

OTOLARYNGOLOGY/HEAD AND NECK SURGERY COMBAT CASUALTY CARE IN OPERATION IRAQI FREEDOM AND OPERATION ENDURING FREEDOM

Section I: History and Recollections



First Operation Iraqi Freedom theater ear-nose-throat (ENT) clinic sign, Balad Air Base, Iraq (September 2004).

Photograph: Courtesy of Colonel Joseph A. Brennan.

Chapter 1

HISTORY OF DEPLOYED ARMY OTOLARYNGOLOGISTS IN OPERATION IRAQI FREEDOM AND OPERATION ENDURING FREEDOM

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INTRODUCTION

During the past 12 years, military otolaryngologists/head and neck (H/N) surgeons have served in the combat zones of Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF), saving countless lives. The US Army deployed the first otolaryngologists in support of combat operations in OIF and OEF. Army otolaryngologists immediately became significantly involved in operations, setting a pre-

cedent for participation in administrative, leadership, and clinical roles that continued for otolaryngologists of all branches throughout both OIF and OEF. In late 2004, the Air Force deployed otolaryngologists when the first Air Force theater hospital in Balad, Iraq, was established that September. The clinical deployment of both Army and Air Force otolaryngologists continues as of the publication date of this text.

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The story of Army otolaryngology during OIF and OEF is intertwined with that of Air Force otolaryngology, particularly during the early stages of OIF. Similar to the story of Air Force otolaryngology told in Chapter 2, the diligent work of senior Army otolaryngologists during the early phases of OIF demonstrated the critical and life-saving skills brought by otolaryngologists to the care of combat casualties. As the wars unfolded, Army otolaryngologists played significant and innovative roles in clinical care, medical leadership, and wartime medical research.

The first US Army (and first US military) otolaryngologist to be deployed in support of OIF and OEF was Colonel Richard W “Tom” Thomas. He served as division surgeon for the 101st Airborne Division, deploying to Afghanistan in 2002 and Iraq with the initial invasion forces under then-Major General David Petraeus in 2003. Lieutenant Colonel Doug Liening, another Army otolaryngologist, commanded the 21st Combat Support Hospital (CSH) in Iraq during the early days of OIF. In 2003 and 2004, Colonel Thomas again deployed in support of OIF as commander of the 47th CSH, the largest and busiest medical facility in the entire theater of operations at the time.

As wound trends continued to include more H/N trauma cases, the otolaryngologist’s role in combat casualty care became increasingly important. The need for H/N surgical capability became evident, and a specialized surgical augmentation team was eventually established within each CSH, the H/N team. The 15-person H/N teams were comprised of one otolaryngologist and one ear, nose, and throat technician; one oral/maxillofacial surgeon and one oral/maxillofacial surgeon technician; two ophthalmologists and one ophthalmology technician; two neurosurgeons; two anesthesiologists; two operating room nurses; and two operating room technicians. Deployments lasted 6 months for the professional staff and 12 months for

the support staff. The teams were theater-level assets assigned to the Air Force hospital at Balad throughout their deployment cycle in OIF. Being highly mobile with very few equipment requirements, they were designed to be capable of split operations, which occurred with varying frequency throughout the war.

Lieutenant Colonel Eugene Ross, who joined the 207th H/N team in September 2005, was the first Army otolaryngologist to deploy in a purely clinical capacity. He was present during the first free Iraqi elections in December 2005 and as sectarian violence expanded to a new level of intensity following the al-Askari Mosque bombing in Samarra in February 2006. Colonel Jeff Faulkner replaced Lieutenant Colonel Ross and took command of the 207th in April 2006, shortly before the newly elected government of Iraq took office. He watched coalition casualty rates climb from 300 per month to over 500 per month, and Iraqi civilian casualties rise to 3,389 in September 2006 as the Sunni insurgency took the country into a civil war.

Colonel Faulkner shook hands with Colonel David Hayes in the middle of a dust storm on the night of October 12, 2006, when the 53rd H/N team arrived to replace the 207th. Twenty hours later Faulkner and Hayes shared the former’s last and the latter’s first major trauma case: a massive pharyngeal injury caused by fragments from an improvised explosive device. Colonel Hayes later recalled standing across the operating room table from Faulkner, “wondering how bad this was going to be” (Figure 1-1). Coalition fatality rates averaged over 100 per month in the final quarter of 2006, with 1,263 total wounded. Colonel Hayes also recalled the muted celebration of Iraqis in Balad on Saturday, December 30, 2006, the day Saddam Hussein was executed.

In February 2007, Iraqi fatalities increased to 2,864, the second deadliest month of the war; David Petraeus replaced General George Casey as commander of Multi-National Force–Iraq; and the surge of US forces began to counter the growing insurgency. But the



Figure 1-1. Colonel Jeff Faulkner and Colonel David Hayes performing a head and neck trauma surgery during their RIP/TOA (relief-in-place/transfer of authority).

surge was not without a cost. The year 2007 would be the most violent year of the conflict, reaching its peak in May, the month after Colonel Hayes transferred command of the 53rd to Lieutenant Colonel Mark Gibbons. That first month of Gibbons's deployment marked the second highest peak of coalition fatalities during the war at 131, with 654 coalition wounded and 1,782 Iraqi civilian wounded. Also in 2007, Lieutenant Colonel Alan Bruns and Colonel Bill Magdycz served back-to-back tours in Baghdad as the surgical consultant for the 3rd Medical Command, providing leadership and guidance for the care of all surgical casualties in OIF. Colonel Rich Holt was also deployed to Iraq during 2007, assigned as the surgeon for an armored cavalry squadron, highlighting the varied jobs performed by otolaryngologists during OIF. During various short windows, four otolaryngologists were deployed simultaneously, meaning that nearly 10% of all Army otolaryngologists were deployed at one time (Figure 1-2).

From 2007 to 2009, the Air Force filled the H/N surgeon assignment at Balad. In 2009, the Army regained the role of staffing the H/N assignment at Balad and the Air Force began deploying their otolaryngologists to Craig Joint Theater Hospital at Bagram Air Field, Afghanistan. Colonel George Coppit, Lieutenant Colonel Phil Littlefield, and Lieutenant Colonel Scott Roof served with the H/N team at Balad from 2009 to 2011. During this period, the majority of injuries managed by H/N surgeons in Iraq consisted of blast injuries with accompanying blunt and penetrating trauma to the face and neck. The nature of these injuries and management algorithms and techniques perfected by

the H/N teams are clearly presented in the subsequent clinical chapters. Meanwhile, Lieutenant Colonel Brian Tonkinson served as a medical officer with a Special Forces unit in Iraq in 2009, again highlighting the eclectic nature of deployments and positions filled by otolaryngologists throughout both OIF and OEF.

Army Otolaryngology in Operation Enduring Freedom

In 2009, Colonel Joe Sniezek deployed to Afghanistan as director of the Joint Combat Casualty Research Team, the reincarnation of the ground-breaking shock trauma research teams from the Vietnam War era. This team functioned to foster and facilitate all medical/trauma research conducted by NATO forces in the combat zone. Over 100 active research protocols were undertaken and managed by deployed physicians during OIF/OEF. During Colonel Sniezek's deployment, the Army Surgeon General placed particular emphasis on evaluating the life-saving interventions performed by combat medics. The data collected during that period resulted in an ALARACT (All-Army Action) published by the Surgeon General that guided all future actions and strategies by combat medics.¹ In particular, the effectiveness of tourniquet placement and hemostatic combat gauze was verified, while early intravenous line placement and fluid resuscitation was found to be less critical than rapid evacuation.

Colonel Jeff Faulkner was also deployed to OEF during 2008 and 2009 (his second tour in OIF/OEF) as a dental officer assigned to a Special Forces unit,



Figure 1-2. Colonel Rich Holt, Colonel David Hayes, and Colonel Jeff Faulkner at Logistics Support Activity Anaconda, Iraq, 2007.

utilizing his prior training as a dentist. In 2009, two Army otolaryngologists were deployed in OIF (Lieutenant Colonels Littlefield and Tonkinson), while two were also deployed to OEF (Colonels Sniezek and Faulkner). However, no Army H/N surgeons were assigned to OEF in a purely clinical capacity because no Army CSH was deployed in that theater until 2010. Craig Joint Theater Hospital at Bagram Air Field served as the only Role 3 hospital in theater at that time, staffed by an Air Force otolaryngologist. All casualties who were evacuated from OEF passed through Bagram on their way to Landstuhl Army Medical Center, Germany, with the goal of remaining no longer than 12 to 24 hours at Bagram prior to evacuation.

In 2010, the Army was finally able to deploy a CSH in support of OEF, located in Helmand Province at Camp Dwyer. The original intention of the CSH commander was to include an oral surgeon, but not an otolaryngologist, on the CSH team. Data and experience from the prior 8 years of war, however, clearly showed the importance of the airway management skills and operative neck explorations performed by H/N surgeons, highlighting the need for an otolaryngologist at Role 2 and 3 facilities. At the urging of the Army otolaryngology consultant (Colonel Hayes), supported by the data supplied by Colonel Sniezek and the Joint Combat Casualty Research Team, the 30th Medical Command clinical operations chief decided to replace the oral surgeon with an otolaryngologist at the Camp Dwyer CSH.

Colonel Doug Sorensen became the first H/N surgeon to serve in a purely clinical role in OEF in 2010. He completed a 3-month tour (he was serving as the otolaryngology residency program director at Madigan Army Medical Center, necessitating a curtailed deploy-

ment) at the Navy Role 2 medical facility at Kandahar while the Army CSH was being established at Camp Dwyer. Sorensen was replaced by Lieutenant Colonel Chris Klem, who served 2 months at Kandahar before joining the CSH at Camp Dwyer. Lieutenant Colonel Klem performed over 13 free tissue transfer procedures while at Kandahar and Camp Dwyer, the most by any surgeon during OIF/OEF, along with numerous microsurgical and reconstructive procedures. This experience is highlighted in Chapter 27, Complex Head and Neck Reconstruction in Theater. He was followed by Major Julie Kerr, Colonel Mitch Ramsey (otolaryngology residency program director at Tripler Army Medical Center), and Lieutenant Colonel Nici Bothwell.

In 2012, the Camp Dwyer CSH was downgraded and split between Dwyer and Camp Bastion, and the otolaryngologist was removed from theater. Also in 2012, Colonel David Hayes became the first otolaryngologist to be deployed in support of operations in Africa, when he served as the senior medical officer in the 402nd Civil Affairs Battalion, one of Africa Command's early maneuver units operating out of Djibouti. The evolving role of Africa Command during that period required the two medical teams of the 402nd to tailor their activities to emerging crises and requests from nations throughout the Horn of Africa. Hayes's duties included coordinating US military medical support with embassies, performing military-to-military exchanges with partner nations, and providing direct medical care alongside host nation physicians. Army otolaryngologists have bravely and admirably served in both war zones and have saved the lives of many Americans and local national patients.

REFERENCE

1. US Department of the Army, Office of the Surgeon General. *Mandatory Pre-Deployment Trauma Training (PDTT) for Specified Medical Personnel*. HQDA EXORD 096-09, 3 February 2009.