2025/06/25 18:55 1/1 General surgeon

## **General surgeon**

Approximately 4.5% of surgical procedures performed at Role 2 (R2) (forward surgical) and Role 3 (R3) (theater) medical treatment facilities can be classified as neurosurgical. These procedures are foreign to the routine daily practice of the military general surgeon. The purpose of a study of Turner et a., was to examine the neurosurgical workload in Iraq and Afghanistan in order to inform the future predeployment neurosurgical training needs of nonneurosurgical providers.

Retrospective analysis of the Department of Defense Trauma Registry for all R2 and R3 hospitals, from January 2002 to May 2016. The 103 neurosurgical International Classification of Diseases, Ninth Revision, Clinical Modification procedure codes identified were grouped by anatomic location. Select groups were further subdivided. Data analysis used Stata version 14 (College Station, TX).: A total of 7,509 neurosurgical procedures were identified. The majority (7,244 [96.5%]) occurred at R3 theater hospitals. Cranial procedures were the most common at both R2 (120, 45.3%) and R3 (4,483 [61.9%]), with craniotomy/craniectomy the most frequent procedure. Spine procedures were performed almost exclusively at R3, with 61.1% being fusions/stabilizations and 26.9% being spinal decompression alone. Neurosurgical caseload was variable over the 15-year study period, dropping to almost zero in 2016.

Neurosurgical procedures were performed primarily at larger R3 theater hospitals where neurosurgeons were assigned if present in theater; however, more than 100 cranial procedures were performed at forward R2 where neurosurgeons were not deployed. Considering that neurosurgeons are not everywhere available within the war zone, deploying general surgeons should have familiarity with trauma neurosurgery <sup>1)</sup>.

1)

Turner CA, Stockinger ZT, Bell RS, Gurney JM. Neurosurgical workload during US combat operations: 2002 to 2016. J Trauma Acute Care Surg. 2018 Jul;85(1):140-147. doi: 10.1097/TA.00000000001915. PubMed PMID: 29965942.

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