Information Needed

1. History: mechanism of injury and forces involved, restraints if any, location of pain, any tingling or numbness, loss of sensation or function, unable to urinate or move bowels, past medical history, medications, drug abuse or alcohol.
2. Physical findings: neurologic status, point tenderness or step off on spine, decrease movement of extremities, lack of awareness when touching extremity, priapism.

Treatment

1. Manually immobilize head, neck and back.
2. Protect airway and assist ventilation as needed.
3. Administer O_2 moderate to high flow.
4. Determine vital signs (pulse, blood pressure, respirations, SPO2)
5. Perform patient assessment, including neurological exam.
6. Apply cervical/spinal immobilization.
7. Reassess local pain or tenderness, sensation and movement of extremities, abnormal sensations, level of deficit.
8. Establish venous access and draw blood. Give fluid bolus if needed.
9. Consider giving antiemetics, muscle relaxants, and pain medication.
10. Consult medical control for doses higher than those in standing orders.

Notes

1. In most cases, the preferred method of spinal immobilization is to use a vacuum mattress. If the patient is to be moved a significant distance before being secured to the gurney, the vacuum mattress must be supplemented with a long spine board for longitudinal support.
2. Be prepared to turn patient with entire immobilization apparatus to the side if patient vomits.
3. Patients with penetrating trauma and a neurological deficit or an impaled foreign body should be immobilized to protect the spine.
4. Follow the spinal clearance algorithm rigorously if patient with a mechanism for spine injury is not going to be immobilized.

Spinal Injury

5. Neurogenic shock is likely with significant spinal cord injury, such as para- or quadra-plegia.

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