Craniofacial Trauma in a Rural States Tertiary Care Level I Trauma Center: Assessing the need for transfer for isolated injury

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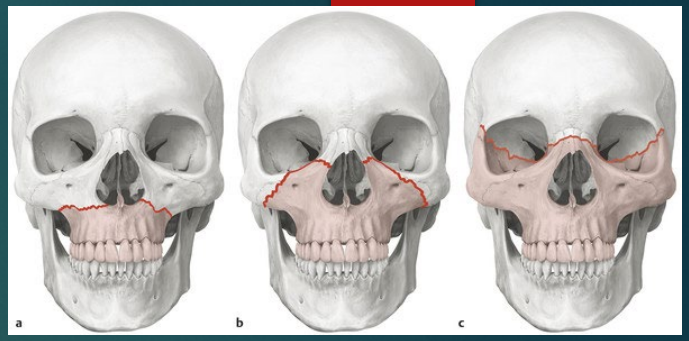

Introduction

Transfer of isolated craniofacial trauma to trauma centers challenges the surgical subspecialist's capacity.

Literature considers many craniofacial reconstructive interventions as non-emergent.

Goal:

Quantify the need to transfer isolated craniofacial trauma victims to a tertiary center as measured by the frequency of craniofacial surgical intervention performed before discharge.

Methods /Results

5-year retrospective IRB-approved investigation, 2017-2021.

Data: craniofacial injuries sustained by elderly ≥ 65 : MOI: 77% falls; mean age was 78.1 ± 8.7; Mortality 9.7%

664 consults total: Plastic (81%), Ophthalmology (28%), Oral Maxillofacial (6%), and Ears, Nose, and Throat (3%). Plastic surgery consults exceeded all others, $p<0.0001$

Most common injuries soft tissue 245 (44%), nasal fractures 167 (30%), orbital167 (30%), maxillary139 (25%)

557 patients, 869 injuries with 34% of injuries undergoing surgical repair Soft tissue (97%), mandible (48%), Lefort III (29%) Lefort II (11%)

Discussion

Majority of injuries not repaired (66%), $p< 0.0001$

Comorbid conditions stratify into unfavorable surgical risk

Cranial structures of mastication over cosmetic significance shifts the surgical risk-benefit curve in favor of intervention.

Clinical Practice Guidelines to determine transfer necessity for isolated craniofacial trauma requires pre-transfer consultation with surgical subspecialist.