



Specialty guides for patient management during the coronavirus pandemic

Clinical guide for the management of neurotrauma patients during the coronavirus pandemic

19 March 2020 Version 2

“...and there are no more surgeons, urologists, orthopaedists, we are only doctors who suddenly become part of a single team to face this tsunami that has overwhelmed us...”

Dr Daniele Macchine, Bergamo, Italy. 9 March 2020

As doctors we all have general responsibilities in relation to coronavirus and for these we should seek and act on national and local guidelines. We also have a specific responsibility to ensure that essential neurotrauma care continues with the minimum burden on the NHS. We must engage with those planning our local response. We may also need to work outside our specific areas of training and expertise, and the General Medical Council has already indicated its support for this in the exceptional circumstances we may face: www.gmc-uk.org/news/news-archive/how-we-will-continue-to-regulate-in-light-of-novel-coronavirus

Neurotrauma may not seem to be in the frontline with coronavirus but we do have a key role to play and this must be planned. Trauma patients will continue to need care. Currently we have a relative luxury to admit patients where we believe advanced neuroscience treatment may provide benefit. But at this time of resource limiting, that need of benefit and its likelihood for the patient in front of you has to be greater than for others needing critical care. We should seek the best local solutions to continue the proper management of these trauma patients while protecting resources for the response to coronavirus.

In addition, we need to consider the possibility that the surgical facility for emergency surgery may be compromised due to a combination of factors including: staff sickness, supply chain shortages and the use of theatres and anaesthetic staff to produce ITU pods.

Categories of neurotrauma patients to consider

- **Emergency department attendance:** Patients should continue to be managed according to the National Institute for Health and Care Excellence (NICE) head injury [guidelines](#).
- **Obligatory inpatients:** Continue to require admission with access to surgical management if required. We must expedite treatment to avoid pre-operation delay and expedite rehabilitation to minimise length of stay.
- **Those who will benefit from admission to major trauma centre (MTC)/neurosurgical centres:** Admission destination (trauma unit/DGH versus MTC/neurosurgical centre) will depend on nature and severity of injury and may depend on resource availability, specifically in relation to the provision of ICU care.
- **Maximal remote support.**
- **Devastating brain injuries.**

When planning your local response, please consider the following:

Obligatory in-patients

- A consultant **must** be designated as ‘lead consultant’. This is an essential role during crisis management.
- It can be very stressful during a crisis. Support each other and share the workload.
- Establish a daily sitrep/handover/dashboard with critical data to share across the workforce. That should include patient flows, workforce issue, stock levels and other key messages (eg state of coronavirus response, personal protective equipment (PPE) requirements).
- An anaesthetic guideline for patients requiring surgery and who are coronavirus positive will be required.
- Make contingency plans for supply chain issues.

Those who will benefit from admission to a MTC/neurosurgical centre

- Those who will benefit most are those with easily reversible conditions. These are usually those with **extra-axial haematoma (extradural/subdural) with mass/clinical effect**.
- Those with diffuse injuries would normally be transferred to an MTC/neurosciences centre for advanced monitoring. However, in a situation where critical care resources are extremely limited, the benefit of advanced monitoring is relatively limited.

- Many injuries, both cranial and spinal, can be managed conservatively and the threshold for intervention changes with resources availability. It is important however, that the condition is still managed, and this may require joint working and good communication between local non-specialists and MTC specialists. Communication may be by telephone or by telemedicine. As the situation with coronavirus escalates, the flowcharts below may be useful.
- Clinical decisions during a serious incident must consider the available facility for the current patient and also the impact this may have on the whole community.

Maximal remote support

- Communication will be key to providing good care remotely. This can be via regular telephone or tele/video discussion and patient review.

Staffing issues

- At a time when staffing levels are likely to be poor, it is important to allocate appropriate work accordingly. For example, staff who are well but self-isolating can still take referrals, review scans (from home) and triage patients, leaving those in hospital to provide direct clinical care.

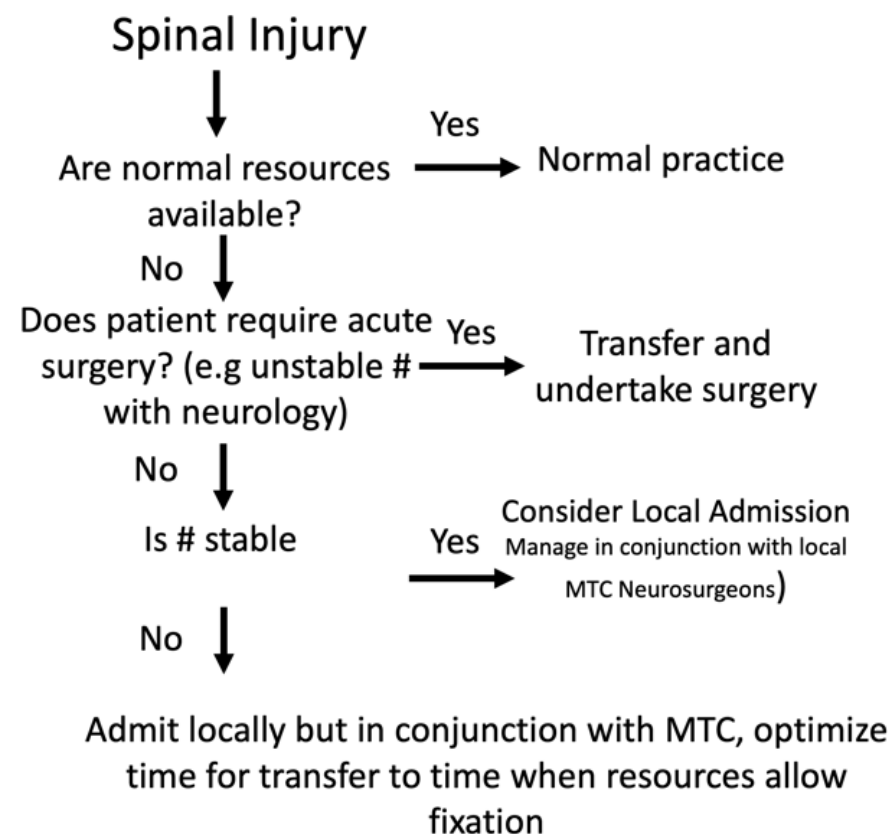
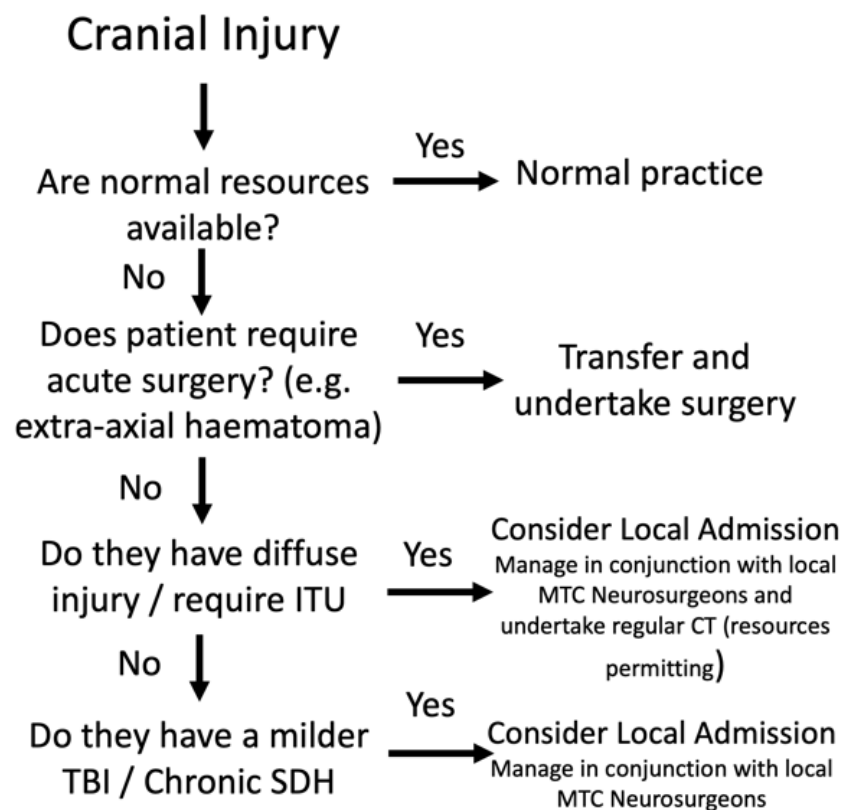
Devastating brain injury

- The current guidelines for devastating traumatic brain injury considered to be unsurvivable are written for times of normality, when critical care is available. They are designed to provide time for diagnosis to be confirmed and reversible factors corrected; time to allow family involvement and organ donation options. In the event of very limited critical care capacity rapid decisions about futility may be required and care withdrawn earlier than in normal circumstances.

General points

- Emergency departments will continue to take patients requiring resuscitation, the trauma team, etc.
- We should avoid unproductive attendances at hospital.
- Senior decision-making at the first point of contact should reduce or even prevent the need for further attendances.
- A decrease in elective work will allow for a greater senior presence at the front door.
- Clinicians may need to work in unfamiliar environments or outside their sub-specialist areas. They will need to be supported.
- No patient should be scheduled for surgery without discussion with a consultant.
- Consider postponing long-term follow-up patients until the crisis has passed.
- Outpatient appointments may be conducted remotely rather than face to face.

Cranial injury and spinal injury flowchart



* Joint Management will require regular telephone / tele-video discussions