Summary of update (2023)

The following new guidance statements have been added:

I. RESUSCITATION AND STABILIZATION

H. In patients with a pelvic ring injury presenting with hypovolemic shock to centers with REBOA capabilities, early femoral arterial access with an 18 gauge or larger should be achieved to allow for a "step up" approach, allowing rapid introduction of REBOA. Most commonly, this can be achieved with a femoral arterial line.

II. TEMPORARY PELVIC RING INJURY IMMOBILIZATION

K. In patients requiring ongoing resuscitative efforts with a posterior pelvic ring injury that is inadequately reduced resulting in enlarged internal pelvic volume, an antishock iliosacral screw can be considered as a resuscitation adjunct to aid in temporizing reduction and stabilization of the pelvic ring. This type of screw fixation should be carried out by an experienced orthopedic surgeon; it may not be definitive and could result in injury to surrounding anatomical structures.

V. OPEN PELVIC RING INJURIES AND ASSOCIATED GASTROINTESTINAL / GENITOURINARY INJURIES

K. Patients with a pelvic ring injury who have undergone surgical repair of a bladder injury should receive urethral catheter drainage without suprapubic (SP) cystostomy unless SP drainage is specifically indicated. [Adopted from AUA guidelines 2020 amendment] Extensive efforts at primary realignment of the acutely injured urethra are discouraged, and SP catheter is recommended in this situation.

- Specialist Advisory Group member list has been updated.
- Algorithm has been updated.