







Make early contact with ARV for advice and to initiate retrieval where required.

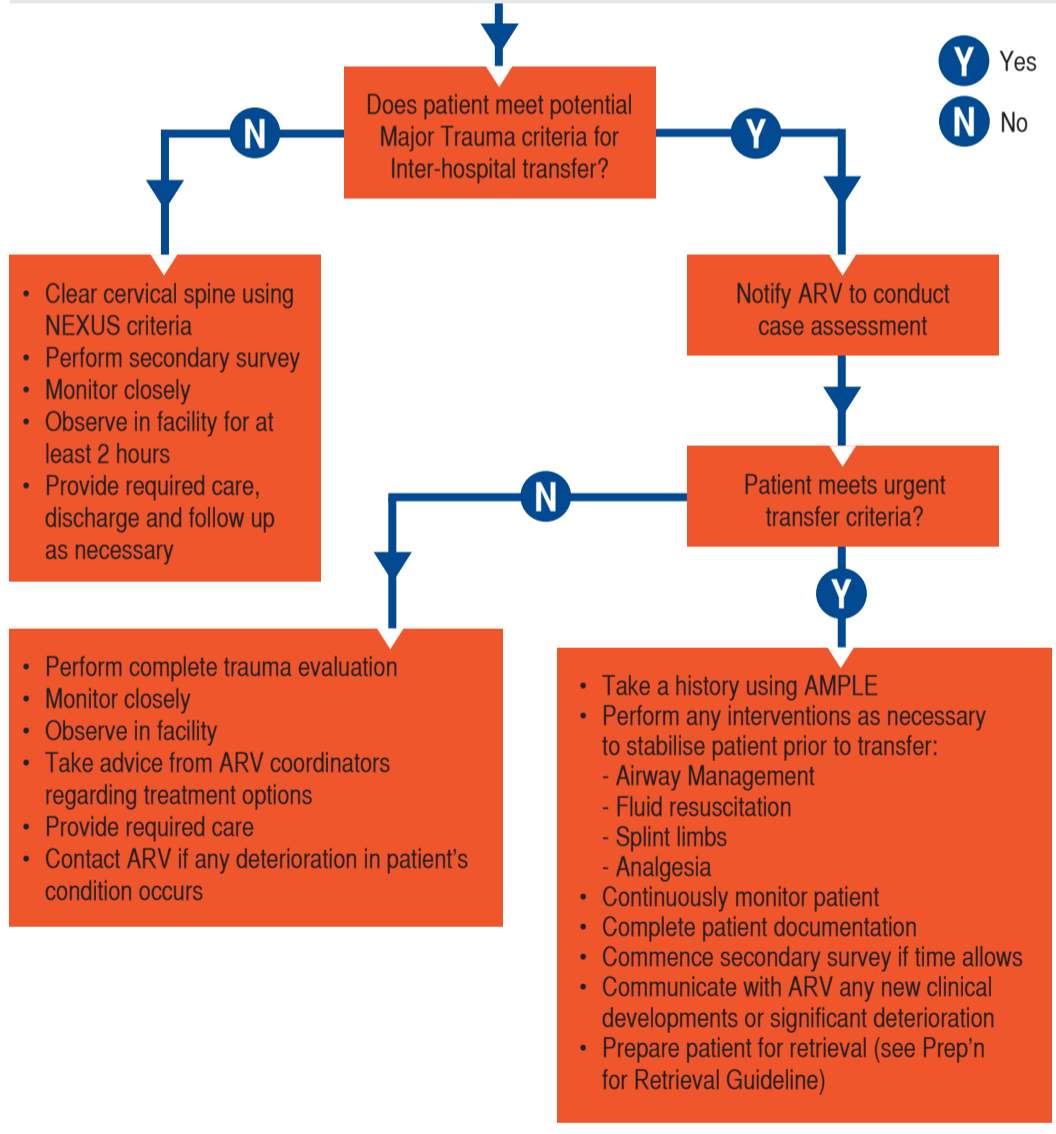
- Ascending spinal cord injury
- Aspiration
- Neurogenic Shock

Early Activation

- Gather vital information
- Ensure safety using PPE
- Activate Trauma Team
- Set up to receive patient
- Designate roles

Primary Survey

 <p>AIRWAY / C SPINE:</p> <ul style="list-style-type: none"> • Protect Airway • Airway adjuncts as available • Secure the airway using available means • Maintain full spinal precautions 	 <p>BREATHING:</p> <ul style="list-style-type: none"> • Identify and treat any life threats (i.e: pneumo) • Apply oxygen • Ventilate as necessary • SpO₂ monitoring • ETCO₂ monitoring 	 <p>CIRCULATION:</p> <ul style="list-style-type: none"> • Control life threatening haemorrhage • Insert x 2 large bore IV cannulas • Assess HR/BP/Shock Index • Take bloods • Identify source of haemorrhage • Continuous ECG monitoring 	 <p>DISABILITY:</p> <ul style="list-style-type: none"> • Assess level of consciousness • Check pupils • Check BSL <p>BASIC SCI ASSESSMENT: NO hand grip = C8 injury or above -> quadriplegia NORMAL hand grip = C8-T1 injury -> paraplegia</p> <p>DETAILED SCI ASSESSMENT: ASIA assessment and examination</p>	 <p>EXPOSURE / ENVIRONMENT:</p> <ul style="list-style-type: none"> • Fully expose patient • Ensure normothermia 	 <p>ADJUNCTS:</p> <ul style="list-style-type: none"> • FAST scan • X rays: Lat c spine, Chest, Pelvis • 12 lead ECG
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Early Management

- Airway management**
 - If there is potential that the patient's airway may deteriorate then intubation should be considered.
 - Always have emergency airway equipment available.
 - Prevent bradycardia during airway manipulation.
- Fluid resuscitation**
 - *Crystalloid fluids:* Initial treatment of hypovolaemia with normal saline is recommended, up to 20 - 30 mL/kg.
 - Avoid excess fluid administration-treat bradycardia and hypotension caused by neurogenic shock.
 - *Blood products:* if minimal response to fluids, administration of packed red blood cells (PRBC) is advised if available.
- Prevent hypothermia**
 - Use warmed IV fluids; cover the patient with warm blankets as well as keeping the room warm, use a forced air warming machine if available.
- In-dwelling catheter / Naso or orogastric tube**
 - Ensure the above are placed if necessary and time allows.
- Glasgow Coma Scale**
 - Assess the patient's level of consciousness as well as pupillary size and reactivity, gross motor function and sensation.
- Reassess**
 - Patients should be re-evaluated at regular intervals as deterioration in a patient's clinical condition can be swift
 - If in doubt, repeat ABCDE.

Secondary Survey

- History**
 - Take an adequate history from the patient, bystanders or emergency personnel of the surrounding events
 - Use AMPLE to assist with gathering relevant information.
- Head-to-toe examination**
 - A thorough exam of all body regions should take place.
 - Consider using ASIA charts for assessment and communication.
 - Assess for pressure area risk. Soft, rigid collar if available
- Log Roll**
 - Maintain in-line stabilisation. Inspect the entire length of the neck and back noting any deformity, bruising and lacerations. Palpate for any tenderness or steps between the vertebrae.
 - The cervical spine will generally be cleared after transfer to a major trauma service and specialist assessment.
- Document any findings and treat accordingly.**

Interhospital Transfer Guidelines (Discuss via ARV)

Paediatric MTP AND SCI	Adult MTP with SCI	Isolated SCI patient
Royal Children's Hospital	Major Trauma Service Interhospital transfer	Victorian Spinal Cord Service at Austin Health