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Area	Trauma Surgical Critical Care
Applicability	Tennessee Hospitals ONLY

Pregnant Trauma Patient Practice Management Guideline

1. Process/Procedure Description

To provide an immediate systematic approach to the care of injured pregnant adult trauma patients.

2. Who Should Read This Process/Procedure?

3. Process/Procedure

Step:	Process Instructions/Description:
1.	The pregnant trauma patient will be managed according to established trauma service protocols, policies, and patient management guidelines.
2.	When a pregnant trauma patient meets trauma activation criteria (Level 1 or 2) the ED unit clerk, or designated person, will send a text page out to the “Trauma OB” group that includes Trauma Services, L&D, and NICU. The L&D charge nurse and OB Chief Resident will report to the Trauma Bay with any other necessary staff. NICU will respond with an NICU Attending Physician and other necessary staff as needed. After the initial assessment by the obstetrical team, the Maternal Fetal Medicine (MFM) service on call attending will be notified to assist with further management.
3.	The patient will be upgraded to a level 1 trauma if an emergent Cesarean is needed.
4.	The Trauma Chief or Trauma Attending will notify the Pediatric surgeon on duty should an emergency Cesarean become necessary.
5.	When practical, the gravid trauma patient > 20 weeks gestational age will be placed in a 15 degree left lateral rotation.
6.	Intravenous fluids (LR or NS) will be given to maintain the volume status. Volume assessment monitoring is encouraged for critically injured patients including urine output, acid base status, CVP or echocardiography.
7.	PT, PTT, Fibrinogen and D-Dimer will be added to the trauma labs.
8.	Doppler fetal heart tones will be obtained with the initial vital signs and will be monitored throughout the resuscitation at the same frequency as the maternal vital signs. When the fetus is > 23 weeks gestational age, continuous fetal monitoring should be initiated and maintained by the obstetrical team until the workup is complete and patient disposition determined.
9.	Radiographic imaging necessary to adequately assess the patient will be performed. The gravid uterus will be shielded whenever possible.
10.	Focused Abdominal Sonography for Trauma (FAST) should be employed to evaluate hypotensive patients for evidence of intra-abdominal injury. Diagnostic peritoneal lavage (DPL) can be performed in the unstable patient when interpretation of the FAST exam is in question. An open technique with the incision made above the umbilicus and above the gravid uterus is necessary.
11.	If a pregnant trauma patient shows signs of non-reassuring fetal status, uterine contractions, decreased fetal movement, uterine tenderness, and/or uterine bleeding, an urgent fetal ultrasound will be obtained and managed by MFM as part of the ongoing workup.
12.	Tocolytics will be used at the discretion of the obstetrical or MFM consultant.
13.	The patient’s private obstetrician will be notified of patient’s arrival per obstetrical or MFM service.
14.	In addition to all Level 1 and Level 2 trauma activations, all pregnant Level 3 trauma patients and pregnant Trauma Consults will be evaluated by the Obstetrical Team including the OB Chief Resident and by MFM as indicated. A formal consult note will be provided.
15.	Emergent Cesarean Section:

	a. If the need is identified while the patient is in the emergency department or CT scanner then this should be performed in the main OR by reason of the mother may require additional operative procedures.
	b. If the need is not evident until after the mother is in Labor and Delivery then the patient should remain in the L&D OR.
	Continuous Fetal Monitoring (CFM) Admission Status of Pregnant Trauma Patient ≥ 23 weeks Gestational Age: 1. Non-critical obstetrical patients requiring admission following trauma requiring CFM as deemed by the obstetrical evaluation will be admitted to High Risk Pregnancy Unit (HRPU) and Trauma and other services consulted as indicated. A D-Dimer may be obtained every 6 hours. 2. Critically injured pregnant trauma patients requiring ICU admission will be admitted by Trauma Services and the Obstetrical/MFM services will be consulted. CFM (if ordered by MFM) in the ICU will be coordinated by the obstetrical Charge Nurse on duty each shift.

References:

Attachments

Pregnant Trauma Practice Management Guideline.pdf

Approval Signatures

Step Description	Approver	Date
COO	Robert Maloney: Executive VP & Chief Operating Officer	03/2023
Trauma Services Committee Approval	Stephanie Spain: Trauma Program Manager	03/2023
	Stephanie Spain: Trauma Program Manager	03/2023