as they serve no purpose.

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TRIAGE IN THE MODERN BATTLE FIELD

Dear Editor,

Proper triage and allotment of priority is an important aspect of smooth and efficient medical cover in the battlefield. The situation in a modern battlefield has drastically changed in view of the high intensity conflicts with all modern weapons and the consequent number of casualties. With increasing risks of nuclear, biological and chemical warfare, the problems can be well appreciated. About 40% of the wounded casualties who otherwise survive, die before reaching a medical aid post [1]. It should also be understood that most trauma patients are reasonably stable for the first one hour after injury (Physiological compensation) and their vital organs will regain function if resuscitated within this period (Golden Hour). After this period decompensation and organ failure is progressively more common [2].

The existing system of prioritising the battlefield casualties into 3 groups (P-I: those needing immediate resuscitation and urgent surgery, P-II: those needing early surgery and possible resuscitation, P-III: remaining casualties) needs to be reconsidered in view of the changing battlefield scenario. In order to do maximum good to maximum number of casualties, the following 5 (Five) category triage is suggested, as modified from the text book [3].

- P-I: Life threatening but savable
- P-II: Serious but stable injury
- P-III Non-walking wounded
- P-IV: Walking wounded
- P-V: Life threatening but unsavable

The priority discs for identification can be issued to only the first 2 or 3 categories for sake of simplicity. The remaining two categories (P-IV and P-V) are self identifiable. By using this system of triage, precious time can be saved in managing P-I casualties than on

moribund P-V casualties, keeping in view the golden hour concept.

It may be argued that the existing categorisation into P-I to P-III is simpler and helps in quicker calculations of surgical load, fluids etc. In that case to achieve more realistic figures in calculation, a P-IV categorisation should be included in the existing system for moribund or unsavable casualties (Equivalent to P-V of the above suggested triage). Thus some of the P-I casualties will be diverted to P-IV and help in achieving more realistic figures in calculations and subsequent medical planning.

Although there is ethical issue related to such categorisation, but the tremendous number of casualties generated by modern warfare cannot be ignored. Hence, to achieve more realistic planning figures for prompt management of salvageable casualties, it is suggested that one of the above classification should be adopted.

Views of the editorial board and the readers are welcome to reach a consensus.

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HIGH INCIDENCE OF SEVERE PARASITEMIA IN FALCIPARUM MALARIA

Dear Editor,

We are writing to you in order to share our recent experience of a high incidence of severe parasitemia in falciparum malaria that we have been noting, this malaria season.

During the past 105 days, with effect from 1st August, we admitted 111 cases of falciparum malaria, of these 10 patients were found to have more than 10% parasitemia and 3 of these patients had more than 50% parasitemia. Only 2 of these patients expired, one from ARDS and the other from renal failure, although all were severely ill with renal, hepatic and cerebral dysfunction. Exchange transfusion was not performed and quinine resistance has not been

noted so far. All patients with severe parasitemia were local residents and no immunocompromise state was noted. These cases were seen in all age groups and both sexes. It is possible that a new strain has been recently introduced in the region. We would be extremely interested in the views of our colleagues on this phenomena being observed for the first time by us, with such high incidence.

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