Hemodynamically unstable patients require immediate surgery with abdominal trauma and suspected liver lesions (3) except the laparotomy for this, present high risk. (16) necessity of an emergency surgery, as the patients who require a classification is the main prediction factor regarding the conservative approach to immediate surgical intervention. This establishing different therapeutic protocols, varying from the being ranked in 6 classes based on the importance of the importance of the examination (see figure no. 1).

Today, this is the most popular classification used for trauma of the polytraumatized patient.

CONCLUSIONS: The nonoperational management of the hemodynamically stable patients with hepatic trauma is becoming a standard conduct in trauma services.

Abstract: Introduction: The liver is the second important abdominal viscera regarding its frequency in abdominal trauma but at the same time, it represents the main cause of death determined by this kind of lesion. We present the case of a 51 year-old patient, victim of a car accident, for whom the abdominal computed tomography (CT) shows hepatic contusion and hydropneumoperitoneum. Results: During the surgical intervention, we discovered an intrahepatic hematoma, cecum depolisation with complete lining, mesenteric rupture at approximately 150 cm from the Treitz angle, with complete anastomosis. We decided for a conservative approach regarding the intrahepatic hematoma, practicing enteroraphy, mesenteriorrhaphy, cecorrhaphy, epiplon segmentectomy and multiple abdominal drainage. Conclusions: The nonoperational management of the hemodynamically stable patients with hepatic trauma is becoming a standard conduct in trauma services.

Introducere: Ficatul este al doilea viscera abdominal interesat ca frecvență în cursul traumatismelor abdomenale, dar în același timp reprezintă și principală cauză de mortalitate prin acest tip de leziuni. Prezentăm cazul unei paciențe în vârstă de 51 de ani, victima unui accident rutier, la care, CT abdominal relevă contuzie hepatică și hidro-pneumo-peritoneu. Rezultate: Se intervine chirurgical și intraoperator se constată hematom intrahepatic, depolizare la nivelul cecului cu mucoasa integra, ruptură de mezenter în aproxiimat 150 cm de unghiul Treitz, cu integritatea anseii. Se decide o atitudine conservativă în ce privește hematomul intrahepatic și se practică enterorafie, mezenteriorafie, cecorrhafie, rețeaua segmentară de epiplon, drenaj abdominal multiplu. Concluzii: Managementul nonoperativ al pacienților traumatizați hepatic stabili hemodinamic a devenit astăzi un standard al conduitei în serviciile de traumatologie.
hospitalization

Figure no. 1. Abdominal ultrasound examination upon hospitalization

The thoraco-abdominal CT examination taken on the same day at 11:15 AM, shows a non-iodophil hypodensity with anfractuous contour localized in the 6th LDH segment, a minimum quantity of perihepatic ascitic fluid and a greater quantity in the rectouterine pouch, ascitic fluid with para-fluid densities, comminuted fracture of the left inferior ischiopubic ramus, fracture of the left superior ischiopubic ramus.

Figure no. 2. Thoraco-abdominal CT examination upon hospitalization

The patient is monitored under conservative treatment tracking the dynamics of the biological invariants and clinical arterial tension and symptomatic values. The ultrasounds taken upon hospitalization do not present any important modifications over time.

24 hours after hospitalization, the clinical exam highlights an increase of the abdominal pains and signs of peritoneal irritation with slight volume relaxation of the abdomen, with muscular defence. An abdominal CT is taken which reveals hydro pneumoperitoneum, perihepatic and perisplenic fluid retention, in the omental bursa, in Morrison’s pouch, in both paracolic gutters and in the rectouterine pouch. The 5th and 6th segments of the LHD level of the liver present vague ill-defined hypodense areas, hypocaptation in arterial and portal time resembling hepatic contusion, costal fractures CVII and CVIII right axillary line and CIX right anterior arch.

Surgical intervention is decided and during the operation, approximately 1500 ml of peritoneal fluid is observed, as well as false membranes at the level of the intestinal anaes and of the epiploon, necrosis of the epiploon blocked in rectouterine pouch. Lesions are found at approximately 70 cm and 100 cm from the Treitz angle involving the lumen of the intestinal ansa, cecum depolisation with complete lining, mesenteric rupture at approximately 150 cm from the Treitz angle, with complete ansa, without effraction of the intrahepatic hematoma.

The following surgical fixations are performed: enterorrhaps, mesenteriorrhaps, cecorrhaps, epiploon segmentectomy and multiple abdominal drainages. All these interventions support a conservative approach regarding the intrahepatic hematoma.

Postoperative evolution is favourable, with resumption of the intestinal transit and alimentation and gradual removal of the drainage tubes starting day 4. The abdominal CT taken on the 8th day after the surgery shows hypodensity in the band with arborescent ramifications, weakly iodophil in the 5th, 6th and 7th LHD segments, permeable portal and suprarenal arteries without blood extravasation in the hepatic laceration solution.

The patient is released from hospital 21 days after the operation.

DISCUSSIONS

The local clinical exam can highlight abdominal sensitivity of variable intensity, in the context of a moderately relaxed abdomen, or it can show clear signs of acute peritonitis, especially if extrahepatic abdominal lesions are associated. Moreover, full examination of the patient targets the identification of all associated lesions (at skull, thorax, basin or limb level), as well as a classification of these.

The paraclinical diagnosis of the hepatic lesions requires an abdominal ultrasound which usually represents the first exploration performed by the emergency service on the abdominal traumatized patient, as this exploration can be done quickly, both in the emergency room and in the surgery room. Nowadays, it is considered that the sensitivity of the method in these situations approximates 98% for third and above degree hepatic lesions. The CT, especially the helical CT, is today the exploitation of choice in hepatic trauma. The hepato-CT allows the proper evaluation of the hepatic lesions and classifications of these according to the AAST taxonomy. Assuming a conservative approach, several clinical, biological and paraclinical elements are essential.

Consequently, the most important problem, immediately upon hospitalization or after the resuscitation of the patient, is to decide upon a surgical intervention. The determinant factors for this decision are the gravity of the lesions found during the CT exam (6,7) and also the hemodynamic status of the patient.

Admittedly, the conservative approach represented a major progress in the treatment of the polytraumatized patient with hepatic lesions. The particularity of the case presented in this paper resides in the fact that, although the associated abdominal lesions required surgical interventions, the hepatic trauma was treated conservatively.

CONCLUSION

Currently, it is considered as a standard procedure that patients with lesions of degree 1, 2 and 3, hemodynamically stable and without signs of acute peritonitis will benefit from the non-surgical treatment with very good results.

REFERENCES

2. Khan AN. Liver Trauma, eMedicine, Last Updated September; 2005.


