Initial Management of All Pediatric Trauma Patients

- Stabilize ABCs and c-spine (Airway, Breathing, and Circulation)
  - IMMOLIZE SPINE as indicated. Position for optimal airway and suction as needed. Position infants and children < 2 yrs supine on a backboard with a recess for the head or use a pad under the back from the shoulders to the buttocks.
  - Consider needle decompression for signs of pneumothorax, hemothorax or tension pneumothorax
  - Obtain weight (actual or use of weight/length based tool)
  - Establish 2 peripheral IVs (consider large bore if possible) or if unable, establish intraosseous (IO) access
  - Control any external bleeding
  - Avoid removal of penetrating objects in the emergency department (should be performed in operating room due to risk of hemorrhage)
  - Monitor
    - Heart Rate (HR), Blood pressure (BP), Oxygen Saturation ($\text{SpO}_2$), mental status, temperature, perfusion, urine output, bedside glucose
  - Perform detailed primary and secondary history & physical exam including mechanism of injury, Pediatric Trauma Score (PTS) and Pediatric Glasgow Coma Scale (PGCS)
  - Consult pediatric care medical specialist for assistance with care of the acutely and critically injured patient (see below for Level I Trauma Criteria), to individualize the care of patient, if patient does not improve and needs to be admitted/transfered and as needed for further support and consult.

- Category 1 Trauma Criteria (minimum):
  - All penetrating injuries to head, neck, torso, and/or groin
  - Two or more body regions with potential threat to life or limb
  - Combination trauma with ≥20% TBSA burn
  - Limb paralysis and/or sensory deficit above the wrist and ankle
  - Flail chest
  - Amputation proximal to wrist or ankle
  - Blunt or penetrating trauma with unstable vital signs AND/OR:
    - Hemodynamic compromise (Pediatric SBPs≤80)
    - Respiratory compromised (Respiratory rate <10 or >29)
    - Altered mentation (PGCS≤10)

- Additional Blast Injury Considerations:
  - Classification of Blast Injuries (see page 8 for more detailed information on pediatric clinical presentations for common blast injuries and management of specific blast injuries)
    - Primary
      - Results from impact of the over-pressurized blast wave
      - Gas filled/hollow structures most susceptible
      - Examples: blast lung, tympanic membrane rupture, abdominal hemorrhage and perforation, eye globe rupture, traumatic brain injury (TBI) without physical signs of head injury
    - Secondary
      - Results from flying debris and bomb fragments
      - Entire body may be affected
      - Examples: penetrating and blunt trauma injuries, eye penetration
o Tertiary
  ▪ Results from victims being thrown by blast wind
  ▪ Entire body may be affected
  ▪ Examples: fractures, amputations, closed and open brain injury

o Quaternary
  ▪ All injuries, illnesses not due to Primary, Secondary or Tertiary mechanisms
  ▪ Entire body may be affected
  ▪ Example: crush injuries, burns, asphyxia, toxic exposures, exacerbation or complications from existing or chronic conditions
Management for Pediatric Trauma & Blast Injury Patients

Determine if patient is critically ill/injured
- Capillary refill >2 seconds
- Slow or fast breathing rate
- Penetrating wound to head/chest/abdomen
- Significant blunt trauma to chest/abdomen
- Pelvic/femoral fracture
- Open chest wound
- Spinal injury with paresthesia
- Unconscious/history of LOC
- Amputation/crush injury
- Respiratory distress/failure
- Signs/symptoms of intra-abdominal injury:
  - Hematuria, Grey Turner sign (discoloration of flank/periumbilical area), abdominal asymmetry/distention, tender/guarding/pain on palpation
- Signs of Shock
- Prolonged extrication

YES

NO

Treat all life threatening injuries:
- Protect airway:
  - Apply supplemental oxygen to maintain SpO₂ ≥ 94%
  - Use NPA/OPA as needed if not contraindicated
  - Intubated as needed to protect airway
    - Tidal volume: 6-10mL/kg
    - I-time: 0.5-1.0
    - Respiratory rate: set based on age
    - PEEP: 3-5 mm H2O
    - Peak Inspiratory Pressure: 20-30 mm H2O
  - For more information, see: Use of Strategic National Stockpile (SNS) Ventilators in the Pediatric Patient: Instructional Guidelines with Training Scenarios, 2nd edition
- Control any bleeding
  - Administer 0.9NS IVF bolus 20mL/kg if signs of hypoperfusion exist. Repeat x 2 PRN
  - Consider PRBCs if patient does not respond to IVF boluses (10mL/kg)
- Perform x-rays, CTs as indicated:
  - Immobilize/splint/stabilize any fractures
- Draw labs as indicated (CBC, CMP, PT/PTT, urine analysis, Type and Screen)
- Initiate pain control
- Administer antibiotics and tetanus as indicated
- Perform detailed head to toe assessment (see pg. 7 for details)

Additional Blast Injury Considerations:
- See page 8 for detailed assessment and management for blast injuries
- Maintain urine output of 2-4mL/kg/hr
- Prolonged extrication requires high fluid volume and possible alkalinization of the urine
  - For potential potential rhabdomylosis (0.45% NS with 50mEq/liter of sodium bicarbonate).
  - Monitor urine for RBCs and myoglobin
  - Obtain CKMB, ECG and maintain cardiac monitor
  - Consider compartment syndrome if pain disproportionate to injury
    - Consider performing a fasciotomy (if experienced/skilled practitioner available or after...
- Administer 0.9NS IVF bolus 20mL/kg x 1 PRN
  - Perform x-rays, CTs and labs as indicated by injuries.
- Immobilize and splint and identified fractures
  - Check for growth plate involvement
  - C-Spine x-rays NOT required if (per ATLS Guidelines):
    - No neck pain or palpable tenderness AND
    - No distraction injury AND
    - GCS 15 AND
    - Not intoxicated or under influence of drugs
- Assess circulation, movement and sensation (CMS) and neuro checks every 2 hours as indicated
- Pain control as needed (consider pharmacological and non-pharmacological pain control measures)
- Blast injury Considerations:
  - Monitor urine for RBCs and myoglobin
  - Obtain ECG if indicated
  - Maintain urine output of 2-4mL/kg/hr

Reassess

Worse, not improved or not normalized, or improved but not normalized

- Repeat 0.9NS IVF bolus 20mL/kg x 2 PRN
- Consult with pediatric care medical specialist for possible transfer
- Monitor CMS, neuro status and vital signs every 2-4 hours
- Admit patient
- See Sample admission orders (pg. 5)

Reassess

Worse, not improved or not normalized

Monitor for 6-8 hours and if:
- Stable vital signs AND
- Neuro status appropriate for age AND
- CMS intact AND
- Serial exams show no signs of deterioration
Discharge with appropriate follow up instructions

Improved
Sample Pediatric Trauma/Blast Injury Admission Orders

Admitting physician:__________________________________________

Diagnosis:___________________________________________________

Condition: □ Critical □ Serious □ Stable

Weight (kg):__________________ Height (cm):__________________

Allergies:__________________________________________________________________________

Assessment:
□ Continuous cardiac monitoring
□ Continuous pulse oximetry
□ Blood pressure with all vital signs
□ Routine I&O
□ Strict I&O q 1 hour (maintain urine output at 2-4mL/kg/hr)
□ Daily weight
□ Seizure precautions
□ Neuro checks ever_____ hours
□ Perform CMS checks on extremities every ____ hours to monitor for compartment syndrome/crush syndrome

Tests:

Medications:
□ Fever/Pain Control:
  □ Acetaminophen (Tylenol) (15mg/kg/dose)________mg PO/GT every 4 hrs PRN for temperature ≥ 38.6°C/101.5°F or discomfort (max dose 3000mg/day)
  □ Acetaminophen (Tylenol) (20mg/kg/dose)________mg PR every 4 hrs PRN for temperature ≥ 38.6°C/101.5°F or discomfort (max dose 3000mg/day)
  □ Ibuprofen (Motrin) (10mg/kg/dose) _________mg PO/GT every 6 hours PRN for temperature ≥ 38.6°C/101.5°F or discomfort (for infants >5 months). Ensure adequate renal function before utilizing.
  □ Morphine (0.1-0.2 mg/kg) _____ mg IV every 2-4 hours as needed (max 10mg/dose)
  □ Fentanyl _______mg IV every ______hours as needed.

□ Antibiotics:
□ ____________________________________________________________
□ ____________________________________________________________
□ ____________________________________________________________

□ Topical anesthetic for IV start and lab draws
  □ Apply topically once 30-90 minutes prior to procedure (maximum 1gm, 10 centimeter area squared, or application time of 2 hours)

IV Therapy:
□ Saline Lock
□ NS bolus _________ mL IV to run over 1 – 2 hours
□ LR bolus _________mL IV to run over 1-2 hours
□ D5 0.45 NS with 20 mEq KCl/L to run at _________mL/hr (Ensure adequate renal function before utilizing potassium)
D5 0.2 NS with 20 mEq KCl/L to run at _________mL/hr (Ensure adequate renal function before utilizing potassium)
□ Other__________________________________________

Supplemental Oxygen Orders:
- If SpO₂ < 90% on room air, apply oxygen to maintain SpO₂ 91-94%
  ○ Nasal Cannula
  ○ Aerosol Mask
- Titrate oxygen to maintain SpO₂ > 90%
- Wean oxygen if SpO₂ maintains 94%.
  ○ Decrease oxygen by ½ liter per minute (LPM) and reassess patient 5-10 minutes after change in oxygen
  ○ Do not decrease oxygen more frequently than every 60 minutes

Ventilator Settings:
- For more information, see: Use of Strategic National Stockpile (SNS) Ventilators in the Pediatric Patient: Instructional Guidelines with Training Scenarios, 2nd edition

See Sample Pediatric Standard Admission Orders for additional examples for diet, IV, labs etc
□ If hypovolemic, refer to Pediatric Shock Care Guidelines: Sample Hypovolemic Shock Admission Orders
Detailed Assessment of Pediatric Trauma Patients

- Inspect/palpate each body area for DCAP-BLS, TIC, PMS (Deformity, contusions, abrasions, punctures, burns, lacerations, swelling, tenderness, instability, crepitus; + pulses, motor, and sensory ability) as appropriate plus:
- MENTAL STATUS: Assess mentation using the Pediatric Glasgow Coma Score (PGCS), Neuro exam, motor/sensory, nuchal rigidity, appearance, tone, acting appropriate for age, consolability, look/gaze, and speech/cry.
- HEAD, FACE, EYES, EARS, NOSE, MOUTH: Note any drainage; re-inspect pupils for size, shape, equality, fixed deviation and reactivity; conjugate movements; note gross visual acuity
- NECK: Carotid pulses, neck veins, subcutaneous (Sub-Q) emphysema, location of trachea, and cervical spines
  May need to temporarily remove anterior aspect of c-collar to re-assess neck
- CHEST: Expose chest as needed. Auscultate breath/heart sounds.
- RESPIRATION/VENTILLATION: rate, rhythm, pattern and work of breathing
- ABDOMEN: Signs of injury/peritonitis. Note contour, visible pulsations, wounds/bruising patterns, pain referral sites, localized tenderness, guarding, rigidity
- PELVIS/GU: Inspect perineum and apply PASG/mast trousers if suspected pelvic fracture.
- EXTREMITIES: Inspect for position, false motion, skin color, and signs of injury
- BACK: Note any muscle spasms
- SKIN/SOFT TISSUE: Inspect/palpate for color, temperature, moisture, signs of SQ emphysema, pulses in all extremities, capillary refill

<table>
<thead>
<tr>
<th>Pediatric Trauma Score (age 12 and under)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Component</strong></td>
</tr>
<tr>
<td>Size</td>
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<tr>
<td>Airway</td>
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<td>Systolic BP</td>
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<tr>
<td>CNS</td>
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<tr>
<td>Skeletal Injury</td>
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<tr>
<td>Open Wounds</td>
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</tbody>
</table>

Score of < 8 usually indicates the need for evaluation at a Trauma Center.

<table>
<thead>
<tr>
<th>Pediatric Glasgow Coma Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Category</strong></td>
</tr>
<tr>
<td>Eye Opening (E)</td>
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<td>Verbal Response (V)</td>
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<td>Motor Response (M)</td>
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</table>
### Detailed Assessment and Management of Blast Injury


<table>
<thead>
<tr>
<th>Type of Injury</th>
<th>Presentation</th>
<th>Diagnosis</th>
<th>Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal injury</td>
<td>• Injury presentation may be subtle and variable</td>
<td>• Similar to standard abdominal trauma</td>
<td>• NPO</td>
</tr>
<tr>
<td></td>
<td>• Signs/symptoms: abdominal pain, rebound tenderness, absent bowel sounds,</td>
<td>• Serial abdominal exams</td>
<td>• Avoid removal of penetrating objects in the emergency department</td>
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<tr>
<td></td>
<td>nausea, vomiting, fever and signs of hypovolemia or hemorrhage</td>
<td>• Laboratory tests</td>
<td>(perform in OR)</td>
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<tr>
<td></td>
<td>• Injuries following underwater blasts have increased severity</td>
<td>• Radiology tests: free air, unexplained ileus, intra-abdominal hematoma/hemorrhage, solid organ contusion/laceration, intra-abdominal abscess</td>
<td>• Antibiotics, tetanus vaccination</td>
</tr>
<tr>
<td>Pediatric Considerations:</td>
<td>o Smaller and more pliable ribs and thinner abdominal walls leaves abdominal organs unprotected so children are more prone to abdominal injuries</td>
<td></td>
<td>• Serial exams and laboratory monitoring</td>
</tr>
<tr>
<td></td>
<td>o Proportionally, children have larger organs so they are more prone to injury</td>
<td></td>
<td>• Women in 2nd and 3rd trimester should have fetal monitoring</td>
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<tr>
<td></td>
<td>o Spleen and liver are especially more vulnerable to injury from blunt and penetrating force trauma.</td>
<td></td>
<td>• All pregnant women should have a Kleihauer-Betke test:</td>
</tr>
<tr>
<td></td>
<td>o Traumatic asphyxia results from sudden compression of the abdomen or chest against a closed glottis. Symptoms include: hyperemic sclera, seizures, disorientation, petechiae on upper body, respiratory failure. Treatment is supportive.</td>
<td></td>
<td>o Positive requires mandatory pelvic ultrasound, fetal non-stress test monitoring and OB/GYNE consult</td>
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<td></td>
<td></td>
<td>• Radiology exams: plain abdominal films, CT scan, Focused Abdominal Sonography for Trauma (FAST)</td>
</tr>
<tr>
<td>Brain/ Neurological/ Cervical Injury</td>
<td>Head injury is most common cause of death in bombings</td>
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<td></td>
<td>Diffuse axonal injury, skull fractures, coup-counter-coup injury, subarachnoid and subdural hemorrhage common</td>
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<td></td>
<td>Mild Traumatic Brain Injury (mTBI) may go undiagnosed or misdiagnosed as PTSD</td>
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<td></td>
<td>May or may not have history of loss of consciousness (LOC)</td>
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<td></td>
<td>Headache, seizures, dizziness, memory problems</td>
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<td>Gait/balance problems, nausea, vomiting, difficulty concentrating</td>
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<td>Visual Disturbances, tinnitus, slurred speech</td>
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<td></td>
<td>Disoriented, irritable, confused</td>
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<td></td>
<td>Extremity weakness or numbness</td>
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<tr>
<td><strong>Pediatric considerations:</strong></td>
<td>Glasgow Coma Scale (GCS)/ Pediatric Glasgow Coma Scale (PGCS)</td>
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<tr>
<td></td>
<td>- Mild TBI: At least 1 of the following inclusion criteria present:</td>
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<td>- Any period of LOC of &lt; 30 minutes and GCS/PGCS of 13-15 after the LOC</td>
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<td>- Any loss of memory of the event immediately before or after the incident with posttraumatic amnesia of &lt; 24hrs</td>
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<td></td>
<td>- Any alteration in mental status at the time of incident</td>
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<td></td>
<td>- Moderate to Severe TBI: GCS/PGCS &lt; 12</td>
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<tr>
<td></td>
<td>CT scan for hemorrhage, cerebral contusion, fracture, foreign bodies</td>
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<td></td>
<td>Cervical spine imaging for all patients with head injury</td>
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<td></td>
<td>MRI is more sensitive to diagnosis diffuse axonal injury</td>
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<td>Record initial GCS/PGCS and reassess per protocols</td>
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<td></td>
<td>Re-evaluate patient every 24 hours or sooner if symptoms worsen</td>
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<td></td>
<td>Maintain:</td>
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<tr>
<td></td>
<td>- Cerebral perfusion pressure</td>
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<tr>
<td></td>
<td>- Body temperature</td>
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<tr>
<td></td>
<td>- Neuromuscular blockage and sedation (for intubated patients)</td>
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<tr>
<td></td>
<td>- Cervical spine control</td>
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<td></td>
<td>- Glucose control</td>
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<td>- Seizure control</td>
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<td></td>
<td>- DVT prophylaxis</td>
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<td></td>
<td>Complete rest until asymptomatic</td>
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<tr>
<td></td>
<td>Symptoms that persist beyond 7-10 days suggests post-concussion syndrome and warrants additional follow up</td>
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</tbody>
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Illinois EMSC | www.luhs.org/emsc
susceptible to SCIWORA (spinal cord injury without radiographic abnormality)
- Consider cervical spine injury in children with head injury

| Crush Injury and Crush Syndrome | Reperfusion syndrome:
| - Hypotension
| - Renal failure d/t rhabdomyolysis, myoglobinuria and metabolic abnormalities
| - Metabolic abnormalities (hypocalcemia, hyperkalemia, metabolic acidosis)
| - Cardiac arrhythmias
| - Compartment syndrome | History of events/ injury
| - Laboratory tests | If possible, administer IVF before releasing crushed body part
| - Administer IV hydration
| - Maintain urine output of 2-4mL/kg/hr
| - Monitor for cardiac arrhythmias
| - Treat hyperkalemia and hypocalcemia
| - Alkalize the urine
| - Monitor for renal failure-consider hemodialysis as needed
| - Monitor for compartment syndrome
| - Monitor urine for red blood cells
| - Treat open wounds with antibiotics and tetanus vaccination
| - Observe all crush injuries and monitor for the pain, pallor, paresthesia, pain with passive movement and pulselessness

| Ear Injury | External Ear: may have degloving of cartilage which is considered a serious injury
| Tympanic Membrane (TM):
| - Can be stretched and displaced medially
| - Range of injuries includes intratympanic hemorrhage to TM perforation
| - Injuries can be unilateral or bilateral, small or complete, single or double
| - Laceration can be smooth and linear, punched out or ragged with inverted or everted edges
| Middle Ear:
| - Conductive and sensorineural hearing | Otoscopic evaluation
| External Ear:
| - Manage injuries with foreign body removal, clean and close wounds
| - Consider consultation on closure requirements if cartilage of pinna is degloved
| Tympanic Membrane:
| - Rupture: Keep ear clean and dry. Refer patient to specialist
| - Perforation: Antibiotic eardrops to irrigate and clear ear of debris
| Middle and Inner Ear:
| - Can defer until patient can see specialist
| - Will need audiometry exams
<table>
<thead>
<tr>
<th>Extremity Injuries</th>
<th>Eye Injuries</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Traumatic amputations: primarily occur through bony shaft rather than joint disarticulations</td>
<td>• Presents with wide range of symptoms</td>
</tr>
<tr>
<td>• Fragments imbedded into extremity</td>
<td>• Significant eye damage may be present with normal vision and minimal symptoms (irritation, foreign body sensation, altered vision, bleeding, periorbital swelling or bruising)</td>
</tr>
<tr>
<td>• Blunt force injuries</td>
<td>• Minor injuries include: Corneal abrasions, conjunctivitis, superficial foreign bodies</td>
</tr>
<tr>
<td>• Crush injuries (see above for more information)</td>
<td>• Open globe (360° conjunctival hemorrhage, misshapen pupil, brown/pigmented tissue outside of globe, clear gel like tissue outside of globe, abnormally deep or shallow anterior chamber</td>
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<td></td>
<td>• Eyelid lacerations are common</td>
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<td></td>
<td>• Serious non-penetrating injuries: hyphema, traumatic cataract, citrous hemorrhage, retinal detachment,</td>
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<td></td>
<td>• Obtain visual acuity</td>
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<tr>
<td></td>
<td>• Test for light perception, hand motion and count fingers</td>
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<tr>
<td></td>
<td>• Thin cut CT scan of orbits may help identify foreign bodies</td>
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<tr>
<td></td>
<td>• MRI is contraindicated until proven that no metal foreign bodies are present</td>
</tr>
<tr>
<td></td>
<td>• Do not force eyelid open-defer exam if massive swelling is present</td>
</tr>
<tr>
<td></td>
<td>• Assume all eye injuries may also be ruptured globe</td>
</tr>
<tr>
<td></td>
<td>• Do not patch or bandage the eye</td>
</tr>
<tr>
<td></td>
<td>• Use convex plastic or metal shield or the bottom of a clean paper/Styrofoam cup taped in place</td>
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<td></td>
<td>• Do not remove impaled FBs</td>
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<tr>
<td></td>
<td>• Tetanus if indicated</td>
</tr>
<tr>
<td></td>
<td>• Administer anti-emetics for nausea and vomiting</td>
</tr>
<tr>
<td></td>
<td>• Administer IV broad spectrum antibiotics if rupture globe is suspected</td>
</tr>
<tr>
<td></td>
<td>• Consult an ophthalmologist as soon as possible</td>
</tr>
<tr>
<td></td>
<td>• Rapid transport to facility with ophthalmic OR capabilities is primary goal</td>
</tr>
</tbody>
</table>

- Inner Ear:
  - Damage to auditory and vestibular components
  - Temporary hearing changes

- Document systemic musculoskeletal, neurological, and vascular states of each extremity
- Document each open wound
- Photograph if possible
- Radiological exams as indicated
- Perform thorough debridement
- Antibiotics for all open fractures
- Obviously contaminated wounds:
  - Irrigate with sterile saline; dress with Betadine soaked sponges
  - Tetanus prophylaxis if indicated
  - Splint fractured extremities
  - Surgical management:
    - Initial debridement and bony stabilization should be done in OR

- Obviously contaminated wounds:
  - Iritis/uveitis
  - Infected corneal wounds

- Do not force eyelid open—defer exam if massive swelling is present

- Assume all eye injures may also be ruptured globe
- Do not patch or bandage the eye
- Use convex plastic or metal shield or the bottom of a clean paper/Styrofoam cup taped in place
- Do not remove impaled FBs
- Tetanus if indicated
- Administer anti-emetics for nausea and vomiting
- Administer IV broad spectrum antibiotics if rupture globe is suspected
- Consult an ophthalmologist as soon as possible
- Rapid transport to facility with ophthalmic OR capabilities is primary goal
<table>
<thead>
<tr>
<th>Database</th>
<th>choroidal rupture and optic nerve injuries</th>
</tr>
</thead>
</table>
| Lung/Chest Injury | • May present with no external injuries to chest  
  • Symptoms: dyspnea, hemoptysis, cough, chest pain  
  • Signs: tachypnea, hypoxia, cyanosis, apnea, wheezing, decreased breath sounds, hemodynamic instability  
  • Associated pathology: bronchopleural fistula, air emboli, hemothorax, pneumothorax  
  **Pediatric Considerations:**  
  o Chest injuries are a common cause of death in children after an explosive event. Below are some anatomical features found in children that affect their injury pattern:  
  o Chest wall is more compliant so rib fractures are less common. Severe thoracic injuries can occur without significant external evidence of injury  
  o Mediastinal structures are more mobile. Tension pneumothorax can shift mediastinum and cause respiratory and cardiovascular compromise. Suspect tension pneumothorax in children who are hypotensive and hypoxic  
  o Traumatic asphyxia results from sudden compression of the abdomen or chest against a closed glottis. Symptoms include: hyperemic sclera, seizures, disorientation, petechiae on upper body, respiratory failure. Treatment is supportive. | • Chest radiography: characteristic “butterfly” pattern  
  • Arterial blood gases (ABG)  
  • CT Chest  
  • Doppler  
  • Care is similar to a pulmonary contusion  
  o Cautious IVF use ensuring tissue perfusion without volume overload  
  • High flow oxygen to prevent hypoxemia  
  • Secure airway for: impending airway compromise, secondary edema, injury or massive hemoptysis  
  • Prompt decompression for hemo or Pneumo thorax  
  • Use caution with decision to intubate patient-mechanical ventilation and positive end pressure may increase risk of alveolar rupture and air embolism  
  • Air embolism: high flow oxygen; place patient in prone, semi-left lateral or left lateral position and transfer to hyperbaric chamber  
  • Patients with normal chest xray and ABG and no complaints can be discharged after observing for 4-6 hours |
| Mental health | Will vary based on age and developmental level | Provide psychological first aid (PFA)  
| Refer to behavioral health specialist as indicated |