

Victorian State Trauma System Guideline

# Older Person Trauma



Make early contact with ARV for advice from the major trauma services and to initiate retrieval.

- Older patients are more vulnerable and less adaptable to physiological changes due to pre-existing health issues .
- A high index of suspicion of injury should be considered even with mild injury mechanism.
- Medications may mask signs of shock.

Early Activation

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

Primary Survey

**AIRWAY / C-SPINE**

- Assess airway stability & protect as required
- May have diminished cough and gag
- Care needed when inserting OPA/NPA
- Incomplete, ill-fitting dentures may need to be removed prior to intubation
- Maintain full spinal precautions

**BREATHING**

- Identify and treat life threats
- Assess RR, work of breathing, SpO<sub>2</sub> & symmetry
- Oxygen therapy to maintain SpO<sub>2</sub> >94%
- ETCO<sub>2</sub> monitoring if intubated, maintain btw 35- 45mmHg

**CIRCULATION:**

- Insert x 2 large bore IV cannulas
- IO access if required
- Assess HR/BP/Cap refill
- Initial management of hypovolaemia - early admin of blood products. If unavailable small boluses of crystalloid fluids to maintain end organ perfusion.

**DISABILITY**

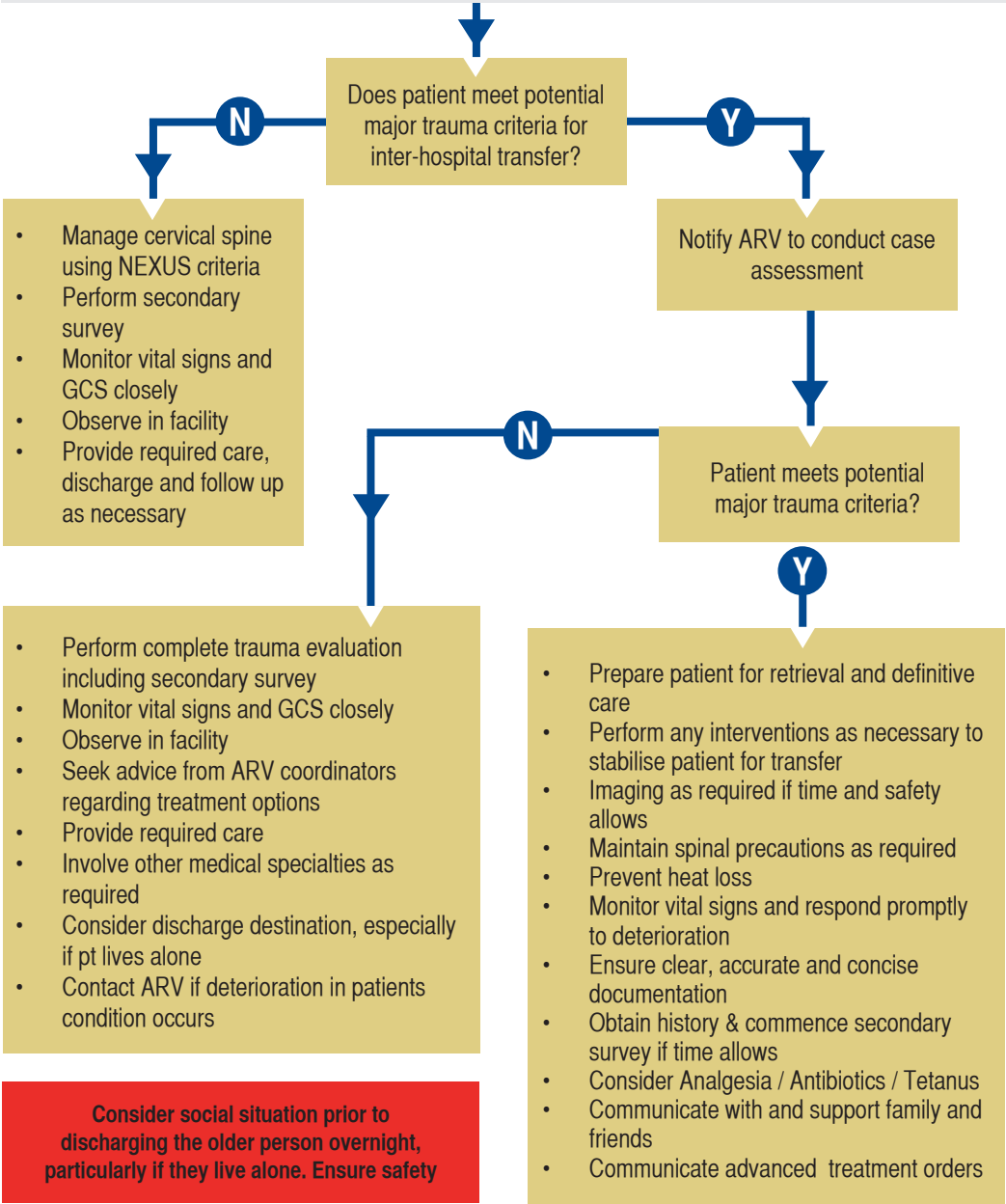
- Assess conscious level - AVPU
- Check pupils
- Test BSL
- Note if patient is taking anti-coagulant medication

**EXPOSURE / ENVIRONMENT**

- Fully expose and inspect patient
- Prevent heat loss
- Log roll

**ADJUNCTS**

- eFAST scan
- Analgesia
- X-ray: Chest, Pelvis
- CT: Brain and C-spine
- Bloods – FBE, X-match, coags screen, U&E, Lipase, LFT, Lactate, blood gas, Troponin
- 12 lead ECG
- Orogastric tube if intubated
- AMPLE mnemonic



Key Points

**Mechanism**

- Falls are the leading cause of trauma related mortality in the older people, with low falls (<1m) steadily rising. Trauma may also have been preceded by a medical event.
- A higher index of suspicion of injury should be maintained even with a seemingly innocuous mechanism of injury.
- Older patients are twice as likely to have a spinal cord injury as a younger patient with the same mechanism. Degenerative changes and stiffening of the lower cervical spine make higher (C1-C3) fractures likely.

**Pre-existing illness**

- The older patient may be slower or unable to generate an adequate physiological response to shock.
- Fluid resuscitation – administer blood products to maintain perfusion. If blood products are not available admin small amounts (250ml boluses) to maintain end organ perfusion and observe the response.

**Medications**

- A combination of cardiac medication may blunt a patient's response to trauma, masking the physiological signs of shock.
- Patients taking oral anticoagulants have a higher risk of significant ICH due to minor head injury, with a higher frequency of bleeding and severity. A lower threshold for CT scanning is appropriate in this cohort of patients.
- A reduction in mortality of those with intracerebral haemorrhage is seen when the anticoagulation is rapidly reversed.

Management Considerations

**Treatment orders**

- Established Advance Care Plans should be integrated into management strategies. Patient centred care should aim to preserve or improve quality of life, not simply extend it.
- It is vital to consider the patients requests with relation to resuscitation as well as the possible futility of efforts. Early consultation with the patient and/or next of kin is essential to understand the patients' wishes.

