

H07: Abdominal Trauma

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Reviewed:

Introduction

Abdominal trauma is one of the major causes of preventable death. Whether blunt or penetrating, the possibility of intra-abdominal injury must be recognized and treated in a timely fashion.

All types of abdominal trauma carry the risk of significant hemorrhage and infection. Blunt abdominal trauma carries a mortality rate of up to 30% and can prove challenging to assess in the pre-hospital environment. Penetrating trauma is easier to identify, is more often a true surgical emergency, and has a lower mortality rate than blunt trauma.

For both blunt and penetrating abdominal injury, the mainstays of treatment are virtually the same: rapid recognition and rapid transport, gentle patient handling, minimal crystalloid fluids to maintain vital organ perfusion, and early administration of tranexamic acid.

Essentials

- Abdominal distension is often a late sign and is indicative of severe intra-abdominal bleeding
- Penetrating trauma from the nipple line to the umbilicus may result in both chest and abdominal injuries
- Early TXA administration for suspected intra-abdominal bleeding is associated with decreased mortality rates
- Aggressive fluid resuscitation in abdominal trauma is associated with higher mortality rates. Titrate fluid administration to achieve normal mentation, peripheral pulses or a systolic blood pressure of 80-90 mmHg.

Additional Treatment Information

- Retro-peritoneal hemorrhage, often from damage to the kidneys or their supplying vasculature, may be difficult to detect and can produce life-threatening blood loss
- Eviscerated contents should be covered with moist, sterile dressings with an occlusive layer above
- Blunt trauma to the abdomen is frequently associated with concurrent pelvic injury

General Information

- The most common causes of intra-abdominal injuries are motor vehicle collisions followed by stabbing and gunshot wounds.
- Paramedics should pay particular attention to visual clues on inspection prior to palpating. The "seat-belt sign" is a large bruise or abrasion across the lower abdomen, and is associated with significant hemorrhage in 25% of patients. Peri-umbilical bruising, or Cullen's sign, is a late sign indicative of a retroperitoneal hemorrhage. A "scaphoid" or sunken appearance to the abdomen may indicate diaphragmatic rupture.
- On physical exam, tenderness or rigidity is often a sign of blood or digestive contents in the abdomen, resulting in irritation to the peritoneum. Fractures to the lower ribs may suggest splenic or hepatic injuries. Splenic injury often presents with referred pain to the left posterior shoulder while hepatic injuries refer pain to the right posterior shoulder.
- Auscultation of the abdomen in the pre-hospital trauma setting rarely yields pertinent information.
- Administration of excessive crystalloid fluids has been shown to increase mortality due to hemorrhage and to increase the risk of secondary abdominal compartment syndrome. When intra-abdominal hemorrhage is suspected or likely based on mechanism of injury or physical exam, crystalloid fluids should only be given when absolutely necessary to restore perfusion to vital organs.
- The application of abdominal junctional tourniquets has been shown to reduce mortality in patients with large vessel hemorrhage of the abdomen and pelvis. In some studies, the benefits of junctional tourniquet application were similar to those achieved through resuscitative endovascular balloon occlusion of the aorta.
- Pre-hospital use of focused assessment with sonography in trauma (FAST) has demonstrated benefit in the early

detection of abdominal trauma in both blunt and penetrating injuries. However, while a positive FAST is highly specific for intra-abdominal bleeding, a negative FAST by itself should not be used to rule out injury or haemorrhage.

Interventions

First Responder

- Control external hemorrhage
- Limit patient movement to reduce clot disruption
- Protect against heat loss: foil blanket against the skin, cover with blankets for insulation, consider chemical heating blanket
- Cover extruded bowel or eviscerated abdominal contents with moist, sterile dressings followed by an occlusive layer
- Correct hypoxemia from diaphragmatic or concurrent thoracic injury:
 - → [A07: Oxygen and Medication Administration](#)
 - → [B01: Airway Management](#)

Emergency Medical Responder – All FR interventions, plus:

- Consider application of T-POD pelvic binder if evidence suggests concurrent pelvic injury
 - → [PR02: Pelvic Binders](#)

Primary Care Paramedic – All FR and EMR interventions, plus:

- Obtain vascular access and correct hypoperfusion
 - → [D03: Vascular Access](#)
- Consider [tranexamic acid](#)

Advanced Care Paramedic – All FR, EMR, and PCP interventions, plus:

- Correct hypoxemia from diaphragmatic or concurrent thoracic injury
- Needle thoracentesis as needed for suspected tension pneumothorax
 - → [PR21: Needle Thoracentesis](#)

Evidence Based Practice

[Abdominal Trauma](#)

[Pelvic Trauma \(Corsette-Style Compression Device\)](#)

References

1. Balogh Z et al. Secondary abdominal compartment syndrome is an elusive early complication of traumatic shock resuscitation. 2002. [\[Link\]](#)
2. Cole E et al. Tranexamic acid use in severely injured civilian patients and the effects on outcomes: A prospective cohort study. 2015. [\[Link\]](#)
3. Do WS et al. Minimally invasive preperitoneal balloon tamponade and abdominal aortic junctional tourniquet versus open packing for pelvic fracture-associated hemorrhage: Not all extrinsic compression is equal. 2019. [\[Link\]](#)
4. Haut ER et al. Prehospital intravenous fluid administration is associated with higher mortality in trauma patients: A national trauma data bank analysis. 2011. [\[Link\]](#)
5. Hussmann B et al. Does increased prehospital replacement volume lead to a poor clinical course and an

- increased mortality? A matched-pair analysis of 1896 patients of the Trauma Registry of the German Society for Trauma Surgery who were managed by an emergency doctor at the accident site. 2013. [\[Link\]](#)
6. Kheirabadi BS et al. Physiological consequences of abdominal aortic and junctional tourniquet (AAJT) application to control hemorrhage in a swine model. 2016. [\[Link\]](#)
 7. Kirkpatrick AW et al. Acute resuscitation of the unstable adult trauma patient: bedside diagnosis and therapy. 2008. [\[Link\]](#)
 8. Madigan MC et al. Secondary abdominal compartment syndrome after severe extremity injury: Are early, aggressive fluid resuscitation strategies to blame? 2008. [\[Link\]](#)
 9. Maegele M et al. Early coagulopathy in multiple injury: An analysis from the German Trauma Registry on 8724 patients. 2007. [\[Link\]](#)
 10. Quinn AC et al. What is the utility of the Focused Assessment with Sonography in Trauma (FAST) exam in penetrating torso trauma? 2011. [\[Link\]](#)
 11. Schechtman DW et al. Abdominal aortic and junctional tourniquet versus zone III resuscitative endovascular balloon occlusion of the aorta in a swine junctional hemorrhage model: 2020. [\[Link\]](#)
 12. Smith S et al. The effectiveness of junctional tourniquets: A systematic review and meta-analysis. 2019. [\[Link\]](#)
 13. Spahn DR et al. The European guideline on management of major bleeding and coagulopathy following trauma: Fifth edition. 2019. [\[Link\]](#)
 14. Wherrett LJ et al. Hypotension after blunt abdominal trauma: The role of emergent abdominal sonography in surgical triage. 1996. [\[Link\]](#)
 15. Williams-Johnson JA et al. Effects of tranexamic acid on death, vascular occlusive events, and blood transfusion in trauma patients with significant haemorrhage (CRASH-2) A randomised, placebo-controlled trial. 2010. [\[Link\]](#)

