Is it Urgent Care or Emergent? Where to refer the sick child

Amy K. Graf, APRN, DNP, FNP, PNP-AC

Refer Everything to the ED!

Is it Urgent or Emergent Care?

Is it Urgent or Emergent?

- Seizures
- Altered mental status
- Facial nerve palsy
- Spinal cord dysfunction

Is it Urgent or Emergent?

• Format of presentation:
  • Head to toe
  • Categorized by body systems
  • Emergencies first then urgent issues
  • Clinical judgment supersedes any textbook.
Bell's palsy-idiopathic
• GBS-Antecedent viral respiratory or GI symptoms
• Parasthesias to fingers and toes
• Lower extremity ascending weakness
• Pain or Gait difficulty
• Demyelinating form is most common (85% of cases)
• Most common cause of flaccid paralysis in children
• Rare under age 2 years

Altered mental status
• Meningitis
• Brain tumor
• Ingestion
• Endocrine/Metabolic Disorders

Facial nerve palsy
• Facial nerve palsy-Cranial nerve VII
• Congenital-delivery trauma, genetic/malformative diseases
• Myotonic dystrophy & myasthenia, chromosomal abnormalities
• Acquired-infective, inflammatory, neoplastic, traumatic or iatrogenic
• Bell's palsy-idiopathic
• 90% of cases of facial palsy
• Herpes Simplex 1
• 70% have a favorable prognosis with spontaneous resolution within 3 mo
• Bilateral palsy-uncommon. EBV, H. influenza, leukemia, TB or Lyme Disease
• Other causes: CMV, adenovirus, rubella, varicella, HIV, Guillain-Barré Syndrome, early disseminated Lyme disease—often as an isolated finding

Lyme Disease
• Borrelia burgdorferi bites may be useful at this stage (early disseminated)
• Appropriate treatment is 21-28 days of doxycycline or amoxicillin.
• Amoxicillin preferred risk of dental staining from use of doxycycline.

Guillain-Barré Syndrome
• Post-infectious, acute, auto-immune mediated polyneuropathy
• Bilateral facial nerve palsy is most common pattern of cranial nerve involvement in GBS
• Unilateral facial palsy rare but can be seen in GBS
• Demyelinating form is most common (85% of cases)
• Most common cause of flaccid paralysis in children
• Rare under age 2 years

GBS-Antecedent viral respiratory or GI symptoms
• Parasthesias to fingers and toes
• Lower extremity ascending weakness
• Pain or Gait difficulty
• Diminished absent reflexes
• Hypotension alternating with hypertension
• Cranial Nerve weakness, usually facial nerve
• Respiratory failure in 10-20%
• Nerve conduction studies show slowing or block
Neurologic Emergencies: Spinal Cord Dysfunction
• Symptoms of spinal cord dysfunction:
  • Weakness, incoordination or paralysis in any part of body
  • Numbness, tingling or loss of sensation in hands/fingers or feet/toes
  • Loss of bowel or bladder control

Neurologic Emergencies: Spinal Cord Dysfunction
• Causes: birth injuries, falls, MVA, sports, diving, trampoline, gun/stab wound, infections
• Rare for peds to have spinal cord injury-MVA, sports, NAT
• SCIWORA-Spinal Cord Injury Without Radiologic Abnormality-sports and NAT
• Physical exam is most important part of diagnosis
• Midline cervical tenderness most common physical finding in C-spine injury without rad abnormality

Psychological Emergencies
• Suicidal/Homicidal Ideations
• Ingestions/Toxidromes-dangerous level of toxins
• Eating Disorders

Psychological Emergencies: SI & HI
• Risk factors:
  • Age over 12 years
  • Past suicidal behavior
  • Substance abuse
  • Major depression are all risk factors for suicidal behavior.
  • Past suicidal behavior is the single best predictor of future suicidal behavior

Psych Emergencies: Ingestions
• 80% of all pediatric exposures occurred in patients 5 years of age or younger
• Unintentional poisonings 80-85%
• Intentional 10-15%

Psych Emergencies: Ingestion
• Common "One pill can kill" ingestions
  • Calcium channel blockers (verapamil, diltiazem, nifedipine, isradipine)
  • Beta blockers (propranolol, metoprolol, atenolol)
  • Anti-dysrhythmics (procainamide, flecainide)
  • Opiates
  • Sulfonylureas (glipizide, glyburide)
  • Tricyclic antidepressants (amitriptyline, nortriptyline, doxepin)
  • Methyl salicylate (oil of wintergreen, 7.5 gm/5 mL of salicylate)
Psych Emergencies: Ingestion
- Acetaminophen
- PE is usually unremarkable in acute ingestion
- GI distress
- Metabolic acidosis
- Tachypnea
- Altered mental status
- Renal impairment
- Hepatic impairment
- Jaundice
- RUQ Pain
- Coagulopathy
- Encephalopathy
- ECG Findings: usually none

Psych Emergencies: Eating Disorders
- Level of care guidelines for children needing hospitalization
- VS: HR near 40, BP < 80/50, Orthostatic BP changes
- Hypokalemia, hypomagnesemia, hypophosphatemia
- Suicidality-lethal plan
- Weight < 70% of healthy body weight

Psych Emergencies: Eating Disorders
- Co-occurring disorders- substance abuse, depression, anxiety
- Purging behaviors- laxatives/diuretics
- Structure needed for eating gaining weight-needs supervision
- Environmental stress
- Ability to control compulsive exercise

Ophthalmologic emergencies
- Retinal detachment-retina separates from layer underneath
- Open globe-full-thickness injury to cornea/sclera/both
- Chemical burns-Akali injury
- Orbital cellulitis
- Corneal/scleral lacerations
- Globe rupture-outer membranes of eye compromised
- Orbital fracture-fracture around the eye socket

Ophthalmologic Emergencies: Orbital Cellulitis
- CT orbits with IV contrast
- Hospital admission for IV antibiotics

Ophthalmologic Urgencies
- Conjunctivitis
- Stye
Dental Emergencies

- Dental avulsion - Knocked out permanent tooth
- Dental intrusion - Tooth forced into the jawbone
- Tooth extrusion - Displacement - Tooth angled

Dental Emergencies

- Dental intrusion

Urgent Dental Issues

- Cavities
- Dental pain

Dental Avulsion

Dental Emergencies

- Tooth extrusion - Tooth elongated due to displacement & is excessively loose

ENT Emergencies

- Lodged disc battery and magnets / Foreign bodies
- Post-tonsillectomy
- Mastoiditis
- Peritonsillar abscess
- Retropharyngeal abscess
ENT Emergencies: Disc battery & magnets

- Battery ingestion following characteristics:
- Majority of ingestions: children younger than 6 years of age, peak frequency between one to two years of age.
- Among children, over half of the batteries were ingested immediately after removal from a product.
- Ingested batteries obtained from a variety of devices (in decreasing order of frequency) hearing aids, games and toys, watches, calculators, lighting devices (eg, flashlights, laser pointer, penlight), and remote control devices (eg, television, garage door, key fob).
- By 2008, 38 percent of ingested batteries were 220 mm, and most of these large diameter batteries were lithium cells.
- Patients with hearing aid battery ingestions were the user of the hearing aid.

ENT Emergencies: Batteries

- Emergency evaluation & plain radiography for patients who meet any one of the following criteria:
  - All children under 12 years of age who ingest button batteries
  - All patients who have ingested a button battery that is 21.2 mm in diameter
  - All patients for whom the diameter of the button battery is not known
- Plain radiographs should include anteroposterior (AP) and lateral views from the nasopharynx to the anus.

ENT Emergencies: Battery Ingestion

- Guidelines developed by the National Battery Ingestion Hotline (NBII, available at its website) and the North American Society for Pediatric Gastroenterology, Hepatology, and Nutrition Endoscopy Committee (NASPGHAN) provide the basis for the approach to button battery ingestion. The National Battery Ingestion Hotline (NBII) (800-922-8666) or a Poison Control Center (in the US, call 1-800-222-1222 or access the World Health Organization list

ENT Emergencies: FB Ingestion

- Urgent and sometimes emergent intervention to remove a foreign body is indicated in the following situations:
  - When the object is sharp, long, or consists of high-powered (neodymium) magnets or a superabsorbent polymer in the esophagus or proximal gastrointestinal tract.
  - When the object is a disk battery in the esophagus.
  - If airway compromise, such as tracheal compression, is present.
  - If evidence of esophageal obstruction—unable to swallow secretions.
  - Signs/symptoms suggesting inflammation or intestinal obstruction (fever, abdominal pain, vomiting).
  - If the object is in the esophagus and the suspected ingestion occurred 24 or more hours prior to the evaluation, or if the time of ingestion is unknown.

ENT Emergencies: Post-tonsillectomy

- Post-tonsillectomy bleeding
- Occurs at two peak times.
  - Early within the first 24 hours
  - Late at post-op days 5-8.

ENT Emergency: Mastoiditis

- Acute mastoiditis is a suppurative infection of the mastoid air cells with symptoms less than one month’s duration.
- May be uncomplicated or complicated (ie, associated with one or more extra- or intracranial complication.
- Bacterial species most often implicated are Streptococcus pneumoniae, Streptococcus pyogenes, and Staphylococcus aureus.
- Treatment of acute mastoiditis depends upon pathologic stage, presence or absence and type of complications.
- Antimicrobial therapy and drainage of the middle ear and mastoid are the cornerstones of therapy.
**ENT Emergencies: Abscesses**

- Peritonsillar abscess (PTA) is a collection of pus located between the capsule of the palatine tonsil and the pharyngeal muscles.
- The typical clinical presentation of PTA is a severe sore throat, fever, a "hot potato" or muffled voice, drooling, and trismus.
- Examination findings consistent with PTA include an enlarged and fluctuant tonsil with deviation of the uvula to the opposite side.
- Retropharyngeal infection—children who present with fever, stiff neck, pain with neck extension, dysphagia, and other symptoms related to inflammation or obstruction of the upper aerodigestive tract.
- Neck stiffness is an important symptom and may occur in the absence of respiratory symptoms.

**Urgent ENT**

- Nasal foreign bodies
- Ear foreign bodies
- Epistaxis

**Pulmonary and Allergic Emergencies**

- Respiratory distress
- Anaphylaxis

**Respiratory Emergencies: Respiratory Distress**

- Inability to maintain gas exchange—hypoxia
- Multiple etiologies
- Signs and symptoms vary by age
- Abnormal respirations: tachypnea, bradypnea, apnea
- Retractions/Accessory muscle use
- Head bobbing/position of comfort
- Nasal flaring, grunting, color change—cyanotic, pale
- Altered mental status

**Pulmonary Emergencies**

- Causes of respiratory distress/failure
  - Asthma
  - Foreign body
  - Stridor at rest with croup
  - Bronchiolitis/RSV
  - Epiglottitis

**Pulmonary and Allergic Emergencies**

- Anaphylaxis—potentially life threatening manifestation of immediate hypersensitivity
- Most commonly involves pulmonary, circulatory, cutaneous, GI & central neurologic systems.
- IgE mediated reaction
- Any route of exposure—parenteral, oral or inhalation may cause anaphylaxis
- Increased risk of fatal anaphylaxis: adolescents, peanut, cashew, tree nuts especially when consumed outside the home, asthmatics
Pulmonary and Allergic Emergencies
- Anaphylaxis: more than one body system affected at the same time

Cardiac Emergencies
- Pediatric cardiac emergencies comprise a range of pathology
- Four main categories:
  - Undiagnosed congenital heart disease in infant
  - Complications of palliated congenital heart disease
  - Dysrhythmias
  - Acquired heart disease

Cardiac Emergencies: Infants
- Infants may have a benign clinical presentation due to patent ductus arteriosus
- Ductus typically closes within first 2 weeks of life.
- May take up to 6 weeks to close.
- Any infant 6 weeks or younger with symptoms of:
  - Respiratory distress
  - Cyanosis
  - Hypoxia

Cardiac Emergencies: Infants
- Any infant 6 weeks or younger with symptoms of:
  - Respiratory distress
  - Hepatomegaly
  - Tachycardia
  - Poor perfusion
  - Weak/absent femoral pulses
  - BP difference between upper/lower extremities
  - Infants born to mom’s with Lupus can develop complete heart block

Cardiac Emergencies
- Child with history of palliated congenital heart disease
- Refer to the ED
Cardiac Emergencies: Dysrhythmias
- Majority of pediatric dysrhythmias occur among children with congenital and acquired heart disease
- Symptoms of cyanosis or CHF may precede the dysrhythmia
- Children with an initial presentation of dysrhythmia-conduction disorder in a structurally normal heart.
- Most common symptomatic pediatric dysrhythmia is SVT
  - HR greater than 220 in infants
  - HR greater than 180 in children
- Examples: Ebstein’s anomaly or WPW

Cardiac Emergencies: Acquired
- CHF may present in infants 4-6 weeks & older children
- Causes: left to right shunt & pulmonary congestion
- Older children
  - Dyspnea
  - Exercise intolerance
- Infants
  - Poor feeding
  - Failure to thrive
  - Tachypnea
  - Diaphoresis

Cardiac Emergencies: Acquired
- CHF may be due to:
  - ALCAPA-Anomalous left coronary artery arising from pulmonary artery
  - Cardiomyopathy
  - Myocarditis-inflammation of myocardium
  - Shunting-intracardiac-VSD or Extracardiac-vein of Galen malformation
  - Dysrhythmias

Cardiac Emergencies: Acquired
- Kawasaki disease-acute vasculitis of unknown etiology
- Affects children predominantly < 5 years of age
- Coronary artery aneurysms & progressive stenosis
- Clinical criteria:
  - Must have 5 or more consecutive days of fever (greater than 100.4)
  - Polymorphous rash
  - Non-exudative conjunctivitis-Erythema but no drainage, limbic sparing
  - Mucocutaneous symptoms: strawberry tongue, dry, cracked lips
  - Cervical lymphadenopathy
  - Extremity changes-edema of hands/feet, palmar erythema
  - May have partial Kawasaki: fever x 5 + days and 3 or more symptoms

Cardiac Emergencies: Acquired
Cardiac Emergencies: Pediatric
• All complaints of chest pain needs an ECG!
• Worrisome symptoms/history:
  • Dyspnea
  • Exertional syncope
  • Radiation of chest pain
  • Females on OC + smoking-PE
  • Marfan syndrome-aortic dissection
  • Family history of hypertrophic cardiomyopathy or sudden cardiac death

Dermatologic Emergencies
• Burns
• Dog bites
• Eczema herpeticum
• Idiopathic Thrombocytopenia Purpura
• Stevens-Johnson Syndrome
• Rocky Mountain Spotted Fever
• Meningococcemia

Burns
• Superficial: epidermis-only
  • erythematous, intact skin
• Partial thickness: epidermis and dermis, sparing skin appendages
  • erythematous with blisters
  • spared dermal appendages allow excellent re-epithelialization
• Full thickness: all structures in epidermis and dermis
  • white or charred

Dermatologic Emergencies
• Animal bites
• Augmentin or Doxy, Bactrim or Cipro
  Plus Clinda or Metronidazole
• Closure if large wound or cosmetic
• Imaging: deep bite wounds esp near joints to eval for FB & fracture
• CT head: less than 3 years old & bite to scalp
Dermatologic Emergencies

- Eczema herpeticum
- Umbilicated vesicles superimposed on an atopic dermatitis
- Usually HSV 1 or coxsackie virus
- Treatment with antiviral Acyclovir and IV antibiotics

Dermatologic Emergencies

- Immune Thrombocytopenia Purpura- platelet count less than 100,000 with normal WBC and Hgb.
- Treatment: Watchful waiting or IVIG or anti-D immune globulin
- No platelets unless bleeding is life-threatening

Dermatologic Emergencies

- Stevens-Johnson Syndrome/TEN Toxic Epidermal Necrolysis
- Symptoms: fever, flu-like symptoms, mucocutaneous lesions, skin tenderness, cutaneous exfoliation, conjunctival burning, or photophobia
- Causes:
  - Drug induced: Sulfa, allopurinol, Cephalosporins, Vanc
  - Viral, mycoplasma pneumonia

Dermatologic Emergencies

- Rocky Mountain Spotted Fever-Most severe of rickettsial spotted fevers
- Symptoms: fever, headache, myalgia, rash
- Rash: erythematous macules and papules on wrists, forearms and ankles then spreads to thighs, trunk, face
- Exposure to tick
- 3% present with history of rash, fever and hx of tick bite within the first 3 days

Dermatologic Emergencies

- Meningococcemia
- Symptoms: fever, petechial/purpuric lesions smudged, hypotension, signs of meningitis
- Very ill appearing child

Dermatologic Urgencies

- Atopic dermatitis
- Hand, Foot and Mouth Syndrome
- Urticaria
- Pityriasis Rosea
- “Fight bite”
**Urgent Dermatology: Fight Bite**

**Endocrine Emergencies: Electrolytes**
- Hyperglycemia-new onset DM, ketoacidosis
- Hyper/hyponatremia-seizures
- Hypocalcemia-abnormal muscle tone, seizure activity, prolonged QTc

**Gastrointestinal Emergencies**
- Vomiting
- GI bleeding
  - Hematemesis
  - Hematochezia
  - Incarcerated hernia
- Acute abdominal pain in adolescent female

**Gastrointestinal Emergencies: Vomiting**
- Prolonged vomiting
- >12 hours in a neonate
- >24 hours in children younger than two years
- >48 hours in older children may require urgent intervention.
- Prolonged vomiting increases risk of dehydration and electrolyte abnormalities.
- Symptoms and signs suggestive of intestinal obstruction include marked abdominal distension, visible bowel loops, absent bowel sounds or increased high-pitched bowel sounds ("borborygmi"), severe abdominal pain, or vomitus that is bilious (green or yellow) or feculent (odor of feces).

**GI Emergencies: Vomiting**
- Bilious vomiting warning sign of possible intestinal obstruction in a neonate-intestinal atresia or volvulus.
- Sudden onset of intermittent, severe, crampy, progressive abdominal pain in an infant/toddler suggests possible intussusception-most common cause of intestinal obstruction in infants between 6 and 16 months of age.
- Projectile vomiting-gastric stenosis. Presents between 3 - 5 weeks of age, rarely after 12 weeks
- Headache, positional triggers for vomiting, lack of nausea, and/or vomiting on awakening suggest the possibility of increased intracranial pressure.
- Adolescent female with early morning vomiting-evaluate for pregnancy.
- Altered consciousness, seizures, focal neurologic abnormalities suggest possible toxic ingestion

**Gastrointestinal Emergencies: GI Bleeding**
- Common causes of UGI bleeding in children vary depending upon age.
- Most common causes are Mallory-Weiss tears, gastric and duodenal ulcers, esophagitis, gastritis, and varices
- Breastfeeding moms of newborns may have irritated/cracked nipples
GI Emergencies: Hematochezia
- Rectal bleeding presenting as acute abdominal crisis
- Malrotation with midgut volvulus - usually newborn infants but may be seen in children of any age
- Hirschsprung disease complicated by obstruction - usually in newborns
- Hirschsprung disease-associated enterocolitis - usually in infants or those with known Hirschsprung disease
- Intussusception usually in infants or preschool aged children

Gastrointestinal Emergencies: Incarcerated Hernia
- Manual reduction should be attempted for children with an incarceration without signs of peritoneal irritation
- Unless child appears extremely ill, signs of peritonitis, intestinal obstruction, or toxicity from gangrenous bowel, manual reduction should be attempted.
- Manual reduction is successful in 95 to 100 percent of patients

GI Emergencies: Acute abdominal pain in the adolescent female
- Ectopic pregnancy - bleeding, crampy pelvic pain, 6-8 weeks after menstrual cycle. Hx of ectopic preg & pelvic infection.
- Appendicitis - peri-umbilical pain, RLQ pain, fever, vomiting, anorexia. CBC, ESR, CRP, US/CT scan
- Ovarian and fallopian tube torsion - sharp intermittent abd pain, nausea and vomiting.
- Uterine rupture - tenderness & bleeding. Laboring female with history of C-section or uterine surgery
- Placental abruption - bleeding, abd/back pain, contractions

Hematologic Emergencies
- Pancytopenia
- Sickle cell disease and fever
- ITP
- Post-splenectomy and fever

Hematologic Emergencies: Pancytopenia
- WBC, RBC & platelet counts are low
- Causes:
  - Leukemia
  - Lymphoma
  - Medications
  - Systemic Lupus Erythematosus
- Viral infections - HIV, EBV, unknown viral infection

Hematologic Emergencies: SCD & fever
- Concern for bacterial sepsis in children with sickle cell disease and fever
- Sepsis remains the most common cause of mortality in SCD
- Functional asplenia and reduced immune response
- Need CBC with diff, Reticulocyte count, Blood culture, UA and urine culture, CXR
Hematologic Emergencies: ITP

- Immune Thrombocytopenia (ITP) of childhood is characterized by isolated thrombocytopenia (platelet count <100,000/microl), with normal white blood cell count and hemoglobin.
- Initial management of children with newly diagnosed ITP may be either "watchful waiting" or pharmacologic intervention. First-line treatment options include glucocorticoids, intravenous IVIG and IV anti-D immune globulin.
- Therapy is based on severity of bleeding symptoms and degree of thrombocytopenia.

Hematologic Emergencies: Post-splenectomy

- Impaired splenic function- at risk for severe and overwhelming infection with encapsulated bacteria (eg, Streptococcus pneumoniae, Haemophilus influenzae, and Neisseria meningitidis), bloodborne parasites, and other infections that the spleen plays an important role in controlling.
- Patients with impaired splenic function need vaccinations against S. pneumoniae (pneumococcus), H. influenzae, and N. meningitidis (meningococcus).

Neonates

- Febrile neonate
- Herpetic rash
- Inborn error of metabolism
- Positive newborn screenings
- Respiratory distress
- Electrolyte abnormalities-Congenital adrenal hyperplasia

Febrile Neonate

- Needs evaluation in the ED
- CBC, CMP, UA, urine culture, blood cultures, LP, possible HSV
- Admission to hospital for IV antibiotics

Neonate

- Neonatal Herpes- high morbidity and mortality.
- HSV transmitted to infant during delivery through an infected maternal genital tract. Transplacental and nosocomial infection may occur.

Orthopedic Emergencies

- Deformed extremities
- Limp with a fever
- Slipped capital femoral epiphyses
- Suspected non-accidental trauma (discussed later)
- Felon
Orthopedic Emergencies

- Deformed extremities
- Xrays 2 views please!
- One view is too few

Orthopedic Emergencies

- Limp with a fever
- Labs: CBC, ESR, CRP, imaging
- Concern for septic joint

Orthopedic Emergencies

- Slipped Capital Femoral Epiphyses

Orthopedic Emergencies

- SCFE
  - More common in obese, adolescent boys
  - African-Americans, Latinos
  - Time is of the essence: prevent osteonecrosis
  - Treatment: Surgical repair with percutaneous hip pinning

Orthopedic Emergencies

- Felon- subcutaneous abscess of fingertip pulp
  - Treatment: I & D and IV antibiotics by Hand or Ortho

Urgent Orthopedic Issues

- Nursemaid’s elbow- subluxation of annular ligament when longitudinal traction applied to hand
Genitourinary Emergencies

• Paraphimosis- cannot reduce the foreskin back over the penis

Can be normal up to 3 years old.
Clinically significant after age 4.

Treatment:
• Topical warm cream
• Periodic gentle retraction

Paraphimosis

Genitourinary Emergencies

• Priapism - ischiemic priapism is painful, rigid erection present for longer than 2 to 4 hours in the absence of sexual excitation.
• Causes: Idiopathic, sickle cell disease, leukemia, trauma, cocaine.
• May cause permanent erectile dysfunction.
• Recommend urologic consultation.

Genitourinary Emergencies

• Burns
• Blunt trauma-MVA, falls from height, sexual or physical assault.
• Straddle injury - inability to void or large hymenal tear or vaginal bleeding may indicate urethral involvement.

Genitourinary Emergencies

• Testicular torsion- abrupt onset of severe pain associated with nausea/vomiting.
• Testicle may lie transversely in scrotum and be retracted.
• Cremasteric reflex absent.
• Needs immediate intervention for survival of testis. US and Urology consult.
• May attempt manual detorsion if emergency operative care is not readily available.

Genitourinary Urgencies

• Urinary tract infections - not vomiting, tolerating po, able to take antibiotics, able to void.
• Nephrolithiasis - tolerating po, able to urinate, pain managed.
• STDs-gonorrhea, chlamydia treat with Azithromycin 1 gram and Rocephin injection of 250 mg. Consider HIV and syphilis testing.
Traumatic Emergencies

- Sexual assault
- Non-accidental trauma

Orthopedic Emergencies

- Suspect non-accidental trauma:
  - Delay in presentation
  - Vague or inconsistent explanation of mechanism
  - Mechanism described is inconsistent with injury
  - Injury inconsistent with developmental stage of the child
  - NAT can present with any type of fracture pattern

Traumatic Emergencies: NAT

- Skeletal survey
- CT head
- Trauma labs: CBC, Amylase, Lipase
- Abdominal CT if Amylase or Lipase elevated
- Consult Forensics, CPS
- Admission or Safety Plan from CPS

Traumatic Emergencies: NAT

- “Those who don’t cruise rarely bruise”

- Sexual assault – majority of physical exams are normal
- Complaints may be non-specific
- Clinical photography and forensic evidence as indicated.
References


References