Resuscitative thoracotomy

So, your patient has PEA or is in cardiac arrest.

CPR is useless in a hypovolemic patient.

PATIENTS WHO ARRIVE TO ED

- **with penetrating chest injuries** **BLUNT INJURIES DON'T QUALIFY**
- **without a pulse**
- **with cardiac electrical activity**

ARE CANDIDATES FOR RESUSCITATIVE THORACOTOMY

- **A SURGEON MUST BE PRESENT FOR THIS**

Patients with penerating chest injuries who need CPR in the field need to be assessed for signs of life. This means

- **reactive pupils**
- **spontaneous movements**
- **spontaneous ECG activity**

If they have none of those, resuscitation efforts should cease.

WHAT DO YOU ACCOMPLISH WITH A RESUSCITATIVE THORACOTOMY:

- **Evacuation of the pericardial tamponade**
- **Direct control of thoracic hemorrhage**
- **Open cardiac massage**
- **Cross-clamping of the descending aorta to increase supply to the brain and heart, and to decrease blood loss below the diaphragm**

Thoracotomy in ED is rarely effective.

Stab wounds survive more often than gunshot wounds

In general survival rate is 18% to 33%

"The surgeon who should attempt to suture a wound of the heart would lose the respect of his surgical colleagues" - Theodore Bilroth, 1882 – from this online articlehttp://www.trauma.org/archive/thoracic/EDToperative.html

This source also wisely advises, *"The first time you see a Gigli saw should not be the first time you perform a thoracotomy."*