

**Traumatic Brain Injury (TBI) Pathway, GCS<9**

(1) Intubation (RSI + lidocaine 100 mg)  
 (2) abg/ ETCO<sub>2</sub>; keep PaCO<sub>2</sub> 35-40, PaO<sub>2</sub> > 60  
 (3) HOB >30 degrees or reverse Trendelenburg if spines not cleared  
 (4) Maintain MAP > 70 mmHg until ICP available  
 (5) CT Head (? Surgical lesion, consider FFP early)

(1) Neurosurgical consultation  
 (2) TICU admission/ OR  
 (3) Establish access/monitoring (CVP/PAC, arterial line, ICP monitor)  
 (4) Pain control (fentanyl IVP, then gtt) and sedation (propofol, midazolam)  
 (5) Phenytoin/fos-phenytoin for 7 day course (following 1 gm load)

Continue monitoring  
& current therapy

**ICP**

≥ 20 mmHg OR  
CT with increased shift/ edema

**Maintain ICP <20,  
CPP >60, PaCO<sub>2</sub>~35,  
Sedation-pain control**

CSF drainage  
via EVD

If ICP > 20,  
is CPP >60?

**NO**

3% hypertonic saline bolus  
(Repeat if Cl<sup>-</sup> <120, Na<sup>+</sup> <160)

**YES**

Mannitol  
0.25-1.0 g/kg IVP

May repeat if serum Osm <320  
& patient is euvolemic

Euvolemia:  
PCWP 10-15  
CVP 5-10  
EDVI 95-120

Euvolemic, but  
CPP < 60

**HR < 120**

Norepinephrine  
gtt

**HR ≥ 120**

Phenylephrine  
gtt

ICP >20 and CPP <60, then  
Repeat CT Head  
Notify attending/fellow

**Consider pentobarbital coma**  
 Increase propofol/fentanyl  
 Contact neurosurgery re: decompressive craniectomy  
 Check intra-abdominal pressure\*\*\*

\*\*\*Consider decompressive laparotomy if intra-abdominal pressure ≥25

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