

Crush Injury

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Abstract: Crush injury is a condition in which a part of the body of an is caused by ischemia and muscle injury after being trapped between two bodies. Depending on the condition of the oppressed part of the body, different clinical tables may develop. In these cases, complications that may arise due to timely and correct interventions can be avoided

Keywords: crush syndrome, complication, correct interventions

1. INTRODUCTION

Crush occurs after ischaemia and muscle injury. Potassium, myoglobin and creatine kinase are increased. Different clinical tables may develop depending on the oppressed part of the body. Compartment syndrome may develop only after extremity injuries. Coma and shock table can be seen after metabolic disorder or central causes (1,2).

2. CASE

A 40-year-old male patient was brought to the emergency room after 2 hours of stay under the denture. The general condition of the patient was poor, the conspicuously closed glaskow coma scale: 6. Blood pressure arterial: 100 / 60mmHg, pulse 122 / min, no spontaneous breathing, enthusiasm. The patient had urine output. On physical examination, subcutaneous hematoma, superficial abrasions and subcutaneous ecchymotic lesions were present in the lower limbs. The initial hemogram and biochemical values of the patient were normal. Culled tomography revealed cervical 5-6 fracture, free air in the abdomen. The patient was followed closely in terms of crush injuries and complications. Two courses of saline 2% saline, 5% dextrose 2% NaHCO₃ / h and 20% mannitol

50cc / h were started. The patient, who had been observed in the emergency department for 6 hours and had an urine output of 200 ml per hour, was given intensive care for follow-up and treatment.

3. DISCUSSION

In crush injuries, hypovolemia, myoglobinuria, hypocalcemia, hyperkalemia, increased creatine kinase, arrhythmia, toxic shock, metabolic acidosis and disseminated intravascular coagulation may be seen. Kidney failure is the most serious complication. The treatment should begin when the patients are under the denture so that the clinical presentation does not progress (1,2). If there is a suitable limb in place, fluid therapy with 1-2 liters of saline should be started immediately. NaHCO₃ may be given 1 ampoule / hour and analgesic if the patient remains in the dent for a long time. In terms of risk of arrhythmia and sudden death, the patient should be followed up for potassium. Urine output should be 200 ml per hour, 6 liters per 24 hours. Alkaline urine should be provided as urine pH is greater than 6. Fluid therapy should continue with serum physiologic-0.045 NaCl and 5% dextrose. 20% mannitol should start at 1 gr / kg / 4 h. Hemodialysis; anuria, hyperpotasemia and volume loading.

4. CONCLUSION

Complications that can occur on time and in a correct manner can be avoided in cases where crush syndrome is suspected.

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