The Treatment Of Abdominal Trauma

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Primary Diagnosis Approach Considerations

The treatment of abdominal trauma begins at the scene of the injury and is continued upon arrival of the patient in the emergency department or trauma center. Administration may include non-operational measures or surgical treatment, as appropriate.

The indications for laparotomy in a patient with blocked abdominal injuries are as follows:

- • signs of peritonitis
- • uncontrolled shock or bleeding
- • Clinical impairment during observation
- • Haemoperitoneum results after a traumatic examination (FAST) or Peritoneal Wash Diagnostic Exam (DPL)

Finally, surgery is indicated in patients with peritoneal evidence based on physical examination results. Operative treatment is not indicated in all patients with positive FAST scan results. Hemodynamically stable patients with positive FAST results may require a CT scan to define the nature and extent of the lesions better. Operation in each patient with positive FAST scan results may lead to a highly unacceptable laparotomy rate.

Resuscitative thoracotomy is not recommended in patients with traumatic thoracic and thoracic trauma who have impulsive electrical activity upon arrival at the emergency department. The survival rate in this situation is almost 0%. These patients may be allowed to receive a thoracotomy in the ED only if they have signs of life upon arrival.

Hirschsprung’s Disease

Imaging can help diagnose Hirschsprung’s disease. A simple abdominal x-ray may show a small dilated bowel or proximal colon. Colon contrast radiographs are normal during the first three months of life and indefinitely in patients with total colon disease. After the dilatation process begins, the diseased part of the colon will appear normal, and the proximal colon will dilate. A “transition zone” (the point where the normal bowel clumps) may be visible on a contrasting contrast radiograph; However, the agglomerated colon will extend beyond this point in about 10 percent of patients. In some patients with enterocolitis, it is necessary to avoid the coagulation of the contrast due to the risk of perforation. Anal manometry (relaxation of the rectangular balloon) demonstrates the absence of relaxation of the internal anal sphincter in rectal distension3. The contraction climate and anal

manometry are similar in sensitivity and specificity.

Treatment

After Hirschsprung's disease is diagnosed, surgery is necessary. Physicians should have a general understanding of common procedures to facilitate communication between the surgeon and the patient's family. Before surgical intervention, radial rectal irrigation helps to decompress the intestine and prevent enterocolitis. In healthy infants with indistinguishable colon and short-segmented Hirschsprung's disease, the final breathable ileoanal anastomosis may be performed. There are several traction techniques, with complication rates ranging from 4 to 16 percent. Swenson's operation involves removing the rectum, extracting the healthy lymph node and connecting it to the anus. The latest techniques (e.g., Operation Duhamel, Operation Soave) help preserve the intricate nervous supply of the rectum and bladder. Extensions of anastomosis are needed for several months after the Soave operation to prevent stenosis; The patient's parents can do it at home. All of these procedures have high success rates, and morbidity is minimal.

Some surgeons perform Soave transanal single-phase phase in neonates with short segment disease, eliminating the need for abdominal incision and colostomy. Complication rates were similar to Soave's more invasive operations; However, short follow-up periods have limited studies of this approach.

In addition to making early diagnosis and timely delivery for treatment, the role of the family physician should include post-operative complication monitoring and providing self-help counseling and resources to the patient's family.

Traumatic Brain Injury (TBI)

With moderate or severe traumatic brain injury (BIT), the diagnosis is often evident. In the presence of other life-threatening injuries, which is often the case with car accidents, you may lose your head injury. The focus is on rescue measures. (Burrus Gr, 1961)

The patient may be on a ventilator (ventilator) and sedated, and the evaluation of the brain injury will be limited until the patient is allowed to leave the medication and mechanical ventilation. Mild traumatic brain injury cannot be diagnosed until the individual has no problems in what was once easy or social situations. (National Institute of Neurological Disorders and Stroke, 2012)

Injuries to specific areas of the brain will cause some symptoms. For example, lesions in the frontal lobe will result in further cognitive impairment, such as loss of inhibitions leading to inappropriate social behavior. Cervical injuries will result in loss of coordination and balance. The brain system controls things like breathing and heart rate as well as emotion. An injury in this area could inhibit any of these processes.

Diagnostic Methods

A detailed neurological examination is important and will bring evidence of brain injury.

Brain images with CAT, MRI, SPECT, and PET may be useful. Cognitive evaluation by a neuropsychologist with formal neuropsychological tests. Evaluations by physical, professional, and logical therapists help clarify individual deficits.

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