Textbook of
ADULT EMERGENCY MEDICINE

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Sixth Edition

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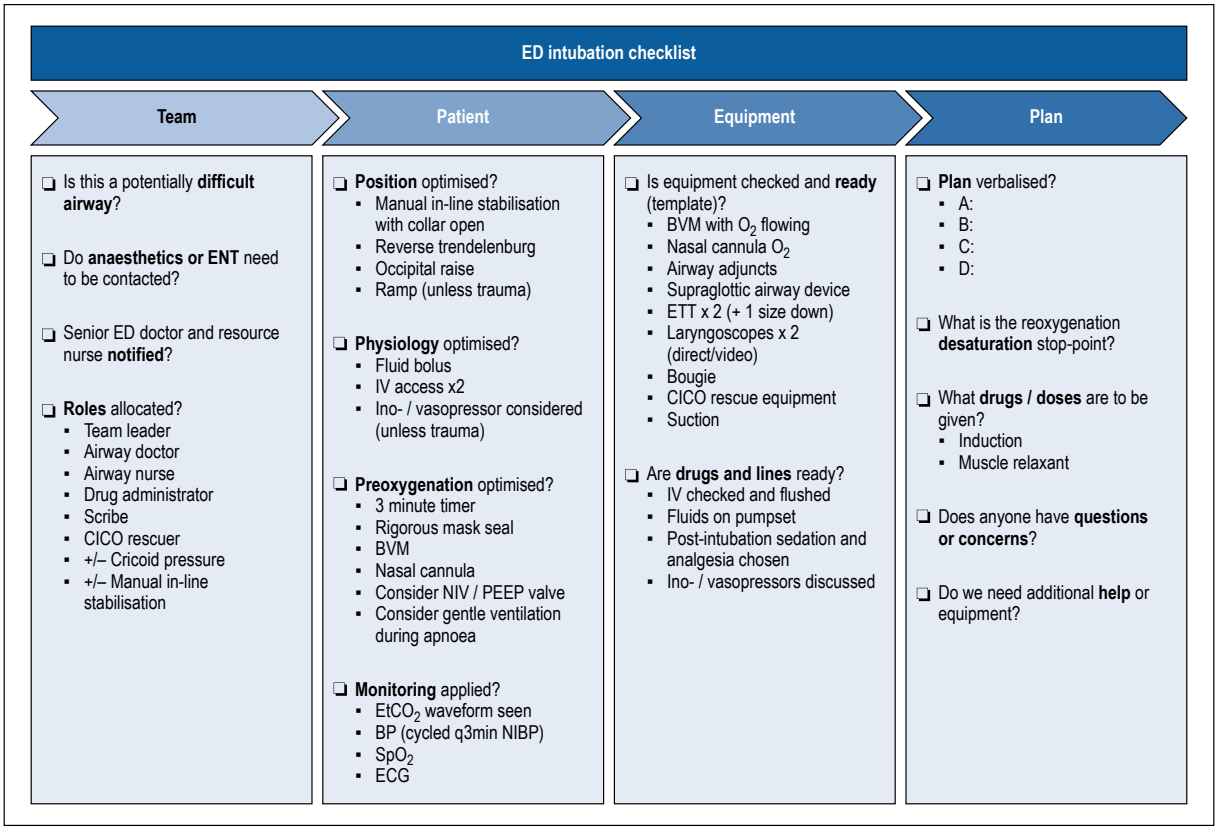

FIG. 2.1.3 **Example of an emergency department *(ED)* intubation checklist.** *Bp*, Blood pressure; *BVM*, Bag-valve-mask; *CICO*, can't intubate can't oxygenate; *ENT*, ear, nose and throat; *EtCO2*, end-tidal carbon dioxide; *ETT*, endotracheal tube; *NIBP*, noninvasive blood pressure; *NIV*, noninvasive ventilation; *O2*, oxygen; *PEEP*, positive end-expiratory pressure; *SpO2*, peripheral capillary oxygen saturation.

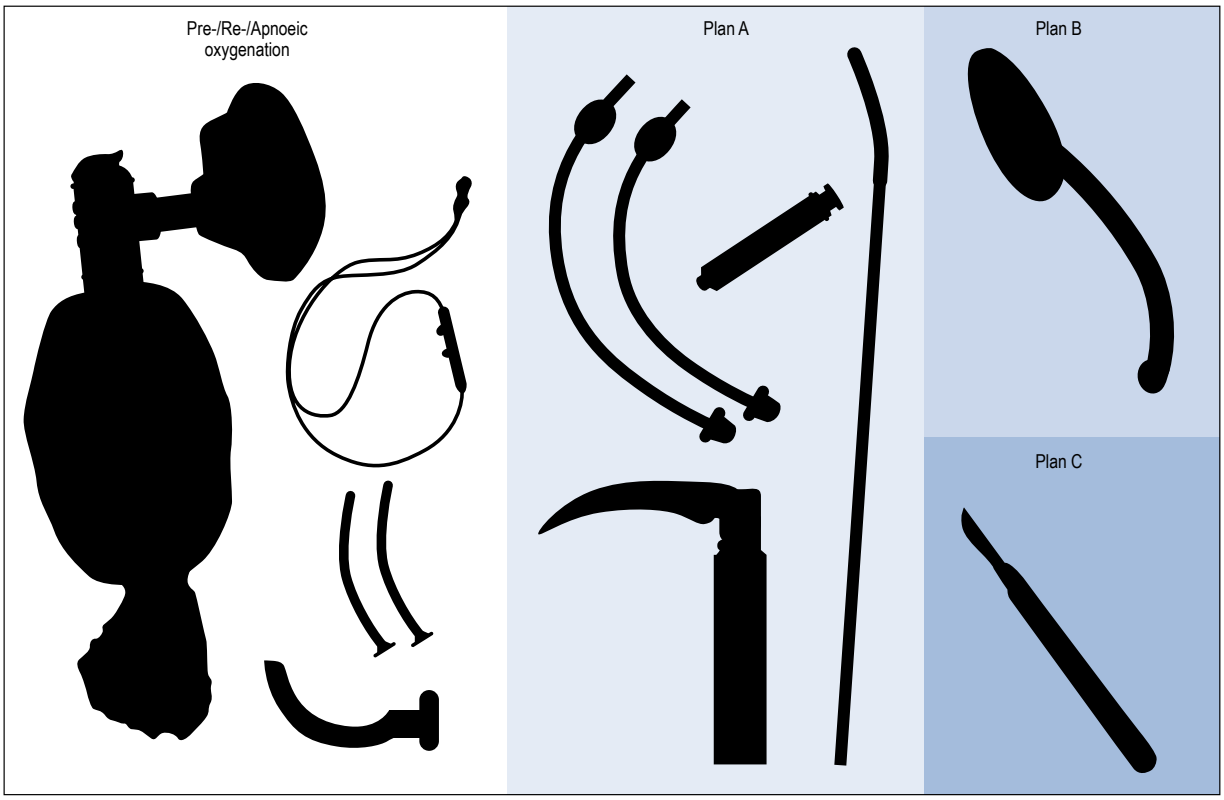

FIG. 2.1.4 **Emergency department Rapid-Sequence Intubation kit dump.**

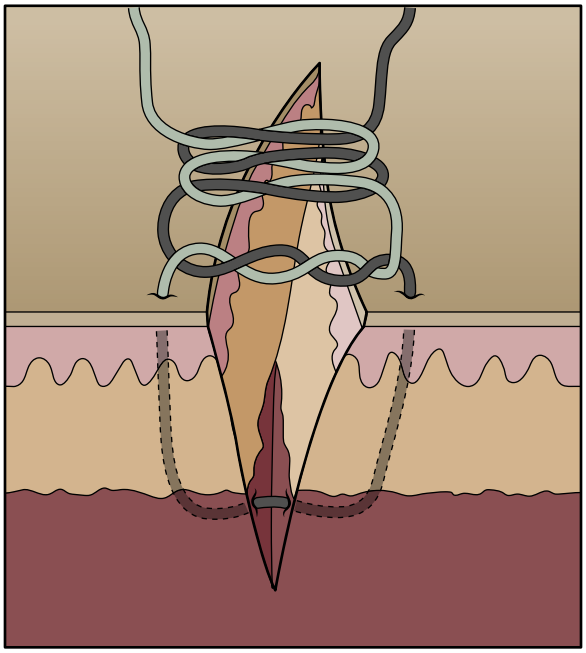

FIG. 3.10.10 The loop suture method of avoiding excessive tension on a stitch. (From Patel PR, Miller MA. Postcare recommendations for emergency department wounds. *Emerg Med Clin North Am.* 2007;25[1]:147–58. From an original drawing by Elaine Wheildon.)

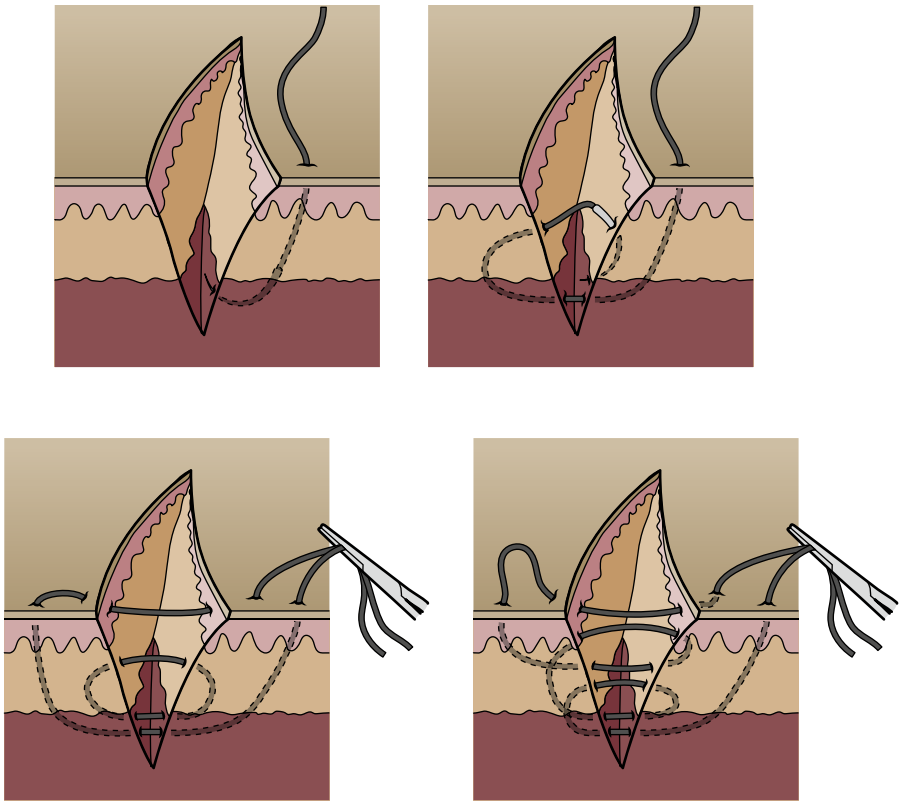

FIG. 3.10.11 A deep closure method utilising a variable number of loops, modified from a Mayo Clinic stitch. (From Drake DB, Gear AJ, Mazzarese PM, Faulkner BC, Woods JA, Edlich RF. Search for a scientific basis for continuous suture closure: a 30-yr odyssey. *J Emerg Med.* 1997;15[4]:495–504. From an original drawing by Elaine Wheildon.)

Table 3.10.3 Complications of facial wounds

Complications	*Notes*
	Potentially fatal owing to the valveless venous communication
Arteriovenous fistulae	Due to profuse vascularity—uncommon
Scarring	Producing facial asymmetry and cosmetic implications
Deformity	Due to unrecognised fractures, such as of the nose or malar bone
Facial palsy	Due to damaged facial nerves
Epiphora damage	With tissue loss or scarring everting the lower lid, or canaliculus
Salivary fistula	After disruption of the parotid duct
Drooling	With tissue loss, scar contracture or local nerve damage
Corneal exposure	With tissue loss, scar contracture or local nerve damage

there is evidence of a poor correlation with wound appearance 6–9 months later in head and neck wounds. The degree to which different factors such as wounding mechanism, wound repair technique and patient host factors have a role remains to be determined.[41]

All percutaneous stitches will cause needle marks if left in situ longer than 8 days, as epithelium migrates down the needle track. Removal too early predisposes to wound dehiscence (Fig. 3.10.15); however, the wound may be supported by skin tapes. If tapes were the primary method of closure, they may be left on for at least 10 days or until they fall off, provided that the skin is not sensitive to the adhesive, as evidenced by erythema or bulla formation.

Suture removal technique is also important. To avoid tissue trauma and additional scarring, stitches should be cut at the knots with iris scissors after gentle washing with saline to remove suture scissors are too big for the task.

Newer techniques of wound closure

Knotless barbed sutures are being used in select procedures, and studies have shown them to reduce suturing time, facilitate effective wound closure and minimised knot-related complications.[42] Absorbable staples are being used in some surgeries but are yet to show any clinical benefit over standard techniques.[43]