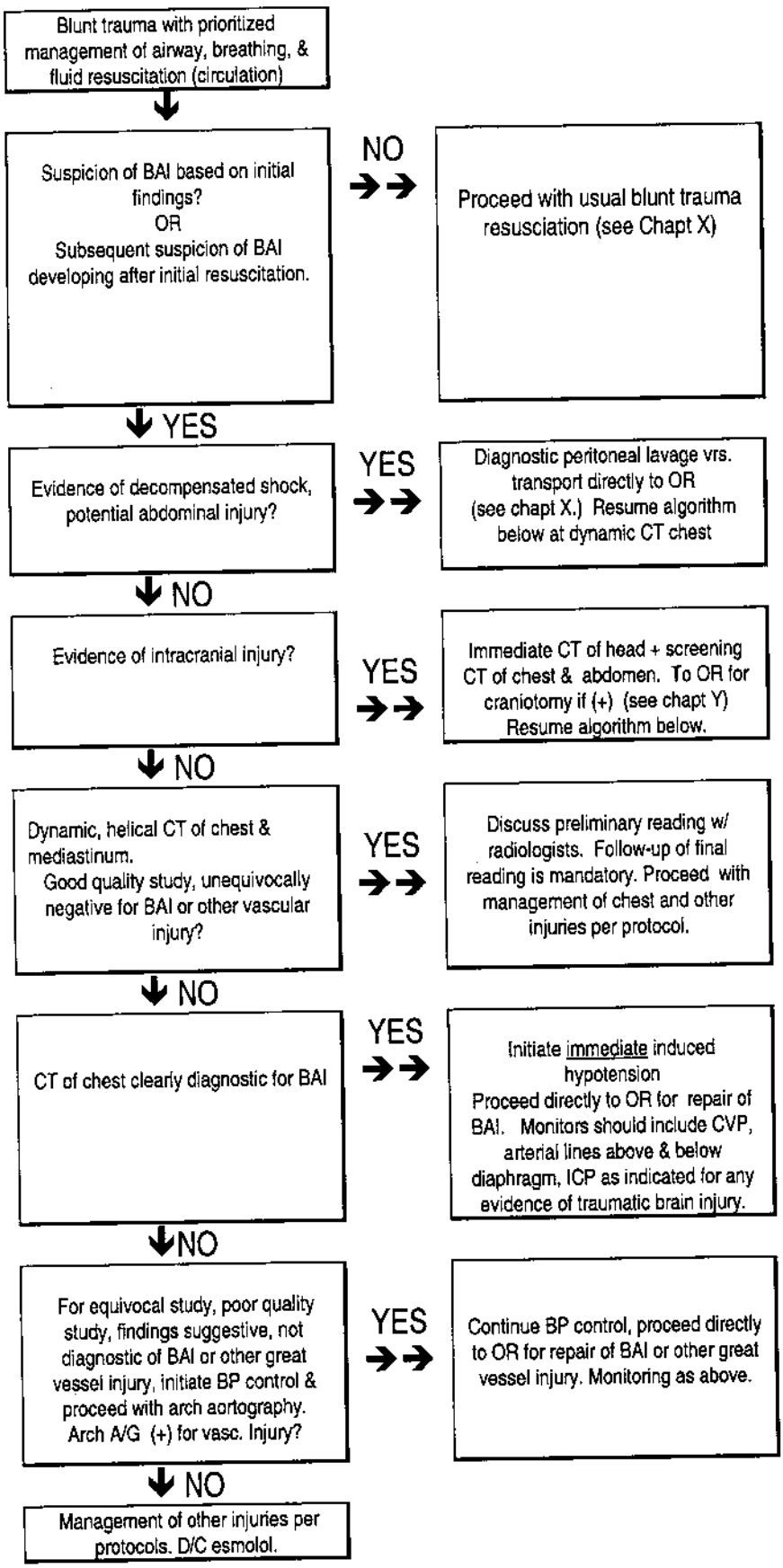

COMMENTS

Suspicion for BAI based on major mechanism AND:

- wide mediastinum (>8cm upright AP CXR)
- irregularity of aortic arch
- apical cap, PA window opacity, depr. L. bronchus
- unexplained chest or back pain
- other significant chest wall injuries (pulm contusion, multiple rib fractures, high lying rib fx.)
- Mediastinal abnormalities developing on any subsequent CXR's
- peri-aortic fluid seen on upper cuts of abd. CT scan

- Laparotomy should consider the potential for BAI with avoidance of intraop hypertension & "damage control" approach if indicated.

- The use of vasopressors for CPP may be modified depending on index of suspicion for BAI & severity of head injury.

In the absence of any evidence of BAI, arch A/G is probably not needed, depending on quality of study, experience of center & radiologists, & index of suspicion.

- Unless contraindicated by brain or spinal cord injury, all patients with abnormalities strongly suggestive of BAI should be maintained on BAI anti-HTN protocol:
  - Continuous arterial line monitoring
  - Esmolol infusion: target syst. BP 90-100 unless otherwise contraindicated. Nipride added PRN
  - Sodium nitorprusside contraindicated for traumatic brain injury.

- BAI should still be suspected based on peri-aortic hematoma. Concommitant injury to inominate or proximal carotid vessels may be suspected on the basis of: [peri-vascular hematoma, intimal flap, abdnormal vessel flow or abnormal contour]
- Pseudocoarctation syndrome is relatively strong contra-indication for arch aortography, regardless of circumstances.

INITIAL DIAGNOSIS & MANAGEMENT OF BLUNT AORTIC INJURY (BAI)

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