

## UpToDate grafik görüntüleme özelliği!

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Overview of inpatient management in the adult trauma patient

contraindication to enteral nutrition mandate parenteral nutrition therapy and are given below. A recent bowel resection

Temporary abdominal closure

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Acute respiratory distress syndrome

Transfusion-associated complications

Ventilator-associated pneumonia

Contrast-induced nephropathy

Catheter-associated blood stream infection

OUTCOMES

Organ donation

SUMMARY AND RECOMMENDATIONS

ACKNOWLEDGMENT

REFERENCES

GRAPHICS View All

FIGURES

Measurement of intraabdominal pressure

PICTURES

Temporary abdominal closure

RELATED TOPICS

Abdominal compartment syndrome

Acute compartment syndrome of the extremities

Acute respiratory distress syndrome: Clinical features and diagnosis in adults

Acute respiratory distress syndrome: Supportive care and oxygenation in adults

Acute stress disorder: Epidemiology, pathogenesis, clinical manifestations, course, and diagnosis

Antimicrobial prophylaxis for prevention

The indications for complete parenteral nutrition include: patients with persistent progressive ileus, bowel obstruction, massive bowel resection refractory to enteral nutrition, malabsorption, splanchnic hypoperfusion that places the patient at high risk for nonocclusive mesenteric ischemia and bowel necrosis, high output enteral fistula, intolerance of enteral nutrition (documented), and failure of enteral nutrition to meet caloric requirements [70]. (See "Nutrition support in critically ill patients: Parenteral nutrition.")

**Glucose control** — Patients with blood glucose above or below the accepted target range should be treated with insulin or glucose containing intravenous fluids, respectively. (See "Glycemic control and intensive insulin therapy in critical illness".)

There are increasing numbers of studies evaluating the adverse impact of the hyperglycemic stress response in injured patients. Prospective studies of injured nondiabetic patients have found that elevated serum glucose on admission, defined as glucose >200 mg/dL, was significantly associated with an increased risk of infection (eg, urinary tract, pneumonia, wound), increased length of stay (hospital, intensive care unit), and mortality [71-74]. In a study of 6852 trauma patients, patients with stress-induced hyperglycemia had a more than twofold increased risk for mortality compared with normoglycemic patients (RR 2.41, 95% CI 1.81-3.23), whereas, although there was a trend toward increased mortality among patients with diabetes, the difference was nonsignificant (RR 1.47, 95% CI 0.92-2.36) [75].

**WOUND CARE** — Injured patients present with a myriad of different wounds depending upon the injury mechanism. Upon admission, the location and size of each wound should be documented. Deep and more extensive wounds, particularly those in proximity to major vessels, should be explored in the operating room where lighting is optimal, debridement can be undertaken, and any disrupted vessels can be managed in a controlled fashion.

Individual wounds are managed with moist dressings, and closure or coverage, as indicated. (See "Basic principles of wound management".)

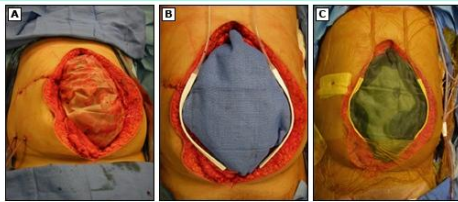
**Open abdomen** — Open abdomen is an abdominal wall defect created by intentionally leaving the fascia and skin open at the completion of surgery. Damage control surgery and suspected abdominal compartment syndrome are the most frequent reasons for open abdomen. The open abdomen is managed using temporary abdominal closure techniques that control abdominal fluid losses and assist with the progressive closure of the defect. (picture 1). Management of the abdominal defect is discussed in detail elsewhere. (See "Management of the open abdomen in adults".)

**Fasciotomy wounds** — Patients with acute extremity compartment syndrome are treated with fasciotomy. Prophylactic fasciotomy may be indicated in some patients (eg, ischemia-reperfusion following arterial repair, tibial fracture). The fasciotomy wounds are managed with moist dressings initially with subsequent closure of the skin when muscle edema has resolved. The indications for fasciotomy and management of fasciotomy wounds are discussed in detail elsewhere. (See "Lower extremity fasciotomy techniques" section on "Indications" and "Patient management following extremity fasciotomy" section on "Wound management".)

**CATHETERS, TUBES, DRAINS AND LINES** — During the initial assessment in the emergency department, most severely injured patients will have received an indwelling bladder catheter, various intravenous catheters and possibly an endotracheal or chest tube. Postoperative patients, particularly those who underwent damage control surgery, may also have had intraoperative drains placed.

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### Temporary abdominal closure



Temporary closure of the abdomen involves (A) covering the bowel with a fenestrated drape, (B) laying drains laterally and covering the bowel with a sterile towel, and (C) covering the wound with a sterile occlusive dressing with the drains exiting the drape superiorly (as shown) or inferiorly.

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(216) 464 33 00 - [bilgi@geminiltd.com.tr](mailto:bilgi@geminiltd.com.tr) - [www.geminiltd.com.tr](http://www.geminiltd.com.tr)