**Trauma workup at the non-trauma center**

**Michael S Bohanske, MD**

**Maine Medical Center**

**Assistant Professor, Tufts School of Medicine**

**Maine Medical Center Winter Symposium 2019**

* Overview
  + A sick trauma patient arriving at a non-trauma center can suck your resources and leave you feeling overwhelmed. Did I do enough? Should I have done more? Where do I draw the line on diagnostics and treatment for the patient that needs to be transferred to a trauma center? While the answer to this is not black and white, the tips below and presented today will help to guide your decision-making.
* Tips
  + Respect the mechanism – Take 30 seconds and listen closely to the EMS report, asking followups about the mechanism. This will drive much of your clinical suspicions and subsequent decisions. This can be really hard to appreciate by looking at a patient lying flat on a bed in front of you.
  + Know your environment – Northern New England has a very dispersed population, localized hospital resources, and limited critical care transport capabilities. Compared to the more urban centers where most of us trained, much of our “when and how to transfer” decision-making will be based on location, resources, and stability.
  + Airway – Forget anyone that taught you to intubate based on GCS. Can the patient ventilate? Can the patient oxygenate? Can the patient protect their airway? Do you predict their airway is going to decompensate during transport?
  + Breathing- Not all chest trauma requires an immediate intervention, and those that do, do not all require a chest tube. If placing a chest tube is not working or not currently an option – consider a finger thoracostomy. Especially in the patient who is mechanically ventilated, turning their hemo/pneumothorax into an open hemo/pneumothorax will stave off the life threat.
  + Circulation – Get control of major or bleeding but don’t sweat the small wounds. Remember that direct pressure fixes most localized bleeding but don’t hesitate to move to a tourniquet if needed. 1:1:1 (PRBC:Plasma:Plt) remains the standard for massive transfusion. Consider TXA early if your patient is in hemorrhagic shock.
  + Deformity – MSK injuries are rarely life threatening and should not be your focus, but a quick splint will make transport more tolerable for the patient.
  + Imaging – A lot can be accomplished with a portable CXR and a bedside FAST. Don’t get bogged down in tons of cross-sectional imaging, but a CT head may be a helpful prognosticator for your next steps.
  + Preparation prior to transfer – Imaging performed, meds given, and your initial interpretations get lost in the telephone game of transfers. Send anything you have with the patient in writing and if new results become available, fax them to the receiving facility to streamline care and prevent duplicate testing.
* Resources
  + Taming the SRU: Air Care Procedures – A great resource for narrated videos on common and uncommon emergency procedures. Available at: [www.tamingthesru.com/air-care-procedures-quick-reference](http://www.tamingthesru.com/air-care-procedures-quick-reference)