

**UAMS MEDICAL CENTER
TRAUMA SERVICES MANUAL**

SUBJECT: Admission and Care of Pregnant Trauma Patients

SECTION: Trauma Services

REVIEWED: 10/2017, 10/2018, 10/2019

PAGE: 1 of 2

RECOMMENDATION(S): Dr. Joseph Jensen

APPROVAL: 10/10/2016

CONCURRENCE(S): Dr. Rawle Seupaul/Dr. Paul Wendel

EFFECTIVE: 10/10/2016

Trauma patients with significant injury who are pregnant and have, or are suspected to have reached a gestational age consistent with fetal viability, will be admitted to the trauma center as a Level 1 trauma activation. In addition, for these patients emergency obstetric and neonatal teams will respond to the trauma bay along with the trauma team.

- The specific definition of “significant injury” will be delineated in the UAMS Trauma activation criteria.
- The gestational age threshold for Level 1 trauma activation will include a margin to accommodate prehospital or referring hospital underestimation of gestational age. As of the original writing of this guideline, the gestational age for Level 1 trauma activation is 20 weeks.
- These definitions are subject to periodic revision based on changes in medical knowledge or other factors.

When a trauma patient requiring emergency obstetric response is reported enroute or arrives unannounced to the trauma center, the ED CDF or designee is responsible for notification of emergency obstetric and neonatal teams as well as the trauma team.

- The primary alerting mechanism is by activation of the Trauma group pager and the Stork group pager. A single group page combining these two groups is in development.
- The OB chief resident will be notified by calling the OB chief cell phone number **231-6643**.
- In the event of failure of the primary alerting mechanism, the emergency obstetric team can be contacted by calling Labor and Delivery by telephone, and the emergency neonatal team can be contacted by the infant emergency group on Vocera.

It is the intent that evaluation of the fetus by the emergency obstetric team shall occur simultaneously with evaluation and initial management of the trauma patient by trauma and emergency medicine personnel.

- This will often require close coordination between anesthesia, emergency medicine, obstetrics, and trauma surgery attendings and house staff.

In the event that fetal distress or other findings warrant emergency Caesarian section, the case will be done in the main OR trauma room (usually Room 13, but may be a backup room).

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- Main OR rooms are equipped with all necessary Caesarian section and emergency neonatology equipment and supplies.
- Performing the Caesarian section in the main OR allows optimal management of other injuries which may be encountered.
- In unusual circumstances, selected Caesarian sections in Trauma patients may be performed on L & D with the concurrence of the obstetrics attending, trauma attending and anesthesiology attending.

Trauma patients requiring admission and who are pregnant at or beyond the gestational age of viability will be jointly managed by trauma and obstetric services. The specific unit of admission will be determined by the services based on these guidelines:

- Patients requiring ICU care will be admitted to the SICU with fetal monitoring as deemed necessary by the obstetric service.
- Patients with significant injuries, but not requiring ICU admission will be admitted to the appropriate trauma unit with fetal monitoring as deemed necessary by the obstetric service.
- Patients with minor injuries will be admitted to the unit deemed appropriate by the obstetrics service, and the trauma service will follow until discharge.

Trauma patients requiring admission and who are pregnant prior to the gestational age of viability will be managed by the trauma with obstetric or gynecology consultation. The specific obstetric or gynecologic care of these patients will be determined on an individual basis.

- The primary goal of care of these patients will be optimal care of the mother.
- Unit of admission of the patient will be determined by the medical needs of the mother.

Rhogam will be considered on a case by case basis after consultation with the OB Attending.