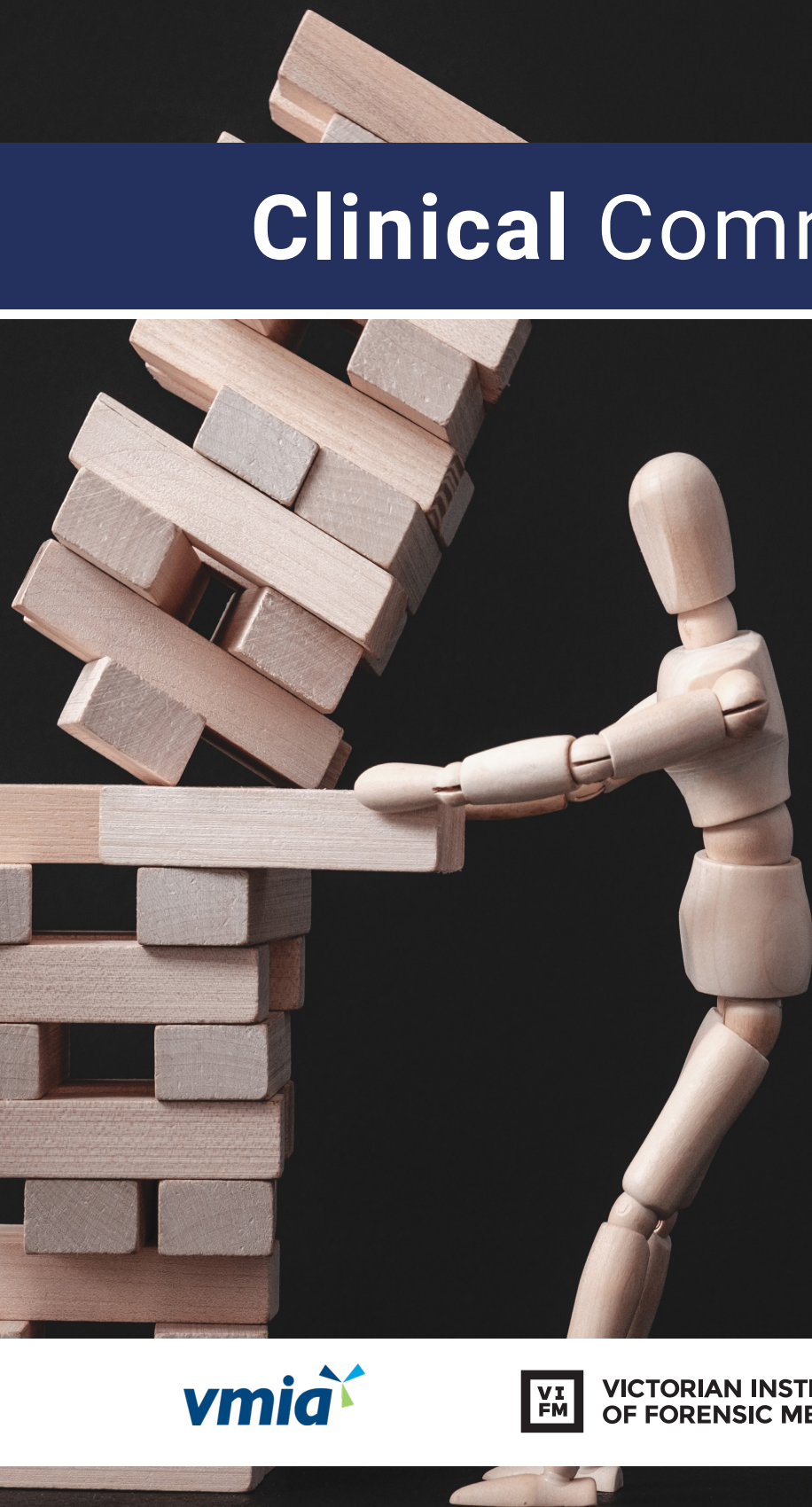


# Clinical Communiqué >



Next Edition: June 2022

# Editorial

Dr Nicola Cunningham

Welcome to the March 2022 edition of the Clinical Communiqué. Whereas our [previous edition](#) focussed on paediatric patients and the difficulties in assessing symptoms and signs in the younger age-group, this edition looks at some of the specific challenges clinicians face in assessing older patients.

We present two case summaries of falls in the older patient that resulted in chest or head injuries. In each case, the extent of injury was not fully appreciated until it was too late. This occurred in one case because a radiological investigation was not ordered that would have identified areas of concern, and in the other, because a clinician was not aware of the significance of the presentation and the associated risks of complications in that age group of older patients. In addition to the case summaries, are two case vignettes, that reiterate how common falls in the older person are, with important messages about primary and secondary prevention of falls in the older person.

Our expert commentary has been written by Dr Glenn Arendts, a specialist emergency physician with extensive clinical and research experience in the care of the older person. Dr Arendts holds prominent roles in the development of best practice guidelines for the management of acute geriatric syndromes at local, national, and international levels. Bringing attention to the size and complexity of the problem, he provides practical measures to deal with the low signal/high noise scenario of a fall in the older patient. He astutely highlights the importance of retiring a commonly used phrase to reduce the risk of anchoring bias in the clinical care of these patients.

The best management strategy for falls in the older person is to prevent the falls from occurring. The [February 2022 edition](#) of the Residential Aged Care Communiqué provides a comprehensive overview of this area of work by presenting another two cases of falls in residential aged care settings, followed by expert commentaries that skilfully enunciate the need for a multifactorial approach to falls prevention.

The number of falls a person has increases with age and with their level of frailty. Older adults are more susceptible to injury from lesser mechanisms of trauma than younger adults. Once a patient falls, the odds of preventable mortality increase with age. The presence of frailty, increasing age, and fall frequency, act synergistically to form a potent combination of risks. This edition looks at the health consequences of falls in the older person – specifically the importance of appropriate investigation, diagnosis, and multidisciplinary treatment of older trauma patients. Recognition of the risks of anticoagulant medication, trauma call criteria that incorporate age, lower thresholds for advanced imaging, and early involvement of specialists in treating older trauma patients are important factors in reducing preventable harm.

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## FEEDBACK

The editorial team is keen to receive feedback about this communication especially in relation to changes in practice. Please contact us at:  
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# Editorial (continued)

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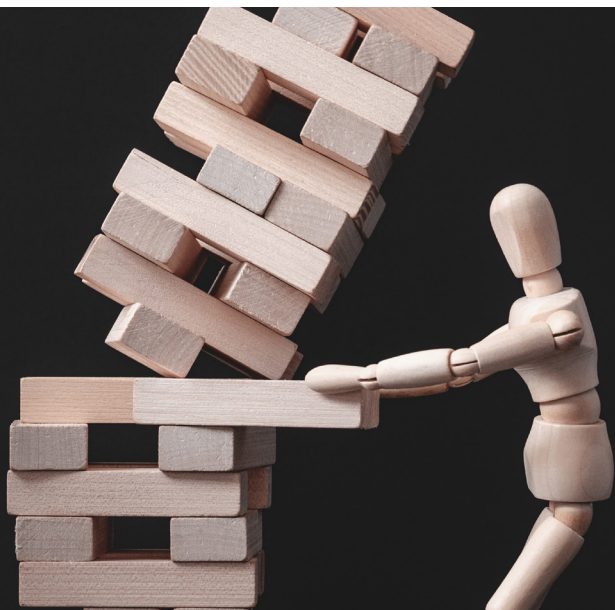
Major trauma in the older adult population is on the rise. In Victoria in the 2019-20 period, the most common cause (35%) of hospitalised major trauma was falls from a low height (<1m) and 80% of those hospitalisations were adults over the age of 65 years. More than half of that group (54%) sustained a head injury. Falls were the most common cause of all injury deaths (46.1%). It is imperative that as clinicians, we pay close attention to our patients that are at risk of falling, or who have suffered a fall. This is an area of medicine where small changes in our processes could result in substantial improvements to health outcomes for older adults.

## Resources

Ang D, Nieto K, Sutherland M, O'Brien M, Liu H, Elkbuli A. Understanding Preventable Deaths in the Geriatric Trauma Population: Analysis of 3,452,339 Patients from the Center of Medicare and Medicaid Services Database. *The American Surgeon*. November 2021. doi:10.1177/00031348211056284

Victorian State Trauma Registry Annual Report 2019–2020, Melbourne, Victoria. Available at: <https://www.monash.edu/medicine/sphpm/vstorm>.

Victorian Injury Surveillance Unit. Fall-related injury profile for Victorians aged 65 years and older. *Hazard* 2015 Edition 80. Monash University Accident Research Centre (MUARC). Available at: [https://www.monash.edu/\\_data/assets/pdf\\_file/0003/455961/Monash-Uni-Hazard-Issue-80-summer.pdf](https://www.monash.edu/_data/assets/pdf_file/0003/455961/Monash-Uni-Hazard-Issue-80-summer.pdf).



# Case #1 Don't fall for it: Fall injuries in the older person are serious

Case Number  
5/2018 SA

Case Précis Author  
**Dr Rachel Marr**  
MBBS (Hons) FRACGP  
General Practitioner and Forensic  
Physician

## i. Clinical Summary

Mr GC was an 81 year old well and active man with a past history of hypertension, type 2 diabetes and gout. He presented to the local regional hospital after pruning a tree and falling from a ladder onto soft ground from a height of approximately 1.5m. Following the fall, he reported right-sided chest pain.

On the day he presented, Mr GC was assessed by Dr R, a rural general practitioner (GP) registrar who was on-call for the hospital. Dr R found no clinical evidence to suggest Mr GC had a

pneumothorax (collapsed lung) or pneumonia. Dr R requested a chest X-ray; however, this service was not available as it was a Sunday and so the X-ray was deferred to the next day. Mr GC was admitted to the hospital for observation and to await further investigation. When the X-rays were done and reported the next day, they showed fractures to the right ribs from the 2nd to 11th ribs. The report was seen by Dr W, another GP from the same clinic as Dr R, who was the duty doctor for the hospital that week.



Mr GC was provided with analgesia (pain-relieving medications) for his chest pain. His stoic disposition meant that it was difficult to gauge his level of pain, but over the coming days he required large doses of analgesia and looked more uncomfortable than expected.

A CT scan of Mr GC's chest, abdomen and pelvis done on day 4 of his admission showed nine right-sided rib fractures as well as fractures to three of Mr GC's thoracic vertebrae. Bilateral pleural effusions were also seen (fluid between the lung and the chest wall) with associated atelectasis (compression/collapse of parts of the lungs).

On day 5 of Mr GC's admission, a covering GP (Dr C) took over his care and became concerned about his condition. Mr GC was grey and sweaty, extremely breathless, and barely able to speak due to pain. Dr C organised for him to be urgently transported to a major trauma centre by helicopter. Once there, Mr GC was found to be in profound shock with associated kidney failure.

Despite intensive medical care, Mr GC continued to deteriorate over the next 24 hours and the treating

team discussed comfort measures with his family. Mr GC was palliated and died later that day.

## ii. Pathology

Mr GC's cause of death, as determined from his medical records, was multi-organ failure complicating multiple right-sided rib fractures due to a fall from a ladder.

## iii. Investigation

A coronial inquest was held to consider several issues, including whether:

- Mr GC was diagnosed in a timely manner;
- His treatment at the regional hospital was timely and appropriate;
- His deterioration was foreseeable;
- He should have been transferred to the tertiary hospital upon the diagnosis of multiple rib fractures;
- His death was preventable; and
- The general public should be educated about the dangers of older adults using ladders and working from heights.

An intensive care physician gave evidence at the inquest that rib fractures in older persons can cause pneumonia, acute respiratory distress syndrome, pulmonary embolism (clot in the lungs), pneumothorax (collapse of the lung, for example when a fractured rib punctures the lung), aspiration and atelectasis. The intensive care physician also noted that older

patients with rib fractures are more likely than younger patients to suffer significant complications; take longer to heal; and may require intravenous infusions of analgesia to adequately control the associated pain. Once Mr GC's multiple rib fractures were identified the day after his fall, he should have been transferred to a tertiary hospital for further management. The intensive care physician testified that had this occurred, it was 'very likely' Mr GC would have survived his injuries.

### The lack of availability of X-ray services over the weekend at the regional hospital was considered by the coroner.

Dr W explained that he had not been aware of the evidence that multiple rib fractures in older patients are a significantly more serious issue than they are in the younger population and require care in a tertiary hospital with medical staff who are experienced in managing trauma patients. Dr W considered the small pleural effusions with associated atelectasis seen on CT to be minor and would not have impaired ventilation or breathing. Mr GC's vital signs had been "normal" up until he was seen by Dr C on day 5 when he was transferred to a tertiary hospital.



The lack of availability of X-ray services over the weekend at the regional hospital was considered by the coroner. This meant that Dr R did not see the X-ray result and that Dr W saw the result the day after Mr GC's fall. Dr R gave evidence that had the X-rays been

taken more promptly, he would have arranged for Mr GC to be transferred to a tertiary hospital or at least sought specialist advice with regards to managing him. Dr R further explained that the local GPs had been trying to have radiological services to the area improved for some time.

During the inquest, evidence regarding the use of ladders by older adults was presented which demonstrated a need for ladder safety education among

older adults; namely the use of a supervising person, ladder placement and safe practices with regards to reaching from ladders.

## iv. Coroner's Findings

The coroner found that:

- Mr GC's diagnosis was delayed because the X-rays could not take place until the day after he presented. Once his rib fractures were diagnosed, Mr GC should have been transferred to a trauma centre. The fact that this did not occur was the main reason Mr GC did not survive his injuries.
- As a result of Dr W not appreciating the seriousness of Mr GC's injuries, nor for the potential for those injuries to cause life-threatening complications, Mr GC remained in a low acuity regional hospital until he was critically unwell. His transfer to a trauma centre on day 5 was too late to save his life.

The coroner made the following recommendations to the local health network and the Australian Medical Association:

- That weekend and after-hours radiological services be made available at the regional hospital.
- That the diagnosis of multiple rib fractures in older adults should be made in a timely manner and if in a regional setting, should prompt a request for advice from, and/or transfer to a trauma centre.
- That medical practitioners, especially those working in regional areas, should be educated regarding the seriousness of multiple rib fractures in older patients.
- That there should be a public advertising campaign regarding the dangers of the use of ladders by older adults.

## v. Author's Comments

It is important that when assessing an older person after any injury, even a seemingly trivial one, there is a low threshold for investigation, admission, and referral. Injuries such as fractures and concussions can be relatively minor and self-resolving in young adults, but in older adults, such injuries can more readily evolve into debilitating and fatal complications.



Early diagnosis and aggressive pain management strategies are key in the optimal management of chest trauma.

Ultrasound-guided nerve blocks and patient-controlled analgesia are two advanced multimodal options for pain-relief that should be considered from the outset.

## vi. Resources

1. Bulger EM, Arneson MA, Mock CN, Jurkovich GJ. Rib fractures in the elderly. *J Trauma*. 2000; 48(6):1040-1046.
2. Llompарт-Pou JA, Pérez-Bárcena J, Chico-Fernández M, Sánchez-Casado M, Raurich JM. Severe trauma in the geriatric population. *World J Crit Care Med*. 2017; 6(2):99-106.

## vii. Keywords

Falls, rib fractures, older adult, trauma, X-rays, chest pain, regional

# Case #2 Tunnel vision strikes again

Case Number  
2021 TASCD 267

Case Précis Author  
**Ms Libby Newman**  
Clinical Nurse Specialist  
Forensic Pathology, MPH, RN,  
DHSc (Pre-Hospital Care)

## i. Clinical Summary

Mr BL was an 81 year old man who lived independently in a retirement village. His main medical complaint was hypertension and he enjoyed relatively good health. In the final twelve months of his life, however, his mobility had deteriorated, and he had lost weight.

While out shopping one day, Mr BL was pushing a shopping trolley with a shuffling gait when his legs began to shake, and he fell to the ground. An ambulance was called, and he was transferred to the local regional hospital's emergency department. He was confused and had bruising to the back of his head and arms. He complained of

chest pain later in the evening and was reviewed by the cardiology team. An electrocardiograph (ECG) did not show any evidence of cardiac ischaemia. Anticoagulation medication was commenced, and Mr BL was admitted to the hospital.

Two days later Mr BL complained of a headache and was given paracetamol. Shortly afterwards he was discovered slumped over in bed, unresponsive. A CT scan of Mr BL's head taken after this demonstrated an extensive right-sided subdural haemorrhage. He was palliated and died later that night.

## ii. Pathology

Mr BL's cause of death following post-mortem examination was acute subdural haematoma, in the setting of a closed head injury sustained in a fall from standing height. Significant contributing factors were identified as frailty of age and hypertension.

## iii. Investigation

Mr BL's death was reported by the hospital to the coroner as it was unexpected and the result of an accident or injury.



The coronial investigation involved a review of the medical records, as well as consideration of affidavits provided by Mr BL's family, a shop employee where the fall had occurred, and from the facility manager where Mr BL resided. The coroner also received a statement from an emergency specialist at the hospital who had been consulted about Mr BL at the time, and an opinion from a coronial medical advisor. Closed circuit television (CCTV) footage of Mr BL's fall was examined. In his affidavit, Mr BL's son asked why a CT scan of Mr BL's head had not been carried out earlier, at the time of his presentation to hospital.

The coroner acknowledged that the paramedics treating Mr BL did not specifically describe that he had struck his head in the fall. Their report did describe, however, a developing haematoma in the right parietal area. In the emergency department, he was noted to be confused and had evidence of blunt head trauma with bruising. It appeared though, that the

## v. Author's Comments

The clinicians treating Mr BL focussed on a single aspect of his clinical presentation (plus their own interpretation of the circumstances that brought him into the emergency department), to the detriment of assessing all his injuries and taking into account his age.

circumstances, injury patterns, and so on. In addition, it is crucial that clinicians remember that once a plan is made, it must be seen through. If an investigation is intended but not carried out, robust feedback and review mechanisms should be in place that can alert the treating team to any omissions in the planned care for a patient.

## vi. Resources

Beedham W, Peck G, Richardson S, Tsang K, Fertleman M, Shipway D. Head injury in the elderly – an overview for the physician. *Clinical Medicine (London)* 2019; 19(2): 177-184.

Colwell C. Geriatric Trauma: Initial evaluation and management. In: UpToDate, Moreira M (Ed), UpToDate. Waltham, MA (accessed on October 20, 2021). <https://www.uptodate.com/contents/geriatric-trauma-initial-evaluation-and-management>.

Hashmi, A, Ibrahim-Zada, I, Rhee, P, Aziz, H, Fain, M, Friesse, R and Joseph, B. Predictors of mortality in geriatric trauma patients: a systematic review and meta-analysis. *Journal of Trauma Acute Care Surgery*. 2014; 76 (3): 894-901.

## vii. Keywords

Older adults, falls, trauma, subdural haemorrhage, CT scan, rule, headache

## Head trauma in the older person brings with it specific considerations for clinicians.

treating clinicians interpreted Mr BL's fall as a likely syncopal event relating to a possible cardiac issue and from that point the head injury was not considered further.

The emergency consultant in his submission, referred to documentation made by the treating ED doctor in Mr BL's medical record of 'Canadian CT head rule 1 – for age alone'. It appeared there was recognition at the time that a CT head scan was warranted based on the criteria of Mr BL's presentation and his age, but for reasons unclear, this did not occur.

Mr BL's case was not taken to inquest for further investigation, rather an "In Chambers" Finding was handed down by the coroner.

## iv. Coroner's Findings

Although no comments or recommendations were made, the coroner stated, 'There is no reason I can discern why a CT scan of [Mr BL's] head was not performed. His chances of survival and recovery were, in my view, markedly reduced by the decision not to carry out that standard procedure'.

In this way there appears to have been an element of tunnel vision and a loss of situational awareness. A consideration of Mr BL's age, his injuries, the circumstances surrounding his presentation, followed by the careful application of clinical rules and guidelines to aid in the decision-making process for appropriate clinical investigations, may have prevented the missed diagnosis and subsequent deterioration.



Falls, especially from ground level, in older adults are common. Head trauma in the older person brings with it specific considerations for clinicians. Subdural haemorrhages, related, in part, to increased adherence of the dura to the skull in the aged as well as brain atrophy (providing more room for bleeding within the cranium) are factors clinicians need to weigh up in their assessment of patients presenting with falls and possible head trauma.

This case serves as a reminder to be open to all the information the patient brings – including the

# More on the Matter

## From up high or down low

**Dr Nicola Cunningham**  
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Forensic Physician  
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Medicine (Monash University)

### COR 2020 5113 Vic

Mr PS was a 72 year old man in relatively good health who fell a distance of approximately 3m to the ground through a plastic skylight on a roof he had been attempting to clean. He was flown to a major trauma centre where CT scans revealed non-survivable head injuries and he died the following day. Post-mortem investigations showed a left subdural haemorrhage, generalised subarachnoid haemorrhage, a left scalp haematoma, and a possible left parietal fracture. He also had fractured several ribs and thoracic vertebral bodies, and right scapula.

His cause of death was listed as multiple injuries sustained in a fall from a height. The coroner reviewed Victorian coronial data on falls leading to death between 1 January 2013 and 31 December 2020, noting that there were 60 deaths (averaging 5 to 10 per year), the majority of whom were men aged between 75 to 79 years.



The coroner referenced findings from the Victorian Government's Ladder Safety Matters campaign that reported there were approximately 1200 emergency department presentations due to ladder falls each year, and hospital admissions for ladder falls had increased by more than 20% in the past five years.

The coroner commended the campaign in continuing to improve community awareness in this area and reiterated safety advice for older persons using ladders such as maintaining three points of contact with the ladder, and having another person assist with the stability of the ladder.

### 2012 TASCD 340 Tas

Ms BS was a 67 year old woman with a history of Addison's disease and arterial thrombosis for which she was prescribed warfarin. She felt dizzy at home, and collapsed, falling through a glass door and sustaining deep cuts to her left arm and leg. She managed to call a taxi to take her to her GP – who then dressed her wounds and called an ambulance to transport her to an emergency department. From there, she was admitted and transferred to the operating theatre for debridement and suturing of her wounds.

Post-operatively, she was seen by a physician to review possible causes for her fall.



The following day, she was seen by a physiotherapist, the surgeon, and the physician with a view to discharge. The physician noted she had extensive bruising around her back without focal rib or spine tenderness. She went home later that day. The next morning, Ms BS called on her neighbour for assistance. She complained of feeling clammy and faint, and her breathing was shallow. An ambulance was called to convey her to hospital, however on their arrival she suffered a cardiopulmonary arrest and could not be revived. An autopsy revealed multiple rib fractures and contusion of the lung which histologically appeared to have pre-dated the resuscitation efforts. There was 250mL of blood in the left pleural cavity.

Her cause of death was listed as hypoxic respiratory failure due to a traumatic chest injury from a fall at home. The coroner noted that a tertiary trauma survey was missing from the hospital documentation and a CXR had not been done during Ms BS's admission, both of which may have revealed more extensive trauma, particularly in the setting of chest bruising. The coroner highlighted the importance of recognising the special area of trauma.

## The Canadian CT Head Rule

# Canadian CT Head Rule

CT head is only required for minor head injury\* patients with any one of these findings:

### High Risk (for Neurological Intervention)

1. GCS Score < 15 at 2 hrs after injury
2. Suspected open or depressed skull fracture
3. Any sign of basal skull fracture\*\*
4. Vomiting ≥ 2 episodes
5. Age ≥ 65 years

### Medium Risk (for Brain Injury on CT)

6. Amnesia before impact ≥ 30 min
7. Dangerous mechanism \*\*\* (pedestrian, occupant ejected, fall from elevation)

#### \* Minor Head Injury

- defined as a loss of consciousness, definite amnesia or witnessed disorientation in patients with a GCS 13-15

#### \*\* Signs of Basal Skull Fracture

- haemotympanum, 'raccoon' eyes, CSF otorrhoea/rhinorrhoea, Battle's sign

#### \*\*\* Dangerous Mechanism

- pedestrian struck by vehicle  
- occupant ejected from motor vehicle  
- fall from elevation ≥ 3 feet or 5 stairs

#### Rule not applicable if:

- Non-trauma cases  
- GCS < 13  
- Age < 16 years  
- Anticoagulants or bleeding disorder  
- Obvious open skull fracture

Stiell IG, et al. The Canadian CT Head Rule for patients with minor head injury. *Lancet*. 2001; 357(9266): 1391-1396.



## Expert Commentary

# The trips and traps of falls

**Dr Glenn Arendts**  
MBBS, MMed, PhD, FACEM  
Associate Professor, Medical  
School, The University of  
Western Australia  
Consultant Emergency  
Physician, Fiona Stanley  
Hospital, WA

Falls are the leading cause of trauma-related death in older people, and the age-adjusted mortality in adults aged 75 years or more directly due to falls has increased by 5% per annum over the last decade. For any health system that concerns itself with major trauma, falls should be core business.

However, injurious death is still only a tiny part of the falls story. The lifetime risk of dying from a fall is less than 1 in 100, and many older people have recurrent falls, so the likelihood of any single fall from standing height being fatal is very low. There are about four

million Australians aged 65 years or more, of which approximately one million will fall at least once per year, with fewer than 5% of these falls resulting in any medical consultation. And where injury does occur, the majority is non-life-threatening injury including abrasion, contusion, and minor fracture.

For me, this represents the many traps, but also fulfilling opportunities, of falls assessment. At the extreme pointy end of the falls pyramid is serious life-threatening injury. Yet, the vast majority of falls-related work is appreciating what a fall represents in the life of an older person – a sentinel indicator of increasing frailty and multifactorial perceptual disturbance, sometimes with an acute medical condition superimposed. Concentrating your efforts on identifying and managing injury alone is likely to miss the point in most falls consultations.

A simple thing we can all do to help shift focus in our clinical practice is to stop using the term “mechanical fall”.



In my experience, this is immediately interpreted as the fall being just situational bad luck, and as long as we can patch up the injuries today, we need not worry about the fall too much. I recommend getting rid of the term “mechanical fall” from your lexicon. Try to view a fall in any circumstance not as a diagnosis, but as an **outcome** of another diagnosis, or diagnoses combined.

I lead a team that has transformed falls management in emergency departments (EDs), with a model that has since been adopted in selected EDs nationally and internationally.

Comprehensive falls assessment can seem overwhelming, as there appears to be so much to be done, and a blurring in the lines of responsibility between what is, and is not, core ED work. We try to break down falls assessment into manageable priorities and devote appropriately weighted time to each of these (see Table 1). The key is starting the process from triage – do not under-triage falls but use the fall as a trigger to start this time-guided process from the moment the patient arrives.

Our falls program works optimally with a high volume of falls presentations and the space in a short stay ward to manage these.

An important consideration is that the patient may initially look comfortable with no oxygen requirements, but subsequently deteriorate over the next 12-24 hours as the underlying lung becomes stiffer and less compliant and hypoventilation due to pain worsens. We default to admit all older patients with more than one rib fracture, with continuous oximetry monitoring and aggressive multimodal analgesia including where possible regional anaesthesia. Specialised cardiothoracic trauma centres are now using surgical rib fixation in highly selected older patients with multiple fractures.

The case in this edition of Mr BL is atypical in that anticoagulation to manage his acute coronary syndrome was being considered post head injury, and I agree that as the patient lost consciousness and was confused, and anticoagulation being commenced, an early cranial CT is good practice in those circumstances. You may still choose to do neuroimaging in some trivial injuries based on your clinical gestalt, especially patients on anticoagulation or dual antiplatelet therapy. I also have a lower threshold for a cranial CT scan in trivial head injuries in older patients that fall backwards, rather than forwards. Forward falls are more often cushioned by the forearms and wrists as well as the face that acts, as a colleague once aptly described to me, as ‘*the human airbag for the brain*’.

**Though most falls are not fatal, the deaths highlighted in this edition are illustrative of fall-related death, and there are important lessons from each of these.**

But even smaller and less well-resourced settings can use the principles of our program: (i) start the process at triage; (ii) use standardised structured processes to screen for serious injury, underlying medical illnesses and falls risks factors; and (iii) prioritise the things that need to be done early over the things that still need to be done but can wait.

Though most falls are not fatal, the deaths highlighted in this edition are illustrative of fall-related death, and there are important lessons from each of these. Rib fractures (such as in the case of Mr GC) are a cause of morbidity and mortality in trauma in older people, and cumulatively each fracture matters: the odds ratio of death in an older person increases by 1.2 with every additional rib fracture.

In my experience, even amongst specialist emergency physicians and neurosurgeons, there is widespread misapplication of clinical decision rules to guide neuroimaging such as the Canadian Head CT rule because of an unfortunate term: minor head injury. A minor head injury (as described in the derivation of the rule) is an injury followed by a loss of consciousness or ongoing disorientation in a patient with a GCS 13-15. Patients aged over 65 years with a minor head injury cannot safely be discharged without a cranial CT, but minor head injuries have a specific definition. Trivial bumps on the head with no symptoms are not minor head injuries, and the Canadian CT rules do not imply that CT scanning is necessary in all older patients with a trivial head injury.



Finally, cervical spine plain X-rays are of limited value in trauma in older people, and a CT scan should be the first line investigation in an older person with suspected cervical spine trauma after a fall.

## Resources

<http://thehearingaidpodcasts.org.uk/episode-1-5-acute-management-post-fall/>.

<https://bestpractice.bmj.com/topics/en-gb/880>.

Nagaraj G et al. Avoiding anchoring bias by moving beyond ‘mechanical falls’ in geriatric emergency medicine. *Emerg Med Australas* 2018; 30(6):843-850.

Table 1. Falls assessment in the older person

Timeline	Risks	Examples of evaluation enables
Initial Assessment	Acute medical illness associated with fall	ECG, septic screen, orthostatic vital signs, fluid balance assessment, neurological including vestibular assessment
	Acute injury e.g. hip and back, face/head/neck, ribs	X-rays. Consider neuroimaging if indicated by Canadian CT rules or equivalent
Within 3-4 hours	Cognitive impairment including delirium	4AT or other delirium screen
	Gait and balance disturbance	Current mobility, need for aids, feet and footwear assessment
	Discharge risk stratify	Home safety, escalation plan if falls again
Within 24-48 hours	Bladder and bowel incontinence	Generally requires multidisciplinary assessment and/or specialist screening tools such as the geriatric depression scale, STOPP/START* criteria
	Functional decline and frailty, malnutrition	
	Home environment modifications	
	Depression	
	Hearing and vision	
	Medication review	
<p><b>* STOPP (Screening Tool of Older Persons' Prescriptions) and START (Screening Tool to Alert to Right Treatment) assist clinicians with appropriate prescribing as part of a comprehensive geriatric assessment</b></p>		

## The Communiqués Podcasts

We were delighted to see that in October 2021 our podcasts of The Communiqués was ranked fourth for the Apple Podcast category of medicine for Australia. We are building quite an extensive library with over 20 episodes released now. Currently, we have seven episodes of the Clinical Communiqué, seven episodes of the Future Leaders Communiqué and ten episodes of Resident Aged Care Communiqué podcasts to listen to. More are in the pipeline.

You can find the Podcasts at:

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