VERSION 1.3 Aug 2017

Pretibial Injury/Infection Flowchart from the RIE Emergency Department

Pretibial Infection

With consent mark affected cellulitic area with skin marker in all patients

Suspected Sepsis

Any of T>38, RR>20 P> 100

Follow SEPSIS 6

Take bloods, CRP, cultures, measure lactate and give antibiotics as indicated

Simple cellulitis consider OPAT if improves and severe sepsis excluded. All others **admit medicine or ID**

Suspected collection or joint involvement Refer ortho for local Ix and Mx initially (if ortho feel plastics more appropriate they can review and refer directly)

Systemically well (beware diabetics and immune compromised patients who may mask the severity of their illness)

Simple cellulitis if mild consider oral antibiotics, elevation at home and worsening statement or GP review

Patients with large areas affected, failure to improve with oral antibiotics or ascending lymphangitis should be referred to OPAT and treated with IV ceftriaxone as per protocol on EMIBANK

BEWARE NECROTISING FASCIITIS IF PAIN DISPROPORTIONATE OR SEPTIC SHOCK – IF SUSPECTED GET SENIOR HELP

Pretibial laceration/ haematoma

MOST Patients managed and discharged from the ED with steristrips (+/- suture/staples) and non adherent dressings (may require OT before DC and GP follow up in 2-3 days)

Patient with closed wound requiring admission for OT/ Physio, investigation or falls/collapse **ONLY** – admit AMU medicine (N.B. the wound MUST be suitable for management at home otherwise i.e. closure and haemostasis **without** tight pressure dressings and need for strict elevation) –if unsure discuss with ED Senior or AMU Consultant)

INCOMPLETE CLOSURE, HAEMOSTASIS NOT ACHIEVED OR LARGE HAEMATOMA REQUIRING EVACUATION – D/W ED Senior (Registrar or Consultant initially) **Do not admit to Medicine with pressure dressings and elevation as a plan**

Not bleeding but needs admission for wound management (e.g. strict elevation, observation for bleeding, severe pain, haematoma needing evacuation or inadequate wound closure) – **refer to ortho for admission (can be referred to plastics by orthopaedics if felt more appropriate after review)**

Unable to achieve haemostasis

Involve local team to control bleeding (ortho/ vascular or interventional radiology depending on source/severity)

Once haemostasis achieved **admit locally under the treating local surgical team** for observation and further wound management

- Patients admitted to medicine should not be expected to require ongoing wound management. However should a patient in CAA deteriorate unexpectedly and require emergent wound care (e.g. to control bleeding) it is expected that surgical teams locally will assist rather than the ED team. These patients should not remain in AMU and once stable should be transferred to the ward of the surgical team involved
- This policy has been agreed with Brian Cook Medical Director and Caroline Whitworth Assoc Medical Director for Surgery and Orthopaedics