NORTHERN TRAUMA NETWORK NTN	Paediatric Abdominal Trauma

Key Points

- **Penetrating or High energy injuries bypass to MTC**
- **Consider left lateral thoracotomy prior to laparotomy when patient *in extremis***
- **Anticipate abdominal injuries in a child with head plus lower limb injury**

All penetrating or high energy / significant abdominal injuries should by-pass directly to the nearest MTC. Any such injury presenting to a TU should be transferred ED to ED without delay.

JCUH
Call vascular surgeon on-call

RVI
Call Paediatric Surgery team, adult general surgeon and PINC anaesthetist

TU
A patient who presents to a TU ED *in extremis* should have resuscitative surgery performed by the most senior surgeon/clinician available.

Where patient is *in extremis* following blunt or penetrating abdominal injury, consider resuscitative left lateral thoracotomy to control abdominal aorta before performing emergency laparotomy.

Penetrating Abdominal Trauma:

1. Ballistic wound (gunshot, missile or fragment wound). Ballistic injuries to the abdomen will require laparotomy in most cases. CT has a role in stable patients.
2. Stab wounds. Do not remove retained weapons from the torso or neck in ED.
3. Haemodynamically unstable patients require emergency surgery

4. CT indicated in stable patients. Patient with normal CT can be observed regularly (2 hourly) Development of peritonitis requires laparotomy
5. Evisceration or omental herniation requires laparotomy
6. Laparoscopy is not indicated in emergency cases in children

Blunt Abdominal Trauma

1. Clinical assessment is difficult particularly in presence of multiple injuries. Specialist paediatric surgical opinion is mandatory.
2. Where there is head / chest injuries combined with lower limb / pelvis injuries, abdominal trauma must be anticipated and excluded regardless of absent physical signs.
3. Abdominal CT is first line investigation.

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VERSION NUMBER/DATE	1.0 / June 2017
REVIEW DATE	**01/06/2019**
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