



Abdominal Injury

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Abdominal Injury

Blunt Abdominal Trauma

Formal abdominal CT is usually first line investigation in children – discuss with the surgeon and the trauma team radiologist should be able to facilitate.

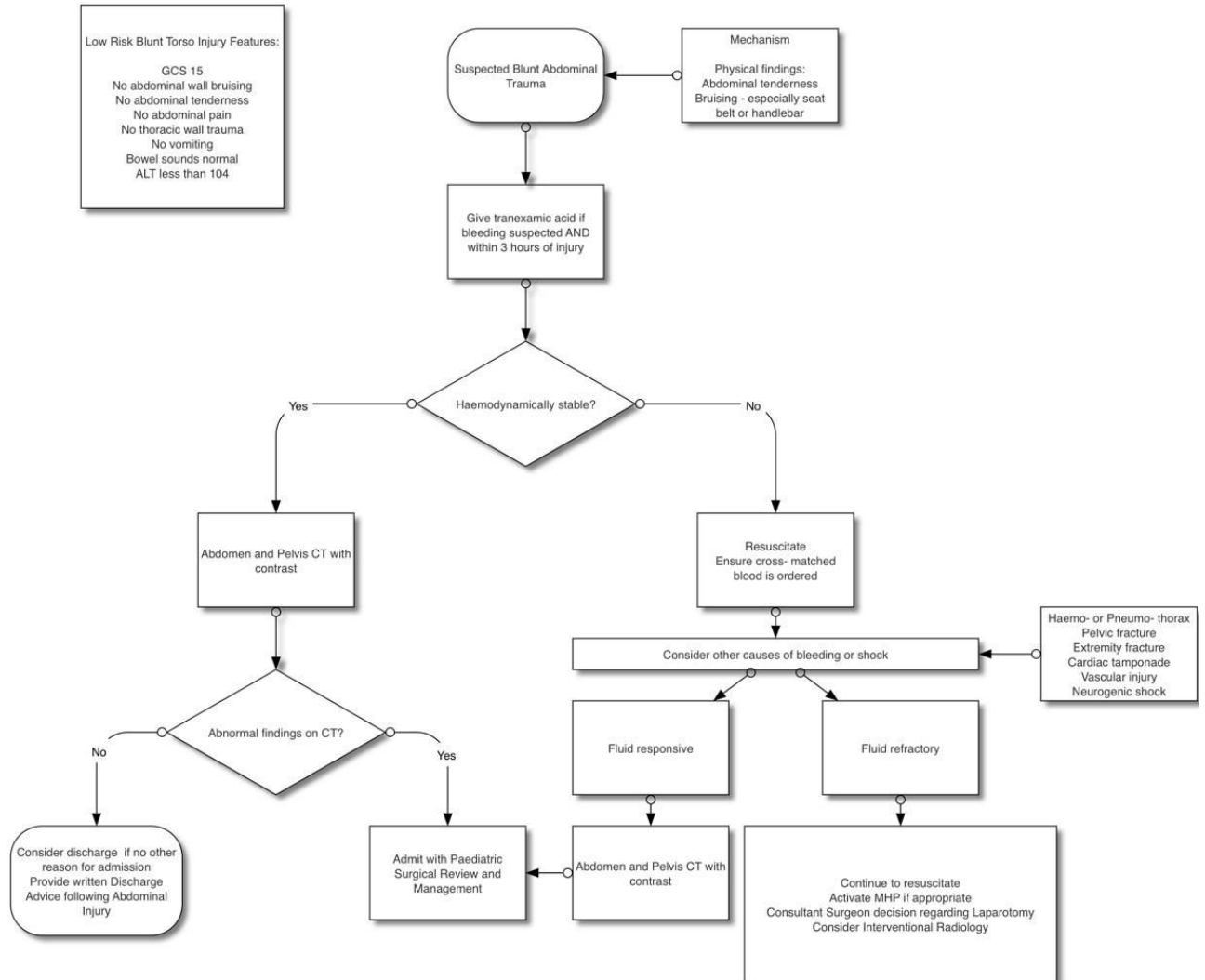
1. Clinical abdominal assessment **is difficult**. The paediatric surgical SpR /consultant should assist in the clinical assessment:
 - All patients will be assessed and the decision to proceed to laparotomy will be made by the Consultant Paediatric Surgeon.
 - Patients with head/chest injuries and lower limb/pelvis injuries require formal **exclusion** of abdominal injury regardless of absent physical signs as the risk of abdominal injury is significant.
2. CT
 - Solid organ injury on CT in a stable patient may be managed conservatively in a critical care area with continuous observations and review by the Paediatric Surgical Registrar every 6 hours or earlier if requested to attend.
 - Development of peritonitis or cardiovascular instability requires resuscitation, further investigation and, if appropriate, laparotomy.
 - There is a 2-15% incidence of missed hollow viscus injury in patients with solid organ injury – **BEWARE**
 - The lack of free air on an abdominal CT does **NOT** rule out hollow viscus injury

The Paediatric Surgical Consultant should be present for all trauma laparotomies

INDICATIONS FOR EMERGENCY LAPAROTOMY (WITH OR WITHOUT CT) (this list is not exhaustive):

1. Unstable patient, despite resuscitation, with abdominal trauma
2. Evidence of hollow viscus injury on imaging
3. Retained weapon
4. Gunshot wound abdomen
5. Evisceration

Blunt Abdominal Trauma Algorithm



Low Risk Blunt Torso Injury Features:
 GCS 15
 No abdominal wall bruising
 No abdominal tenderness
 No abdominal pain
 No thoracic wall trauma
 No vomiting
 Bowel sounds normal
 ALT less than 104

Penetrating Abdominal Trauma Algorithm

