# FAQs

APLS serious injury update

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| *Do we teach use of cervical collar at all now?* |
| Response: Do not need to concentrate on teaching collars as they are now used less frequently. Available as an adjunct now, but may not be the case for long as more trauma centres gather evidence in practice. Also, see other responses re collars below … |
| *Is there is any particular age cut off for the use/or not of collars* |
| Response: Collars don’t fit under 5s; when considering the upper age limit for the new guidance from APLS (as collars are still used in adults) – think about the situation and if possible, discuss with child. If in older children a collar is fitted it is important to make sure it fits. There is no evidence that they make things better and they could make things worse. There is still 30 degree movement in the best fitting collar. This is an evolving field and we are recommending this approach based on the best evidence available currently. |
| *What if the child’s GCS renders them unable to protect their own neck?* |
| Response: In children who’s GCS renders them unable to protect their own neck, head blocks will suffice. A collar, if it is used, is just a visual sign to say ‘think neck’. |
| *Figure 13.5 does not match the text* |
| Response: This algorithm has been reviewed and an update is being issued on 12/03/2015 |
| *Trauma stabilisation: do we have to have all of the splints mentioned in the skill station material?* |
| Response: It is more important to cover the concept behind splintage in terms of trauma management and some examples of splints need to be available. You can use what you have available locally. If you do not have any splints available, then purchase a few samples. It is only necessary to have the splint itself. |
| *Trauma stabilisation: please can you advise when the scoop is to be used and if it is indeed essential?* |
| Response: Yes, you need to have one. We will make it more explicit on the skill station where it is to be used by adding “the 20 degree tilt is used to facilitate the use of a scoop stretcher. Practice this manoeuvre with a manikin during the course skill station. It is important that it is included because it emphasises why 20 degree tilt important in ensuring that there is minimal handling; 20 degrees is the maximum you need to tilt the child to put a scoop stretcher underneath them and this will avoid disrupting the ‘first clot’ and any unstable pelvis. ” |

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| *What is the rationale for the 20 degree tilt* |
| Response: it is important for minimal handling; Moss, Greaves and Porter 2014; Leech, Porter, Bosanko 2014; Bryan et al 2012 have written about the dangers of logrolling patients who are unstable. 20 degree is the maximum needed to tilt a child to put a scoop stretcher underneath them and to avoid disrupting the important ‘first clot’ and any unstable pelvis. This is in blunt trauma. Logrolling is not useful to determine if there is any spinal fracture. In penetrating trauma you can put your hand underneath the child during the tilt and if it comes out with blood on then you have to investigate further. |
| *How much is minimal fluid? And when exactly should it be given?*  *When is blood commenced?* |
| Response: You can’t quantify minimal fluid, you have to give it according to the reaction of the child. If they respond and have a good pulse and good blood pressure no need to give more. Blood should be commenced after first 10ml/kg if clinically indicated. |
| *How can we teach  Thomas splint, pelvic splint,20 degree tilt and MILS in 40 mins to 8 candidates?* |
| Response: Discuss Thomas splint to get concepts, each candidate doesn’t have to do the splintage. Do a run through of 20 degree tilt with scoop stretcher for whole group and demonstrate MILS and will be achievable in 40 minutes. |
| *On APLS recertification course, which part of trauma stabilisation should candidates be assessed on* |
| The simulation will be updated to clarify that this is not a formal assessment and the time should be used to make sure all candidates are familiar with the updated approach. |