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Violent side of pediatric trauma-priorities in pediatric care and emergency medicine

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Significant number of the children brought to emergency department and injury is one of the leading cause for which they seek emergency services. Injury especially in children is the leading cause of the death and disability. Severely injured child need immediate attentions for transfer to well-equipped healthcare facility to diagnose and manage the injuries in children. Children and adults are anatomically, physiologically and emotionally different from each other. Early recognition and treatment of life-threatening airway obstruction, inadequate breathing, and intra-abdominal and intra-cranial hemorrhage significantly increases survival rate after major trauma. The initial assessment and management of the injured child follows the same ATLS® sequence as adults: primary survey and resuscitation, followed by secondary survey. Life-threatening conditions are dealt with as soon as they are identified. Necessary imaging studies are obtained early. Constant reassessment ensures that any deterioration in the child's condition is picked up immediately. The secondary survey identifies other injuries, such as intra-abdominal injuries and long-bone fractures, which can result in significant hemorrhage. The relief of pain is an important part of the treatment of an injured child. Focused abdominal sonography for trauma (FAST) has become a useful part of the initial trauma evaluation. Computed tomography (CT) remains the gold standard for diagnosing abdominal injuries. Although CT detects most abdominal injuries, pediatric victims of polytrauma have near-normal vital signs even in the presence of significant blood loss, and can deteriorate rapidly. These children should be monitored with extra vigilance during transport to the CT scanner, in the CT scanner, and in the emergency room. After penetrating trauma, high likelihood of requiring surgical intervention timely and accurate assessment in the emergency department (ED), with appropriate resuscitation and stabilization either until hemodynamic stability or until the patient is transferred to the operating room (OT) for definitive management. A coordinated and organized approach between the ED, pediatric intensivist, surgeons, radiology, blood bank, and the OT is necessary.

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