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vascular injuries are the most common and life-threatening injuries that occur after blunt trauma to the chest. blunt trauma can cause aortic, pulmonary, and esophageal injuries. depending on the injury, patients can have associated injuries such as chest, pelvic, or head trauma. aortic injuries may result in aortic disruption, aneurysm, pseudoaneurysm, or bleeding

within the aorta. the most common site for aortic disruption is the ascending aorta or aortic arch. the diagnosis is made with radiography, ct, or angiography. depending on the location of the injury, repair can be performed through a median sternotomy or thoracotomy.

pulmonary injuries are usually associated with blunt trauma to the chest wall and include acute and chronic traumatic pneumothoraxes, hemothoraxes, or pneumonias. in trauma patients with acute traumatic pneumothorax, a chest tube may be inserted through the emergency room (er) to drain the air from the pleural space. a chest tube can be placed in the emergency department or at the

operating room during thoracotomy or thoracoscopy. hemothoraxes can be diagnosed with a focused assessment with sonography for trauma (fast) exam. intrathoracic injuries, such as tracheal and esophageal injuries, are rare, but when present, require urgent intervention. esophageal injuries occur infrequently in adults and most often occur after blunt trauma. the incidence of esophageal perforation is estimated to be 0.01% in adults. a patient with a perforation usually presents with pain, dysphagia, and signs of shock. diagnosis is made with esophagoscopy or endoscopy, bronchoscopy, and ct of the chest. morbidity associated with

esophageal injuries can be significant, and mortality rates approach 70% when there is delay in diagnosis or treatment. exploratory thoracotomy is typically needed. a venous air embolism is an uncommon complication in patients with blunt chest trauma, particularly in those who are hemodynamically unstable. a venous air embolism is usually accompanied by pulmonary contusion and is associated with a poorer prognosis. treatment includes supportive care for the hemodynamically unstable patient and mechanical ventilation. patients with stable or improving hemodynamics should be observed in the icu for 48 hours and then

transferred to the ward.

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