Wounds at Specific Sites (https://galwayem.ie/guidelines/trauma-and-musculoskeletal/wounds-specific-sites)

Category
Trauma and Musculoskeletal (https://galwayem.ie/guidelines/trauma-and-musculoskeletal)

Scalp

In deep wounds, inspect the wound and put a gloved finger into the wound to detect any skull fractures. Close the wound with sutures or staples. The wound may be closed under tension to stop bleeding.

Face

It is important to get a good cosmetic result, so ask advice if you are not happy about any wound. Ask advice about any patient with skin loss.

Do **NOT** shave eyebrows, as they do not regrow well.

Significant facial lacerations in children are best sutured under a general anaesthetic. These are referred to the plastic surgeons. Beware of lacerations that might involve the parotid duct, facial nerve, tear duct, tarsal place, conjunctivae etc. Ask advice.

If a patient has a laceration of the eyelid - beware of penetrating eye injuries.

Penetrating wounds of the upper eyelid may fracture the roof of the orbit and cause intracranial injury.

Lips

The first suture should approximate the vermillion border on each side.

Nose and Ear

If the edge of the nostril or ear is involved, the first suture must approximate the edges to avoid a step.

Mouth

Most lacerations inside the mouth can be left unsutured and the patient told to wash their mouth out with water after meals until it is healed.

Significant lacerations should be sutured with an absorbable suture. Suturing may also be needed for haemostasis.

Anterior of wrist / palm of hand

Always examine all the tendons and nerves no matter how superficial the wound seems. Altered sensation is an indicator of nerve injury until proved otherwise.

Tendon, nerve and vascular injuries - Ask advice

Burst lacerations of fingers

Some wounds of the finger tips are caused by the skin “bursting” as a result of a major blunt force (e.g. a sledgehammer blow to a finger). There is often a fracture of the terminal phalanx and the wounds are frequently stellate with small flaps of dubious viability. These wounds always swell considerably. They should **not** be sutured but can be closed approximately with steristrips and given a high arm sling. All should be followed up in 3 to 5 days at the Review Clinic.

Lacerations involving nail beds

The full extent of the injury can often not be determined until the nail is removed. Therefore, remove the nail under ring block and repair the finger tip. The nail should be cleaned and replaced in the nail fold. Ask advice.

Pretibial lacerations

Only linear lacerations in young patients with good quality, full thickness skin should be sutured. Others, especially flap lacerations must not be sutured. They should be cleaned, and any non-viable tissue should be trimmed, haematoma removed from under the flap with irrigation and the flap straightened out, held in place with steristrips and then dressed. The leg should be bandaged, toe to knee. The patient should be instructed to keep the leg rested and elevated. Arrange to see in one week in Review clinic.

If there is a large area of skin loss ask advice about referral for a skin graft.

Vulval injuries in young girls

Usually "falling astride" injuries.

Minor and superficial injuries -

- Advise daily salt baths, give gauze to wear inside pants as a dressing, review in Review Clinic or GP as indicated.

More MAJOR wounds -

- It is important that the full extent of the wound is seen. This may be difficult to do in children and it will certainly be impossible to repair wounds other than under an anaesthetic. Therefore, refer to duty Gynaecologist for EUA/repair.

If you suspect sexual abuse, do not do a genital examination, but refer the child to the duty Consultant Paediatrician.
