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Opinion Article

The Impact of Trauma: How It Can Change Lives

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ABOUT THE STUDY

There has been a significant movement in the last three decades from operational to selective nonoperative therapy of the injured patient. When an increasing amount of evidence supported nonoperative therapy of the vast majority of pediatric splenic and hepatic injuries, traumaticologists caring for adult patients began to follow the trend started by their paediatric counterparts. It was further demonstrated that the presence of hemoperitoneum and changed mental condition do not appear to exclude first nonoperative therapy in acute abdominal trauma, even in patients with higher grade injuries or those of advanced age. The multiple advanced and very accurate noninvasive imaging methods at the trauma surgeon's disposal promote the rising use of nonoperative, or "conservative," care of abdominal solid organ injuries. The availability of trauma-trained surgeons, modern radiographic imaging, proper interpretation of such high-quality radiographic images, and specialized institutional support and infrastructure are all critical components of the nonoperative method.

Despite some initial resistance, targeted nonoperative care of abdominal stab wounds has become standard practice in the majority of trauma centers. Some trauma centers have lately begun to use selective nonoperative therapy of gunshot wounds. The growing use of a selective nonoperative strategy for Gun Shot Wounds (GSW) is consistent with developments in nonoperative therapy of other types of severe injuries. However, the efficacy and safety of the nonoperative approach to blunt or penetrating traumatic injury, particularly in a resource-constrained situation, remain debatable. Nonoperative methods to penetrating abdominal trauma were the norm for the majority of the nineteenth century. By 1887, when the American Surgical Association endorsed surgical treatments for civilian penetrating abdominal wounds, this paradigm began to shift. Due to the significant death rate associated with nonoperative therapy of penetrating abdominal injuries during World War I, surgical investigation became the norm. This rule was bolstered by the fact that many surgeons returning from WWII pushed for the ongoing use of forced surgical exploration for all civilian GSWs. When a trend towards targeted nonoperative management of abdominal knife wounds emerged.

Surgical exploration of all GSWs to the abdomen was the conventional treatment until the 1990s, when large metropolitan trauma centres published their findings on selective non-operative care of penetrating abdominal injuries.

Just around one-third of the patients presented with Blunt Abdominal Trauma (BAT) are found to have definite intra-abdominal injuries. The abdomen, on the other hand, embodies the problem of missed injuries, with important findings missing in up to one-third of BAT patients. It is worth noting that the most common cause of preventable death in BAT patients is an undetected splenic damage. Concurrent extra-abdominal injuries and impaired sensorium from shock, head damage, or alcohol/drug intoxication exacerbate the situation. Because of the proclivity for low pressure bleeding from solid viscera, predicting which injuries are likely to be self-limiting based only on early findings is difficult. Abdominal discomfort, tenderness, guarding, and distention are the most prevalent symptoms of intra-abdominal damage. Significant abdominal injuries may also cause other symptoms such as shortness of breath or chest pain.

Nonetheless, keep in mind that 40% of patients with severe hemoperitoneum have no peritoneal symptoms. Studies of blunt hepatic, splenic, and renal injuries have clearly demonstrated the trend towards nonoperative therapy of solid organ injuries, which has been supported by the increased availability and accuracy of various advanced imaging techniques and hemodynamic monitoring technologies. As a result, both therapeutic and nontherapeutic laparotomy rates dropped dramatically. Nonoperative management carries the inherent risks of a missed hollow visceral injury, delayed bleeding, and transfusion-related risks, whereas laparotomy carries a unique set of risks related to the surgeon, anaesthesia, the nature of the operation and potential complications, and patient-related risk factors. Data suggests that the decision between the two therapy techniques should be driven by hemodynamic considerations rather than the severity of organ impairment.

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