

EDITORIAL

Trauma audit

There are several papers in this issue that demonstrate clearly the relevance and value of trauma audit to emergency practice. The TRISS methodology (Boyd *et al.*, 1987) is established in the USA and will soon incorporate data from Australasia. It combines the trauma score on admission (TR –)—a measure of the physiological impact with the injury severity score at death or discharge (–ISS)—a measure of the physical impact to produce the TRISS index when weighted for age (</>55 years).

This can be used to calculate a ‘probability of survival’ and patient outcomes can be compared in an objective manner. The true value of TRISS is not simply its ability to provide a numerical value for patient outcome (this can be misleading), but its ability to identify those cases worthy of further study. It identifies well those patients who were clearly unsalvageable or were destined to live. The remainder should be looked at closely particularly when the probability of death (or survival) was less than 50%. The identification of anomalous outcome and the monitoring of care in general will improve as more institutions pool their data in a major trauma outcome study (MTOS).

This was first established in the USA and uses the TRISS methodology. A retrospective study (Anderson *et al.*, 1988) has confirmed that trauma care can be less than good in the UK. A prospective study (Spence *et al.*, 1988) has shown that specialized units can improve outcome and that TRISS has relevance to UK practice. The UK major trauma outcome study, MTOS (UK) is established and data have already been analysed. It is a duty for all of us involved in the care of trauma patients to ensure our treatment is the best. Quality can be measured. The more data that are collected the more accurate will be the measurement. Further information can be obtained from the North Western Injury Research Centre, MTOS (UK), Stopford Building, The Medical School, University of Manchester, Oxford Road, Manchester, England.

Trauma audit can identify specific problems in patient management. Correcting the faults requires training. The Advanced Trauma Life Support Course (ATLS) has been established to provide that training. Many of the lessons taught on the course would clearly have benefited patients in the trauma studies published in this issue. The need for early decompression of the chest and rapid adequate fluid replacement are particular features of the ATLS course. The need for these procedures before final diagnostic proof is available is particularly emphasized during ATLS training. Those who might think such basic lessons need not be (re) learned by British surgeons should think again. The evidence is against you.

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Editor

REFERENCES

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