8-13-19 Trauma Clinical Leadership Committee Minutes

Participating: Dr. Traci Bilski, Lynne Drawdy, Dr. Edgar Figueroa, Dr. John McPherson, Matt Meyers

Dr. McPherson advised that Dr. Plumbley and Susan Ono can't attend today. There are several patient issues we want to standardize within our region, including use of TXA and spinal immobilizations. Dr. Plumbley was working on standardized trauma care for pediatric patients. We have not yet received any protocols. Dr. McPherson will send his protocols to Lynne and ask others to send so she can distribute to the committee. Dr. Figueroa reviewed his policy for TXA and will send it. The group discussed use of TXA, including for children, based on size, expanded use in field for TXA, e.g. for ectopic pregnancy or for trauma with obvious internal hemorrhage or not responding to liters. Dr. Bilski asked if they will know in the field if it is a massive GI bleed or obvious bleeding. Dr. McPherson said he thinks that is reasonable; he hasn't seen that in protocols. He asked Dr. Figueroa how he feels about receiving patients with TXA. Dr. Figueroa said he hasn't looked at the literature but thinks this might be appropriate if the patient is not responding or really far away; in other situations, he feels it should be administered in the hospital after diagnosis. He stated that he is leaning more toward more hospital based than field. Dr. Bilski stated that they do use TXA but not broadly, it is used more liberally in rural areas where transport times are longer. Dr. Figueroa stated that he agrees with that but most are close enough to the hospital. He stated that he feels this is worth exploring. Dr. McPherson stated they have been using TXA in the field for the last 2-3 years, very infrequently. He has sent out his protocols which outline when TXA can be used; both Dr. Bilski and Dr. Figueroa agreed with the criteria for usage in his protocol. Dr. Bilski suggested that the protocols be simple and limited to the trauma population and Dr. Figueroa agreed. He stated that First Flite carries TXA for usage in trauma when they lose pulse and it is given as a bolus instead of slowly. He agreed with exploring us for GI bleeds. This is commonly used in Israel and middle east. Dr. McPherson will talk to Todd Husty and will send out the literature for review. He stated that early in the discussions some trauma surgeon expressed concerned re hypercoagulation and DVT or stroke. Dr. Bilski stated that the literature doesn't bear that out. Dr. McPherson asked if they felt the other trauma surgeons would have an issue with this and no one did. Some counties, including Seminole and Volusia, already have this in their protocol. Dr. McPherson stated that his goal is to have a common protocol for TXA use for presentation to the Executive Committee in September.

The group continued discussions on spinal immobilizations. Dr. McPherson will ask the region's EMS medical directors to share their protocols and review the literature. Dr. McPherson sent information from a large study in Canada in 2005, and protocols from Maine. He stated that in the Canadian study of 2,200 patients, six of them had C spine injuries and using the nexus criteria all six received a collar. Dr. Bilski stated the criteria is clear and easy to use. She stated she will share a three-page position paper on this issue from last year. Dr. McPherson stated that he has seen this and it reinforces the group's discussions. Dr. Bilski stated that there is confusion between immobilizing the spine and using a backboard. With a c collar, it is important to maintain alignment of the body. For EMS, there are downsides to immobilization, including discomfort, pain, lack of cooperation, and that if a c collar is used when not needed it increases difficulty in intubation when an airway is needed which may worsen pulmonary function. There is no evidence that a hard collar decreases secondary injury, and it makes physical examination of the patient harder. New information shows that in closed head injury patients, c collars can decrease venous return in the jugular and decrease cranial pressure. Dr. Figueroa stated that you cannot legislate common sense. He stated that in the field, they need to make the best call. He stated that whatever the literature supports, we should support. He stated that the literature is unclear on penetrating trauma including the head but the literature is clear on the use of the c spine use unless there is a loss of consciousness. Dr. McPherson suggested that the proposed protocol not try to address every potential issue but be clear and simple. He will review the protocols to try to get the best example out to the group.

Dr. McPherson suggested that these protocols be sent out to the trauma physicians to get their buy-in, and then bring these to the Trauma Executive Committee to approve for disbursal to all agencies within the region. He suggested that we set a go live date and include training, beginning with TXA.

Dr. McPherson advised that he has reviewed the literature on elderly individuals with head injuries who take anti-coagulant medications, and including that as part of the trauma scorecard methodology. He cited a study that looked at more than 2,000 patients and most were not flagged under the current trauma alert criteria. Out of 2100 patients, 131 had a traumatic hemorrhage and 41 had hospital death or neurosurgery. Only 62 (8%) met the standard trauma alert criteria and got flagged. The number that did not get sent to a trauma center was startling (1,948 did not meet trauma alert criteria and 566 (29%) were taking anticoagulant medications. He stated that this was a large, well-done study and while we don't want to overwhelm the trauma centers, we can estimate the number of patients this would add. He suggested this as a topic for the group to consider. Dr. Figueroa would like an in-person discussion with the entire committee, and Dr. McPherson agreed. He asked for other topics of discussion, including changes in EMS care, and permissive hypotension. Lynne reported that Dr. Zuver emailed and tried to call in today but could not get through. All agreed that an in-person meeting would be productive.

Dr. McPherson asked the group to send protocols to Lynne to collect and send out to the group. Dr. McPherson will reach out to the other counties to gain their protocols. He asked Lynne is the coalition can support additional calls and meetings and she said the coalition will provide whatever support is needed. Dr. Figueroa stated that as the group represents Region 5, we need to look at that as a real network where what affects one affects all. That way in an event, mutual aid is more effective as well are using the same protocols, equipment, supplies, etc.

Dr. McPherson will send information to Lynne to send out to the group, checking that the 8 am time is ok, and asking that they share protocols for TXA and spinal immobilizations.