

Management of Hip Fractures from Emergency Physician Perspective

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Dear Editor

We read with great interest the article “Early Mortality Rates and Types of Surgery in Geriatric Patients with Hip Fractures Undergoing Surgical Treatment” prepared by Özel et al, published in the first issue of your journal in 2024 (1). We would like to thank the authors and the editorial board for the article revealing the relationships between mortality within 30 days after surgery and fracture incidence, implant type and surgical timing in patients older than 65 years who developed hip fractures after a simple fall and were treated surgically. Furthermore, we would like to touch upon a few points to contribute to the discussion of the mentioned study and give readers a different perspective.

Hip fractures represent a significant health problem frequently encountered in emergency departments, leading to decreased quality of life, increased morbidity, and mortality. Annually, an estimated 1.5 million people suffer a hip fracture, and this number is expected to rise with the aging population. The initial point of contact for these patients is typically the emergency department, where the first medical interventions are performed by emergency medicine specialists. Therefore, proficiency in managing hip fractures is crucial for emergency department personnel (2).

Fractures are inherently painful conditions, and pain management in elderly patients is often inadequate, exacerbating the risk of delirium, prolonging hospital stays, impairing functional recovery, and increasing the likelihood of chronic pain syndromes. Appropriate pain management in the emergency department is essential. Peripheral nerve blocks, if available, can be effective in managing pain while minimizing the sedation and other potential complications associated with opioid use. In patients awaiting surgery, both single injections and continuous blocks can be used preoperatively and continued for postoperative analgesia. Given that older adults are generally more sensitive to opioids, lower initial doses should be administered and titrated rapidly to achieve adequate analgesia. Intravenous opioids provide faster relief, but oral medications can also be used.

Notably, preoperative traction does not offer any benefit in

reducing pain or improving hip fracture reduction quality (3).

Patients with hip fractures are at high risk for venous thromboembolism. The decision to use pharmacological or mechanical prophylaxis should be based on the patient-specific risk of bleeding. For patients receiving pharmacological deep vein thrombosis prophylaxis, the selection and timing of antithrombotic drugs must be carefully coordinated with the surgical and anesthesia teams to mitigate the risk of epidural hematoma. Effective thromboembolic prophylaxis requires close collaboration between the surgeon and anesthesiologist (4).

Delirium is a common complication among hospitalized older adults, occurring in approximately two-thirds of patients with hip fractures. Although it is less likely to develop during the emergency department phase, it should still be anticipated and monitored (5).

In the emergency department, it is crucial to determine whether a fall resulting in a hip fracture was a simple fall or secondary to other events such as syncope or central neurological events. Patients should be thoroughly evaluated for additional injuries and any forensic implications.

Another critical aspect to consider in the management of geriatric patients with hip fractures is the role of underlying comorbid conditions. Chronic illnesses such as diabetes mellitus and hypertension are common in this population and can significantly impact perioperative outcomes (6). For instance, poorly controlled blood glucose levels in diabetic patients may increase the risk of infection and impair wound healing, while inadequate blood pressure regulation in hypertensive patients may elevate the risk of perioperative cardiovascular complications. Incorporating routine monitoring and optimization of these comorbidities in emergency and perioperative care protocols could further enhance patient outcomes and reduce mortality. Emphasizing the importance of a multidisciplinary approach that includes endocrinologists and cardiologists in caring for these patients would be a valuable addition to the discussion.

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In conclusion, the study by Özel et al. provides valuable insights into the factors influencing early mortality in geriatric patients with hip fractures undergoing surgical treatment. To enhance the clinical utility of the findings, we recommend further attention to the integration of comorbid condition management, optimized pain control strategies, and preventive measures for complications such as thromboembolism and delirium in the emergency department. A holistic, multidisciplinary approach that addresses both the acute injury and the patient's overall health status is essential to improving outcomes in this vulnerable population. This comprehensive perspective will better equip clinicians to manage geriatric hip fracture patients effectively, from the emergency department to postoperative recovery.

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