ABDOMINAL EVALUATION

At the end of this workstation, one should have an idea of how to determine presence or absence of abdominal injury, the potential options available in the remote and rural location and finally the options available in an urban centre.

HOW TO DETERMINE INJURY

History

Obviously high speed motor vehicle crashes give rise to the potential for significant intra-abdominal injuries particularly the splenic and liver injuries and also small bowel injuries and viscus perforations due to safety belt injuries. The diagnosis should be on clinical examination. The options, if there is a surgical presence, is diagnostic peritoneal lavage. History is helpful - for example in footy, a knee in the left upper quadrant often gives rise to splenic laceration. This can be again diagnosed in clinical grounds.

Clinical examination is important in abdominal evaluation. The patient may or may not have general signs. Young men are often difficult to examine because they have a good physiological reserve and may have lost up to two litres of blood before there is any significant tachycardia. Increasing fluid requirements during resuscitation should alert you to impending major blood loss. Tenderness away from the safety belt injury site is also suggestive of small bowel injury. Guarding or rebound is as important. Absent bowel sounds is a vital clue to impending peritonitis and the presence of an intra-abdominal injury. Blood tests are useless in the early phase of injury. Serum Amylase is not a goods indicator of pancreatic damage. If there is doubt about the presence of an abdominal injury, early transfer to a surgical centre is essential.

During this workstation we will outline three common scenario scenes at rural and urban centres and will identify ideal trauma management with some tips for the rural environment. Some of the scenarios are ubran based but knowlegde of these will this help in a romote location.