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Retrospective Analysis of Blunt Abdominal Trauma and Seatbelt Sign: The Hollow Viscus Injury Predictor Score (HPS)

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This study was conducted under a protocol reviewed and approved by the San Antonio Military Medical Center Institutional Review Board and in accordance with the approved protocol.



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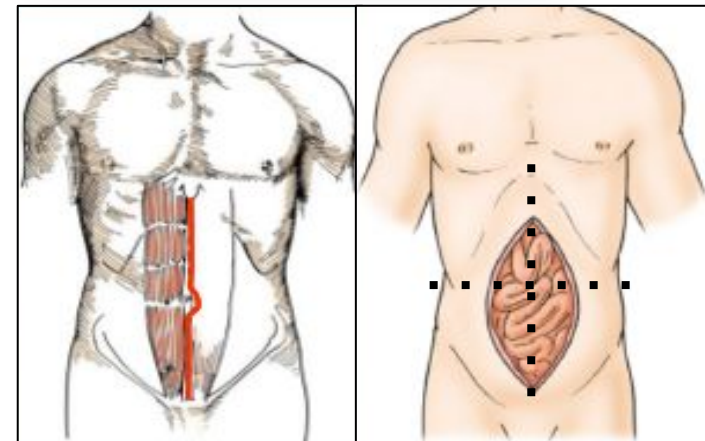
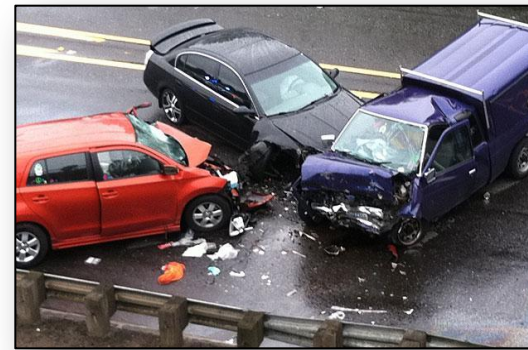
Background



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Key Terms

- Blunt Abdominal Trauma (**BAT**)
- Hollow Viscus Injury (**HVI**)
- Exploratory Laparotomy, also known as **ex-lap**
- Seatbelt Sign (**SBS**)





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Introduction

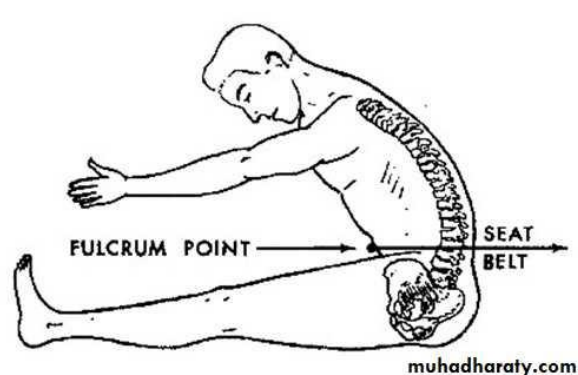
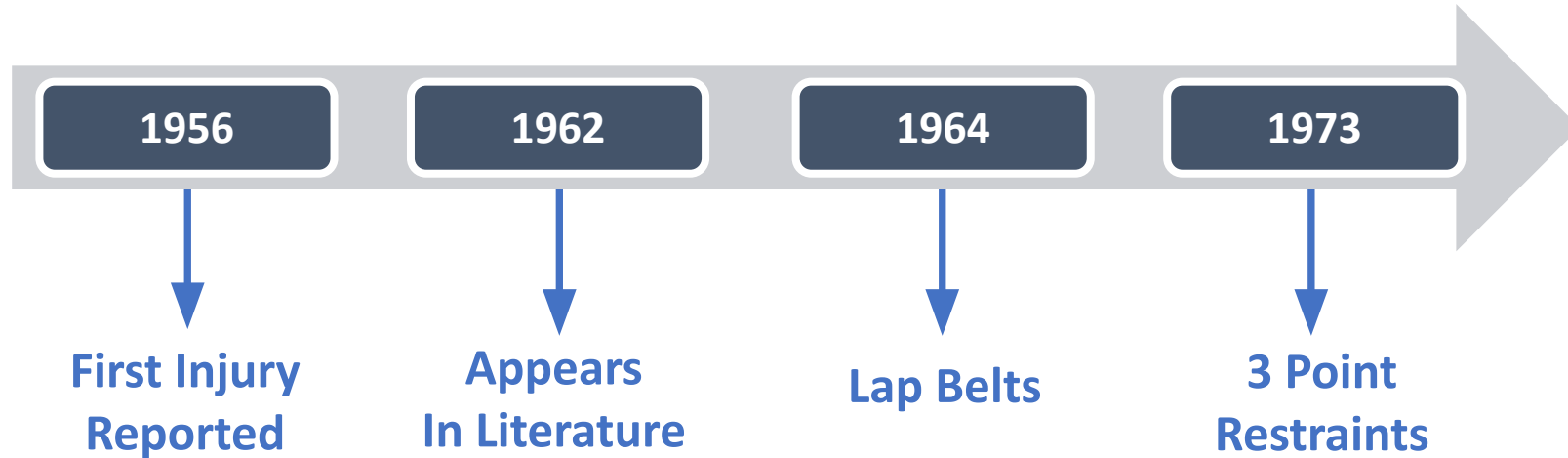
- Difficult to diagnose hollow viscus injury
- Management based on judgment
- Hollow viscus injury can be missed
 - High mortality (10-28%) & morbidity (44%)





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Background: Seatbelt Sign

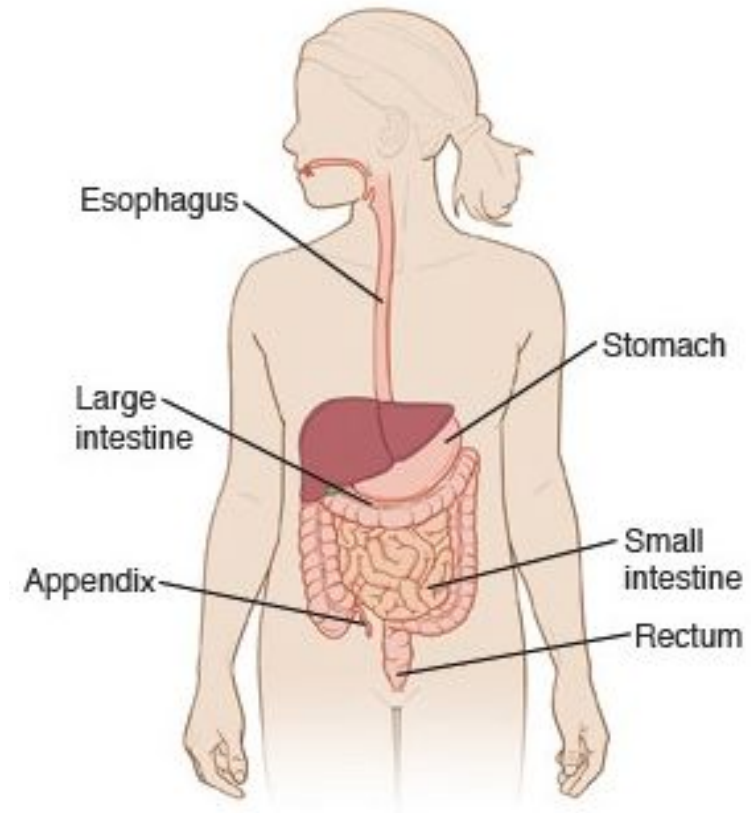




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Seatbelt Sign

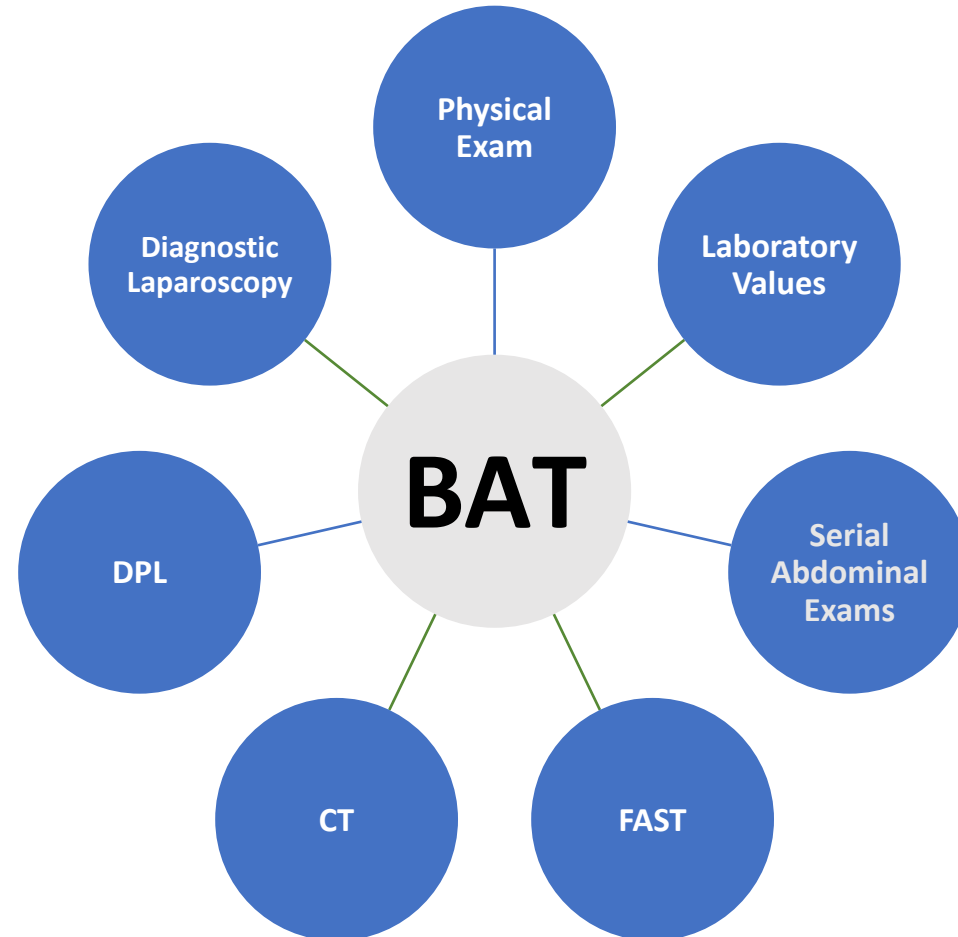
- Classic injury pattern
- 10-15% HVI incidence
- Most common HVI is in **small bowel**





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Background: Diagnosis

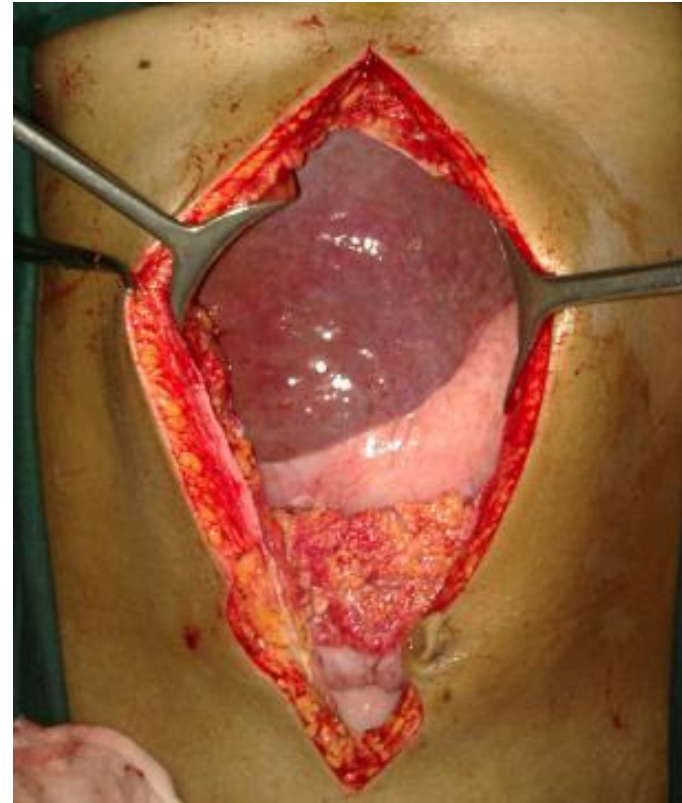




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Background

- Exploratory laparotomy for unstable patients
- Nontherapeutic ex-lap rates up to 23-53% in BAT
- Role of nonoperative management





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Objectives



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The “WHY?”

- Lack of pathway to diagnose HVI
- Need for a **tool** to identify HVI

Determine if the hollow viscus injury predictor score (HPS) was higher in patients with a known hollow viscus injury (HVI)



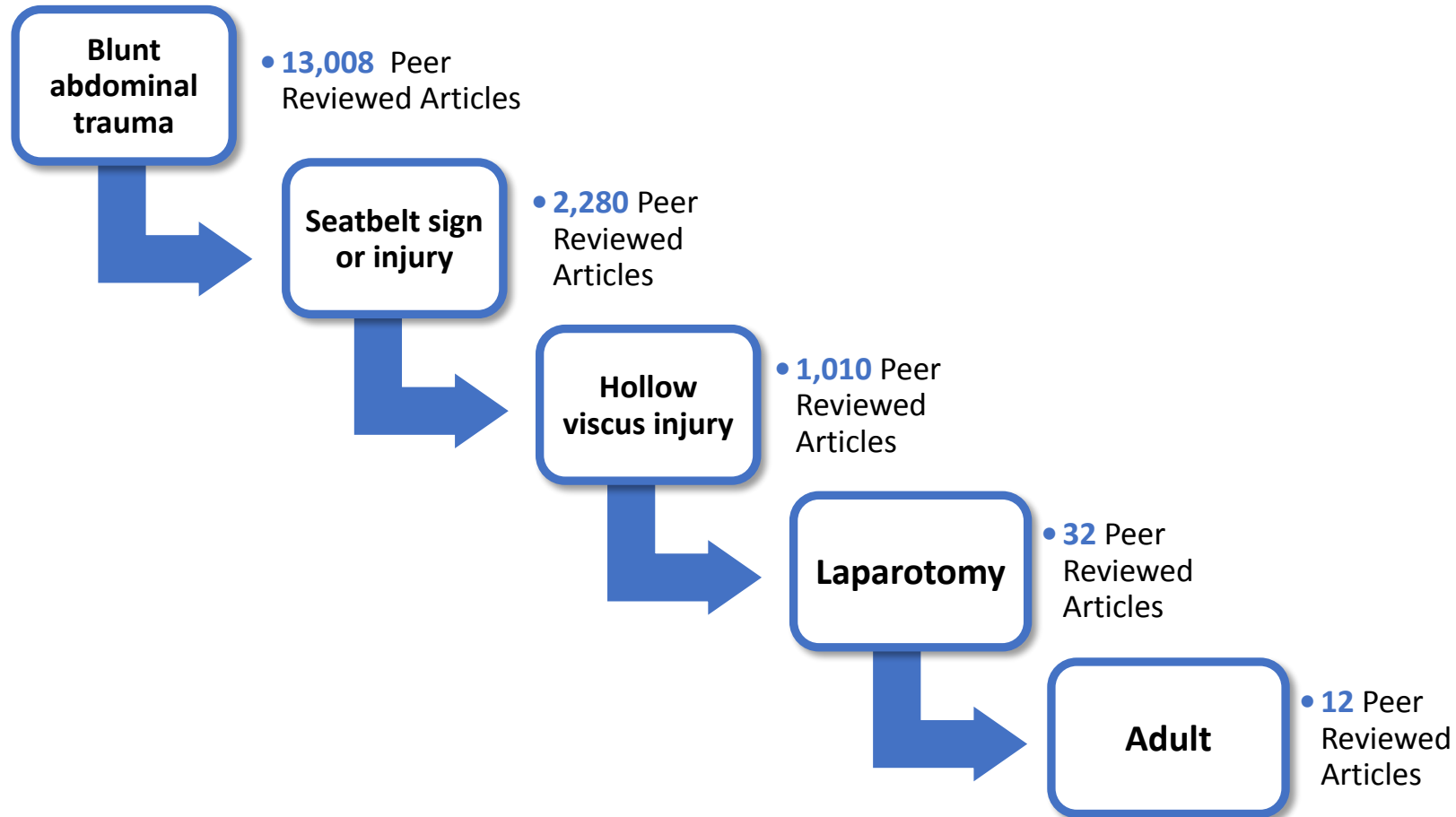
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Methods



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Literature Review



Retrospective Analysis of Blunt Abdominal Trauma and Seatbelt Sign: The Hollow Viscus Injury Predictor Score (HPS)



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Literature Review

The Journal of TRAUMA® Injury, Infection, and Critical Care

Colon Injury after Blunt Abdominal Trauma: Results of the EAST Multi-institutional Hollow Viscus Injury Study

Michael D. Williams, MD, Dorraine Watts, RN, PhD, and Samir Fakhry, MD

- Retrospective case-control study that examined 2,632 BAT patients matched by age and injury severity with a HVI compared to those without
- Admission exam, imaging, labs, and diagnostic modalities were examined alone and in combination
- Peritonitis 81% specific



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Literature Review

The use of computed tomography imaging for abdominal seatbelt sign: A single-center, prospective evaluation ☆

Patrick T. Delaplain^{a,*}, Cristobal Barrios^b, Dean Spencer^a, Michael Lekawa^b, Sebastian Schubl^b, Austin Dosch^a, Areg Grigorian^a, Megan Smith^c, Marija Pejcinovska^c, Jeffry Nahmias^b

^a Department of Surgery, University of California, Irvine Medical Center, United States

^b Division of Trauma, Burns and Critical Care, University of California, Irvine Medical Center, United States

^c Center for Statistical Consulting, University of California, Irvine, United States

- Prospectively examined 220 adult trauma patients admitted with an abdominal SBS
- Examined CT findings and other admission data (vital signs, exam, & labs) to identify HVI
- Hypotension and leukocytosis with HVI



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Literature Review

Early surgical intervention for blunt bowel injury: The Bowel Injury Prediction Score (BIPS)

**Michelle K. McNutt, MD, Naga R. Chinapuvvula, MD, Nicholas M. Beckmann, MD, Elizabeth A. Camp, PhD,
Matthew J. Pommerening, MD, Rece W. Laney, MS, O Clark West, MD, Brijesh S. Gill, MD,
Rosemary A. Kozar, MD, PhD, Bryan A. Cotton, MD, MPH, Charles E. Wade, PhD,
Phillip R. Adams, MD, and John B. Holcomb, MD, Houston, Texas**

- Retrospectively examined 110 BAT patients
- Created the Bowel Injury Predictor Score (**BIPS**) to identify HVI
 - WBC \geq 17, abdominal tenderness to palpation (TTP), and CT scan
- Leukocytosis & TTP significant in HVI



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HVI Predictor Score

• Hypotension

- Delaplain: BP lower in HVI ($p < .001$)

• Leukocytosis

- Delaplain: WBC count higher in HVI ($p = .013$)
- McNutt: WBC ≥ 17 with HVI ($p = .003$)

• Abnormal abdominal exam finding

- McNutt: tenderness (TTP) clinically significant ($p < .001$)
- McNutt: TTP combined with elevated WBC \square HVI was 19x higher
- Williams: peritonitis highly specific (81%)



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HVI Predictor Score

	Yes	No
SBP (≤ 110)	1	0
WBC (≥ 17)	1	0
Abnormal Abdominal Exam	1	0

Hypothesis:

Those **with a HVI**
will have an
increased HPS
compared to those
without (nHVI)

HPS



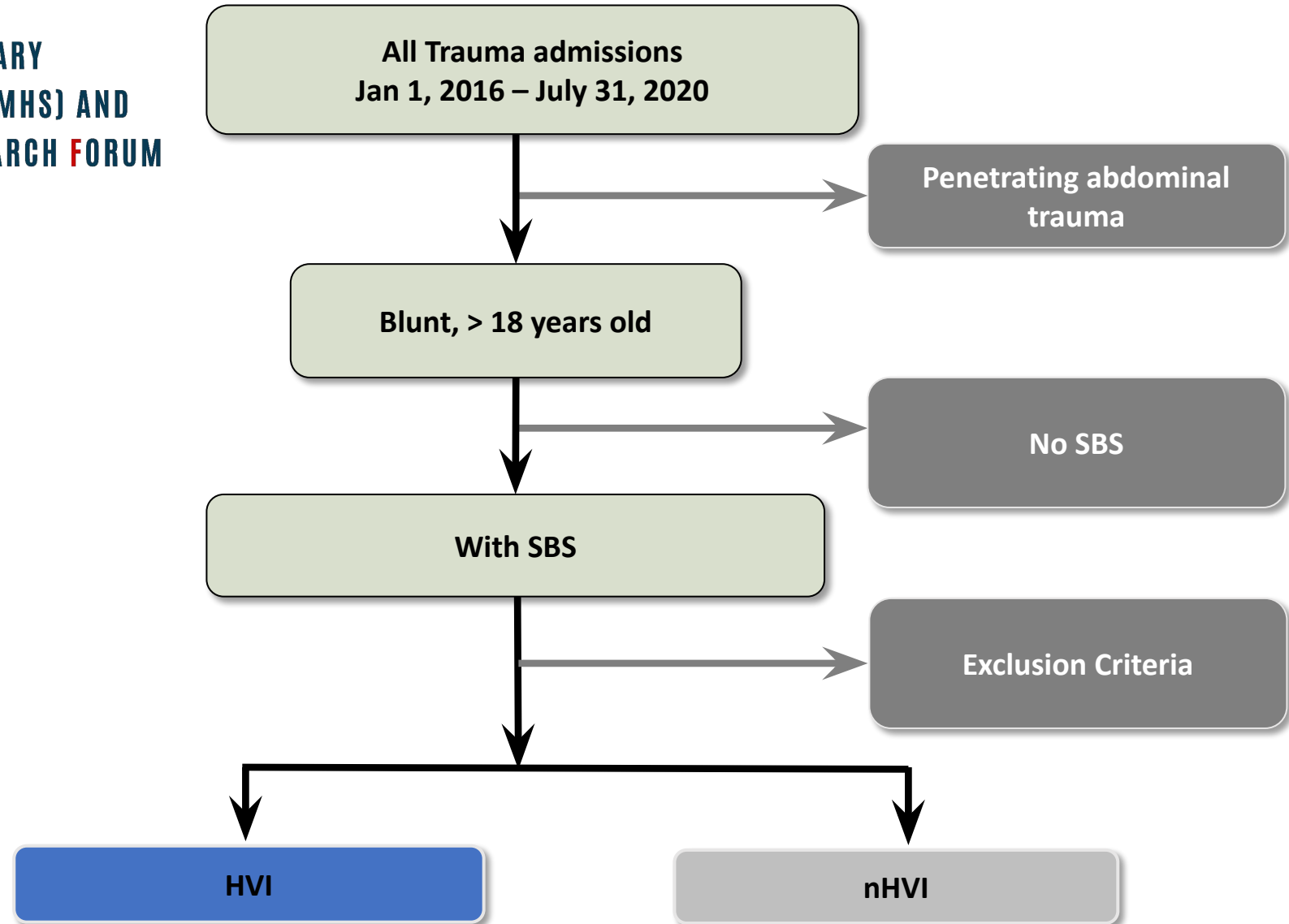
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Methods: Study Design

- **Single-center retrospective cohort analysis**
- All **adult** trauma patients (age 18 or older)
- Inclusion:
 - ≥ 18 years old
 - Blunt abdominal trauma with a seatbelt sign
- Exclusion:
 - Penetrating abdominal trauma
 - Pregnant
 - Emergency resuscitative thoracotomy
 - Death within 60 minutes of arrival
 - Surgery at an outside facility prior to arrival
 - Unstable needing emergency surgery



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Methods

- The dependent variable and primary outcome was **presence of HVI**
- Independent variable was our **HPS**
- Secondary Variables
 - Laparotomy
 - Abdominal pain
 - Specific abdominal exam findings



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Statistical Analysis

- Continuous data
 - Summarized using means and standard deviations or **medians** and **inter-quartile ranges**
 - Analyzed using **a Student's T-Test** and ANOVA or **Wilcoxon's Test**
- Categorical data
 - Summarized using **count and percentages**
 - Analyzed for association between the variables using **Chi-Squared** or Fisher's exact test



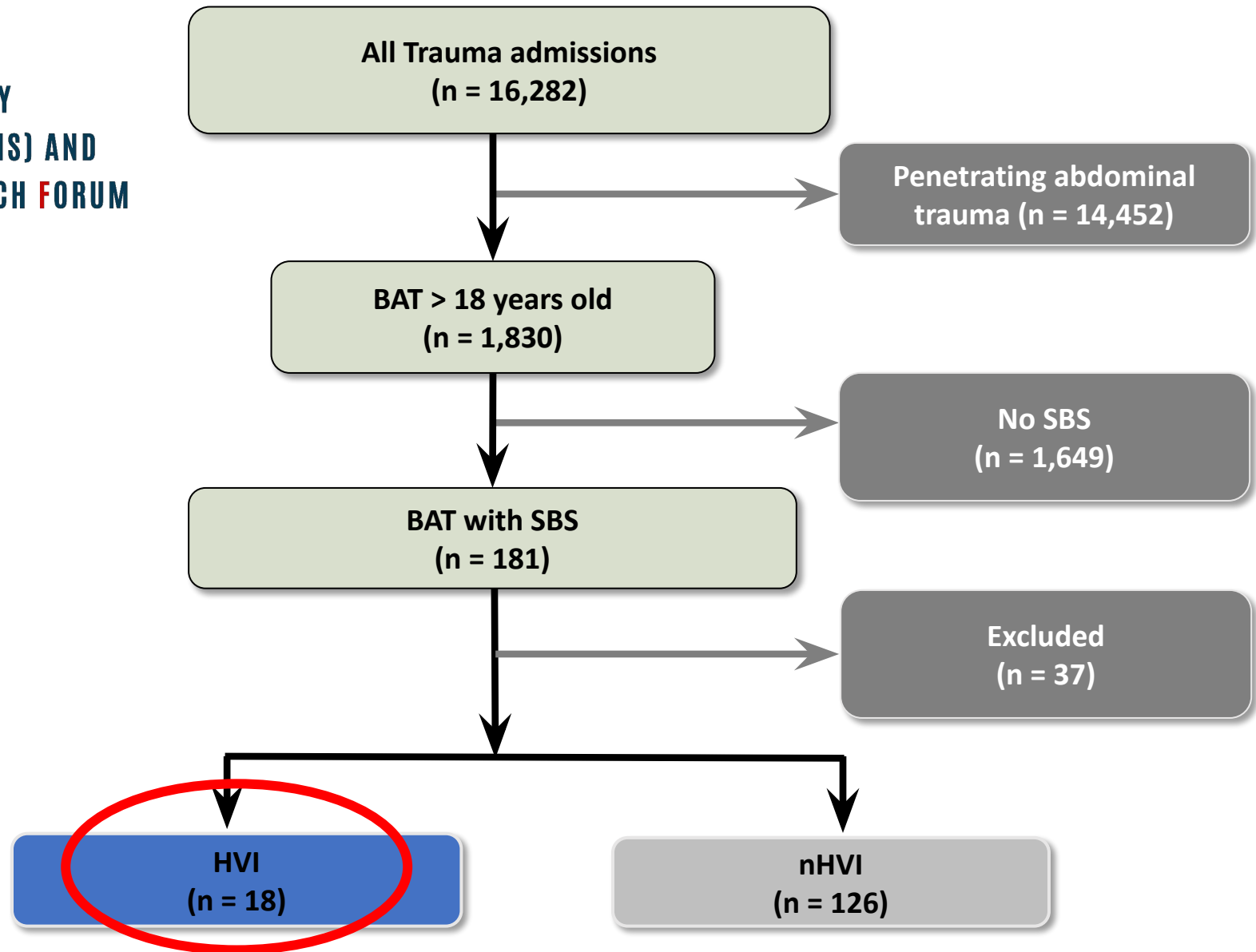
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Statistical Analysis

- **Logistical regression** was performed to determine independent prognostic factors for diagnosis of a HVI
 - Odds ratio with 95% Confident Interval (CI)
- **Receiver Operating Characteristic (ROC)** performed to analyze discrimination accuracy of independent variable
 - **Area under the curve (AUC)** with 95% CI



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Results



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Demographics

<i>Demographics</i>	<i>HVI (n = 18)</i>	<i>nHVI (n = 126)</i>	<i>p-value</i>
Age (y)	47.5	45.5	.686
Male (%)	9 (50)	63 (50)	1
BMI (kg/m ²)	32.02	32.77	.477
ISS	14.5	9	.002



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Primary Outcome

	HVI (n = 18)	nHVI (n = 126)	P-value
HPS Score	1.28 ± .85	.82 ± .72	.008*

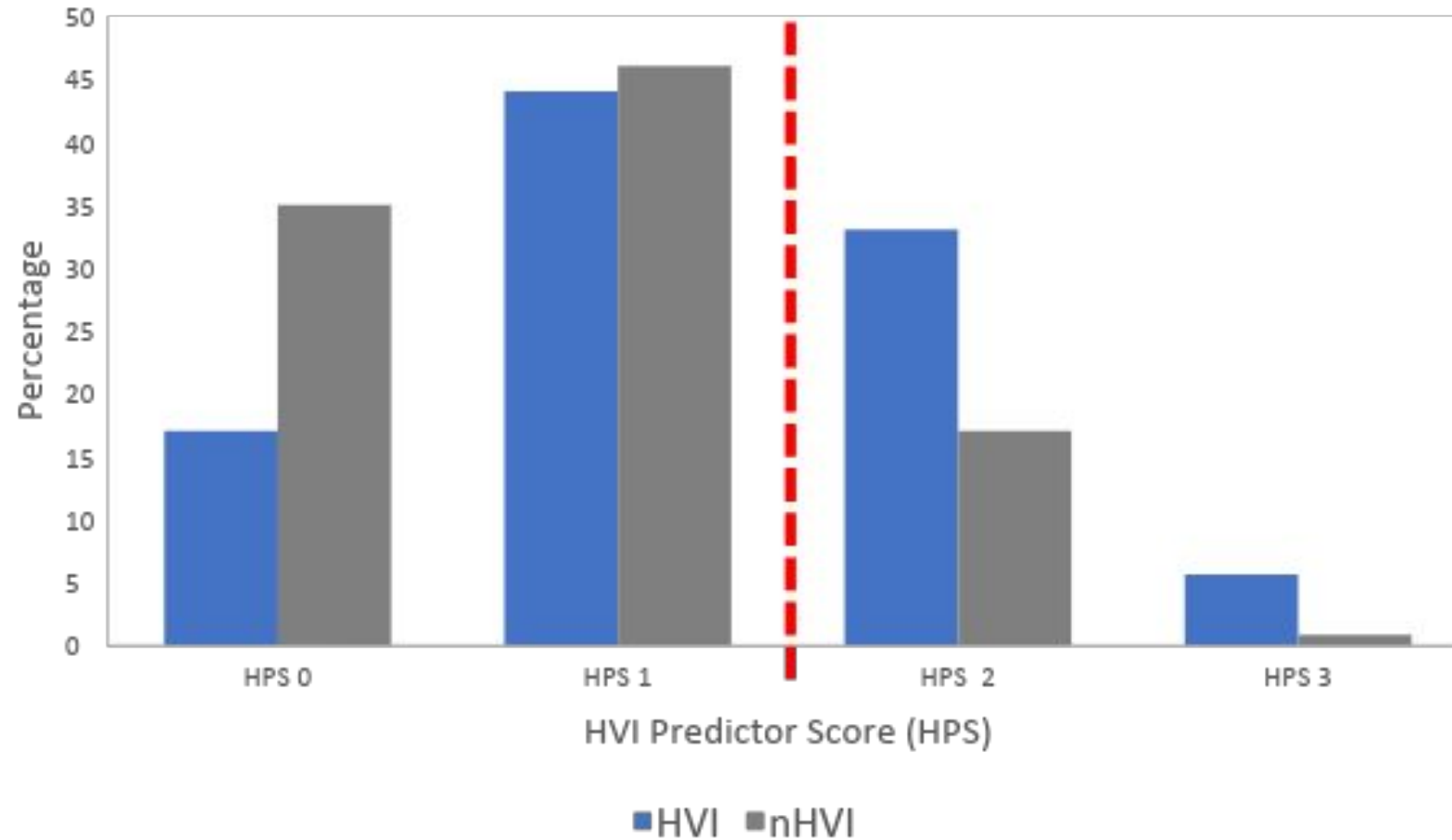
Data expressed as mean ± standard deviation

*Statistically significant (p < .05)



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Secondary Outcomes



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Secondary Outcomes

	HPS 0 (n = 48)	HPS 1 (n = 66)	HPS \geq 2 (n = 30)	P-value
HVI	3 (17)	8 (44)	7 (39)	.035*
nHVI	45 (35)	58 (46)	23 (18)	

Note. Each cohort had 1 patient with HPS score of 3.

Data expressed as number (%)

*Statistically significant ($p < .05$)



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Secondary Outcomes

HPS Score	OR	95% CI	P-value	AUC
1 vs 0	3.47	(0.71 – 16.90)	.123	.665 (p = .042*)
≥ 2 vs 0	6.70	(1.29 – 34.88)	.024*	

*Statistically significant (p < .05)

Factor	OR	95% CI	P-value	AUC
ISS	1.01	(1.03 – 1.16)	.001*	.767 (p < .001*)
HPS				
1 vs 0	2.79	(.55 – 14.24)	.217	
≥ 2 vs 0	5.86	(1.08 – 31.76)	.040*	

*Statistically significant (p < .05)



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Secondary Outcomes

Cutoff Point	True Positives	True Negatives	Coordinates of the ROC curve			P-value
			Sensitivity	Specificity	False Positives	
1	16	44	89%	37%	63%	.136
≥ 2	7	103	39%	82%	18%	.233

Note. A HPS of ≥ 2 had a negative predictive value (NPV) of 90% and a positive predictive value (PPV) of 23% for a HVI.



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Discussion/Conclusion

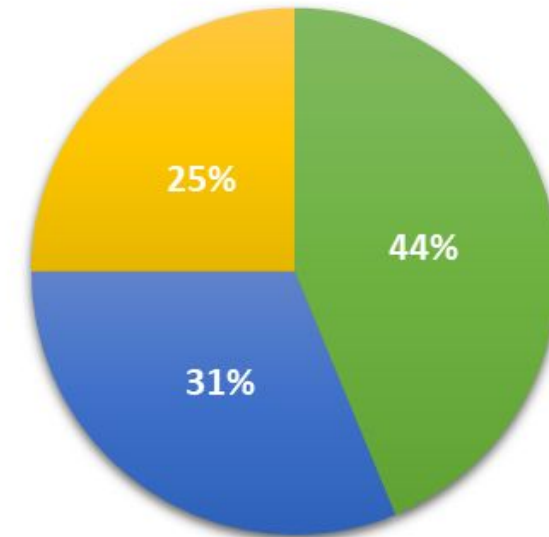


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Discussion

	Literature	Ours
BAT	12%	11.2%
HVI in trauma	1%	1.1%
HVI in BAT with SBS	10-15%	12.5%

HVI Injuries



■ Small Bowel ■ Large Bowel ■ Mesentery



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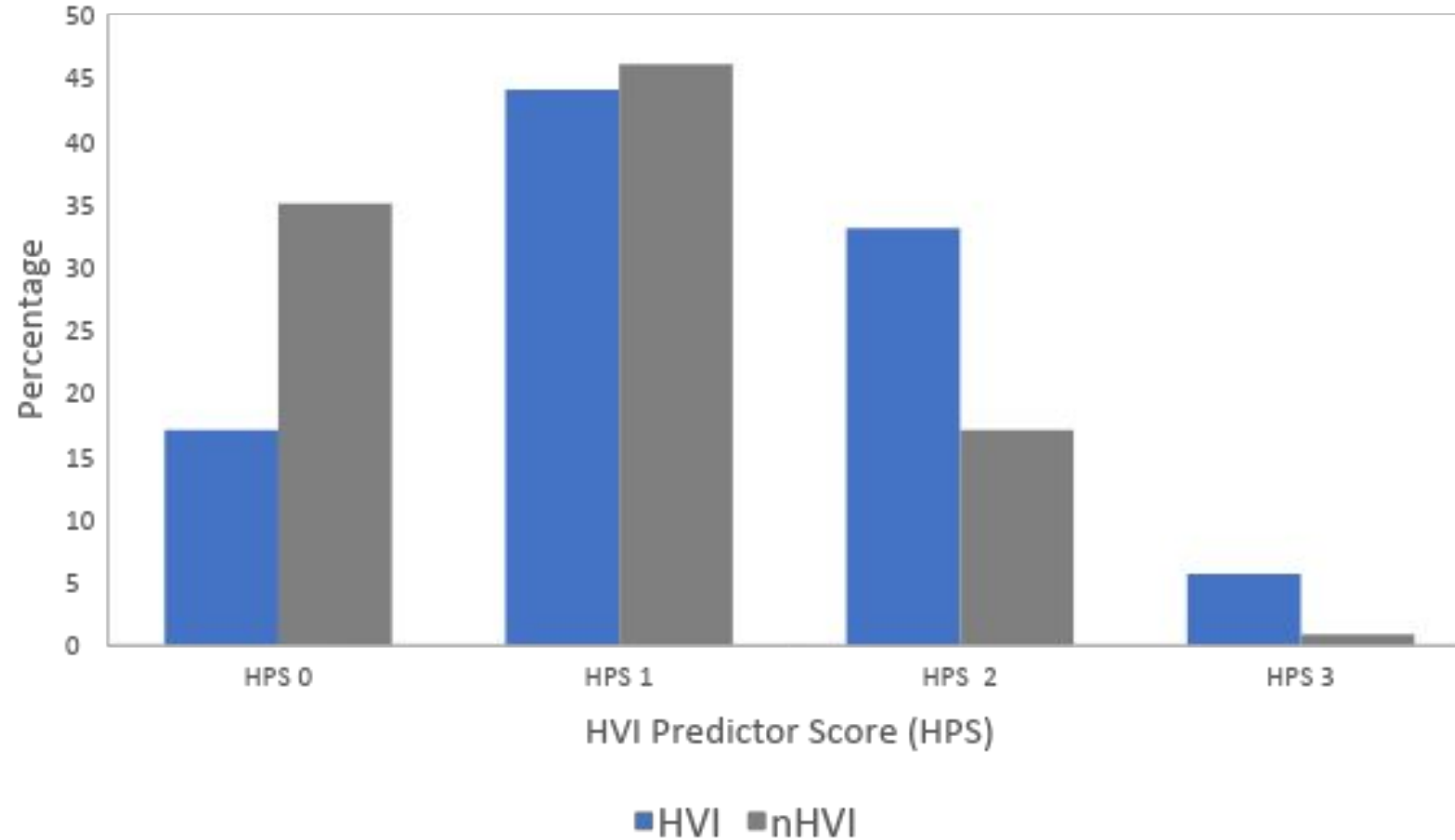
Discussion

- HPS **higher** and **predictive** of HVI
- HPS ≥ 2 had an AUC .76 ($p < .001$)
 - Sensitivity 39%, specificity 82%, & NPV 90%
- BIPS ≥ 2 had AUC .81
 - Sensitivity 86%, specificity 76%, & NPV 89%



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Secondary Outcomes



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Conclusion

- Fills the gap in literature
- Not only statistically significant, but clinically relevant
- HPS is a useful tool



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Questions?



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Recommendations

	Yes	No
SBP		
100-110mmHg	1	0
91-99mmHg	2	
≤ 90mmHg	3	
WBC		
17-18.99	1	0
19.01-20.99	2	
≥ 21	3	
Abnormal Abdominal Exam	1	0