

Slide 1



Time needed- 3mins for 1st 3 slides
 Review Instructor notes for each slide
 50 minutes – interactive session – with whole candidate group

Requirements

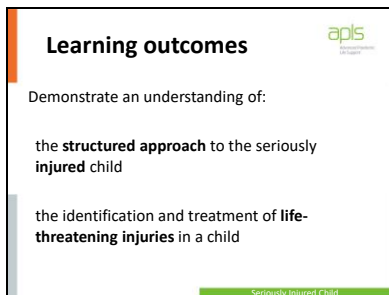
- 4 assistant instructors with appropriate prompting materials needed. One for each group. (optional)
- Powerpoint slide set
- Handouts to groups
 - Pencils
 - Activity 1 and 2 on A3
 - Activity 3 on A3

Environment/Set

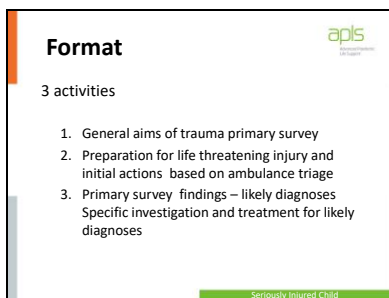
- Allow candidates to get themselves into 4 groups
- One instructor allocated per group (optional)

Read as on slide

Slide 2



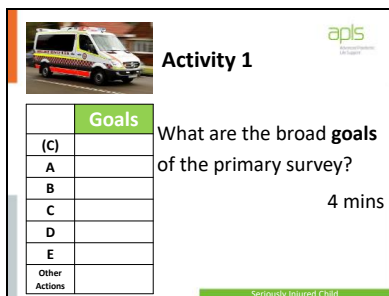
Slide 3



Read as on slide

Time 03mins (Time 03 mins at completion)

Slide 4



Activity 1 – Goals of the Primary Survey

Time needed 04 mins (Running time 7 mins at completion)

4 min breakout

Small group activity

Handout proforma – Activity 1

Ask the groups to write on the A3


List the goals of each component of the structured approach of the primary survey'

Start the groups at different places. This ensures all areas are covered well.

They should try and get through all goals but will be responsible for reporting back on the one they started on Allocate 1st group start with A, 2nd Group B, 3rd group C, 4th group D/E/Other. (1 facilitator per group with 4 slide handout to keep group on track.)

- **Activity 1 – Primary Survey Goals**
 - **Review the goals of each component of the structured approach**
 - ***This section is not about specific diagnoses – but rather the broad physiologic goals***
- Bring groups back together for plenary discussion with the next slide

Slide 5

Goals of primary survey 

(C) Control catastrophic external haemorrhage

A Maintain and protect airway patency
Minimise unnecessary cervical spine movement

B

C

D


E

Rx

Seriously Injured Child

- Start at 7 min
- Time needed 5mins to complete this exercise (Running time 12 mins at completion)
- As per slide
- Each group has a representative speak loudly and clearly
- After group has presented display 'correct response'

Slide 6

Goals of primary survey 

(C) Control catastrophic external haemorrhage

A Maintain and protect airway patency
Minimise unnecessary cervical spine movement

B Maintain oxygenation
Maintain ventilation

C

D


E

Rx

Seriously Injured Child

-

Slide 7

Goals of primary survey 

(C) Control catastrophic external haemorrhage

A Maintain and protect airway patency
Minimise unnecessary cervical spine movement

B Maintain oxygenation
Maintain ventilation

C Assess for shock
Seek & control haemorrhage
Restore & maintain perfusion

D


E

Rx

Seriously Injured Child

-

Slide 8

Goals of primary survey 

(C) Control catastrophic external haemorrhage

A Maintain and protect airway patency
Minimise unnecessary cervical spine movement

B Maintain oxygenation
Maintain ventilation

C Assess for shock
Seek & control haemorrhage
Restore & maintain perfusion

D Identify neurological injury
Prevent secondary insult


E

Rx

Seriously Injured Child

-

Slide 9

Goals of primary survey 

(C) Control catastrophic external haemorrhage

A Maintain and protect airway patency
Minimise unnecessary cervical spine movement

B Maintain oxygenation
Maintain ventilation

C Assess for shock
Seek & control haemorrhage
Restore & maintain perfusion

D Identify neurological injury
Prevent secondary insult


E Identify other threats to life & limb
Extremities, exposure but maintain environment & euglycaemia

Rx

Seriously Injured Child

-

Slide 10

Goals of primary survey 

(C) Control catastrophic external haemorrhage

A Maintain and protect airway patency
Minimise unnecessary cervical spine movement

B Maintain oxygenation
Maintain ventilation

C Assess for shock
Seek & control haemorrhage
Restore & maintain perfusion

D Identify neurological injury
Prevent secondary insult

E Identify other threats to life & limb
Extremities, exposure but maintain environment & euglycaemia

Rx Expedite definitive treatment, transfer
Limit suffering

Seriously Injured Child

-

Slide 11

Paul's case

Paul is a 13 year old boy (40kg) who was climbing a tree in his own garden, which overhung the street. His mother was out shopping and on her return, she found that he had fallen from the tree, onto a low garden wall, and then onto the pavement. He could not stand up and she called an ambulance.



Seriously Injured Child

Start at 12 min-

Time needed 2 mins for next 2 slides (Running time 14 mins at completion)

The initial presentation of the case is now relayed to the candidates over the next two slides.

This is your typical prehospital notification which is brief but not comprehensive.

The groups will now think about how they prepare their environment for this patient reception based on the likely injuries to each area of the primary survey

Time 2 mins (Running time 14 mins at completion)

Activity 2 – prehospital info preparation

Candidates will work through this case, using a structured approach, discuss in their groups the likely injuries, preparation for these.

Slide 12

Activity 2: En route Paul 13yo, 40Kg

In pain, bruised left forehead with left chest and abdominal pain
RR ~38/min, SpO₂ 98%
HR 140/min, BP 140/75
CRT 3 sec, GCS 14, given IN fentanyl

What preparation is needed to address his potential injuries?
6 mins

	Prep
(C)	
A	
B	
C	
D	
E	
Rx	

Seriously Injured Child

Time needed 6 mins for activity (Running time 20 mins at completion)

Allocate groups different starting points. . This ensures all areas are covered well.

They should try and get through all goals but will be responsible for reporting back on the one they started on.

Works best going anticlockwise or right to left, so that Group 4 get A (had D/E) , Group 1 now get B (had A), group 2 get C (had B), , group 3 get D/E/Other (had C),

This way each group is moving down the primary survey rather than backward, and once reaching the end start at the beginning again.

That is once they have finished E they'll be dealing with A next.

(1 facilitator per group with 4 slide handout to keep group on track.)

Activity 2 – Preparations

- groups should list the specific preparations for the likely injury

Slide 13

Activity 2 Pre arrival preparation

(C) Stop exsanguinating haemorrhage - compression, suture, binder

A	Airway equipment Minimise unnecessary neck movement
B	
C	
D	
E	
Rx	

Seriously Injured Child

Activity 1B – Prehospital preparation

Start at 20 min – Time needed 8 mins for feedback (Running time 28 mins at completion)

A – important to stress that haemoglobin is responsible for 95% oxygen carriage. As trauma patients may be losing haemoglobin, oxygen is imperative to allow dissolved oxygen, PO₂, to carry oxygen to the tissues in the absence of haemoglobin.

Manipulation of the airway, particularly in the obtunded patient, should respect the possibility of an occult or unstable neck injury, and so unnecessary neck movement should be minimised

Slide 14

Activity 2
Pre arrival preparation

(C) Stop exsanguinating haemorrhage - compression, suture, binder

A Airway equipment
Minimise unnecessary neck movement

B ICC for tension pneumothorax, massive haemothorax, open pneumothorax, ventilation for flail chest/lung contusion, CXR

C

D

E

Rx

Seriously Injured Child

Activity 1B – Prehospital preparation

Time needed 8 mins for feedback (Running time 28 mins at completion)

B – with the history of blunt trauma and left chest pain any of these conditions are possible. Preparation for how to clinically detect these conditions, with the aid of chest x-ray, and how to rapidly manage, need to be prepared for.

Slide 15

Activity 2
Pre arrival preparation

(C) Stop exsanguinating haemorrhage - compression, suture, binder

A Airway equipment
Minimise unnecessary neck movement

B ICC for tension pneumothorax, massive haemothorax, open pneumothorax, ventilation for flail chest/lung contusion, CXR

C IVC x2, warmed IV crystalloid 10 mL/kg +/- 5mL/kg O-ve blood, tranexamic acid, massive transfusion protocol, FAST, pelvic X-ray

D

E

Rx

Seriously Injured Child

Activity 1B – Prehospital preparation

Time needed 8 mins for feedback (Running time 28 mins at completion)

C - C – ABC – the focus is on detecting and stopping exsanguinated blood loss. Systematic approach to how to look for areas of declared as well as occult blood loss need to be thought about, as well as the utility of chest x-ray, pelvic x-ray, FAST scan. Areas of active bleeding should be managed with direct compression bandaging, suturing, reduction of fractures, pelvic binding.

Large bore IV access is needed. Circulating blood volume should be maintained, with infusion of warmed fluid.

The choice of resuscitation fluid is dependent on multiple variables including the presence of shock, estimated starting haemoglobin, the detectable areas of active bleeding and whether there is ongoing bleeding or not, and the response to initial fluid resuscitation. TXA helps decrease clot dissolution which contributes to acute traumatic coagulopathy. MTP is reserved for those requiring large volumes of blood or who are shocked at any stage.

Slide 16

Activity 2
Pre arrival preparation

(C) Stop exsanguinating haemorrhage - compression, suture, binder

A Airway equipment
Minimise unnecessary neck movement

B ICC for tension pneumothorax, massive haemothorax, open pneumothorax, ventilation for flail chest/lung contusion, CXR

C IVC x2, warmed IV crystalloid 10 mL/kg +/- 5mL/kg O-ve blood, tranexamic acid, massive transfusion protocol, FAST, pelvic X-ray

D Rapid neurological assessment, AVPU or GCS, pupils, limb movement, secondary brain and spinal protection – avoid hypotension, hypoxia

E

Rx

Seriously Injured Child

Activity 1B – Prehospital preparation

Time needed 8 mins for feedback (Running time 28 mins at completion)

D- A crude but important neurological assessment is necessary. Progress of neurological status needs to be observed. Factors that aggravate primary brain injury result in secondary brain injury. The major focus is avoiding hypotension and hypoxia. But hypercarbia, hyper/hypoglycaemia, hyperthermia, acidosis, hyponatraemia, seizures all need to be optimised to prevent this occurring.

Slide 17

Activity 2
Pre arrival preparation

(C) Stop exsanguinating haemorrhage - compression, suture, binder

A Airway equipment
Minimise unnecessary neck movement

B ICC for tension pneumothorax, massive haemothorax, open pneumothorax, ventilation for flail chest/lung contusion, CXR

C IVC x2, warmed IV crystalloid 10 mL/kg +/- 5mL/kg O-ve blood, tranexamic acid, massive transfusion protocol, FAST, pelvic X-ray

D Rapid neurological assessment, AVPU or GCS, pupils, limb movement, secondary brain and spinal protection – avoid hypotension, hypoxia

E Extremity review, exposure – log roll to assess posterior and thoracolumbar spine
Environment – keep warm & check BGL

Rx

Seriously Injured Child

Activity 1B – Prehospital preparation

Time needed 8 mins for feedback (Running time 28 mins at completion)

E – exposure and a thorough examination of the posterior aspect and extremities of the patient is critical to not missing injuries. Remembering that heat loss needs to be minimised.

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Activity 2
Pre arrival preparation

(C) Stop exsanguinating haemorrhage - compression, suture, binder

A Airway equipment
Minimise unnecessary neck movement

B ICC for tension pneumothorax, massive haemothorax, open pneumothorax, ventilation for flail chest/lung contusion, CXR

C IVC x2, warmed IV crystalloid 10 mL/kg +/- 5mL/kg O-ve blood, tranexamic acid, massive transfusion protocol, FAST, pelvic X-ray

D Rapid neurological assessment, AVPU or GCS, pupils, limb movement, secondary brain and spinal protection – avoid hypotension, hypoxia

E Extremity review, exposure – log roll to assess posterior and thoracolumbar spine
Environment – keep warm & check BGL

Rx Trauma page, blood, trauma imaging, consider analgesia, O-ve blood, Notify surgeon, anaesthetist, telemedicine, inter-facility transfer?

Seriously Injured Child

Activity 1B – Prehospital preparation

Time needed 8 mins for feedback (Running time 28 mins at completion)

Rx - Other actions – the patient’s mechanism of injury and initial descriptions of injuries and vital signs would recommend the presence of trauma team on arrival. As well as this notification of relevant complimentary services such as radiology, Blood Bank, surgical team, anaesthetic and intensive care team would be appropriate depending on the facility.

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Activity 3:
Progress on arrival (7min)

(C) Nil

A groaning, gurgling secretions

B SpO₂ 94% non-rebreather bag RR 40/min
Decreased A/E, left chest, hyperresonant and tender

C Pale, cold & clammy
pulse thready, HR 155/min
BP 90/ systolic, CRT 6 sec

D Confused conversation, occasionally combative, GCS 10, left pupil dilated

E Temp 35°C, no extremity abnormalities, moving all limbs (7 mins)

	Dx	Rx/Ix
(C)		
A		
B		
C		
D		
E		
Other		

Seriously Injured Child

Activity 3 – Diagnoses & further Actions

Time needed 2 mins for this slide (Running time 30 mins at completion)
Start at 28 min-

Time needed 2 mins for this slide (Running time 30 mins at completion)

Read the following

‘Pt now arrives. A number of features of his primary survey have progressed.’

Utilise the next seven minutes to consider his latest primary survey injury status and the associated treatment or intervention required.

Both areas of activity 3 need to be filled out on the A3 forms for this exercise. You have 7 minutes’

Time 7 mins (Time 37 mins at completion)

Time needed 7 mins for activity (Running time 37 mins at completion)

Start the groups at different places. This ensures all areas are covered well.

They should try and get through all goals but will be responsible for reporting back on the one they started on.

Works best going anticlockwise or right to left, so that Group 4 get B (had A) , Group 1 now get C (had B), group 2 get D/E/Other (had C), group 3 get A (had D/E/Other),

This way each group is moving down the primary survey rather than backward, and once reaching the end start at the beginning again.

That is once they have finished E they’ll be dealing with A next. (1 facilitator per group with 4 slide handout to keep group on track.)

Activity 3 – Diagnoses & further Actions

Slide 20

Activity 3:
What are the diagnoses and treatment/investigations?

(C) Nil

A groaning, gurgling secretions

B SpO₂ 94% non-rebreather bag RR 40/min
Decreased A/E, left chest, hyperresonant and tender

C Pale, cold & clammy
pulse thready, HR 155/min
BP 90/ systolic, CRT 6 sec

D Confused conversation, occasionally combative, GCS 10, left pupil dilated

E Temp 35°C, no extremity abnormalities, moving all limbs (7 mins)

	Dx	Rx/Ix
(C)		
A		
B		
C		
D		
E		
Other		

Seriously Injured Child

Slide 21

Activity 3 – Diagnoses & further Actions 'Lets start with A' -

	Dx	Rx/Ix
(C)		
A		
B		
C		
D		
E		
Other		

Diagnoses and Actions:

- (C) Nil
- A groaning, gurgling secretions
- B SpO₂ 94% non-rebreather bag RR 40/min
Decreased A/E, left chest, hyperresonant and tender
- C Pale, cold & clammy pulse thready, HR 155/min
BP 90/ systolic, CRT 6 sec
- D Confused conversation, occasionally combative, GCS 10, left pupil dilated
- E Temp 35°C, no extremity abnormalities, moving all limbs (7 mins)

Seriously Injured Child

Activity 3 – Diagnoses & further Actions 'Lets start with A' -

Refresher whilst group give answers over next 2 slides
Let them give answer before showing answer
Time needed 2 mins for this and next 2 slides (Running time 39 mins at completion)

Slide 22

Re-assessment - Possible diagnoses

(C)	
A	Airway threatened, may become obstructed secondary to diminished LOC (closed head injury, opiates, shock)
B	
C	
D	
E	

Seriously Injured Child

A – likely issues

Slide 23

Treatment and investigation

(C)	
A	HFO NRB, suction, OPA ? NPA maintain cspine immobilization – BVM, prepare for RSI
B	
C	
D	
E	

Seriously Injured Child

A – likely intervention. Talk about MILS with intubation. Avoidance of NPA with facial fractures but not if no evidence of such.

Slide 24

Activity 3 – Diagnoses & further Actions. 'Lets talk about B'

	Dx	Rx/Ix
(C)		
A		
B		
C		
D		
E		
Other		

Diagnoses and Actions:

- (C) Nil
- A groaning, gurgling secretions
- B SpO₂ 94% non-rebreather bag RR 40/min
Decreased A/E, left chest, hyperresonant and tender
- C Pale, cold & clammy pulse thready, HR 155/min
BP 90/ systolic, CRT 6 sec
- D Confused conversation, occasionally combative, GCS 10, left pupil dilated
- E Temp 35°C, no extremity abnormalities, moving all limbs (7 mins)

Seriously Injured Child

Activity 3 – Diagnoses & further Actions. 'Lets talk about B'

Refresher whilst group give answers over next 2 slides
Let them give answer before showing answer
Time needed 2 mins for this and next 2 slides (Running time 41 mins at completion)

Slide 25

Re-assessment - Possible diagnoses

(C)	
A	Airway threatened, may become obstructed secondary to diminished LOC (CHI, opiates, shock)
B	Tension pneumothorax Massive haemothorax Flail chest & pulmonary contusions ? Diaphragmatic hernia
C	
D	
E	

Seriously Injured Child

B – likely DDx for decreased A/E

Slide 26

Treatment and investigation

apls

(C)

A HFO NRB, suction, OPA ? NPA maintain C-spine immobilisation – BVM, prepare for RSI

B Left ICC – before or after RSI? CXR before/after?

C

D

E

Seriously Injured Child

B – indications for ICC. CXR before if sats > 90% and not shocked or tension Ptx. CXR may reveal contusion or traumatic diaphragmatic hernia that doesn't need ICC.

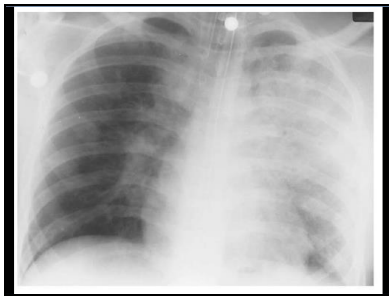
If A needs intubation, what is timing for ICC ?
Before or after intubation. With preparation for tension Ptx, better to do once intubated.

Slide 27



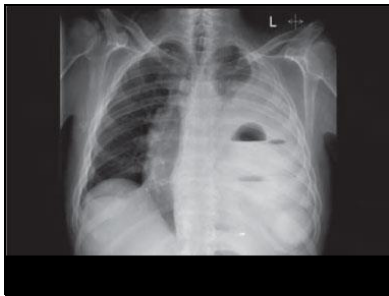
CXR DDx for decreased air entry – not all need ICC
Pneumothorax

Slide 28



CXR DDx for decreased air entry – not all need ICC
Lung contusion

Slide 29



CXR DDx for decreased air entry – not all need ICC
Traumatic diaphragmatic hernia

Slide 30

C

apls

	Dx	Rx/Ix
(C)		
A		
B		
C		
D		
E		
Other		

(C) nil

A groaning, gurgling secretions

B SpO₂ 94% non-rebreather bag, RR 40/min
Decreased A/E, left chest, hyperresonant and tender

C Pale, cold & clammy
pulse thready, HR 155/min
BP 90/ systolic, CRT 6 sec

D Confused conversation, occasionally combative, GCS 10, left pupil dilated

E Temp 35°C, no extremity abnormalities, moving all limbs (7 mins)

Seriously Injured Child

Start at 41 mins

Activity 3 – Diagnoses & further Actions. 'Lets talk about C'

Refresher whilst group give answers over next 2 slides

Let them give answer before showing answer

Time needed 2 mins for this and next 2 slides (Running time 43 mins at completion)

Slide 31

Re-assessment - Possible diagnoses

(C)

A Airway threatened, may become obstructed secondary to diminished LOC (closed head injury, opiates, shock)

B Tension pneumothorax
Massive haemothorax
Flail chest & pulmonary contusions
? Diaphragmatic hernia

C Intra-peritoneal haemorrhage – ruptured spleen
Retro-peritoneal haemorrhage – pelvis +/- kidney
Cardiac tamponade/contusion, BP 90 systolic = large blood loss

D

E

C – likely Dx if tachycardia = bleeding. If BP low = significant bleeding. Need to search for blood loss.

Slide 32

Treatment and investigation

(C)

A HFO NRB, suction, OPA ? NPA maintain C-spine immobilization – BVM, prepare for RSI

B Left ICC – before or after RSI? CXR before/after?

C Pelvic binder + Xray, FAST, 10mL/kg warmed blood, 10mL/kg crystalloid until available. Tranexamic acid. Surgeon needed

D

E

C – Note output from ICC. Bind pelvis and Xray to ensure no fracture or position with binder satisfactory. CXR and Pelvic Xray if NAD helpful for excluding these areas as sources for significant blood loss.

FAST scan in accredited hands detects blood in abdomen – if blood present then

- need surgeon NOW
- resus with blood, TXA and consider MTP,
- pt needs advanced imaging (CT abdo).

Slide 33

Specific Updates – Primary Survey

New fluid resuscitation algorithm for shocked trauma patient

- Tranexamic acid
- 10mL/kg blood
- 10mL/kg blood
- Massive transfusion protocol (MTP)
- Crystalloid if blood not available

Pg 120

Now Advocating Tourniquets, direct pressure and early tranexamic acid

Minimal Volume resuscitation

Slide 34



Xray with pelvic binder in place

Slide 35

Activity 3 – Diagnoses & further Actions. 'Lets talk about D'

(C) Nil

A groaning, gurgling secretions

B SpO₂ 94% non-rebreather bag, RR 40/min
Decreased A/E, left chest, hyperresonant and tender

C Pale, cold & clammy
pulse thready, HR 155/min
BP 90/ systolic, CRT 6 sec

D Confused conversation, occasionally combative, GCS 10, left pupil dilated

E Temp 35°C, no extremity abnormalities, moving all limbs (7 mins)

	Dx	Rx/Ix
(C)		
A		
B		
C		
D		
E		
Other		

Activity 3 – Diagnoses & further Actions. 'Lets talk about D'

Refresher whilst group give answers over next 2 slides
Time needed 2 mins for this and next 2 slides (Running time 45 mins at completion)

Slide 36

Re-assessment - Possible diagnoses

(C)

A Airway threatened, may become obstructed secondary to diminished LOC (closed head injury, opiates, shock)

B Tension pneumothorax
Massive haemothorax
Flail chest & pulmonary contusions
? Diaphragmatic hernia

C Intra peritoneal haemorrhage – ruptured spleen
Retro-peritoneal haemorrhage – pelvis +/- kidney
Cardiac tamponade/contusion. BP 90 = large blood loss

D Progressive head injury – raised ICP, lateralising signs.
Progressive spinal injury needs consideration

E

Seriously Injured Child

D – Decreased GCS and signs raised ICP – severe head injury

Slide 37

Treatment and investigation

(C)

A HFO NRB, suction, OPA ? NPA maintain C-spine immobilization – BVM, prepare for RSI

B Left ICC – before or after RSI? CXR before/after?

C Pelvic binder + X-ray, FAST, 5mL/kg warmed blood, 10mL/kg crystalloid until available. Tranexamic acid. Surgeon

D A VPU – likely intracranial haemorrhage – secondary brain protection
Avoid hypotension or hypoxia. Hyperventilate (pCO2 35-40)
Mannitol/hypertonic saline?

E

Seriously Injured Child

- **D – management** – secondary brain protection principles. Best outcome for D is to ensure A, B and particularly C stable. Safe intubation, hyperventilation to PCO2 30-35 is most HD stable way to decrease raised ICP – rapid effect within mins. HTS also better if trying to avoid hypotension and diuresis, but takes 20-30 mins to have effect.

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E to end

(C) Nil

A groaning, gurgling secretions

B SpO₂ 94% non-rebreather bag RR 40/min
Decreased A/E, left chest, hyperresonant and tender

C Pale, cold & clammy
pulse thready, HR 155/min
BP 90/ systolic, CRT 6 sec

D Confused conversation, occasionally combative, GCS 10, left pupil dilated

E Temp 35°C, no extremity abnormalities, moving all limbs (7 mins)

	Dx	Rx/ix
(C)		
A		
B		
C		
D		
E		
Other		

Seriously Injured Child

Activity 3 – Diagnoses & further Actions. ‘Lets talk about E and Rx’

Refresher whilst group give answers over next 2 slides
Time needed 2 mins for this and next 2 slides (Running time 47 mins at completion)

Slide 39

Re-assessment - Possible diagnoses

(C)

A Airway threatened, may become obstructed secondary to diminished LOC (closed head injury, opiates, shock)

B Tension pneumothorax,
Massive haemothorax
Flail chest & pulmonary contusions
? Diaphragmatic hernia

C Intra peritoneal haemorrhage – ruptured spleen
Retro-peritoneal haemorrhage – pelvis +/- kidney
Cardiac tamponade/contusion. BP 90 = large blood loss

D Progressive head injury – raised ICP, lateralising signs.
Progressive spinal injury needs consideration

E Hypothermia, hypoglycaemia, hidden injuries

Seriously Injured Child

E – keep warm, check BSL, log roll for occult injury.

Slide 40

Treatment and investigation

(C)

A HFO NRB, suction, OPA ? NPA maintain C-spine immobilization – BVM, prepare for RSI

B Left ICC – before or after RSI? CXR before/after?

C Pelvic binder + X-ray, FAST, 5mL/kg warmed blood, 10mL/kg crystalloid until available. Tranexamic acid. Surgeon

D A VPU – likely ICH – secondary brain protection
Avoid hypotension, hypoxia. Hyperventilate. Mannitol/hypertonic saline?

E Exposure, look for injuries, keep warm, euglycaemia

Ix, Meds C-spine X-ray, CXR, pelvic X-ray – CT brain, CT abdomen
Surgical and neurosurgical review

Seriously Injured Child

Trauma series xrays reasonable
Pt needs CT Abdo and CTB
Need surgical and Neurosurgical attendance

Slide 41

Diagnoses & Specific therapy

Diagnoses

- C-spine Xray – NAD
- CXR – L ICC – resolved pneumothorax, # ribs
- Pelvic X-ray – left pubic bone #
- CT abdomen – ruptured spleen
- Multiple lacerated left kidney
- CTB – left SDH, midline shift

Specific therapy options

- Conservative ?
- Operative ?
- Interventional radiology ?
- Telemedicine ?
- Interfacility transfer required ?

Seriously Injured Child

Start at 47 min Time 3 mins (Time 50 mins at completion of next 3 slides)

Eventual findings

Review the treatment options – but do not dwell upon these

The important point of all management options is that emergent paediatric trauma surgery should be available.

Text 6e Section 13.4 Page 136-137

What are the pre-requisite conditions for conservative management?

- Frequent monitoring
- Blood bank service including coagulation factors
- Accurate fluid management
- Emergent paediatric surgery immediately available

What are the indications for immediate laparotomy?

- Perforated viscous
- Penetrating injuries
- Refractory shock with clinical suspicion of intra-abdominal haemorrhage

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Seriously Injured Child

Slide 43

A structured approach ...

- <C> - control external bleeding
- Airway - oxygen, C-spine control
- Breathing - ventilatory support
- Circulation - haemorrhage control
- Disability - prevent secondary insult
- Exposure - temperature control

Seriously Injured Child

Slide 44

Airway & C-spine **Imaging**

Circulation/ MTP/TXA **Blunt vs penetrating**

Seriously Injured Child

A prompting slide to remind the candidates of the *differences* in resuscitation of the traumatic patient v the ill patient

- control of catastrophic haemorrhage, care of the cervical spine, need for x 2 lvs, early blood products in major haemorrhage, analgesia...