Contents:

- Provide an overview of trauma developments in South Western Sydney
- Review interesting cases each month
- Identify challenges and opportunities for improvement
- Maintain an update on the latest in trauma from around the world

INTRODUCTION

Dr. David Sloane has retired as Director of Trauma Services at Liverpool Hospital, five years after establishing one of Australia's first standalone Trauma Services. Dr. Sloane established many firsts, including a multidisciplinary trauma team and a computerised trauma registry in 1991. His commitment and foresight will be missed and we hope that the department will build on its strong foundation. James Boyden has left the Trauma Fellow position and joined ICU. James will be missed, having developed strong links within the area, in education and hospital feedback.

I have joined the Trauma Department as Director in February and look forward to providing a comprehensive service for patients and providers of trauma care in the South West. The concept of an Area-wide focus on trauma care will continue and to help in its achievement your ideas and suggestions would be very welcome.

Michael Sugrue Click here to find out who's who in the Trauma department.

TRAUMA EDUCATION

Over the next 12 months we will expand our trauma education program. At present we have the following events planned:
- Trauma Audit 07:30 Every Thursday (sharp) Conference Room, Level One, SWAPS Building
- Trauma Education Sessions February 20 and 27th 12:30-12:45 Emergency Conference Room.

These meetings are open to all trauma care providers in South West Sydney. We would welcome your potential input in choosing cases for the trauma audit meeting. In addition an Area-wide trauma education programme will continue with visits to urban and rural hospitals in the area. We start 1996's programme with a visit to Bowral on April 12th.

Maria Seger is currently canvassing for nursing topics, which will be dealt with in the next six months.

Ambulance Education evenings will continue and the next will take place in August this year.

MEETINGS

SWAN IV SWAN IV will take place on November 8th and this year will feature three overseas speakers:
Dr. Ken Boffard Director of Trauma, Johannesburg Trauma Service, South Africa.
Carol Shagoury Trauma Co-ordinator, San Francisco General Hospital, USA.
Dr. Tim Hodgetts Emergency Consultant, British Army Aldershot UK.
The program will be as exhausting and exciting as ever, with the emphasis this year on penetrating trauma and pelvic fractures. Keep an eye out for the registration form and full program.

**DEFINITIVE SURGICAL TRAUMA CARE COURSE (DSTC)**

This course on the definitive care and surgery of complex trauma, will run for the first time in Australia in May. The course will be run by Professor Stephen Deane (of Liverpool Hospital) with a local and overseas faculty. Guest overseas faculty include Don Trunkey, Howard Champion (leading US traumatologist) and Abe Fingehut. This is one of the most exciting courses to be piloted since the introduction of EMST in 1987.

Further information about the meeting, which will be run with the support of the RACS, can be obtained from Professor Stephen Deane or myself.

**RURAL TRAUMA COURSE**

The Department of Trauma at Liverpool has over the last few years run a 2 day rural trauma course in Alice Springs (Northern Territory) and this year we plan to pilot a major restructured course with input from Dr. Tim Hodgetts and Sabrina Knight (remote Nurses Council) on November 10th and 11th.

**ROYAL AUSTRALASIAN COLLEGE OF SURGEONS ANNUAL SCIENTIFIC CONGRESS - MAY 1996 - MELBOURNE**

This year Professor Stephen Deane of Liverpool Hospital has been honoured as the foundation speaker in Trauma at the College Meeting, recognising his tremendous contribution to trauma care over the last 15 years.

If you feel that a trauma patient may need an intensive care bed at Liverpool, ring the trauma hotline number:

**(02) 828 3666**

and the ICU registrar will organise an interhospital trauma transfer should one be required. This is preferable to ringing the Emergency or Surgical Registrar.

**Los Angeles**

Ortega and colleagues in a study of penetrating abdominal trauma have found that the diagnostic laparoscopy may be useful in reducing the negative laparotomy rate for abdominal stab wounds.

Laparoscopy was used in abdominal stabbing to determine if peritoneal penetration had occurred in patients who were haemodynamically stable. They found that 21% of these stab patients had no penetration and so did not require a laparotomy. Laparoscopy also had the advantage of clearly visualising the diaphragm. Ortega emphasised that care
must be taken to avoid a pneumothorax during laparoscopy and a pre-laparoscopy chest drain insertion may be required if the stab wound could have transversed the diaphragm.

Surg Endosc 1996 10; 19 - 22

**TRAUMA X-RAY LIBRARY**

We are delighted to welcome Dr. Ulvi Budak as Trauma Associate to the Trauma Department. Ulvi is developing a comprehensive trauma fracture library with the help of Glen Burt and Dr. Richard Bell (Radiology).

**CASE OF THE MONTH**

At 09:34 on the 12 February, a car hit a pole, trapping a 23 year old driver. The patient was trapped for 50 minutes.

**At The Scene**

The ambulance officers and paramedics applied a hard collar, administered Oxygen at 14L/min, placed a 16 G IV line and gave 300mls of Hartmans solution. 10mg of Morphine was also given IV for analgesia.

A Intact.
B Tachypnoea (RR 20/min), 96% saturated, decreased air entry left base.
C Pale, Tachycardic (P 120), Normotensive (SBP 120), Good Capillary Return.

**Emergency Room**

10:46
Primary Survey
A Intact
B Tachypnoea (RR 22/min), 99% saturated, Trachea central, decreased air entry left chest.
C Tachycardic (P 115), Normotensive (SBP 120).

**What would you do? Chest drain or CXR first? CXR or CspineXR first?**

11:00
Progress
2 IV's in place, bloods obtained, 1200mls of haemaccel administered
Xrays taken and the secondary survey (with the exception of the log roll) was complete:
CspineXray was normal
CXR revealed a left sided pneumothorax, # Right Clavicle, and # Left 2nd Rib.

11:06
Left chest drain inserted

11:25
Repeat Primary survey
A Intact
B Improved air entry both sides
C Tachycardic (P120), Normotensive (SBP 115), cold peripheries, poor capillary filling after 2500mls of haemaccel and 300mls of pre-hospital fluid.

Is this patient haemodynamically stable?

Repeat Secondary Survey revealed marked upper abdominal tenderness. A urinary catheter is in place.

How would you progress from here?

The outcome of the case and a discussion will take place in next month's Trauma Grapevine.

During the year we will present to you some real scenarios which have occurred in South Western Sydney and provide a critique of care for your benefit.

I hope you enjoyed the first edition and if you wish to write (or fax) to the trauma Department with your comments, observations, or letters please do so.

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