Traumatic injury

Simple scoring systems for stratifying injury severity appeal to clinicians in every field of medicine [1)]

Classification

Blast injury.

Blunt injury.

Burn injury.

Crush Injury.

Reperfusion injury.

Thermal injury.

Trampoline injury.

Brain injury

Spine injury

Vascular injury...

Case series

A multicenter, population-based, prospective study was conducted with patients of all ages with traumatic injury New Injury Severity Score (NISS) > 9] admitted within 72 h after the injury to regional trauma centers in southeastern and northern Norway over a 1-year period (2020).

In total, 601 patients were included; a majority (76%) sustained severe injuries, and 22% were discharged directly to specialized rehabilitation. Children were primarily discharged home, and most of the patients ≥ 65 years to their local hospital. Depending on the centrality of their residence [Norwegian Centrality Index (NCI) 1-6, where 1 is most central], we found that patients residing in NCI 3-4 and 5-6 areas sustained more severe injuries than patients residing in NCI 1-2 areas. An increase in the NISS, number of injuries, or a spinal injury with an Abbreviated Injury Scale (AIS) ≥ 3 was associated with discharge to local hospitals and specialized rehabilitation than to home. Patients with an AIS ≥ 3 head injury (RRR 6.1, 95% Confidence interval 2.80-13.38) were significantly more likely to be discharged to specialized rehabilitation than patients with a less severe head injury. Age < 18 years was negatively associated with discharge to a local hospital, while NCI 3-4, preinjury comorbidity, and increased severity of injuries in the lower extremities were positively associated.

Two-thirds of the patients sustained severe traumatic injury, and 22% were discharged directly to

specialized rehabilitation. Age, centrality of the residence, preinjury comorbidity, injury severity, length of hospital stay, and the number and specific types of injuries were factors that had the greatest influence on discharge destination [2)]

A retrospective study included 44 (77.2%) patients who were referred to the neurosurgery department after being diagnosed with spinal and cranial injuries due to earthquake at the emergency department between October 23 and 27, 2011.

The patients comprised 32 male (72.7%) and 12 (27.3%) female patients with a mean age of 23.5 years. The injuries included scalp injury (n = 16), burst fracture (n=7), compression fracture (n=3), epidural hematoma (n=9), subdural hematoma (n=3), contusion (n=1), traumatic subarachnoid hemorrhage (n=2), depressed skull fracture (n=3), linear fracture (n=9), cervical fracture (n=2), and pneumocephalus (n=1). Most of the patients (90.9%) had isolated injuries and the others (9.1%) presented with combined cranial and spinal injuries. At discharge, the 3 patients with spinal fractures were paraplegic, and of the 2 patients who were operatively treated due to subdural hematoma, 1 was hemiparesic and the other was hemiplegic. No mortality occurred in our patients.

The results of this study demonstrated that, in the aftermath of a natural disaster, conducting correct triage procedures and performing a prompt intervention with appropriate and qualified equipment play key roles in reducing morbidity and mortality [3)].

1)
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2)
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3)
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