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Letter to the Editor

Trauma pain – a military perspective

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We read with interest the article on the military perspective of trauma pain.¹ We agree that the dose and the intramuscular route of the morphine autojet is sub-optimal for patients in shock who require analgesia.² Either fentanyl or ketamine would be a more suitable alternative. The fentanyl lozenge has been in military use since the early 1990s, and there are reports of soldiers biting and swallowing the contents of the lozenge. The UK military has chosen the 400 µg dose, but interestingly the US military has opted for the 800 µg dose.³ In 2012 the Danes opted for intranasal fentanyl (Instanyl®) based on the experience of their civilian ambulance service (personal communication with Dr S. Trautner, Senior Medical Officer, Falck Ambulance Services, Denmark). We feel that fentanyl is potentially better administered via the intranasal or the sublingual/buccal route than as a lozenge.

Whatever the pre-hospital analgesia choice(s), education of the provider must include clinical observation of these analgesic approaches. At our hospital we have a long tradition of military paramedics being placed on clinical attachments. They are shown how ketamine in 10- to 20-mg boluses administered intravenously or sublingual fentanyl tablets (Abstral®) can be used safely for painful procedures at the regional burns centre. For medical officers, the benefits of rapid analgesia by combining morphine (10 mg) and alfentanil (1 mg) have been seen in the recovery unit.⁴

The biggest difference between civilian and military hospital practice is the early use by the military of co-analgesics⁵ (amitriptyline and pregabalin) for high-risk neuropathic pain conditions such as amputations, burns,⁶ plexus or nerve injuries. In the pain clinic, we treat both veterans and serving members of the military. Although there is a particular military perception regarding everyday aches and pains, it cannot always be generalised to the trauma patient. We have observed that soldiers will recall with great detail their memories of the time leading up to and following injury. They can vividly remember the kindness or cruelty of the people around them along their journey. A recurring theme is

the failure to relieve thirst and/or pain. The importance of early aggressive analgesia is emphasised on the Battlefield Advanced Trauma Life Support (BATLS) course, provided there is C>ABC stability.⁷ The emphasis should be on not only drugs but also non-drug approaches such as reassurance, distraction, elevation, splintage and cling film (for burns). Early pain relief also addresses the psychosocial complications of traumatic injury. Holbrook et al.⁸ have shown a reduction in perceived pain levels with morphine or other opiates, which may also lower the rate of post-traumatic stress disorder onset after major military trauma.

The best advice for civilian doctors with no military experience would be to read the excellent article by Gauntlett-Gilbert and Wilson in the same issue.⁹ It highlights the differences between military and civilian populations and provides a useful history-taking checklist. Future publications should include outcome measures, otherwise we run the risk of basing our responses on misleading sound bites rather than sound statistics.¹⁰

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