MEMO

Date:  May 11, 2015

To:   Trauma Multidisciplinary Committee Members

From:  Dennis Ashley, MD
       Chairman, Trauma Multidisciplinary Committee

The Trauma Multidisciplinary Review committee met Tuesday, April 28, 2015, 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.

- Chest tube management – Patients who have subcutaneous emphysema on chest xray without an obvious pneumothorax may need a chest tube inserted before transport out of the emergency room. Each patient must be individualized. The goal is to avoid respiratory decompensation while the patient is in CT or other areas of the hospital going through their diagnostic work up.

- Placement of ICP monitors – Patients presenting with severe traumatic brain injury may require an ICP monitor. These monitors may be placed in the emergency room, operating room, or ICU. In the event that a patient is hemodynamically unstable and needs to be taken to the operating room for an exploratory laparatomy emergently, the neurosurgery team can place these monitors in the operating room at the same time the trauma team is performing the laparatomy.

- Reduction of hip dislocations – Patients who present to the emergency room with a hip dislocation should have attempted reduction as soon as possible. The orthopedic team should be consulted immediately. Reduction of the hip in a timely fashion should decrease the incidence of avascular necrosis and reduce pain.

- Control of hemorrhage – Two major therapeutic interventions for hemorrhage control are vascular embolization in the vascular lab and exploratory laparotomy in the operating room. Both therapies can have a significant impact on patient outcomes. Once the trauma surgeon decides on the appropriate therapy, the team should move the patient to the appropriate location expeditiously to gain control of hemorrhage.
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