

INTRODUCTION

Introduction to algorithms for managing the common trauma patient

L Wallis, MB ChB, MD, DIMCRCSEd, Dip Sport Med, FRCS (Edin), FRCP (Edin), FRCCEM, FCEM (SA), FEMSSA, FIFEM

Division of Emergency Medicine, Department of Surgery, Faculty of Health Sciences, University of Cape Town; Division of Emergency Medicine, Department of Interdisciplinary Health Sciences, Faculty of Medicine and Health Sciences, Stellenbosch University; and Emergency Medicine, Western Cape Government, Cape Town, South Africa

Corresponding author: L Wallis (lee.wallis@uct.ac.za)



It has been four years since I wrote an editorial in the *SAMJ*^[1] relating to the problems of trauma in South Africa (SA). I was more optimistic, naïve perhaps, and looking for meaningful change. In the face of the daily carnage from road accidents and interpersonal violence, I asked, 'is 2011 the year we will stand up and do something?'^[1] – apparently not. We continue to face the same onslaught, the same 1 200 deaths on our roads each month, and the same number of violent attacks of one man (it is usually men) on another human being.^[2] Trauma is an epidemic and, as with any other epidemic, demands policy intervention, preventive measures and provision of care.

The factors that drive SA's levels of violence are complex and difficult to address. We have policies, but poor implementation. We know that prevention is better than cure and that prevention efforts are critical and must be supported at all levels. But prevention – real prevention – to bring us to 'acceptable' injury levels, will take years or even decades.

Globally, 4.8 million people die of trauma each year compared with 3.8 million who die of HIV/AIDS, tuberculosis (TB) and malaria combined. A single type of trauma – road injury – was the fifth leading global cause of death by 2013, ahead of HIV.^[3] The myriad reasons behind the gross mismatch of disease burden and funding efforts are beyond the scope of this introduction, but perhaps we now see the first small steps towards normalisation. After reports such as that of the World Bank,^[4] injury is finally being recognised as a problem: two key steps include the recommendations of the *Lancet* Surgical Commission,^[5] and the World Health Organization (WHO)'s recent moves to appoint a lead for Emergency, Trauma and Acute Care and strengthen the Global Alliance for Care of the Injured.

In the meantime, in SA, better care of the injured must be a higher priority for a health system traditionally vertically orientated to HIV/

AIDS and TB. Effective early care dramatically improves outcome, perhaps by as much as 45% for deaths and 36% for disability.^[6] The need for effective trauma care cannot be more eloquently expressed than by Kobusingye *et al.*,^[7] when 10 years ago they noted that 'Emergencies occur everywhere, and each day they consume resources regardless of whether there are systems capable of achieving good outcomes'. It is our responsibility – your responsibility – as front-line clinicians, to provide the best care we can for the victims of trauma.

Those of you facing injured patients in your clinical practice know that sources of advice for care come in many formats and from many sources, and that some are easier to use than others. In this edition of CME, John^[8] provides simple flowchart-based algorithms to guide that care. His recommendations are in line with international and national guidelines, easy to follow, and – with the exception of a small number of advanced imaging requirements – implementable at all levels of care. We may not be making much impact on the numbers of injured patients that we see daily, but we can impact on the care they receive.

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