

A Report on Cervical Trauma Care

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PERSPECTIVE

The treatment of spinal trauma spans from minor injuries that require no intervention to serious complicated, spinal cord, and life-threatening spinal column injuries. For the best assessment, decision-making, and treatment of this patient group, much experience is required, and the concepts of early management and treatment. Management of cervical spine injuries has traditionally been treated as an afterthought in the treatment of the multi-injured patient, but the widespread adoption of Advanced Trauma Life Support protocols has highlighted the importance of assuming a cervical spine injury in all patients with a history of trauma until proven otherwise. The cervical spine should be assumed to be injured during resuscitation and first examination, and should be splinted using a cervical spine collar, two sandbags, and a forehead tape. The thoracolumbar spine should be stabilized on a spine board for transfer and subsequently on a flat emergency room trolley for log rolling with only in-line neck stabilization.

Surgery, A significant amount of injury to the neck, spine, and vertebrae may necessitate surgery. Surgical procedures can be used to Reattach the bone fragments and secure them in place, their spine's vertebrae must be repaired, reduce the amount of pressure on their spinal cord, vertebral discs that have been injured should be removed, plates, screws, and wires may be used in some procedures. The degree of instability as evidenced by the degree of injury to the two spinal columns, or any major displacement, should be evaluated when determining which patients are candidates for surgery. By adopting an evidence-based methodology to estimate the likely outcome in terms of neurological sequelae, discomfort, deformity, and degenerative change with one or more treatment methods, a surgical option should be weighed against a non-surgical one.

Many individuals can be treated without surgery, and non-operative therapy options for the cervical spine include everything from wearing a lightweight orthosis to halo traction and rigid stabilization using a halo jacket. The acceptance of halo jacket treatment for unstable cervical spinal injuries is gradually changing, and much like the care of tibial fractures has shifted from non-surgical treatment to surgery stabilization, there is a similar shift in trends for managing unstable cervical spine injuries. In any displaced injury of the cervical spine, except a Hangman's type IIA fracture, traction done with a halo rather than tongs can always be employed as an emergency treatment. IIA fracture traction in the Hangman's type can shift the fracture, increasing the risk of spinal cord damage and mortality considerably. The physician should perform an MRI scan on all patients with a displaced cervical spine injury who are attempting a closed reduction by traction unless it is impossible to do so in the treating center and the reduction is clinically necessary.

In today's world of spinal injury treatment, patients are not expected to stay in bed for weeks or even months after a catastrophe. Surgical stabilization should be considered if a spinal injury is not stable enough to allow the patient to move within 24-48 hours with appropriate bracing. Patients should be able to move as soon as the anesthetic effects have worn off, and in the absence of spinal cord injury, they should be up and walking within a day of surgery. There will be a time of acclimatization to gravitational challenge in patients with spinal cord injuries, but most spinal cord injury rehabilitation centers will now begin tilting into an upright posture within 48 hours of surgical stabilization. The spinal cord rehabilitation community is still hesitant to start a super early mobilization programme, although one of the key benefits of contemporary surgical stabilization is that it allows for such early mobilization.

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