**The incident swept off my feet – ripped my vessel and broke my heart**

-a rare incident of fatal traumatic aortic dissection

Shobna Veerapan

Hospital Tengku Ampuan Rahimah General Hospital, Klang, Malaysia

**Introduction**

We present an interesting MVA case in our centre which turned to be an unexpected fatal traumatic aortic dissection.

**Case Description**

A 29 years old lady, with morbid obesity involved in a MVA (motorbike skidded). Presented with central chest pain, facial injuries and left upper limb pain. Upon arrival to emergency department, GCS full, vital signs within normal parameters, primary survey was unremarkable. E-FAST scan negative.

During secondary survey, we noticed patient unable to move bilateral lower limbs despite absence of any deformities. Patient did not complain of any back pain and there were no spine tenderness/crepitus or step deformities over spine. Power 0/5 over bilateral LL and absence of sensation from T12 and below which is unusual for any trauma patient without brain/ spine injury. Bilateral femoral, popliteal, DPA/PTA pulse were absent. Doppler ultrasound shows absence of blood flow over bilateral lower limbs.

Patient were co-managed with general surgical team and proceeded with CTA thorax & abdomen and CECT abdomen & pelvis which confirmed descending thoracic aortic transection/rupture with intramural and mediastinal hematoma. There were no intra-abdominal injuries.

**Discussion**

Managing traumatic aortic transection may be challenging, especially in centre without cardio thoracic surgery team services.

In this case, challenges include allowing targeted lower systolic blood pressure (SBP) to maintain integrity of formed intramural hematoma besides maintaining MAP and CPP as this patient was intubated.

Much to learn as this patient safely and successfully transferred from Tengku Ampuan Rahimah general hospital to Serdang general hospital which located about 43km away for cardiothoracic team intervention is not an easy task.

However, we were informed by Serdang GH team that patient succumbed to her condition and passed away in Serdang GH, Intensive Care Unit (ICU) hours after transfer.

**Conclusion**

Managing traumatic aortic transection is not an easy task especially in centre without cardiothoracic team. We proudly present case which well managed in our centre juggling between maintaining integrity of thoracic aortic transection hematoma, maintaining CPP and high risk interfacility transfer of critically ill patient.

The learning point from this case is secondary survey should not be delayed at any cost as there are many other conditions that can lead to mortality in a trauma patient and disproportionate pain should always be examined and investigated thoroughly.

**Keywords**

**Aortic Transaction , E-FAST, CECT , cardiothoracic team , SBP**