



TRAUMA

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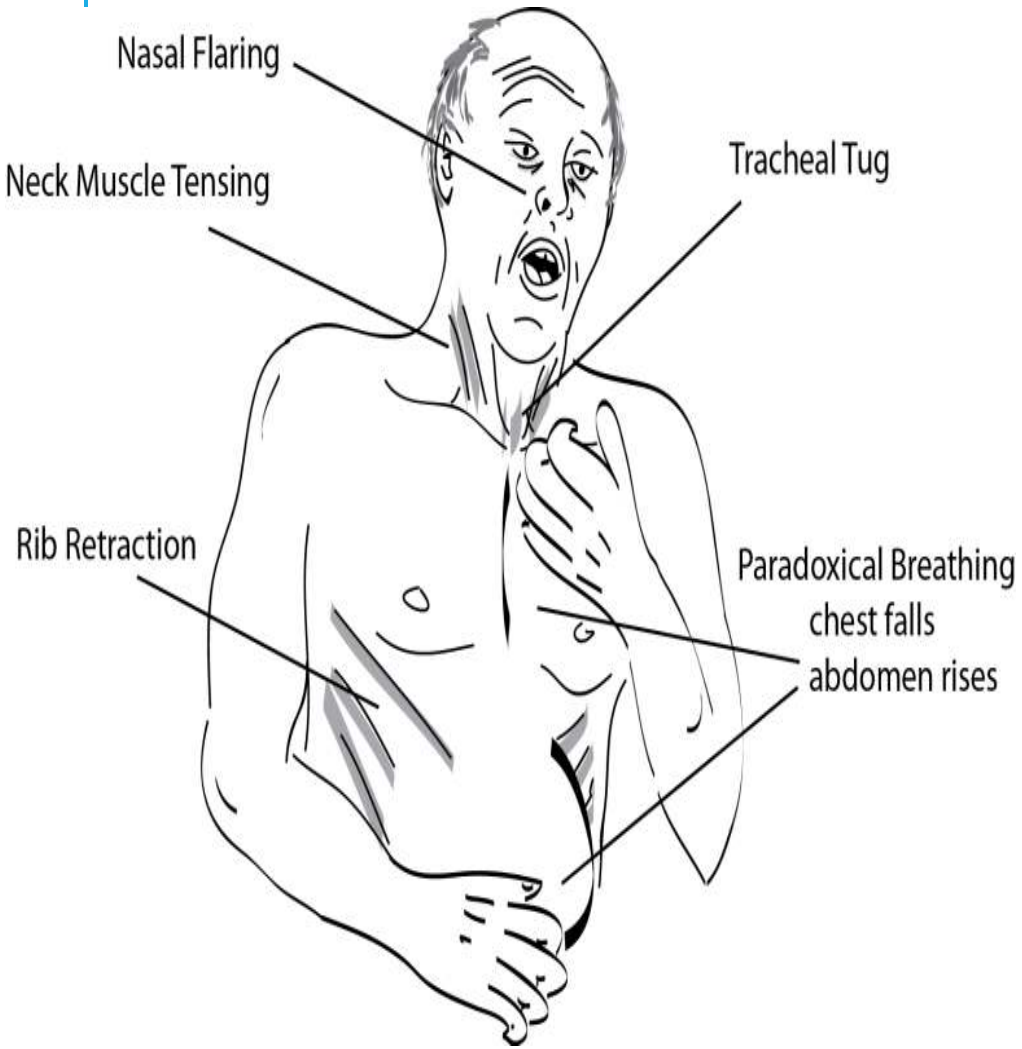
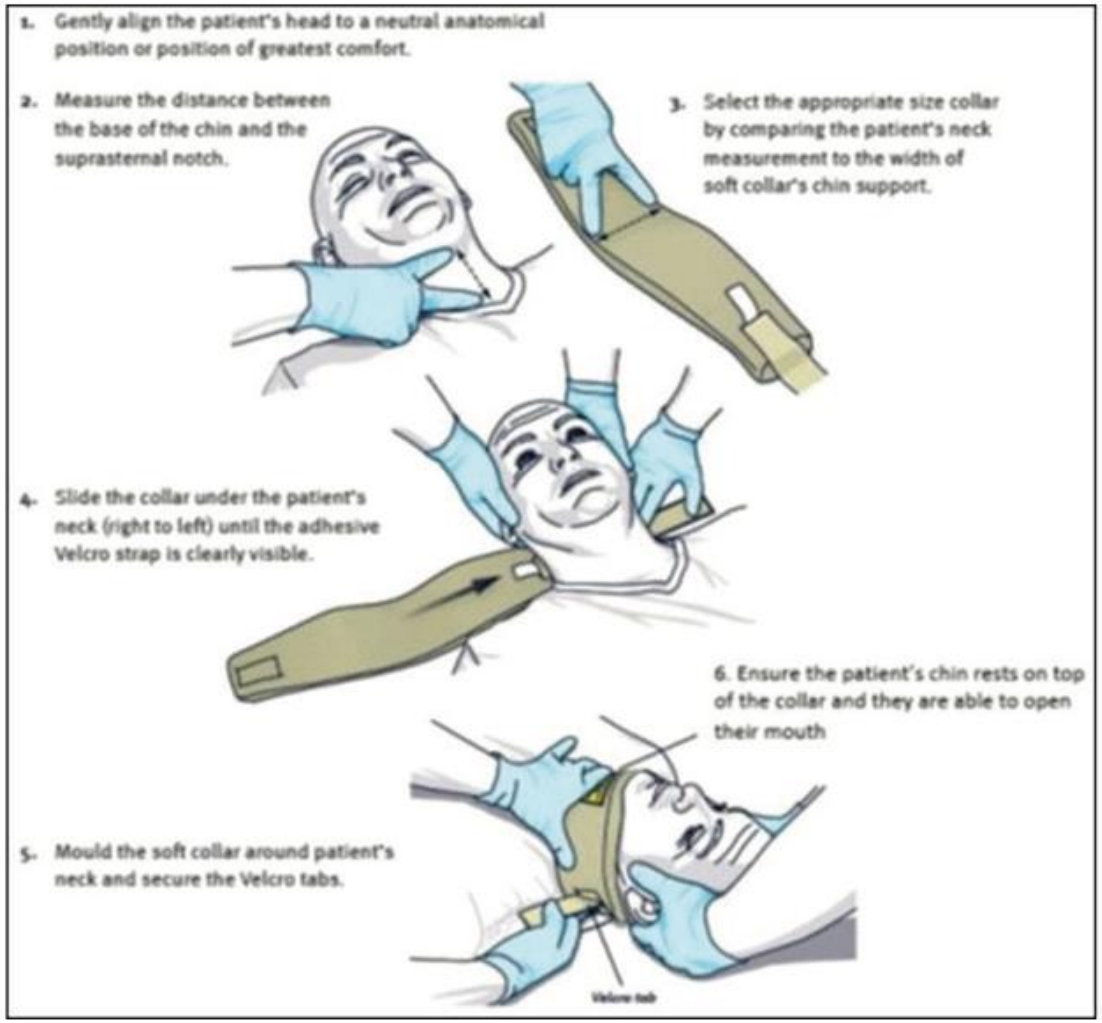
AIRWAY OBSTRUCTION: BASIC MEASURES



- Severely injured patients die rapidly unless oxygenated blood reaches the brain and other vital organs.
- Clear, maintain, and protect the airway.
- ensure that ventilation is adequate and give O2 in as high a concentration as possible
- .The most urgent priority is to clear an obstructed airway, but avoid causing or exacerbating any neck injury.
- instruct someone to hold the head and neck in a neutral position until the neck is satisfactorily

  immobilized.
- Ensure you always wear personal protective equipment. When treating any seriously injured patient,

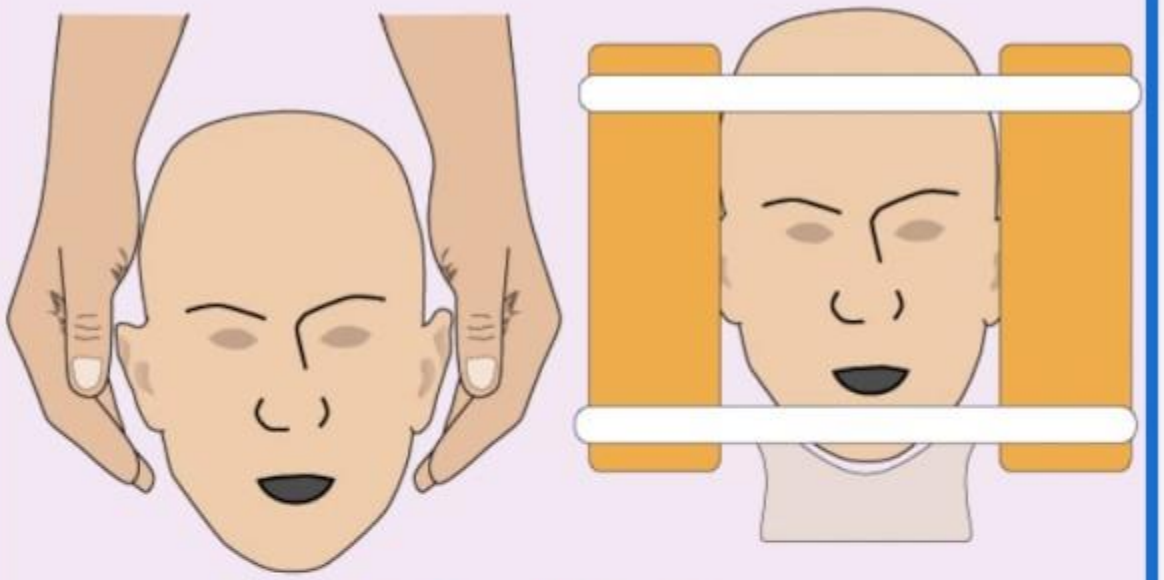
CERVICAL SPINE CONTROL

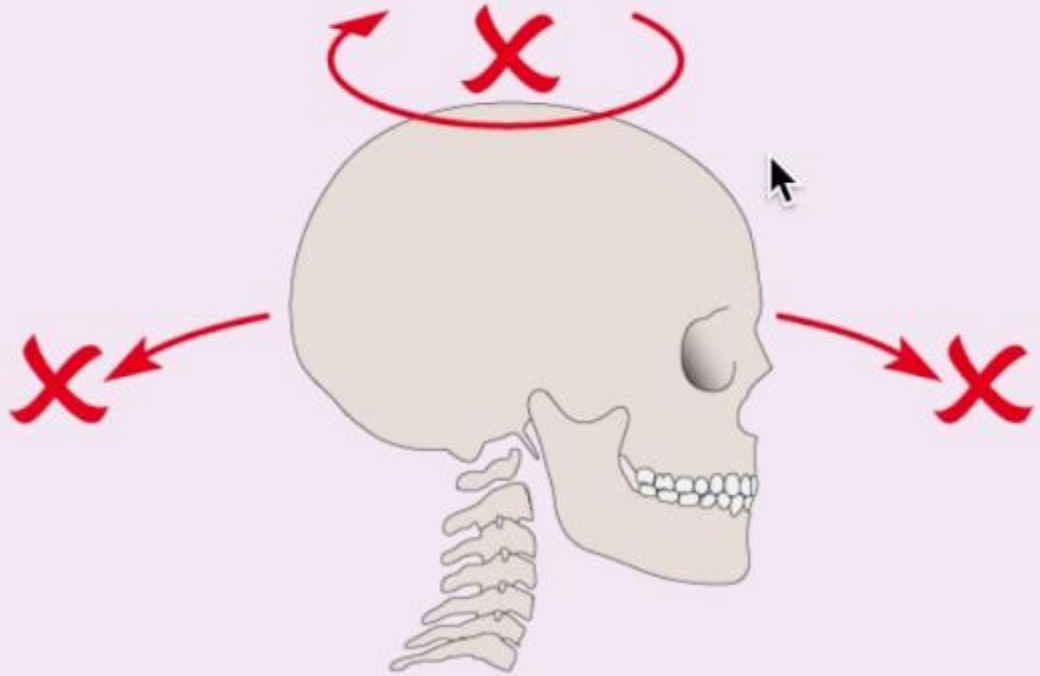


- This is the first priority in any patient who presents with possible spine injury (eg neck pain, loss of consciousness).
- Provide immediate in-line manual cervical immobilization by placing one hand on each side of the patient's head and holding it steady (without traction) and in line with the remainder of the spine.
- Whilst maintaining manual immobilization, ask an assistant to apply an appropriately sized hard cervical collar.
- Adhesive tape and sandbags may be applied .

Protect the cervical spine at all times!

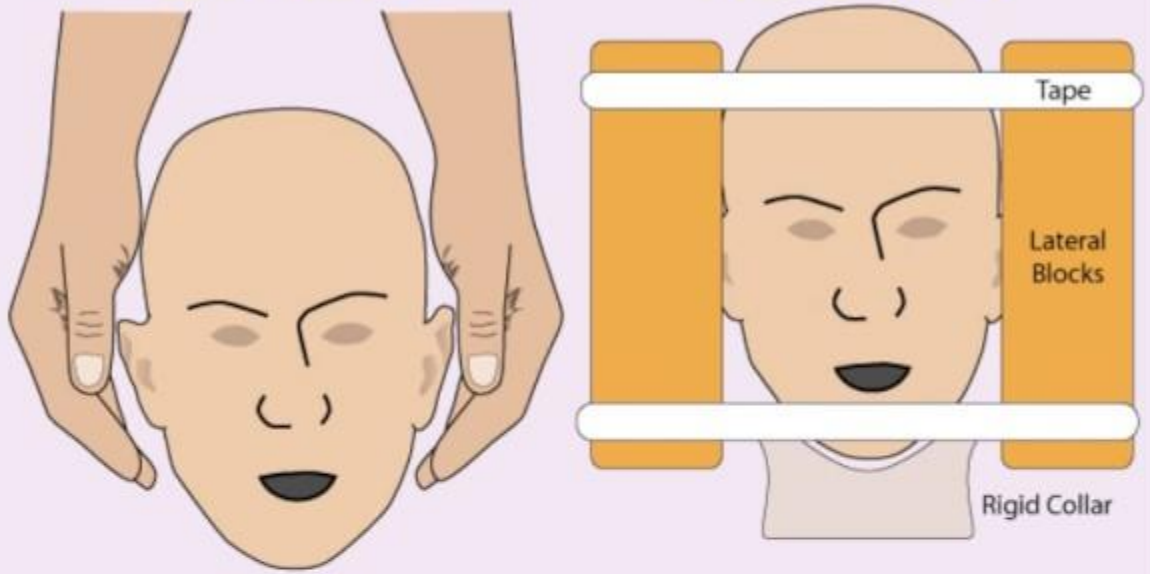
Either by manual stabilization or by using appropriate stabilization devices.

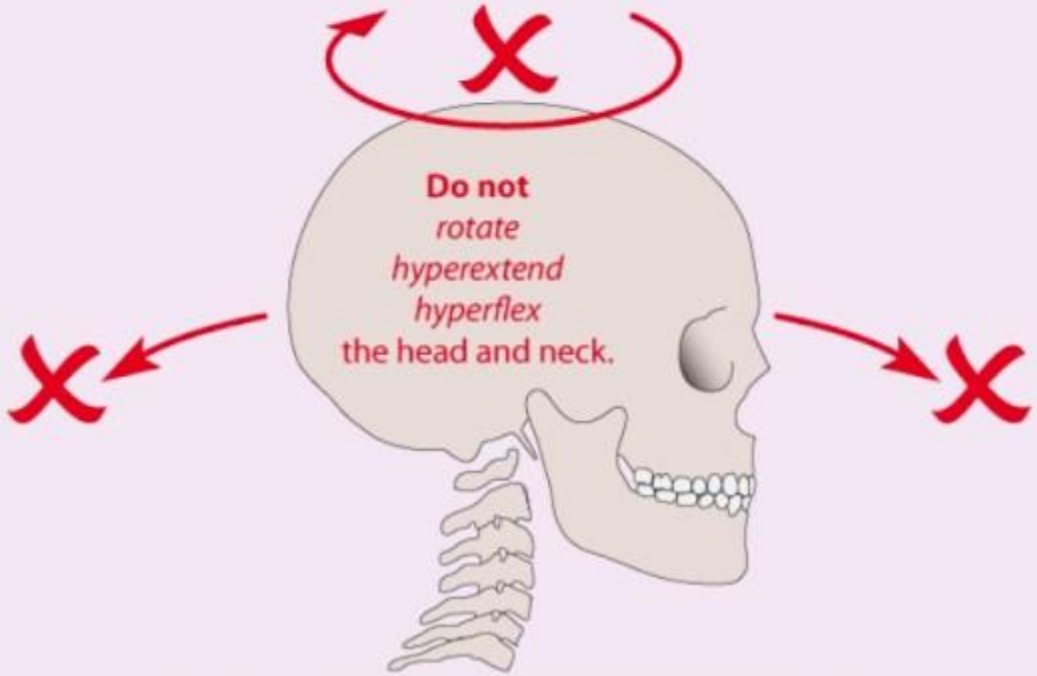




Manual Stabilisation

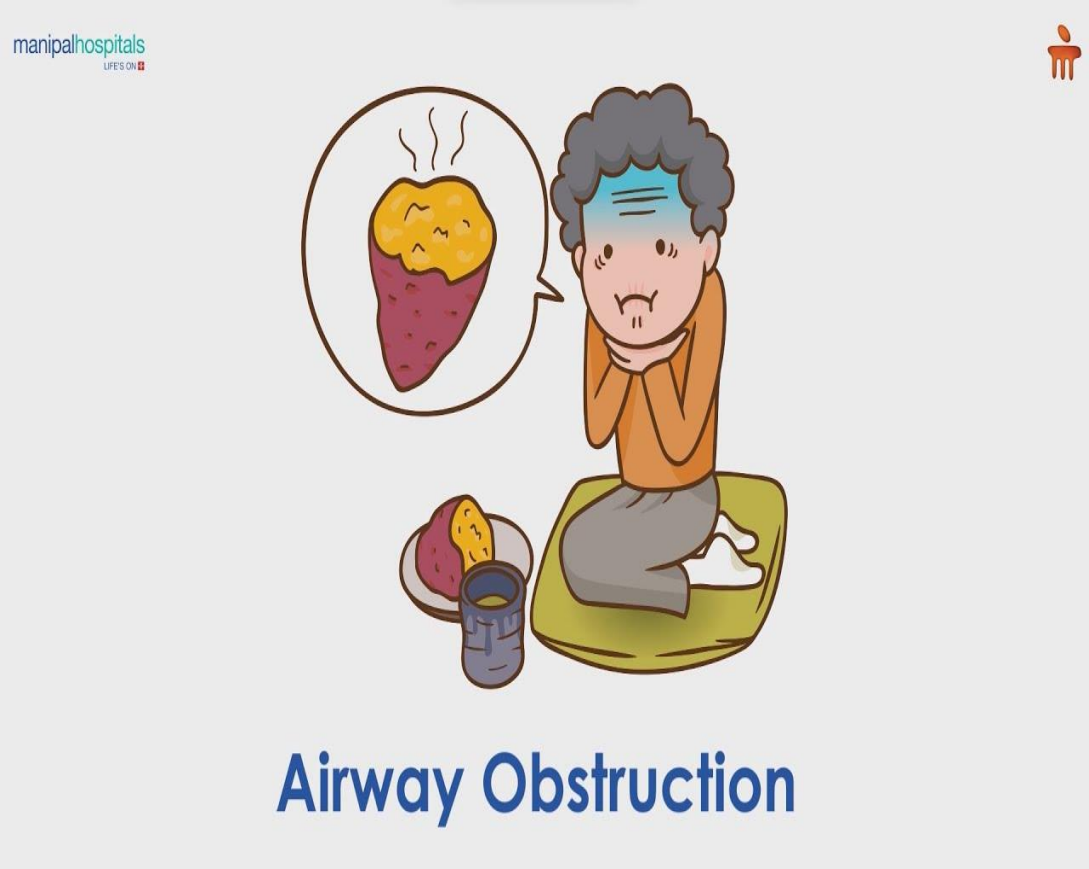
Stabilisation Devices





So long as the cervical spine is protected

CAUSES OF AIRWAY OBSTRUCTION

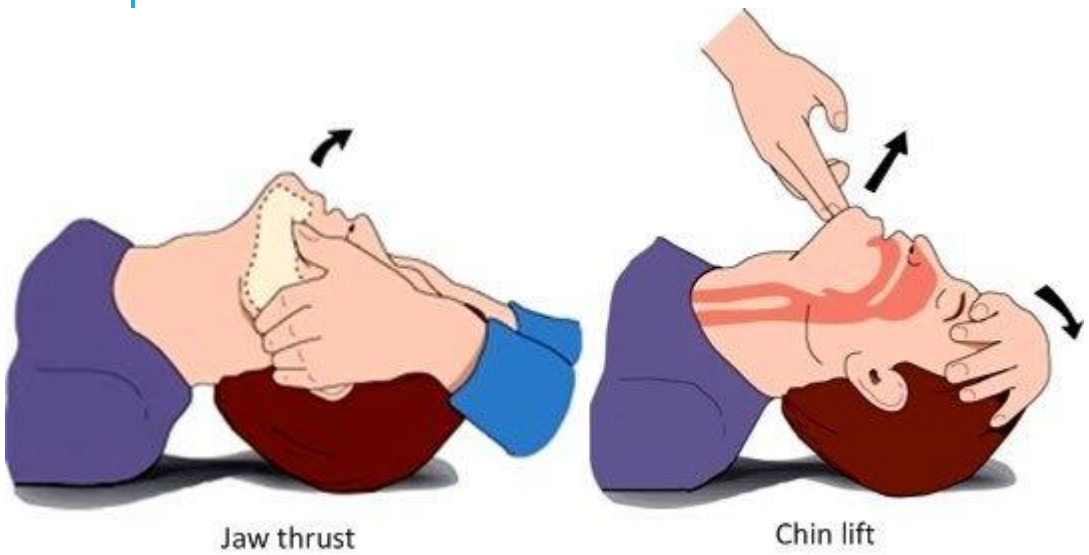


1. • Coma from any cause can result in airway obstruction and loss of protective airway reflexes.
2. • Blood or vomit may block the airway.
3. • The airway may be disrupted by trauma of the face or larynx, or may be occluded by a hematoma or by oedema following burns.

ASSESSMENT OF AIRWAY OBSTRUCTION

- Talk to the patient and see if he responds.
- A lucid reply shows that the airway is patent, that he is breathing and that some blood is reaching the brain, at least for the moment.
- Ensure that the neck does not move until it has been checked and cleared of injury.
- Look and listen to check how the patient is breathing.
- Gurgling, snoring and stridor are signs of partial obstruction

MANAGEMENT OF AIRWAY OBSTRUCTION





- Look in the mouth and pharynx for FBs, blood, and vomit.
- Remove any FB with Magill's forceps and suck out any liquid with a large rigid suction catheter.
- If vomiting occurs, tilt the trolley head down and suck out any vomit.
- Lift the chin and use the jaw thrust maneuver to open the airway, but do not flex or extend the neck
- After any airway intervention, look, listen, and feel to reassess airway patency and efficacy of breathing.

If the gag reflex is absent or poor, insert an *oropharyngeal airway* , This helps to hold the tongue forwards.

If the airway is now patent and the patient is breathing, give high concentration O 2 (via a non-rebreathing reservoir mask).

If the airway is patent, but breathing inadequate, ventilate the patient with O2 bag and mask device and prepare for tracheal intubation





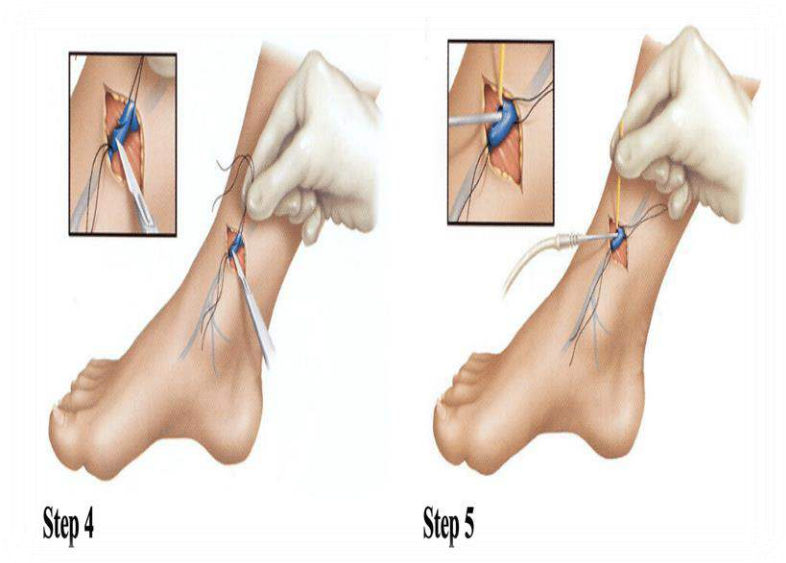
IV FLUIDS

Insert 2 large cannula into forearm or antecubital fossae veins. If initial attempts fail, consider a femoral venous line or an intra-osseous line.

If these fail or are inappropriate, consider a central line or a cut-down onto the long saphenous vein.

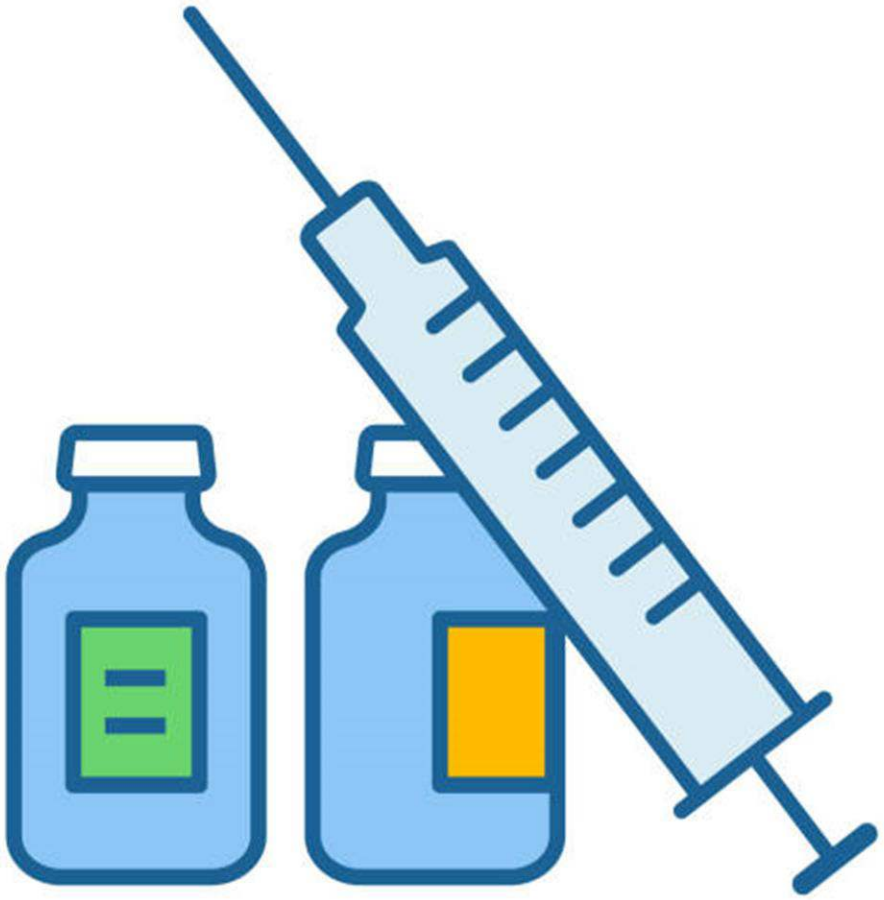
Commence IV fluids for patients with hypovolemic shock with 1L of 0.9 % saline in adults (20mL/kg in children).

Consider urgent blood transfusion if > 2L (in an adult) have been given.









Analgesia

Adequate pain relief is often forgotten or deferred. Give morphine IV titrated in small doses according to response.

Provide an antiemetic at the same time.

Antibiotics

Give prophylactic IV antibiotics for compound fractures and penetrating wounds of the head, chest or abdomen

Tetanus

Ensure tetanus prophylaxis in all patients


Thank you