Interview with Dr Rodd Brockett – ICU Specialist (Logan Hosp) and General Physician
19 Oct 04

Based upon facts supplied by m yself, Dr Brockett believed there were two scenarios most likely in this case. The first is a slow haemorrhage with corresponding slow changes in HR and RR or clot blown off with significant arterial bleed leading to shock with patient potentially irretrievable thereafter. This latter point would require review by experienced intensivist (esp in management of chest injury). He inquired to use of epidural analgesia – none recorded.

Patient required adequate resuscitation, control of acidosis, reversal of coagulopathy and temperature regulation.

He agreed the most likely bleeding source was R thorax based upon blood loss from ICCs. Suggested treatment was clamping of ICC to aid tamponade and transfuse, plus intubation and single lung ventilation.

Thoracic intervention rarely required due to tamponade effect, but surgical interventions available including clamping of pul artery on temporary basis to stabilise for transfer to thoracic surgeon to identify bleeding source. He agreed that transfer of unstable patient including urgent blood transfusion wasn't desirable.

He believed the raised WCC was stress related, L side lung pathology was contra-coup type injury and raised troponin was only relevant if there was a rhythm disturbance. He agreed that 2nd CT Chest wasn't useful.

Dr Darren Keating
DMS

25 Oct 04