner it is started the better, so evacuation of thawed severe frostbite should be as soon as possible.

No more RICE (December 2017)

We no longer teach RICE as a treatment for musculoskeletal injury. Resting an injury makes sense in the short term evacuation context, but modern approaches to rehabilitation include early and judicious use of an injury. Ice is helpful as a short term OTC pain management tool, and we will continue to advise for its use in that context. We don't advise long term use of ice to suppress swelling, as this likely interferes with healing. There is no evidence that compression aids in healing. Elevation has limited usefulness, mostly to prevent throbbing pain that will interfere with sleep.

We are replacing RICE with the concept of managing the pain of a musculoskeletal injury with support through tape, braces or splints, short term ice as a non-pharmaceutical topical pain management tool, elevation to reduce throbbing and allow sleep and OTC pain management.

Syncope/Fainting (December 2017)

Syncope (fainting) is a brief loss of postural tone followed by a spontaneous and complete recovery. It is often caused by a decreased blood flow to the brain, usually from low blood pressure. It may be due to severe pain, strong emotion, urination, defecation, vomiting, swallowing, or carotid sinus stimulation. Syncope may also be a sign of underlying disease, especially if symptoms do not resolve.

The patient may report prodromal symptoms such as dizziness, vision changes, warmth, light headedness. A fainting episode may be accompanied by twitching or seizure-like activity, which is not a seizure.

Treatment is to lay the patient flat, elevate the legs, make the patient comfortable (shade, out of the cold, etc.) and to complete a PAS. Assess for residual signs and symptoms.

Most syncope is benign and resolves promptly without further symptoms. Sometimes syncope suggests an underlying medical problem and in these cases this patient should be evacuated. We want to evac syncope that occurs during exertion; that occurs without the presence of prodromal symptoms such as dizziness, light-headedness, pallor, diaphoresis, vision changes; and where there are residual signs and symptoms. Rapidly evacuate all events of syncope that are accompanied by chest pain, headache, SOB, abdominal pain, known pregnancy, or with signs and symptoms of shock.

Pain Management (February 2016)

Pain management reduces both physical and psychological stress. It helps support as comfortable an evacuation as possible. Inadequate pain management may cause a significant stress response as well as an increase in the risk of developing posttraumatic stress disorder. Patients may also become increasingly sensitive to painful stimuli the longer pain remains uncontrolled, making their pain more difficult to control.

Our pain management principles for the lay provider in the wilderness

Comfort Care

Simple techniques, such as using the patient's name, attending to basic needs such as hygiene, warmth, food and hydration, allowing the patient to place themselves in a position of comfort, as well as keeping the patient informed and involved in their care can be comforting, decrease anxiety and improve the patient's perception of pain.

Injury Management

Protection from further injury and providing stability in the form of taping, bracing, or splinting is an essential pain management tool.

Ice and elevation

Cooling the area with ice for 20-40 minutes may help manage pain; may continue ice every 2-4 hours or after use. Ice can decrease skin temperature to the point where nerve conduction is inhibited and pain decreases and can be an effective non-pharmacological pain intervention. Raising the injury above the patient's heart may reduce throbbing and allow for rest.

Medications (oral, non-opioid, non-prescription)

The combination of a non-steroidal anti-inflammatory (NSAID) medication with acetaminophen has been demonstrated in a number of studies to provide superior pain control to either drug alone or in combination with an oral narcotic. There are a number of sequences of acetaminophen and ibuprofen recommended in the medical literature. Our sequence is chosen because it is easy to remember and avoids exceeding the maximum daily dose: 1000mg acetaminophen every 8 hours administered with 800mg ibuprofen every 8 hours. This gives daily doses of 3000 mg and 2400 mg respectively. This is for short term use during evacuation. These medications are not benign. As always, review the 5 rights of medication use before suggesting a medication to a patient.