OPTIMIZATION SONOGRAPHIC ASSESSMENT OF THE NATURE AND SEVERITY OF CLOSED ABDOMINAL TRAUMA

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Relevance.

Quantitative assessment of the volume of blood spilled and ultrasound identification of the severity of trauma to the internal organs of the abdominal cavity, mainly parenchymal organs, is of no small importance in choosing the tactics of surgical treatment of closed abdominal trauma (CAT). Today, in emergency surgery of abdominal injuries, the initial method of instrumental examination of the abdominal organs is ultrasound, which is aimed at improving the quality of care for victims by early detection of injuries, especially when these conditions are potentially life-threatening, and the outcome of surgical treatment depends on the time of its start. The American College of Surgeons has included in its extended protocol of training courses for emergency department physicians the use of the FAST protocol in providing assistance to trauma victims (Advanced Trauma Life Support-ATLS) [1]. Moreover, the Agency for Healthcare Research and Quality (AHRQ) has included ultrasound-guided central vein catheterization in its clinical guidelines to increase the safety of the procedure [2]. Similarly, the American Society of Echocardiography (ASE), together with the American College of Emergency Physicians (ACEP), developed a protocol focused on focused cardiac ultrasound (FOCUS) examination of the heart ultrasound in emergency situations [3].

Goal. Objective: to study the diagnostic effectiveness of sonography in detecting signs of abdominal organ damage and to provide a detailed description of ultrasound semiotics of HRT.

Material and methods

Ultrasound was performed in 160 patients with a closed abdominal injury as an initial method for diagnosing intra-abdominal injuries and was performed in the emergency department immediately upon admission of the patient to the clinic.

Results and discussion

Our observations show that in patients with HRT, the sensitivity (Se), specificity (Sp), and accuracy (Ac) of ultrasound in detecting one of the main signs of trauma – free fluid (hemoperitoneum) in the abdominal cavity-is 88.3, 87.8, and 88.1%, respectively (Tab. 1), which is not considered high enough by modern standards.

Table 1. Informative value of ultrasound in detecting signs of HRT, n=160

Ultrasound sign	TP	FP	TN	FN	Se	Sp	Ac	VPV	NPV
Free fluid	98	6	43	13	88,3%	87,8%	88,1%	94,2%	76,8%

Note: TR – true positive results, FP – false positive results, TN – true negative results, FN – false negative results, Se-sensitivity(sensitivity), Sp-specificity(specificity), Ac-accuracy (test accuracy), VPV – predictive value of a positive result (positive predictive value), NPV – predictive value of the negative result (negative predictive value).

However, sonographic signs of free fluid in the abdominal cavity in patients with PTA can serve as a relatively reliable criterion that allows the predicting of the presence of intra-abdominal complications of trauma with a high degree of confidence, since the predictive value of a positive result (VPV) according to this criterion is 94.2% (Table 1). However, it should be taken into account that the absence of pathological effusion in the abdominal cavity on ultrasound does not always exclude the presence of trauma to the abdominal organs and can not serve as a contraindication to surgical intervention. Thus, our calculations of the predictive value of a negative result (NPV) for the diagnostic feature "free fluid in the abdominal cavity" show a low value (76.8%) of this criterion in reliably excluding abdominal trauma.

When studying the expediency and effectiveness of using the sonographic criterion "presence of free fluid in the abdominal cavity" in determining the tactics of surgical treatment of patients with PTA, it became necessary to develop a method for measuring the volume of the hemoperitoneum. To solve this problem, we selected 67 patients with HRT, who evaluated the ratio of the hemoperitoneum volume assessed intraoperatively and the width and prevalence of free fluid in the abdominal cavity assessed by ultrasound (Table 2).

Table 2. Volume of intraoperatively determined blood in the abdominal cavity as a function of ultrasound data of layer width and free fluid prevalence, n=67

Free liquid layer width	1 region		2 regions		>3 regions	
	VSt.	liquid n	VSt.	liquid n	VSt.	liquid n
<1 cm	169,2±72,3	13	418,2±160,1	11	633,3±152,8	3
1-2 see	250,0±129,1	4	575,0±103,5	8	1233,3±111,8	9

2-3 cm	450.0±129.1	4	966,7±57,7	3	1740,0±207,4	5
3-4 see	600	1	1233,3±152,8	3	2500	1
>4 see	500	1	1600	1-0	-	0
Total	265,2±163,4	23	669,2±359,7	26	1144,4±608,0	18

The above calculations based on the comparison of the prevalence and thickness of sonographically detected free fluid with the volume of blood removed intraoperatively from the abdominal cavity made it possible to develop an "Ultrasound scale for assessing the volume of hemoperitoneum in patients with abdominal trauma" (Table 3).

Table 3. Scale of ultrasound assessment of hemoperitoneum volume in patients with abdominal trauma

Liquid layer width	1 area	2 areas	>3 areas
<1 cm	<200	300-500	500-1000
1-2 cm	200-300	300-500	1000-1500
2-3 cm	300-500	500-1000	1500-2000
3-4 cm	300-500	1000-1500	>2000
>4 cm	300-500	1500-2000	>2000

In order to assess the practical significance of preliminary measurement of the volume of free fluid in the abdominal cavity using ultrasound in patients with PTA, we decided to compare the volume of intraoperatively detected blood in the abdominal cavity (actual volume) with the nature and volume of surgical intervention performed (Table 4).

Table 4. Comparison of the hemoperitoneum volume with the volume of surgical intervention performed, n=155

Type of intervention	<300 ml, n=44	300-500 ml, n=34	>500 ml, n=77

	abs.	%	abs.	%	abs.	%
Sanitation and drainage of the abdominal cavity	9	20,5	1	2,9	-	0,0
Electrocoagulation of a bleeding vessel	23	52,3	6	17,6	3	3,9
Suturing of a rupture of the first stage according to Moore parenchymal organ	6	13,6	10	29,4	2	2,6
Suturing of deserotic sections of the intestine, ruptures of the mesentery and greater omentum	6	13,6	2	5,9	-	0,0
Suturing of the tear ≥II art. by Moore parenchymal organ	-0.0	0,0	6	17.6	24	31.2
Organ resection and removal	-	0,0	7	20,6	44	57,1
Suturing the wall of the hollow organ	-	0,0	2	5,9	4	5,2

Note: the table does not include 5 (3.1%) patients out of 160 patients who did not have intraoperative damage to internal organs and hemoperitoneum.

Here we would like to point out as a discussion that today there are numerous experimental and clinical studies [4,5] that prove the possibility of spontaneous resorption of a sufficiently large volume of blood from the abdominal cavity, and there is a need for additional study of the feasibility of expanding and specifying indications for conservative treatment of PTA in patients with ultrasound or MSCT signs of a small volume of hemoperitoneum without clinical signs of ongoing internal bleeding. Moreover, our observations on the management of patients with the volume of free fluid in the abdominal cavity less than 300 ml (n=44) show that with this volume of hydroperitoneum in patients with PTA, there are practically no cases of damage to the hollow organs of the abdominal cavity.

And taking into account the above 44 patients, in whom the hemoperitoneum volume did not exceed 300 ml, the proportion of patients potentially subject to correction of intra-abdominal trauma complications by laparoscopic method without the use of wide laparotomy increases to 80.8% (63 patients out of 78) (Table 4).

In the presence of more than 500 ml of blood in the abdominal cavity (n=77), the possibilities for using laparoscopic techniques were extremely limited and occurred only in 5 (6.5%) patients (Table 4).

Conclusions

Among the diverse sonographic semiotics of intra-abdominal injuries in PTA, the most common ultrasound signs are the presence of different volumes of free fluid in the abdominal cavity. The sensitivity, specificity and accuracy of ultrasound in detecting free fluid in the abdominal cavity is quite high and amounts to 88.3, 87.8 and 88.1%, respectively. The proposed approach to ultrasound assessment of discrete volumes of free fluid in the abdominal cavity, based on taking into account the thickness of the fluid layer and its prevalence in the abdominal cavity, does not complicate or lengthen the FAST protocol procedure, and allows us to determine critical hemoperitoneum volumes that are crucial in choosing the tactics of surgical treatment of PTA.

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