MEMO

Date: April 25, 2017

To: Trauma Multidisciplinary Committee Members

From: Benjie Christie, MD
        Co-chair, Trauma Multidisciplinary Committee

The Trauma Multidisciplinary Review committee met Tuesday, April 25, 2017 for our monthly review. Please find the following teaching points and synopsis of the discussion. Please share this information with physicians from your Department who participate on the Trauma Call schedule.

- Sources of fever: Etiology of fever in the multi-trauma patient is a common problem often heralding the onset of infection and potential organ dysfunction. A high index of clinical suspicion and investigative diligence is required to properly identify the fever’s driving source to provide an appropriate therapeutic maneuver. Consideration to delayed injury presentation, missed injury, or a hospital acquired infection must be given to all clinically significant temperature elevations. Culturing for antimicrobial influence from the lungs, blood and urine is recommended while initially providing broad spectrum antibiotics with de-escalation of therapy pending source control and microbial sensitivity analysis. Extreme temperature elevations are acknowledged to often represent infections with particularly virulent micro-organisms such as acinetobacter, multi-drug resistant pseudomonas, or c. diff and should alert the provider to the need for meticulous attention to patient physiologic support measures as a septic response is eminent.

- Liver injury and sequela: Complex liver injuries can evolve over a hospital course as the initial trauma has passed and the parenchyma of the liver remolds. Injuries encountered in addition to the admission liver fracture and bleed include: biliomas, hepatic abscesses, pseudoaneurysms, and biliary-enteric fistulas. When suspected,
workup with the appropriate radiographic imaging is required as prompt recognition is needed to prevent patient deterioration.

- Arrhythmia recognition and medication delivery: Pre-injury medical conditions can complicate the trauma patients recovery from an acute injury. A thorough review of all the patients pre-injury medications, indications and patient’s compliance with these medications is required to optimize patient outcomes after acute injury. Cardiac arrhythmias are common, silent, and present, or exist, in patients with varying symptom magnitudes. When suspected, in-hospital monitoring with telemetry, a thorough medication review and reconciliation is needed. If oral anti-arrhythmics are contraindicated due to the patients current clinical condition, preparation for IV delivery is required which may include the need to transfer the patient to the ICU or cardiac observation floor. If dysphagia is present, consideration for nasogastric tube placement or gastrostomy tube placement for medication delivery must be made and discussion had with the patient and family regarding goals of care and directives.