COLUMBIA

COLUMBIA UNIVERSITY
DEPARTMENT OF
EMERGENCY MEDICINE

NewYork-Presbyterian
The University Hospital of Columbia and Cornell

Milstein ED Trauma Guidelines Updates

Rationale

- We are updating our trauma guidelines in order to standardize the approach to various levels of traumatic injuries
- Our goal is to provide a more timely, thorough and efficient trauma evaluation
- Patients that initially appear stable, may have significant injuries that are predictable based on the mechanism of injury
- There were several cases that highlighted the need for these updates and two examples are discussed here

Case Example 1

- 42 yo M crashed motorcycle into tunnel wall going ~65 mph. Arrived via EMS.
- CC: L chest, arm and leg pain. VSS.
- Initially sent to Mint
- After evaluation, sent to Main ED
- Diagnosed multiple rib fractures, pulmonary contusions, open L knee laceration
- Admitted to Orthopedics and taken to OR next day

Case Example 2

- 24 yo F walk in, CC at intake “R leg pain s/p fall from bicycle”
- Triaged to Mint. VSS. Evaluated approximately 2 hours after arrival
- Further questioning: was riding electric scooter with husband and both hit by car at unknown speed but “fast” per pt
- Both thrown and husband with leg fracture in Main ED
- Pt with negative XRs and negative FAST

Response Process

Milstein ED Trauma Activation Guidelines

***ALL** Trauma CODE and ALERT Patients Evaluated in DART Room*

Trauma CODE

If a patient has below criteria or pre-arrival notification of below criteria, call **305-3333** and say "*Trauma STAT Adult ED Trauma Room 305-5747*"

Activate as above so surgery team is involved, Broadcast ED notification "**Trauma CODE**" & place patient in **DART room** if there is trauma with:

- GCS < 10, sBP < 90, RR < 10 or > 29
- Traumatic arrest
- Emergent airway
- Penetrating injury to:
  - head, neck, thorax, back, abdomen
  - extremities proximal to knee or elbow
- Multiple long bone fractures
- Extremities crushed, degloved, mangled, pulseless, or amputated proximal to knee/elbow
- Fall > 20 feet
- Paralysis/Spinal Cord injury
- MVC with ejection, death in same compartment
- Burns >10% or inhalational injury
- Open or depressed skull fracture
- Chest wall instability/deformity (i.e. flail chest)
- Motorcycle crash > 20 mph or separation of bike and rider
- ED team deems necessary

Trauma ALERT

Broadcast ED notification "**Trauma ALERT**" & place patient in **DART room** if there is trauma that meets below criteria. **Do not need to activate surgery unless CODE criteria also met**:

Anatomy:

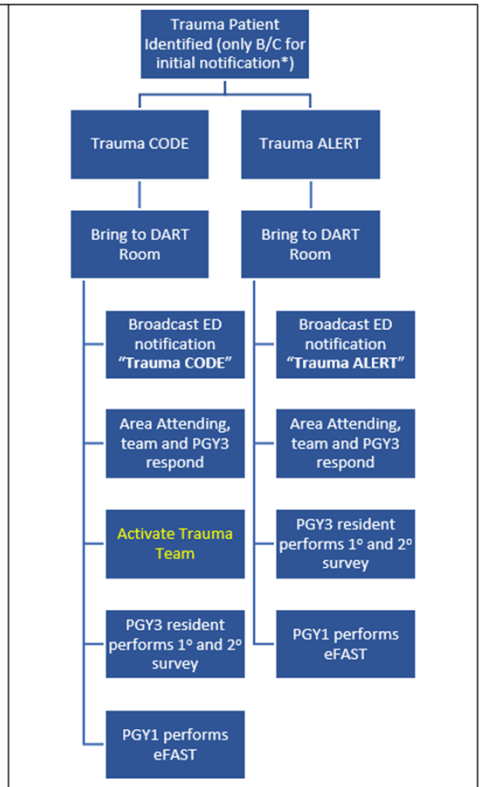
- Penetrating extremity trauma **distal** to elbow & knees **only if hard signs of vascular injury**
  - Absent pulses
  - Signs of ischemia
  - Palpable thrill
  - Active pulsatile hemorrhage
  - Expanding hematoma

Mechanism:

- MVC prolonged extrication (> 20 minutes)
- MVC rollover
- MVC with significant damage (high speed (>40 mph), intrusion >12 in., vehicle deformity >20 in.)
- Pedestrian vs. vehicle with > 5 mph impact, thrown or run over
- Bicyclist/scooter/moped run over, separated from vehicle, or significant injury to another person involved
- Trauma in pregnant patient >20 weeks (consider OB consult)
- High suspicion of injury

Specific Head Trauma Criteria for Alert:

- Head injury on anticoagulants/anti-platelets
- Head injury with AMS, intoxication, seizure
- Head trauma AND GCS ≤ 14
- Violent/agitated patient with evidence of head trauma
- ≥ 65-year-old patient WITH head trauma



*If clinical observation is required after initial evaluation and stabilization, formal handoff to Area D attending can occur. Initial attending responsible for primary documentation.

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Highlights

- Initial trauma notifications only for areas B and C
- ALL trauma notifications evaluated in DART room (will need to be brought back around from Pivot)
- No longer will have “Head Trauma” notifications as this would be a “Trauma Alert” or “Trauma Code” notification depending on their degree of injury