

CLINICAL PRACTICE GUIDELINE: Open Fracture Guideline

STANDARD:

There must be protocols in Level I and II Centers for the following orthopedic emergencies: 1) the type and severity of pelvic and acetabular fractures that will be treated at the institutions as well as those that will be transferred out for care; 2) the timing and sequence for the treatment of long bone fractures in multiply injured patients; and 3) the wash out time for open fractures. These protocols must be included as part of the PIPS process. (CD 9-14)

DEFINITIONS:

Open Fracture: Is one in which the fracture fragments communicate with the environment through a break in the skin. The presence of an open fracture either isolated or as part of a multiple injury complex increases the risk of infection and soft tissue complications.

GUIDELINES:

1. The Orthopedic Consult should occur within 30 minutes of notification of the request.
2. The fracture should be stabilized.
3. The patient's tetanus status should be determined and updated as necessary.
4. Wound management:
 - a. Washout and debridement within 24 hours
 - b. Flap closure within 7 days.
5. Determine the type of fracture utilizing Gustilo Classification
6. Type I & II: antibiotic coverage for gram positive organisms started within 60 minutes and continue for 24 hours after successful skin closure.
7. Type III: antibiotic coverage for both gram positive and negative organisms started within 60 minutes and continue for 72 hours subsequent to injury or 24 hours after successful skin closure.
8. High dose penicillin should be added for any open fracture with presence of fecal or potential clostridial contamination.

Type I	Open fracture with as skin wound <1 cm in length and clean.
Type II	Open fracture with a laceration >1 cm in length without extensive soft tissue damage, flaps, or avulsions
Type III	Open segmental fracture with >10 cm wound with extensive soft tissue injury or a traumatic amputation (special categories in Type III include gunshot fractures and open fractures caused by farm injuries)
III _A	Adequate soft tissue coverage
III _B	Significant soft tissue loss with exposed bone that requires soft tissue transfer to achieve coverage.
III _C	Associated vascular injury that requires repair for limb preservation

MONITORING PERFORMANCE IN PI PROGRAM

- 1) Average antibiotic timing for open fractures tracked on Trauma Dashboard
- 2) Time to ORIF tracked on Trauma Dashboard
- 3) PI Indicators in place:
 - ORIF > 24 hours after arrival
 - Open fractures with no antibiotics within 60 min
 - No ortho surgery arrival within 30 minutes of consult for level 1 and 2 trauma activations

REFERENCES:

1. ^ **ab** Gustilo RB, Anderson JT. Prevention of infection in the treatment of 1025 open fractures of long bones: retrospective and prospective analyses. *J Bone Joint Surg Am.* 1976;58:453–458.
2. ^ **ab** Gustilo RB, Mendoza RM, Williams DN. Problems in the management of type III (severe) open fractures: a new classification of type III open fractures. *J Trauma.* 1984;24:742–746.
3. ^ **ab** Luchette FA, Bone LB, Born CT, et al. EAST Practice Management Guidelines Workgroup: practice management guidelines for prophylactic antibiotic use in open fractures. Eastern Association for the Surgery of Trauma. 2000. Available at: <http://www.east.org/tgp/openfrac.pdf>. Accessed November 15, 2009.
4. ^ Pasquale M, Fabian TC. Practice management guidelines for trauma from the Eastern Association for the Surgery of Trauma. *J Trauma.* 1998;44:941–956.
5. ^ Agency for Health Care Policy and Research. *Interim Manual for Clinical Practice Guideline Development.* Rockville, MD: Agency for Health Care Policy and Research; 1991.
6. ^ DeLong WG Jr, Born CT, Wei SY, Petrik ME, Ponzio R, Schwab CW. Aggressive treatment of 119 open fracture wounds. *J Trauma.* 1999;46:1049–1054.
7. ^ Vasenius J, Tulikoura I, Vainionpää S, Rokkanen P. Clindamycin versus cloxacillin in the treatment of 240 open fractures. A randomized prospective study. *Ann Chir Gynaecol.* 1998;87:224–228.

8. ^ Greenbaum B, Zions LE, Ebramzadeh E. Open fractures of the forearm in children. *J Orthop Trauma*. 2001;15:111–118.
9. ^ Yang EC, Eisler J. Treatment of isolated type I open fractures: is emergent operative debridement necessary? *Clin Orthop Relat Res*. 2003;410:269–294.
10. ^ Patzakis MJ, Bains RS, Lee J, et al. Prospective, randomized, double-blind study comparing single-agent antibiotic therapy, ciprofloxacin, to combination antibiotic therapy in open fracture wounds. *J Orthop Trauma*. 2000;14:529–533.
11. ^ Huddleston PM, Steckelberg JM, Hanssen AD, Rouse MS, Bolander ME, Patel R. Ciprofloxacin inhibition of experimental fracture healing. *J Bone Joint Surg Am*. 2000;82:161–173.
12. ^ Holtom PD, Pavkovic SA, Bravos PD, Patzakis MJ, Shepherd LE, Frenkel B. Inhibitory effects of the quinolone antibiotics trovafloxacin, ciprofloxacin, and levofloxacin on osteoblastic cells in vitro. *J Orthop Res*. 2000;18:721–727.
13. ^ Sorger JI, Kirk PG, Ruhnke CJ, et al. Once daily, high dose versus divided low dose gentamicin for open fractures. *Clin Orthop Relat Res*. 1999;366:197–204.
14. ^ Russel GV Jr, King C, May CG, Pearsall AW IV. Once daily high-dose gentamicin to prevent infection in open fractures of the tibial shaft: a preliminary investigation. *South Med J*. 2001;94:1185–1191.