

Southeast Texas Trauma Regional Advisory Council (SETTRAC) Hospital Guidelines for Stabilization & Rapid Transfer of Severe Head Trauma

I. Initial Resuscitation of the Severe Head Injury Patient

1. Complete and rapid physiologic resuscitation (follow ATLS Standards)
2. No treatment should be directed toward intracranial hypertension in the absence of decrease in level of consciousness (for example, neurologic progression from awake to comatose or from localizing motor response to extensor posturing).
3. When there is neurologic progression:
 - • Hyperventilation (one breath every 3-4 seconds) to an end tidal PaCO₂ of 30 mm Hg.
 - • Administer mannitol, 1 gram/kg as a bolus but only if systolic BP \geq 120 mm Hg.
4. Avoid sedation or analgesics in patients who are not following commands. If respiratory control is required, or if a patient is extremely agitated, low doses of short-acting sedating or paralyzing drugs may be considered.
5. When muscle relaxants are needed use the lowest possible dose of very short-acting agents such as rocuronium.

II. II. Airway

Intubation and controlled ventilation should be carried out promptly in patients with questionable airway or respiratory effort.

III. III. Resuscitation of Blood Pressure & Oxygenation

Use ATLS Guidelines

IV. IV. Glucocorticosteroids

Do not use glucocorticosteroids.

V. V. Seizures

If a patient is actively seizing, use Ativan, 2-4 mg (given at a rate not to exceed 2mg/min) intravenously. May repeat one time if a second seizure occurs, or if the first seizure does not stop within 5 minutes.

VI. VI. Rapid Stabilization & Transfer

Patients requiring a higher level of care should be stabilized and transferred within two (2) hours of arrival at the referring facility.