

CLINICAL PRACTICE GUIDELINE: Pelvic Fracture Management

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:

Instability: Unstable pelvic ring disruption may be rotationally and/or vertically unstable. Instability can be a result of fractures of the sacrum, ilium, and pubis. Instability can also result from ligamentous disruption of the pelvic ring at the iliosacral joints and the pubic symphysis.

Open fracture: Associated soft tissue injury allowing contamination of the fracture. Increase in mortality has been associated in markedly increased mortality rates. Open fracture in the pelvis include lacerations in the skin, perineum, vagina, and rectum.

GUIDELINES:

1. Follow the ABC's per ATLS protocol
2. Perform physical exam. If pelvic ring fracture suspected or if patient presents with a high energy mechanism of injury (MVC, Motorcycle, Fall from height, etc) obtain AP Pelvis x-ray ASAP as standard trauma work up in addition to the standard CXR.
3. If pelvic ring injury is present, early consult to orthopedic surgery to address the pelvic ring injury in the trauma bay.
4. Appropriate placement of a pelvic binder and/or traction in patients with pelvic ring injury and hemodynamic instability.
Majority of intra-pelvic bleeding with pelvic ring injuries is venous and can be stabilized with appropriate trauma bay management to limit fracture movement and allow the bleeding to tamponade.
5. Perform CT scans after appropriate resuscitative modalities have been applied.
6. If patient remains hemodynamically unstable consider other treatments in the OR with possible placement of an external fixator, exploratory laparotomy, or interventional radiology for selective arterial embolization.

MONITORING PERFORMANCE IN PI PROGRAM

No ortho surgery arrival within 30 minutes of consult for level 1 and 2 trauma activations

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