

DEPARTMENT: Algorithm	POLICY TITLE: Geriatric Hip Fracture Guidelines
Page 1 of 4	REPLACES POLICY DATED: New
EFFECTIVE DATE: 09/2018	REFERENCE NUMBER: ALG-32

SCOPE:

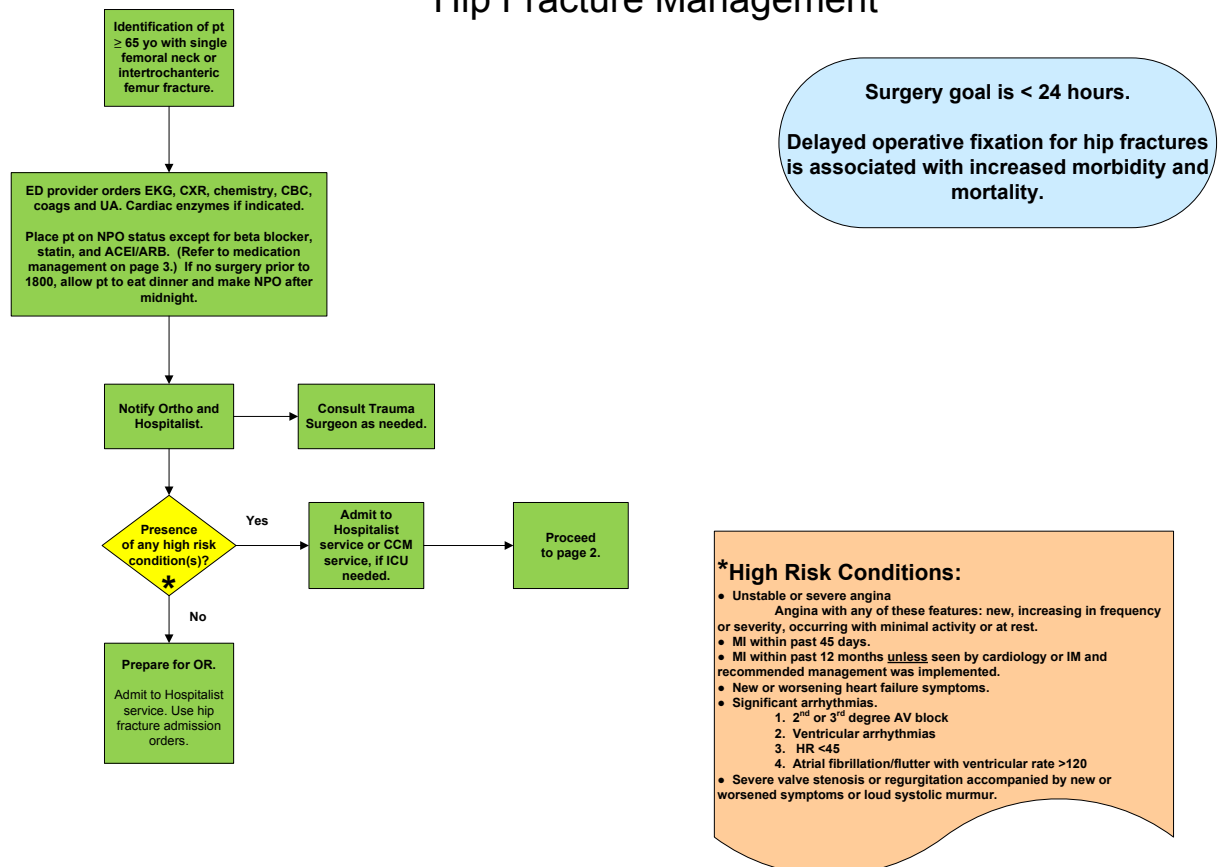
X	Medical City Plano
	Medical City Frisco, a facility of Medical City Plano

PURPOSE: To provide recommendations for the management of geriatric patients suffering hip fractures (from low mechanism) requiring surgical treatment.

GOALS

- Provide guidance for risk stratification for surgery.
- Minimize unnecessary workup and surgical delays past 24 hours after patient arrival. Delayed operative fixation for hip fractures is associated with increased morbidity and mortality.

Hip Fracture Management

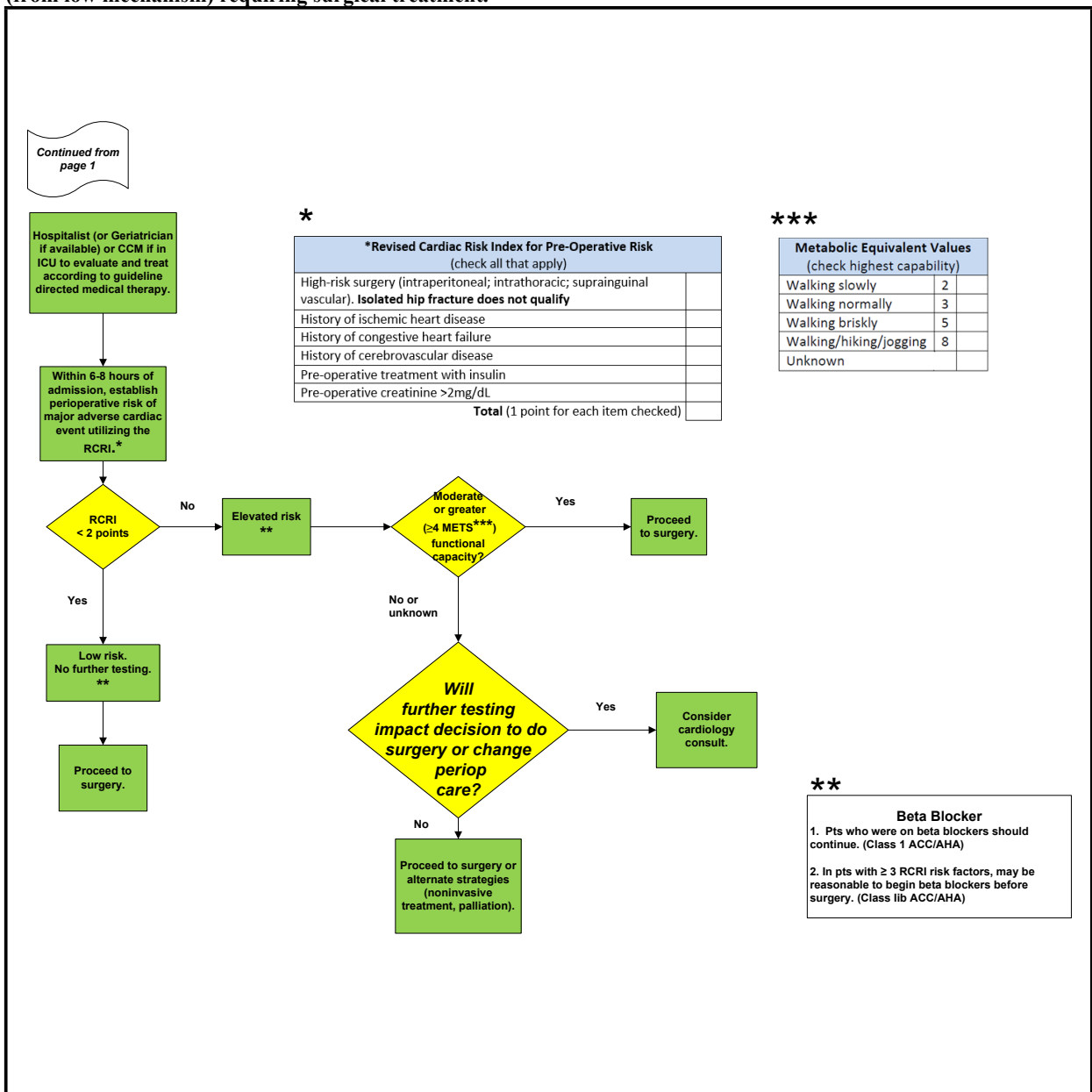


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MEDICATION MANAGEMENT

- a. **Coumadin – stop and reverse** in preparation for surgery.
- b. **Antiplatelet therapy** (Plavix and/or ASA) - **continue** if current home medication (no increased bleeding risk perioperatively).
- c. **Beta blocker – continue** if current home medication.
 - i. Patients who were on beta blockers should continue (Class I ACC/AHA recommendation)
 - ii. Patients should be started on beta blockers the day prior to surgery if Revised Cardiac Risk Index for Pre-Operative Risk score is > 2 (Class IIb ACC/AHA recommendation) <https://www.mdcalc.com/revised-cardiac-risk-index-pre-operative-risk>
 - iii. Do not start beta blockers on day of surgery (Class III ACC/AHA recommendation)
 - iv. In patients with 3 or more RCRI risk factors (e.g. DM, HF, CAD, renal insufficiency, CVA), it may be reasonable to begin beta blockers before surgery (Class IIb ACC/AHA recommendation)
- d. **Statins – continue** if current home medication, start if ASCVD > 7.5% (see risk calculator)
 - i. Continue if already on (Class I ACC/AHA recommendation)
- e. **ACEI or ARB – continuation is reasonable** (controversial).
 - i. Consider holding if SBP is > 90 or < 140 mmHg. Newer VISION study in 2017 suggests withholding ACEI/ARB results in reduced all-cause mortality, stroke, and MI outcomes
 - ii. Continuation of ACEI or ARB is reasonable (Class IIa ACC/AHA recommendation)
 - iii. If held, it is reasonable to restart as soon as clinically feasible post operatively (Class IIa ACC/AHA recommendation). Recommend within 48 hours due to increased 30 day mortality if delayed > 48 hours)
- f. **Novel oral anticoagulants** (e.g. dabigatran, rifaroxaban, apixaban) – **stop before surgery**.

POST-OP CONSIDERATIONS

- a. If patient is considered high risk, admit to ICU for monitoring.
 - i. High risk patients include: Age > 90 or patients > age 80 with two or more of the below:
 - EF < 35 %
 - Moderate to severe aortic stenosis
 - Hx of CHF with systolic dysfunction
 - Renal insufficiency
 - Insulin requiring diabetics
 - Hx of CVA



Approved by: Trauma Services

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- b. Pre/Post-operative atrial fibrillation of new onset (Most convert within 24 hours)
 - i. Continue cardiac medications as soon as possible
 - ii. Check electrolytes, thyroid, Mg, K+
 - iii. LV function with echo
 - iv. Rate control with oral beta blockers with goal HR < 100 bpm
 - v. Check cardiac enzymes at 0, 4, 8 hours IF there is chest pain, hemodynamic instability, or ischemic EKG changes
- c. VTE prophylaxis per protocol.

REFERENCES:

Fleisher LA, Fleischmann KE, Auerbach AD, Barnason SA, Beckman JA, Bozkurt B, et al. 2014 ACC/AHA guideline on perioperative cardiovascular evaluation and management of patients undergoing noncardiac surgery: executive summary: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines. Circulation. 2014;130:2215–45

Pincus D, Ravi B, Wasserstein D, et al. Association between wait time and 30-day mortality in adults undergoing hip fracture surgery. JAMA. Doi:10.1001/jama.2017.17606

Trauma Quality Improvement Program (2014). ACS TQIP geriatric trauma management guidelines. Chicago, IL: American College of Surgeons.