South West London & Surrey Trauma Network

Pan Network Policy for Interventional Radiology in Trauma Units

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Introduction

Increasingly Trauma Units participate in IR rotas based on other specialities and services offered. This has led to the potential for IR in Trauma units for the trauma patient. There is a clinical risk and delay for patients if IR is unsuccessful and transfer to the MTC for definitive care is needed.

Experienced and senior, readily available surgical back is crucial for the safe delivery of this service.

Some injury patterns should not even be attempted in the TU. These are outlined below.

Trauma patients **must not** be transferred from one TU to another TU for IR. If IR is not available in the first unit then onward referral to the MTC should occur.

The following examples should ***NOT*** be considered for TU IR:

a) Polytrauma with or without haemodynamic instability
b) Liver trauma – for the SWL and S Trauma network these cases should be discussed with a Liver MTC (Kings College Hospital)
c) Pelvic trauma – pelvic fractures requiring IR are likely to be complex. A pelvic binder should be applied and the patient transferred to the MTC with ongoing resuscitation and escorts.
d) Lack of immediate availability of a senior surgeon is a contraindication for local IR.

Assuming there is surgical back up, then the following are suitable for Trauma Unit IR:

a) Isolated splenic injury with or without haemodynamic instability.
b) Isolated renal trauma where embolization is felt likely to improve haemodynamics

Remember; All these patients are likely to have an ISS>15. The trauma team leader must ask " Should this patient be going to a MTC ? "

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