

# Blunt chest trauma

20% of patients with a major [spine injury](#) will have a second spinal injury at another level, which may be noncontiguous. These patients often have simultaneous but unrelated injuries (e.g. chest trauma, TBI...). Injuries directly associated with spinal cord injuries include arterial dissections (carotid and/or vertebral arteries).

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Possible etiology of [Horner's syndrome](#), [Hyperprolactinemia](#), usually  $\leq 50\text{ng/ml}$ .

In some cases of [Shaken baby syndrome](#) there may be finger marks on the chest, multiple rib fractures and/or pulmonary compression  $\pm$  parenchymal lung hemorrhage. Deaths in these cases are almost all due to uncontrollable intracranial hypertension.

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[Purtscher's retinopathy](#): Loss of vision <sup>1)</sup> following [major trauma](#) (chest crush injuries, airbag deployment <sup>2)</sup> ...), pancreatitis, childbirth or renal failure, among others. Posterior pole ischemia with cotton-wool exudates and hemorrhages around the [optic disc](#) due to microemboli of possibly fat, air, fibrin clots, complement-mediated aggregates or platelet clumps. No known treatment.

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Blunt chest wall injuries are a significant cause of mortality and morbidity in trauma patients. Accurate identification and description of chest wall injuries by the radiologist can aid in guiding proper patient management. The American Association for the Surgery of Trauma (AAST) has devised a classification system based on severity.

A article of Marro et al., described the features of each injury grade according to the AAST injury scale and discusses the implications for management. Additionally, common mechanisms of blunt chest trauma and multimodal imaging techniques are discussed <sup>3)</sup>.

## Unclassified

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