As winter has now officially arrived in our part of the world, ATS members are getting ready either to manage our ever increasing number of trauma patients or to head off to warmer temperatures in the northern hemisphere to attend meetings or just have a break.

I recently attended the “Innovations in Trauma Care” Meeting of the 15th European Congress of Trauma and Emergency Surgery and the 2nd World Trauma Congress in Frankfurt, Germany on behalf of the ATS. There was a broad surgical and orthopedic trauma focus at the meeting but there were also a wide range of more general trauma topics which provided significant interest.

It was a large meeting with over 1000 delegates representing 29 national European Societies for Trauma and Emergency Surgery and 31 Societies for the World Coalition for Trauma Care. The ATS was well represented and I think that all those who made the trip over learnt some new things and enjoyed the famous German hospitality.

The sessions included global trauma epidemiology, emergency surgery, disaster and military surgery, infections and antibiotic use, coagulopathy, new radiology procedures and lots of orthopaedic trauma management. There was an industry sponsored session on one of the new oral anticoagulants (dabigatran) and I learnt that the thrombin time is the best way to measure effect. Prothrombinex may also have some (limited) role in reversal of anticoagulant effects and the pharmaceutical company is also developing an antidote for reversal of more severe cases of overdose or bleeding while on this drug but it is not yet available.

The ATS provided speakers for a session “New Developments in Trauma care” and were represented by Michael Handy, Alicia Jackson, Michael Muller, Michael Parr and myself. Alicia Jackson entertained the crowd with an introduction to her talk with an audio of the “Men at Work” song “Down Under” and it was the only musical introduction that I heard at the meeting. A number of ATS members attended the meeting and presented both free and invited papers which were all very well received.

The World Trauma Coalition led by Raul Coimbra is making some headway in addressing the increasing burden of trauma in middle and low income countries. There is still a long way to go but there is increased collaboration with WHO.

On behalf of the ATS I would like to thank our hosts and organisers of the meeting, in particular Dr Ingo Marzi and Dr Luke Leenan, for organizing an excellent meeting and for their very generous hospitality.

On the local front, I understand from Russell Gruen that the Australian Trauma Registry is soon to provide its first report as part of the Australian Trauma Quality Improvement Program. We look forward to the initial report with interest.

Ian Civil in his role as the Clinic Lead for the recently constituted New Zealand Major Trauma National Clinical Network reported on the progress so far.
The NZ Minister of Health has recently required all hospitals and regions to have major trauma in their organizational plans for the 2014/15 financial year and the plan has to be consistent with the recommendations of the Network. Thus, by the end of June 2015, all hospitals will be required to have trauma coordinators, a clinical lead, and collect the data elements within the major trauma Minimum Data Set. All of the above indicates a very constructive and collaborative approach towards the management of major trauma by the NZ Government.

Hopefully, in the future the Australian Trauma Registry will be able to combine with the NZ Trauma Registry and the combined dataset could inform decisions around resource allocation, clinical guideline development and trauma research in both countries.

I remind you all that registration for **Trauma 2014 Making a difference**, the ATS Annual Scientific Meeting, 3-5 October at the Sofitel Wentworth Hotel in Sydney is now open and I encourage as many of you as possible to attend. The program committee believes that we have produced a good program with excellent international and local content and I don’t think you will be disappointed if you are able to attend. You can find it on the ATS website or [www.traumaconference.com.au](http://www.traumaconference.com.au).

Also it is time to renew your annual subscriptions and, at $198 for Ordinary member and $132 for Associate member, it is very good value for a professional society. The Society is in a good financial position at present thanks to the efforts of our diligent Treasurer, Andrea Herring, and the support of all of our members.

I hope you all have an enjoyable and productive next few months and I will look forward to seeing you at the Annual Scientific Meeting in October.

Best wishes

Tony Joseph
President, ATS
The chest wall thickness in the 4th anterior axillary line was of the order of 4cm (but the maximum recorded was 113.9cm!) and in the 2nd mid-clavicular line it was 4.5cm. The distance to a vital structure was over 11.5cm in the MCL and a similar distance in the right AAL. On the left side however the distance was between the skin and a vital structure was only 9.2cm.

The authors concluded that the chest wall was thinner in the anterior axillary line that in the mid-clavicular space and that the pleural cavity could be reached by an 8cm needle in 96% of cases compared to a 5cm needle where the failure rate on anatomical grounds alone could be as high as 34%. It was suggested that insertion of an 8cm needle at 90degrees to the skin in the 4th anterior axillary line is a feasible method for decompressing a tension pneumothorax but did note that if placed incorrectly on the left side had quite a high anatomic possibility of reaching a vital structure, namely the left ventricle.

Undoubtedly an 8cm needle is more likely to reach the pleural cavity than a 5cm one and based on this study more likely to do so in the anterior axillary line than in the mid-clavicular line. But is the risk of injuring a vital structure worth it? Given the findings in relation to chest wall thickness in this study it seems surprising that the authors chose 8cm, presumably because such a length cannula exists. If they had chosen 6.5cm there would have been almost as great a likelihood of decompressing a pneumothorax and a reduced possibility of hitting a vital structure. Given the environment in which needle decompression is used the risk of inadvertent injury has to be minimized and therefore while the rationale for using longer needles to accomplish decompression is valid the risk of inadvertent and possibly fatal iatrogenic injury negates that to a substantial degree.

A 6.5cm needle in the 2nd ICS in the mid-clavicular line would still be effective and safe in the vast majority of cases.

Evaluation of 8.0cm needle in the fourth anterior axillary line for needle chest decompression of tension pneumothorax Chang SJ, Ross SW, Kiefer DJ et al. J Trauma 2014;76;1029-1034
Splenic embolisation, when should we really use it?

This is a perennial issue and obviously the answer depends on a number of factors, most notably the availability and enthusiasm for interventional radiologists in any given institution to undertake this procedure. The Catch-22 in some circumstances is that if the patient is stable the argument is that they don’t need the procedure (which might be true about false aneurysms or extravasation in some other body regions) and if they are unstable the surgeons will want to take them to the OR for splenectomy. While this latter statement is almost always true, when should stable patients be considered for splenic embolisation?

This paper is from Wayne Meredith, recent President of AAST, and his team at Wake Forest University in Winston-Salem, North Carolina.

The study was a prospective one using historical controls. Before 2010 splenic embolisation was largely undertaken in patients with a splenic blush or extravasation on CT but from this time on all Grade III-V splenic injuries were subjected to angio and many embolised. Those with lower grade injuries who showed bleeding on CT were also subjected to angio.

In the three years prior to 2010 there were 153 Grade III-V splenic injuries and in the three years after that date, 168. The early group were similar to the latter group except for their overall ISS which at 29 was statistically greater than for the post-2010 group which had an ISS of only 24. The earlier group not surprisingly had a much higher mortality as well. The latter group which was the ones where all were angio’d had a successful non-operative management rate of 67% compared to 52% in the earlier group.

The conclusions of the authors were that pre-emptive angio of all high grade splenic injuries was associated with a higher success rate of non-operative management. This paper was presented at the Southern Surgical Association meeting in December last year and was discussed. The discussants included Tony Meyer who reminded the audience that this conclusion was the only one which the authors could claim as the overall improvement in outcome could well have been due to differences in patient case-mix and injury severity. Tom Scalea, from MIEMSS in Baltimore reminded the audience that his group in Kings County reported on this issue first in 1995 where there was little enthusiasm and he was delighted that things had moved on from there. He made a particularly relevant statement in relation to this issue and other areas of healthcare “These data cement the notion that protocol-driven care is better than individual judgement”. Put another way, variation in care for the same condition is the enemy of quality improvement.

So should all high grade spleens be embolised? Where the resource is available there seems little doubt from this and other papers that they should. But regardless, if a patient comes into your hospital with a Grade IV injury and is stable the same approach should be taken whether it is 9am on a Monday morning with Dr X on call or 3 am on a Sunday morning with Doctor Y.

Prospective trial of angiography and embolisation for all Grade III-V blunt splenic injuries: Non-operative management success rate is significantly improved

Incidental findings on trauma CTs – How common are they and how should we deal with them?

Any investigation can show up incidental findings. In an elective setting these are easily dealt with after discussion with the patient with an appropriate priority. In the trauma setting they occur when other vastly more pressing issues need to be dealt with and the patient and their relatives are not well placed to have the discussion about what to do.

This paper is from the trauma unit under Professor Goslings in the Department of Surgery in Amsterdam. They looked at a consecutive series of trauma patients having pan-CT between 2009 and 2011 and categorized incidental findings as either potentially severe (further diagnostic work-up required), moderate (diagnostic work-up dependent on patients symptoms and minor (no diagnostic work-up required). There were 321 patients in this study and a total of 186 incidental findings were discovered. Most incidental findings were located in the abdomen. There were 13 potentially severe incidental findings, 45 with moderate findings and 125 minor findings.

The authors documented their follow-up of the severe and moderate findings and the ultimate outcome which included diagnoses such as malignant tumours, AAA and cholelithiasis. While the authors documented meticulous follow-up of these cases they discussed the complexity of ensuring the relevance of the incidental findings were not lost and the patient is not lost to follow-up. This is another systems issue for trauma care. While we tend to be good at finding trauma diagnoses with primary, secondary and tertiary surveys, incidental findings can fly under the radar. Missing the opportunity to intervene on a significant diagnosis in a timely and effective way may be just as important for the patient in the longer term as treating their injuries.

Incidental findings are very common. In our trauma records we should have a way of listing and categorizing these and ensuring that relevant discussions occur with the patient and effective follow-up planned.

Incidental findings on total-body CT scans in trauma patients.
Sierink JC, Saltzherr TP, Russchen MJAM et al. Injury 2014:45;840-844
Your ATS renewals are due

The Australasian Trauma Society, the only multidisciplinary trauma society in Australia and NZ, needs new members. Just like the trauma team, if not everyone is involved, then its effectiveness is limited. Consider the benefits! This is the most cost-effective society you are likely find.

**WHY RENEW/JOIN THE ATS?**

The ATS is the only multidisciplinary trauma society in Australasia. It brings together those who are treating, researching and teaching in trauma as well as those wanting to learn more with the aim to provide the highest standard of trauma care in Australasia. The diversity of members and their vast experiences is a great forum for building improvements in injury management across Australia and New Zealand.

The society is now 17 years old and has grown from a small group to a membership of around 250 today.

The society has an annual scientific meeting which rotates around Australasia. There are collaborative meetings with other organizations in order to foster the exchange of concepts in trauma management. At these meetings there is a combination of plenary sessions with invited speakers, free papers, research papers, skills workshops and interactive debates. The meetings are a chance for you to Ask the Specialists (ATS) and keep up with the latest in trauma advances, care and controversies.

**BENEFITS OF MEMBERSHIP**

Ordinary Member - $198.00 (AUD) (inc GST) 2014-2015
- Quarterly Trauma Talk newsletter
- Three hard copy issues of *Injury* journal and online access to a further nine issues (value $300 per year). Note this is also the official journal of: the British Trauma Society, the Saudi Orthopaedic Association in Trauma and affiliated with the Hellenic Association of Orthopaedic Surgery and Traumatology
- Eligibility to apply for Travelling Scholarship
- Eligibility to serve on National Executive
- Discounted rate for ATS Annual Conference

Associate Member - $132 (AUD) (inc GST) 2014-2015
- Quarterly Trauma Talk newsletter
- Discounted rate for ATS Annual Conference

All new members will be charged a one-off administration fee of $22.00

**HOW TO JOIN**

Application forms can be completed and members renewals can be made online at [www.traumasociety.com.au](http://www.traumasociety.com.au)

**HOW TO RENEW:**

To renew your ATS Membership please login into Currinda [here](http://www.traumasociety.com.au) and follow the prompts.
Registrations for **TRAUMA 2014** are now OPEN!

Take advantage of your ATS Member rate!

click [HERE](#) to register

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A Basic Trauma Course for Physiotherapists is to be held at The Alfred Hospital on Friday 19 September 2014 (TBC)

For more information visit: [www.alfredhealth.org.au/physiotherapy](http://www.alfredhealth.org.au/physiotherapy)

and follow the link on the right hand side to Basic Trauma Course (Acute)

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**Definitive Surgical Trauma Care Course**

**DSTC Australasia in association with IATSC** (International Association for Trauma Surgery and Intensive Care) announce courses for 2014.

- [Adelaide](#) 24 & 25 March 2014
- [Sydney (Military Module)](#) 22 July 2014
- [Sydney](#) 23 – 24 July 2014
- [Auckland](#) 26 – 30 July 2014
- [Melbourne](#) 9 - 11 November 2014

Only available to qualified surgeons (including overseas) and surgical trainees their final 2 years of advanced training.

For more details please email: [DSTC@sswahs.nsw.gov.au](mailto:DSTC@sswahs.nsw.gov.au)
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