TITLE: CARE OF THE PREGNANT TRAUMA PATIENT

PURPOSE:

To provide guidelines for the coordination of care for trauma patients who are pregnant when presenting to the Emergency Center (EC) for care.

POLICY STATEMENT:

All obstetrical patients presenting to the Emergency Center with trauma are to be initially triaged to the Emergency Medicine service. All obstetrical trauma patients initially presenting to OB Triage with trauma must be escorted by an L&D nurse and/or OB physician to the Emergency Center to be cleared by the Emergency Medicine service. If the patient cannot be moved to the Emergency Center the Emergency Medicine service should be called to OB Triage to see patient.

DEFINITIONS:

A. ATTENDING OBSTETRICIAN: The faculty physician responsible for Labor and Delivery.

B. OBSTETRICAL EMERGENCY TEAM: L&D nurse and a resident physician appointed by the Attending Obstetrician.

C. EMERGENCY MEDICAL SERVICES: The faculty physician responsible for the Emergency Center (EC Attending).

PROCESS:

I. PREGNANT TRAUMA PATIENT
   A. The EC physician or nurse will obtain an initial estimate of gestational age of the fetus
   B. All pregnant trauma patients \( \geq 20 \) weeks should be activated as a code 2 unless criteria is met for code 1 activation
C. For patients who are ≥20 weeks pregnant and meet code 1 activation criteria the following should be observed:
   1. Trauma Attending or EC Attending will contact the L&D charge nurse and the L&D Attending using the L&D Trauma call list. See Appendix A.

D. For patients who are ≤20 weeks pregnant and meet code 1 activation criteria the following should be observed:
   1. Trauma Attending or EC Attending will contact the L&D charge nurse and the L&D physician on call using the L&D Trauma call list. See Appendix A.

E. If Trauma Attending or EC Attending determines there are no other significant injuries and the patient still requires monitoring, then the patient is cleared to go to L&D at the discretion of the Obstetrician.

F. If it is determined that the patient cannot go to L&D, then the L&D nurse and Obstetrician will monitor, assess and document fetal and maternal status in the EC as needed.
   1. The determination, duration, and method of EFM will be decided by the Obstetrician
   2. If deemed necessary by the Obstetrician, continuous electronic fetal monitoring (EFM) for fetal assessment and uterine activity will be initiated.
   3. If clinical presentation, physical exam or history warrants imaging studies, EFM is to remain applied throughout the procedure, if possible, or removed for the duration of the procedure and immediately resumed upon completion of the study.

G. If it is determined that the obstetrical trauma patient requires surgery or inevitable delivery the appropriate operating room
Guidelines and Protocols

should be made available and the case posted as for any other emergency surgical case.

H. Neonatal ICU will be notified and the case posted as for any other emergency surgical case.

I. A major procedure tray, (i.e. caesarean tray) will be available in the E.C. and postmortem cesarean deliveries may be performed when appropriate.

J. Advanced Directives cannot be implemented until after delivery of the infant. (Advanced Directives do NOT apply to a pregnant patient regardless of gestational age).

**STAT C-section in ED with blunt or penetrating abdominal trauma will be performed via a midline laparotomy incision by OB-Gyn physicians in conjunction with trauma surgery, when exploratory laparotomy is indicated. C-sections performed in OR with abdominal trauma requiring exploratory laparotomy, will be done in the TRAUMA OR via a midline laparotomy incision in conjunction with trauma surgery.**

Advanced Directives cannot be implemented until after delivery of the infant. (Advanced Directives do NOT apply to a pregnant patient regardless of gestational age.)
OB/GYN Trauma Protocol
L&D Trauma Call List

Please notify the following for pregnant trauma patients 20 weeks gestation or less arriving to EC:

1. **OB/GYN EC Resident:**
   - Cisco Phone = 39334
   - Pager = (281) 952-3931

   OB/GYN EC Resident will need to come down to evaluate the patient ASAP

2. **Labor and Delivery Charge Nurse:**
   - Cisco Phone = 39039
   - L&D Ext. = 65503
   - OB Triage Ext. = 65742

   OB/GYN will send down a nurse to monitor the baby (heart tones/TOCO monitor) until the patient is cleared by trauma

Please notify the following for pregnant trauma patients 20 weeks gestation or greater arriving to EC:

1. **OB/GYN EC Attending:**
   - Cisco Phone = 39331/39334

   OB/GYN EC Attending will need to come down to evaluate the patient ASAP

2. **Labor and Delivery Charge Nurse:**
   - Cisco Phone = 39039
   - L&D Ext. = 65503
   - OB Triage Ext. = 65742

   OB/GYN will send down a nurse to monitor the baby (heart tones/TOCO monitor) until the patient is cleared by trauma
**Note:** If OB/GYN EC Resident is unable to be reached, please contact the OB physician team in the following order (if OB/GYN EC Resident is reached, there is no need to contact the remaining physicians):

3. **Chief Resident:**
   Cisco Phone = 39331

4. **Attending:**
   Cisco Phone = 39330

5. **3rd & 2nd year Resident:**
   3rd year Cisco Phone = 39332
   2nd year Cisco Phone = 39333

6. If an OB patient ≥ 20 weeks presents to OB-Triage after trauma, but cannot be sent to the EC for further work-up call the EC charge nurse Cisco Phone 69261. The EC charge nurse will notify the EC attending to assess the patient.

**If there is significant OB trauma, please page the following message overhead:**

“OB to EC”
REFERENCE / BIBLIOGRAPHY:


OFFICE OF PRIMARY RESPONSIBILITY:

LYNDON B. JOHNSON HOSPITAL TRAUMA SERVICES

REVIEW / REVISION HISTORY

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