St. George Hospital Trauma Committee

# TRAUMA SURGERY CONSULTANT RESPONSE TO ED

Approved by SGH Trauma Committee on 11/02/2005

## I. Purpose

The on-call trauma surgery consultant (i.e. Trauma Surgeon) should be actively involved in the initial resuscitation of severely injured patients. This policy identifies patients for whom the Trauma Surgeon's presence in the ED is required, and the mechanism by which the Trauma surgeon will be notified.

## II. Call-In Criteria

The on-call Trauma Surgeon should report promptly to the ED for any one or more of the following:

1. A patient with **two or more** documented systolic blood pressures of **< 90 mm Hg** at any time during the prehospital (i.e. scene or ambulance) or ED phase.

2. A patient with a **penetrating injury** (gunshot, shotgun, knife or other piercing object) to the neck, chest, back, abdomen, perineum or groin.

3. A patient with evidence of **massive haemothorax** as per any one of the following:

    a. chest x-ray showing obliteration of lung markings by fluid-density opacification(s) in one or both hemithoraces
    b. evacuation of > 1,000 mL of blood from a chest drain within the first hour after drain insertion
    c. evacuation of > 200 mL of blood/ hr from a chest drain for two or more consecutive hours

## III. Call-In Mechanism

The Trauma Team Leader in charge of the resuscitation will determine the need for calling in the Trauma Surgeon, based on the three criteria listed above. The Trauma Team Leader will then either personally contact the Trauma Surgeon by telephone or ask another member of the trauma team do this. Ideally, the trauma Team Leader should speak to the Trauma Surgeon to inform him/her of the patient's condition and to ensure that the surgeon understands that his/her presence in the ED is expected as soon as possible.

## IV. Documentation

The Trauma Surgeon should document his/her arrival to the ED by entering a brief progress note in the medical record.