

The Victorian Surgical Consultative Council

Code Crimson: A life saving measure to treat exsanguinating emergencies in trauma

CODE CRIMSON : A life saving measure to treat exsanguinating emergencies in trauma, Australian & New Zealand Journal of Surgery 2008: 78, 523-525

The bottom line message from this article is “to facilitate the rapid transfer to operating theatres of massive exsanguinating trauma or vascular emergencies”. The authors – from St. Vincent’s Hospital in Sydney – aim for 20 minutes from arrival at the hospital to operating theatre.

The point is made that although resuscitation, monitoring and simple chest x-ray in the Emergency Department, any or each take only a few moments, the combined affect can be significant.

Code Crimson is an emergency call and involves 4 steps:

- 1) Pre-hospital notification – by paramedics, ambulance etc.
- 2) Major trauma “page to trauma team”
- 3) The most senior clinician in Emergency upgrades to a Code Crimson on arrival of the patient
- 4) Code Crimson relayed to surgical and anaesthetic team and operating theatres.

The authors quote six cases in the last 12 months where Code Crimson was called. The average time to theatre was 20 minutes 20 seconds. Two patients died and four lived – three of which were stab wounds to the abdomen and chest.

I consulted with Directors of two major trauma centres in Melbourne and they reveal that neither used Code Crimson but were aware of it, but they did have appropriate call systems in place, which they used in instances of exsanguinating haemorrhage – sometimes with varying success.

This is not new and was introduced to Nepean Hospital and further popularised at Westmead in 1999.

I believe this article highlights an important principal – that there is a group of patients that benefits from immediate i.e. 20 minute transfer to a fully equipped operating theatre. There are practical considerations – size of hospital, availability of staff, availability of trauma teams and theatre accessibility but in “major hospitals” it must be worth consideration.

The situation needs not be confined to trauma – other vascular emergencies such as ruptured aortic aneurysm would be included but I am sure that it would overcome the frustration of many surgical units regarding what they see as unnecessary delays in resuscitating a patient and investigating them in the Emergency Department.

In short it would be used for shocked patient with exsanguinating wounds or conditions.

Liaison with the College of Emergency Medicine and The Royal Australasian College of Surgeons would be worth consideration if it was considered that formalising such a process would be appropriate – keeping in mind that at least the two major trauma centres do have similar protocols although not under the Crimson Code.

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