Disclaimer: This clinical pathway is provided as a general guideline for use by Licensed Independent Provider’s (LIPs) in planning care and treatment of patients. It is not intended to be and does not establish a standard of care. Each patient’s care is individualized according to specific needs.

ACH Trauma
Blunt Cardiac Injury (BCI)

On admission, any patient with suspected BCI should have:
- 12 lead ECG
- Troponin T & I drawn
- FAST exam of the pericardium
- CXR

Suspicion of BCI should occur with:
- History of a direct blow to the precordia or epigastrium
- Bruising over to manubrium, sternum or xyphoid
- Rhythm disturbance on initial ECG monitoring
- Hypotension in multisystem injury, not explained by other mechanism
- Murmur on physical exam

Normal ECG, FAST, and Troponin levels?
- Yes: No further work-up or monitoring needed
- No:
  - FAST exam with pericardial fluid
    - Immediate trauma surgery consultation and formal echo by cardiology
  - Abnormal ECG or troponin level
    - Patient should be monitored at least in IMU for 24 hours with continuous ECG
    - Consider serial troponin levels if initially normal in the presence of abnormal ECG

Patients with hypotension, new or previously unknown murmur should have cardiology consultation urgently in the ED for trans-thoracic or transesophageal echocardiography

Is patient stable?
- Yes:
  - Stable patients with an abnormal ECG and elevated troponin level should routine consultation with cardiology
  - Follow up echocardiography in three weeks is recommended for patients with initial abnormality in FAST, ECG or troponin levels
  - Documentation in the patient’s record should avoid the term “cardiac contusion”. It should instead be listed as “blunt cardiac injury with....(hypotension, valvular injury, wall motion abnormality, arrhythmia, etc.)”
- No:
  - Management with consultation
    - PICU
    - Cardiology
Revision Notes

- Trauma Council Approval 8-20-20