

# Telemedicine for the remote mentoring of damage control surgery in critically injured trauma patients

<b>Submission date</b> 17/02/2015	<b>Recruitment status</b> No longer recruiting	<input type="checkbox"/> Prospectively registered <input type="checkbox"/> Protocol
<b>Registration date</b> 07/03/2015	<b>Overall study status</b> Completed	<input type="checkbox"/> Statistical analysis plan <input checked="" type="checkbox"/> Results
<b>Last Edited</b> 20/12/2024	<b>Condition category</b> Surgery	<input type="checkbox"/> Individual participant data

## Plain English summary of protocol

### Background and study aims

Bleeding to death is the most preventable cause of post-traumatic death on earth. Many of these victims could be saved with relatively basic surgery if only they were in a location where surgery could be performed. Damage Control Surgery (DCS), is an approach which aims to simplify basic operations to save lives even if further surgery is required. Medical technology is fast advancing. Telemedicine is used to provide medical direction over a distance, and includes remote telementoring (RTM) where experts provide real-time remote guidance might allow non-surgeons to do DCS. Therefore this study will study numerous factors required to best support non-surgeons in the performance of life-saving techniques of resuscitation including performing DCS in the abdominal cavity. These factors will consist of the performance differences between trained surgeons and non-surgeons, the ability to remotely mentor non-surgeons, and their relative stress while doing so, and the ability to do so in stressful and difficult situations including a remote medical outpost, on board a ship, and during weightless aboard a "zero-G" aircraft. The main tools to be used will be the plastic organs and blood vessels of the Human Worn Partial Task Surgical Simulator (CutSuit) which is a hyper-realistic training tool that allows the performance of realistic surgical procedures on a simulated victim with realistic bleeding and the feel of real skin and tissue. We want to test if (a) experienced surgeons will lose less blood and experience less stress than non-surgeons and (b) whether RTM non-surgeons can be guided to perform life-saving procedures and that RTM will reduce stress even in far-forward operating bases, on-board ships, and weightlessness.

### Who can participate?

Surgeons and military medical technicians.

### What does the study involve?

In general, this study assesses "naïve first responders" (i.e. medical technicians) ability to pack the abdomen of a seriously injured person at risk of bleeding to death with the guidance of a surgeon though RTM. Participants are randomly allocated into one of two groups. Those in group 1 receive RTM with an experienced surgeon. Those in group 2 do not receive RTM. Each participant fills in a questionnaire about their medical training background and any surgical

training background in particular. They are also asked questions regarding any familiarity that they have with surgical simulation and, in particular, any experience of the CutSuit. They are all given a brief refresher course on hemorrhage control and how to potentially handle medical cases where the victim is bleeding to death from either a massive limb or abdomen injury. Each participant is then asked to perform hemorrhage control using either a first aid method or to perform a cut in the middle of the abdomen to gain entrance to the abdominal cavity, determine the site of the bleeding and pack within the abdominal cavity to compress this bleeding. Each participants performance is assessed according to the time taken to complete the procedure (TTTC) and the volume of shed blood (VSB). Comparisons are made within the two groups assessing different techniques for closing wounds and performing life changing procedures in different environments. We also compare the TTTC and VSB between naïve first responders and experienced surgeons and between surgeons performing in a normal gravity environment verses a weightless environment.

What are the possible benefits and risks of participating?

As with any surgical intervention, there is always a risk to the participant in self-inflicted injuries from handling scalpels, hemostatic clips, or other sharp instruments. These are similar risks to those that medical personal face when learning any invasive procedures. In order to partially mitigate these risks there will be very experienced "safety surgeons" present who will be observing for any unduly unsafe procedures that are that may place the participant at risk. The "safety surgeons" have the authority to halt the simulation and to exclude the participant from further participation at no penalty to the participant. While sharp injuries are possible there will be no risks of biocontamination as the CutSuit and fluids are completely inanimate. If the "safety surgeons" also perceive that any participant is undergoing undo physical or psychological distress they will halt the simulation and debrief the participant at no penalty to the participant. The purpose of this study is to collect data in order to further the mission of advancing resuscitative surgery in the field and "far forward situations". This is not intended as a training exercise for the participants.

Where is the study run from?

Flight Research Laboratory, National Research Council of Canada and the Canadian Field Hospital (Ottawa Detachment)

When is the study starting and how long is it expected to run for?

October 2014 to September 2025

Who is funding the study?

1. Canadian Forces Medical Services
2. Royal College of Physicians and Surgeons of Canada

Who is the main contact?

Professor Andrew Kirkpatrick  
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## Contact information

Type(s)

Scientific

Contact name

Mr Andrew Kirkpatrick

**Contact details**

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**Additional identifiers****Clinical Trials Information System (CTIS)**

Nil known

**ClinicalTrials.gov (NCT)**

Nil known

**Protocol serial number**

Nil known

**Study information****Scientific Title**

The marriage of advanced surgical simulation training with telepresence mentoring: training for damage control surgery in austere environments

**Study objectives**

Motivated but surgically-inexperienced first responders can be guided to perform expedited extremity wound closure and midline trauma laparotomy with visceral packing of simulated solid organ bleeding in austere environments, including weightlessness, through TM.

**Ethics approval required**

Old ethics approval format

**Ethics approval(s)**

University of Calgary Conjoint Health Research Ethics Board Research Services Office, ref: REB14-0634

**Study design**

Incrementally progressive randomised controlled trial studies using surgical simulation

**Primary study design**

Interventional

**Study type(s)**

Treatment

**Health condition(s) or problem(s) studied**

Exsanguination

## **Interventions**

The Human Worn Partial Task Surgical Simulator (Cut Suit) is a hyper-realistic surgical training tool that allows the performance of realistic surgical procedures on simulated casualties. Real-time telementoring is a telemedicine technique that facilitates procedure naïve responders to perform complex tasks while mentored by remote experts. Responders will be required to perform potentially life-saving technical procedures:

1. Close a thigh incision with a simulated lacerated superficial femoral artery
2. Incise the midline of the cut suit, enter the peritoneal cavity and pack with standard surgical gauze to control a standardized and randomized visceral (splenic/hepatic or both) haemorrhage
3. Perform life-saving interventions and follow damage control resuscitation principals.

Telementoring will be provided through a freely-available Voice over Internet Protocol (VOIP) system (Skype) in which the first responders will wear head-mounted video-cameras allowing the remote mentor to view and guide their hand movements in real-time. Variable gravitational environments will be provided through the use of the National Research Council of Canada's (NRC) Flight Research Laboratory's (FRL) Falcon 20 research aircraft. The relative effectiveness of naïve first responder's ability to viscerally pack with TM guidance will be quantified through:

1. Comparison between the time to task completion (TTTC) and volume of shed blood (VSB) between naïve first responders (NMFRs) and board-certified general surgeons (BCGSs).
2. Comparison between the time to task completion (TTTC) and volume of shed blood (VSB) between telementored (TM) surgically inexperienced first responders (TM-SIFRs) and surgically inexperienced first responders without TM. The first responders will be randomly allocated into one of the two aforementioned groups.
3. Comparison of the resultant TTTC and VSB, in the comparative environments of 1g normal gravity and 0g weightlessness, as well as the descriptive practicality of (a) closing a serious extremity wound and (b) performing a DCS laparotomy in weightlessness. We will be using experienced surgeons who will do the procedures in weightless (0g) or on the ground (1g) and this will not be randomized, but will consist of each subject constituting their own comparison between on the ground and parabolic flight.
4. Comparison of the time to overall task completion (TTOTC) when performing suture closure of the skin only, versus abbreviated closure using the ITclamp rapid wound for (a) extremity (b) laparotomy for randomly allocated telementored (TM) surgically inexperienced first responders (TM-SIFRs) and surgically inexperienced first responders without TM.
5. Demonstration of the feasibility to conduct remotely mentored live saving procedures including damage control laparotomies between BCGSs and TM-SIFRs when the TM-SIFRs are (a) separated from the mentors by many times zones and oceans or (b) on-board a ship. We will be comparing randomly allocated telementored (TM) surgically inexperienced first responders (TM-SIFRs) and surgically inexperienced first responders without TM.

## **Intervention Type**

Procedure/Surgery

## **Primary outcome(s)**

Volume of shed simulated blood (VSB)

## **Key secondary outcome(s))**

1. Time to task completion (TTTC)
2. Adequacy of life-saving procedures
3. User satisfaction surveys
4. Physiological and biomedical response data of the users during the simulated procedures

## **Completion date**

01/09/2025

## Eligibility

### Key inclusion criteria

1. Surgeon
2. Military medical technician

### Participant type(s)

Healthy volunteer

### Healthy volunteers allowed

No

### Age group

Adult

### Sex

All

### Key exclusion criteria

Unwillingness to participate

### Date of first enrolment

17/10/2014

### Date of final enrolment

31/12/2016

## Locations

### Countries of recruitment

Canada

### Study participating centre

**Flight Research Laboratory, National Research Council of Canada**

Building U-61

1920 Research Rd

Ottawa Airport

Ottawa

Canada

K1A 0R6

### Study participating centre

**Canadian Field Hospital - Ottawa Detachment**

National Defence

1745 Alta Vista Dr.  
Ottawa  
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## Sponsor information

### Organisation

Canadian Forces Medical Services

### Organisation

Royal College of Physicians and Surgeons of Canada

## Funder(s)

### Funder type

Government

### Funder Name

Canadian Forces Medical Services (Canada)

### Funder Name

Royal College of Physicians and Surgeons of Canada

## Results and Publications

### Individual participant data (IPD) sharing plan

Not provided at registration

### IPD sharing plan summary

Available on request

### Study outputs

Output type	Details	Date created	Date added	Peer reviewed?	Patient-facing?
<a href="#">Results article</a>	Haemorrhage management pilot study	01/11/2015		Yes	No

<a href="#">Results article</a>	Tube thoracostomy	01/08/2019	Yes	No
<a href="#">Results article</a>	Haemorrhage management	07/01/2020 25/11/2020	Yes	No
<a href="#">Results article</a>	Patient-performed lung ultrasound	03/01/2022 04/01/2022	Yes	No
<a href="#">Participant information sheet</a>	Participant information sheet	11/11/2025 11/11/2025	No	Yes