



Clinical Practice Procedures: Trauma/Facial packing

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Scope	Applies to Queensland Ambulance Service (QAS) clinical staff.
Health care setting	Pre-hospital assessment and treatment.
Population	Applies to all ages unless stated otherwise.
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Facial packing

February, 2021

Maxillofacial trauma is a potentially life-threatening trauma emergency due to the risk of major haemorrhage and airway obstruction through the following mechanisms:^[1]

- Posteroinferior displacement of a fractured maxilla may block the nasopharyngeal airway.
- A bilateral fracture of the anterior mandible may cause the mandible and tongue to slide posteriorly and block the oropharynx.
- Fractured teeth, bone fragments, vomitus, blood, and secretions as well as foreign bodies may block the airway.
- Haemorrhage from open wounds or severe vascular injury within the mid face may also contribute to airway obstruction.
- Soft tissue swelling and oedema may cause delayed airway compromise.
- Trauma of the larynx and trachea may cause swelling and displacement of structures, increasing the risk of cervical airway obstruction.

The goal of management in major maxillofacial trauma is to provide haemorrhage and airway control through endotracheal intubation and splinting of the midface to reduce fractures.^[1]

Indications

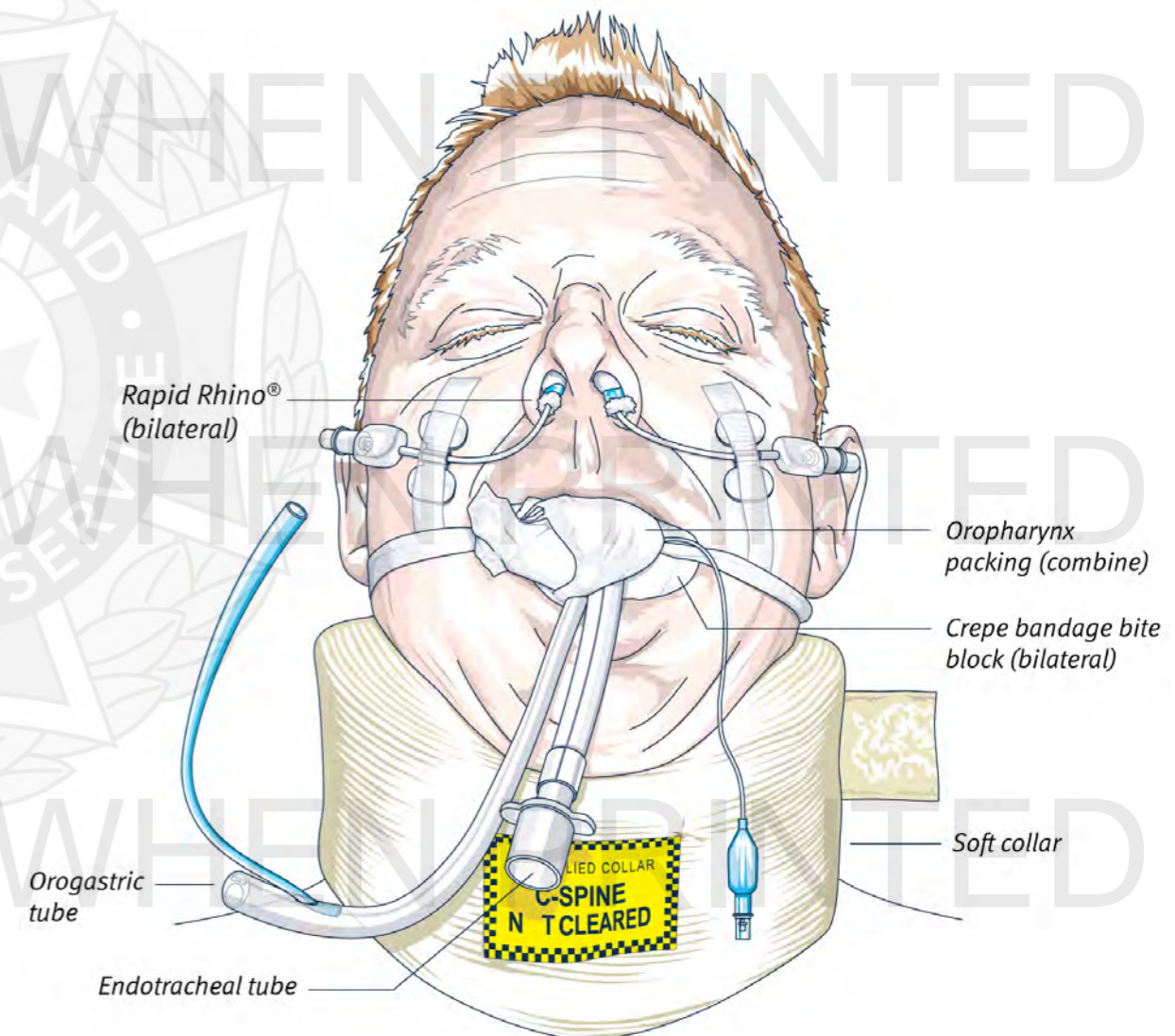
- The major maxillofacial trauma patient with threatened or confirmed airway obstruction **AND/OR** major haemorrhage

Contraindications

- Nil in the setting of acute facial trauma that satisfies the indications above.

Complications

- Migration of Rapid Rhino[®] posteriorly or through a base of skull fracture
- Aspiration/ingestion of bite blocks and/or oropharyngeal packing



Procedure – Facial packing^[2,3]

1. Establish a secure airway with the insertion of an endotracheal tube.

Consider:

- i. SSCOR DuCanto suction catheter™ use to clear gross airway contamination.
 - ii. Induction of anaesthesia while the patient is semi upright or in a position of comfort, to maintain airway patency.
 - iii. Primary surgical cricothyrotomy **OR** small bore transtracheal ventilation or early transition if unable to intubate or oxygenate (refer to *CPP: Airway/Surgical cricothyrotomy OR CPP: Airway/Small bore transtracheal ventilation*).
2. Insert orogastric tube (refer to *CPP: Other/Orogastric tube insertion*).
 3. Insert bilateral bite blocks (7.5 cm crepe bandages cut in half) – to maintain reduction and prevent migration of the midface.
 - i. Ensure anatomical alignment of the maxilla – gentle repositioning of the mandible with forward traction may be required.
 - ii. Insert an appropriately sized crepe bandage bite block on either side of the mouth between the rear molars to brace the hard palate against the lower jaw.
 4. Apply a cervical collar to brace the mandible (refer to *CPP: Trauma/Cervical collar*).
 5. Apply direct pressure haemorrhage control by packing the oropharynx with combine dressing.
 6. Consider using Rapid Rhino® RR 550 nasal packs to splint the midface and reduce fractures (refer to *CPP: Trauma/Nasal pack*).

+ Additional information

- If fracture separation occurs consider deflating the Rapid Rhino® RR 550 and making sequential adjustments.
- Ensure the number of bite blocks and combine trauma dressings used for pharyngeal packing are communicated to the receiving medical team and documented clearly on the eARF.
- Avulsed teeth should be placed in a suitable medium (sodium chloride 0.9% or milk) and transported with the patient for possible replantation (refer to *CPG: Trauma/Dental injury*).