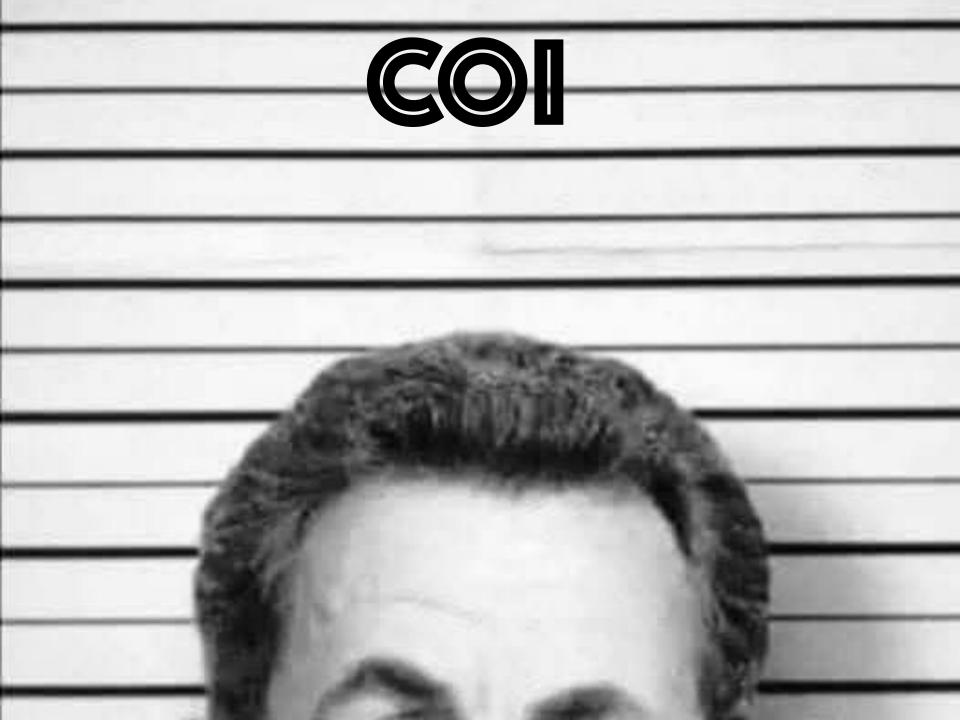


Gestion de l'oxygène en situation d'isolement prolongé

Médecin en chef Nicolas CAZES

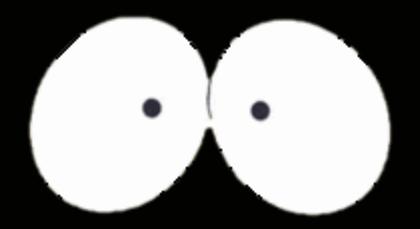


























-ACTION PLAN





#Oueskon Va



L'oxygène, WTF?



Quelles solutions?

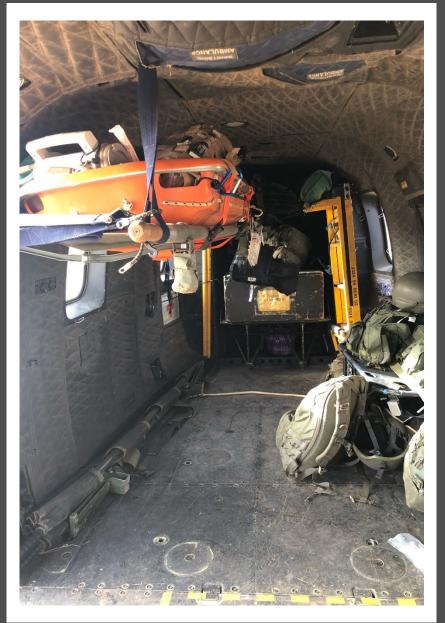
















-ACTION PLAN-





#Oueskon Va



L'oxygène, WTF?



Quelles solutions?









REVUE GÉNÉRALE

Évolution des conflits armés, conséquences pour l'anesthésiste-réanimateur militaire ?*

Evolution of armed conflicts, consequences for military anesthesia and intensive care?

Eric Meaudre a,*,b

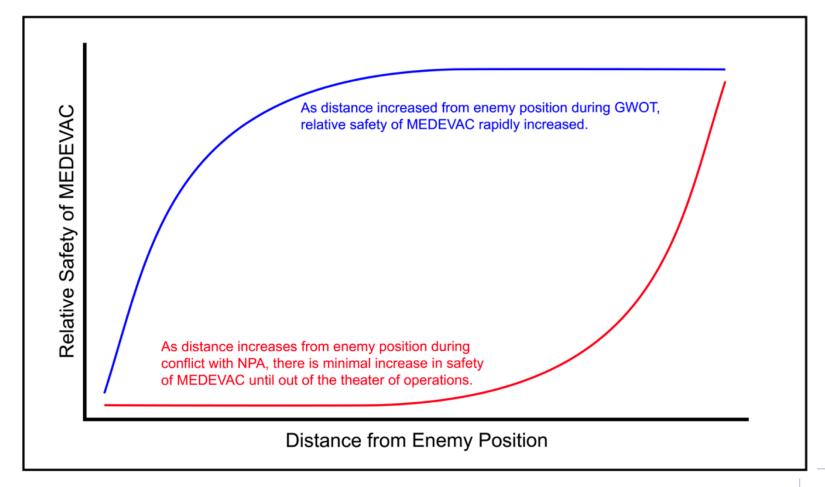




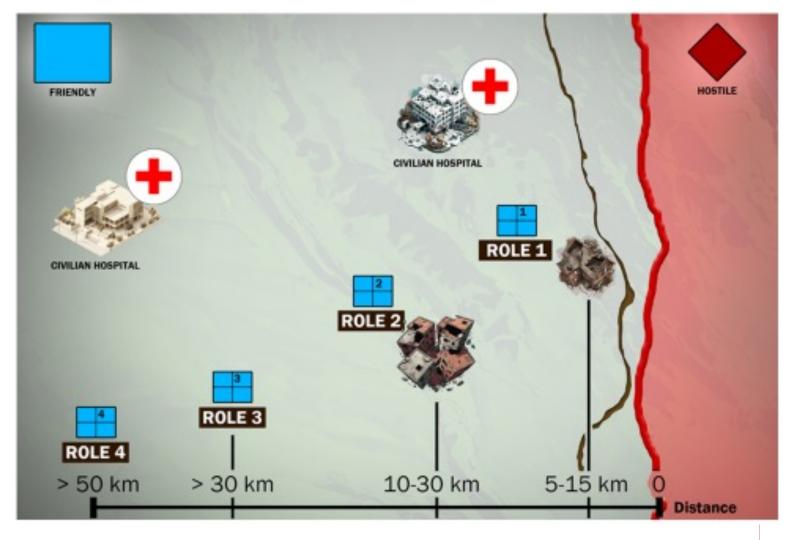
Not talk about « new » war, it's old war with some new « flavors »



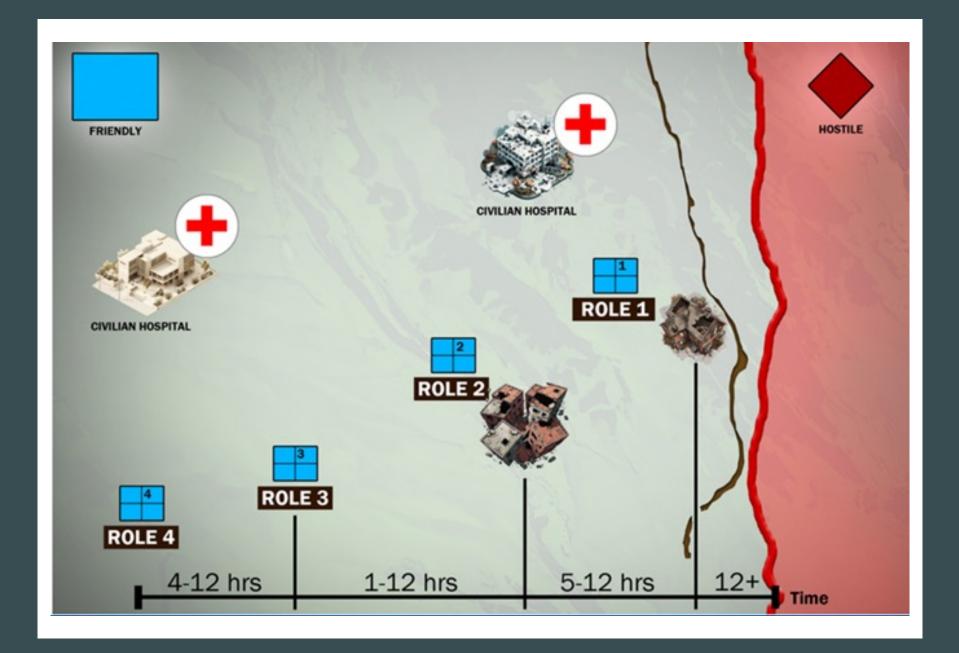








Service de santé des armées







--ACTION PLAN ---



Contexte





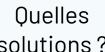
L'oxygène, WTF?



solutions?



Conclusion







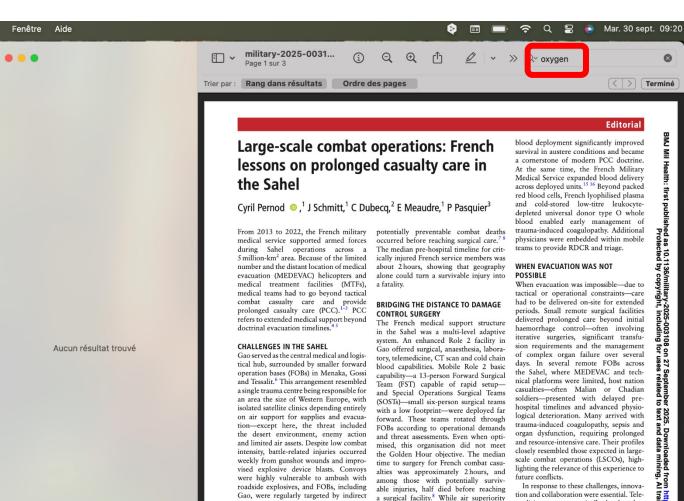
Large-scale combat operations: French lessons on prolonged casualty care in the Sahel

Cyril Pernod , ¹ J Schmitt, ¹ C Dubecq, ² E Meaudre, ¹ P Pasquier ³





Liberté Égalité Fraternite



fire. Gao also faced high-profile attacks

such as vehicle-borne suicide bombers

attempting to breach camp perimeters-

showing that even rear medical hubs were

not sanctuaries. Radar detection systems

helped mitigate risks by providing early

warnings, allowing medical teams to reach

shelter when necessary. Protecting medical

personnel was essential-not only to

preserve life but also to maintain trauma

EVACUATION CONSTRAINTS IN THE

care capacity across the theatre.

within 24 hours following injury. 10 11 SHIFTING THE FRONTLINE: BLOOD AND RESUSCITATION

and secure corridors ensured feasibility of

MEDEVAC, the vast distances, logistical

burden and the sheer scale of the theatre

prevented consistent surgical access within

60 min.9 Definitive surgical care was often

completed in homeland Role 4 facilities

French special forces were early adopters of forward resuscitation, bringing farforward remote damage control resusciblood deployment significantly improved survival in austere conditions and became a cornerstone of modern PCC doctrine. At the same time, the French Military Medical Service expanded blood delivery across deployed units. 15 16 Beyond packed red blood cells, French lyophilised plasma and cold-stored low-titre leukocytedepleted universal donor type O whole blood enabled early management of trauma-induced coagulopathy. Additional physicians were embedded within mobile

0

Terminé

tactical or operational constraints-care had to be delivered on-site for extended periods. Small remote surgical facilities delivered prolonged care beyond initial haemorrhage control-often involving iterative surgeries, significant transfusion requirements and the management of complex organ failure over several days. In several remote FOBs across the Sahel, where MEDEVAC and technical platforms were limited, host nation casualties-often Malian or Chadian soldiers-presented with delayed prehospital timelines and advanced physiological deterioration. Many arrived with trauma-induced coagulopathy, sepsis and organ dysfunction, requiring prolonged and resource-intensive care. Their profiles closely resembled those expected in largescale combat operations (LSCOs), highlighting the relevance of this experience to

In response to these challenges, innovation and collaboration were essential. Telemedicine was systematically developed to overcome specialist shortages, including in neurosurgical emergencies. A 22-year retrospective analysis of the French mobile neurosurgical unit has demonstrated the feasibility and value of such approaches in deployed environments.1

When cold and stored blood products were not directly available or sufficient, walking blood banks generated in 45 min provided a small supply after minimal screening (HIV, hepatitis). Predeployment testing to identify low-titre group O 'super donors' is now mandatory,



« Polytrauma resulting from high-velocity penetrating vascular injuries, explosive injuries, traumatic brain injuries, and blast injuries have been the largest injury mechanisms reported »



OPEN

Casualty care implications of large-scale combat operations

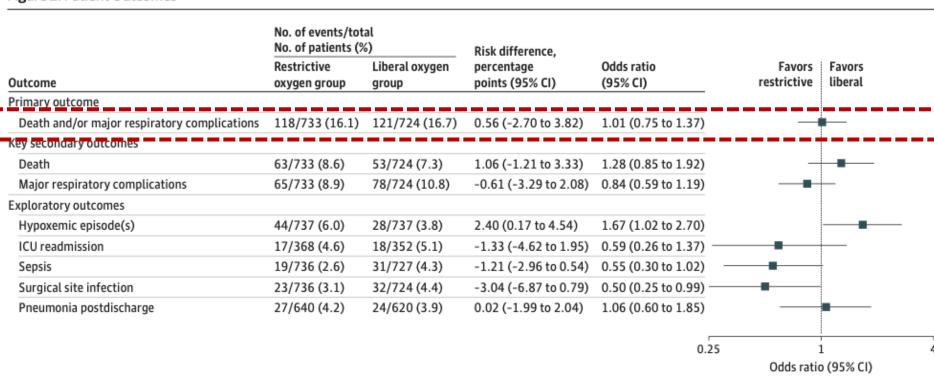
Mason H. Remondelli, Kyle N. Remick, MD, Stacy A. Shackelford, MD, Jennifer M. Gurney, MD, Jeremy C. Pamplin, Travis M. Polk, MD, Benjamin K. Potter, MD, and Danielle B. Holt, MD, Bethesda, Maryland



JAMA | Original Investigation | CARING FOR THE CRITICALLY ILL PATIENT

Early Restrictive vs Liberal Oxygen for Trauma Patients The TRAUMOX2 Randomized Clinical Trial





Trial outcomes for trauma patients randomized to either a restrictive oxygen strategy or liberal oxygen strategy. The odds ratios were adjusted for stratification variables. Further adjusted analyses are presented in eTables 4 and 5 in Supplement 2. Death and/or major respiratory complications, surgical site infection, and pneumonia postdischarge were evaluated within 30 days. Hypoxemic episode(s) were defined as the presence of any Spo₂ less than 90%

during the 8-hour intervention from the hourly collected ${\rm Spo}_2$ values. ICU readmission and sepsis were evaluated during the initial hospital admission (not at hospital readmission).

ICU indicates intensive care unit; and Spo₂, arterial oxygen saturation measured by pulse oximetry.









SOURCES D'O2





SOURCES D'O2







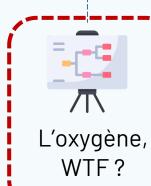
--ACTION PLAN ---



Contexte



#Oueskon Va





Quelles solutions?



Conclusion



177-27 1 3141592 6-18mg (U.E) BMOSK $y\left(\frac{1}{2}xy\right)+\frac{3}{2}xy\left(2x\right)-x\left(\frac{1}{2}xy\right)+x\left(2x\right)$



MINIATURISATION

















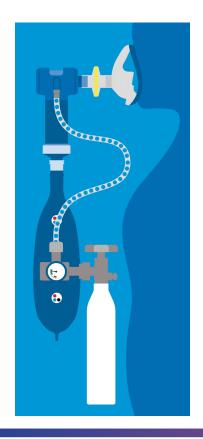


BUDI

Traumaid



DES SYSTÈMES INNOVANTS













--ACTION PLAN ---



Contexte



#Oueskon Va



L'oxygène, WTF?



Conclusion





CONCLUSION







