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Cervical Collar

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1. Abstract

Any patient who arrives in our environment with a cervical collar, globally or partially immobilized by this and/or other systems should suggest to us, from the outset, an observational and respectful care attitude at first, before making decisions to free them from the containment procedures they may be carrying.

2. Introduction

Our clinical and surgical experience, through our specializations in Stomatology, Oral and Maxillofacial Surgery, Reconstructive Surgery and General Traumatology and, above all, that acquired in polytraumatized patients, confirms our suspicions and conclusions about the physical and psychological risks (and of the latter, which we are going to emphasize) that are determined by the indiscriminate use of, among others, the ubiquitous cervical immobilization collars, which are only apparently purely cephalic cervical, both in out-of-hospital and in-hospital environments and associated or not with other immobilizers in the type of patients referred to above.

3. Material, Method and Treatment

So we arrive, without having any measurable statistics on hand, but with sufficient experience (more than fifty years in reference hospitals), at the conclusion that the most appropriate thing to do in general is to retire as soon as possible!

In craniofacial traumatized patients, especially those who have to wear collars, it is very important to assess the concomitant deterioration of the aero-digestive structures and of the senses that may be associated with facial fractures and what the collars may imply, so that they do not further complicate the functionality of the cephalic pathways and organs, since this creates, at best, situations of at least handicap, if not discomfort and aspiration risks and the maintenance and/or appearance of bleeding, pain, incontinence of oral fluids, etc.

If our thought is to remove them as soon as possible, we will usually do it after Preferential or even Urgent Consultation, mainly to the Services or Specialists of Traumatology, Neurosurgery and/or even Neurology (once our observational capacities have been previously completed and followed by a meticulous and atraumatic clinical exploration of the functions of organs and aerodigestive structures, craniofacial and cervical structures, as far as our knowledge allows us, and even of the most distant and not-for-that-reason presumably involved), either in our own office or service, if it is the case, or in the emergency room, ICU, resuscitation rooms, etc. or wherever we may be required. To immediately ask ourselves if it is indeed indicated in that patient, it is always punctual to keep them

immobilized to those extremes and/or as it usually turns out most of the time, that it is not usually appropriate (Morris CG, 2004).

By freeing them from the device, and that is the most benevolent word we can think of, they stop suffering, even multisystemic (speaking of conscious patients), among others, due to the general organic handicaps, which the inadequately prescribed collar for so long can cause and which leads, at the very least, to situations and feelings in the patient, at the very least, of claustrophobic perceptions or physical and psychomotor entrapment, sometimes even associated with unquestionable vital risks and/or extreme anxiety, due to difficulties in basic survival functions, such as the aerodigestive functions (which are often already severely disrupted by the nature of the accident) and the reduction or even disappearance of the traumatized person's ability to relate, with or without loss of the visual field and control of the immediate environment and

even of hearing (clogging of the auditory conduits and/or excessive bandaging, etc.) and dysfunctions, including dysfunctions of the hearing system (e.g., hearing loss, etc.).) and dysfunctions, even of the limbs, with the impossibility of re-establishing and using primitive capacities, such as autonomous attempts to change posture, which determine the impossibility and difficulty of urination and the general release of excrement, of eating, reading, communication and functions that might seem elementary, etc.

One of the most striking ones are those derived from the aerodigestive functional impediments we mentioned, as the patient feels captured and invalidated by «the device in oppressive functions» and which compromises and hinders the expulsion of secretions and/or the swallowing of their own saliva, and even chewing, speech, oral hygiene, etc.

It is remarkable to see the patients' faces of satisfaction and recovery as soon as the incombustible «adhesive» to which we refer is removed, always with the utmost care, which leads, when removed, to the immediate restoration of their mood and the recovery of their comfort.

Even for experienced professionals and healthcare personnel, they are no longer seriously ill or untouchable but can be considered, treated and felt - we insist - with the necessary caution, as if they were just another patient. This «lack of fear» facilitates, among other things, measured intra-hospital transfers for radiological examinations, etc., which may have been relegated for too long due to cervical immobilization. The studied and active removal of the «cervical retainer» (Figure 1) dramatically de-dramatises the situation!

We cannot go into the details of intubated patients (due to the difficulties in caring for tubes and endotracheal cannulas that the collar causes, or in tracheostomized patients, on many occasions, due to their mere presence in the area), etc., where we must be even more critical and careful, if possible, to avoid the chronification of these artificial airways, which become even less manageable and tolerable than they already are, with the aforementioned device [1].

Figure 1: Picture of a cervical retainer on a patient.

4. Conclusion

In medicine, as in almost everything in life, routines can be very dangerous and enormously counterproductive. Cervical immobilization can usually form part of an excessively established and - why not - rigidly established system of care.

We do not always believe that the Protocols, in general, are the best option for patients but rather the opposite, and this is something that professionals, hospital management, lawyers, forensic experts and judges should be aware of, so that they do not become too institutionalized and, in this way, they avoid becoming too protocol-dependent. Some of these Protocols even try to take advantage of, and often succeed in doing so, given that medicine is fundamentally an art, with the help, of course, of scientific procedures.

In future releases, we will deal with different aspects of other «invasive» procedures, also «invalidating», such as those necessary for the maintenance of artificial pathways, sometimes in the control of vital functions and/or their capacity as vehicles for different therapeutics, often «disregarding» the capacity of natural pathways.

References

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