Pediatric Ortho E-Consult Guidelines
as of 2/12/2020

GENERALITIES

As a department there is very little Orthopaedic providers can do to triage when we cannot see outside images. Please ensure OSH Imaging is uploaded to PACS and if unable to upload, then obtain new XRs.

An acute open fracture or displaced fracture with neurovascular compromise should ***not*** be in clinic or urgent care. If a patient does present with this, please re-direct to ED independent of the below recs.

If you want to order any equipment/splinting/casting from VSC cast room: Place order in Epic and then refer to 2nd floor of VSC. Cast room tech ph# 408-885-3471.

ELBOW FRACTURES

"cannot rule out" or fat pad alone:

1. Immobilize: long arm splint, can write "double sugar tong" in the text if directing patient to VSC cast room
2. Routine referral
3. No need to call

Definite elbow fracture (confirmed on outside images):

1. Please make all efforts to get outside images uploaded.
2. If cannot get uploaded and any concern about displacement – page on call resident
   Supracondylar fractures will most likely be directed to ED, lateral condyle and medial epicondyle more likely not.

Definite elbow fracture – images available or clearly no displacement:

1. Call on call Ortho Resident to confirm nothing more to do, most likely will lead to...
2. Immobilize: long arm splint, can write "double sugar tong" in the text if directing patient to VSC cast room
3. Routine referral

WRIST FRACTURES

Buckle distal radius or distal ulna fractures:

1. Immobilize: Removable Velcro wrist brace preferred (can order from VSC Cast room and can be removed for hygiene and be self-discontinued by family in 3-4 weeks and no need for Ortho f/u).
   References:
   Kuba et al *"One brace: One Visit: Treatment of Pediatric Distal Radius Buckle Fractures with Removable Wrist Brace and No Follow-up Visit."* J Pediatr Orthop 38(6):e338-e342
   Little KJ et al. "Increasing Brace Treatment for Pediatric Distal Radius Buckle Fractures: Using Quality Improvement Methodology to Implement Evidenece-based Medicine." J Pediatr Orthop. 2018.
2. No referral needed
3. No need to call

Displaced distal radius and/or ulna fractures (seen on outside images):

1. Please make all efforts to get outside images uploaded
2. If cannot get uploaded and any concern about interval displacement, obtain new 3V wrist XRS

Displaced or uncertain – images available in VMC PACS:

1. Call Ortho on call resident to get advice

Non-displaced:

1. Immobilize: Removable velcro wrist brace (see buckle fracture recs above)
2. Routine referral
3. No need to call

CLAVICLE, NON DISPLACED - PROXIMAL HUMERUS

1. Sling
2. Routine referral
3. No need to call

DISPLACED PROXIMAL HUMERUS OR HUMERUS SHAFT

1. Call on call Ortho resident

FOREARM FRACTURES

Displaced (outside images):

1. Please make all efforts to get outside images uploaded.
2. If cannot get uploaded and any concern about displacement – call on call Ortho resident

Displaced or uncertain and VMC PACS images available:

1. Call on call Ortho resident

Non-displaced:

1. Immobilize: Double sugar tong splint
2. Routine referral
3. No need to call

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HANDS AND FINGERS ******Pedi Hand Referrals should go to "Hand surgery" NOT "Peds Ortho"******

Carpus or metacarpals

Displaced (outside images):

1. Please make all efforts to get outside images uploaded.
2. If cannot get uploaded and any concern about displacement obtain new XRs and call on call Hand resident
3. In general, for immobilization of ulnar sided injuries (digits long, ring and small) → ulnar gutter splint, for radial sided injuries (thumb, index, middle) → radial gutter, for thumb only → thumb spica

Displaced or uncertain and images available:

1. Call on call Hand resident

Non-displaced fractures:

1. Splint *(see above and below for immobilization recs)*
2. Routine referral to hand surgery
3. No need to call

Thumb or scaphoid – thumb spica splint

Index or middle finger – radial gutter splint

Hamate, ring, or small finger – ulnar gutter splint

CMC, MCP, or PIP dislocation – refer to ED

SCFE, HIP or IMPENDING HIP FRACTURE, FEMUR FRACTURE, TIBIAL TUBERCLE, TIBIA *(EXCEPT TODDLERS FRACTURE)*

1. Call on call Ortho Resident

TODDLERS FRACTURE

1. Long leg splint
2. Routine referral
3. No need to call

ANKLE

Salter – Harris II distal tibia, triplane, any "transitional" fracture, any subluxed or dislocated tibiotalar joint, any displaced medial malleolus, displaced lateral malleolus, or bi- tri-malleolar fracture.
1. Call on call Ortho resident

ANKLE (continued):

Cannot rule out Salter – Harris I distal tibia or fibula without evidence of fracture displacement or tibiotalar subluxation:

1. Immobilize:
    - Short leg splint if in pain
    - CAM or "ski" boot ok
2. NWB if in pain. WBAT if no pain.
3. Routine referral
4. No need to call

TALUS, CALCANEUS, OTHER TARSAL BONE ANY JOINT DISLOCATION

1. Call on call Ortho resident

TOES

1. Immobilize: Hard soled shoe for metatarsals, buddy taping for phalanges
2. Routine referral
3. No need to call

SCOLIOSIS

1. Should have had at least 1 2V scoliosis film and a 1V scoliosis within a year of the referral.
2. Routine referral
3. No need to call

ADOLESCENT KNEE PAIN

1. Effusion = MRI without contrast, knee immobilizer, routine referral, no need to call
2. All others should have a physical exam of the hip, standing 2V of the affected knee and a sunrise view if patellofemoral concerns.
3. No need to call.
4. Routine referral.
5. Can use knee immobilizer if symptomatic benefit