

# TRAUMA

## PALO ALTO VA TRAUMA POLICY

The Emergency Room physician will perform standard evaluation of **all** trauma patients that presents to the Palo Alto VA Emergency Room. Patient evaluation and treatment will be based on ATLS principals and will include standard bloodwork, XRAY, CT scans, and procedures as indicated. The ER physician will then make the decision about need for transfer to the closest Level 1 Trauma Center. There will not be a call to the general surgery team to “check” with them about this decision. ER- ER transfer would then be arranged.

### Indications for transfer

1. Multisystem trauma that would likely require admission to a trauma center.
2. Hemodynamically stable patients with evidence of chest/abdominal/retroperitoneal hollow viscus or solid organ injury that would reasonably require 24 hour access to an operating room or interventional radiology suite.
3. Hemodynamically stable patients with penetrating neck trauma (must be beyond platysma) within zone 1 and 3.

Zone 1 of the neck is defined as the space from the level of cricoid to clavicle.

Zone 3 of the neck is defined as the space from the skull base to the angle of the mandible.

### Indications for care at Palo Alto VA

1. Hemodynamically unstable trauma with abdominal or chest hemorrhage - please do the following **ASAP**

**STAT** page the following teams

- On call general surgeon (resident and attending)
- Anesthesia and ICU team to help with resuscitation and line placement
- Nursing supervisor to call in the OR nursing staff

Perform the following key tasks

- Damage control resuscitation using O negative PRBC for resuscitation instead of crystalloids
- Tranexaminic acid administration, type and cross, activation of the massive transfusion protocol
- Pelvic binder if pelvic fracture present

- Place chest drain if indicated for pneumothorax, hemothorax, or hemo-pneumothorax

2. When there is a single system trauma that **would not** require observation for ongoing bleeding then the surgical service that is responsible for that system should be called for consultation.

- Orthopedics for fractures and non-reducible dislocations
- Neurosurgery for traumatic brain injury and spinal injury
- Ophthalmology for ocular injuries
- Plastics/hand for hand fractures or burns
- Facial fractures call alternates monthly between plastics (odd months) and ENT (even months)
- ENT (stat/urgent) for penetrating neck injury limited to zone 2 (from angle of the mandible to the cricoid)

### CHEST TRAUMA

- Isolated rib fractures without clinical pneumothorax or hemothorax DO NOT require consultation by Thoracic Surgery unless deemed clinically necessary by the ED staff.
- Rib fractures with CXRs that have no new effusion or pneumothorax should be trialed on oral pain management in the ED. Patients can be discharged from the ED if they have pain control that allows for a strong cough and achievement of 1000cc on incentive spirometer. If pain control is not adequate by oral regimen Medicine will admit patients for isolated rib fracture admissions after a complete trauma evaluation by the ED attending.
- Hemothorax/pneumothorax may require Thoracic Surgery consultation. If a chest tube is NOT indicated the patient would be managed according to the other medical issues. The patient can be otherwise discharged and may follow up either with their PCP or Thoracic Surgery.
- Hemothorax/pneumothorax for which a chest tube is indicated, will be jointly discussed between Thoracic Surgery and Medicine to determine which service should admit the patient. The decision will be based on the number and degree of active medical issues or significant comorbid conditions (including need for additional work up for syncope and social evaluations for discharge planning (ie ground level falls in the elderly).
- Elderly or severely ill patients ( $\geq 65$  y/o) with  $>2$  acute rib fractures ( $\leq 24$  hrs) that have poor pain control in the ED with oral agents should have an ICU consult for admission for regional anesthesia and pulmonary toilet.

*Please note that there is no "TRAUMA" service at the VA. The majority of surgeons have no recent experience or expertise in the diagnosis and treatment of traumatic injury. There is also no immediate access to the OR or Interventional Radiology outside of business hours. It may take up to 2 hours to get an OR team in and ready to start a case off hours. These resources must be factored into decision making.*