



Damage Control Guideline

To define conditions when damage control is appropriate technique for stabilization of patients.

To define the technique for temporary control of life-threatening injuries through damage control surgery.

1. Hemodynamically unstable patient with blunt abdominal injury with positive FAST or CT should be taken emergently to the OR
2. If two (2) large bore IVs were not inserted in trauma bay, inform anesthesiologist so access can be gained.
3. Activate MTP & Code Red
4. Ensure all warming techniques are employed:
 - a. Kimberly Clark warming pads
 - b. Room temperature at 78
 - c. Infuse all fluids and/or blood through warmer
5. Open the abdomen. Control bleeding *first*
 - a. Pack all 4 quadrants
 - b. Examine mesentery for bleeding
6. Consider damage control for the following:
 - a. Hypothermia, coagulopathy, non-surgical brisk bleeding
 - b. Diffuse oozing from cut or injured surfaces
 - c. Diffuse uncontrollable retroperitoneal or pelvic bleeding
 - d. Liver fractures that can not be controlled by ligation, suture or clips
 - e. Massive bleeding from multiple sites which repair will be patient at risk for hypothermia or coagulopathy due to prolonged OR times.
7. Proceed with damage control
 - a. Control all surgical bleeding as rapidly as possible
 - b. Remove damaged organs versus repair
 - c. Do not create ostomies
 - d. Pack all areas of oozing
 - e. Close abdomen with temporary technique

- i. Continuous non absorbable sutures for fascia
 - ii. If skin left open consider JP drains, kerlix, loban dressing
 - f. Proceed to ICU as quickly as possible to correct and/or prevent hypothermia, acidosis, coagulopathy, and any other derangements.
 - g. If liver continues to be major source of bleeding, consider angiography and embolization
- 8. Return to the OR for definite closing when:
 - a. Normothermic
 - b. Hemodynamics stable
 - c. Coagulopathy resolved