Trauma imaging & diagnostic blind spots

Choose the investigation that changes the next action.

RESUSCITATION / ADULT TRAUMA

Imaging must fit the patient's physiological state. A reassuring test does not replace continuing clinical assessment.

01 Unstable non-responder

When haemorrhage is suspected and resuscitation is failing, restrict imaging to the minimum that directs immediate intervention. Do not allow an elaborate diagnostic sequence to delay haemorrhage control.

02 Responding or stable

Consider immediate CT when the patient responds to resuscitation or is haemodynamically normal. In adults with blunt major trauma and suspected multiple injuries, use the trauma network's whole-body CT pathway.

03 Know what FAST misses

A negative focused assessment with sonography for trauma (FAST) cannot exclude intraperitoneal or retroperitoneal bleeding. Do not use FAST as a gatekeeper to decide whether an otherwise indicated CT is necessary.

04 Review the whole picture

Act promptly on the images and formal report. Match findings to physiology and examination; investigate discrepancies. Document remaining diagnostic questions and who will reassess them when the patient becomes more examinable.

WATCH POINT These are adult major-trauma principles. Children require age-specific imaging decisions and radiation-conscious pathways.

DISCUSS WITH THE TEAM

What will the result change now, and can the patient safely reach and remain in the scanner?

READ THE SOURCES

[1] NICE NG39 (2016), major trauma: haemorrhage and imaging, section 1.5.
[2] WHO Trauma Care Checklist (2016), primary/secondary survey and handover checks.

Educational summary for clinicians. Apply local protocols and patient-specific judgement.