Trauma: development of a sub-algorithm

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Background: Anaesthetists are regularly involved in the management of patients who have suffered trauma. Acute physiological derangements can occur at any time after the original injury, with life threatening sequelae. These problems may be complex in nature and evolve rapidly, often with an obscure aetiology, so a systematic approach to them is essential.

Objectives: To examine the role of a previously described core algorithm “COVER ABCD–A SWIFT CHECK” supplemented by a specific sub-algorithm for trauma, in the management of anaesthesia involving trauma cases.

Methods: The potential performance of a structured approach for each of the trauma incidents among the first 4000 incidents reported to the Australian Incident Monitoring Study (AIMS) was compared with the actual performance as reported by the anaesthetists involved.

Results: There were 38 relevant reports relating to trauma in the first 4000 reports to AIMS. In 39% of these there was “emergency corner cutting”, although in the majority the urgency was thought to have been more perceived than real. The previously described "core" crisis management algorithm for crises during general anaesthesia was an effective means of discovering 82%, diagnosing 68%, and correcting 66% of trauma incidents. However, a sub-algorithm specific for the traumatised patient was required for unusual, obscure, or complex presentations.

Conclusion: Although the small numbers preclude validation of the sub-algorithm, it would have successfully managed all the trauma cases reported to AIMS.

METHODS

Of the first 4000 reports to AIMS, those which made reference to “trauma” were extracted and analysed for relevance, causes, diagnosis, management, and outcome. The COVER ABCD–A SWIFT CHECK algorithm, as presented elsewhere in this set of articles,7 was applied to each relevant report to determine the stages at which the problem might have been diagnosed and to confirm that activating the COVER portion would have led to appropriate initial steps being taken. As patients suffering from trauma are not dealt with by this algorithm, a specific crisis management sub-algorithm for crises arising in patients under anaesthesia for these problems, and provides an indication of the potential value of using this structured approach.

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ACUTE TRAUMA SUB-ALGORITHM
Early Management of Severe Trauma (EMST) protocol

As many incidents in trauma patients involve "corner cutting" such as failure to check due to perceived urgency, it is essential to recheck everything carefully.

The best way to do this is to start again with COVER ABCD. If not successful consider possible missed diagnoses – follow EMST system – repeat primary survey, review results to date, and look for missed injuries.

A airway injury
- Look for
  - Failure to secure airway, failure to ventilate with tube in airway
- Manage
  - Failed intubation drill, consider surgical cricothyrotomy early with facial injury

B tension pneumothorax
- Look for
  - Distended neck veins, decreased air entry on ipsilateral side, hyperresonance on ipsilateral side, medistinal shift away
- Manage
  - Immediate needle thoracostomy, formal UWSD insertion

C unexplained blood loss/hypovolaemia
- Look for
  - Sites of concealed bleeding: chest/abdomen/pelvis, sites of visible bleeding
- Manage
  - Consider chest x-ray, consider pelvis x-ray, diagnostic peritoneal lavage or if severe urgent laparotomy, view operative site, examine known wounds

D undiagnosed intracranial collection
- Look for
  - Dilating pupil under GA, unexplained bradycardia and hypotension in presence of known or suspected head injury, raised ICP if monitored, failure to waken
- Manage
  - Urgent CT scan if available, urgent neurosurgical consultation

E hypothermia
- Look for
  - Temperature fall during long cases
- Manage
  - Cover as much of patient as possible, active heating methods, warm theatre

TRAUMA/BLEEDING

CONSIDER WITH
Any unexplained change in the patient’s condition

HIGH RISK SITUATIONS
After high velocity motor vehicle accidents
With any neck/head/chest/abdominal injury, no matter how trivial the external signs
With multiple injuries
Patients with pre-existing systemic disease
Elderly patients

PREPACITATING FACTORS (1)*

Breathing: Pneumothorax
Pulmonary contusion
Ruptured larynx/bronchi
Circulation: Ongoing haemorrhage (evert or occult)
Intracranial hypertension from any cause
Cardiac tamponade
Myocardial contusion

EMERGENCY MANAGEMENT (3)

Complete COVER-A SWIFT CHECK
Treat all cervical spines as unstable until cleared
Inform the surgeon about any concerns
If there is cardiovascular instability, consider:
Haemorrhage. Many blood volumes may disappear
Into a pelvis
Into the retroperitoneal space
Into extensive soft tissue damage
Myocardial contusion
Hypothermia

IF THE SITUATION IS STILL UNRESOLVED, RECHECK FOR:

Airway injury
Cervical spine injury
Pulmonary contusion
Bronchopleural fistula
Unexplained blood loss/hypovolaemia
Cardiac tamponade
Myocardial contusion
Hyperkalaemia after suxamethonium

Hypothermia

FURTHER CARE

Maintain vigilance
Continuously reassess the situation
Consider admission to ICU/HDU post operatively.

NOTES:
The COVER-ABCD algorithm detected (82%), diagnosed (68%) and corrected (66%) a high proportion of relevant incidents reported to AMS.

(1) Commonest modes of presentation were, hypoxia/desaturation – 8%, aspiration – 8%, cardiac arrest – 8%, air embolus – 6% and hypotension – 3%.
(2) 39% of incidents were sequelae of ‘cutting corners’ in an effort to save time. Retrospectively, in 73% of these incidents the urgency was judged to be perceived rather than real. Failure to check the machine resulted in equipment related problems in 5% of cases.
(3) EMST – Early Management of Severe Trauma protocol (Australia), USA/UK equivalent is ATLS – Acute Trauma Life Support protocol.


* Numbers in brackets refer to Notes in the right hand panel.
RESULTS

There were 87 reports that contained the word “trauma”. Of these, 49 were either related to accidental trauma caused during anaesthesia to a non-trauma patient, most commonly damage to a tooth, or involved patients who had a past history of trauma mentioned in the report but which was unrelated to this episode. These unrelated cases were not used in the subsequent analysis and results. The remaining 38 reports related to patients with trauma where the trauma occurred in an acute trauma setting. Eight (21%) of these 38 cases involved children 14 years or younger. Incidents were evenly spread across the range of ASA status (table 1) with a surprisingly high proportion (29%) being ASA 1. Hypoxia/desaturation was the clinical situation occurring most commonly with 20 instances (53%). Fifteen incidents (39%) in apparently urgent cases had “corner cutting” as a factor (table 2). In 11 of these 15 cases, further analysis revealed that the urgency was perceived rather than real. The high percentage of emergency ASA E codes (95%) bears witness to this (table 1). The “emergency” situation seems to engender a sense of urgency that may then lead to “corner cutting” in an attempt to save time; 39% of incidents seem to have occurred at least in part due to this tendency to overlook checks in “emergency” trauma cases, leading to a failure to prevent a failure of equipment. It is also crucial to note that on review monitors (R1) were a missed C1 fracture, a nerve block on the wrong side, and the giving of uncrossmatched blood. None of these incidents required any special corrective manoeuvres once they had been identified.

DISCUSSION

It is clear that anaesthetising the acutely injured patient can be very stressful. The high percentage of emergency ASA E codes (95%) bears witness to this (table 1). The “emergency” situation seems to engender a sense of urgency that may then lead to “corner cutting” in an attempt to save time; 39% of incidents seem to have occurred at least in part due to this “corner cutting” (table 2). For example, there seems to be a tendency to overlook checks in “emergency” trauma cases, when clearly these are the situations where one can least afford a failure of equipment. It is also crucial to note that on further analysis 11 of the 15 “corner cutting” cases were not would have been amenable to prevention simply through better checking. These were a missed C1 fracture, a nerve block on the wrong side, and the giving of uncrossmatched blood. None of these incidents required any special corrective manoeuvres once they had been identified.
Key messages

- There were 38 reports relating to trauma in the first 4000 incidents reported to AIMS. Eight (21%) of these involved children less than 14 years of age.
- These trauma cases related to incidents in which either the trauma may have contributed to the incident or the incident occurred in an acute trauma setting.
- Hypoxia/desaturation was the commonest occurring clinical incident (53%).
- Fifteen incidents (39%) involved unjustified “corner cutting”, where the level of urgency appeared to be more perceived than real. The commonest “corner cutting” incident was ventilation/circuit failure due to no/poor checking.
- ASA grades I to IV were almost equally represented among the 38 cases; 36 cases were emergencies, with three moribund cases.
- A specific trauma sub-algorithm was developed based on the widely accepted Early Management of Severe Trauma (EMST) course principles and its effectiveness was tested against the reports.
- The COVER ABCD core algorithm discovered 82%, diagnosed 68%, and corrected 66% of the trauma incidents.
- The application of several sub-algorithms from this series of papers, including the proposed trauma sub-algorithm, would have corrected the remaining incidents in this trauma series. The sub-algorithms that definitively addressed the presenting incident were: desaturation in nine cases, trauma in eight cases, embolism in two cases, and bronchospasm, hyperthermia, and hyperthermia in one case each.
- The single largest contributor to the successful correction of the trauma incidents was “ventilate by hand” (V1) in COVER.
- Although consistency with current EMST principles is important, a larger series of trauma incident reports is needed for ongoing validation and revision of the protocol.

shown to be time critical. The use of the ASA E code causes the patient to be labelled as either “elective” or “emergency”. This “black and white” classification does not accord with reality, as there is clearly a spectrum of cases ranging from the true elective case to the true emergency. Thoughtful and careful attention to management may not be compatible with haste. A good example of this is acute trauma, where it is appropriate, even advantageous, to use a regional block for analgesia before surgical intervention. Even in those cases that are felt to be time critical, not taking the minimal time necessary to carry out routine equipment checks is at best a false economy and at worst extremely dangerous, as well as medico-legally indefensible.

As with the initial overall evaluation of the first 2000 incidents, the single largest contributor to the successful correction of incidents using COVER ABCD was “ventilate by hand” (V1); this would have corrected 32% of incidents (table 3). The small numbers make it difficult to comment on the other elements of COVER ABCD, but 34% of trauma incidents would not have been addressed by COVER ABCD compared with 5% of such incidents in the original overall report. This again supports the view that trauma incidents have their own pattern and require the application of a specific trauma sub-algorithm. Given the small number of trauma cases, it is not possible to make much comment on the use of sub-algorithms in this 34% of the 38 trauma cases, other than to say that all cases would have been addressed if the trauma sub-algorithm had been used correctly (table 4).

EMST elements (fig 1, left panel) have been used to compose the acute trauma sub-algorithm by transposing them to the operating theatre environment. However a major issue in developing and testing the acute trauma sub-algorithm has been the infrequency of reported trauma incidents that relate specifically to the injuries. Disregarding the failures of checking, there were only four problems identified (table 5). Accordingly although the proposed trauma sub-algorithm identifies a number of major trauma problems, it has not been possible to validate it by this review. The number of relevant cases is still too small and clearly many possible problems which have been reported previously in the literature have not been reported in these 4000 incident reports. Equally, rewriting the algorithm to address only the trauma incidents found would leave major gaps when compared with well recognised if apparently uncommon problems. For example, the analysis of pneumothoraces in the first 4000 cases revealed that 24 were reported, with 17 associated with general anaesthesia, six with nerve blocks in the chest wall or clavicular regions, and one with an intercostal drain mishap, but although pneumothorax is a not uncommon trauma diagnosis, none were found among the trauma incidents reports. It is felt that it would be unwise to exclude pneumothorax from the trauma algorithm.

At this time, while the above data are insufficient to validate any trauma sub-algorithm, the sub-algorithm suggested (fig 1) is consistent with EMST principles currently used for management of acute trauma in the field and has successfully addressed the few trauma cases in the data. It will be appropriate to wait for further reports with a view to ongoing validation and revision as necessary.

Finally, it is important that a full explanation of what happened be given to the patient and that the problem be clearly documented in the anaesthetic record. If a particular precipitating event was significant, or a particular action was useful in resolving the crisis, this should be clearly explained and documented.

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