EDITORIAL

Traumatic Deaths

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The whole exercise of writing and publishing academic papers is done in the belief that expanding our knowledge leads to better and more effective medical and health care. Papers such as clinical trials, that show one form of treatment being superior to another, report advances in practice that have been found and just need to be put to general use. On the other hand, some research reveal data that only point the way for us to improve patient care. Audits are like that. We can only derive benefit by taking note of the facts revealed and search for measures to strengthen areas of weaknesses.

In this issue we have a report of one of the major audit programmes of the Ministry of Health surgical services; its Perioperative Mortality Review (POMR). It is a review based on 2092 perioperative deaths over an 18 month period[1]. Although that seems to be a rather large number of perioperative deaths, the denominator is huge; consisting of 216,191 surgical procedures during that period. The audit of 1,519 deaths (73% reporting rate) shows that surgery for trauma (34%) is our leading cause of perioperative deaths.

Road accidents account for 79.4% of these deaths, reminding us again that road safety is one of the most urgent public health issues in Malaysia today. Everyday nearly 17 people are killed and over 120 others are injured as a result of roads accidents in Malaysia. Road accidents are the second most common reason for hospital admissions in Malaysia, rising from 53 per 100,000 population in 1960 to 324 per 100,000 in 1988, (a six fold increase) and further doubling to 673 admissions per 100,000 in 1988[2].

The POMR reports that neuro-trauma contributed to 48.2% of deaths due to trauma and polytrauma occurred in 29.2% of these fatalities. It highlights delays in referrals, inter-hospital transfers, missed diagnosis and inappropriate resuscitation as problems that need to be addressed. In that regard, the Ministry of Health hospitals that handle the vast majority of trauma cases in Malaysia have the advantage of being networked and run under that same administration and under the same policies. This has significant potential for future programmes. Measures identified to strengthened services can be applied broadly. For instance, telecommunication in the Accident and Emergency and Radiology departments has the potential to revolutionize our trauma care. Accident and Emergency Departments can be networked electronically such that expertise and radiological information can be transferred to appropriate centers so that advice on management and timely transfers can be expedited quickly. The POMR also indicates that expertise in management of neuro-trauma must be adequately positioned and distributed throughout the country to be within reach of road accident victims everywhere.

The other major causes of perioperative deaths must also not be overlooked. The total number gives us an indication of their importance. The mortality rate, however, as pointed out, is not

known as the number of operations in each of the fields is not available. That would be a useful parameter for comparison with other reports (with the report by Nariandas *et.al.*[3] mentioned below, for example) and with data in the future. Nevertheless the importance of colorectal malignancies as a major disease is obvious. The authors noted that late presentation is an important problem, not only for these colo-rectal perioperative deaths but also for paediatric and gastroduodenal perioperative deaths. Vascular aneurysms, with a total of 43 perioperative deaths, rank eighth is the list. In this regard, Nariandas et.al. note their experience with abdominal aortic aneurysms in Penang over 4 years in the issue. They feel that the condition is under-diagnosed and often detected late[3]. The majority of their patients (61.1%) were operated on as emergencies with a high mortality rate of 42.4%. They call for a greater awareness for aortic aneurysms among doctors. In the same vein the POMR report is alert signal to the medical profession to be more vigilant to diagnose colorectal malignancies early and detect peptic ulcers, especially in the elderly, before they perforate.

On the other hand, late presentation, is often also due to how patients themselves perceive their sicknesses, and they are obviously not coming forward as they should. Our population still needs to be educated and led to put a greater trust in our medical services.

References

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