

surgical precision with psychological care. Improving conflict-related trauma care is a necessity, so that the patient remains at the forefront of surgical decisions. Future research may include long-term outcomes of scar revision in conflict survivors and development of integrated surgical-psychosocial protocols.

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## No Reds, No CT heads: Assessing Inappropriate Trauma CT Head Scans in UK Emergency Departments

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**Background:** Evidence-based guidelines (NICE NG232) are designed to safely identify ED trauma patients who truly need CT head scans. Practitioners may understandably request scans in the absence of these criteria defensively, yet this can expose patients to unnecessary radiation and costs. The authors aimed to assess how often CT head requests adhere to these guidelines and to evaluate the necessity of scans performed when criteria are not met.

**Methods:** The authors undertook a two-cycle audit of adult trauma CT head scans at a West Midlands DGH in 2025. Each request was assessed against NICE criteria, and it was recorded whether any intracranial pathology was identified or management was affected. In cycle 1, a poster ("No Reds? No CT Heads") was introduced, visually demonstrating all criteria in one cartoon mnemonic. In cycle 2, the poster was further amended to incorporate local audit data, emphasising that none of the previous inappropriate scans had been positive, and including information on radiation dose (2mSv/scan) and cost (£120/scan).

**Results:** Across three two-week periods, 148 scans were reviewed. At baseline, 78.8% (41/52) met criteria. This increased to 81.6% (40/49) after cycle 1 (not significant) and 89.4% (42/47) after cycle 2, a statistically significant improvement over baseline ( $p=0.042$ ). Yield for acute injury increased from

11.5% to 17.0%. No inappropriate scan identified an acute injury in either cycle.

**Conclusions:** Defensive ordering is prevalent. Non-specific interventions alone had little effect. When combined with targeted local feedback, cost, and radiation data, inappropriate scanning halved without loss of sensitivity.

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## Management of Heart Failure in Primary Care

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**Background:** Heart failure is a frequent and advancing condition that significantly contributes to morbidity and mortality in the UK. Effective primary care management is critical for early diagnosis, optimal treatment, and suitable ongoing monitoring. This clinical audit aims to assess the quality of heart failure management within a primary care setting and its comparison to NICE guideline NG106 across the following domains: diagnostic confirmation, pharmacological treatment, specialist referrals and annual reviews with lifestyle advice.

**Methods:** A retrospective clinical audit was conducted at a single general practice in Tyldesley, Manchester. This involved 39 patients with a confirmed diagnosis of heart failure. Data was collected manually from electronic health records using a structured data extraction template. Descriptive statistics were used to analyse diagnostic practices, medication prescribing, lifestyle interventions and referral patterns.

**Results:** Echocardiogram data was available for 97% of patients with only 44% of BNP results documented. 55% of patients with HFrEF or HFmrEF were managed using full guideline recommended therapy. 90% of patients received annual review follow-ups which included lifestyle advice, with disparities relating to alcohol dependent counselling and weight management. Of the 39 patients included in the clinical audit only 56% of patients were referred to specialist heart failure services.

**Conclusions:** This audit acknowledged areas of strong guideline adherence, specifically in diagnostic and review domains. Suboptimal pharmacological management and sparse BNP testing were noted. Targeted interventions, medication optimisation, and consistency of referrals can contribute to effective heart failure primary care management.

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## SIEGE-TBI: A Conflict-Zone, First-Hour Neurotrauma Protocol and Tele-Brief for Civilian Blast Head Injury

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**Background:** In besieged urban settings, civilian traumatic brain injury (TBI) surges while CT, theatre access, blood products and bandwidth collapse. Early neuroprotective actions and clear referral messages are frequently delayed by chaos, power loss and inexperienced teams.

**Methods:** Using an education-design approach, we can compress ATLS/major-incident principles and frontline neurosurgical priorities into a single workflow, stress-tested in tabletop mass-casualty drills with novice responders. Pre-specified feasibility targets were: teach time  $\leq 20$  minutes; run with blackout-tolerant kit; and assessment via a 12-item critical-actions checklist.

The SIEGE-TBI bundle contains five deployables:

- (1) Triage matrix (penetrating/blunt  $\times$  GCS strata) with immediate life-threat red flags.
- (2) Neuroprotect pack with explicit targets: SpO<sub>2</sub>  $>94\%$ ; SBP  $\geq 110$  mmHg; EtCO<sub>2</sub> 35–40 mmHg; head-up; normothermia; glucose control; anticonvulsant triggers.
- (3) No-CT pathway to decide treat-and-transfer vs hold-and-observe when scanners/staff are unavailable.
- (4) Tele-brief encoding GCS, pupils, lateralising signs, vitals and time-stamped actions for SMS/radio when data fail.
- (5) Blackout pack: headlamp checklist card, paper timestamp strip, pulse-ox and manual BP workflow, reusable for repeated strikes.

**Conclusions:** SIEGE-TBI offers a pragmatic, teach-today protocol for neurosurgical damage-control and escalation in the trenches.

\*Editorial Note: This article describes a study protocol. The proposed study has not yet been conducted, and therefore no data or results are included.

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## Pelvic and Acetabular Fractures: A Narrative Review

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**Background:** Pelvic and acetabular fractures are a subset of orthopaedic injuries which result from high- and low-energy trauma mechanisms. This literature review's objective is to provide an overview of the epidemiology, patient outcomes, and management of pelvic and acetabular fractures, with an emphasis on low-energy fractures.

**Methods:** A literature search was conducted using papers up to May 2024.

**Results:** Epidemiologically, increased incidence of pelvic and acetabular fractures is observed in socioeconomically deprived areas and is influenced by patient age, sex, and ethnicity. Negative patient outcomes are associated with the presence of certain pre-morbid variables, namely increased frailty status, significant comorbidities, low mobility status, and obesity. Management of these fractures can constitute either conservative or surgical approaches, which are reported to yield comparable results. Many management-related variables have been identified to also influence patient outcomes, including length of hospital stay, delays to surgery, discharge destinations, post-operative complications, and surgeon experience. Modern research indicates early post-operative weight bearing and mobilization to help promote fracture recovery. Recent development in the care of these fractures includes the regionalization of major trauma centres. Numerous studies link increased mortality risk with advanced age, frailty, low pre-fracture mobility, comorbidities, inpatient discharges, and post-operative complications. Evidence in the association between length of stay