Abdominal trauma & missed bowel injury

Observation is an active management strategy.

INJURY PRIORITIES / ADULT TRAUMA

An initially reassuring examination or CT does not eliminate the possibility of evolving bowel or mesenteric injury.

01 Let physiology lead

Haemodynamic decompensation or peritonitis requires urgent surgical assessment. For a stable, evaluable patient, integrate mechanism, examination, laboratory trends and contrast-enhanced CT.

02 Recognise high-risk clues

A seatbelt mark, concerning mechanism, unexplained fluid or non-specific CT findings should increase suspicion. Consider how sedation, intoxication or neurological injury limits the reliability of the examination.

03 Observe deliberately

Use repeated examinations by an experienced team, vital-sign monitoring and review of trends. Specify the reassessment interval, responsible clinician and escalation triggers. Selected equivocal cases need repeat imaging.

04 Revisit the decision

Increasing pain, tenderness, physiological deterioration or evolving CT findings should trigger renewed surgical review. Penetrating-injury observation requires a selected patient and a centre able to provide close surveillance and immediate intervention.

WATCH POINT Inflammatory markers are supportive information; do not use them alone to exclude or diagnose bowel injury.

DISCUSS WITH THE TEAM

What change will end observation and trigger intervention?

READ THE SOURCES

[1] WSES bowel injury guideline (2022), diagnosis, observation and intervention.