

## Management of OPEN FRACTURES - CHILDREN

### WOUND management

1. Photograph of the wound
2. Remove gross contamination (i.e. leaves, etc.)
3. DO NOT wash out the wound at this stage
4. Cover the wound with Saline Soaked Gauze/s
5. Leave wound and dressing undisturbed
6. Check Tetanus status
7. Give ASAP Antibiotics IV according to *LTHT antimicrobial guideline*  
<http://www.lhp.leedsth.nhs.uk/common/guidelines/detail.aspx?id=2682>
  - Co-Amoxiclav 30mg/kg IV (max 1.2gr per day) tds
  - Clindamycin 6.25 mg/kg IC qds and Gentamicin 2.5mg/kg (for penicillin allergy)
  - Contact microbiology for advice on patients if in doubt
8. Continue Antibiotics IV for 72hrs or until definitive skin closure
9. At Induction: single doses of **Gentamicin 2.5mg/kg and Teicoplanin 10mg/kg IV** for initial debridement and every secondary procedure until definitive skin closure
10. Antibiotics may be varied by local TU advice

### FRACTURE management

1. Neurovascular Examination & Documentation
2. Align and Splint the fracture
3. Repeat Neurovascular Examination
4. XRAYs – CT imaging as required
5. Document all findings

### DEFINITIVE management

1. AT MTC: Decision balanced between oncall MTC Consultant – Plastic Surgery and Vascular Surgery consultants
2. At TU - decision on local Mx vs MTC Transfer depends on local expertise.
3. Timing depends on other injuries and available expertise
4. Irrigation/Debridement, Wound coverage and Fixation should be within 24hrs
5. Severely contaminated injuries, farm and aquatic remain a surgical Emergency and MUST be Debrided in Theatres **ASAP**
6. **Definitive Coverage – Fixation** optimally within 72hrs



BRITISH ORTHOPAEDIC ASSOCIATION and  
BRITISH ASSOCIATION OF PLASTIC, RECONSTRUCTIVE  
AND AESTHETIC SURGEONS  
STANDARD for TRAUMA – 2009



## BOAST 4: THE MANAGEMENT OF SEVERE OPEN LOWER LIMB FRACTURES

### Background and Justification:

The British Orthopaedic Association and the British Association of Plastic, Reconstructive and Aesthetic Surgeons have reviewed their 1997 guidance and now publish a review of all aspects of the acute management of these injuries using an evidence-based approach, leading to the "Standards for the Management of Open Lower Limb Fractures," which are free to download from [www.boa.ac.uk](http://www.boa.ac.uk) and [www.bapras.org.uk](http://www.bapras.org.uk). This BOAST is derived from these standards. Contrary to traditional teaching, best outcomes are achieved by timely, specialist surgery rather than emergency surgery by less experienced teams.

### Included Patients:

All patients with high energy open fractures as manifest by the following injury patterns:

- Fracture Pattern:
- Multifragmentary (comminuted) tibial fracture with fibular fracture at same level
  - Segmental fractures
  - Fractures with bone loss, either from extrusion or after debridement
- Soft tissue injury:
- Swelling or skin loss, such that direct, tension-free wound closure is not possible
  - Degloving
  - Muscle injury that requires excision of devitalised muscle via wound extensions
  - Injury to one or more major arteries of the leg
  - Wound contamination with marine, agricultural or sewage material

### Standards for Practice Audit:

1. Intravenous antibiotics are administered as soon as possible. [redacted] [redacted] are continued until wound debridement. [redacted] hourly if penicillin allergy
2. The vascular and neurological status of the limb is assessed systematically and repeated at intervals, particularly after reduction of fractures or the application of splints
3. Vascular impairment requires immediate surgery and restoration of the circulation using shunts, ideally within 3-4 hours, with a maximum acceptable delay of 6 hours of warm ischaemia
4. Compartment syndrome also requires immediate surgery, with 4 compartment decompression via 2 incisions (see overleaf)
5. Urgent surgery is also needed in some multiply injured patients with open fractures or if the wound is heavily contaminated by marine, agricultural or sewage matter.
6. A combined plan for the management of both the soft tissues and bone is formulated by the plastic and orthopaedic surgical teams and clearly documented
7. The wound is handled only to remove gross contamination and to allow photography, then covered in saline-soaked gauze and an impermeable film to prevent desiccation
8. The limb, including the knee and ankle, is splinted
9. Centres that cannot provide combined plastic and orthopaedic surgical care for severe open tibial fractures have protocols in place for the early transfer of the patient to an appropriate specialist centre
10. The primary surgical treatment (wound excision and fracture stabilisation) of severe open tibial fractures only takes place in a non-specialist centre if the patient cannot be transferred safely
11. The wound, soft tissue and bone excision (debridement) is performed by senior plastic and orthopaedic surgeons working together on scheduled trauma operating lists within normal working hours and within 24 hours of the injury unless there is marine, agricultural or sewage contamination. The 6 hour rule does not apply for solitary open fractures. [redacted] are administered at wound excision and continued for 72 hours or definitive wound closure, whichever is sooner
12. If definitive skeletal and soft tissue reconstruction is not to be undertaken in a single stage, then vacuum foam dressing or an antibiotic bead pouch is applied until definitive surgery.
13. Definitive skeletal stabilisation and wound cover are achieved within 72 hours and should not exceed 7 days.
14. Vacuum foam dressings are not used for definitive wound management in open fractures.
15. The wound in open tibial fractures in children is treated in the same way as adults

**ADHERENCE to BOAST-4 PRINCIPLES is MANDATORY for the WY Major Trauma Network**

- SEVERE OPEN FRACTURES are the subject of prospective data collection covering adherence to antibiotic management, timing of interventions including definitive fixation and wound closure, clinical outcomes and complications.
- More importantly: providing the best care we can for these patients will improve their chances of the best possible recovery.
- To discuss any issues with the management of open fractures please contact (in hours) directly (via email or the switchboard) Mr Paddy Foster, Mr Nik Kanakaris (MTC Consultants) and/or Mr Jay Wiper (Consultant Plastic Surgeon), or out of hours the MTC Case Managers at bleep **2661** via the LGI switchboard.