

How to Treat a Rib Fracture

By eHow Health Editor



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Most rib [fractures](#) are minor injuries, but they're also extremely painful. The basic treatment of one involves managing the pain and monitoring for more serious injuries. Of course, you should also get to a doctor as soon as possible.

Things You'll Need:

- 1- 2-inch adhesive tape
- Over-the-counter pain relievers

Pain Management

Step1

You might be dealing with a simple fractured rib if any of the following symptoms are present: Sharp pain at a particular point on the chest that's touched, sharp pain when [coughing](#) or breathing, bruising or deformity of the chest.

Step2

Cut 4 or 5 strips of 1- or 2-inch adhesive tape. Make sure the strips are long enough to stretch from the injured person's sternum (the midsection of the rib cage where the ribs meet) to the spine.

Step3

Place a strip of tape directly over the fractured rib, [running](#) from the sternum and wrapping around the back to the spine. Don't place the adhesive tape around the entire chest--this will restrict breathing.

Step4

Place the 3 or 4 additional pieces of tape on either side of the broken rib, running parallel to one another. This tape should help decrease pain by restricting the movement of the fractured area.

Step5

Improvise a splint if you don't have adhesive tape--whatever it takes to minimize movement without restricting breathing. Some options are to fill a stuff sack with some clothes and tie it to the chest using bandannas. Have the injured person hold one hand against the fractured site. Then put the arm on the injured side into a sling and secure the arm against the fractured site using a bandanna or triangular bandage tied around the chest.

Step6

Give the injured person ibuprofen, acetaminophen or naproxen sodium for pain.

Step7

Encourage the injured person to cough frequently. It's going to hurt, but it will prevent secretions from pooling in the lung, which could cause pneumonia.

Serious Fractures

Step1

Look for the signs of serious fractures that may involve injury to the lungs: Rapid and shallow breathing, elevated heart rate, increased difficulty breathing, coughing up blood.

Step2

Place 1 hand on each side of the injured person's chest and observe the way in which the chest moves with each breath. If one side of the chest rises during inhalation while the other falls, at least 3 ribs have been broken on the falling side of the chest. This is called a "chest flail."

Step3

Roll the person onto their injured side if there is severe difficulty in breathing or if the chest is rising and falling asymmetrically.

Step4

Place a rolled piece of clothing underneath the fractured area to support it. This will help control the pain with breathing.

Step5

Fill a plastic bag with sand or dirt and hold this against the side of the fractured rib if this side is rising and falling asymmetrically during inhalations.

Step6

Tape a large pad of gauze across the weighted bag, bringing the tape from one side of the chest to the other. Do not tape across the back.

Step7

Keep the person on his or her side and continually monitor for difficulties breathing. You may need to roll the person over and provide CPR if the person ceases to breathe.

Step8

Go to the hospital immediately for even the simplest of rib fractures. The injured person must be flown or carried out if there are any signs of respiratory distress, but they'll be able to walk out with simple fractures.

Step9

Continually monitor the injured person's breathing. You may need to make adjustments to the bandage or splint device if it begins to restrict breathing.

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5.02 Rib Fracture and Costochondral Separation

Presentation

A patient with an isolated rib fracture or a minor costochondral separation usually has a history of falling on the side of the chest, being struck by a blunt object, coughing violently or leaning over a rigid edge. The initial chest pain may subside, but over the next few hours or days pain increases with movement, interfering with sleep and activity and becoming severe with coughing or deep inspiration. The patient is often worried about having a broken rib, and may have a sensation of bony crepitus or abnormal rib movement. Breath sounds bilaterally should be normal unless there is substantial splinting or a pneumothorax or hemothorax is present. There is point tenderness over the site of the injury and occasionally bony crepitation can be felt.

What to do:

- Examine the patient for possible associated injuries; e.g., do an abdominal exam to look for any signs of a splenic or hepatic injury. If there was a significant mechanism of injury, the patient may require a comprehensive evaluation to rule out life and limb threatening injuries.
- When there is a history of minor trauma, check for pain with indirect stress on the suspected fracture site. Compress the rib medially if a posterior or anterior fracture is suspected. Compress the rib anteriorly/posteriorly if a fracture is suspected at a lateral location. When pain occurs at the suspected fracture site with indirect stress, this is clinical evidence of a fracture or separation and should be so documented on the chart.
- Obtain any history of chronic pulmonary problems or heavy smoking.
- Unless the patient is elderly or has pulmonary disease, have him try out a rib belt during his wait for x rays.
- Send the patient for a PA & lateral chest x ray to rule out a pneumothorax, hemothorax, evidence of pulmonary contusion, etc. Additional oblique rib films for radiological documentation of a fracture are optional and often unproductive, but these films are indicated when there is a suspicion of multiple rib fractures, especially in the elderly.
- If there is no suspicion of underlying injury and when there is clinical or radiologic evidence of a rib fracture or chondral separation:
 - Provide a potent oral analgesic (Motrin, Aleve, Tylenol with codeine, Lorcet, Percocet).
 - Instruct the patient on the intermittent use of an elastic and velcro rib belt if it reduces pain. Place the top of the belt at the inferior tip of the xyphoid process, tightening it around the chest enough to obtain maximum pain relief. The rib belt may be left on almost continuously for the first one to four days but it should be removed as comfort allows thereafter.
 - Instruct the patient on the importance of deep breathing and coughing (without the rib belt but using a pillow splint) to help prevent pneumonia. Tell him to take enough pain medicine to allow coughing and deep breathing.
 - Provide the patient with an appropriate work excuse and refer him for followup care in 48 hours. Tell him to expect gradually decreasing discomfort for about two weeks, and forbid strenuous activity for approximately eight weeks.
 - Severe worsening of chest pain, shortness of breath, fever or purulent sputum may signal pulmonary complications and should prompt a return visit. A greater incidence of complications can be expected in patients with displaced rib fractures.
- When patients are elderly or have pulmonary or cardiac compromise, or multiple fractures or other injuries which might compromise respiratory dynamics, consider hospitalization for observation, pain control and pulmonary toilet. Blood gases and pulmonary function tests can aid in evaluation of breathing.
- When there is no clinical or radiologic evidence of a fracture, treat the pain as you would any other contusion, using an appropriate analgesic.

What not to do:

- Do not confuse simple rib fractures with massive blunt trauma to the chest. The evaluation and management is quite different.
- Do not tape ribs or use continuous strapping. This will lead to an atelectatic lung prone to pneumonia.
- Do not assume there is no fracture just because the x rays are negative. Rib fractures are often not apparent on x ray, especially when they occur in the cartilagenous portion of the rib. The patient deserves the disability period and analgesics commensurate with the real injury.

Discussion

Most fractures and separations are treated with immobilization, but ribs are a special problem because patients have to continue breathing. In the presence of severe pain one should consider the use of an intercostal nerve block or injection of the fracture hematoma with 0.5% bupivacaine hydrochloride (Marcaine). Because of the risks of pneumothorax or hemothorax, this procedure, in most cases, should be reserved for secondary management when initial treatment has proven ineffective.