Summary

Damage control approach (is one of the most major advances in surgical technique in the past 20 years), as rising of violence in the streets and easy accessibility of semiautomatic hand guns lead to increase in admissions of severly injured patients to trauma centers.

It is known that the best operation to a patient is one difinitive procedure but the situation is different in poly traumatized patients, as many of them arrive to hospital or trauma centers with hypothermia, cogulopathy, and metabolic acidosis. And this triad if not properly corrected, it will result in death.

The Damage control approach comes out to prevent this cascade of fatal events, as such trauma patients can not tolerate one prolonged operation. So, the patient is prepared for initial laparotomy to control hemorrhage and prevent contamination.

The hemorrhage is controlled by direct ligation of the bleeder or by temporary intraluminal shunt if the bleeder is accissible but if not, the best methed to control bleeding is packing as for inaccissible deep liver injuries or rupture pelvic hematoma, while prevention of contramination is via diversion and good drainage to decrease intraperitoneal infection.

During this stage, the patient is hypothermic, coagulopathic, and acidotic, so any attempt for definitive repair will takes much time and costs the patient his life. Therefor the abdomen is temporary closed by mesh closure of fascia or by towel clip closure of the skin, and whatever the method used, the abdominal wall shouldn’t be closed forcibly or under tension to avoid increasing intral abdominal pressure and

development of abdominal compartment syndrome which if occurred the decompression is a must.

The patient is rapidly transferred to SICU, where restoration of circulating volume, correction of coagulopathy and correction of hypothermia take place.

In SICU the patient is monitored continuously for blood pressure, temp., pulse, urine out put, respiratory rate and IAP.

Intra abdominal pressure is measurred by indirect measurement of urinary bladder pressure which reflect any increase or decrease in the intraabdominal pressure, if intra abdominal pressure exceeds 25 cmm H_2O with oligurea and respiratory distress decompression is done.

After the patient is resuscitated, he returned back to the OR, for definitive repair. This return is either planneal or unplanned.

The unplanned return is indicated in

1-Continuous Bleeding

2-Abdominal compartment syndrome

3-Peritonitis

Finally Damage control approach is intensive and involves many personals, so, organization, co operation and meticulous follow up is mandatory to succeed.