Neck of Femur Fracture

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Overview

- One of the most common A&E Referrals
- Initial management is medical
- Time is of the essence
- Common nature of condition and serious outcomes warrants NICE Guideline – CG 124
- Closely monitored condition with data entry into the National Hip Fracture Database (NHFD)
- Management strategies are continuously evolving and developing − be aware of research trials (WHiTE studies)

Disclaimer

- Hip Fractures are part of the wider problem of fragility fractures in ageing.
- The details in this presentation are focused on what a junior orthopaedic doctor needs to know and do when seeing a #NoF in A&E or on the ward
- But good overall management of hip fractures requires a multidisciplinary approach involving surgeons, orthogeriatricians, nursing staff, metabolic physicians, physiotherapists, occupational therapists, etc… which is beyond the scope of this presentation

Guidelines Summary

- Imaging (for occult fractures)
  - MRI or CT scan within 24hrs
- Timing of surgery
  - On day of, or day after admission (24-36hrs)
  - Identify & treat comorbidities
- Analgesia
  - Immediately/Regularly
- Anaesthesia
  - Consider Patient choice
- Theatre Planning
  - Consultant led Trauma list
- Surgical Procedures
  - Aim for FWB
  - Offer THR where possible
  - Use proven implants
  - Cement
  - Anterolateral Approach
  - Consider DHS/IM Nail
- Mobilisation Strategies
  - Early mobilisation
- MDT
  - Orthogeriatric review
- Patient Information

What does this mean for you?

- Dealing with A&E Referrals
  - "I've got a #NoF for you…."
- Admission (+paperwork)
- Pre-operative Management
- Post-operative Management
- Discharge

FY1 and SHO grades are the most important members of the team in the care of #NoF patients

A&E Referral

- Always see and examine the the patient in ED yourself
- A&E will always consider #NoF in anybody with hip pain
- Make sure all essential initial care pathways are initiated in ED
- Early discussion with Registrar if doubts (may need CT/MRI)

- Signs & Symptoms
  - Pain
  - Hx of fall
  - Short, externally rotated limb
  - Associated injury
    - Wrist #, Head Injury
- Key points to determine
  - Pre-injury mobility/independence
  - Mechanical fall or syncopal fall
  - Social/Support Network

Thoroughness

- History
  - DOCUMENT AMT SCORE
- Examination
  - Document all injuries
  - Neurovascular status
- Investigation
  - AP Pelvis + Lateral Hip
  - Chest X-ray
  - ECG
  - Bloods (inc G&S)
- Plan
  - Admit
  - Bloods
  - ECG
  - X-rays (Chest/Pelvis/Hip)
  - Thromboprophylaxis
  - Analgesia
  - Drug chart & Regular meds
  - Mark & Consent
  - Orthogeriatrician Review
  - Catheter + I/O monitoring
  - Urine Dip
  - NBM from <<time>>

Once on the ward…..Check

- Check Blood results – act on them
- CXR/Urine Dip - ?signs of infection
- Stop/Reverse anticoagulation
- Monitor Pain and prescribe relief.

- Optimisation is the key – Talk to Registrar/ Medical Registrar if any concerns or doubts.

- Once injury is identified we are on a clock to manage them

Post-operative Management

- Check Post-Op Note and Anaesthetic Chart
- Bloods (FBC, U+E)
- Monitor AKI, Anaemia, LRTI/UTI
- Thromboprophylaxis
- AMT SCORE POST-OP MUST BE DOCUMENTED
- Mobilisation plan
  - Aim of operative management is to get patients with neck of femur fractures mobilising as quickly as possible
- Discharge Planning

Thank you!

Presentation available on
https://www.bon.ac.uk