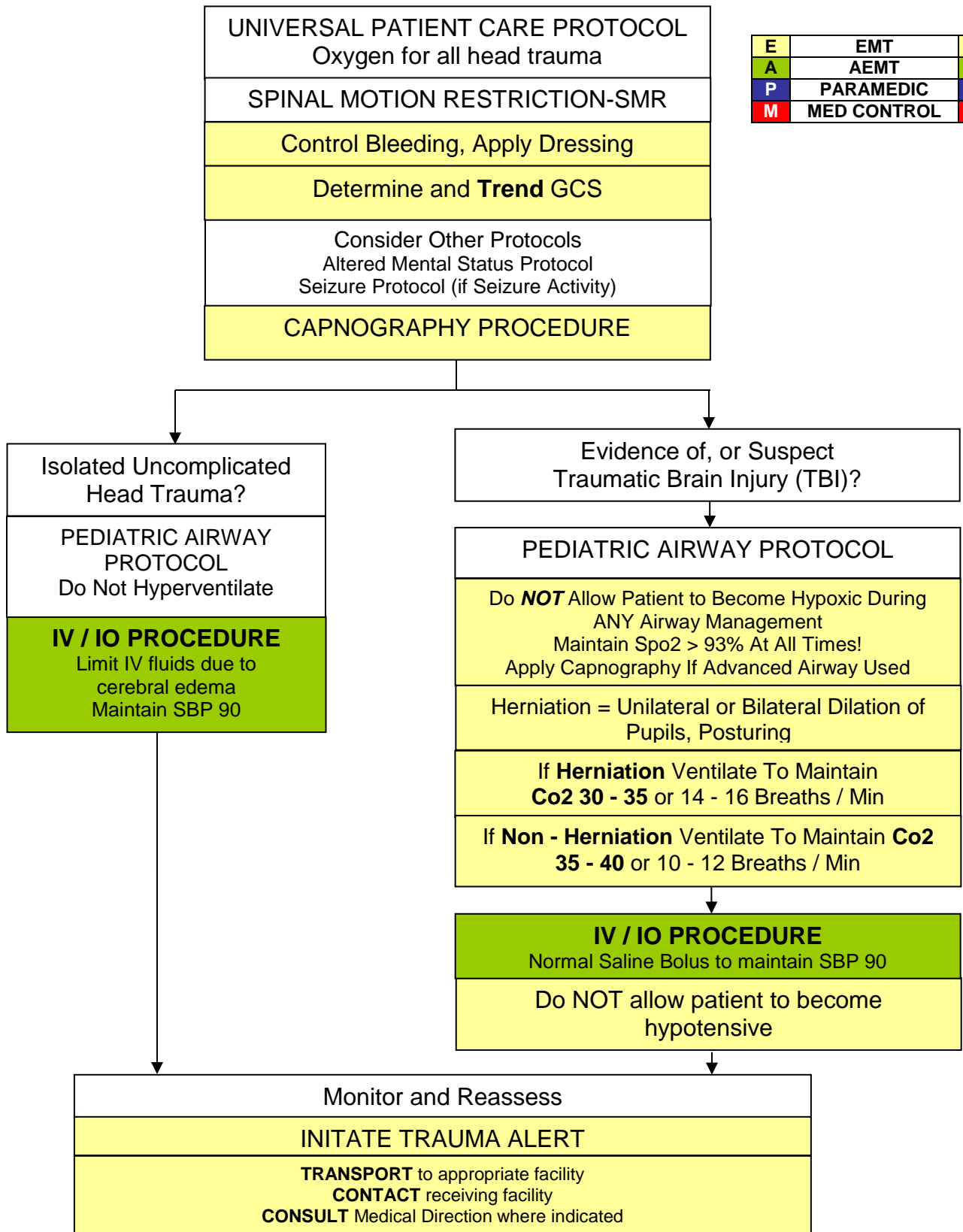




Section 11: Pediatric Trauma Protocols

PEDS TRAUMA: HEAD TRAUMA

| | | |
|---|-------------|---|
| E | EMT | E |
| A | AEMT | A |
| P | PARAMEDIC | P |
| M | MED CONTROL | M |





Section 11: Pediatric Trauma Protocols

PEDS TRAUMA: HEAD TRAUMA-Cont.

PEARLS and KEY POINTS

| HISTORY | SIGNS AND SYMPTOMS | DIFFERENTIAL DIAGNOSIS |
|--|--|---|
| <ul style="list-style-type: none">• Time of injury• Mechanism (blunt vs. penetrating)• Loss of consciousness• Bleeding• Past medical history• Medications• Evidence for multi-trauma | <ul style="list-style-type: none">• Pain, swelling, bleeding• Altered mental status• Unconscious• Respiratory distress / failure• Vomiting• Major traumatic mechanism of injury• Seizure | <ul style="list-style-type: none">• Skull fracture• Brain injury (concussion, contusion, hemorrhage or laceration)• Epidural hematoma• Subdural hematoma• Subarachnoid hemorrhage• Spinal injury• Abuse |

- **Exam: Mental Status, HEENT, Heart, Lungs, Abdomen, Extremities, Back, Neuro**
- If GCS < 12 consider air / rapid transport and if GCS < 8 intubation should be anticipated.
- Increased intracranial pressure (ICP) may cause hypertension and bradycardia (Cushing's Response).
- Hypotension usually indicates injury or shock unrelated to the head injury.
- The most important item to monitor and document is a change in the level of consciousness.
- Maintain SPO2 and BP. If ETCO2 monitoring is available = 35-40