AAST Acute Care Surgery Didactic Curriculum

Colon Injury

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Penetrating Colon Injuries:

Highlight:

- Penetrating injury to the right or left colon requires mobilization of the entire injured side of the colon with evaluation of the posterior wall along with the adjacent ureter
- Every penetrating paracolic hematoma needs to be explored with the underlying colon inspected for injury
- Nondestructive colon injures (<50% of colon wall circumference without devascularization) should be managed with adequate sharp debridement back to bleeding and primary repair in two layers
- Destructive colon injuries (>50% of colon wall destruction or with segmental devascularization) require segmental resection with primary anastomosis
- Consider diversion with >6 u of blood given or patients with significant comorbidities

Blunt Colon Injuries:

Highlight:

- Diagnosis by CT scan is difficult; requires careful inspection for extraluminal gas, fluid or bowel wall thickening
- No current support for mandatory exploration of paracolic hematomas in blunt trauma
- Surgical management should follow penetrating colon injuries with special attention to adequate blood supply
- Routine drain placement is not recommended after primary repair or resection and anastomosis for either blunt or penetrating colon injury

Abdominal Wound Management/Ostomy Management:

Highlight:

- Patients with penetrating colon injuries should have skin left open
- Delayed closure can be considered several days later
- Single dose of antibiotics that covers both aerobic and anaerobic bacteria adequate for prophylaxis
- Timing of ostomy reversal is overall recommended at the earliest 3 months, however in the absence of severe intra-abdominal sepsis, malnutrition, or major wound problems, earlier ostomy reversal can be considered

Penetrating Rectal Injuries:

Highlight:

- Current workup recommendations comprise a combination of clinical and diagnostic studies to include digital rectal exam, computed tomography (CT), contrast enema studies, and endoscopy
- Most sensitive finding on CT imaging is a wound tract that extends adjacent to the bowel
- Nondestructive (<25% of circumference) intraperitoneal rectal injuries should be repaired primarily; destructive (>25% of circumference) intraperitoneal injuries should be resected with primary anastomosis
- Fecal diversion is recommended for destructive extraperitoneal rectal injuries or associated pelvic fractures secondary to concern for open fractures and pelvic sepsis
- Presacral drains should not be placed routinely; can be considered for destructive rectal injuries that communicate with and contaminate presacral and pararectal soft tissues