MEMO

Date: September 29, 2015

To: Trauma Multidisciplinary Committee Members

From: Dennis Ashley, MD
Chairman, Trauma Multidisciplinary Committee

The Trauma Multidisciplinary Review committee met Tuesday, September 22, 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.

- Complex pelvic fractures in a pediatric patient – the initial management of complex pelvic fractures in children is similar to the adult patient as resuscitation follows PALS and ATLS ABCs. Once the airway and breathing components have been stabilized it is imperative to evaluate and treat hemorrhage. Patients with open book or anterior posterior compression type injuries are the most likely to develop significant hemorrhage. These patients should have a pelvic binder placed to stabilize the pelvis and help tamponade bleeding. Patients should also have a FAST exam to rule out intra-abdominal bleeding. If there is major intra-abdominal bleeding with hypotension, patient should be taken to the operating room for an exploratory laparotomy. Pelvis should then be re-evaluated. If the bleeding is confined to the pelvis and the patient is unstable arterial embolization should be considered. Massive transfusion protocol with the appropriate ratio of PRBCs: FFP: Platelets should be used for resuscitation. It is important to note that children have a tremendous ability to compensate for the shock state and will show signs of a significant tachycardia. Hypotension develops when this compensatory mechanism is overcome and a significant clinical sign of deterioration is a decrease in the level of consciousness. Hypotension is usually a late sign of shock. Hypotension in children 1-10 years of age is considered present if the systolic blood pressure reading is less than 70 mm HG + child’s age in years x 2 mm HG (PALS definition).