

Problems of Early Diagnosis of the Abdominal Cavity with Concomitant Abdominal Trauma in Children

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Received: 9 November 2021 Accepted: 30 November 2021 Published: 13 December 2021

Abstract

In the structure of child mortality, trauma comes first among the causes of death in children over one year of age. Mortality in children with multiple and concomitant trauma remains high -from 7.1 to 22

Index terms— polytrauma, concomitant trauma, catatrauma, complex diagnostics, abdominal trauma.

1 Introduction

feature of modern childhood traumatism is an increase in the number of many types of injuriescombined and multiple trauma, leading to an increase in mortality and disability [1]. In peacetime, concomitant injury most often occurs because of road accidents and falls from a height [7].

According to the many authors, the mortality rate in childhood with associated injuries ranges from 7.1% to 22% [2,3]. High mortality is associated with late diagnosis of internal bleeding, as well as the emergence of several foci of nociceptive pathological impulses, which, with a sufficiently long and intense exposure, leads to disintegration and disruption of urgent compensatory mechanisms, therefore, to an increase in the severity and resistance of traumatic shock. [3,4] The combination of trauma to the abdominal organs with damage to other anatomical areas of the body aggravates the condition of the victim, significantly complicates the diagnosis and worsens the prognosis [6]. In a timely manner undetected abdominal injuries lead to an error in the choice of surgical tactics. Despite the improvement of laboratory instrumental and minimally invasive diagnostic methods, in the surgery of abdominal injuries, the errors of diagnosis and, accordingly, the surgical treatment tactics are 20-38%. [3,4] The aim of the study is to develop a therapeutic and diagnostic algorithm for surgical treatment for concomitant abdominal trauma in children.

2 II.

3 Materials and Methods

Over the past 10 years (2010-2019), 118 patients aged 1 to 18 years with combined injuries were hospitalized in the Republican Scientific Center for Emergency Medical Aid (RSCEMA) in the department of emergency surgery. Of these, 61 (33.9%) patients applied through the emergency room, 51 (43.2%) -by gravity without a referral, and 6 (5%) -by gravity in a referral from other institutions. 83 (70.3%) were boys and 36 (29.6%) were girls.

Taking into account the periodization of childhood adopted in pediatrics, the material is divided into three age groups: younger, from 0 to 3 years -17 (14.4%) children, average age 1.8 ± 1.1 years; average, 4-11 years old -69 (58.5%) patients, average age 8.4 ± 2.1 years; the oldest, 12-18 years old -32 (27.1%) children, the average age is 15 ± 1.5 years [5]. Injuries were received by victims of road accidents -78 (66.4%) cases, falls from a height -39 (33.0%) and domestic injuries -1 (0.84%).

Among the patients, a combination of 6 anatomical areas was identified in 6 (5%) cases; 5 regions -8 (6.8%); 4 regions -18 (15.2%); 3 regions -46 (39%) and 2 regions -40 (33.9%) (Diagram. 1).

Diagram 1: Abdominal trauma in combination with other areas of the body.

The most frequent combinations of abdominal injuries were observed in victims with head grass -104 (88%) cases, chest -31 (29.8%), limbs -16 (13.6%), spine -2 (1.7%) and pelvis -1 (0.84%) (Fig. 2)

Diagram 2: Combinations of abdominal injuries with other anatomical areas. [????????]%(31)[????????]%(16) [????????]%(2) [????????]%

4 Combinations of abdominal injuries with other anatomical areas

The logistic factor, which determines the duration of treatment and the timeliness of diagnostic and therapeutic procedures, depending on the severity of the injuries, plays the most essential role in the therapeutic efficacy in concomitant trauma [9]. The key to success at the stages of diagnosis and determination of treatment tactics is the first "golden" hour of hospitalization, during which it provides an opportunity for the survival of victims with associated trauma. Of the 118 hospitalized patients with associated injuries, 73 (62%) patients came to the RSCEMA within 1 hour from the moment of injury, 18 (10%) -2 hours, 9 (5%) -5 hours, 18 (10%) -more than 5 hours.

The severity of the injury was assessed using the ISS scale [8]. Assessment of the severity of the injury showed that among them, injuries of a critical degree prevailed -31 (26.3%) patients, 63 severe (53.4%) and 24 moderate (20.3%).

Among children with concomitant trauma, 64 (54.2%) were admitted in consciousness, 14 (11.9%) -in a state of stunning, 7 (5.9%) -in a soporous state, 33 (28%) -in various degrees of coma.

Determination of the dominant trauma is one of the most difficult sections in the treatment of victims with concomitant trauma. In the analyzes carried out by our center with combined trauma, in 85 (72%) cases, abdominal injuries were the dominant trauma, which posed the greatest threat to the victim's life. In most cases, with combined abdominal trauma, liver damage was noted in 40 (33.9%) cases, spleen -39 (33%), kidney -6 (5.08%), small intestine -6 (5.08%), large intestine -2 (1.7%) and gallbladder -2 (1.7%). (Diagram 3). In our observations, the source of hemoperitoneum was mainly damage to the liver and spleen. According to the classification of injuries of parenchymal organs AATS (American Association of Trauma Surgery, 1994) -the American Association of Injury Surgery, a shortened scale of injuries, where 5 degrees of severity are distinguished [8,10], damage to the spleen I degree was noted in two cases (5.1%); grade II spleen injury was observed in 3 (7.7%) patients; III degree -in 14 (35.9%) patients; IV degree -in 20 (51.3%) victims, respectively. Grade V damage to the spleen was not observed. First-degree liver damage was detected in 8 (20%) patients; second degree -in 12 (30%); the third -in 14 (35%); the fourth -in 6 (15%). the fifth degree of degree of damage was not revealed in our patients.

5 Frequency of abdominal injuries in associated injuries, n = 118

The degree of damage to the parenchymal organs of the abdomen according to AIS III.

6 Results and Discussion

In the diagnosis of combined abdominal injuries, ultrasound played an important role. Instrumental studies were started with ultrasound, with further re-examination 1 hour after admission and every 3 hours during the day. Among 118 children with concomitant injuries, in 90 (76.3%) cases, an ultrasound examination of the abdominal organs was performed, in 5 (4.2%) cases an emergency operation was performed without preliminary ultrasound examination, 23 (19.5%) died during shock measures upon admission before the ultrasound. At the same time, the sensitivity of ultrasound in determining hemoperitoneum in patients with abdominal trauma was 95.6%, and the diagnostic efficiency was 97.9%.

Polypositional radiography was performed according to standard techniques, while in 99 (83.9%) cases a simultaneous plain radiography of the skull, spine, chest and abdomen (including laterography), pelvis and extremities (according to indications) was performed. Of the total number of studies, 54 (53.5%) patients showed various bone-traumatic injuries of the limb on X-ray examination, 6 (5.94%) patients showed rib fractures and 39 (39.4%) children showed no pathology on X-ray. revealed. The sensitivity of X-ray examination in the diagnosis of injuries to the abdominal organs was low and amounted to 41.2 to 66.4%.

Multispiral computed tomography (MSCT) is a non-invasive method that provides valuable additional information about the extent, number and extent of damage in associated injuries. MSCT was performed in 46 (39%) patients. At the same time, MSCT of the head and neck was performed in 11 (24%), chest -4 (8.7%), abdomen -12 (26%), pelvis -2 (4.3%). In 3 (6.5%) cases, a total MSCT examination was performed from the head to the lower extremities, which made it possible to simultaneously reveal the presence of damage to all anatomical regions in a few minutes. MSCT had a sensitivity of 97% -98%, a specificity and accuracy of 98%.

The final method in diagnosing abdominal injuries was laparoscopy, which made it possible to avoid unnecessary laparotomies. Diagnostic laparoscopy was performed in 45 (38.1%) cases of patients with ultrasound examination of the presence of free fluid in the abdominal cavity. Of these, 6 (5.1%) cases of abdominal injuries were not detected, in 4 (3.4%) patients, the operation was completed laparoscopically by coagulation of small ruptures of parenchymal organs and sanitation of the abdominal cavity: in 1 (0.8%) case performed laparoscopic suturing of the rupture of the liver, in 3 (2.5%) diathermocoagulation of ruptures of the spleen. Diagnostic laparoscopy in 35 (29.7%) children revealed the presence of a large amount of blood due to deep damage to the liver and spleen with active bleeding, in connection with which they underwent a conversion to laparotomy. In 30 (25.4%) cases, laparotomy was immediately performed due to a large amount of free fluid on ultrasound and unstable

hemodynamic parameters, among which in 23 (19.5%) cases the operation ended with coagulation and suturing of liver damage, in 32 (27 , 1%) -splenectomy.

Diagnostic laparoscopy makes it possible to determine the amount and nature of fluid in the abdominal cavity and, based on this, the volume of the operation is planned: to complete the operation -66 surgical interventions for injuries of the musculoskeletal system. Most of all were hip injuries -28 operations, lower leg bones -32 and pelvic bones -6.

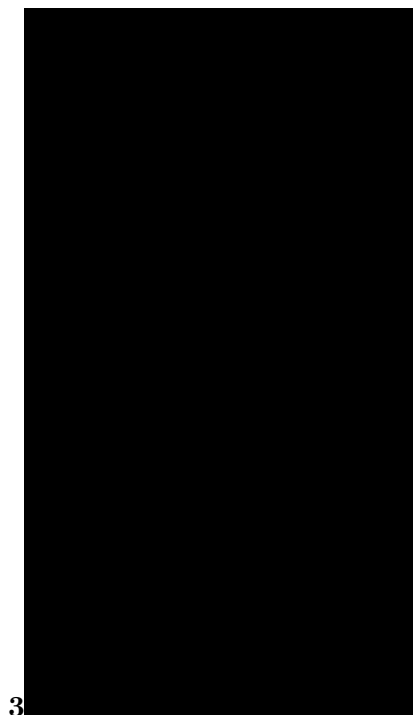
It was created a tactic based on the Ultrasound Score -USS scale (Fig. 2) to improve the diagnosis of injuries to the abdominal organs. An ultrasound scan in dynamics is conducted with a zero USS score, i.e. in the absence of free fluid in the abdominal cavity, and an operation of the dominant injury is performed in the presence of a dominating damage to another anatomical location. Diagnostic laparoscopy or laparotomy are performed when USS is equal to 1 or 2 or more. The operation of other anatomical locations is performed after intra-abdominal bleeding has been stopped and the integrity of the internal organs of the abdominal cavity has been eliminated. According to the recommended algorithm, the first stage is to restore the functions of vital organs with the elimination of damage to the anatomical regions, where there is a dominant, life-threatening nature of damage. The restoration of the anatomical and functional integrity of other anatomical areas, where the nature of the damage is not dominant, is carried out in the second stage.

IV.

7 Conclusions

1. Ultrasound gradation of the volume of free fluid in the abdominal cavity USS (Ultrasound Score) makes it possible to determine the surgical tactics for concomitant abdominal trauma.

2. In cases of severe trauma with unstable hemodynamics, a total MSCT examination from the head to the lower extremities is justified for the timely detection of the dominant injury and other injuries. ¹



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Figure 1: Figure 3 :

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Figure 2: Figure 2 :



Figure 3: 3 .

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