HIP FRACTURE PERIOPERATIVE MANAGEMENT

Hip Fracture management is Standardised – Please complete proforma

Preoperative assessment includes standardised risk assessment & consent.
Hip Fracture proforma is available in Trauma theatre 4 folder. This form will facilitate preoperative assessment.

A Nottingham Hip Fracture score (NHFS) is calculated for all hip fracture patients.
Consent should not be restricted to the generic risks of a General or Regional anaesthetic. It must include discussion of perioperative risks and documentation.
Resuscitation status should be established for all hip fracture patients. If patients have a DNA CPR order in place in the ward, **'perioperative modifications of DNA CPR'** should be done for the perioperative period. *(Forms available in Trauma theatre 4 folder)*

Nearly all patients with hip fracture will require surgery. Early surgery is vital to reducing morbidity and mortality. Any postponements or cancellations must be discussed with a second Trauma Anaesthetist.

If NHFS ≥5, please discuss case with Lead Trauma Anaesthetist

Nottingham Hip Fracture Score		
VARIABLE	VALUE	SCORE
Age	< 66	0
	66 -85	3
	≥ 86	4
Sex	Male	1
Admission Hb	< 100	1
AMT	< 6	1
Living in institution	Yes	1
No of co-morbidities	≥ 2	1
Malignancy last 20 y	Yes	1
TOTAL SCORE		

°***Comorbidities:***
Cerebrovascular disease,□ Chronic respiratory disease □ Diabetes □ Chronic renal disease □ CVS disease □
CVS disease includes: HT, IHD, AF, etc.

Please use following risk assessment Tool

RISK	LOW ⟷ HIGH			
NHFS	<2	3 to 4	5	**≥ 6**
Hb	> 120	100 - 120		**< 100**
AF (HR)	None	< 100	100 -120	**> 120**
eGFR	> 60	40 to 60		**< 40**
CVS disease, Heart Failure, On diuretics				**Yes**
Correctable Electrolyte disorder				**Yes**
Anticipated surgery > 2 hours				**Yes**

≥ 3 high Risk Factors (≥ 3 of shaded boxes)
Consider
Arterial Line +
CO Monitoring using LIDCO Rapid

Anaesthetic Management
Spinal Anaesthetic is the standard anaesthetic of choice
Aim for Femoral Nerve Block/Fascia Iliaca Block prior to turning patient for spinal
Avoid Midazolam / Ketamine. Propofol may be used for turning/ positioning patient prior to spinal
Spinal Dose: **Aim for Bupivacaine < = 10 mg** (e.g. No more than 2ml of 0.5% Heavy Bupivacaine)
If anticipated surgery > 2 hours, consider CSE
AVOID opiates in spinal
Supplemental Oxygen
Consider vasopressor infusion for BP control
If Providing GA – consider Gas induction (better BP control) and BIS monitoring
COMPLETE Hip Fracture Proforma

Intraoperative GOALS
Maintain Blood Pressure within 20 % baseline
Maintain Temperature >36 C, Normothermia
Consider CO Monitoring with LIDCO Rapid – SV and SVR optimisation (protocol on proforma)
Correct Electrolyte disorders if any
STOP ACE inhibitors and AR 2 Blockers for 24 hours
If EBL > 500ml or Starting Hb < 100 g/L, Ensure Hb >=8 g/L and Lactate < 3 in recovery
Consider Tranexamic acid if EBL > 500ml
Beware of Bone Cement Implantation syndrome
Encourage patients to have 1st drink in recovery
All patients are followed up by Trauma anaesthetist on Day 1 and Day 2 postoperatively.