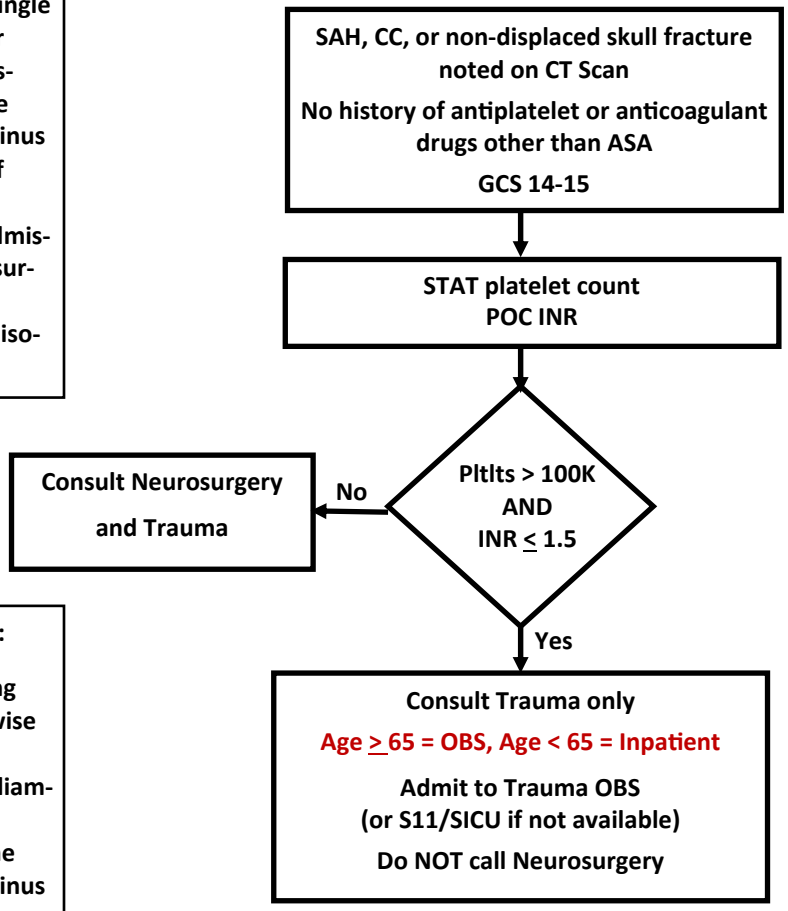
Clinical Practice Guideline

SAH / Cerebral Contusion / Skull Fracture

Definitions:

- **SAH must not involve the basal cisterns or sylvian fissures (no suspicion of aneurysm)**
- **Cerebral contusion must be single and < 1cm in largest diameter**
- **Skull fracture must be nondisplaced and cannot involve the posterior wall of the frontal sinus**
- **Pneumocephalus is allowed if only a few small bubbles**
- **Otherwise, call Trauma for admission. They will consult neurosurgery if needed.**
- **Observation unit preferred if isolated injury**



Trauma will call Neurosurgery for:

- **SAH that is central or involving the Sylvian fissure , or otherwise suspicious for aneurysm**
- **Cerebral contusion ≥ 1cm in diameter, or multiple contusions**
- **Skull fracture that involves the posterior wall of the frontal sinus**

NOTE: All admitted patients should be on Trauma Service. In rare event that patient has multiple/severe comorbidities, may admit to Medicine BUT Trauma must be consulted and follow until protocol is complete

	Orders
Vital signs	Telemetry q2° x 12°, then routine
Neuro/pupil checks	q2° x 12°, then routine
Diet	Regular
Lab	None
Activity	Up ad lib
Repeat imaging	None
TBI screen	Nursing (skull fx) or PT / OT / speech (blood present)
Thresholds	Call MD for SBP>150, P<60, or any decrease in GCS or change in mental status
Discharge criteria	Stable/improving mental status x 16°, screens passed, pain controlled
Followup	TBI clinic if positive TBI screen Neurology if seizure occurred due to TBI PMD recommended in all patients Neurology/neurosurgery if new or recurrent sx occur