MEMO

Date: June 4, 2014

To: Trauma Multidisciplinary Committee Members

From: Dennis Ashley, MD
Chairman, Trauma Multidisciplinary Committee

The Trauma Multidisciplinary Review and Trauma Operations Performance Committee met Tuesday, May 27, 2014, 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: Chest tubes are frequently placed in trauma patients and may be used for both pneumothoraces and hemothoraces. There are multiple points to consider with regard to indications for insertion and technique. It is important to evaluate the chest x-ray paying particular attention to the findings of a mucus plug versus a hemothorax or pleural effusion. A mucus plug will result in volume loss on the side that is affected with possible hyperexpansion of the contralateral lung. Pleural effusion or hemothorax will not show this volume loss and may result in shift of the mediastinum or trachea to the contralateral side. When inserting the chest tube the standard landmarks should always be used even when trying to drain a pleural effusion. Trauma patients are usually supine and a tube placed posteriorly in the fourth or fifth intercostal space should drain the chest cavity appropriately. There is no need to go more inferior for placement in this particular setting. The appropriate side for chest tube insertion should be confirmed before chest tube placement. This may be confirmed with another physician or nurse.
o **MTP Protocol:** MCCG has a massive transfusion protocol. Initially the blood bank representative will bring two units of O negative blood to every trauma alert. If this blood is used and there are still bleeding issues, the MTP protocol should be instituted promptly. The MTP protocol may be initiated while the initial two units of blood are transfusing if it appears that ongoing blood loss will be a problem.