

Letter to the Editor: A Consensus-Based Criterion Standard for the Requirement of a Trauma Team

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We would like to comment on the Invited Commentary by Stewart [1] on our manuscript “A consensus-based criterion standard for the requirement of a trauma team”: Low-resource setting considerations [2].

We would like to thank Dr. Stewart very much for his thoughtful comments on our manuscript “A consensus-based criterion standard for the requirement of a trauma team”. However, first of all, we would like to resolve a major misunderstanding. Our criteria are NOT intended as (field) triage tools, neither in a highly developed nor in a low-resource setting. Instead, they are intended to categorize patients post hoc to have had actually required a trauma team (or not). Their presence should be used to calculate over- and under-triage of field triage criteria.

We agree that different criteria might have been chosen by other clinicians. For example, our group intensely discussed about truncal gunshot wounds. This criterium was eventually omitted, because we felt that not the gunshot wound itself, but the potentially life-threatening consequences (e.g., tension pneumothorax, massive bleeding with shock, chest tube placement, emergency surgery, blood transfusion and others) indicate the actual (post hoc) trauma team requirement so that the criterion truncal gunshot would be covered by the other criteria included in the recommendation. This does not necessarily question that truncal gunshot would appear to be a valid field triage criterion.

It is possible that patients that do not fulfill any of the recommended criteria might be in a medical situation when a trauma team would be required. It is difficult to imagine what that situation would be. Nevertheless, further studies have to validate the consensus criteria for missing patients that could have been saved or morbidity avoided, if a trauma team would have been present. Indeed, a study to validate the consented criteria is already under way.

We agree with Dr. Stewart that the definition of what members a trauma team is composed is a very important one. Even in many high-income countries there is an ongoing discussion about full and limited trauma teams. Furthermore, due to different educational systems the composition of a trauma team may be quite different between different high-income countries or even institutions. This is even more true, as Dr. Stewart pointed out, when the different resources of low and middle income countries are considered.

Nevertheless, if conditions prevail, as are included in our criterion standard, some kind of specialized team appears to be required to fulfill generally accepted treatment standards, irrespective of the setting.

What the exact composition of the trauma team for a specific group of patients should be remains a matter of debate. In the future, the suggested criteria might be divided according to the capabilities of differently composed trauma teams, taking the different settings within and between low-, middle-, and high-income countries into account. In case of limited resources, some kind of triage will have to take place probably resulting in different outcomes than if the resources would not have been limited.

We again like to thank Dr. Stewart to put our “high-income country view” into a broader perspective and for stimulating a global discussion on the organization and quality improvement in the initial care of the severely injured patients.

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References

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2. Waydhas C, Baake M, Becker L et al (2018) A consensus-based criterion standard for the requirement of a Trauma Team. *World J Surg.* <https://doi.org/10.1007/s00268-018-4553-6>