VANDERBILT UNIVERSITY
MEDICAL CENTER
DIVISION OF ACUTE CARE SURGERY

Lower Spinal Cord Injury Management Protocol

(for SCI without neurogenic shock, T6 and below)

Neuro

- Spinal immobilization and log roll orders
- Additional imaging as needed
- Brace per spine recommendations
- Multimodal Pain management

Gastrointestinal

- Bowel regimen:
- Trauma bowel Regimen:
  - (Senna +MiraLAX) AND
  - bisacodyl suppository, qday
- Nursing order: Administer bowel regimen as ordered; notify provider if no daily BM

Musculoskeletal/Integument

- Begin PROM on admission if stable
- PT/OT orders after stabilization
- Early mobility
  - OOBTC when cleared by Spine
  - Frequent position changes
- Podis Boots to prevent foot drop

Genitourinary

- Discontinue Foley per CL 30-15.05 *Indwelling Urinary Catheters: Insertion, Maintenance, and Discontinuation*

- If patient unable to void, initiate scheduled I/O catheterization q6h; if UOP>500ml, increase frequency

Psych/Dispo

- PM&R consult

- Consider psych consult to evaluate patient as depression/anxiety are common after SCI

- Communicate early with Case Management to determine disposition options

Prophylaxis

- DVT prophylaxis per Trauma protocol and
- Operative spine, initiate DVT ppx on POD1 unless delay requested per spine team.
- 3 month DVT ppx if patient non-ambulatory
- Stress Ulcer ppx per Trauma protocol

Upper Spinal Cord Injury Management Protocol

(In addition to Lower SCI Management Protocol interventions:)

Cardiovascular

- Avoid hypotension
- Vasopressors for MAP >85 for 72h post-injury in blunt SCI, norepinephrine first line agent, **attending to attending conversation for extension of MAP goals**
- If persistent vasopressor requirement: Consider midodrine 5mg q8h, and titrate up to 40mg/day
- If bradycardic, consider pseudoephedrine and/or glycopyrrolate as alternatives

Consider for Intubation:

- Patients unable to swallow
- Patients with increasing O2 requirement
- Patients with atelectasis, or plugging on cxr
- Paradoxical respiratory pattern
- Persistent need for frequent suctioning of airway
- Peek Expiratory Flow <5L
- Inability to manage secretions

Respiratory

- Respiratory Care Guidelines: Non-intubated SCI patients
- Early Tracheostomy Protocol/ Respiratory Care Guidelines for Intubated SCI patients
- Respiratory Care Guidelines for Ventilatory weaning of SCI patients

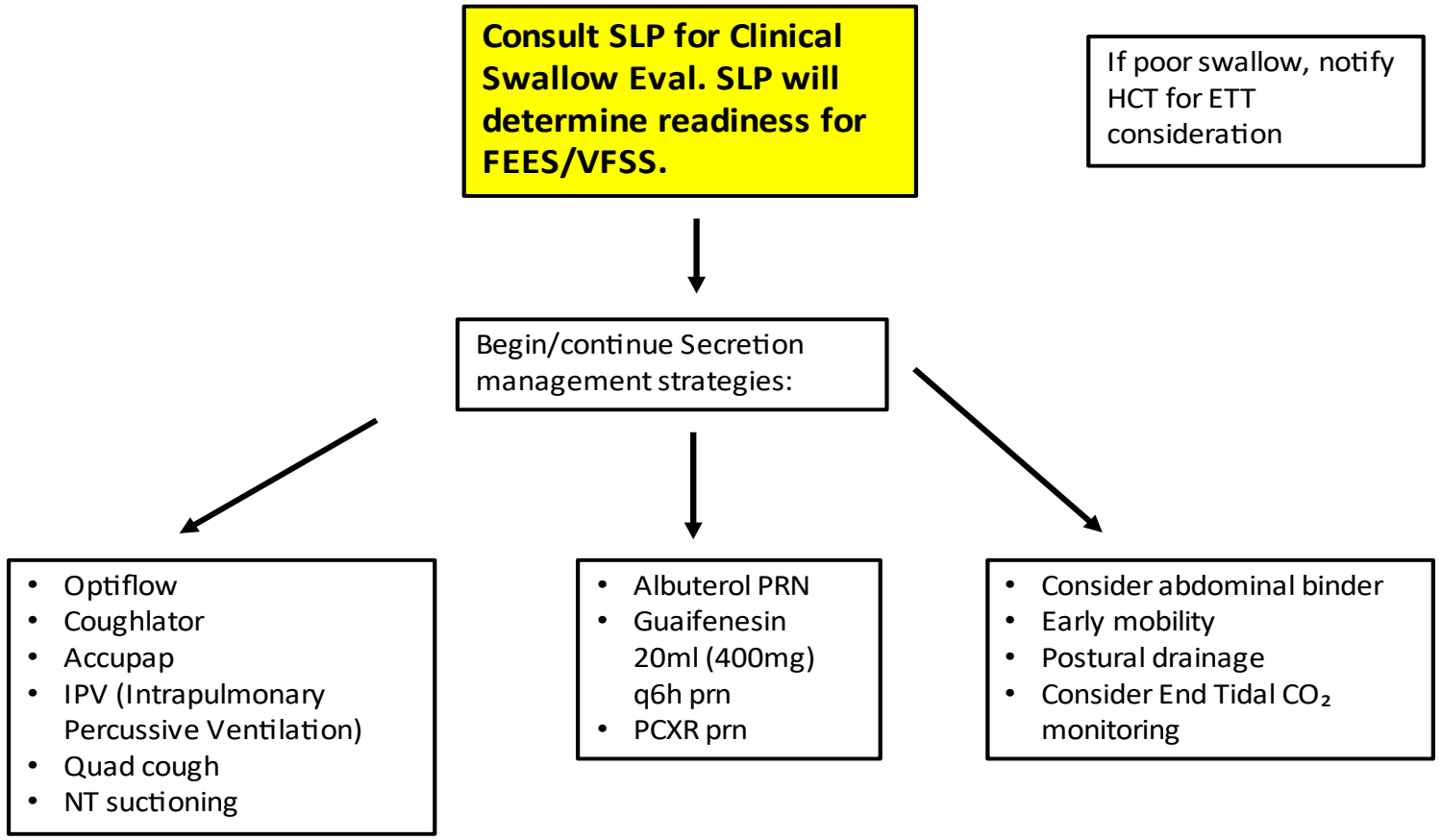
Nutrition

- Patients with upper SCI are at high risk for silent aspiration and respiratory compromise.
- Keep NPO until Clinical Swallow Evaluation
- Consult SLP for Clinical Swallow Evaluation. SLP will determine readiness for FEES/VFSS
- For intubated patients, early DHT placement and TF initiation.

Steroids

- Dexamethasone 10mg 8h x3 may be considered in pts with no significant co-morbidities
- **Attending to Attending agreement required prior to initiation of dexamethasone order**

Respiratory Care Guidelines: Non-intubated SCI patients



Early Tracheostomy Protocol/ Respiratory Care Guidelines for Ventilated SCI patients

Indications for Early Tracheostomy
(2 or more of the following)

C4 and above motor complete injury
Early ETT requirement
Flail chest
Paradoxical respiratory pattern
Persistent need for frequent suctioning of airway
Peek Expiratory Flow <5L

Consider Tracheostomy if:
- Need for multiple operative interventions
- Failed extubation

Tracheostomy/
ETT in-place

Secretion management strategies

- Guaifenesin 20ml (400mg) q6h x 5 days then prn
- Albuterol PRN
- Daily pcxr x 5d then PRN
- Consider abdominal binder
- Early mobility: turn q2h, OOB bid

Initial Ventilator settings:

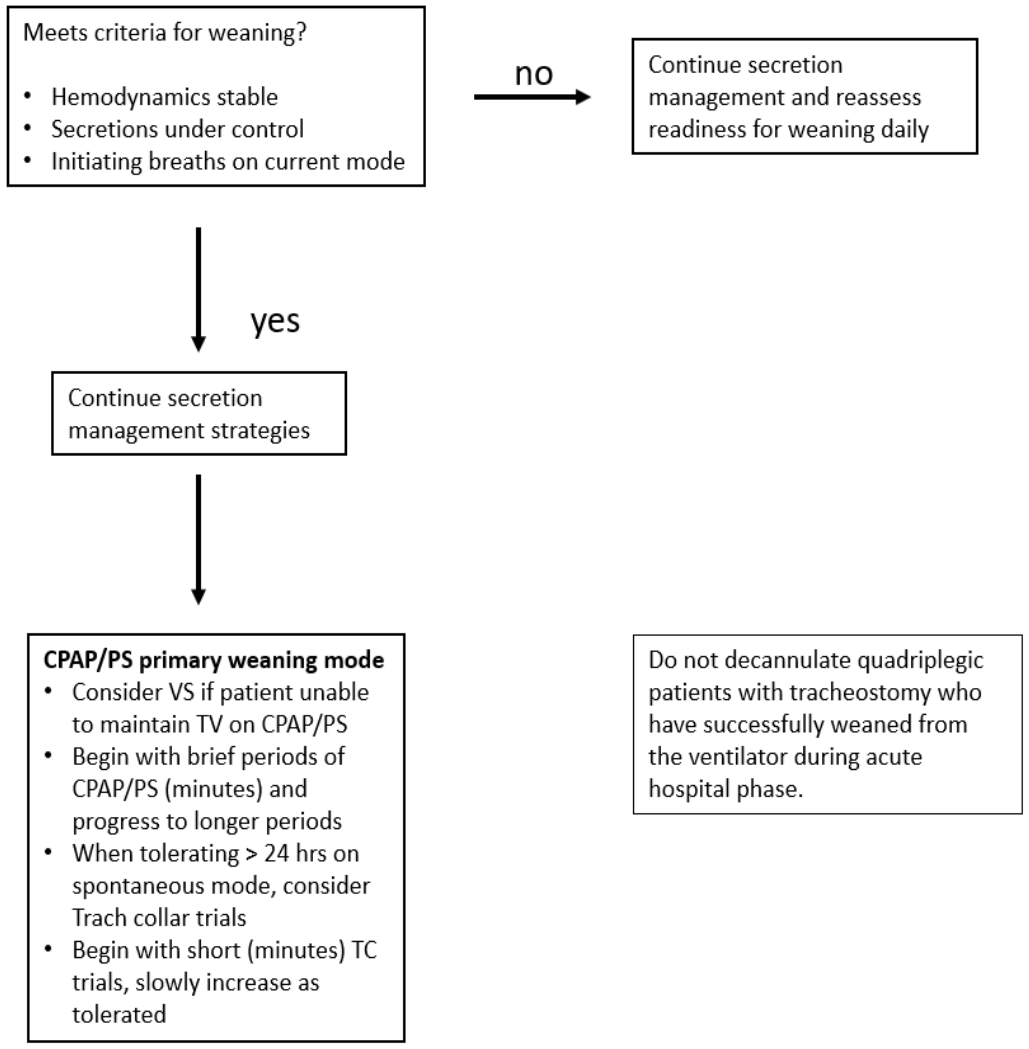
- SIMV/PRVC preferred initial mode
- Heated circuit on ventilator
- PS to deliver goal TV on spontaneous breaths

- IPV
- HIT (Hyper Inflation Therapy)
- Quad cough
- Suction PRN
- Bronchoscopy prn

Planned extubation?
Consider extended 0/0 SBT

Respiratory Care Guidelines for Non-intubated SCI patients

Respiratory Care Guidelines for Weaning Ventilated SCI Patients



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