Pelvic trauma & haemorrhage control

Treat physiological and mechanical instability together.

INJURY PRIORITIES / ADULT TRAUMA

A pelvic fracture does not explain every source of shock. Search for associated bleeding while organising pelvic control.

01 Stabilise & reassess

For suspected unstable pelvic injury with bleeding, apply a pelvic binder over the greater trochanters. Check position, skin and response. Avoid repeated pelvic manipulation; establish a plan for removal or replacement.

02 Choose imaging safely

Use physiology to determine whether CT is appropriate. Uncontrolled shock requires rapid haemorrhage control. A negative FAST does not exclude retroperitoneal bleeding or all associated abdominal injuries.

03 Coordinate haemostasis

Activate trauma, pelvic surgery, anaesthesia and interventional radiology. Packing, mechanical stabilisation and angioembolisation address different components of bleeding; sequence them according to physiology and immediately available expertise.

04 Look beyond the ring

Assess perineal wounds and possible rectal, bladder or urethral injury. Open injuries need early multidisciplinary contamination control. After haemostasis, define stability, definitive fixation and mobilisation plans.

WATCH POINT Persistent shock after a binder is a trigger to escalate source control, not to wait for mechanical stabilisation alone to work.

DISCUSS WITH THE TEAM

Which intervention can control this patient's bleeding fastest in this hospital?

READ THE SOURCES

[1] WSES pelvic trauma guideline (2017), emergency stabilisation and bleeding control.