Greater Manchester Major Trauma Network

NHS

THE FRAIL INJURED PATIENT CONSIDERATIONS

Guidance for self-presenting patients or those not conveyed with a FrIP Amber Pre-alert

Mechanism of Injury

Low Impact Mechanisms

Falls <2m are the largest injury group in major trauma

Consider -

Collapse from Standing

Medical presentations

'Found on floor' presentations

Roll out of bed presentations

Impact Zone

Lack of peripheral injuries should illicit a high index of suspicion

Injury to 2 or more body systems

Pharmacology

Anticoagulants

Consider visible haemorrhage and occult bleeding to head, chest, abdomen, pelvis or long bones.

Consider -

Beta Blockers

Will mask tachycardia in the major trauma patient

Steroids

History of steroid use in chronic disease means fractures are more likely

Other medications

Consider polypharmacy and antiplatelet use (e.g. aspirin)
Anticoagulants include warfarin, LMWH and DOACs (apixaban, rivaroxaban, dabigatran and edoxaban)

LMWH – low molecular weight heparin, DOAC – direct oral anticoagulants

Physiology

SBP <110mmHg

In the presence of significant injury

Consider -

Existing Disease Process

Note any changes in physiology of the chest wall. Chest wall injuries are common and difficult to diagnose and require careful examination.

Previous Recent Injury History

Consider acute on chronic injury to the brain and other regions

Consider previous recent collapses

Consider potential for undiagnosed injury with previous, recent hospital attendances

Older people may sustain serious injury from low mechanisms. Illness may be present as well as injury. Consider TXA. Be aware of anticoagulant use and potential for reversal. Recognise potential for occult injury.