



LocCOV031: COVID19 Fracture Guidelines

Management of patients with urgent orthopaedic conditions and trauma during the coronavirus pandemic

Approved Hywel Dda University Health Board policies can be found on the [Policies and Procedures Approved section of the intranet](#)

Supersedes:	<i>List document Numbers</i>	Classification	Clinical		
LocCOV Reference:	LocCOV031	NatCOV Reference	<i>Ref of linked national guidance</i> NatCOV044: BOASTs: Management of patients with urgent orthopaedic conditions & trauma during the coronavirus pandemic		
Clinical Lead	Mr Mohammed Yaqoob Mr Owain Ennis	CL Approved	Yes	Date of CL approval:	23/05/2020
Version No:	Approved by:	Date Approved:	Date made active:	Review Date:	
v1.1 23/05/2020	Dr PhilKloer, Medical Director & Director of Clinical Strategy Alison Shakeshaft, Exec Director Of Therapies & Health Science Mandy Rayani, Director of Nursing, Quality and Patient Experience	10/06/2020	10/06/2020		
Brief Summary of Document:	Joint guidance has been published by the British Orthopaedics Association and the Orthopaedic Trauma Society to support and guide services on how best to provide trauma and orthopaedic services and care which minimises exposure of patients and staff to COVID-19. This local guideline sets out the services for treating fracture patients within the Health Board				
To be read in conjunction with:	NatCOV044: BOASTs: Management of patients with urgent orthopaedic conditions and trauma during the coronavirus pandemic				
Scope	T&O Services across the health board				
Patient Information:	Include links to Patient Information Library				
Reviews and updates					
Version no:	Summary of Amendments:			Date Approved:	
v1.0	New guideline (GGH only)			Not approved	
V1.1, 23/05/2020	Updated to cover all sites & provide more clarity & PIL recommendations			10/06/2020	

HDUHB Fracture Management during the COVID Pandemic (v1.1, updated 23/05/20)

These are just guidelines please use clinical judgment

All patients:

1. Open fractures iv antibiotics, tetanus, D/W ortho Spr
2. Exclude compartment syndrome and advice patient monitoring
3. Document neurology and vascular status
4. DVT risk assessment all lower limb fractures
5. Check for NAI in paediatric patients & abuse in vulnerable adults
6. Unstable fractures (upper&lower limb) which could benefit from surgery to be presented in trauma meeting even if home/virtual clinic. Consider surgery as pre-covid depending on trauma workload. If conservative management FU 2weeks with xrays (23/5/20).
7. Provide fracture specific advice sheet in A/E . (available; ankle, proximal humerus, radial head, 5th MT, 5th MC, clavicle, scaphoid, mallet finger, torus fracture 23/5/20).

Adult Upper limb

Clavicle Fracture:

All to be treated non-operatively.

A/E: Polysling

Advice; risk of non-union, gentle mobilisation 2 weeks, may need sling for up to 6 weeks

Follow-up: Virtual Fracture Clinic

Fracture clinic: SOS only at least 3 months post injury.

Shoulder Dislocation:

A/E: Reduce by A/E team, if associated surgical neck fracture reduce in A/E by ortho SpR, polysling, document NV status including axillary nerve. Even if they have a cuff tear we are not repairing these acutely.

Advice; start mobilisation ASAP.

Follow-up: Virtual Fracture clinic

Fracture clinic: SOS only at least 3 months post injury.

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Proximal Humerus fracture:

All to be treated non-operatively.

A/E: Collar and cuff

Advice; Elbow, wrist and hand movements ASAP. Start pendulum exercises 3 weeks. Provide advice sheet.

Follow-up: Virtual Fracture Clinic

Fracture clinic: SOS at least 3 months post injury

Humerus shaft fracture:

All to be treated non-operatively.

A/E: Humeral brace.

Advice; stop smoking, non-union risk, document NV status before and after brace application, start pendulum and elbow exercises 2-3 weeks.

Follow-up: Virtual Fracture clinic

Fracture clinic: SOS at least 3 months post injury.

Olecranon fracture:

A/E: >75 years (including displaced) soft cast in 45 degrees, treat conservatively

Advice; remove soft cast at 2 weeks and start ROM exercises

Follow-up: Virtual Fracture clinic

Fracture clinic: SOS at least 3 months post injury.

Displaced olecranon fractures <75years discharge and admit as day case for surgery

Radial head fracture:

A/E: broad arm sling

Advice; start immediate ROM exercises. Provide advice sheet

Follow-up: Virtual Fracture clinic

Fracture clinic: Discharge from VFC.

Elbow dislocation:

A/E: reduce in A/E, backslab

Advice; will be stiff, remove backslab at home in 2 weeks and start immediate ROM exercises

Follow-up: Virtual Fracture clinic

Fracture clinic: Discharge from VFC if no complex fracture patterns

Wrist fracture

Undisplaced or minimally displaced:

All to be treated non-operatively.

A/E: Reinforced soft cast. Remove at home in 6 weeks. Provide advice sheet.

Follow-up: Virtual Fracture clinic.

Fracture clinic: SOS at least 3 months post injury

Displaced:

A/E: reduce in A/E, reinforced soft cast and discharge. Provide advice sheet.

Follow-up: Virtual Fracture Clinic. Unstable fracture FU 2 weeks with xrays.

Fracture clinic: SOS at least 3 months post injury.

5th metacarpal fracture:

A/E: budding strapping + futura splint, document rotation deformity

Advice: remove strapping in 3 weeks and mobilise, Provide advice sheet.

Follow-up: Virtual fracture clinic

Fracture clinic: Discharge from VFC.

Scaphoid fracture or ? scaphoid:

A/E: Colles reinforced soft cast (thumb not included)

Advice: remove cast at 6 weeks. Provide advice sheet.

Follow-up: Virtual fracture clinic

Fracture clinic: SOS only. If still painful at 3 months for repeat x-rays.

Nail bed/ extensor tendon injuries:

A/E: Nail bed repair (resorbable stitches) under LA in A/E, oral antibiotics, discharge

Advice: nail will fall in few weeks, monitor for infection.

Follow-up: no follow-up

Fracture clinic: no follow-up

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Phalangeal fractures and IP dislocations:

A/E: dorsal splint with flexion at MCP joint and xray, if displaced discuss with ortho SpR to be discussed by ortho team at trauma meeting (consultant to request advice and send images of A Bebbington if required)

Follow-up: Virtual Fracture clinic

Fracture clinic: x-rays if displaced

Paediatric upper limb fractures:

Paediatric clavicle fractures:

A/E: Provide a sling for comfort and discharge (xray not required if clinically obvious)

Advice: Prep the family to begin gentle ROM from 1 week onwards

Follow-up: Virtual fracture clinic

Fracture clinic: discharge from VFC

Proximal humerus fractures:

A/E: Provide a collar and cuff and discharge (xray not required if clinically obvious)

Advice: Prep the family to begin gentle ROM from 2 week onwards

Follow-up: Virtual fracture clinic

Fracture clinic: discharge from VFC

Midshaft humerus fractures:

A/E: minimally displaced Provide a collar and cuff and discharge

Displaced well fitting high above elbow backslab remove at 4-5 weeks

Advice: Prep the family to begin gentle ROM from 2 week onwards

Follow-up: Virtual fracture clinic

Fracture clinic: xray at 4-6weeks

Supracondylar humerus fractures (CLOSED, NO NEUROVASCULAR DEFICIT)

Gartland 1:

A/E: Collar and cuff

Advice: Remove collar and cuff and 3 weeks and start mobilisation, avoid risky activity for 6 weeks

Follow-up: Virtual fracture clinic

Fracture clinic: discharge from VFC

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Gartland 2:

A/E: Application of a well-fitting above elbow backslab with flexion to 90 degrees

Advice: Remove collar and cuff at 3 weeks and start mobilisation, avoid risky activity for 6 weeks

Follow-up: Virtual fracture clinic

Fracture clinic: discharge from VFC

Gartland 3 and any patients (gartland 1 or 2) with neurovascular deficit

Admit for surgery, monitor, remove wires at 3 weeks. No further follow up

Medial Epicondyle fractures:

A/E: Reduce if associated elbow dislocation and check medial epicondyle not in joint, apply back slab

Advice: remove backslab in 3 weeks and start mobilisation

Follow-up: Virtual fracture clinic

Fracture clinic: Discharge from VFC

Lateral condyle fractures:

Intrarticular displacement – admit for surgical fixation

No intrarticular displacement

A/E: Reinforced soft cast above elbow

Follow-up: F2F fracture clinic 2 weeks with xrays

Fracture clinic: Xrays 2 weeks if no intrarticular displacement remove cast 6 weeks at home.

Forearm fractures:

Both forearm fractures minimally displaced, or single bone fracture (exclude monteggia or Galeazzi fracture)

A/E: reinforced soft cast in mid-rotation include wrist and sling

Advice: remove soft cast in 6 weeks <10 years, 8 weeks >10years start mobilisation

Follow-up: Virtual fracture clinic

Fracture clinic: Discharge from VFC

Both forearm fractures displaced or fracture dislocations:

Immediate treatment: Admit and check Covid status for theatre manipulation

Follow up treatment: As per operation report

Buckle wrist fractures:

A/E: soft cast

Advice: remove cast in 3 weeks (buckle) and mobilise, provide advice sheet.

Follow-up: Virtual fracture clinic

Fracture clinic: Discharge from VFC.

Undisplaced distal radius fractures:

A/E: reinforced soft cast

Advice: remove at 4 weeks (distal radius) and mobilise

Follow-up: Virtual fracture clinic

Fracture clinic: Discharge from VFC with advice sheet.

Displaced distal radius fractures:

A/E: backslab (D/W SpR or consultant if displacement acceptable) if advised admit for theatre manipulation

Fracture clinic: as per operation report.

Adult and paediatric Lower limb

Tibia fractures Plateau/ shaft/ plafond:

A/E: align fracture, back slab and xrays, admit monitor compartment syndrome

Follow-up: depending on consultant review

Fracture clinic: depending on consultant review

Patella dislocation:

A/E: reduce in A/E, Richard splint

Advice: RICE, remove splint ASAP and start ROM/ quadriceps exercise

Follow-up: Virtual fracture clinic to exclude large OC fragment

Fracture clinic: Discharge from VFC.

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Patella fracture:

Undisplaced and able to SLR:

A/E: Range of motion brace locked in extension 4 weeks then progressive increase in ROM to 90deg at 4-6 weeks

Advice: on how to adjust brace, quadriceps exercises

Follow-up: Virtual fracture clinic

Fracture clinic: See SOS at 3 months if required.

Extensor Mechanism Disruption:

Displaced patella, quadriceps/ patella tendon rupture:

A/E: Richard splint, u/s or MRI to confirm tendon rupture discharge home and admit for surgery as a day case

Follow-up: Trauma meeting discussion

Fracture clinic: as per post-operative instructions.

Acute Locked Knee:

A/E: Discharge home, no brace required.

Advice: RICE, trial to improve ROM, contact fracture clinic if still locked in 7 days, advice surgery might not be possible depending on covid progress

Follow-up: Virtual fracture clinic

Fracture clinic: SOS if still locked in 7 days.

Soft tissue knee injuries:

A/E: Discharge home, IROM brace unlocked if signs of ligament injury

Advice: RICE, quadriceps and ROM exercises e.g static bike, remove brace at 3-4 weeks, contact fracture clinic if still issues at 3 months

Follow-up: Virtual fracture clinic

Fracture clinic: SOS only at 3 months if required.

Ankle fractures:

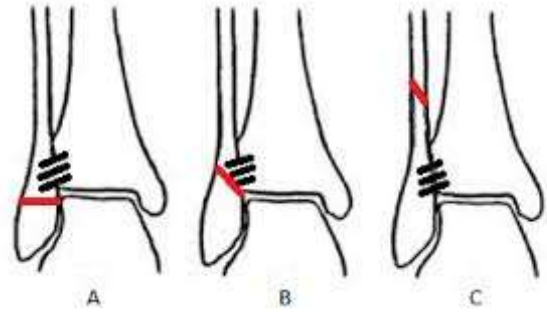
Weber A, lateral ligament injury:

A/E: aircast boot

Advice: elevate, mobilise FWB, remove boot in 5 weeks (fractures). Provide advice sheet. 3 weeks (ligament).

Follow-up: Virtual fracture clinic

Fracture clinic: Discharge from Virtual fracture clinic.



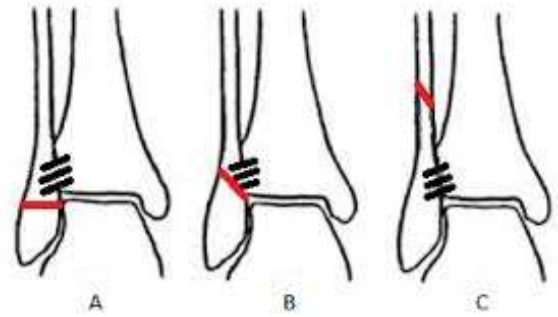
Weber B/ C/ medial malleolus or bimalleolar:

A/E: reduce in A/E, cast and discharge, discuss with ortho SpR if surgery required then to be discussed by ortho team at trauma meeting (if surgery needed day case surgery)

Advice: FWB isolated fibula fracture with no talar shift and NWB all others, needs dvt risk assessment

Follow-up: Virtual fracture clinic then F2F fracture clinic 2 weeks for unstable or bimalleolar.

Fracture clinic: xrays 2 weeks then removal cast 6 weeks no xrays



5th Metatarsal fractures:

A/E: aircast boot

Advice: FWB, elevate, remove boot when comfortable, fracture heals 8 weeks. Provide advice sheet.

Follow-up: Virtual fracture clinic

Fracture clinic: discharge from VFC.

Phalangeal/ metatarsal shaft or neck fractures:

A/E: heel weight bearing shoe

Advice: FWB, elevate, remove shoe when comfortable, fracture heals 8 weeks

Follow-up: Virtual fracture clinic

Fracture clinic: discharge from VFC

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Toe fractures/ nail bed injuries:

A/E: reassure, trephine nail if painful haematoma, oral antibiotics if open fracture

Advice: FWB, elevate

Follow-up: no follow-up

Fracture clinic: no follow-up

Achilles tendon injuries:

A/E: Equinus cast for 4 weeks NWB, plaster tech to measure and order correct Vecoped boot for patient, DVT thromboprophylaxis all patients after risk assessment

Follow-up: F2F fracture clinic 4 weeks to advice below protocol and discharge.

Fracture clinic: *As per protocol*

1. 4-6 weeks: Removal of cast and application of vecoped boot NWB, active ROM (full equinus to neutral dorsiflexion)
2. 6-8 weeks: Vecoped boot weight bearing with foot plate and crutches, active ROM from full equinus to 10 deg dorsiflexion)
3. 8-10 weeks: Vecoped boot weight bearing, active RIM to up 20 deg dorsiflexion allowed.
4. 10 weeks: discard vecoped and physiotherapy.

Calcaneal fractures:

A/E: Air cast boot 6 weeks, NWB 12 weeks in total, DVT thromboprophylaxis for 6 weeks

Advice: stop smoking, monitor for compartment syndrome at home, elevation

Follow-up: Virtual fracture clinic

Fracture clinic: SOS at 3months patient to contact clinic if required

Toddlers fractures:

A/E: soft cast

Advice: remove cast in 3 weeks

Follow-up: Virtual fracture clinic

Fracture clinic: Discharge from VFC with advice sheet.