Head Trauma Quick-Cases

Case 1

A 68 y/o F presents CAOx1 though noticeably confused c/o headache. Her daughter states that the pt "has been acting strange" for the past 3 days, today is noticeably confused, pt is usually CAOx4 and able to have normal conversations. Pt presents today alert to self but not place, time, or event. She is able to follow commands. Pt also c/o nausea and says she vomited 1 hr ago, denies CP, dizz, SOB, syncope, abd or back pn. PE reveals a healing bruise to the occipital region, daughter states pt fell 7 days ago, did not seek medical care. PMH significant for HTN and atrial fibrillation for which she takes vasotec and coumadin. NKDA. HR = 70/min irreg, strong radial, RR = 16/min reg, good TV, BP = 162/96mmHg, SpO_2 = 97% RA.

Questions:

1. What is the most likely cause of the patient's clinical presentation?

2. Is this patient stable or unstable? What is your transport priority?

3. What is the patient's GCS?

4. Does the patient's PMH and medications have any influence on her hemodynamics?

5. Does the patient require transport to a trauma center?

6. What is your treatment? List it out, in roughly the order it would be rendered in the field.

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Case 2

A 21 y/o M presents supine on the ground with snoring respirations after an assault. He responds to pain with withdrawing and muttering incomprehensible sounds and does not open his eyes. Bystanders report that the patient was beaten on the head repeatedly with a bat. Pt was conscious after the assault, but his mental status and level of consciousness deteriorated rapidly over the next 5 minutes. PE reveals contusions over L temporal & parietal regions and a dilated and sluggish L pupil. Unk PMH, Meds, or allergies. HR = 42/min reg, strong radial, RR = 6/min and erratic TV, BP = 210/140mmHg, SpO_2 = 82% RA

Questions:

1. What is the most likely cause of the patient's clinical presentation?

2. Why is this patient hypertensive and bradycardic?

3. Is this patient stable or unstable? What is your transport priority?

4. What is the patient's GCS?

5. Does the patient require transport to a trauma center?

6. What is your treatment? List it out, in roughly the order it would be rendered in the field.

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Case 3

19 y/o M presents CAox3 though slightly dazed after falling of his bike and striking his head. Pt's friend's rpt pt was attempting a bike stunt, fell off a 5-foot high wall and landing on his head on a concrete surface. Pt c/o head pn, denies neck pn, CP, SOB, N/V, dizz, weakness, abd or back pn. Pt did not lose consciousness though was obviously "dazed & confused" according to bystanders, who rpt that pt's MS is improving since the accident. PE reveals a 3 cm diameter contusion to the L temporal region, no neck or back pn noted. Pt noted c amnesia of the event and mild irritability, is mildly resistant to EMS requests and does not reliably follow commands. ∅PMH, ∅Meds, NKDA. HR = 92/min reg, strong radial, RR = 16/min reg, good TV, BP = 132/88mmHg, SpO_2 = 98% RA

Questions:

1. What is the most likely cause of the patient's clinical presentation?

2. Is this patient stable or unstable? What is your transport priority?

3. What is the patient's GCS?

4. Does the patient require transport to a trauma center?

5. What is your treatment? List it out, in roughly the order it would be rendered in the field.