Commentary on the Israeli Head Injury Guidelines

"You aint going anywhere kid. You ought to go back to driving a truck".
Jim Denny, Director of the Grand Ole Opry, to Elvis Presley in 11954.

"If you are very clever, if you have a brain, then you don't understand anything".
AA Milne. Winnie the Pooh

There are definite problems if you create a protocol that is the result of a Delphi panel. That is a panel of experts who base their recommendations on experience only. The most glaring example of this was a recent protocol on PE in which critical elements such as pleuritic chest pain and dyspnea were left out. What results is a protocol that becomes a standard of care without firm evidence, with all its legal reverberations. (1)

That said, the protocol created by the Israeli Association of Neurosurgeons is not that bad. True, there is not much evidence around, but I do hope the Israeli Medical Association will be flexible enough to adapt to new evidence, although I am skeptical. As of yet, real evidence protocols, such as the Ottawa Ankle rules, have not been adopted. In addition, although it is self serving, it must be pointed out that emergency physicians know a lot more about this problem than neurosurgeons - we see many more mild head injuries than they do.

Let us look at the protocol closely. The most problematic part is the way it has been interpreted by physicians in the ED. Basically, emergency physicians and radiologists have found this protocol to mean it is the standard of care for all people over seventy and all under 2 to be imaged. This has resulted in a massive number of CTs that are negative, with all the costs involved. While it is true that as of now we can predict which of the elderly are at risk to have a positive CT (2), we pretty much have an idea on a subset of patients that we can clinically guess will have a normal CT. But this is not the point. We must recognize that most CTs done immediately after minor head trauma in a patient with a GCS of 15 are normal and those that do badly usually do so 24 hours later when the CT has become positive. This is true even of coumadin treated patients who also tend to have their bleeds by drips and not by splashes (3). Therefore, it seems reasonable that observation with a good relative or friend may suffice provided detailed instructions are given.

Many patients are poor surgical risks and even if they have a massive bleed, the care will be conservative as the surgery itself will kill them faster. These people do not need imaging, but as one fellow EP told me - who wants to defend this in a peer review?

Children are a different issue and Dr. Amir has reviewed their protocol in this issue. Parents are well aware that the sedation to give for such scans is more dangerous then the likelihood of a bleed and are usually willing to forgo the imaging.

The guideline recommends neurosurgical consultation but wide scalp lacerations and CTs that are pathological (such as contre coup) but only need conservative treatment gain little by these consultations. Once again, interpretation of the protocol has led to excesses. Patients are transferred long distances for a consultation that could have been done by telephone and then have to be transferred back. This is not always in the patient's best interest..

We live in a litigious atmosphere that is not much different to that in the USA in this matter and protocols such as these just make things worse for patients. This is due to over defensive physicians. So let us leave it as is - it is a good effort for a first time. We need to be able to change with the new evidence coming through. Tomorrow will be here sooner than you think. Be prepared.

References

1. Trowbridge, RL et al Does This Patient Have Acute Cholecystitis JAMA 289(1) 84 1 Jan 03
2. Mack, LR et al The Use of Head CT in Elderly Patients Sustaining Minor Head Trauma J Emerg Med 24(2):157 2003
3. Hoffman J, Bukata, R Emergency Medicine Abstracts 2002

Joseph B. Leibman, MD
Editor in Chief