Ashford and St. Peter's Hospitals NHS Foundation Trust

Paediatric Guideline:

Guidance for the Management of Wounds in Paediatric A&E

History

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Scope:

This guideline is for healthcare professionals who provide care for children presenting to Paediatric A&E with wounds. Refer to the Burns Guideline for the management of burns. To be used in conjunction with Patient Leaflets for Wound Care

Background:

Wounds are common in children and the majority heal well. The ideal management of a wound is to provide adequate analgesia to allow wound cleaning, exploration and neat closure in a manner that is acceptable to the patient and family.

Definitions:

Incision/cut- caused by a sharp object, will often have clean cut edges.

Laceration- caused by a blunt injury, causing the skin to tear. The edges may be irregular.

Puncture- penetrating wound, usually with a sharp object

Abrasion/graze- from blunt trauma

Assessment:

History should include the mechanism (sharp, blunt, bite, glass), when the wound occurred (>6hrs increases the risk of infection) and whether the wound is dirty or clean.

Examination should establish the site, size (length and depth) and presence of foreign bodies or contamination. Confirm that the area is neuro-vascular intact and tendons need to be assessed against resistance.

X-rays are required for wounds in which any radio-opaque foreign bodies (glass, metal) may have penetrated the skin. Wood cannot be viewed on an x-ray. Ultrasound can be considered if necessary.

Management:

Most wounds can be closed at the time of presentation (primary closure).

Wounds that are heavily contaminated, more than 12 hours old require senior advice regarding secondary closure and/or antibiotics.

1. Glue and Steri-strips

The majority of wounds can be closed with Steri-strips or tissue glue. Gluing is performed by nurses. Doctors without significant previous experience should not glue wounds.

Glue is usually used for cuts or wounds that are small or minor (up to 5cm long) and have straight edges that can be easily pulled together. Glue is often used to close wounds on the face or head, some parts of the arms and legs the trunk.

Glue should not be applied near the eyes, or over joints.

A patient information leaflet is available.

General advice is to avoid touching the wound for 24 hours and to keep the wound dry for 5 days. Steri-strips can be removed at home or by the practice nurse at the GP surgery after 5 days. Glue usually peels off in 5 to 7 days and does not require removal or follow up.

2. Suturing

Wounds over joints and wounds that are too deep or under too much tension to be held by other methods require suturing. The procedure should be discussed with the child and carer. Adequate analgesia must be given. Senior review and nursing support is essential.

3. Special considerations:

Some wounds are likely to require further assessment and may require specialist management. These include:

Facial injuries: Facial injuries, including the forehead, are the most cosmetically apparent and therefore require careful evaluation and repair, particularly in large or crossing langer's lines. Consider discussing facial wounds with maxillofacial doctors (at St Peters Hospital) and/or Plastic Surgeons (at St Georges Hospital).

Mouth injuries: External lip lacerations crossing the vermillion border should be discussed with Maxillofacial Surgeons. Lacerations to the mucosa of the mouth usually do not require treatment other than analgesia and good oral hygiene. Any large wound, through and through wound, or wound which continues to bleed should be discussed with the maxillofacial surgeons. Consider antibiotics for deeper wounds or those which look contaminated.

Injuries to the palate do not need treatment unless they are through and through.

Tongue lacerations will only require treatment if the tongue is split at the side or the tip, or there is a through and through injury.

If there is a dental injury, they can usually be managed by the child's own dentist. If an adult tooth is avulsed, it must be replaced immediately, splinted and referred urgently to Maxillofacial service.

Nail bed injuries: The nail bed is the tissue that sits between the fingernail or toenail and the underlying bone. This tissue helps the nail to grow normally and secures the nail plate to the fingertip or toe. Injury to the nail bed is very common in children, and occurs when fingers or toes are crushed or trapped by heavy objects. The underlying nail bed can be damaged even if there is little evidence of this to the nail. Signs of a nail bed injury include a loose nail or blood and/or bruising under nail.. These should be x-rayed to exclude any underlying fracture. Nail bed injuries should be referred to Plastic Surgery.

A subungal haematoma only needs to be trephined if it is causing pain.

External ear wounds: Wounds to the cartilage require discussion with the Maxillo-facial team.

Human and animal bites: People and animals have bacteria in their mouths, which can cause infection. Wounds require meticulous cleaning and antibiotics (Co-Amoxiclav) should be prescribed. The edges should not be closed completely. Discuss with Plastic surgeons if there are extensive wounds.

Tetanus: Wounds heavily contaminated with soil and deep penetrating wounds where removal of soil is not possible are a risk for tetanus. Decide on the tetanus risk and then follow immunisation advice according to the tetanus immunisation status of the patient. Most children who have received primary immunisations do not require a tetanus booster. Confirm with teenagers that a booster has been given in school. A booster may be given up to 72hrs after the injury.

Follow up:

Advise all patients to seek medical attention if the wound splits open or starts to bleed or looks infected. Symptoms of a wound infection may include increased swelling or erythema, increased pain, pus or blood leaking from the wound and a temperature of 38C or over.

Reference

www.nhs.uk