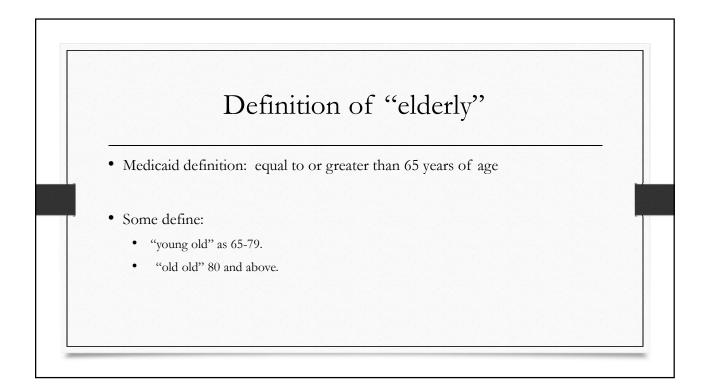
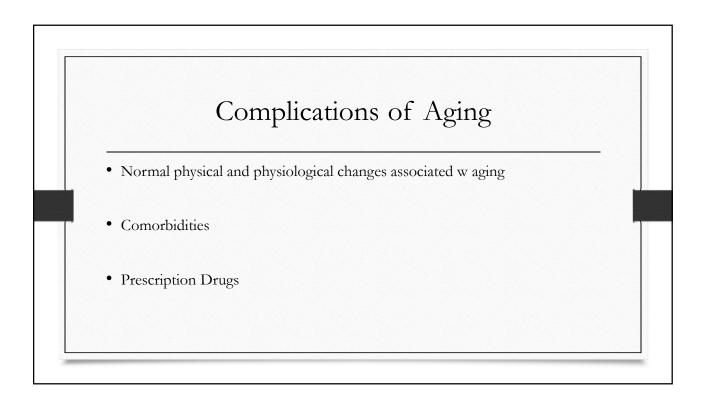
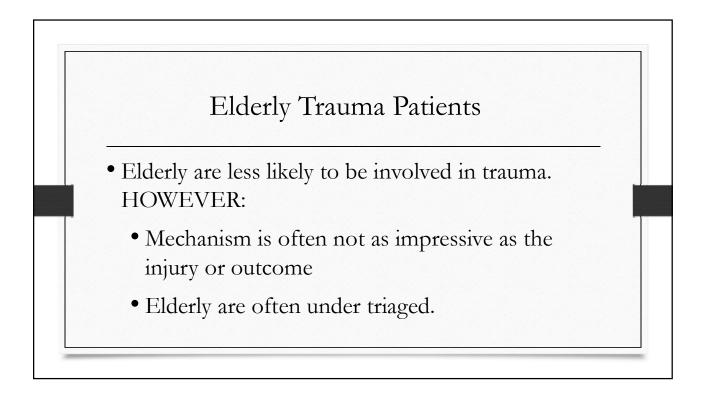
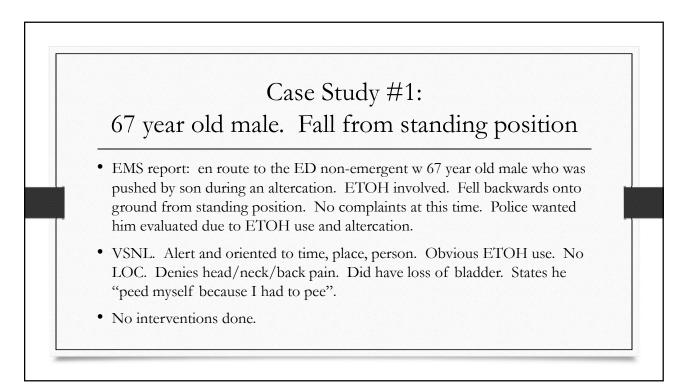


Leading Causes of Accidental Death	
All Ages	>65 years of age
1) MVC	1) Falls
2) Poisoning	2) MVC
3) Falls	3) Unspecified
4)Homicide	4) Suffocation



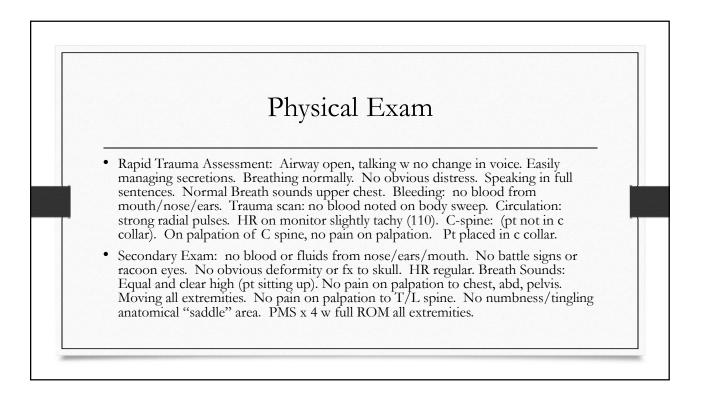


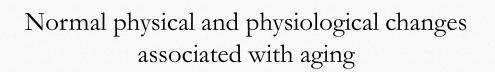






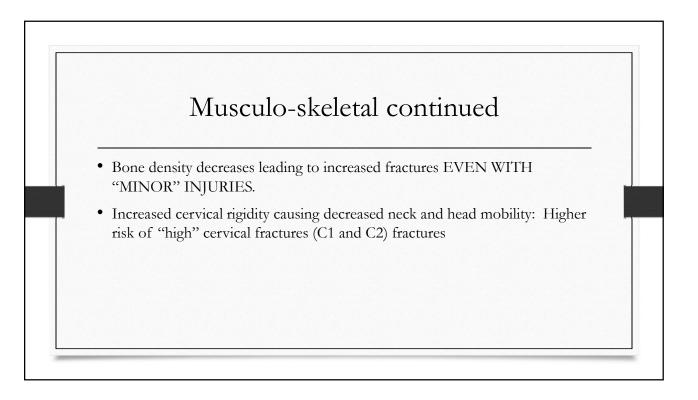
- U/A in ED, pt with obvious slurred speech. Laughing and joking. Denies HA, vision change, neck or back pain. No chest/abd pain. No nausea/vomiting/diaphoresis. Denies recent illness. States he was in an argument w his son. Son pushed him. He fell backwards, landing on bottom and falling onto back. Head did hit ground.
- No medical hx, no allergies, no mediations. Admits to daily alcohol use and 1 ppd smoking.
- VS: BP: 150/89, HR 110, RR 24, SAO2 98% RA.

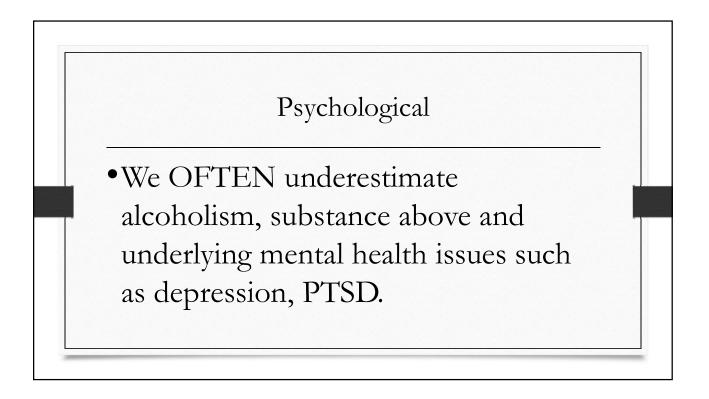


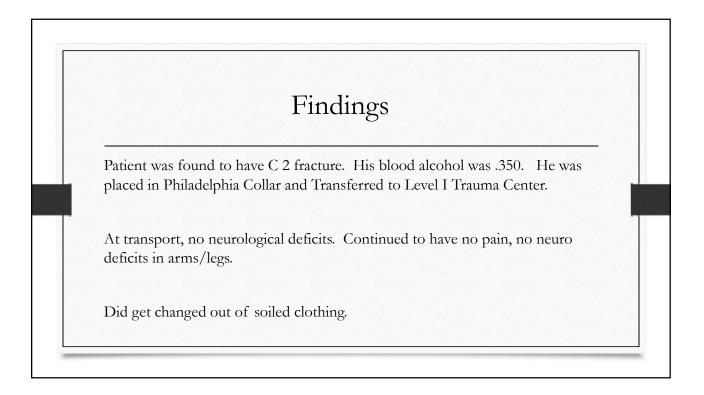


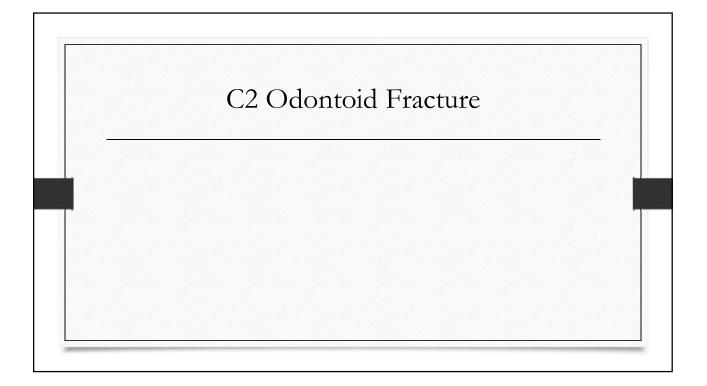
• Musculo-skeletal:

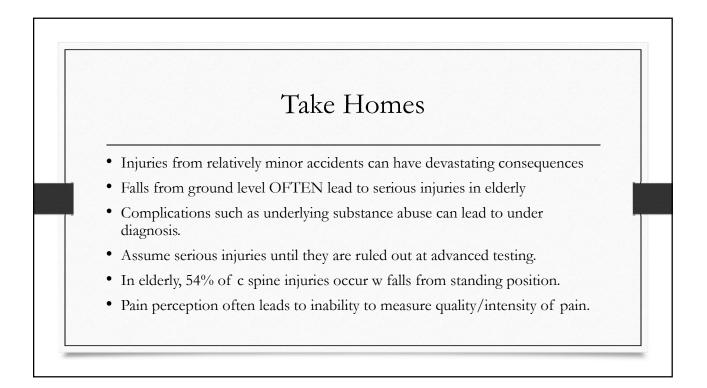
- Age related weakness, unsteady gait, slowed reaction time
- More likely to have osteoarthritis, scoliosis, kyphosis: all impact mobility and functioning.
- Osteoporosis: more common in women than men.
- MOST COMMON FRACTURES: hip, distal radius, humorous, vertebral bodies.

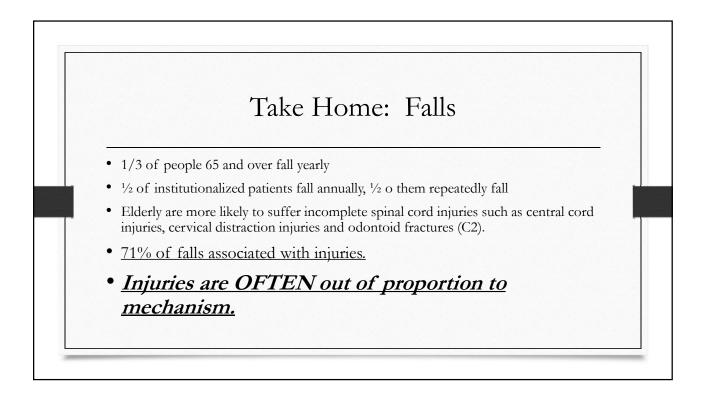


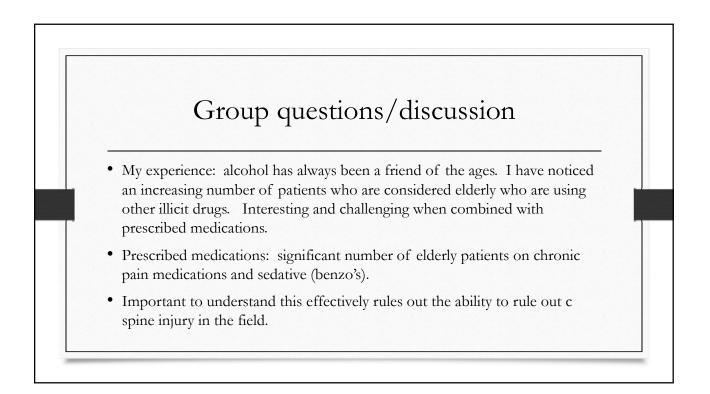










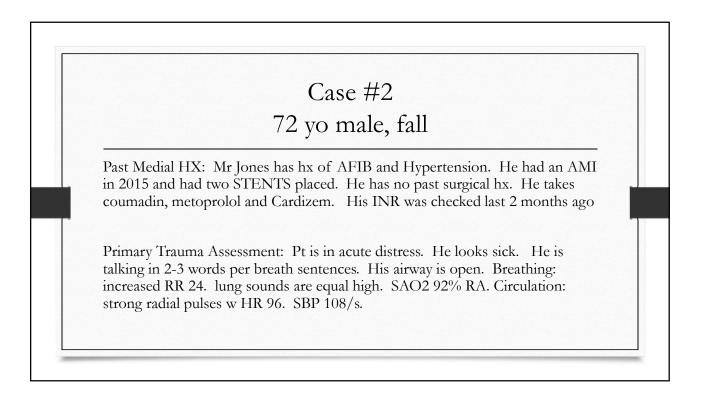


Case Study #2 72 yo male, fall from standing position

HX: Mr Jones transported to the ED code yellow (non-emergent) co LT side pain after tripping and falling in the bathroom at local casino. Per patient, he stepped back away from sink after washing his hands and tripped over "my big feet". He fell backwards and hit LT side on granite sink corner.

EMS responded. Reported stable vital signs w SBP 110, HR 96, RR 24, SAO2 92% RA. IV started, pt given 1 mg dilaudid for pain. Transferred code yellow to ED.

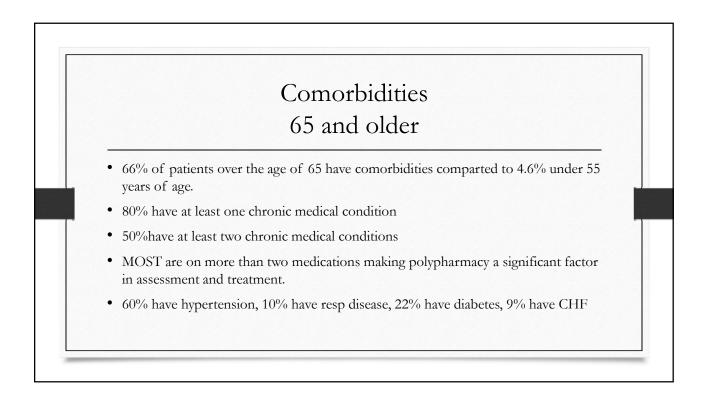
UA in ED, pt is obvious distress, co of constant pain in LT chest wall, increased w movement and/or deep inspiration.



Case #2 72 yo male, fall

Trauma Scan: no blood from nose, ears, mouth. Pain on palpation to LT chest wall. ABD tender LUQ. No blood from rectum/penis. No pain on palpation or obvious injury to back/spine. (c-collar placed in field.) no pain on palpation c spine.

Pt with 1 large bore IV. NS hanging at TKO u/a in ED.



Case #2 Discussion

In Elderly, profound shock may be present even in setting of "normal" vital signs. Our gentleman has SBP 108/s, HR 96, RR 24, SAO2 92%.

However, on Beta blocker and calcium channel blocker.

Beta Blocker: may prevent tachycardia in response to hypotension/shock

<u>Calcium Channel Blocker:</u> may prevent vasoconstriction in response to hypotension.

Case #2 Discussion

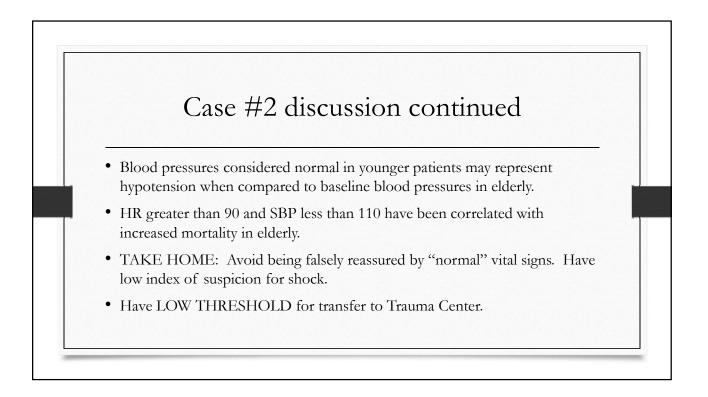
Anticoagulation Drugs:

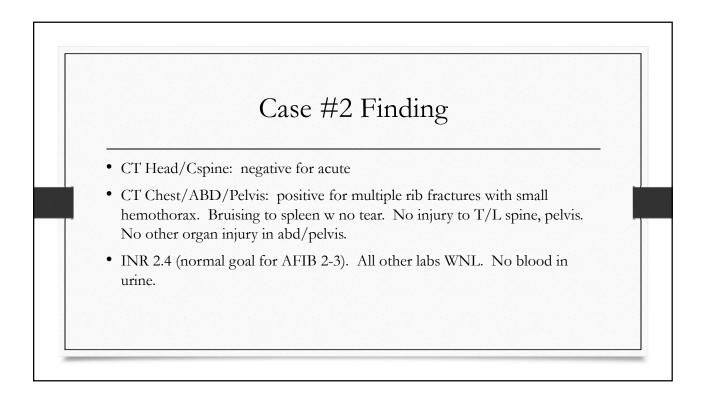
Relatively minor wound can have significant bleeding.

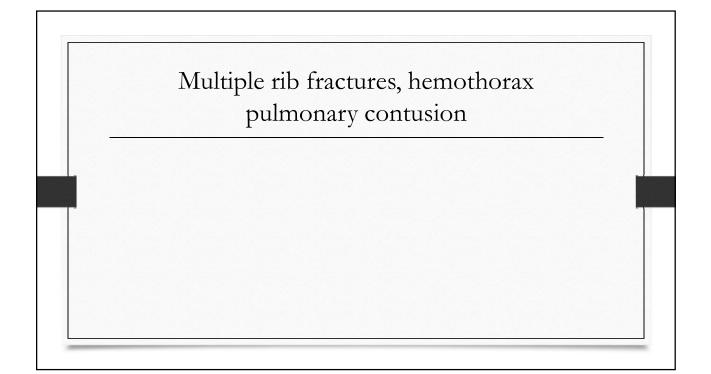
Rates of uncontrollable bleeding increased

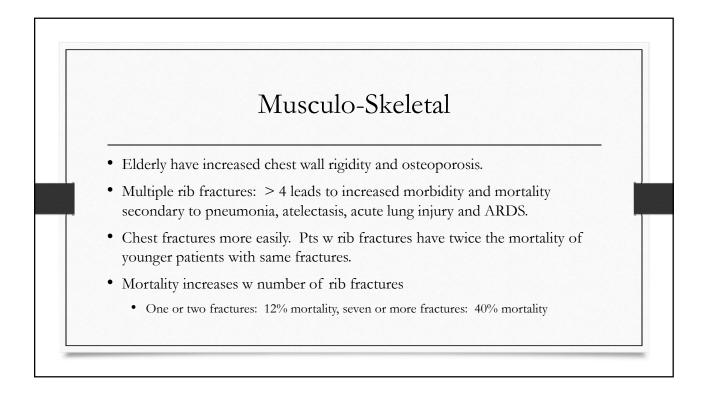
OFTEN the condition taking coumadin to treat increases mortality.

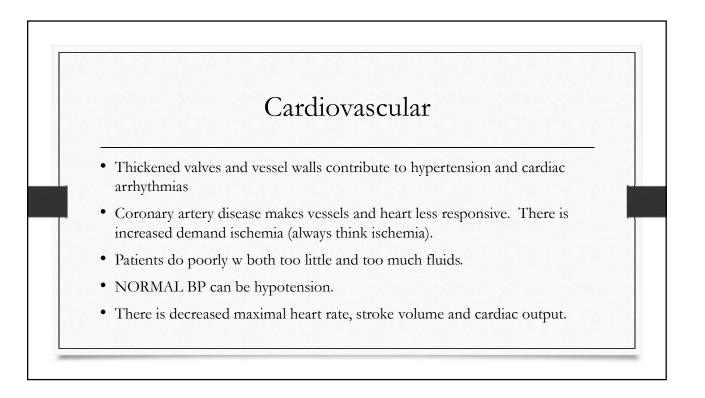
There is an increased risk of trauma related complications such as injury to GI, liver, spleen and kidneys. There is also an increased risk of intracranial bleeds.

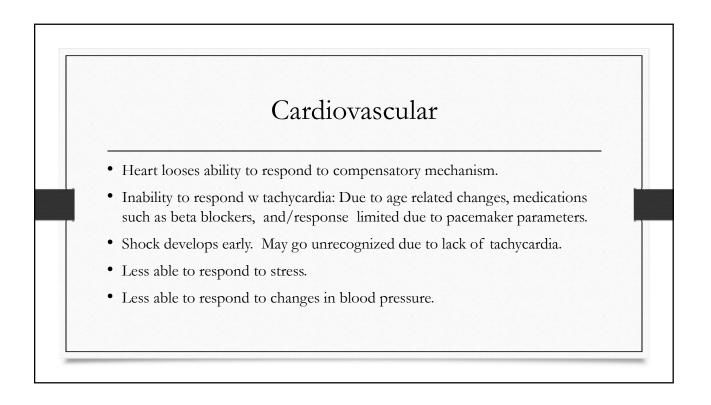


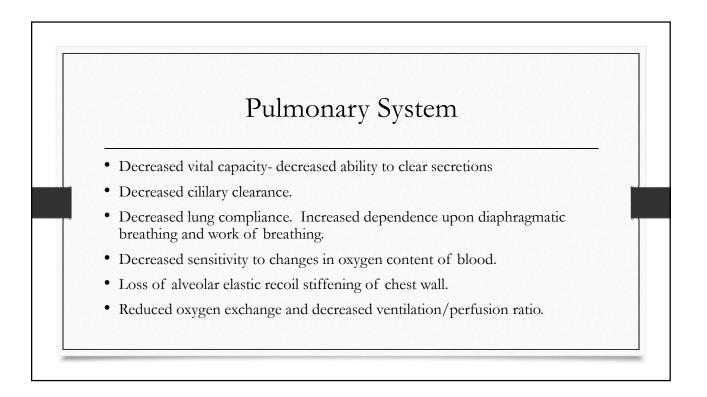


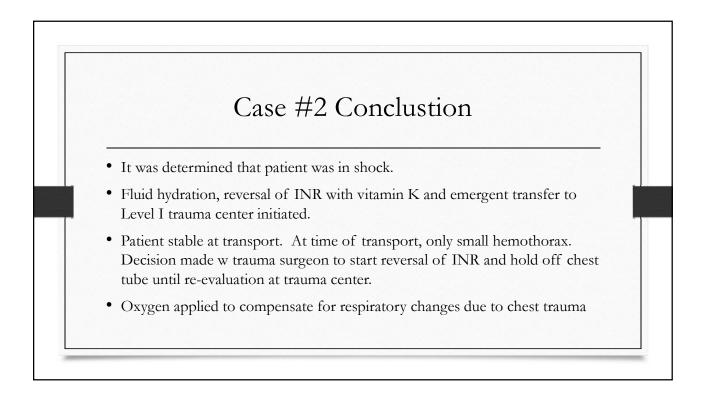






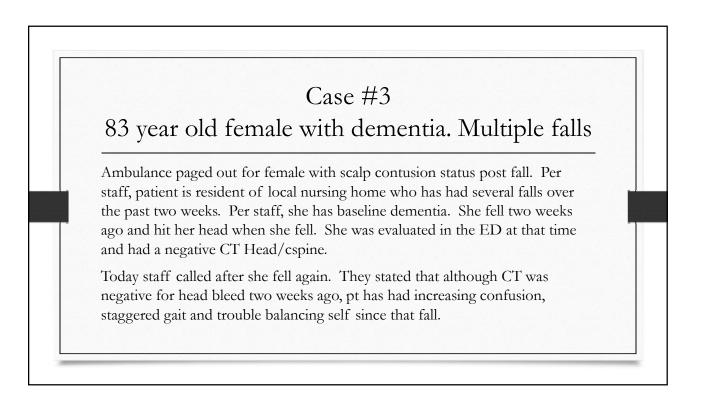






Group Discussio/Questions

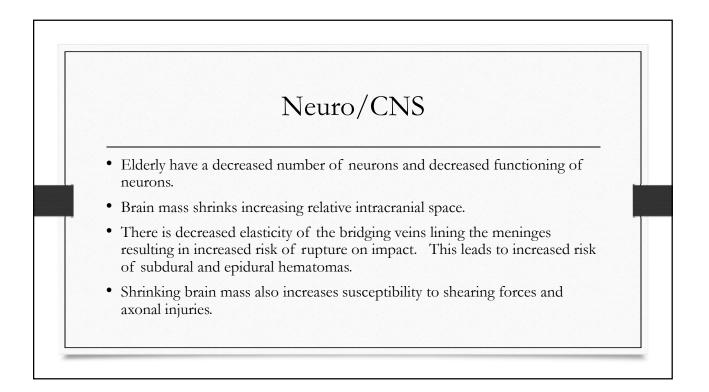
- The medic brought this patient in non-emergent. Trauma Code not activated. This was the middle of the night. I was called from sleep room. I was at the patients bedside within 5 minutes. My assessment was that the patient was in acute distress. When medic returned from putting ambulance away he was surprised by "how much more in distress the patient looked".
- Elderly patients have little reserve and then "fall off the cliff". We, as medics have had this drilled into our heads regarding PEDS. Elderly fit the same pattern.

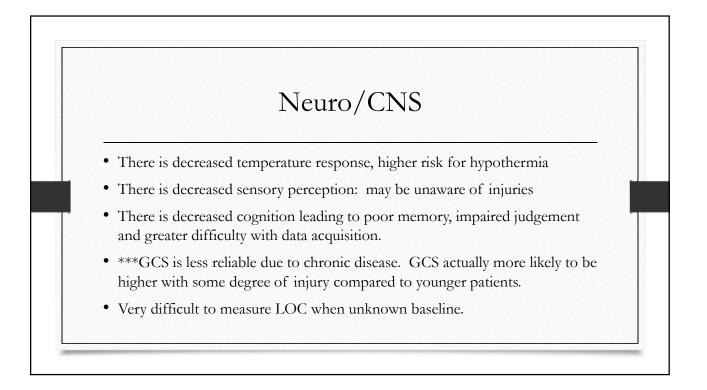


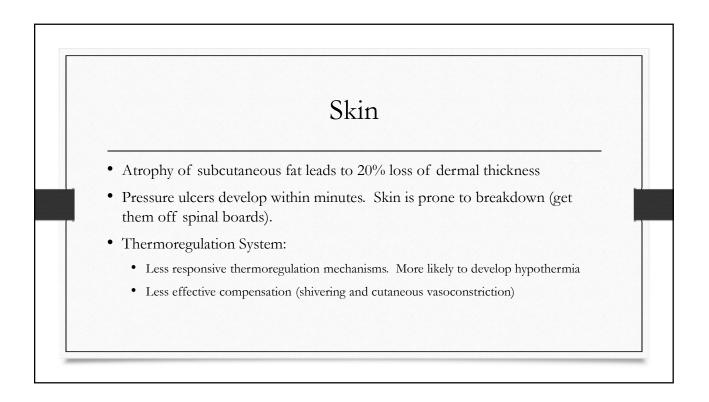
Case #3 83 year old female, multiple falls

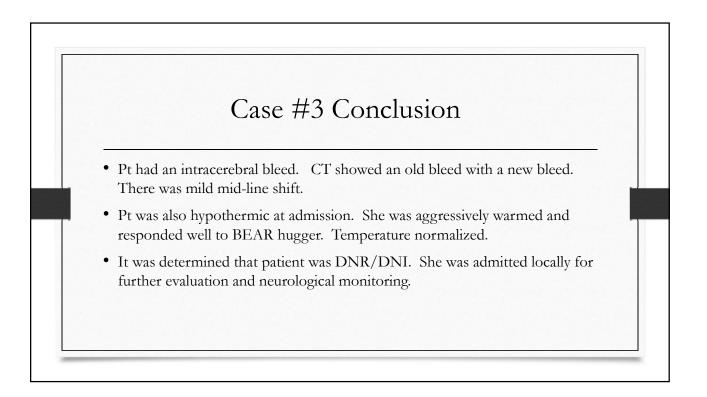
• EMS applied c collar which pt immediately took off. In the ED, moving all extremities. Pleasantly confused. Denies injury. Unaware of contusion LT forehead. Pupils are equal, reactive to light. Unable to obtain further medical hx due to baseline confusion. Pt complaining of "pain all over" asking for pain medications.

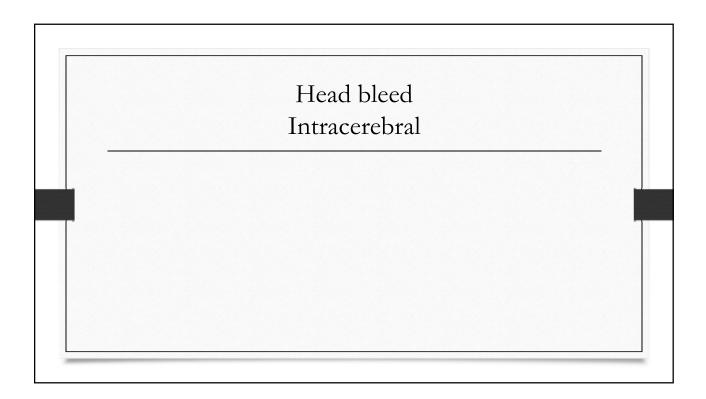
• C Collar again attempted. Pt refused. Became agitated and anxious when we attempted to place collar.





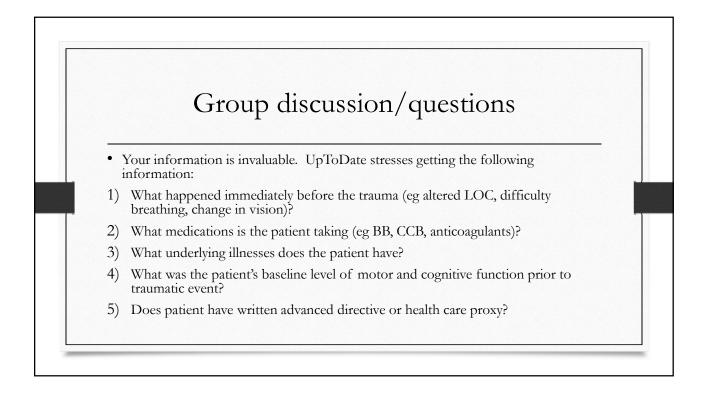


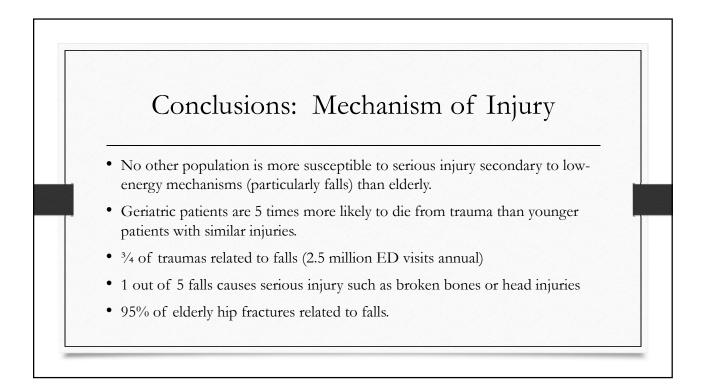


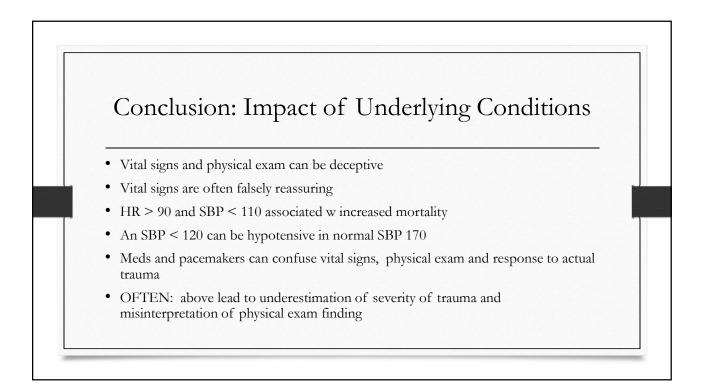


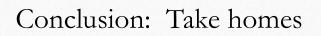
Case #3 Discussion

- There is a small percentage of patients who have an initial CT negative for acute bleed that are found later to have a head bleed. One neurosurgeon that I talked to stated that patients can have a slow, venous bleed that takes time to present.
- Initial traumatic brain injuries (concussions) leave a patient more susceptible to a brain bleed with another head injury
- Assume head bleed w onset of mental status change after fall.
- Low level falls can cause significant damage in elderly.









- There is significant risk for under triaging elderly patients.
- There is improved survival when elderly patients are transferred to a Level I,II trauma center specializing/experienced in dealing w elderly trauma patients: 8% mortality compared to 56% mortality in lower level of care
- Elderly are physiologically different and have significant trauma from more "mild" mechanisms of injury.

