

BOAST 10: DIAGNOSIS AND MANAGEMENT OF COMPARTMENT SYNDROME OF THE LIMBS

Background and Justification Acute compartment syndrome of a limb is due to raised pressure within a closed fascial compartment causing local tissue ischaemia and hypoxia. In clinical practice, it is most often seen after tibial and forearm fractures, high-energy wrist fractures and crush injuries. Other important causes include restrictive dressings or casts, prolonged immobilization and reperfusion of ischaemic limbs. Early diagnosis and treatment is vital to avoid severe disability. Pulses are normally present in compartment syndrome. Absent pulses are usually due to systemic hypotension, arterial occlusion or vascular injury.

Inclusion Patients of all ages.

Standards for practice audit:

1. Assessment for compartment syndrome should be part of the routine evaluation of patients who present with significant limb injuries, after surgery for limb injuries, and after any prolonged surgical procedure which may result in hypoperfusion of a limb.
2. Clear documentation should include: the time and mechanism of injury, time of evaluation, level of pain, level of consciousness, response to analgesia and whether a regional anaesthetic has been given.
3. The key clinical findings are pain out of proportion to the associated injury and pain on passive movement of the muscles of the involved compartments. Limb neurology and perfusion, including capillary refill and distal pulses, should be clearly documented but do not contribute to early diagnosis of the condition.
4. Patients documented to be at risk of compartment syndrome should have routine nursing limb observations for these early signs and these should be recorded. These observations should be performed hourly whilst the patient is deemed still to be at risk. If pain scores are not reducing, then senior clinical review is mandated.
5. In high-risk patients, regional anaesthesia should be avoided as it can mask the symptoms of compartment syndrome. In addition patient-controlled analgesia with intravenous opiates can also mask the symptoms. When evaluating these patients, the rate and dose of opiates and other analgesics must be taken into consideration and recorded in the medical records.
6. Patients with symptoms or clinical signs of compartment syndrome should have all circumferential dressings released to skin and the limb elevated to heart level. Measures should be taken to maintain a normal blood pressure. Patients should be re-evaluated within 30 minutes. If symptoms persist then urgent surgical decompression should be performed. Alternatively, in situations where the clinician is not completely convinced by the clinical signs, compartment pressure measurements should be undertaken. All actions should be recorded in the medical records.
7. Compartment syndrome is a surgical emergency and surgery should occur within an hour of the decision to operate.
8. For patients with diagnostic uncertainty and those with risk factors where clinical assessment is not possible (e.g. patients with reduced level of consciousness), hospitals should have a clear, written management policy.
9. All hospitals treating patients with significant injuries should have the capability to perform intracompartmental pressure monitoring. The pressure sensor should be placed into the compartment(s) suspected of being abnormal or at risk.
10. All patients having compartment pressure measurements should have their diastolic blood pressure recorded; a difference between the diastolic blood pressure and the compartment pressure of less than 30 mmHg suggests an increased risk of compartment syndrome. It is recommended these should either proceed to surgical decompression or continue to be monitored depending on the consultant decision.
11. If the absolute compartment pressure is greater than 40 mmHg, with clinical symptoms, urgent surgical decompression should be considered unless there are other life-threatening conditions that take priority.
12. Surgery should involve immediate open fascial decompression of all involved compartments, taking into account possible reconstructive options. Necrotic muscle should be excised. The compartments decompressed must be documented in the operation record. All patients should undergo re-exploration at approximately 48 hours, or earlier if clinically indicated. Early involvement by a plastic surgeon may be required to achieve appropriate soft tissue coverage.
13. For lower leg fasciotomies it is recommended to perform a two-incision four-compartment decompression (BOAST 4).
14. There is no consensus for the management of foot compartment syndrome.
15. Patients with late presentation or diagnosis (greater than 12 hours) have a high risk of complications with surgery. Decision-making is difficult and should involve two consultants. Non-operative management is an option.

Evidence base Studies with level-1 evidence are lacking. Predominantly retrospective series, with some good prospective studies, meta-analyses and reviews.

Review date: December 2016. For correspondence, contact: policy@BOA.ac.uk