Tips for Trauma Surgery

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1. *Pre-Rounding:* I would arrive 15-20 minutes before the start time to print lists for everyone. We would divide the list in the AM, and I would prepare the notes for my patients.
    a. Things to check on prerounds: handover notes, vital signs, electrolytes, hemoglobin + hematocrit, input/output, bowel movement, gas, anything new overnight, notes from the previous day, housekeeping – DVTp status (DVTp held typically include neurosurgical patients), spine precautions, weight-bearing status, activity, diet, formed vs not formed, antibiotic courses.
    b. Post-op day 2: Remove head wrap, staples, etc.
    c. Drains: Use the 24 h output dot phrase on Epic, pressures, and height.
    d. Incisions: Clean? Dry?

2. *Rounding:* On the service I was on, you presented on the patients you pre-rounded on, took notes for those others prepped (for med students), and put in orders (for residents). If you prepped for the patient, you typically spoke to the patient with the update as well. The fellows would fill in anything missed.
    a. *New patients:* Be thorough with the presentation, i.e., ID + mechanism of injury + any psychosocial stuff (mostly suicide attempts, drug use, agitation), complete list of injuries, to-dos, people to call, follow-ups (e.g., outpatient clinic after discharge).
    b. *Old patients:* Brief ID + mechanism of injury + relevant psychosocial (e.g., active suicidal ideation, aggression towards staff, voluntary vs formed), investigations that have returned (e.g., imaging), new/ongoing to-dos.

3. *Ward stuff:* Things that are must-dos every day include updating handover, doing problem-oriented charting (i.e., updating the discharge summary), calling consultants, and checking on anything new.

4. *Exams:* Get good at primary (ABCDEs), secondary, and tertiary surveys. The easiest way to assess ABCs are to just talk to the patient. If they can talk, you know their airway is patent, they can breathe enough to speak, and their cardiac system is intact enough to be A/O x3 and hold a conversation. Having a good systematic head-to-toe approach is important so you don't miss anything.

5. *Procedures:* Brush up on suturing, hand ties, eFAST, chest tubes, needle decompression, tracheostomy, cricothyroidotomy, intubation, and thoracotomy. Also know their indications and information they provide. Bonus points if you know how to build your own chest tube suction system from scratch/the physics behind it.

6. *New consults:* Before every consult, I would read the patient's course in hospital. This would include items such as why were they admitted, why trauma consulted, the patient's home meds (especially ASA, blood thinners), previous consults, past medical history (e.g., psychiatric for self-inflicted injuries, steroid use for operative indications), social history, etc. I would also note down any relevant dates. During the consult, I would ask about HPI, blood thinners (including ASA), last meal work history, surgical history, (if relevant) cancer history, and (if relevant) family history, i.e., SAMPLE history.

7. *Use electronic resources:* I used the following resources to prepare and study for and during this rotation.
    a. ATLS guidelines.
    b. Western Trauma Association Algorithms.
    c. Epic templates from residents provide surprisingly solid learning.
    d. Spinal trauma stuff (e.g., Canadian C-spine rules, NEXUS criteria, spinal imaging).