Tactical Combat Casualty Care for Medical Personnel
03 June 2016

Tactical Field Care #3
14. Splint fractures and recheck pulse.
Fractures: Open or Closed

- **Open Fracture** – associated with an overlying skin wound
- **Closed Fracture** – no overlying skin wound

Open fracture

Closed fracture
Clues to a Closed Fracture

- Trauma with significant pain AND
- Marked swelling
- Audible or perceived snap
- Different length or shape of limb
- Loss of pulse or sensation distally
- Crepitus (“crunchy” sound)
Splinting Objectives

- Prevent further injury
- Protect blood vessels and nerves
  - Check pulse before and after splinting
- Make casualty more comfortable
Principles of Splinting

- Check for other injuries
- Use rigid or bulky materials
- Try to pad or wrap if using rigid splint
- Secure splint with ace wrap, cravats, belts, duct tape
- Try to splint before moving casualty
Principles of Splinting

• Minimize manipulation of extremity before splinting
• Incorporate joint above and below
• Arm fractures can be splinted to shirt using sleeve
• Consider traction splinting for mid-shaft femur fractures
• Check distal pulse and skin color before and after splinting
Things to Avoid in Splinting

- Manipulating the fracture too much and damaging blood vessels or nerves
- Wrapping the splint too tight and cutting off circulation below the splint
Commercial Splints
Field-Expedient Splint Materials

- Shirt sleeves/safety pins
- Weapons
- Boards
- Boxes
- Tree limbs
- ThermaRest pad
Don’t Forget!

Pulse, motor and sensory checks before and after splinting!
Tactical Field Care Guidelines

15. Antibiotics: recommended for all open combat wounds:
   a. If able to take PO meds:
      - Moxifloxacin, 400 mg PO one a day
   b. If unable to take PO (shock, unconsciousness):
      - Cefotetan, 2 g IV (slow push over 3-5 minutes)
        or IM, every 12 hours
      or
      - Ertapenem, 1 g IV/IM once a day
Outcomes: Without Battlefield Antibiotics

- Mogadishu 1993
- Casualties: 58
- Wound Infections: 16
- Infection rate: 28%
- Time from wounding to Level II care – 15 hrs.

Mabry et al
J Trauma 2000
Outcomes: With Battlefield Antibiotics

Tarpey – AMEDD J 2005:
- 32 casualties with open wounds
- All received battlefield antibiotics
- None developed wound infections
- Used TCCC recommendations modified by availability:
  - Levofloxacin for an oral antibiotic
  - IV cefazolin for extremity injuries
  - IV ceftriaxone for abdominal injuries.
Outcomes: With Battlefield Antibiotics

- MSG Ted Westmoreland
- Special Operations Medical Association presentation 2004
- Multiple casualty scenario involving 19 Ranger and Special Forces WIA as well as 30 Iraqi WIA
- 11-hour delay to hospital care
- Battlefield antibiotics given
- No wound infections developed in this group.
Battlefield Antibiotics

Recommended for all open wounds on the battlefield!
If casualty can take PO meds

- **Moxifloxacin** 400 mg, one tablet daily
  - Broad spectrum – kills most bacteria
  - Few side effects
  - Take as soon as possible after life-threatening conditions have been addressed
  - Delays in antibiotic administration increase the risk of wound infections
Combat Wound Medication Pack

In the event of open combat wound swallow all four pills with water.

Mobic 15mg
Tylenol ER 650mg, 2 caplets
Moxifloxacin 400mg

"Just Got Easier To Swallow"
Battlefield Antibiotics

• Casualties who cannot take PO meds:
  – Ertapenem 1 gm IV/IM once a day
    • IM should be diluted with lidocaine
      (1 gm vial ertapenem with 3.2cc lidocaine without epinephrine)
    • IV requires a 30-minute infusion time

• NOTE: Cefotetan is also a good alternative, but has been more difficult to obtain through supply channels
Medication Allergies

- Screen your units for drug allergies!
- Patients with allergies to aspirin or other non-steroidal anti-inflammatory drugs should not use Mobic.
- Allergic reactions to Tylenol are uncommon.
- Patients with allergies to fluoroquinolones, penicillins, or cephalosporins may need alternate antibiotics which should be selected by unit medical personnel during the pre-deployment phase. **Check with your unit physician if unsure.**
16. Burns

a. Facial burns, especially those that occur in closed spaces, may be associated with inhalation injury. Aggressively monitor airway status and oxygen saturation in such patients and consider early surgical airway for respiratory distress or oxygen desaturation.

b. Estimate total body surface area (TBSA) burned to the nearest 10% using the Rule of Nines. (see third slide)
Degrees of Burns

- Superficial burn
  "First Degree"

- Partial thickness burn
  "Second degree"
Degrees of Burns

Full-thickness burn
“Third degree”

Deep(subdermal) burn
“Fourth-degree”
Rule of Nines for Calculating Burn Area

Do not count superficial (first degree) burns in calculating TBSA burned.
16. Burns (cont)

c. Cover the burn area with dry, sterile dressings. For extensive burns (>20%), consider placing the casualty in the HRS or the Blizzard Survival Blanket in the Hypothermia Prevention Kit in order to both cover the burned areas and prevent hypothermia.
16. Burns (cont)

d. Fluid resuscitation (USAISR Rule of Ten)

– If burns are greater than 20% of Total Body Surface Area, fluid resuscitation should be initiated as soon as IV/IO access is established. **Resuscitation should be initiated with Lactated Ringer’s, normal saline, or Hextend. If Hextend is used, no more than 1000 ml should be given,** followed by Lactated Ringer’s or normal saline as needed.
16. Burns (cont)

- Initial IV/IO fluid rate is calculated as % TBSA x 10cc/hr for adults weighing 40-80 kg.
- For every 10 kg ABOVE 80 kg, increase initial rate by 100 ml/hr.
- If hemorrhagic shock is also present, resuscitation for hemorrhagic shock takes precedence over resuscitation for burn shock. Administer IV/IO fluids per the TCCC Guidelines in Section 7.
16. Burns (cont)

e. Analgesia in accordance with TCCC Guidelines in Section 13 may be administered to treat burn pain.

f. Prehospital antibiotic therapy is not indicated solely for burns, but antibiotics should be given per TCCC guidelines in Section 15 if indicated to prevent infection in penetrating wounds.
16. Burns (cont)

g. All TCCC interventions can be performed on or through burned skin in a burn casualty.

These casualties are “Trauma casualties with burns” - not the other way around

US Army ISR Burn Center
17. Communicate with the casualty if possible.
   - Encourage; reassure
   - Explain care
18. Cardiopulmonary resuscitation (CPR)

Resuscitation on the battlefield for victims of blast or penetrating trauma who have no pulse, no ventilations, and no other signs of life will not be successful and should not be attempted. However, casualties with torso trauma or polytrauma who have no pulse or respirations during TFC should have bilateral needle decompression performed to ensure they do not have a tension pneumothorax prior to discontinuation of care. The procedure is the same as described in section 3 above.
CPR

NO battlefield CPR
CPR in Civilian Trauma

- 138 trauma patients with prehospital cardiac arrest and in whom resuscitation was attempted.
- **No** survivors
- Authors recommended that trauma patients in cardiopulmonary arrest not be transported emergently to a trauma center even in a civilian setting due to large economic cost of treatment without a significant chance for survival.

*Rosezburgy et al. J Trauma 1993*
The Cost of Attempting CPR on the Battlefield

- CPR performers may get killed
- Mission gets delayed
- Casualty stays dead
CPR on the Battlefield
(Ranger Airfield Operation in Grenada)

- Airfield seizure operation
- Ranger shot in the head by sniper
- No pulse or respirations
- CPR attempts unsuccessful
- Operation delayed while CPR performed
- Ranger PA finally intervened: “Stop CPR and move out!”
CPR in Tactical Settings

Only in the case of cardiac arrest due to:

– Hypothermia
– Near-drowning
– Electrocution
– Other non-traumatic cause

should CPR be considered prior to the Tactical Evacuation Care phase.
Traumatic Cardiac Arrest in TCCC

• Mounted IED attack in March 2011
• Casualty unconscious from closed head trauma
• Lost vital signs prehospital
• CPR on arrival at hospital
• **Bilateral needle decompression** done in ER
• Rush of air from left-sided tension pneumothorax
• Return of vital signs – life saved
• This procedure is routinely done by Emergency Medicine physicians and Trauma Surgeons for trauma victims who lose their pulse and heart rate in the hospital Emergency Department.
Questions?
19. Documentation of Care:

Document clinical assessments, treatments rendered, and changes in the casualty’s status on a TCCC Casualty Card (DD Form 1380). Forward this information with the casualty to the next level of care.
TCCC Casualty Card

• Designed by combat medics
• Used in combat since 2002
• Replaced old DD Form 1380
• Only essential information
• Can be used by hospital to document injuries sustained and field treatments rendered
• Heavy-duty waterproof or laminated paper
In order to know if we are doing the right thing, we must first know what we did.

This paper was made possible by the Ranger TCCC Card.
TCCC Casualty Card

- This card is based on the principles of TCCC.
- It addresses the initial lifesaving care provided at the point of wounding.
- Filled out by whoever is caring for the casualty.
- Its format is simple with a circle or “X” in the appropriate block.
TCCC Casualty Card
Front
### TCCC Casualty Card

#### Back

**Battle Roster #:**
- EVAC: [Urgent] [Priority] [Routine]

**Treatments:**
- C: TQ: Extremity, Junctional, Trunical
- Dressing: Hemostatic, Pressure, Other
- A: Intact, NPA, CRIC, ET-Tube, SGA
- B: O2, Needle-D, Chest-Tube, Chest-Seal

**C:**
- Fluid
- Blood Product

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**Meds:**
- Analgesic (e.g., Ketamine, Fentanyl, Morphine)
- Antibiotic (e.g., Moxifloxacin, Ertapenem)
- Other (e.g., TXA)

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**Other:**
- Combat Pill Pack
- Eye Shield (R, L)
- Splint
- Hypothermia Prevention

**Notes:**

**First Responder**
- Name (Last, First):

DD Form 1380, MAR 2014 (Back) TCCC Card
Instructions

- A TCCC Casualty Card should be kept in each Individual First Aid Kit.
- Use an indelible marker to fill it out.
- When used, attach it to the casualty’s belt loop, or place it in their upper left sleeve, or the left trouser cargo pocket.
- Include as much information as you can.
• Record each specific intervention in each category.
• If you are not sure what to do, the card will prompt you where to go next.
• Simply circle the intervention you performed.
• Explain any action you want clarified in the remarks area.
The card does not imply that every casualty needs all of these interventions.

You may not be able to perform all of the interventions that the casualty needs.

The next person caring for the casualty can add to the interventions performed.

This card can be filled out in less than two minutes.

It is important that we document the care given to the casualty.
TCCC Card Abbreviations

- DTG = Date-Time Group (e.g. – 160010Oct2009)
- NBC = Nuclear, Biological, Chemical
- TQ = Tourniquet
- GSW = Gunshot Wound
- MVA = Motor Vehicle Accident
- AVPU = Alert, Verbal stimulus, Painful stimulus, Unresponsive
- Cric = Cricothyroidotomy
- NeedleD = Needle decompression
- IV = Intravenous
- IO = Intraosseous
- NS = Normal Saline
- LR = Lactated Ringers
- ABX = Antibiotics
This electronic AAR is intended to be completed when the first responder returns to base.

Somewhat more complete than the TCCC Casualty Card

TCCC AAR should be submitted to the Joint Theater Trauma System Director within 72 hours of casualty evacuation

Both the TCCC Casualty Card and the TCCC AAR are required by USFOR-A FRAGO 13-139
TCCC After-Action Report

March 2014
Questions ?
Further Elements of Tactical Field Care

- Reassess regularly.
- Prepare for transport.
- Minimize removal of uniform and protective gear, but get the job done.
- Replace body armor after care, or at least keep it with the casualty. He or she may need it again if there is additional contact.
Further Elements of Tactical Field Care

Casualty movement in TFC may be better accomplished using litters.
Litter Carry Video

- Secure the casualty on the litter
- Bring his weapons

Courtesy 75th Ranger Regiment
Summary of Key Points

- Still in hazardous environment
- Limited medical resources
- Hemorrhage control
- Airway management
- Breathing
- Transition from tourniquet to another form of hemorrhage control when appropriate
- For hemorrhagic shock, resuscitate with blood products per the TCCC Guidelines when they are available
Summary of Key Points

- Hypotensive resuscitation with Hextend for hemorrhagic shock when blood products are not available
- Hypothermia prevention
- Shield and antibiotics for penetrating eye injuries
- Pain control
- Antibiotics
- Reassure casualties
- No CPR
- Documentation of care
Questions?

Wear your body armor!
Casualty Collection Point Operations

This section is adapted from:
Casualty Collection Points in the Evacuation Chain

Casualty flow from target to hospitalization.
CCP Site Selection

• Should be reasonably close to the fight
• Located near areas where casualties are likely to occur
• Must provide cover and concealment from the enemy
• Inside a building or on hardstand (an exclusive CCP building limits confusion)
• Should have access to evacuation routes (foot, vehicle, aircraft)
• Proximal to “Lines of Drift” or paths across terrain that are the most likely to be used when going from one place to another.

(continued)
CCP Site Selection

- Adjacent to Tactical Choke Points (breeches, HLZ’s, etc…)
- Avoid natural or enemy choke points
- Choose an area providing passive security (inside the perimeter)
- Good drainage
- Accessible to evacuation assets
- Expandable if casualty load increases
Typically, a First Sergeant (1SG) or Platoon Sergeant (PSG), or equivalent, is given responsibility for casualty flow and everything outside the CCP:

- Provides for CCP structure and organization (color coded with chemlights)
- Maintains command & control and battlefield situational awareness
- Controls aid & litter teams, and provides security
CCP Operational Guidelines

- First Sergeant (1SG), Platoon Sergeant (PSG) or equivalent:
  - Strips, bags, tags, organizes, and maintains casualties’ tactical gear outside of treatment area
  - Accountable for tracking casualties and equipment into and out of CCP and reports to higher command
  - Moves casualties through CCP entrance/exit choke point which should be marked with an IR chemlight
CCP Operational Guidelines

• Medical personnel are responsible for everything inside the CCP
  – Triage officer sorts and organizes casualties at choke point into appropriate treatment categories
  – Medical officers and medics organize medical equipment and supplies and treat casualties
  – EMTs, First Responders, and Aid & Litter Teams assist with treatment and packaging of casualties
Casualties with minor injuries should remain with original element or assist with CCP security if possible.

Those killed in action should remain with original element.
CCP Operational Guidelines

CCP / CEP Template 1
(Adjacent to Breech)
Questions?
Management of Wounded Hostile Combatants
Objective

- DESCRIBE the considerations in rendering trauma care to wounded hostile combatants.
Care for Wounded Hostile Combatants

• No medical care during Care Under Fire
• Though wounded, enemy personnel may still act as hostile combatants
  – May employ any weapons or detonate any ordnance they are carrying
• Enemy casualties are **hostile combatants** until they:
  – Indicate surrender
  – Drop all weapons
  – Are proven to no longer pose a threat
Care for Wounded Hostile Combatants

• Combat medical personnel should not attempt to provide medical care until sure that wounded hostile combatant has been rendered safe by other members of the unit.

• Restrain with flex cuffs or other devices if not already done.

• Search for weapons and/or ordnance.

• Silence to prevent communication with other hostile combatants.
Care for Wounded Hostile Combatants

- Segregate from other captured hostile combatants.
- Safeguard from further injury.
- Care as per TFC guidelines for U.S. forces after above steps are accomplished.
- Speed to the rear as medically and tactically feasible.
QUESTIONS ?
Preparing for Evacuation
NATO/ISAF Standard Evacuation Categories

International Security Assistance Force

SOP #312:

• Governs operations in Afghanistan
• Follows NATO doctrine
• Specifies three categories for casualty evacuation:
  • A - Urgent
  • B - Priority
  • C - Routine
NATO/ISAF Standard Evacuation Categories

• CAT A – Urgent (denotes a critical, life-threatening injury)
  – Significant injuries from a dismounted IED attack
  – Gunshot wound or penetrating shrapnel to chest, abdomen or pelvis
  – Any casualty with ongoing airway difficulty
  – Any casualty with ongoing respiratory difficulty
  – Unconscious casualty
NATO/ISAF Standard Evacuation Categories

• CAT A – Urgent (continued)
  – Casualty with known or suspected spinal injury
  – Casualty in shock
  – Casualty with bleeding that is difficult to control
  – Moderate/Severe TBI
  – Burns greater than 20% Total Body Surface Area
NATO/ISAF Standard Evacuation Categories

- CAT B – Priority (serious injury)
  - Isolated, open extremity fracture with bleeding controlled
  - Any casualty with a tourniquet in place
  - Penetrating or other serious eye injury
  - Significant soft tissue injury without major bleeding
  - Extremity injury with absent distal pulses
  - Burns 10-20% Total Body Surface Area
NATO/ISAF Standard Evacuation Categories

- CAT C – Routine (mild to moderate injury)
  
  - Concussion (mild TBI)
  
  - Gunshot wound to extremity - bleeding controlled without tourniquet
  
  - Minor soft tissue shrapnel injury
  
  - Closed fracture with intact distal pulses
  
  - Burns < 10% Total Body Surface Area
TACEVAC 9 Rules of Thumb: Assumptions

- These Rules of Thumb are designed to help the corpsman or medic determine the true urgency for evacuation.
- They assume that the decision is being made at 15-30 minutes after wounding.
- Also that care is being rendered per the TCCC guidelines.
- Most important when there are tactical constraints on evacuation:
  - Interferes with mission
  - High risk for team
  - High risk for TACEVAC platform
Soft tissue injuries are common and may look bad, but usually don’t kill unless associated with shock.
Bleeding from most extremity wounds should be controllable with a tourniquet or hemostatic dressing. Evacuation delays should not increase mortality if bleeding is fully controlled.
TACEVAC Rule of Thumb #3

Casualties who are in shock should be evacuated as soon as possible.

Gunshot wound to the abdomen
TACEVAC Rule of Thumb #4

Casualties with penetrating wounds of the chest who have respiratory distress unrelieved by needle decompression of the chest should be evacuated as soon as possible.
Casualties with blunt or penetrating trauma of the face associated with airway difficulty should have an immediate airway established and be evacuated as soon as possible.

REMEMBER to let the casualty sit up and lean forward if that helps him or her to breathe better!
Casualties with blunt or penetrating wounds of the head where there is obvious massive brain damage and unconsciousness are unlikely to survive with or without emergent evacuation.
Casualties with blunt or penetrating wounds to the head - where the skull has been penetrated but the casualty is conscious - should be evacuated emergently.
Casualties with penetrating wounds of the chest or abdomen who are not in shock at their 15-minute evaluation have a moderate risk of developing late shock from slowly bleeding internal injuries. They should be carefully monitored and evacuated as feasible.
Casualties with TBI who display “red flag” signs - witnessed loss of consciousness, altered mental status, unequal pupils, seizures, repeated vomiting, visual disturbance, worsening headache, unilateral weakness, disorientation, or abnormal speech – require urgent evacuation to a medical treatment facility.
9-Line Evacuation Request

Required if you want an evacuation from another unit
9-Line Evacuation Request

- Request for resources through tactical aircraft channels.
- **NOT** a direct medical communication with medical providers
- Significance
  - Determines tactical resource allocation
  - DOES NOT convey much useful medical information
9-Line Evacuation Request

Line 1: Pickup location

Line 2: Radio frequency, call sign and suffix

Line 3: Number of casualties by precedence (evacuation category)

Line 4: Special equipment required
9-Line Evacuation Request

Line 5: Number of casualties by type (litter, ambulatory)

Line 6: Security at pickup site

Line 7: Method of marking pickup site
9-Line Evacuation Request

Line 8: Casualty’s nationality and status

Line 9: Terrain Description; NBC contamination if applicable
Preparing for Evacuation
Summary of Key Points

• Evacuation Categories
• Tactical Evacuation Rules of Thumb
• 9-Line Evacuation Request
Questions?
Convoyp IED Scenario

• Recap from Care Under Fire
• Your last medical decision during Care Under Fire:
  – Placed tourniquet on left stump
• You moved the casualty behind cover and returned fire.
• You provided an update to your mission commander
Convoy IED Scenario

Assumptions in discussing TFC in this scenario:

• Effective hostile fire has been suppressed.
• Team Leader has directed that the unit will move.
• Pre-designated HLZ for helicopter evacuation is 15 minutes away.
• Flying time to hospital is 30 minutes.
• Ground evacuation time is 3 hours.
• Enemy threat to helicopter at HLZ estimated to be minimal.
Convoy IED Scenario

Next decision (Command Element)?

• How to evacuate casualty?
  – Helicopter
    • Longer time delay for ground evacuation
    • Enemy threat at HLZ acceptable
Convoy IED Scenario

Next decision (Command Element)?

- Load first and treat enroute to HLZ or treat first and load after?
  - Load and Go
  - Why?
    - Can continue treatment enroute
    - Avoid potential second attack at ambush site
Casualty is still conscious and has no neck or back pain.

Next decision?
- Do you need spinal immobilization?
- No
  - Not needed unless casualty has neck or back pain
    - Why?
      - Low expectation of spinal fracture in the absence of neck or back pain in a conscious casualty
    - Speed is critical
    - NOTE: Casualties who are unconscious from blast trauma should have spinal immobilization if feasible.
Ten minutes later, you and the casualty are in a vehicle enroute to HLZ.

Next action?

- Reassess casualty
  - Casualty is now unconscious
  - No bleeding from first tourniquet site
  - Other stump noted to have severe bleeding
Convoy IED Scenario

• Next action?
  – Place tourniquet on 2\textsuperscript{nd} stump
• Next action?
  – Remove any weapons or ordnance that the casualty may be carrying.
• Next action?
  – Place nasopharyngeal airway
• Next action?
  – Make sure he’s not bleeding heavily elsewhere
  – Check for other trauma
Convoy IED Scenario

• Next action?
  – Establish IV access - need to give TXA and then resuscitate for shock
• Next action?
  – Administer 1 gram of tranexamic acid (TXA) in 100 cc NS or LR
  – Infuse slowly over 10 minutes
Convoy IED Scenario

- Next action?
  - Begin fluid resuscitation – your convoy carries plasma and RBCs – give them in a 1:1 ratio per the TCCC Guidelines

- Next actions?
  - Hypothermia prevention
  - IV antibiotics
  - Pulse ox monitoring
  - Continue to reassess casualty
Convoy IED Scenario

What is your 9-line?

Line 1: Grid NS 12345678
Line 2: 38.90, Convoy 6
Line 3: 1 Urgent
Line 4: PRBCs, oxygen, advanced airway
Line 5: 1 litter
Line 6: Secure
Line 7: VS-17 (Orange Panel)
Line 8: U.S. Military
Line 9: Flat field

* Some individuals recommend adding a tenth line: the casualty’s vital signs
Convoy IED Scenario

Your convoy has now arrived at the HLZ

Next steps?

• Continue to reassess casualty and prep for helo transfer
  – Search casualty for any remaining weapons and remove before loading him or her on the helo
  – Secure casualty’s personal effects
  – Document casualty status and treatment
Remember

• The TCCC guidelines are not a rigid protocol.

• The tactical environment may require some modifications to the guidelines.

• Think on your feet!
Questions?