West Yorkshire
Major Trauma Network

LOW ENERGY (FRAGILITY) PELVIC FRACTURES in OLDER / FRAIL PATIENTS

Patient group: Frail / Older adults (usually ≥ 65 years old) with suspicion or evidence of a low energy pelvic / acetabular fracture.

Initial non T&O assessment (ED, COTE etc)

PLEASE ENSURE:

- Completed haemodynamic and neurovascular assessment with documented past medical history and current drug history. Pay particular attention to any coagulation issues and anti-coagulant / anti-platelet medication.
- AP x-ray pelvis
- Documented clinical examination of pelvis including assessment of hip movement and posterior pelvic tenderness
- If there is evidence of posterior pelvic pathology following clinical examination and x-ray (or if there is doubt over whether or not there is posterior pelvic pathology) then request CT pelvis (or Inlet / outlet views if CT not feasible).
- REFER **LOCAL** T&O service. The majority of these patients will be managed non-operatively (see below) and followed up locally.

Initial T&O management

- Ensure completion of above steps utilising FABER test, Gaenslen Test and sacral compression.
- The majority of low energy pelvic fractures will be treated non-operatively (see below)
- Lesions of the anterior ring (pubic rami fractures) are less significant unless there is disruption of the symphysis pubis.
- If the pelvic ring remains symmetrical post mobilisation it is mechanically stable and non-operative management should be sufficient.
- If the patient's pain is adequately controlled with standard analgesia on mobilisation out of bed then again, the fracture is likely to be mechanically stable and non-operative intervention should suffice.
- If the patient's co-morbidities / ASA status do not allow safe surgery then non-operative management should be followed.
- **ACETABULAR** fractures are different and should be discussed with local T&O consultant and / or referred to the LGI Pelvic & Acetabular recon team (see below for referral mechanism). Do not however consider a fracture at the root of the pubic ramus to represent an acetabular fracture.

Consideration of operative management

- Refer / discuss with P&A Reconstruction consultants at the LGI. From outside LTHT this should be done using Patientpass (https://nww.referrals.leedsth.nhs.uk/website/#/login) together with direct consultant to consultant discussion.
- For patients in LTHT contact the on trauma co-ordinator or on-call registrar for T&O.

APPENDIX 1

NON-OPERATIVE MANAGEMENT

In general this consists of

1. Adequate pain relief (avoiding NSAIDs)
2. VTE risk assessment and thromboprophylaxis for 6 weeks with weekly FBC for thrombopenia if on LMWH.
3. Prevention of pressure sores
4. Falls risk assessment
5. Evaluation of need for osteoporosis treatment (anabolic agent + calcium / vit D)
6. Mobilisation as shown below.

UNILATERAL SACRAL INJURY - **MOBILISATION PLAN 1A**

Under physiotherapy supervision:

Protected weight bearing on the affected SACRAL side for limited distances with zimmer / crutches for the first 6 weeks. If non-compliant may need bed to chair / wheelchairs transfers. Follow up in fracture clinic at 6 weeks OR discharge to physiotherapy. Follow Mobilisation Plan 2 after 6 weeks.

Significant discomfort or pain with this plan? See below

BILATERAL SACRAL INJURY - **MOBILISATION PLAN 1B**

Under physiotherapy supervision:

BED to chair / wheelchair transfers for 6 weeks with assistance on transfer / use of banana board. If the patient is non-compliant or confusion prevents safe transfer they should be hoisted. Follow up in fracture clinic at 6 weeks OR discharge to physiotherapy. Follow mobilisation plan 2 after 6 weeks.

Significant discomfort or pain with this plan? See below

MOBILISATION PLAN 2

From 6 to 12 weeks post diagnosis continue mobilisation under physiotherapy supervision. Weight bearing can be increased on the affected side with zimmer frame or crutches allowing increased distances. Continue adequate pain relief (still avoiding NSAIDs). Anabolic agents and Calcium / Vit D should be continued for a least 6 months. Assuming successful progress move to mobilisation plan 3 at 12 weeks.

MOBILISATION PLAN

3 From 12 weeks post diagnosis continue progressive mobilisation under physiotherapy supervision as pain allows.

FAILURE OF CONSERVATIVE MANAGEMENT

IF there are concerns for failure of conservative management at any stage (primarily significant discomfort or pain whilst following above mobilisation plans) then:

- Perform new AP pelvic x-ray
- Either fax referral (0113 3923290) and contact P&A team secretary on 0113 3922750) **OR**
- Send Patientpass referral and senior T&O clinician to contact P&A Reconstruction consultant via LGI switchboard (0113 2432779).

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