University of Georgia Sports Medicine
Suspected Spinal Injury Protocol

Revised June 30, 2005

General Guidelines

- Any athlete suspected of having a spinal injury should not be moved and should be managed as though a spinal injury exists. C-spine in-line stabilization should be maintained.
- The athlete's airway, breathing, circulation, level of consciousness (AVPU/Glasgow Coma Scale) and neurological status should be assessed. If airway is impaired, maintain c-spine in-line stabilization simultaneously with airway using a modified jaw thrust maneuver. If the athletes breathing is inadequate, assist ventilations with bag-valve-mask and supplemental oxygen.
- EMS should be activated.
- The athlete should not be moved until immobilized unless absolutely essential to maintain airway, breathing and circulation. If the athlete must be moved, the athlete should be placed in a supine position while maintaining spinal immobilization.
- In a situation where it may not be appropriate for on-site medical personnel to transfer the athlete to a long spine board prior to EMS arrival (lack of enough qualified help or other factors), the rescuer(s) should maintain in-line stabilization, place a rigid cervical collar on (if possible), and continue to monitor baseline vital signs and complete secondary evaluation while awaiting EMS.

Spine Immobilization

- If possible, a correctly sized rigid cervical collar should be placed on athlete prior to moving.
- When moving a suspected spine-injured athlete, the head and trunk should be moved as a unit by securing the athlete to a long spine board. Log-roll maneuver should be used to place the athlete on the long spine board. It is ideal that at minimum three (3) rescuers with preferably five to six (5-6) be in place to perform the log roll procedure.
- The rescuer controlling c-spine stabilization will be in command of log roll maneuver and long spine board immobilization.
- Once positioned onto long spine board, the athlete's torso and legs should first be secured, using spider straps or speed clips (if speed clips are used, 5 straps should be applied: 2 crossing chest from shoulder to opposite axilla, one across chest under axilla, 1 across pelvis, and 1 across distal thighs). Athlete's arms should be left free from long spine board straps to facilitate vital sign monitoring and IV access. Athlete's wrists may be secured together in front of the body with velcro strap or tape once secured to long spine board.
- Once torso and legs are secured, the head should be secured last. If necessary, padding should be applied under the athlete's head to fill any voids and maintain

neutral in-line position. The head should be secured with lateral restraint pads and then secured to board with tape over forehead and at chin.

- Following securing athlete to board, neurological status should be reassessed.
- The secondary survey should be completed with baseline vital signs (reassessed every 5 minutes), head-to-toe survey, and SAMPLE history.
- Athlete should be transported to the most appropriate emergency medical facility and head team physician and appropriate subspecialist(s) notified.

Additional Guidelines For Care of Spine-Injured Football Athlete

- The facemask should be removed prior to transportation, regardless of current respiratory status. Tools for facemask removal (FM Extractor, Anvil Pruners, or ratcheting PVC pipe cutter) should be readily accessible.
- All loop straps of the facemask should be cut and the facemask removed from the helmet, rather than being retracted.
- The **football helmet and chin strap should only be removed if:** 1) the helmet and chin strap do not hold the head securely, such that immobilization of the helmet does not immobilize the head; 2) the design of the helmet and chin strap is such that, even after removal of the facemask, the airway cannot be controlled nor ventilation provided; 3) the facemask cannot be removed after a reasonable period of time; or 4) the helmet prevents immobilization for transportation in an appropriate manner.
- If the helmet must be removed, spinal immobilization must be maintained while removing. In most circumstances, it may be helpful to remove cheek padding and/or deflate air padding prior to helmet removal.
- Shoulder pads do not necessarily have to be removed on site. The front of the shoulder pads can be opened to allow access for CPR and defibrillation.
- Should either the helmet or shoulder pads be removed – or if only one of these is present- appropriate spinal alignment must be maintained.

Procedures for Training in Spine Immobilization:

Personnel should review signs and symptoms of spine injury and complete a training session each year with in-line stabilization, rigid cervical collar application, log roll maneuver, and long spine board packaging. Personnel providing football medical coverage should review facemask removal with appropriate tools, helmet removal and shoulder pad removal.

Approved by: _____ ***Medical Director Date:*** _____
Fred Reifsteck, M.D.

Approved by: _____ ***Neurosurgeon Date:*** _____
Kim Walpert, M.D.