Terrorism is the new pandemic in the present era. It does not discriminate between the wealthy and the poor or between types of government or religious affiliations. Its misplaced agenda has been a major cause of grief in the present times, not to mention the loss of lives and the strain that it puts on economies. During 1994 to 2017, India has seen 66,356 fatalities in various terror-linked attacks (the figure includes all civilian, military personnel, and terrorist casualties).[1]

William Halstead once said, “One of the chief fascinations of surgery is to repair vessels.” Our techniques of handling vascular trauma have evolved over a period and have shown tangible effects in reducing amputation rates. During the American civil war and World War I, the usual surgical approach to a major vascular injury was just simple ligation of the afflicted vessel and amputation of the limb; World War II proved that vascular injuries can be repaired and the limb amputation rate can be limited. Application of vascular surgical techniques reduced the rate of amputations from 100% in previous war efforts to a 72% during World War II. The landmark article by DeBakey and Simone in The Annals of Surgery on American World War II casualties is considered to be the first comprehensive review of battle injuries involving arterial trauma. It provided a major stimulus for application of vascular surgical methods of repair and restoration of circulation in both military and civilian casualties;[2] it also provided extensive data on incidence, location of injuries, complications, methods of treatment, and their results. During the Korean War, a policy of mandatory surgical exploration of all potential vascular injuries lowered the amputation rate to 32% for popliteal injuries.[1] During the Vietnam war, a policy of performing arteriography on all suspected vascular injuries combined with evolving vascular repair techniques reduced the amputation rate of these injuries to 15%. At present, with current diagnostic and vascular repair techniques, almost all of these injuries can be revascularized, although severely mangled limbs may still need amputation.

The considerable experience that our military surgeons have built-up in handling battle casualties can be appropriated to evolve management algorithms for these situations. Rai et al. in their review of 5700 casualties in 9 years in a forward location emphasized on speedy evacuation, immediate resuscitation, and early institution of definitive measures.[4] It is often evident that time taken for a casualty to reach a facility is inversely proportional to the lives saved. Proximity of the facility to the site of attack, preemptive evacuation along the lines of “scoop and run,” triage by a team at the hospital, simultaneous resuscitation, and the preparedness of the operating room cumulatively play a significant role in saving lives.

In the aftermath of the Kargil war, Indian military casualties were reported to be at 527 dead and 1363 wounded; vascular trauma was somewhere between 1% and 4%. A majority of the vascular trauma involved extremities (if one were to discount death due to exsanguinating hemorrhage due to major vascular trauma). Needless to say, active participation of vascular surgeons helped immensely in these situations.

Bhandarwar et al.[5] reported that during the Mumbai terror attack, vascular trauma constituted about 2% of the casualties that reached the hospital. Data collected from a service hospital in the Jammu and Kashmir Valley from 2014 to 2016 revealed that 4.3% of patients had vascular injuries.

Terror-related trauma has consistently shown a higher percentage of vascular trauma (9% compared to 1%–4% reported during military conflicts) as reported by Heldenberg.[6] Patients with vascular trauma lead to an increase in the number of surgical interventions by 79%. This is attributed to the types of explosive devices used during these attacks (as compared to missile and gunshot injuries in military conflict). About 5.9% victims had vascular trauma in recent Paris terror attacks.

India, as a country, is ill-prepared to handle large-scale calamities. With only 400 odd vascular surgeons (and a majority of these in major cities), it is the need of the hour to train more vascular/trauma surgeons. It needs to be mandated into our surgical residency programs and more emphasis should be on salvaging limbs instead of condemning them to amputations. We need to change our
surgical practice to allow innovations to be put in place and the only way of achieving them is through preparing us, not only from our own experiences but also by learning from the experiences of others.

The development of vascular and trauma surgery has been accelerated by learning from various war experiences. In this era of hybridized war and increasing civilian casualties, one needs more meticulous documentation and honest appraisal. We need to look at the bottlenecks so as to minimize the damage and save lives. Terror attacks cannot be prevented in this day and age easily. To minimize its aftermath, we need to prepare ourselves. We do form a major cog in the war on terror, and we must rise up to the demand of our times. Tresson et al. experience has shown that mortality and morbidity can be brought down to almost zero percent if adequate training and facilities are provided.

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