CECT in the Evaluation and Management of Blunt Abdominal Trauma

Dr. I. V S S N Prasannapidaparti¹, Dr. Sunil Kumar Naramnatha

¹,²Third Year Resident, G. S. L. Medical College & General Hospital, Rajahmundry, India

Contact Details of Presenting Author:
Address: D.No: 70-7-60/2, Thota Subbarao Nagar, Kakinada – 533005.
Mobile: 9908302354, Email ID: doctorprasanna[at]gmail.com

Abstract: Introduction: Trauma constitutes 3rd commonest cause of death after malignancy & vascular diseases. Abdominal trauma common in 20-40%, blunt trauma constitutes 2/3rd cases. Aims & Objectives: To evaluate the role of CECT in diagnosis, grading, management and follow-up of blunt abdominal trauma in hemodynamically stable patients. Materials & Methods: 46 hemodynamically stable patients were included in this study, 35 were males and 11 females, age between 25 to 60years. CECT (i.v contrast) was done to all the patients. Results: Among the 46 patients, CECT showed splenic injuries in 28 patients, liver injuries in 13, hollow viscus perforation in 2, mesenteric vascular injury in 1, diaphragmatic injury in 1 & duodenal injury in 1 patient. CT signs of hemoperitoneum (30-70HU), sub capsular hematoma, linear laceration, pneumoperitoneum, sentinel clot sign, contrast extravasation, CT collar sign with abdominal visceral herniation for diaphragmatic injury & Grading by AAST (American Association for Surgery of Trauma). Conclusions: Characterization of parenchymal injuries, accessibility to retro peritoneal injuries, detecting the bowel and mesenteric injuries, identifying the source of bleeding has greatly increased the accuracy of CECT in the management and clinical outcome of blunt abdominal trauma in hemodynamically stable patients.

Keywords: CECT, Blunt Abdominal Trauma

1. Introduction

- Trauma constitutes 3rd commonest cause of death after malignancy & vascular diseases¹.
- Abdominal injuries are the third most commonly involved after the head and extremities²(20-40%), of which 2/3rd cases are due to blunt trauma.

Abdominal injuries assessment:

1) Physical examination: poor sensitivity (<50%).
2) Diagnostic peritoneal lavage (DPL): invasive obsolete).
3) Imaging has already replaced DPL³.
   - Ultrasound (FAST): Hemoperitoneum.
   - CT: Hemoperitoneum, solid/hollow viscus Injuries, active extravasation/vascular injuries, retroperitoneal injuries.

Aims and Objectives

- To evaluate the role of CECT in the diagnosis, grading, management and follow-up of blunt abdominal trauma in hemodynamically stable patients.
- To study the various clinical – radiological patterns of blunt abdominal injuries.
- To correlate the CT features with clinical outcome.
- To identify the imaging indicators of poor clinical outcome.

Inclusion Criteria

- All hemodynamically stable patients:
- Mild to moderate responsive hypotension.
- Moderate suspicion of intra-abdominal injury based on clinical signs and symptoms.

Exclusion Criteria

- Patient who are hemodynamically unstable
- Unresponsive profound hypotension.
- Not responding to resuscitation.
- Clinically obvious major abdominal trauma.

2. Materials & Methods

- Patients with clinically suspected blunt abdominal injuries for a period of 12 months (June 2018-May 2019) were subjected for the study.

Equipment: TOSHIBA 16 SLICE CT

CT Protocol:

1) CTH ical mode, Axial thick sections 5mm taken & reformatted to 1mm for viewing. Reformations in coronal and sagittal planes were also done.
2) I.V contrast was given to all the patients to rule out visceral injury. Oral and rectal contrast also given to rule out bowel injuries.

CT signs of abdominal injuries:

3) Hemo-peritoneum (30-70HU),
4) Sub capsular hematoma,
5) Linear laceration,
6) Pneumo-peritoneum,
7) Sentinel clot sign,
8) Contrast extravasation,
9) CT collar sign with abdominal visceral herniation for diaphragmatic injury.

- The various organ injuries were graded by AAST (American Association for Surgery of Trauma)
- The management, therapeutic or conservative was decided based on the CT findings.
- Patients with severe grades of injury (Grade 3 and 4) and with large hemoperitoneum required surgeries⁴.
3. Observation and Results

46 hemodynamically stable patients of age between 25 to 60 years were included in this study.

### Incidence of Various Abdominal Injuries

<table>
<thead>
<tr>
<th>Organ</th>
<th>Number of cases</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spleen</td>
<td>28</td>
<td>61%</td>
</tr>
<tr>
<td>Liver</td>
<td>13</td>
<td>28.3%</td>
</tr>
<tr>
<td>Hollow Viscus Perforation</td>
<td>2</td>
<td>4.34%</td>
</tr>
<tr>
<td>Duodenum</td>
<td>1</td>
<td>2.12%</td>
</tr>
<tr>
<td>Mesentry</td>
<td>1</td>
<td>2.12%</td>
</tr>
<tr>
<td>Diaphragm</td>
<td>1</td>
<td>2.12%</td>
</tr>
</tbody>
</table>

### Agewise Distribution of the Disease

- **45 years**: 29% (13 patients)
- **25-45 years**: 71% (33 patients)

All the injuries show male preponderance.

### Correlation between Injury Grading and Management

<table>
<thead>
<tr>
<th>Injury Grade</th>
<th>Total no of patients</th>
<th>No of conservatively managed cases</th>
<th>No of operated cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Liver Injury</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Grade I</td>
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<td>6</td>
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</tr>
<tr>
<td>Grade II</td>
<td>4</td>
<td>3</td>
<td>1</td>
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<tr>
<td>Grade III</td>
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<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Grade IV</td>
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<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Grade V</td>
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<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>13</td>
<td>9</td>
<td>4</td>
</tr>
<tr>
<td>Splenic Injury</td>
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<td></td>
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</tr>
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<td>Grade I</td>
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<td>16</td>
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<tr>
<td>Grade II</td>
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<tr>
<td>Grade III</td>
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<tr>
<td>Grade IV</td>
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<tr>
<td>Grade V</td>
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</tr>
<tr>
<td>Total</td>
<td>28</td>
<td>21</td>
<td>7</td>
</tr>
<tr>
<td>Hollow Viscus Perforation</td>
<td>2</td>
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<tr>
<td>Duodenum Injury</td>
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<td>1</td>
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</tr>
<tr>
<td>Mesentry Injury</td>
<td></td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Diaphragmatic injury</td>
<td></td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>
AAST Classification of splenic injury:

**Grade I**
- subcapsular hematoma <10% of surface area
- parenchymal laceration <1 cm depth
- capsular tear

**Grade II**
- subcapsular hematoma 10-50% of surface area
- intraparenchymal hematoma <5 cm
- parenchymal laceration 1-3 cm in depth

**Grade III**
- subcapsular hematoma >50% of surface area
- ruptured subcapsular or intraparenchymal hematoma ≥5 cm
- parenchymal laceration >3 cm in depth

**Grade IV**
- any injury in the presence of a splenic vascular injury* or active bleeding confined within splenic capsule
- parenchymal laceration involving segmental or hilar vessels producing >25% devascularisation

**Grade V**
- shattered spleen

*Note: Asterisk indicates injury to the splenic vascular system.
any injury in the presence of splenic vascular injury* with active bleeding extending beyond the spleen into the peritoneum

4. Conclusion

CECT accurately identifies injuries that require early exploration and at the same time avoids unnecessary operative intervention in cases that can be managed conservatively5.

**CECT is the most sensitive** modality in :
- Characterization & grading of parenchymal injuries.
- To access retro peritoneal injuries.
- To detect bowel and mesenteric injuries.
- To identify the source of bleeding.

Thus, CECT reduces mortality of blunt abdominal trauma in hemodynamically stable patients6 as it is accurate in the management & clinical outcome.

References