MAHATMA GANDHI UNIVERSITY
of
MEDICAL SCIENCES & TECHNOLOGY
JAIPUR

VAC 02

VALUE ADDED COURSES

ATLS PROVIDER

Head Office:
RIICO Institutional Area, Sitapura, Tonk Road, JAIPUR - 302 022 (Raj.) INDIA
Phone: +91-141-2771777 • 2771001-2-3 I Fax: +91-141-2770900 • 2770303 I Website: www.mgumst.org I E-mail: info@mgumst.org
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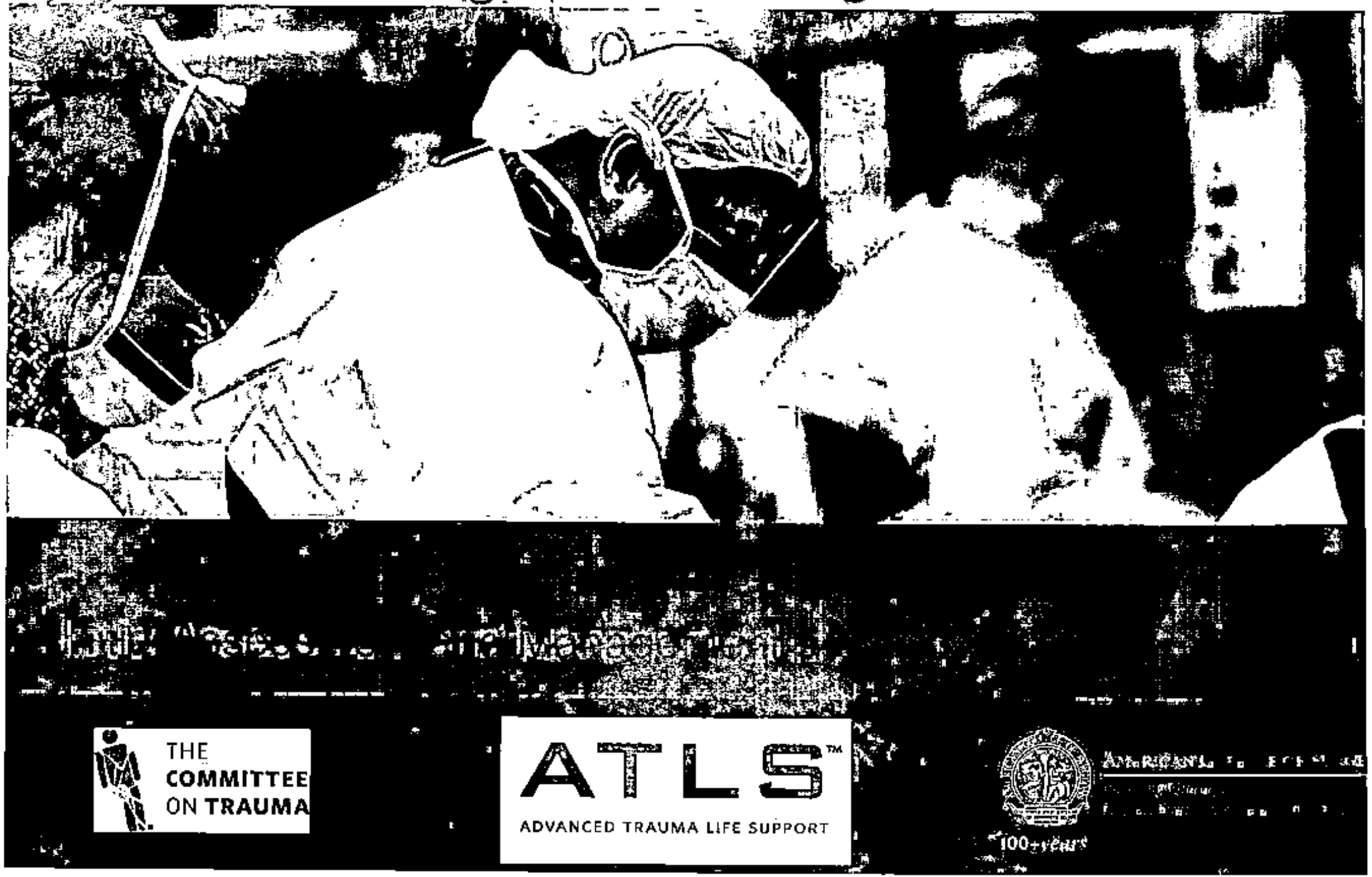
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The primary survey (ABCD) is the cornerstone of the initial assessment of the trauma patient. Repeat the primary survey frequently to identify any deterioration in the patient's status that indicates the need for additional intervention.

bjectives

y the end of this interactive discussion, you will be able to:

- Explain the importance of preparation prior to trauma patient arrival.
- Evaluate the mechanism of injury to determine the patient's potential injuries.
- Identify the correct sequence of priorities for the assessment of a multiply injured patient.
- Apply the principles of the primary and secondary surveys to the assessment of a multiply injured patient.
- Discuss the importance of reevaluating a patient who is not responding appropriately to initial resuscitation and management.
- Recognize patients who require transfer to another facility for definitive management.

ase Scenario Progression

rimary survey reveals:

- Obvious facial trauma and mumbling incoherently.
- Decreased breath sounds, L chest; no visible neck veins
- Minimal bleeding; open L femur fracture; L chest bruising; possible pelvic fracture
- Localizes to pain with upper extremities; moans to painful stimuli; does not open eyes

eview Objectives

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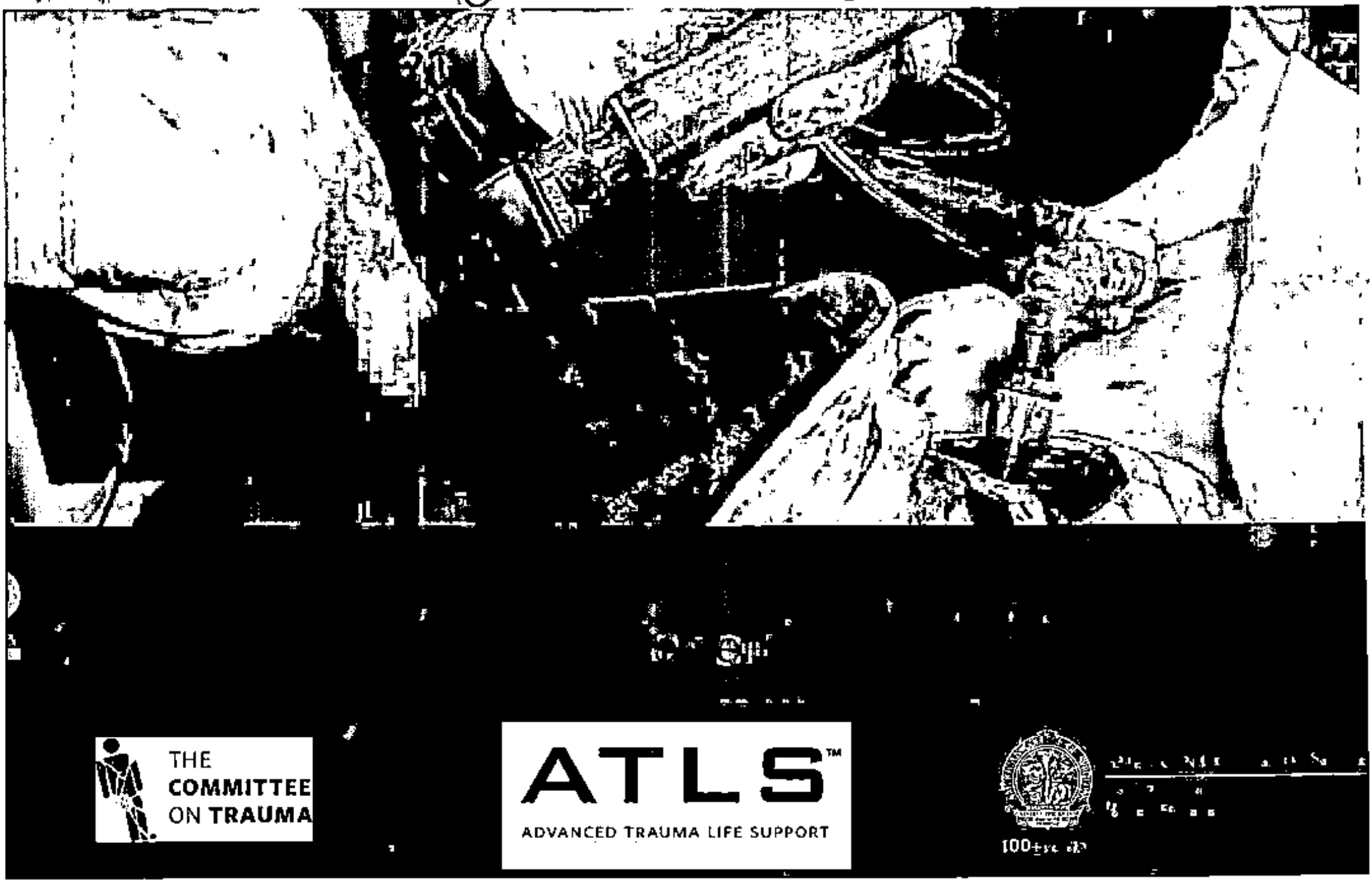
- Evaluate the mechanism of injury to determine the patient's potential injuries.
- Identify the correct sequence of priorities for the assessment of a multiply injured patient.
- Apply the principles of the primary and secondary surveys to the assessment of a multiply injured patient.
- Discuss the importance of reevaluating a patient who is not responding appropriately to initial resuscitation and management.
- Recognize patients who require transfer to another facility for definitive management.

ey Learning Points

1. The initial management of the injured patient requires:
   - coordination with prehospital providers
   - preparation for receiving the patient
   - anticipation of injuries based on the mechanism of injury
2. The evaluation of all trauma patients follows a precise algorithm
3. Patients who exceed the capability of the institution should be identified rapidly and process for transfer begun.
4. Evaluate the patient according to priority using the ABCDEs.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The earliest priorities in managing the injured patient are to ensure an intact airway and recognize a compromised airway.

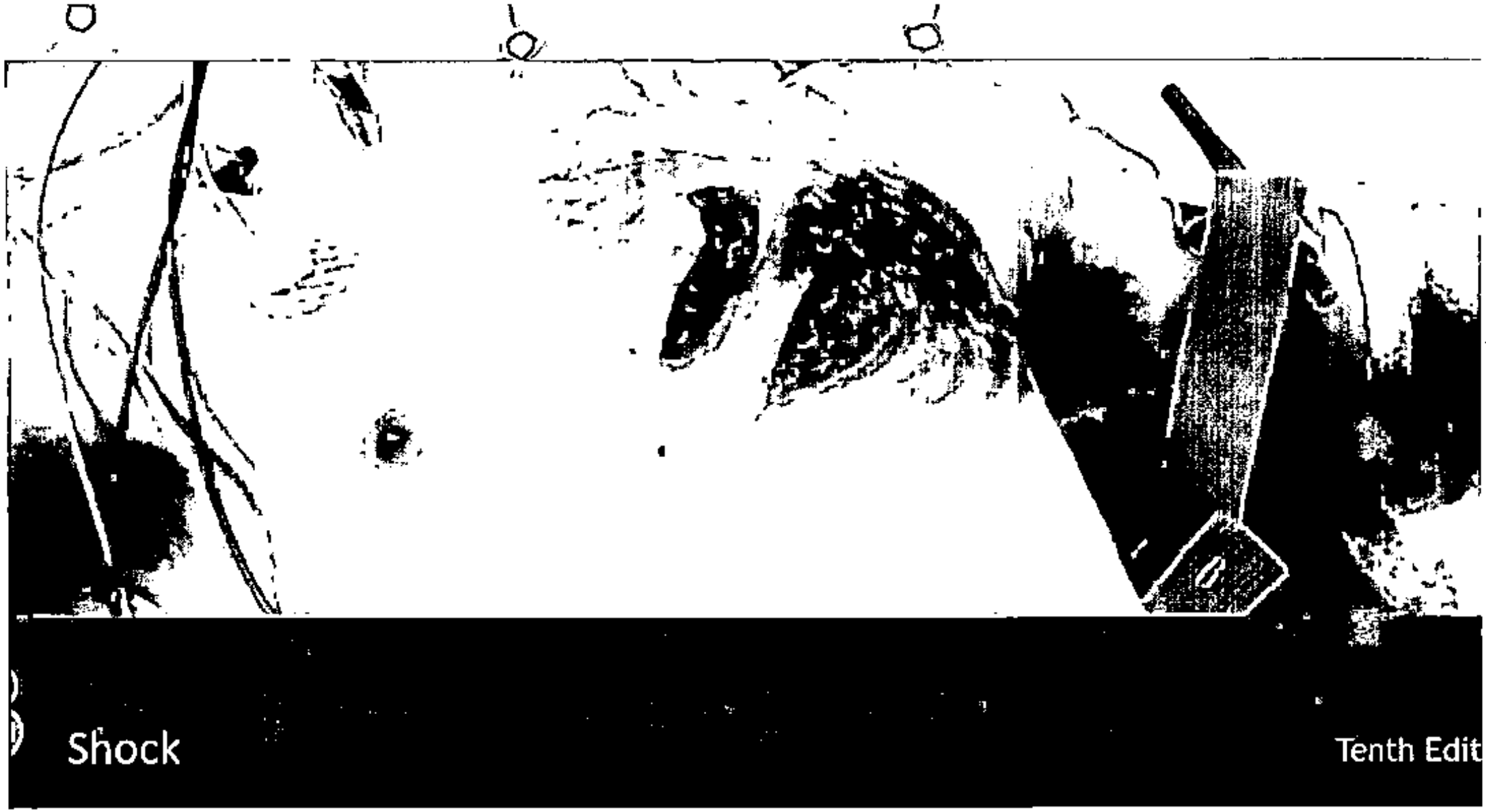
bjectives

y the end of this interactive discussion, you will be able to:

- Identify different clinical situations in which airway compromise is likely t occur.
- Recognize the signs and symptoms of acute airway compromise in a trauma case scenario.
- Determine factors that may lead to a difficult airway.
- Apply the ATLS airway algorithm to a case scenario involving a patient with a difficult airway.
- Define the term *definitive airway*.

ey Learning Points

- One of earliest priorities is recognizing a compromised airway
- All trauma patients should receive supplemental oxygen.
- Risk of airway compromise and difficult airway management can be predicted.
- Alterations in mental status (agitation, combativeness, confusion, or obtundation) may indicate the need for airway management.
- A definitive airway (cuffed tube in trachea below vocal cords) should be obtained in cases of airway compromise.



Shock

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The first step in the initial management of shock is to recognize its presence. The diagnosis of shock is based on clinical recognition of the presence of inadequate tissue perfusion and oxygenation.

bjectives

/ the end of this interactive discussion, you will be able to:

Apply the ATLS principles to the management of a trauma patient with shock

Recognize the signs and symptoms of shock.

Evaluate a patient case scenario to determine the possible causes of shock.

Discuss the changes that may be seen on initial investigations of a patient with shock.

Evaluate the efficacy of initial fluid management of a patient in shock.

Discuss the impact of special patient factors on the management of shock.

eview Objectives

/ the end of this interactive discussion, you will be able to:

Apply the ATLS principles to the management of a trauma patient with shock

Recognize the signs and symptoms of a trauma patient in shock.

Evaluate a patient case scenario to determine the possible causes of shock.

Discuss the changes that may be seen on initial investigations of a patient with shock.

Evaluate the efficacy of initial fluid management of a patient in shock.

Discuss the impact of special patient factors on the management of shock.

ey Learning Points

Hemorrhage is the most common cause of shock after injury.

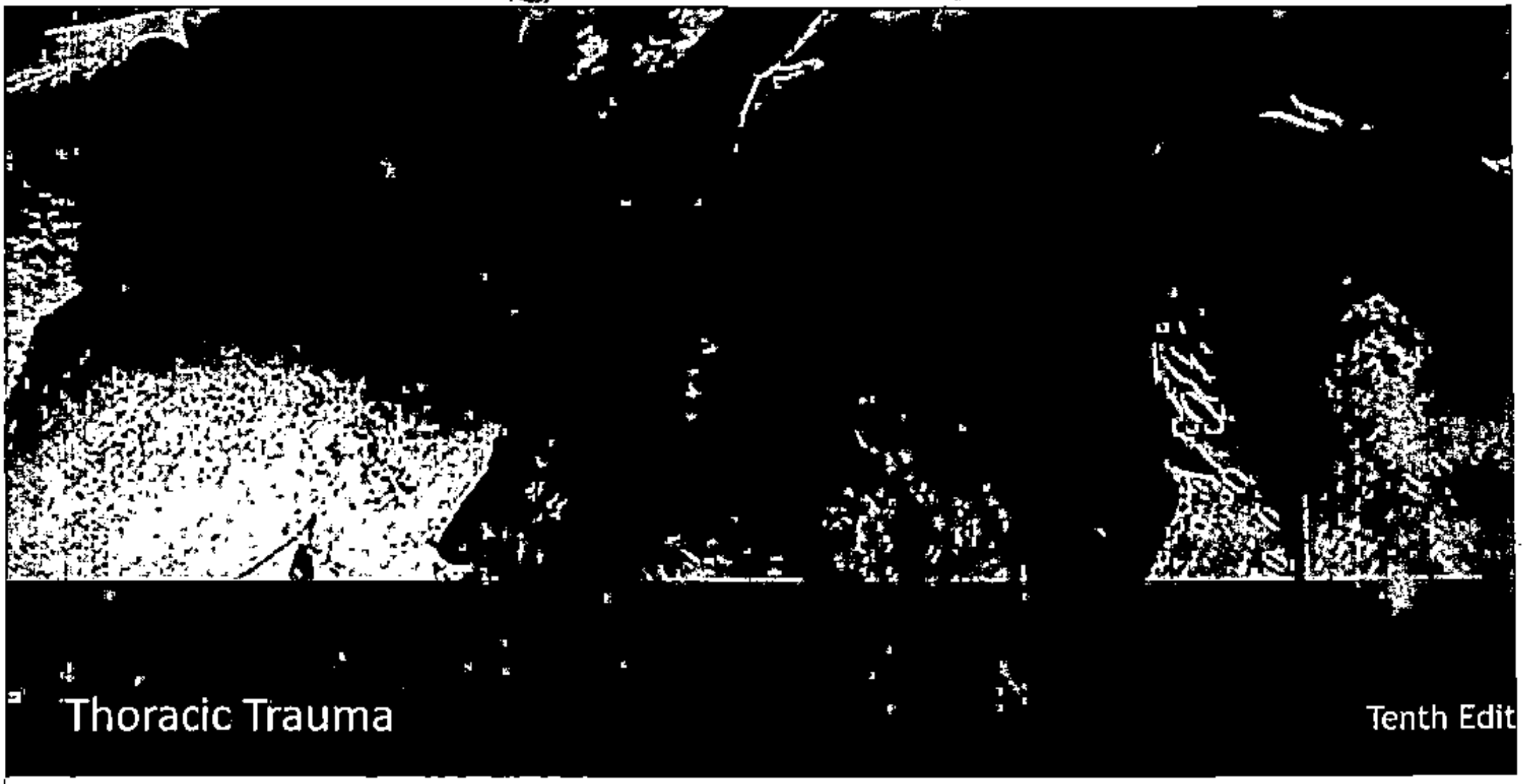
No single laboratory test and no single vital sign on its own can diagnose sho

Massive blood loss may produce only minimal acute decrease in hemoglobin hematocrit.

Major soft tissue injuries and fractures can be associated with significant hemorrhage.

The patient's response to initial fluid therapy will help guide subsequent therapy.

A variety of special conditions may affect the patient's response to shock an the management of it (e.g., age, medication use).



Thoracic Trauma

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Thoracic Trauma

Thoracic injury is common in polytrauma patients and can be life-threatening, especially if not promptly identified and treated during the primary survey.

bjectives

/ the end of this interactive discussion, you will be able to:

Apply the ATLS principles to the management of a patient with thoracic trauma.

Recognize the important life-threatening injuries in a patient with thoracic trauma.

Evaluate the case scenario of a patient with thoracic trauma to identify immediate life-threatening injuries.

Discuss the clinical findings and adjunctive studies that may be useful during the secondary survey in a patient with thoracic trauma.

Thoracic Trauma

Potential Life Threat	Clinical Presentation/Findings	Treatment	Pitfalls
Simple Pneumothorax	+/- shortness of breath No hypotension Diagnosis by chest x-ray	Chest tube drainage	Could become tension pneumothorax if untreated
Hemothorax	Dullness to percussion Diagnosis by chest x-ray	Chest tube drainage	Could become massive hemothorax
Flail Chest and Pulmonary Contusion	May see paradoxical movement of chest wall More commonly presents with pain and poor respiratory excursions	Oxygen Analgesia Intubation if necessary	Progressive respiratory failure
Blunt Cardiac Injury	ECG changes	Cardiac monitoring Therapy based on clinical status	At risk for clinically significant dysrhythmias
Traumatic Aortic Disruption	May be asymptomatic Multiple possible radiographic findings	Endovascular or open surgical repair	Blood pressure control important prior to definitive therapy
Traumatic Diaphragm Injury	Respiratory distress Obscured left diaphragm border Evidence of abdominal viscera in chest	Operative repair	Concomitant pulmonary contusion may mask diaphragm injury
Esophageal injury	Chest pain; mediastinal air on imaging; crepitus delayed fever	Operative repair	Delayed diagnosis

eview Objectives

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Apply the ATLS principles to the management of a patient with thoracic trauma.

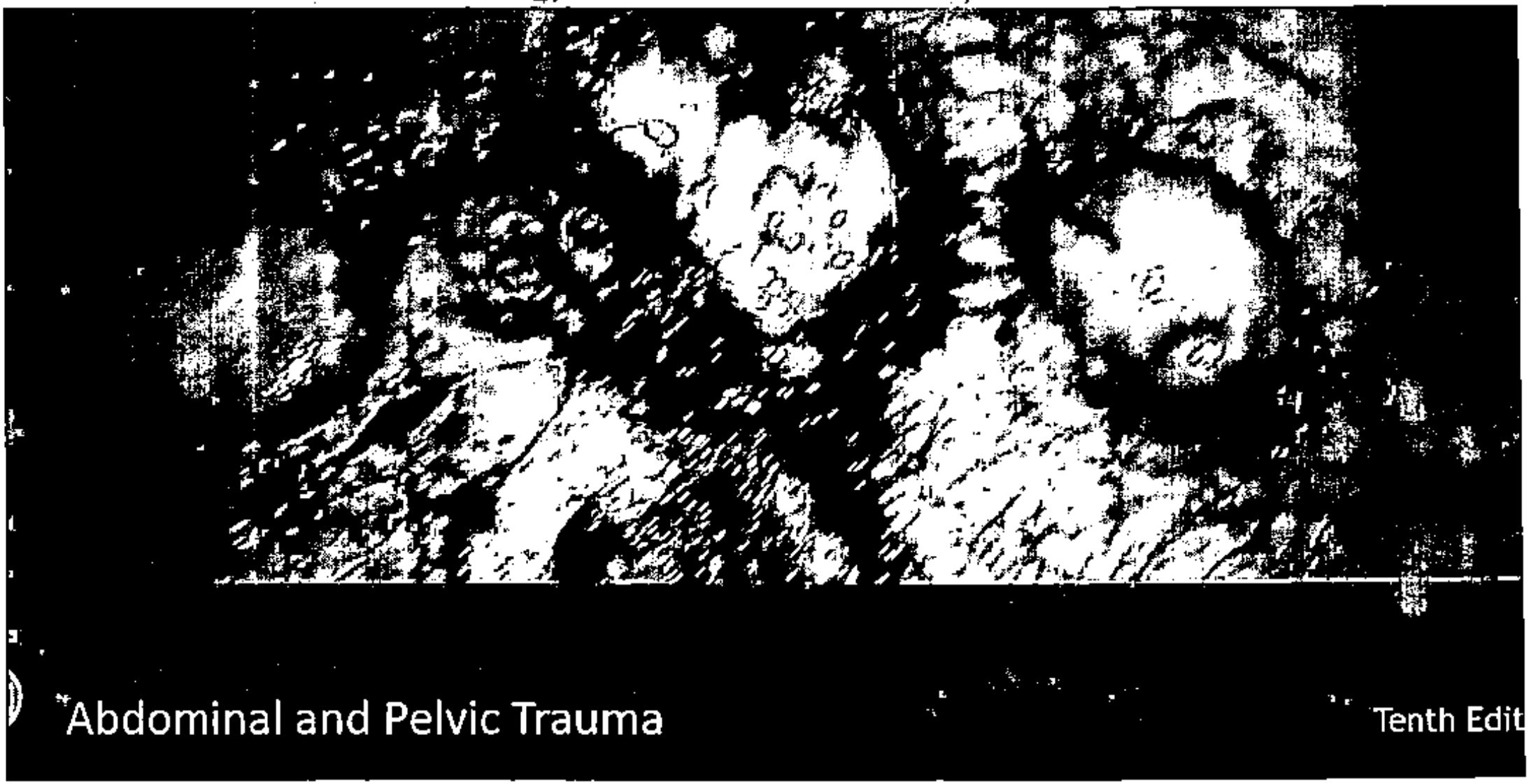
Recognize the important life-threatening injuries in a patient with thoracic trauma.

Evaluate the case scenario of a patient with thoracic trauma to identify immediate life-threatening injuries.

Discuss the clinical findings and adjunctive studies that may be useful during the secondary survey in a patient with thoracic trauma.

ey Learning Points

1. It is important to recognize thoracic life-threatening problems in polytrauma patients.
2. Most immediate thoracic life-threatening problems can be recogniz without special testing and may be treated with:
   - airway control
   - decompression and/or
   - fluid resuscitation
3. Potential life-threatening problems can become immediate life-threatening problems if untreated (e.g., a simple pneumothorax ca become a tension pneumothorax).



Abdominal and Pelvic Trauma

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When uncontrolled or unrecognized, blood loss from abdominal and pelvic injuries can result in preventable death.

bjectives

/ the end of this interactive discussion, you will be able to:

Identify the anatomic regions of the abdomen that are critical in assessing and managing trauma patients.

Discuss the risk for abdominal and pelvic injuries based on the mechanism of injury.

Identify patients who require surgical consultation and possible surgical and/or catheter-based intervention.

Determine appropriate diagnostic procedures to ascertain if a patient has ongoing hemorrhage and/or other injuries that can cause delayed morbidity and mortality.

Formulate an acute management plan for abdominal and pelvic injuries utilizing a case scenario.

Discuss the importance of early identification and emergent management of pelvic hemorrhage.

eview Objectives

/ the end of this interactive discussion, you will be able to:

Identify the anatomic regions of the abdomen that are critical in assessing and managing trauma patients.

Discuss the risk for abdominal and pelvic injuries based on the mechanism of injury.

Identify patients who require surgical consultation and possible surgical and/or catheter-based intervention.

Determine appropriate diagnostic procedures to ascertain if a patient has ongoing hemorrhage and/or other injuries that can cause delayed morbidity and mortality.

Formulate an acute management plan for abdominal and pelvic injuries utilizing a case scenario.

Discuss the importance of early identification and emergent management of pelvic hemorrhage.

ey Learning Points

1. Mechanism of injury is critical when considering abdominal and/or pelvic injury.
2. Thorough examinations of the chest, abdomen, and pelvis (anterior, latera posterior, and perineum) are required to avoid missing significant injuries.
3. Appropriate diagnostic procedures should be employed.
4. Surgical intervention is assessed via clinical findings and the patient's response to management.
5. Early identification and emergent management of pelvic hemorrhage can lifesaving.

Head Trauma

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The primary goal of treatment for patients with suspected traumatic brain injury is to prevent secondary brain injury.

bjectives

/ the end of this interactive discussion, you will be able to:

Recognize the GCS score that corresponds to a severe head injury and indicates a comatose patient.

Identify the different types of intracranial bleeding seen on CT that are associated with traumatic brain injury.

Discuss the role of supplemental oxygen and systolic blood pressure maintenance in limiting secondary brain injury.

Describe the management of intracranial hypertension associated with the mass effect of blood or brain swelling.

Discuss the indications for early, rapid transfer to a center equipped to manage a patient with brain injury.

eview Objectives

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Identify the different types of intracranial bleeding seen on CT that are associated with traumatic brain injury.

Discuss the role of supplemental oxygen and systolic blood pressure maintenance in limiting secondary brain injury.

Describe the management of intracranial hypertension associated with the mass effect of blood or brain swelling.

Discuss the indications for early, rapid transfer to a center equipped to manage a patient with brain injury.

ey Learning Points

GCS score is an objective, reproducible measurement of brain injury severity.

GCS of 8 or less is considered severe and indicative of a comatose patient.

Consider a CT scan of the head for any trauma patient with suspected traumat brain injury.

Initial management of intracranial hypertension includes:

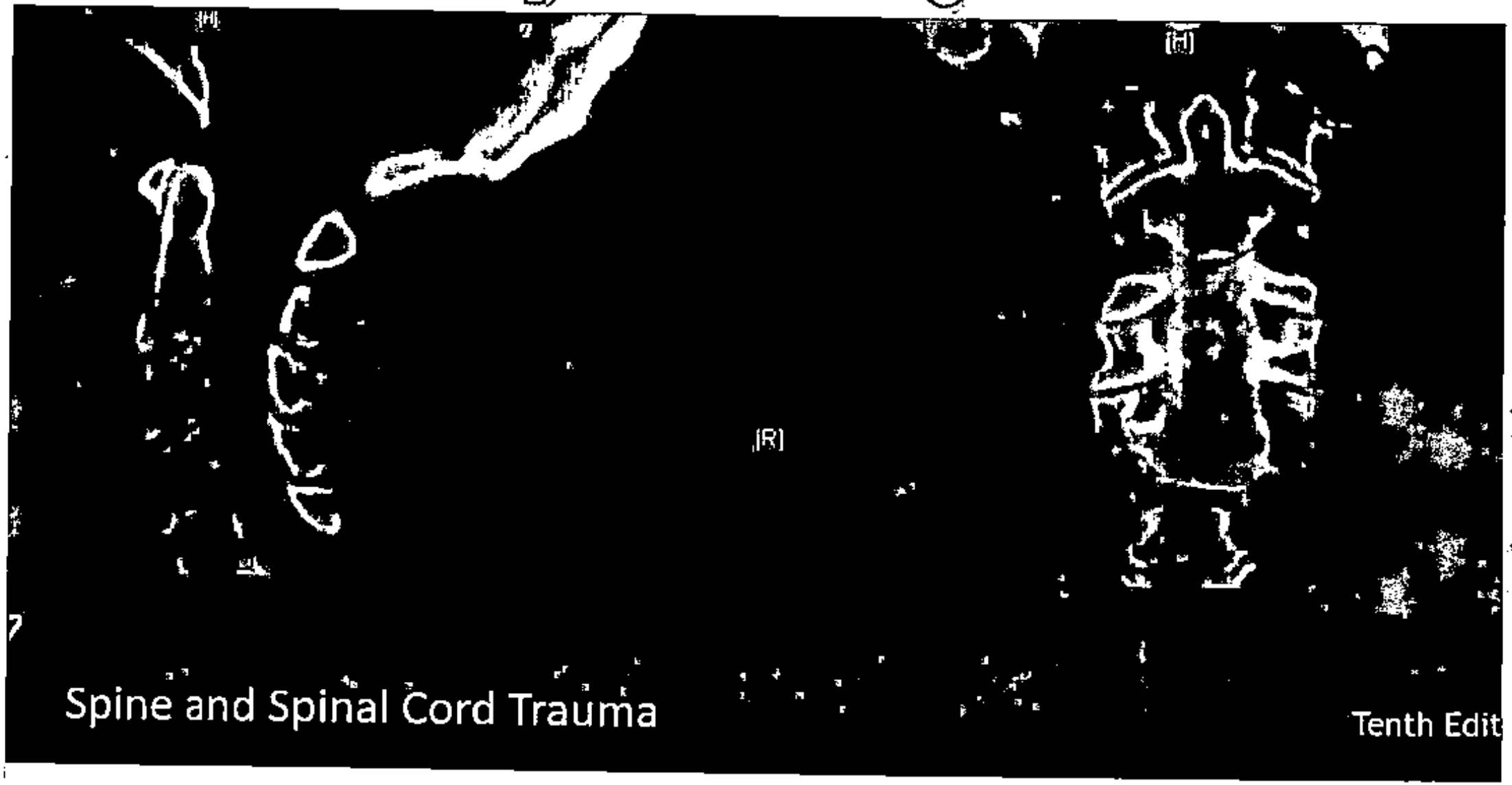
- elevation of the head of bed
- sedation
- selective administration of mannitol and hypertonic saline

ey Learning Points

Minimize secondary brain injury by:

- adequate oxygenation (supplemental oxygen)
- ensuring brain perfusion: SBP > 100 mm Hg (age 50-69) or > 110 mm Hg (15 49 and older than 70)

If no neurosurgical capability, consider early, rapid transfer



Spine and Spinal Cord Trauma

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use spine injury can occur with both blunt and penetrating
na, and with or without neurological deficits, it must be
dered in all patients with multiple injuries. These patients
ire restriction of spinal motion to protect the spine from
er damage until spine injury has been ruled out.

bjectives

/ the end of this interactive discussion, you will be able to:

Apply the ABC principles of ATLS when assessing a patient for spine injury.

Identify a common mechanism and type of spinal injury.

Describe the typical signs and symptoms of a patient with a spinal cord injury.

Describe the technique and importance of documentation of a potential spinal injury.

Describe the appropriate initial treatment of patients with spinal injuries.

Determine the appropriate disposition of patients with spine trauma.

eview Objectives

/ the end of this interactive discussion, you will be able to:

Apply the ABC principles of ATLS when assessing a patient for spine injury.

Identify a common mechanism and type of spinal injury.

Describe the typical signs and symptoms of a patient with a spinal cord injury.

Describe the technique and importance of documentation of a potential spinal injury.

Describe the appropriate initial treatment of patients with spinal injuries.

Determine the appropriate disposition of patients with spine trauma.

ey Learning Points

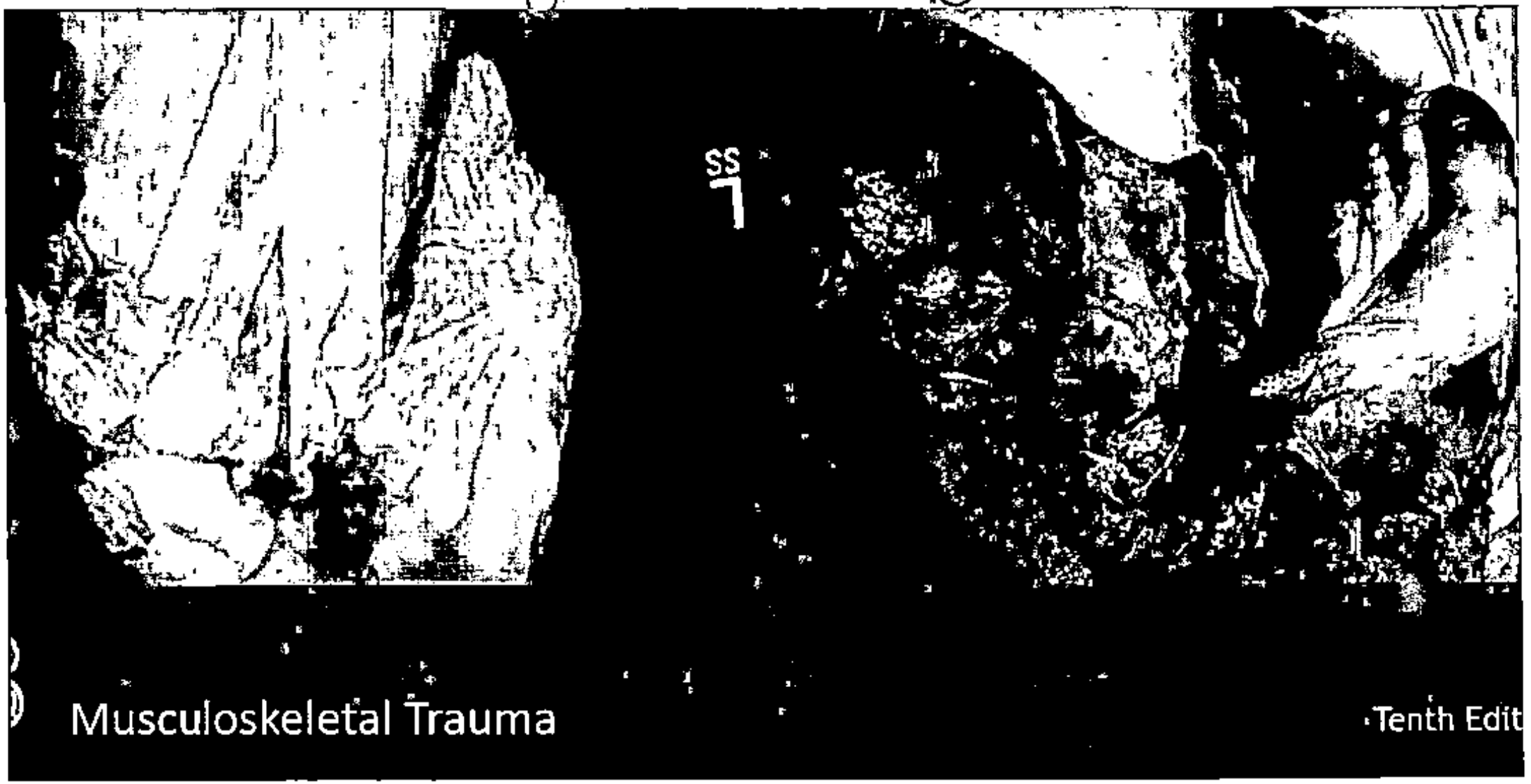
Attend to the life-threatening injuries identified in the primary survey while minimizing movement of the spine.

Assume possible spinal injury until clinical and/or radiographic evaluation can be completed (decision tools such as Canadian C-Spine Rules or NEXUS may be used).

Be as specific and accurate as possible when describing and documenting the level neurologic injury (ASIA tool is extremely useful).

High spinal cord injuries may be associated with respiratory failure and/or neurogei shock, which must be addressed prior to transfer.

Consider obtaining early consultation with a spine surgeon when a spinal injury is suspected and/or detected.



Musculoskeletal Trauma

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Musculoskeletal Trauma

Injuries to the musculoskeletal system are common in trauma patients. The delayed recognition and treatment of these injuries can result in life-threatening hemorrhage or limb loss.

bjectives

y the end of this interactive discussion, you will be able to:

Explain the significance of musculoskeletal injuries in patients with multiple injuries.

Outline the priorities of the primary survey, resuscitation and secondary survey of patients with extremity injuries.

Identify the adjuncts needed in the immediate treatment of life-threatening extremity hemorrhage.

Explain the principles of the initial management of limb-threatening musculoskeletal injuries.

eview Objectives

/ the end of this interactive discussion, you will be able to:

Explain the significance of musculoskeletal injuries in patients with multiple injuries.

Outline the priorities of the primary survey and resuscitation of patients wit extremity injuries.

Identify the adjuncts needed in the immediate treatment of life-threatening extremity hemorrhage.

Describe key elements of the secondary survey of patients with musculoskeletal trauma.

Explain the principles of the initial management of limb-threatening musculoskeletal injuries.

ey Learning Points

Hemorrhage from long bone fractures can be significant

Early splinting helps to control blood loss, reduce pain, and preven further neurovascular compromise and soft tissue injury

Early weight-based dosing of antibiotics for patients with open fractures

Compartment syndrome is a clinical diagnosis, and the treatment i fasciotomy.

Thermal Injuries

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most significant difference between burns and other
uries is that the consequences of burn injury are directly
ted to the extent of the inflammatory response to the injury.

bjectives

/ the end of this interactive discussion, you will be able to:

Discuss the potential risks to the airway of patients with burn injuries.
Discuss resuscitation strategies for patients with burns.
Estimate the extent of a simulated patient's burn injury.
Describe the appropriate management of burn injuries, including circumferential burns.
Discuss the proper handover method for patients with burns.
Describe management of patients with hypothermia, including rewarming risks.
Describe the tissue effects of cold injury.
Describe the initial treatment of patients with tissue injury from cold exposure.

bjectives

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Discuss the proper handover method for patients with burns.
Describe management of patients with hypothermia, including rewarming risks.
Describe the tissue effects of cold injury.
Describe the initial treatment of patients with tissue injury from cold exposure.

ey Learning Points

The most significant difference between burns and other injuries is that the consequences of burn injury are directly linked to the extent of the inflammatory response to the injury. This drives the rate and amount of edei formation.

The airway can become obstructed not only from direct injury (e.g., inhalat injury), but also from the massive edema resulting from the burn injury. Ede is typically not present immediately, and signs of obstruction may initially be subtle until the patient is in crisis.

In contrast to resuscitation for other types of trauma in which fluid deficit is typically secondary to hemorrhagic losses, burn resuscitation is required to replace the ongoing losses from capillary leak due to inflammation.

ey Learning Points

A fresh burn is a clean area that must be protected from contamination.

Ensure that there are flow sheets documenting the patient history, injury, IV fluids given, and urinary output. The flow sheet should be sent with the pati on transfer.

Although rapid rewarming is essential for management of frostbite and hypothermia, reperfusion can cause physiologic changes that need to be managed.

0 Pediatric Trauma

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Injury remains the most common cause of death and disability in childhood. Injury morbidity and mortality surpass all major diseases in children and young adults, making trauma the most serious public health and health care problem in this population.

bjectives

/ the end of this interactive discussion, you will be able to:

Identify the initial priorities of trauma assessment and management for children.

Describe the most appropriate interventions for managing difficult airways i pediatric trauma patients.

Recognize the most common causes of cardiac arrest in children.

Identify methods for obtaining venous access in children.

Discuss how to determine drug and fluid dosages in children.

Evaluate for nonaccidental trauma in a pediatric trauma case.

eview Objectives

/ the end of this interactive discussion, you will be able to:

Identify the initial priorities of trauma assessment and management for children.

Describe the most appropriate interventions for managing difficult airways i pediatric trauma patients.

Recognize the most common causes of cardiac arrest in children.

Identify methods for obtaining venous access in children.

Discuss how to determine drug and fluid dosages in children.

Evaluate for nonaccidental trauma in a pediatric trauma case.

ey Learning Points

The initial priorities of trauma assessment and management are the same fo children and adults.

Surgical cricothyroidotomy is generally considered to be unsafe in small children (<12) due to the small size of the cricothyroid membrane and proximity to vocal cords. Needle cricothyroidotomy is preferred as a temporizing solution until other preparations are made.

Hypoxia and respiratory compromise are the most common causes of cardiac arrest in children.

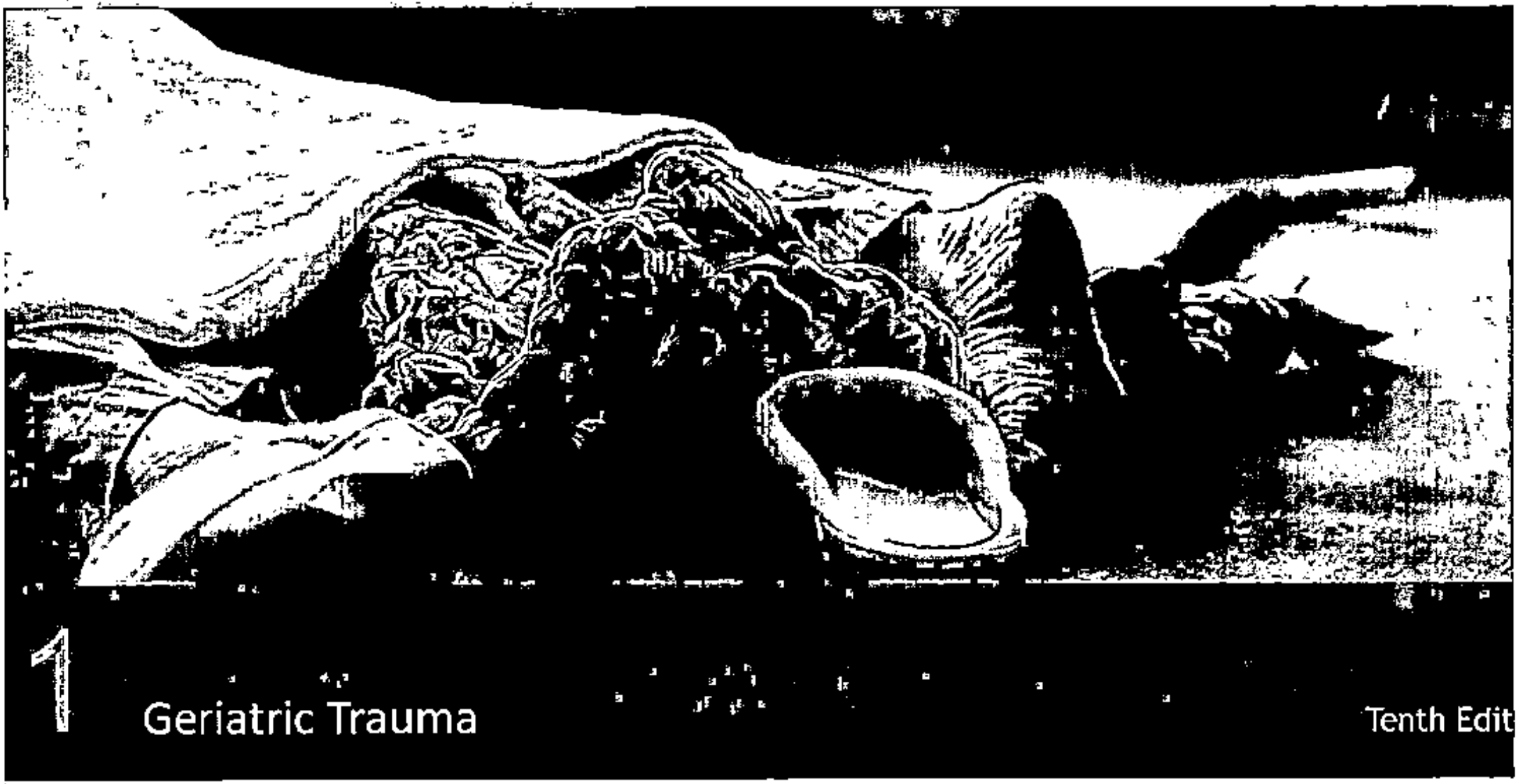
Emergent venous access in children can be difficult. If unable to obtain peripheral access, intraosseous access should be obtained immediately.

ey Learning Points

Determination of weight is essential to pediatric trauma care in order to dos drugs and guide fluid and blood resuscitation. This can be accomplished by history, length-based resuscitation tape, or specialty stretchers with integra scales.

Blunt solid organ injury in pediatric patients is usually managed non-operati by a surgeon unless the patient is hemodynamically unstable or there are otl indications for surgery.

Non-accidental trauma is a significant source of injury in children and has a higher mortality rate than corresponding accidental injuries. Specific injury patterns exist that should heighten concerns. Clinicians must have a high in of suspicion and report these cases appropriately.



1 Geriatric Trauma

Tenth Edit

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1 Geriatric Trauma

When managing geriatric patients with trauma, the effects of aging on physiological function and the impact of preexisting conditions and medications cannot be overemphasized.

1 Geriatric Trauma

bjectives

y the end of this interactive discussion, you will be able to:

. Describe common mechanisms of injury seen in older adults.

. Apply the ATLS principles to the management of an elderly traum patient.

. Understand the physiologic changes that occur with aging and hov they affect the geriatric patient's injury and response to trauma.

. Understand the common signs and causes of elder maltreatment.

eview Objectives

y the end of this interactive discussion, you will be able to:

. Describe common mechanisms of injury seen in older adults.

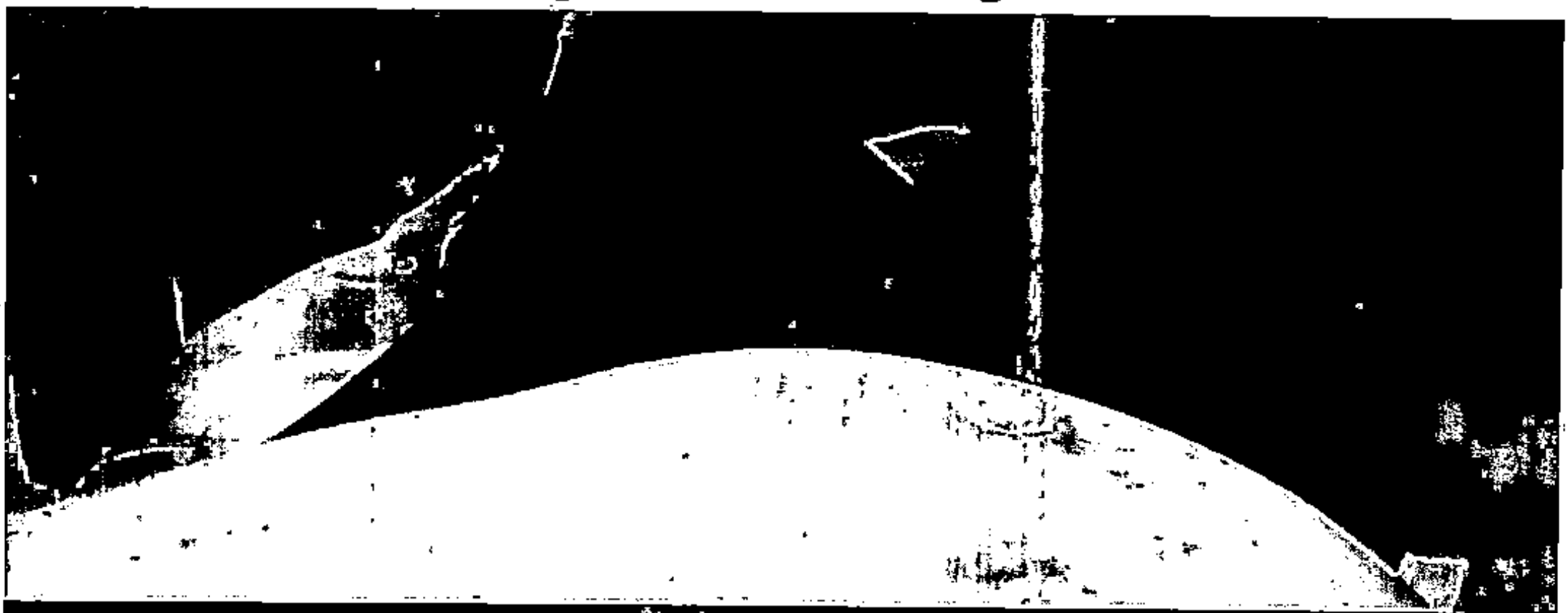
. Apply the ATLS principles to the management of an elderly traum patient.

. Understand the physiologic changes that occur with aging and hov they affect the geriatric patient's injury and response to trauma.

. Understand the common signs and causes of elder maltreatment.

ey Learning Points

- Aging populations require an understanding of the special feature and needs of elderly trauma patients.
- Decreased physiologic reserve and preexisting medical conditions can influence their outcomes.
- Understanding elderly patient anatomy and physiology is key to appropriate care
- Recognize the warning signs and impact of elder maltreatment



2 Trauma in Pregnancy and Intimate Partner Violence

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Although pregnancy causes alterations in normal physiology and responses to injury and resuscitation, the sequence of the initial assessment and management of pregnant patients remains the same as for all trauma patients.

2 Trauma in Pregnancy and Intimate Partner Violence

bjectives

y the end of this interactive discussion, you will be able to:

Recognize that the approach to the care of pregnant trauma patients is the same as for all other trauma patients.

Identify the physiologic changes of pregnancy and their impact on the successful resuscitation of the mother and her pregnancy.

Determine management priorities regarding mother and fetus in a trauma case scenario.

Identify when to administer RH immunoglobulin therapy.

Recognize signs of intimate partner violence as a potential cause of injury ir a pregnant trauma patient.

eview Objectives

y the end of this interactive discussion, you will be able to:

Recognize that the approach to the care of pregnant trauma patients is the same as for all other trauma patients.

Identify the physiologic changes of pregnancy and their impact on the successful resuscitation of the mother and her pregnancy.

Determine management priorities regarding mother and fetus in a trauma case scenario.

Identify when to administer RH immunoglobulin therapy.

Recognize signs of intimate partner violence as a potential cause of injury in a pregnant trauma patient.

ey Learning Points

The goals and approach to the care of pregnant patients are the same as for other trauma patients: Utilizing the ABCDE approach of the primary survey t identify and treat life-threatening problems, followed by the thorough head toe assessment of the secondary survey.

Knowledge and understanding of the physiologic changes of pregnancy are k to the successful resuscitation of the mother and her pregnancy.

Fetal outcome is dependent upon successful maternal outcome; resuscitate mother first, and then assess the fetus.

3 Transfer to Definitive Care

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3 Transfer to Definitive Care

The decision to transfer a patient to another facility for definitive care is influenced by the identified and suspected injuries, the expected progression of these injuries, and the capabilities on hand to expeditiously diagnose and treat them, especially the potentially life-threatening injuries.

3 Transfer to Definitive Care

bjectives

y the end of this interactive discussion, you will be able to:

- Identify injured patients who require transfer to definitive care.
- Describe the responsibilities of the referring and receiving doctors during the process of timely transfer.
- Identify patients who require further timely imaging and/or stabilization before transfer.
- Recognize the need to provide ongoing care during transfer.

eview Objectives

y the end of this interactive discussion, you will be able to:

- Identify injured patients who require transfer to definitive care.
- Describe the responsibilities of the referring and receiving doctors during the process of timely transfer.
- Identify patients who require further timely imaging and/or stabilization before transfer.
- Recognize the need to provide ongoing care during transfer.

ey Learning Points

Physicians must assess and realize the capabilities of their institution prior t the arrival of a traumatically injured patient.

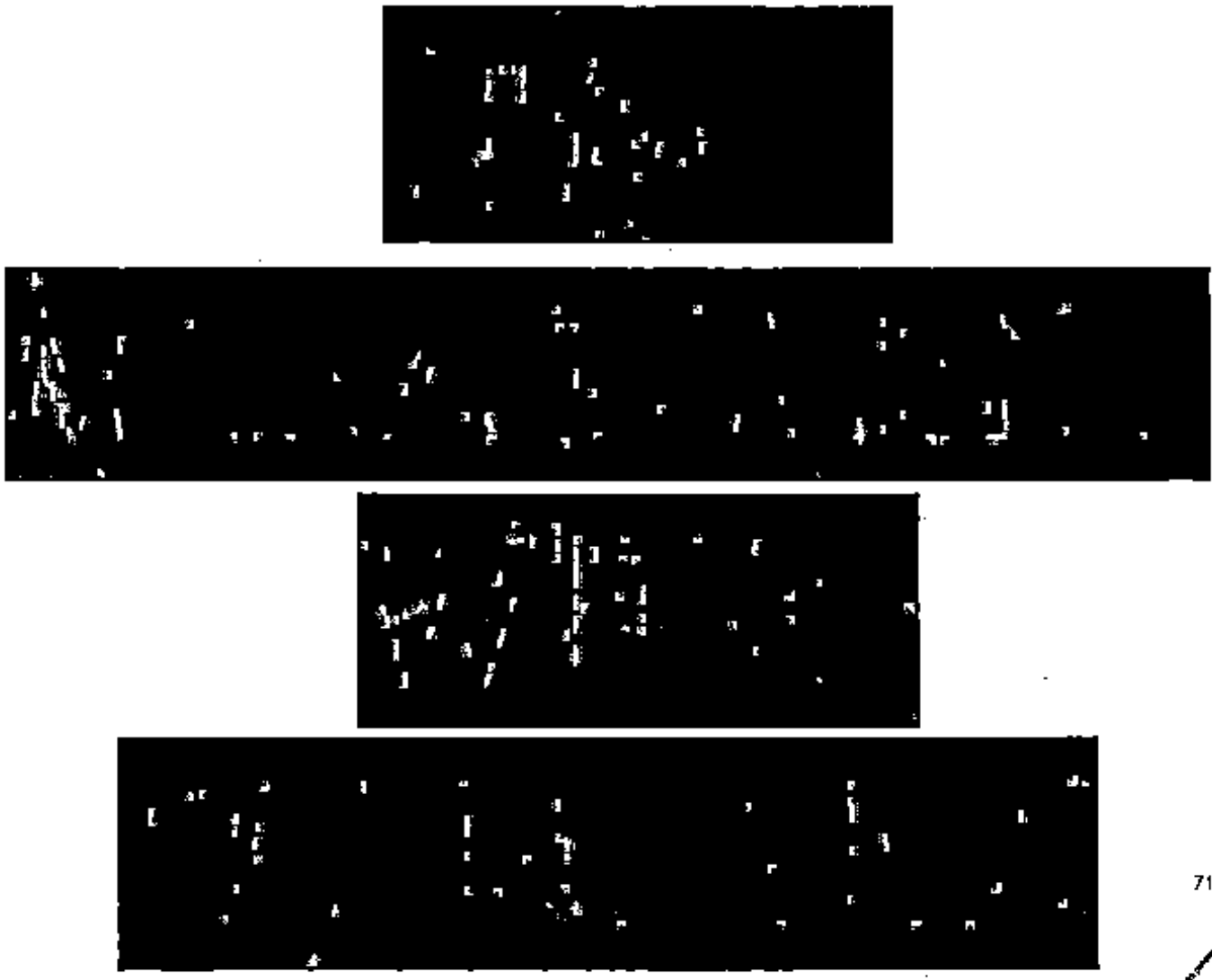
Because patient outcome is directly related to time elapsed between injury and appropriate definitive care, transfer agreements between institutions should be established and understood prior to their need for implementatior

Life-threatening injuries should be treated prior to transfer, to the extent possible with the capabilities of the transferring facility.

Mode of transportation should be determined by patient acuity and transpor availability. Appropriate personnel should be available for the safe and expeditious care of patients.

ey Learning Points

Transfer to definitive care should not be delayed for additional radiographic studies or to prepare for procedures that the transferring institution is not a to perform.



American College of Surgeons
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ATLS® Student Course Schedule

Mahatma Gandhi University Medical Sciences & Technology, Jaipur

y 1,

:0 - 0730 REGISTRATION / FACULTY :ETING/ BREAKFAST

0730 - 0745 **WELCOME & INTRODUCTION**

0745 - 0805 **ATLS® COURSE OVERVIEW**

0805 - 0845 **INITIAL ASSESSMENT A MANAGEMENT (Interactive Discussion)**

0845 - 0900 **INITIAL ASSESSMENT A MANAGEMENT DEMONSTRATION**

0900 - 0915 **CRITIQUE & DISCUSSION**

0915 - 0930 Break

0930 - 1000 **AIRWAY AND VENTILATO MANAGEMENT (Interactive Discussion)**

1000 - 1030 **SHOCK (Interactive Discussior**

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- 1110 **THORACIC TRAUMA (Interactive Discussion)**

- 1140 **ABDOMINAL& PELVIC TRAUMA (Interactive Discussion)**

- 1210 **PEDIATRIC TRAUMA (Interactive Discussion)**

– 1245 Lunch

-1645 **PRACTICAL SKILLS SESSIONS**

Skills Stations 60 minutes each for Stations

Station	Skills Stations Name	Faculty
on I	Basic/Advanced Airway Management	
on II	Breathing	
on III	Circulation	
on IV	Pediatric Airway and Surgical Cricothyrotomy	

Day 1, continued

1645-1700 Break

1700-1740 **PRETEST GROUP DISCUSS FACULTY**

1740-1750 **DAY'S SUMMARY/ADJOURN (ulty Meeting)**

2,

- 0730 **GOOD MORNING**

- 0800 **HEAD TRAUMA (Interactive ussion)**

- 0830 **MUSCULOSKELETAL UMA (Interactive Discussion)**

- 0900 **SPINE and SPINAL CORD**

TRAUMA (Interactive Discussion)

0900 - 0915 Break and move to skills sta

0915 - 1315 **PRACTICAL** **SK**
STATIONS each Rotations 60 min

Skill Station	Skills Stations Name	Faculty
Station V	Disability	
Station VI	Adjuncts	
Station VII	Secondary Survey	
Station VIII	Initial Assessment Practice and Team Training	

Practical Skills Stations Rotation Schedule

Time	Group A	Group B	Group C	Group D
0915 - 1015	Station V	Station VI	Station VII	Station
1015 - 1115	Station VI	Station VII	Station VIII	Statio
1115 - 1215	Station VII	Station VIII	Station V	Station
1215 - 1315	Station VIII	Station V	Station VI	Station

1315 - 1400 Lunch

- 1430 **GERIATRIC TRAUMA – (Inter-**
e Discussion)

- 1500 **THERMAL INJURIES – Inter-**
e Discussion

1530 **TRAUMA IN PREGNANCY –**
active Discussion

- 1540 Break

- 1610 **TRANSFER TO DEFINITIVE**
E - Interactive Discussion

1710 **TRIAGE SCENARIOS Discus-**

1720 **DAY'S SUMMARY / ADJOURN**
ılty Meeting)

Day 3,

[0630 – 0800]
- Moulage Patients
- All patient models and assistants]

0730 – 0800 Faculty meet with patients ar
sistants

0800 -1100 **SKILLS STATIONS**
(See page 9 and 10 for rotation s
ules)

Written Test
- Coordinator

Initial Assessment Skills Stations

0 – 0800 Faculty meet with patients and assants

0 -1100 **SKILLS STATIONS**
(See page 9 and 10 for rotation schedules)

Written Test
- Coordinator

Initial Assessment Skills Stations

Patient #1 **Patient**

Patient #3 **Patient#4**

) - 1130 **Post course Faculty Meeting**

Selection of Instructor Cou

Participants

1130 - 1200 **SUMMARY/CLOSURE**

GROUP PHOTO

American College of Surgeons

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ATLS® Instructor Course

ıedule

hatma Gandhi University Medical ences & Technology, Jaipur

DAY 1-

12:30-13:00	Registration & Lunch, Mento
Mentee Meeting	
13:00-13:30	Welcome, Introduction & Cou
Overview	
13:30-14:15	Adult Teaching & Learning
14:15-14:35	Interactive Teaching
14:35-15:15	Demonstration of Interactive
cussion	
15:15-15:35	Questioning Techniques
15:35-15:50	Break
15:50-16:25	Feedback
16:25-16:45	Micro Session Review and
cro Session Preparation	
16:45-18:15	Interactive Lecture Microteac
sessions	

(See rotation schedule) 6 IP cand dates

ROTATION SCHEDULES- MICRC TEACHING

0-13:30 Welcome, Introduction & Course view

0-14:15 Adult Teaching & Learning

5-14:35 Interactive Teaching

5-15:15 Demonstration of Interactive Dis-ion

5-15:35 Questioning Techniques

5-15:50 Break

0-16:25 Feedback

5-16:45 Micro Session Review and Mi-lession Preparation

5-18:15 Interactive Lecture Microteaching ons

(See rotation schedule) 6 IP candi-dates

:OTATION SCHEDULES- MICRO-TEACHING

DAY 2-

07:15 – 07:30 Welcome and Revie of Day #1

07:30-08:30 Interactive Lecture Micro teaching sessions

08:30-09:00 Principles of Teaching a chomotor Session

09:00-09:15 **Break**

09:15-10:00 Skill Station Demonstr tion and Preparation for Teaching

10:00 – 11:30 Practice Skill Stati (See Schedule)

11:30-12:00 **LUNCH**

14:05-14:30 Initial Assessment Preparation

14:30-16:00 Initial Assessment Practice (See Schedule)

16:00-16:15 Looking Back, Looking Forward

16:15-16:30 Course Summary, Closure and Student Evaluations

16:30-17:00 Post Course Faculty Meeting

ROTATION SCHEDULES- SKILLS STATIONS

Station I	Airway
Station II	Breathing
Station III	Circulation
Station IV	Disability