Emergency Department / Orthopaedic Trauma Service Collaboration

These guidelines were created to describe patient conditions and recommendations for musculoskeletal injuries that do not require consultation by orthopaedic surgery. Our team remains available to discuss questions or perform consultation if there are any concerns by the Emergency Department provider. This list serves as a starting point, and we aim to adjust over time as Emergency Department providers and orthopaedic providers adapt to the system. These guidelines do not pertain to patients being admitted to other services, and OTS will always perform formal consultation on those patients. It is the expectation that the Emergency Department Attending be aware of all fracture care provided to their patients in the ED. It is also expected that the Emergency Department Resident collaborates with the Orthopaedic Resident on the fracture care and reductions performed on patients in the ED.

<u>Upper Extremity</u>
Injury: clavicle fracture
Evaluation: x-ray clavicle bilateral (specify in comments that patient should be sitting upright if they can tolerate)
Reason for consultation: concern for open fracture
Treatment: sling
Follow up: 2 weeks, and you can call OTS resident who will coordinate follow up

Injury: AC joint injury
Evaluation: x-ray shoulder and clavicle
Reason for consultation: any concern for scapulothoracic dissociation, absent or asymmetric upper extremity pulses
Treatment: sling
Follow up: 4 weeks, and you can call OTS resident who will coordinate follow up

Injury: proximal humerus fracture
Evaluation: shoulder XRs (AP, scapular Y, and axillary views) and humerus XRs (AP and lateral)
Reason for consultation: associated glenohumeral dislocation, any concern for open fracture
Treatment: sling
Follow up: call OTS resident who will coordinate follow up and determine need for shoulder CT

<u>Lower Extremity</u>
Injury: traumatic knee pain and effusion with normal x-rays
Evaluation: knee x-rays
Reasons for consultation: any concern for septic joint
Treatment: WBAT in knee immobilizer
Follow up: sports clinic in 2-3 weeks (can call OTS resident to facilitate follow up if needed)

Injury: proximal fibula fractures
Evaluation: tibia x-rays, ankle x-rays
Reasons for consultation: concern for ankle syndesmotic injury (typically identified on x-ray with widening of medial malleolus clear space)
Treatment: WBAT, no immobilization needed
Follow up: 4 weeks, and you can call OTS resident who will coordinate follow up

Injury: metatarsal or foot phalangeal fractures
Evaluation: foot XRs
Reason for consultation: concern for lis franc injury; ballistic injuries don't need seen by OTS unless deemed necessary. By ED provider
Treatment: WBAT in CAM boot or post op shoe; all ballistic wounds can be left open to heal on their own (no sutures should be placed to close the wound)
Follow up: 4 weeks, and you can call OTS resident who will coordinate follow up

<u>Other</u>
Injury: concern for traumatic arthrotomy
Evaluation: x-ray and CT of nearby joint; orthopaedic resident will review imaging and determine need for assessment or operative management
Reason for consultation: CT consistent with traumatic arthrotomy
Treatment: laceration can be treated by ED provider if traumatic arthrotomy not present
Follow up: ED clinic for suture removal