

ORIGINAL ARTICLE / ОРИГИНАЛНИ РАД

Evaluation of independent predictors of in-hospital mortality in patients with severe trauma

Marija Milenković¹, Zaneta Terzioski¹, Adi Hadžibegović¹, Jovana Stanisavljević¹, Ksenija Petrović¹, Jovanka Nikolić¹, Mirjana Mihajlovska¹, Vesna Bumbaširević^{1,2}

¹Clinical Center of Serbia, Emergency Center, Department for Anesthesiology, Belgrade, Serbia;

²University of Belgrade, Faculty of Medicine, Belgrade, Serbia



SUMMARY

Introduction/Objective The aim of this study was to determine independent predictors and the best trauma scoring system (REMS, RTS, GSC, SOFA, APACHE II) of in-hospital mortality in patients with severe trauma at the Department of Emergency, Emergency Center, Clinical Center of Serbia, Belgrade.

Methods Longitudinal study included 208 consecutive patients with severe trauma. In order to determine independent survival contributors, univariate and multivariate Cox regression analyses were performed. The power of above-mentioned scoring systems (measured at admission to the Emergency center) to predict mortality was compared using the area under the curve (AUC).

Results There were 208 patients (159 male, 49 female), with the average age of 47.3 ± 20.7 years. Majority of patients were initially intubated (86.1%) on admission to the emergency department, and 59.6% patients were sedated before intubation. After finishing of diagnostic procedures, 17 patients were additionally intubated, and, at that time, 94.2% patients were on mechanic ventilation. The majority of patients was traumatized in a car crash (33.2%), followed by falls from height (26.4%) and as pedestrians (22.6%). Patients had an average of 24.7 ± 21.2 days spent in intensive care unit. The overall case-fatality ratio was 17/208 (8.2%). In Cox regression analysis only elevated heart rate (HR = 1.03, $p = 0.012$) and decreased arterial oxygen saturation (SpO₂) (HR = 0.91, $p = 0.033$) singled out as independent contributors to in-hospital mortality of patients with severe trauma. REMS (AUC 0.72 ± 0.64) and SOFA (AUC 0.716 ± 0.067) scores were found fair and similar predictor of in-hospital mortality, while APACHE II (AUC 0.614 ± 0.062) and RTS (0.396 ± 0.068) were poor predictors.

Conclusion Results of this study showed an important role of REMS, which appears to provide balance between the predictive ability and the practical application, and components of REMS in prediction of outcome in patients with severe trauma and that HR and SpO₂ are independent predictors of in-hospital mortality.

Keywords: injury; Rapid Emergency Medicine Score; cohort study

INTRODUCTION

Trauma remains an increasingly common entity and one of the leading causes of death among young adults, killing a million people worldwide. Therefore, trauma is significant factor of morbidity, disability, mortality and has important financial and social impact [1]. Keeping in mind the frequency and consequences of trauma, it is very important to define predictors of outcome with certain level of accuracy. However, this issue is related to measuring quality of trauma system, including feasibility, ethical considerations, risk assessment, and other type of evaluation. All these activities have the same goal, to support the concept of preventable death resulting from poor medical care [2].

In order to assess injury severity and predict prognosis, many different trauma-scoring systems are used. These measures vary widely in terms of design, complexity, and accuracy in predicting mortality after severe trauma [3, 4]. Besides that, the robustness of certain trauma scoring system depends on population under

study. For example, the presence of very healthy patients who will probably survive as well as elder patients or patients with severe comorbidity who probably won't survive might significantly affect the ability of the scoring system to correctly predict the outcome [5]. Furthermore, the use of trauma scoring systems helps clinicians in management of trauma patients. Besides that, prediction of severe trauma is associated with presence of comorbidity, time interval between trauma and its care, treatment settlements [6].

Over the last decades many scoring system have been developed and used for trauma. The Revised Trauma Score (RTS) is the most commonly used physiological score. It is widely used in hospital and pre-hospital patients (pre-hospital triage). It consists of the Glasgow Coma Scale (GSC), systolic blood pressure, and respiratory rate (RR) [7]. The Rapid Emergency Medicine Score (REMS) was developed for predicting in-hospital mortality in nonsurgical emergency department (ED) patients [8]. REMS incorporates GSC, age, mean arterial pressure (MAP), RR, heart rate (HR) and arterial

Received • Примљено:
March 13, 2019

Revised • Ревизија:
May 20, 2019

Accepted • Прихваћено:
May 22, 2019

Online first: May 28, 2019

Correspondence to:

Marija MILENKOVIĆ
Department for Anesthesiology
Emergency Center
Clinical Center of Serbia
Pasterova 2, Belgrade 11000
Serbia
smgk055@gmail.com

oxygen saturation (SpO₂). The most spread used scoring system is The Acute Physiology and Chronic Health Evaluation (APACHE II). This scoring system evaluates the severity of surgical, non-surgical and intensive care unit (ICU) patients. APACHE II consists of the body temperature, RR, HR, MAP, oxygenation of arterial blood, arterial pH, serum sodium and potassium levels, serum creatinine, hematocrit, white cell count and GCS [9]. The Sequential Organ Failure Assessment (SOFA) was designed in 1994 for assesses the severity of illness in patients in the ICU [10]. The score incorporates PaO₂/FiO₂ mmHg, MAP, vasopressors, serum creatinine, serum bilirubin, platelets, and GSC.

Bearing in mind all of the mentioned above, the aim of this study was to determine independent predictors and the best trauma scoring system (REMS, RTS, GSC, SOFA, APPACHE II) of in-hospital mortality in patients with severe trauma at the Department of Emergency, Emergency Center, Clinical Center of Serbia, Belgrade.

METHODS

Study design

Prospective cohort study included 208 consecutive patients with severe trauma admitted to the Emergency Center, Clinical Center of Serbia in Belgrade, from June 1, 2015 to June 1, 2016. Patients were followed until discharge or death. The study was approved by the Ethics Committee of the Faculty of Medicine, University of Belgrade (decision no. 29/IV-19; 25-APR-2016).

Inclusion and exclusion criteria

All patients with severe trauma, aged over 18 years, were included in the study. Mechanism of injury was established as Injury Severity Score (ISS) of over 15 [10]. Exclusion criteria were unknown identity of person, absence of accompanying person, patients transferred from other emergency centers, patients intubated and reanimated at the place of injury, sedated patients.

Data collection

Data on demographic characteristics, personal history, concomitant therapy, and mechanism of injury were collected by questionnaire. Additionally, for all patients ISS, RTS, and REMS were determined at admission in the Emergency center (EC) [7, 8, 10]. Furthermore, SOFA score and APACHE II score were determined at the admission in ICU [9, 10]. Information on clinical characteristics (body temperature, systolic and diastolic blood pressure, HR, RR, SpO₂), blood sample analyses (serum sodium and potassium levels, serum creatinine, serum bilirubin, hematocrit, leucocytes count, platelets) and other analyses (PaO₂/FiO₂ mmHg, vasopressor, oxygenation of arterial blood, arterial pH) were obtained from medical records. Initial vital signs (HR, RR, systolic, diastolic blood

pressure and SpO₂) and GCS recorded immediately upon arrival at ED. The assessments of noninvasive blood pressure, HR, SpO₂ (determined by peripheral pulse oximeter) done by Infinity Vista XI Drager monitor. Normal ranges of hemodynamic and respiratory parameters are defined by Advanced Trauma Life support classification of shock [11]. For example, arterial hypotension is defined as systolic blood pressure lower than 90 mmHg, tachycardia is defined as HR faster than 100 beats per minute (BPM).

Statistical analysis

Baseline characteristics of the study sample (mean, standard deviation, percentages) are presented. Nonparametric test was used for the comparisons between groups (Mann-Whitney test for continuous variables). Moreover, the predictive factors were tested in univariate and multivariate models using Cox proportional hazard regression models for reaching clinical outcome (death). In these analyses, death was considered as dependent variable. All variables that were associated ($p < 0.100$) with the outcome in the univariate analysis were analyzed together in multivariate Cox proportionate hazard regression model in order to determine independent predictors of in-hospital mortality in patients with severe trauma. The power of scoring systems to predict mortality was compared using the area under the curve (AUC). All analyses were performed using the SPSS (SPSS Inc. Chicago, USA), version 17.0 for Windows. Probability level of < 0.05 was considered statistically significant.

RESULTS

The characteristics of 208 patients with severe trauma are shown in Table 1. There were 159 (76.4%) male and 49 (23.6%) female patients, with average age of 47.3 ± 20.7 years. Almost all patients (99.5%) came to the ED by ambulance. Average time spent in Emergency ambulance prior to hospitalization was 1.3 hours. The largest proportion of patients was traumatized in car crash (33.2%), followed by falls from the height (26.4%) and as pedestrians (22.6%) (Figure 1). The overall case-fatality ratio was 17/208 (8.2%).

Regarding clinical characteristics, values of systolic and diastolic blood pressure and number of respirations were in the normal range, while average HR was elevated (110 ± 25 beats per minute) and SpO₂ was decreased ($85.4 \pm 4.5\%$) (Table 1).

Majority of the patients were initially intubated (86.1%), at admission to ED, and 59.6% patients were sedated before intubation. After finishing of diagnostic procedures, 17 patients were additionally intubated, and, at that time, 94.2% patients were on mechanic ventilation (Table 1).

Different values of scale scores at admission to ED and ICU are shown in Table 2. Based on their values, it is obvious that included patients suffered from severe trauma, which requires hospitalization in ICU. There is a statistically significant difference between REMS and SOFA score

Table 1. Patients' characteristics

Variable	Values*
Age (years)*	47.3 ± 20.7
Sex**	
Male	159 (76.4%)
Female	49 (23.6%)
Arrival to the Emergency Department by:**	
Emergency	207 (99.5%)
Private car	1 (0.5%)
Time spent in ambulance on admission (hours)*	1.3 ± 0.5
Systolic blood pressure (mmHg)*	118.8 ± 36.1
Diastolic blood pressure (mmHg)*	71.2 ± 22.4
Heart rate (bpm)*	110 ± 25
Number of respirations*	14 ± 10
Saturation (%)*	85.4 ± 4.5
Intubation**	
Yes	179 (86.1%)
No	29 (13.9%)
Mechanic ventilation**	
Yes	196 (94.2%)
No	12 (5.8%)
Sedation**	
Yes	124 (59.6%)
No	84 (40.4%)
Hemodynamics**	
Stable	138 (66.3%)
Unstable	70 (33.7%)
Inotropic support**	
Yes	70 (33.7%)
No	138 (66.3%)

*Mean ± SD;

**values are presented as frequencies (%)

values between dead and alive patients (Table 3), p-value for the REMS score is 0.002 and for the SOFA score p-value is 0.003 (according to the Mann-Whitney test).

Patients had an average of 24.7 ± 21.2 days spent in ICU.

According to the results of univariate Cox proportional regression analysis, following variables entered in multivariate model ($p < 0.100$): HR ($p = 0.008$), SpO₂ ($p = 0.019$), REMS ($p = 0.058$), SOFA on admission ($p = 0.077$) (Table 4). These variables were statistically significant in univariate analyses. After multivariate Cox regression model using above mentioned variables significant in univariate analysis, only elevated HR (HR = 1.03, $p = 0.012$) and decreased of SpO₂ (HR = 0.91, $p = 0.033$) at admission remained significant, i.e. singled out as independent contributors to in-hospital mortality of patients with severe trauma. In other words, an increase of HR for one unit is associated with an increase of risk of death by 3%. Additionally, a decrease of SpO₂ for one unit is associated with an increase of risk of death by 9%.

We compared RTS, REMS, APACHE II and SOFA in predicting in-hospital mortality by using Receiving Operating Curve (ROC) analysis (Figure 2). REMS (AUC 0.72 ± 0.64) and SOFA (AUC 0.716 ± 0.067) were found fair and similar predictors of in-hospital mortality. On the other hand APACHE II (AUC 0.614 ± 0.062) and RTS (0.396 ± 0.068) were found poor predictors of in-hospital mortality.

Table 2. Scores at admission

Scale	Mean ± SD
GCS	8.5 ± 4.1
ISS	33.1 ± 10.2
RTS	5.5 ± 1.5
REMS	10 ± 4.1
APACHE II	18.5 ± 8.6
SOFA	7.5 ± 3.1

GCS – Glasgow Coma Scale; ISS – Injury Severity Score; RTS – Revised Trauma Score; REMS – Rapid Emergency Medicine Score; APACHE II – Acute Physiology and Chronic Health Evaluation; SOFA – Sequential Organ Failure Assessment

Table 3. Injury scores

Scores	Dead (mean ± SD)	Alive (mean ± SD)	p-value
REMS	13.17 ± 4.36	9.73 ± 3.94	0.002
RTS	5.01 ± 1.39	5.54 ± 1.45	0.162
GCS	7.18 ± 3.14	8.58 ± 4.2	0.33
SOFA	9.59 ± 3.04	7.39 ± 2.96	0.003
APACHE	21.41 ± 6.65	18.28 ± 8.61	0.126

GCS – Glasgow Coma Scale; RTS – Revised Trauma Score; REMS – Rapid Emergency Medicine Score; APACHE II – Acute Physiology and Chronic Health Evaluation; SOFA – Sequential Organ Failure Assessment

Table 4. Results of univariate Cox regression analysis

Variable	Hazard ratio	95% confidence interval	p-value
Age	0.99	0.97–1.01	0.33
Sex	0.59	0.17–2.07	0.414
Admission to the Emergency Department	0.05	0–0.75	0.856
Time spent in ambulance on admission	1.53	0.52–4.56	0.443
Systolic blood pressure	0.99	0.98–1	0.173
Diastolic blood pressure	0.98	0.96–1	0.109
Heart rate	1.03	1.01–1.05	0.008
Number of respirations	1.01	0.96–1.07	0.593
Saturation	0.90	0.82–0.98	0.019
Comorbid hypertension	1.11	0.37–3.31	0.857
Mechanism of injury	1.01	0.75–1.37	0.939
GCS	1	0.87–1.14	0.964
Breathing	20.35	0–26.05	0.856
Intubation	1.04	0.13–8.31	0.973
Mechanic ventilation	0.05	0–5.83	0.711
Sedation	1.7	0.65–4.43	0.282
Hemodynamic	1.19	0.46–3.06	0.723
Inotrop support	0.81	0.31–2.15	0.676
RTS	0.9	0.61–1.33	0.606
REMS	1.1	1–1.22	0.058
APACHE II on admission in ICU	0.99	0.94–1.06	0.87
SOFA on admission in ICU	1.17	0.98–1.38	0.077
Mechanic ventilation in ICU	0.05	0.01–5.83	0.914
Hemorrhage	1.48	0.56–3.94	0.427
Surgical intervention	0.8	0.29–2.20	0.66

Bold values denote statistical significance ($p < 0.100$)

GCS – Glasgow Coma Scale; RTS – Revised Trauma Score; REMS – Rapid Emergency Medicine Score; APACHE II – Acute Physiology and Chronic Health Evaluation; SOFA – Sequential Organ Failure Assessment; ICU – intensive care unit

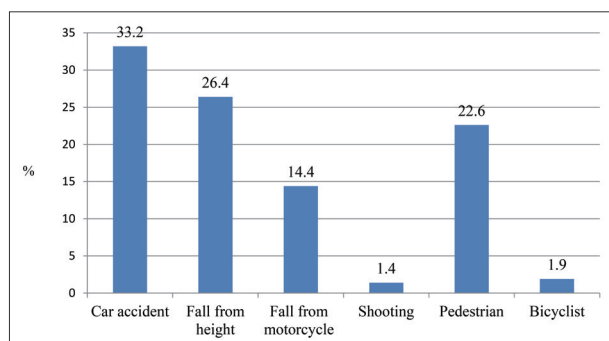


Figure 1. Mechanisms of injury

DISCUSSION

The assessment of outcome in severe trauma patients is a demanding task due to the diversity and variation in severity of trauma, and consequently, heterogeneity of patient population. Additional factors, which may influence the assessment of outcome in these patients, are related to the issue of appropriate assignment of severity of symptoms and presence of different comorbidities [11].

Our mortality rate is 8.2%, which is higher than in other study where, were mortality rate found to be around 5% [1]. This difference may be because in these studies, all traumatized patients were included, and one of our inclusion criteria was ISS over 15. Considering this inclusion criterion our patients had greater mortality risk.

In our study the largest proportion of patients was traumatized in car crash (33.2%), followed by falls from the height (26.4%) and as pedestrians (22.6%). Our findings were similar like in previous studies [12].

Our finding of predictive role of age in in-hospital mortality in univariate analysis was not significant, which is opposite than in the other studies [13, 14]. Miyamoto et al. [13] and Jawa et al. [14] found that older age was an indicator of in-hospital mortality. The possible reason for different findings might be a larger sample size, and different statistical approach in these studies.

In our study, regarding the trauma scoring system, REMS is similar to or better than the other system. REMS has similar results as the SOFA, the advantages of REMS is more rapid and less invasive than SOFA. APACHE II and RTS were found poor predictors of in-hospital mortality [15]. Imhoff et al. [16] and Lee et al. [17] found that the REMS scoring system, performed in the ED, was a strong predictor of in-hospital mortality. Slight differences between REMS and RTS as predictors of in-hospital mortality can be observed in both studies. REMS scoring system is easier and simpler than RTS because it is consisting of six variables (GSC, age, MAP, RR, HR, SpO₂) which are easy to obtain. Considering all this, REMS scoring system can be highly applicable at the ED and in the prehospital treatment of patients. Our findings support the growing body of literature examining the use of REMS in judgment after major injury [18, 19].

In this prospective cohort study, we demonstrated that HR and SpO₂ on admission are independent predictors

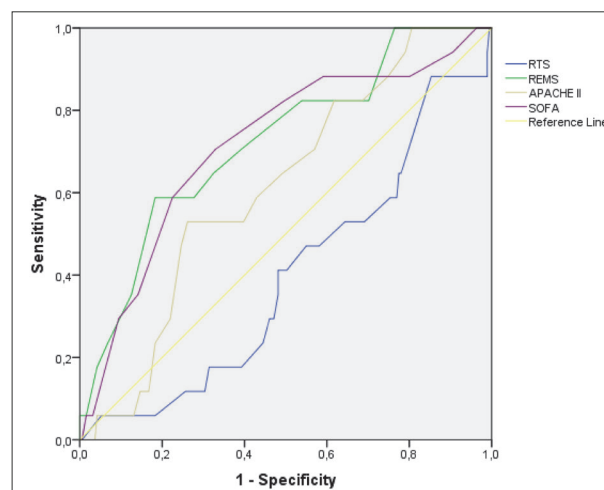


Figure 2. Area under curve for the injury scores;

RTS – Revised Trauma Score; REMS – Rapid Emergency Medicine Score; APACHE II – Acute Physiology and Chronic Health Evaluation; SOFA – Sequential Organ Failure Assessment

of in-hospital mortality in patients with severe trauma. Using the Cox proportional hazard regression models we demonstrated that an increase of HR for one unit is associated with increase of risk of death for 3%, while a decrease of SpO₂ for one unit is associated with increase of risk of death for 9%. Both these variables are components of the REMS, which has been developed for predicting in-hospital mortality in nonsurgical ED patients [20]. Our work confirms that in the most severely injured patients, initial measurement of REMS components, especially HR and SpO₂, are reliable indicators of those who are at the greatest risk of in-hospital death. These findings are opposite then in the literature, Imhof et al. [16] found that HR do not have statistically significant contribution in mortality prediction, on the other hand age and GSC have high statistically significant contribution in mortality prediction. These opposite findings can be explained by autonomic compensation to severe trauma [21]. In our study, we had only severe traumatized patients which is different between Imhof et al. [16], regarding to the SpO₂ we have same finding like in other studies [22].

It is well known that determination of vital signs such as SpO₂ and HR upon arrival at the ED is frequently used as prognostic indicators for adverse outcome in patients with severe trauma. On the other hand, analysis of HR variability provides insight into adequacy of autonomic compensation to severe trauma in pre-hospital settings [21]. In the same study, authors stated that their findings support the fact that autonomic balance and pulse pressure are associated with mortality, and may give important diagnostic and prognostic findings in management of patients with severe trauma. Physiological response to injury with consequent reductions of central blood volume includes increased HR and peripheral vascular resistance. These autonomic compensations are mediated by decrease of parasympathetic and activation of sympathetic efferent neural way to the heart and vasculature [23, 24]. Additionally, alterations of tissue perfusion and oxygenation due to an impaired

microcirculation have been shown to contribute to the subsequent development of organ dysfunction and unfavorable outcome [25, 26]. In line with these results, low SpO₂ values at baseline have been associated with the development of multiorgan dysfunction and death [27, 28, 29].

Some limitations of our study have to be mentioned. First, 208 patients with severe trauma were enrolled in this study, and a larger sample size would have been beneficial for generalizability of the results. Second, traumatized patients who died in pre-hospital settings were not included in the analysis, which represents a type of selection bias. Third, the patient's vital parameters varied over time, so the values presented might not be representative. Finally, the lack of available data regarding the presence of comor-

bidities, and their management was not included and may have resulted in bias in the outcome.

CONCLUSION

Results of this study showed the important role of REMS, which appears to provide balance between the predictive ability and the practical application, and components of REMS in prediction of outcome in patients with severe trauma and that HR and SpO₂ are independent predictors of in-hospital mortality.

Conflict of interest: None declared.

REFERENCES

- Miller RT, Nazir N, McDonald T, Cannon CM. The modified rapid emergency medicine score: A novel trauma triage tool to predict in-hospital mortality. *Injury*. 2017; 48(9):1870–7.
- Fevang E, Perkins Z, Lockey D, Jeppesen E, Lossius HM. A systematic review and meta-analysis comparing mortality in pre-hospital tracheal intubation to emergency department intubation in trauma patients. *Crit Care*. 2017; 21(1):192.
- Wandling MW, Nathens AB, Shapiro MB, Haut ER. Police transport versus ground EMS: A trauma system-level evaluation of prehospital care policies and their effect on clinical outcomes. *J Trauma Acute Care Surg*. 2016; 81(5):931–5.
- Rating the severity of tissue damage: I. The abbreviated scale. *JAMA*. 1971; 215:277–80.
- Chawda MN, Hildebrand F, Pape HC, Giannoudis PV. Predicting outcome after multiple trauma: which scoring system? *Injury*. 2004; 35(4):347–58.
- Kondo Y, Abe T, Kohshi K, Tokuda Y, Cook EF, Kukita I. Revised trauma scoring system to predict in-hospital mortality in the emergency department: Glasgow Coma Scale, Age, and Systolic Blood Pressure score. *Crit Care*. 2011; 15(4):R191.
- Champion HR, Sacco WJ, Copes WS, Gann DS, Gennarelli TA, Flanagan ME. A revision of the Trauma Score. *J Trauma*. 1989; 29(5):623–9.
- Olsson T, Terent A, Lind L. Rapid Emergency Medicine score: a new prognostic tool for in-hospital mortality in nonsurgical emergency department patients. *J Intern Med*. 2004; 255(5):579–87.
- Knaus WA, Draper EA, Wagner DP, Zimmerman JE. APACHE II: a severity of disease classification system. *Crit Care Med*. 1985; 13(10):818–29.
- Ferreira FL, Bota DP, Bross A, Mélot C, Vincent JL. Serial evaluation of the SOFA score to predict outcome in critically ill patients. *JAMA*. 2001; 286(14):1754–8.
- American College of Surgeons Committee on Trauma. Advanced Trauma Life support (ATLS). 10th edition, Student Course Manual, American College of Surgeons, Chicago, 2018.
- Yucel N, Ozturk Demir T, Derya S, Oguzturk H, Bicakcioglu M, Yetkin F. Potential risk factors for in-hospital mortality in patients with moderate-to-severe blunt multiple trauma who survive initial resuscitation. *Emerg Med Int*. 2018; 6461072.
- Miyamoto K, Shibata N, Ogawa A, Nakashima T, Kato S. Prehospital quick sequential organ failure assessment score to predict in-hospital mortality among patients with trauma. *Am J Emerg Med*. 2019.
- Jawa RS, Vosswinkel JA, McCormack JE, Huang EC, Thode HCJ, Shapiro MJ, et al. Risk assessment of the blunt trauma victim: The role of the quick Sequential Organ Failure Assessment Score (qSOFA). *Am J Sur*. 2017; 214(3):397–401.
- Eskesen TG, Baekgaard JS, Christensen RE, Lee JM, Velmahos GC, Steinmetz J, et al. Supplemental oxygen and hyperoxemia in trauma patients: a prospective, observational study. *Acta Anaesthesiol Scand*. 2019; 63(7):531–6.
- Imhoff BF, Thompson NJ, Hastings MA, Nazir N, Moncure M, Cannon CM. Rapid Emergency Medicine Score (REMS) in the trauma population: a retrospective study. *BMJ Open*. 2014; 4(5):e004738.
- Lee SB, Kim DH, Kim T, Kang C, Lee SH, Jeong JH, et al. Triage in Emergency Department Early Warning Score (TREWS) is predicting in-hospital mortality in the emergency department. *Am J Emerg Med*. 2019.
- Olsson T, Terent A, Lind L. Rapid Emergency Medicine score: a new prognostic tool for in-hospital mortality in nonsurgical emergency department patients. *J Intern Med*. 2004; 255(5):579–87.
- Nakhjavan-Shahraki B, Baikpour M, Youseffard M, Nikseresht ZS, Abiri S, Mirzay Razaz J, et al. Rapid Acute Physiology Score versus Rapid Emergency Medicine Score in Trauma Outcome Prediction; a Comparative Study. *Emerg (Tehran)*. 2017; 5(1):e30.
- Ha DT, Dang TQ, Tran NV, Vo NY, Nguyen ND, Nguyen TV. Prognostic performance of the Rapid Emergency Medicine Score (REMS) and Worthing Physiological Scoring system (WPS) in emergency department. *Int J Emerg Med*. 2015; 8:18.
- Cooke WH, Salinas J, Convertino VA, Ludwig DA, Hinds D, Duke JH, et al. Heart rate variability and its association with mortality in prehospital trauma patients. *J Trauma*. 2006; 60(2):363–70.
- Ho KM, Williams TA, Harahsheh Y, Higgins TL. Using patient admission characteristics alone to predict mortality of critically ill patients: A comparison of 3 prognostic scores. *J Crit Care*. 2016; 31(1):21–5.
- Schadt JC, Ludbrook J. Hemodynamic and neurohumoral responses to acute hypovolemia in conscious mammals. *Am J Physiol*. 1991; 260(2 Pt 2):305–18.
- Sharif H, Hou S. Autonomic dysreflexia: a cardiovascular disorder following spinal cord injury. *Neural Regen Res*. 2017; 12(9):1390–400.
- De Backer D, Donadello K, Sakr Y, Ospina-Tascon G, Salgado D, Scolletta S, et al. Microcirculatory alterations in patients with severe sepsis: impact of time of assessment and relationship with outcome. *Crit Care Med*. 2013; 41(3):791–9.
- Green MS, Sehgal S, Tariq R. Near-Infrared Spectroscopy: The New Must Have Tool in the Intensive Care Unit? *Semin Cardiothorac Vasc Anesth*. 2016; 20(3):213–24.
- Paladino L, Sinert R, Wallace D, Anderson T, Yadav K, Zehtabchi S. The utility of base deficit and arterial lactate in differentiating major from minor injury in trauma patients with normal vital signs. *Resuscitation*. 2008; 77(3):363–8.
- Cohn SM, Nathens AB, Moore FA, Rhee P, Puyana JC, Moore EE, et al. Tissue oxygen saturation predicts the development of organ dysfunction during traumatic shock resuscitation. *J Trauma*. 2007; 62(1):44–54.
- Baekgaard JS, Isbye D, Ottosen CI, Larsen MH, Andersen JH, Rasmussen LS, et al. Restrictive vs liberal oxygen for trauma patients—the TRAUMOX1 pilot randomized clinical trial. *Acta Anaesthesiol Scand*. 2019; 63(7):947–55.

Евалуација независних предиктора интрахоспиталног mortalитета код болесника са тешком траумом

Марија Миленковић¹, Жанета Терзиоски¹, Ади Хаџибеговић¹, Јована Станисављевић¹, Ксенија Петровић¹, Јованка Николић¹, Мирјана Михајловска¹, Весна Бумбаширевић^{1,2}

¹Клинички центар Србије, Ургентни центар, Служба анестезиологије, Београд, Србија;

²Универзитет у Београду, Медицински факултет, Београд, Србија

САЖЕТАК

Увод/Циљ Циљ ове студије био је одређивање најбољег бодовног система код траума (*REMS*, *RTS*, *GSC*, *SOFA*, *APPACHE II*) и независних предиктора интрахоспиталног mortalитета код болесника са тешком траумом, лечених у Ургентном центру Клиничког центра Србије у Београду.

Метод Лонгитудинална студија је укључила 208 консекутивних болесника са тешком траумом, примљених у Ургентни центар. У циљу одређивања независних предиктора преживљавања, урађене су униваријантна и мултиваријантна Коксова регресиона анализа. Такође, утицај система бодовања раније поменутих резултата на пријему у Ургентни центар у предикцији mortalитета поређен је коришћењем теста *Area under curve* (*AUC*).

Резултати Испитивани узорак чинило је 208 болесника (159 мушкараца, 49 жена), просечног узраста $47,3 \pm 20,7$ година. Већина болесника била је иницијално интубирана (86,1%), на пријему у Ургентни центар, а 59,6% болесника било је седирано пре интубације. После завршетка дијагностичких процедура, 17 болесника је додатно интубирано, тако да је

на механичкој вентилацији било 94,2% болесника. Болесници су најчешће повређивани у саобраћајним несрећама (33,2%), приликом пада са висине (26,4%) и као пешаци (22,6%). Просечна дужина боравка у Јединици интензивне неге износила је $24,7 \pm 21,2$ дана. Леталитет је био 17/208 (8,2%). Коксовом регресионом анализом показано је да су повишена срчана фреквенца ($HR = 1,03$, $p = 0,012$) и снижена сатурација крви кисеоником ($XP = 0,91$, $p = 0,033$) независни предиктори смртог исхода болесника са тешком траумом. *REMS* ($AUC 0,72 \pm 0,64$) и *SOFA* ($AUC 0,716 \pm 0,067$) показали су сличну предиктивну вредност, док су *APACHE II* ($AUC 0,614 \pm 0,062$) и *PTC* ($0,396 \pm 0,068$) били лоши показатељи интрахоспиталног mortalитета код болесника са тешком траумом.

Закључак Резултати студије показали су важну улогу компоненти *REMS* у предикцији исхода болесника са тешком траумом, као и да су срчана фреквенца и сатурација крви кисеоником независни предиктори интрахоспиталног mortalитета.

Кључне речи: повреде; бодовни систем *REMS*; кохортна студија