

DRAFT On-Call Referral Guidelines

If you would like to comment on this draft, please send your comments to COA: coa1@pacbell.net Fax: 916-454-9882.

Orthopedic Decision Tree

for those patients who do not meet other criteria for transfer to Trauma Center

South East Regional Trauma Coordinating Committee (RTCC)

- Pelvic fracture resulting from high energy (excluding same height falls)
- Displaced acetabular fractures > 0.5cm
- Irreducible joint dislocation
- Limb injury with neurovascular compromise (attempt fracture alignment prior to transfer).
- Compartment syndrome. Fasciotomy should be performed prior to transfer.
- Traumatic Amputation (proximal to wrist and ankle)
- Open fractures (femur, tibia, mangled extremity) without orthopedic surgery availability to perform debridement/irrigation and provisional external fixation or even definitive fixation (excluding fingers and toes)
- Closed femur fractures if no orthopedic surgeon available
- Displaced femoral neck fractures and talar neck fractures
- Closed fractures with severe soft tissue compromise
- Displaced/comminuted periarticular fractures (large joints)

Ideal:

Orthopedic MD from transferring facility should examine patient and review radiology images.

There should be ortho to ortho communication in addition to communication with accepting Trauma Surgeon

Pelvic binders should be placed prior to transfer for Open Book pelvic fractures

DRAFT - Adult Open Fracture Guidelines

Draft - Pediatric Open Fracture Guidelines

South East Regional Trauma Coordinating Committee (RTCC)

<p>Antibiotics:</p> <ul style="list-style-type: none">• Cefazolin for low Grade open fractures• Add Gentamycin for high Grade open fractures• Add PCN if you suspect dirt (barnyards, soil, etc.)• Antibiotics should be ordered with scheduled repeat doses (not just one time doses)• Update Tetanus	<p>Grades I, II, III A Grades III B & C</p>	<p>If the patient has a sensitivity to Cefazolin, Clindamycin is the second antibiotic of choice.</p>
<p>Wound Wash Outs:</p> <ul style="list-style-type: none">• All visible debris should be removed• Document the size, shape, and location of the wound• Cover wound with a saline soaked dressing• Apply splint or traction as required	<p>Ideally photographs of the wound should be taken.</p>	<p>Realign/reduce limb</p>

<p>Bedside Washouts for Interfacility transfers</p> <p>Do not do delay interfacility transfers for bedside washouts</p>	<p>Definitive treatment is debridement done in the Operating Room.</p> <p>Rarely there are instances when a provisional washout may be considered definitive treatment.</p> <p>These situations are limited to open fractures in the forearm and certain low velocity GSWS.</p>	
<p>Time to OR</p> <p>The Time to the Operating Room remains a controversial topic. Many hospitals use a 6 hour time frame but there is no research showing this affects outcome. There is one article that shows a 13 hour time frame is beneficial:</p> <p>(J Orthop Trauma. 2002 Aug;16(7):484-90. The effect of time to definitive treatment on the rate of nonunion and infection in open fractures. Harley BJ, Beaupre LA, Jones CA, Dulai SK, Weber DW.)</p> <p>For this reason the South East RTCC makes the following recommendation.</p> <p>Patients <u>without</u> life-threatening injuries</p> <ul style="list-style-type: none"> • To OR within 13 hours for non-mangled limbs • ASAP with mangled limbs 		

- Consideration should be given for severity of injury, fracture Grade, degree of contamination, comorbidities such as diabetes.

Patients with life-threatening injuries

- To OR within 13 hours if patient can tolerate procedure
- ASAP if patient can tolerate procedure
- Consideration should be given for severity of injury, fracture Grade, degree of contamination, comorbidities such as diabetes.

Although a 13 hour time frame is recommended, hospitals should continue using their current audit filter to trend Delay reasons and analyze appropriateness of care.