

COMPARTMENT SYNDROME

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Compartment syndrome is raised pressure in a fascial compartment to a level that compromises tissue perfusion. There are several causes of compartment syndrome, fractures being the most common (70%), followed by soft-tissue contusions (23%). Rarer causes include: bleeding disorders, including anti-coagulation; burns (particularly circumferential third-degree burns); postischaemic swelling (reperfusion injury); tight casts/dressings; and extravasation of intravenous infusions (contrast under pressure). The pathophysiology involves increased tissue pressure, which leads to reduced microperfusion, resulting in tissue ischaemia and irreversible muscle damage from cellular anoxia. Compartment syndrome is a clinical diagnosis characterised by pain out of proportion, increasing pain, and pain on passive stretch, with paraesthesia possible. Paralysis, numbness and pallor are late signs and pulselessness is an extremely late sign. Compartment pressure monitoring may be useful in cases of diagnostic uncertainty and in patients with altered levels of consciousness (intubated, head injury). Measure multiple sites near but not in the fracture site, in all the compartments of the affected limb. Generally accepted pressure thresholds include an absolute pressure greater than or equal to 30 mmHg or pressure difference (diastolic pressure - compartment pressure) less than or equal to 30 mmHg. Emergency treatment involves splitting casts and/or dressings to the skin and elevating the extremity. Senior input should be sought and arrangements put in place to perform definitive treatment with fasciotomies. There are some common pitfalls to remember. The incidence of compartment syndrome associated with high- and low-energy injuries is nearly equal. Compartment syndrome can occur in open fractures. Have a high index of suspicion and be particularly vigilant in patients with an altered level of consciousness. COMPARTMENT SYNDROME

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