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Traumatic Brain Injury

In patients with moderate (GCS 9-12) to severe (GCS ≤8) traumatic brain injury (TBI) after resuscitation and without systemic sedation for whom ICU admission is appropriate: the patient should be admitted to the NTICU if the injury is isolated TBI or TBI with facial fracture or scalp laceration but no other injuries.

ICU Overflow: NTICU patients in the STICU

If the NTICU is full, patients meeting above criteria for NTICU admission will be admitted to the STICU as overflow.

- The patient will be assigned to the Neurosurgery service attending and admitted to the STICU.
- The STICU team will round on the patient and provide all primary critical care services.
- The patient will be transferred to the Neurosurgery service when a clinically appropriate bed becomes available.
- The STICU team in conjunction with the Neurosurgical team will coordinate Neurosurgical care and will respond to all emergencies. Any acute neurosurgical decompensation or acute escalation of care will be immediately communicated to the Neurosurgical team. Please refer to “Guideline for the Management of Severe Traumatic Brain Injury (TBI)” [LINK] for further details.

If the STICU is full (or only has one bed), patients with TBI and multi-system trauma will be admitted to the NTICU as overflow.

- The patient will be assigned to the Trauma service attending and admitted to the NTICU.
- The Neuro Critical Care team will round on the patient and provide all primary critical care services.
- The trauma team will round on and evaluate the patient daily, and communicate any surgical concerns to the NTICU team, until the patient transfers back to the trauma service or has resolution of multi-system trauma injuries and care.
- The patient will be transferred to the Trauma service when a clinically appropriate bed becomes available (ICU, IMU or Floor as necessitated by patient’s condition).
- NTICU team will consult the trauma team for any surgical procedures (tracheostomy, PEG tubes).

Exceptions to the above guidelines AND transfers between ICU should be discussed between attending physicians only.
Trauma Evaluation of Patients with Orthopedic Extremity and/or Pelvic Injuries

Patients with orthopedic injuries NOT meeting the criteria for trauma team activation or consultation [LINK] may be directly admitted to the Orthopedic or Hospitalist service. The trauma service may still be asked to evaluate the patient at the discretion of the admitting service, and these requests will be monitored.

Orthopedic Surgery Treatment and Transfer Policy for Orthopedic Emergencies

Type and severity of acetabular fractures that will be treated versus transferred:

- All acetabular and pelvic fractures will be treated at our institution.
- Exception – Ground level fall patients with isolated orthopedic injuries requiring joint replacement may be transferred to a MHH joint center after clearance by Orthopedic surgery and the ED physician

Timing and sequence for the treatment of long bone fractures in multiply injured patients:

- Hemodynamically stable patients
  - definitive fixation/reduction/splinting within 24 hours of clearance by the trauma team
- Hemodynamically unstable patients
  - external fixation/reduction/splinting at first OR visit or once cleared by the trauma team
  - temporary splinting for all fractures in the Emergency Department

Wash out time for open fractures

- I&D of fractures with definitive fixation/external fixation/reduction and splinting within 24 hours of admission

If any further trauma related issues or questions arise on the patient, the trauma service is always available and happy to see the patient. The trauma chief resident can be reached at 713-704-7055.

UTHealth Medical School
Facial Trauma Call

Rotation Schedule

Facial trauma call is taken by three services: oral maxillofacial surgery (OMFS), plastics surgery, and ENT on a q3 day rotating basis. The on-call day starts at 7:00 am and concludes at 6:59 am on the following morning. Patients in the emergency department and patients already admitted to the hospital will be assigned to the on-call service based upon the time the consult is initiated, not based on time of patient arrival to the ER.

Facial Trauma with Vascular Injury

Patients with facial injuries and a suspected extra-cranial vascular injury (e.g. branch of external carotid artery) will be initially evaluated by Endovascular Neurosurgical Radiology (ENR) through the UTH Neurosurgery Department call schedule. They will decide on and perform arteriography and intervention as appropriate.

Hand and Microsurgery Call

Rotation Schedule

Daily call will begin at 0700 and conclude at 0659 the following morning. Assignments of patients in the Emergency Department will be made based on the time the consult is requested of the on-call service.

Example: If a patient with an isolated hand injury presents at 0630 and the Emergency Department requests a consult form the Hand Service at 0702 then the service beginning at 0700 will provide the attending and resident for that patient.

Patients transferred from outside facilities will be assigned to the on-call service that is current at the time the patient is physically present in the Emergency Department and contact with the on-call service is made by the Emergency Department staff, even if the patient was accepted by the service on call the previous shift.

Example: If a patient with an isolated hand injury is accepted in transfer by the on-call service at 0300, but is not physically present in the Emergency Department and contact with the Hand service is not made until 0715, then the service beginning at 0700 will provide the attending and resident for that patient.

Delayed or deferred diagnosis requiring hand service intervention will be directed to the service (attending physician) on call at the time the consultation is made whether intra-operative, in a unit or a case of a return to the Emergency Department of a patient previously unassigned to a hand consult service.
Drowning/Near Drowning

Initial evaluation will be per usual Emergency Medicine (EM) standard of care. A trauma activation is needed only if mechanism criteria are met for a trauma activation (i.e. see criteria for level 1 & 2 trauma activation or Urgent consult). Intubation WITHOUT a traumatic mechanism to the drowning (i.e. fall from height, MVC into water, boating accident, etc.) DOES NOT necessitate trauma activation. However, patients with a level 2 trauma activation who require intubation (either for drowning related issues or otherwise) should be upgraded to a level 1 per our typical process for level 2 trauma activations. Radiographic evaluation of an intubated patient with suspicion of trauma will routinely include a CT scan of the head and cervical spine in addition to other imaging studies at the discretion of the EM faculty.

Patients without traumatic injuries can be admitted to the appropriate medical services (18 and over to the adult services, 17 and younger to the pediatric services).

If traumatic injuries are identified, then appropriate consultation with trauma service (age 16 and over) or pediatric trauma service (age 15 and younger) will be required and patient should be admitted to appropriate service per usual standard of care.

Spinal Cord Injury

All confirmed or suspected spinal cord injury patients will be assessed by the Trauma Service. If an isolated injury, the patient may be admitted to the appropriate spine service.

If the patient requires ICU admission, patients admitted to or followed by to orthopedic spine will go to the STICU and patients admitted to the neurosurgery spine service will go to the NTICU, unless they are multi-trauma, in which case they will be admitted to STICU per the above protocol.

Snake Bites

Please see Snake Bites Clinical Practice Algorithm.