Rib Fracture Management Guideline

All interventions assuming no concurrent contraindications

**ADMIT to ICU**
- Transfer to tertiary trauma center
  - Force Vital Capacity (FVC) < 1000 or
  - Any new O2 requirement > 5 LPM or
  - Worsening mental status
  - Provider discretion
  - Flail Segment (≥ 3 ribs in ≥ 2 places each)
  - Supratherapeutic anticoagulation

**ADMIT to IMC**
- Recommend tx to tertiary trauma center
- FVC 1000-1500 or
- Any new O2 requirement > 3 LPM

**ADMIT to Med/Surg or Observation**
- FVC >1500 with new O2 requirement
  - (For isolated rib fx < 2 obs)
  - (For isolated rib fx ≥ 3 admit to inpt)

**Respiratory Toilet**
- FVC q 8 hr
- Change FVC to daily when stable or improving > 48 hr
- +/- CPAP/BiPAP
- Albuterol Nebs QID
- IS q 1 hr + Acapela
- CXR PRN
- Continuous O2 Sats

**PAIN CONTROL**
- Schedule: acetaminophen, NSAIDS and muscle relaxants, topicals
- Epidural, rib or paravertebral block
- Narcotics IV/PCA, change to PO when appropriate
- Consider Pain Service Consult

**DISCHARGE to HOME**
- FVC >1500 with No new O2 requirement & ≤ 2 rib fx

**Respiratory Toilet**
- Send home with incentive spirometer
- Use IS QID for 1 month

**Respiratory Toilet**
- IS and Acapela q 1 hr
- +/- Nebs
- Continuous O2 Sats

**Consider for pain management:**
- Robaxin 750 mg (500 mg -1000 mg) IV/PO q 6 hours as first line muscle relaxant
- Flexeril 5-10 mg PO q 8 hours second line muscle relaxant
- Avoid valium 2nd to sedating properties and likely co-administration of narcotics
- For patients > 65 years old adding Calcitonin for acute phase only. (used as a pain adjunct to decrease narcotic needs)

All discharges should include “Going Home with a Chest Injury” handout:
https://m.fairview.org/fv/groups/internet/documents/web_content/s_114038.pdf