Safe definitive fracture surgery

Let physiology, associated injuries and operative burden guide timing.

SURGICAL DECISIONS / ADULT TRAUMA

Choose early definitive fixation when the patient can tolerate it; use staged care when physiology or associated injuries make it unsafe.

01 Assess the whole patient

Review haemodynamics, transfusion requirement, temperature, coagulation, acid-base status and respiratory support. Check trends after resuscitation. A single normal result does not establish readiness for major surgery.

02 Account for other injuries

Agree priorities for brain, chest, abdominal, spinal and vascular injuries. An unstable associated injury may outweigh the benefits of immediate definitive fixation. Document the multidisciplinary rationale.

03 Match the operation

Consider expected blood loss, duration, positioning, soft-tissue injury and the burden of multiple procedures. In a suitable patient, the IMPACT consensus supports early major fracture care, commonly within 24 hours, with explicit exceptions.

04 Reassess & adapt

Continue physiological assessment during surgery. Agree triggers to shorten or stage the procedure. After temporary fixation, specify what must improve, who reviews it and when definitive treatment will be reconsidered.

WATCH POINT Do not convert a timing target or one lactate value into automatic clearance. Deterioration requires a new decision.

DISCUSS WITH THE TEAM

What finding would make this team change from definitive fixation to a staged strategy?

READ THE SOURCES

[1] Safe definitive surgery concept (2024), assessment and surgical clearance.
[2] IMPACT consensus (2024), early fracture care with associated injuries.

Educational summary for clinicians. Apply local protocols and patient-specific judgement.