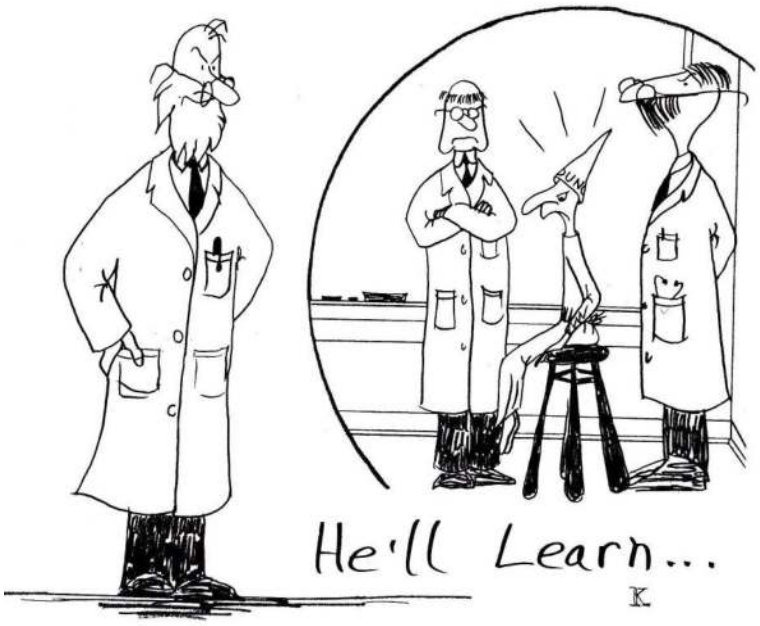

DR. WITHERSPOON
CHIEF OF STAFF

by J. M. MacDavid M.D.

Motor Vehicle Trauma

An American serviceman stationed overseas was involved in a violent motor vehicle accident. He was rushed to the base hospital.

Concerned he might be bleeding internally, the surgeon explored his abdomen. He found no damage to his internal organs.

After surgery, the young man refused to get out of bed. He complained of severe pain when attempting to do so.

Days went by but the patient wouldn't move. The staff did all they could to get him up. They chided him, called him a wimp. They placed his food tray at the end of the ward and told him if he wanted to eat, he would have to walk to get it. Eventually he did so using a single crutch borrowed from another patient. This went on for some time.

At some point, the surgeon ordered an x-ray of his pelvis. After that x-ray was taken, the patient was transferred to a major treatment center back in the United States.

Upon arrival at the big hospital, the young man told his tale. His medical records had somehow been lost. The doctor promptly obtained an x-ray of his pelvis.

The pelvis was broken into two halves. The right sacroiliac joint was disrupted. On the same side, there were superior and inferior pubic rami fractures. The breaks were nearly healed but improperly aligned. Unprotected weight bearing had caused a slight upward migration of the right half of the pelvis with a corresponding difference in leg lengths, left greater than right.

The young man was independently ambulatory without crutches. He complained of pelvic pain and walked with the stumped gait typical of a leg-length discrepancy.

Dr. Witherspoon Says:

Dang *BLAST* it! Where in the Sam Hill does this fellow get off kicking a trauma victim out of bed who, day after day, complains of agonizing pain without doing a dad-gummed thing to investigate it? Trauma victims are famous for having an undiscovered injury lurking within that maybe gets missed the night of admission.

But that's okay. You pick it up in the next day or so because, for the first few days, ya watch 'em like a hawk! If they hurt in new places or in ways they shouldn't be hurting, just order an x-ray or two: there's the break! Or you see the blood count drift down, order a CAT scan and pick up a cracked liver.

It's a famous mistake to miss something else going on with a trauma patient as everybody focuses on the obvious. A high "index of suspicion," as they say, is essential otherwise, a serious injury may be neglected.

I once treated a young lady who came into my office with two undiagnosed fractures three weeks after an automobile accident. The other guy nailed her broken tibia but, once the surgery was done, he never listened to her other complaints. I had to take her back to the OR and fix one of the breaks he missed.

In this case, the clinical picture would be most unlike a post-op abdomen. A sacroiliac disruption causes back pain and pubic rami fractures hurt in the groin.

Did anybody listen to him when they made their morning rounds? Did anybody *make* morning rounds?!

And whatever happened to the ol' concept of "pain out of proportion?" Or "predictable patterns of recovery?" A good surgeon knows about how long a patient should hurt after an operation and quickly becomes suspicious when things don't seem to be going according to plan.

Sure, it hurts the day after an operation. Nothin' strange about that. But you get 'em up and moving and, after a few days, they're feeling fairly tolerable. You know they're on the mend.

This fellow was in agony for days, weeks even, clinging to the bed. Eventually, even the janitor's gonna start thinking: "something ain't right..."

And I must say, this business of forced ambulation to the food tray, allowing the ward staff to make fun of your patient, and the final boot out of there after your gaffe is discovered is about as unprofessional as it gets!

As the reader has almost certainly determined, this is an old case involving an overseas facility with limited resources. It would be fair to question its relevance to medicine today, but there are important lessons here that are timeless.

The physical examination.

Movement of the hip on that side or compression of the iliac spines would have immediately pointed to a pelvic injury, and those are essential components of the physical examination of a trauma patient. Don't know how many times I've done it: compress the iliac crests, then on to the chest, etc. That maneuver would have sent this patient through the roof, a positive test pointing straight to the pelvis, after which you go straight to an x-ray. He had an inexcusably inadequate examination for a trauma patient, especially considering the facility did not have a CT scanner. Nowadays, we CT the entire body for anything more serious than a stubbed toe; without that resource, a good physical examination becomes ever more important.

Pain out of proportion.

This is a big one. Pain that exceeds what is reasonably expected for the diagnosis is almost always a red flag. Sure, it hurts after an ex-lap, but the astute practitioner anticipates a predictable pattern of recovery and quickly gets his radar up when a patient's pain continues outside the expected recovery window. Something else may be going on, so you start looking. In this case, a simple physical examination (I refer you to the previous paragraph) would have pointed the doctor straight to the heart of the matter. Which brings me to the next point.

Assumption of malingering.

Nothing, and I mean *nothing,* will get you in trouble quicker 'n' deeper than this. When I first started out in this business, every time I thought I had a patient who was being a bit too dramatic for what I believed was a simple problem, I got blind-sided by something that hit me at a hundred miles an hour. I learned my lesson. Big time. You take these unexpected complaints seriously and investigate every dad-gummed one of 'em! If you don't, ye will surely have your day of reckoning. If there is a financial incentive to remain incapacitated, that will certainly complicate things, but that is yet another thorny situation we doctors deal with to earn our keep. 'Tis our lot. Do the needful and skull it out.

I'm surprised the nurses bought into the doctor's skepticism, as they usually set us straight about things we doctors miss. This level of humiliation nowadays would get them all fired. Also, friends and relatives can be valuable assets. Don't be afraid to point out your concerns to the doctor when he's on rounds and you should expect your concerns to be taken seriously.

I'm assuming this doctor was fairly new to his practice and still had much to learn. The ol' sinking feeling he got when he saw that x-ray of the pelvis must have provided a whopping leap forward in the education department for him. Experience will probably straighten him out, but if he didn't learn a couple of serious lessons from this one, he's hopeless.