a. Respiratory distress
b. Suspected severe head trauma
c. Promotion of patient compliance

Notes/Educational Pearls

Key Considerations

1. Evidence is lacking to support or to refute the use of manual stabilization prior to spinal assessment in the setting of a possible traumatic injury when the patient is alert with spontaneous head/neck movement. Clinicians should not manually stabilize these alerts and spontaneously moving patients since patients with pain will self-limit movement and forcing immobilization in this scenario may unnecessarily increase discomfort and anxiety
2. Certain populations with musculoskeletal instability may be predisposed to cervical spine injury. However, evidence does not support or refute that these patients should be treated differently than those who do not have these conditions. These patients should be treated according to the Spinal Care Guideline like other patients without these conditions
3. Pediatric considerations:
   a. Age alone should not be a factor in decision-making for prehospital spine care, yet the patient's ability to reliably be assessed at the extremes of age should be considered. Communication barriers with infants/toddlers or elderly patients with dementia may prevent the clinician from accurately assessing the patient
   b. There is no evidence that children experience non-contiguous multilevel injuries. The existing evidence suggests that the rate of contiguous multilevel injuries is exceedingly low at 1%
   c. Because of variation in head size to body ratio, consider additional padding under the shoulders to avoid excessive cervical spine flexion
4. Spinal precautions should be considered a treatment or preventive therapy
5. Patients who are likely to benefit from immobilization should undergo this treatment
6. Patients who are not likely to benefit from immobilization, who have a low likelihood of spinal injury, should not be immobilized
7. Ambulatory patients may be safely immobilized on gurney with cervical collar and straps and will not generally require a spine board. The role for standing take downs is extremely limited, e.g., extrication of a patient with a high likelihood of a spinal cord injury from a large body of water. Ambulatory patients may have a collar applied and walked to the EMS gurney
8. Reserve long spine board use for the movement of patients whose injuries limit ambulation and who meet criteria for the use of spinal precautions. Remove from the long board as soon as is practical

Pertinent Assessment Findings

1. Mental status
2. Normal neurologic examination
3. Evidence of intoxication
4. Evidence of multiple traumas with other severe injuries

Quality Improvement

Associated NEMSIS Protocol(s) (eProtocol.01) *(for additional information, go to www.nemsis.org)*

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