

CMG 17 – CHEST INJURIES

(Revised: January 2015)



GENERAL TREATMENT		
ICP	Oxygen administration – high-flow, high-concentration	AP
ICP	Early, rapid transport to appropriate hospital. Advise hospital early of pending arrival.	AP
ICP	Analgesia as required	AP
ICP	Treatment of specific condition/s as below (if applicable)	AP
ICP	IV fluid resuscitation as required – as per CMG 14	AP

PNEUMOTHORAX:

ICP	If suspected: avoid coughing, Valsalva manoeuvres and IPPV	AP
ICP	(note: diminished air entry may be an unreliable sign if the patient is receiving positive pressure ventilation)	AP
ICP	Suspect a tension pneumothorax in a patient with diminished air entry and with significant respiratory or cardiovascular compromise. Decompress tension as indicated.	
ICP	Continue to observe and reassess a patient who has been decompressed – tension may redevelop. In this situation, repeat decompression immediately lateral to the initial successful site (leave plastic cannulae from failed attempts in situ).	

UNCOMPLICATED RIB FRACTURES:

ICP	Position patient as they are most comfortable, and provide analgesia adequate enough to allow reasonable tidal volume	AP
ICP	Elderly patients and children may have more significant injury for any given mechanism, and so require transport for assessment	AP

continues over

CMG 17 (cont) – CHEST INJURIES



OPEN (“SUCKING”) CHEST WOUND:

ICP	Cover, preferably with chest seal (alternatively cover with waterproof material and tape down on three sides only)	AP
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PENETRATING OBJECT IN CHEST

ICP	Penetrating object should NOT be removed. It should be left in situ and protected from movement.	AP
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ICP	Penetrating objects that appear to be intracardiac (i.e. move with each heartbeat) <i>should be left as they are</i> – not bandaged or padded to prevent movement. Handle patient gently.	AP
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FLAIL CHEST:

ICP	Stabilise the chest wall: posture patient with affected side down, or by manual pressure (by hand or by taping a bag of fluid over the area of flail)	AP
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CARDIAC ARREST FOLLOWING CHEST TRAUMA:

ICP	Manage as per CMG 39 (adult agonal trauma) or CMG 5 (paediatric)	AP
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ICP	Check for and treat reversible causes specific to chest trauma as appropriate: hypoxia, hypovolaemia and tension pneumothorax	AP
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SPECIAL NOTE – PAEDIATRIC PATIENTS:

Children compensate well, and evidence of shock is a late sign. Due to soft, flexible bones, children can have severe internal chest injuries with minimal or no external evidence of chest injury. Rib fractures in children signify a significant mechanism of injury and therefore serious injury should be suspected.

Check for multiple injuries – an isolated chest injury is rare in children.

Assume time criticality.