

MANAGEMENT OF CHEST TRAUMA

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Initial management

- The initial management
- ABC air way and neck protection
 - breathing
 - circulation
- The goal of primary survey identify and treat conditions that are immediate treat of life

AIR WAY

- Air way obstruction tongue and foreign bodies and airway injuries
- GCS below 8 consider intubation

Air way

- No needs for intervention in conscious patient with normal voice without tachypnea except:
- Expanding hematoma in neck
- Extensive subcutaneous emphysema
- Chemical and thermal injuries
- Complex maxillofacial trauma
- Airway bleeding

Air way

Neck immobilization:

Cervical hard collar

Sand bags on both sides of head with taping of fore head

Not recommended for penetrating neck trauma

Breathing

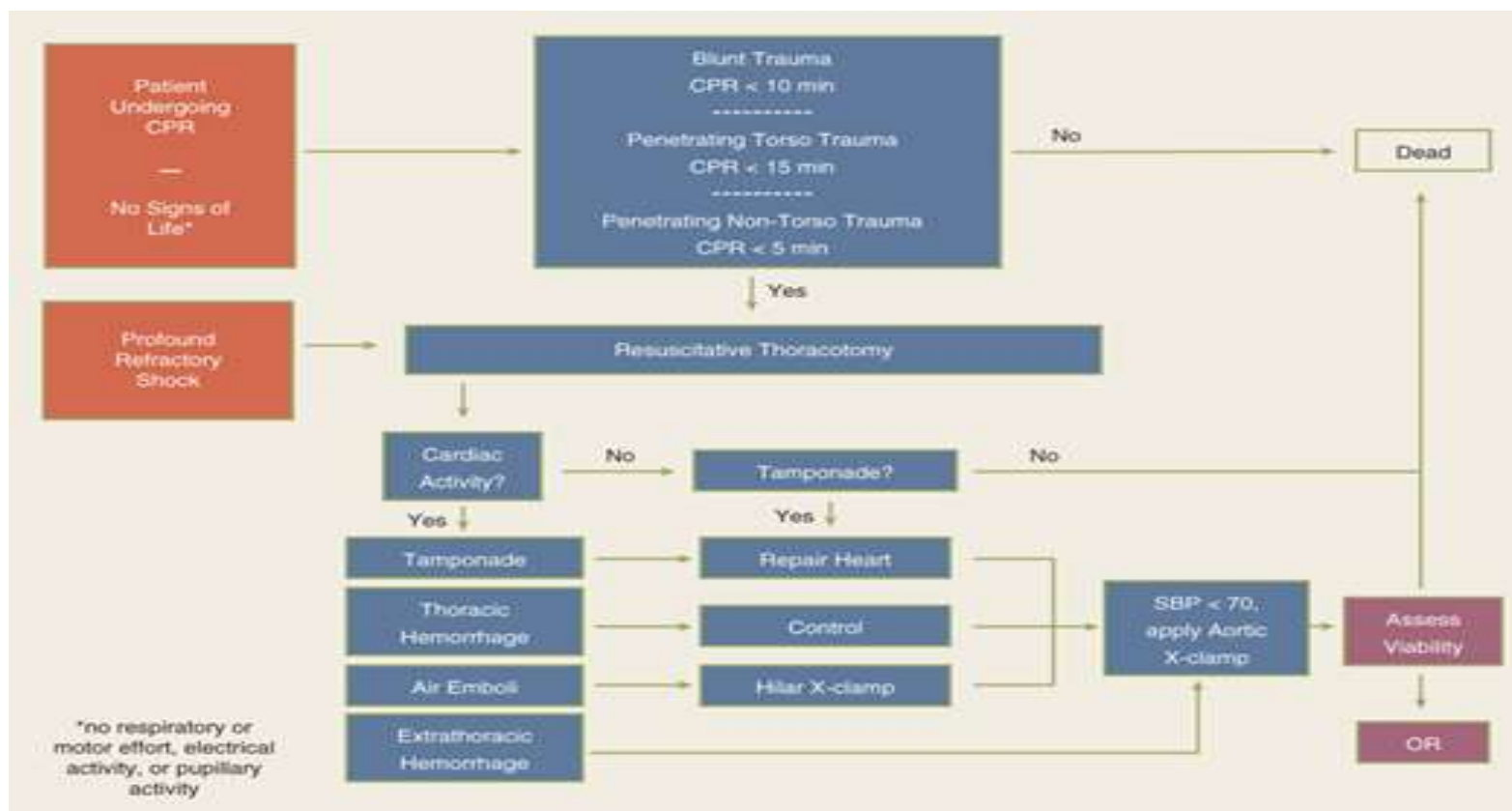
- Breathing tension pneumothorax
- open pneumothorax
- massive airleak from tracheo
 bronchial tree
- flail chest with contusion

Circulation

- Hemorrhagic shock
- External source: skull limbs etc
- Internal :chest:massive hemothorax
abdomen:massive hemoperitoneum
pelvis:unstable pelvic fracture

Cardiogenic shock

- Cardiac tamponade
- Rarely MI due to previous history



Indications for operation

- Chest tube drainage >1000cc penetrating >1500cc blunt trauma
- Ongoing drainage >200cc for three consecutive hours
- Cacked hemothorax
- Tamponade
- Cardiac herniation
- Massive air leak
- Tracheal and main bronchus
- Great vessel injuries
- Open pneumothorax
- Esophageal perforation
- Air embolism

important

- Patient who presents after delay with chest drainage 1500cc but drainage ceased lung completely reexpands hemodynamically stable may be managed non operatively

Diaphragmatic rupture

- Blunt most in left and large
- Penetrating equal in both side usually small and may diagnose late
- Approach from abdomen

Traumatic pneumatocele

- Post traumatic pulmonary pseudocyst
- Diagnose with ct-scan
- May become infected fever leucocytosis
- Antibiotic CT guided drainage if unresolving surgery