

Traumatic brain injury is a leading cause of disability worldwide and most of them presenting to the hospital are those in the mild category. The current management of patients with mild traumatic brain injury varies amongst health centres across regions, due to lack of proper consensus and guidelines. In recognizing post traumatic amnesia duration as a predictor of the severity of mTBI, the Abbreviated Westmead Post Traumatic Amnesia Score (A-WPTAS) was created by Shores et al, 2008. The aim of this study was to validate the A-WPTAS to be used in the local setting and whether it can predict the optimal time of discharge of patients. This prospective cohort study was carried out in the Emergency Department of PPUKM for duration of 2 years beginning from 1st May 2013 which involved a total of 62 patients. Patients were observed and assessed using the A-WPTAS at hourly intervals for a minimum of 4 hours. All patients had a full A-WPTAS at 2 hours of observation. Patients who were fit for discharge were sent home and called back after 24 hours to determine whether they had any post concussive symptoms or not. Forty eight patients were discharged home well and did not report any post concussive symptoms after 24 hours. There were 7 (11.3%) patients who were admitted to the neurosurgery ward for abnormal CT scan results despite having a full A-WPTAS score. Two (3.2%) of them had intracranial bleeds. However none of the patients required any surgical intervention. Although the safety and reliability of the A-WPTAS in the current setting remains inconclusive because of study limitations, it does show promise as an aiding tool for physicians to decide on patient discharge.

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EARLY COAGULOPATHY AND ITS
RELATIONSHIP
WITH SEVERITY OF TRAUMA
(ECAST)

Roslanuddin M S¹, Sabariah F J¹, Julina M N²
¹Sungai Buloh Hospital, Sungai Buloh,
 Selangor, Malaysia
²Universiti Teknologi MARA, Malaysia

INTRODUCTION

Coagulopathy occurs very early in trauma especially in more severe victims. Unlike Thromboelastography (TEG), conventional coagulation test (PT/APTT/INR) only measures about 4% of total coagulation process. Using TEG, our study aims to explore the relationship between Acute Coagulopathy in Trauma (ACoT) with severity of injury. (using ISS score).

METHODOLOGY

We conduct a prospective cross-sectional study over 6 month period where eligible, acute (less than 2 hour) polytrauma patient was selected. TEG readings performed upon arrival was compared with different ISS score.

RESULT

Thirty-six patients were included where 8.3% (3/36) have an ACoT, defined as APTT > 35sec. However there was a statistically significant drop of MA (maximal amplitude) in high ISS group (42.9mm) compared to low ISS group (54.8mm). Other TEG parameters showed no statistical significant.

DISCUSSION

The prevalence of ACoT in our study is small (8.3%) compared to previous work. This may be due to small sample size or a different in the timeframe of the blood sampling of other studies, ranging from 12 hour to

72 hour from injury. Patients with reduced clot strength (maximal amplitude < 50mm) evaluated by TEG was associated with higher mortality in multiple studies conducted in emergency setting. For example, Nystrup et al showed means ISS of 27 in this subgroup of patients with a high mortality. Amy JP et al showed relationship between low MA and platelet dysfunction and ultimately, the need of transfusion. Although statistically not significant, the trend of prolong R, more acute alpha angle and longer K values indicates more generalized coagulation dysfunction. Therefore, individualized transfusion strategy involving TEG-goal-directed approach appears promising.

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CONCURRENT AND PREDICTIVE VALIDITY FOR FRAILTY SYNDROMES IN THE ACUTE MEDICAL CARE SETTING

J Soong^{1,2}, L Dineson², A J Poots², D Bell²

¹Royal College of Physicians, London, United Kingdom

²Imperial College London, London, United Kingdom

INTRODUCTION

For some, population ageing is associated with increasing frailty. Existing frailty assessment scores exhibit poor predictive power for adverse events in the acute medical setting. We have published work validating a model based on frailty syndromes (cognitive impairment, falls, reduced mobility, pressure sores, functional dependence and anxiety/depression) on English administrative

data(doi:10.1136/bmjopen-2015-008457). We aim to explore concurrent (comparison with frailty index) and

predictive validity (30-Day mortality, emergency readmission and institutionalization) for this model in the acute medical setting.

MATERIALS & METHODS

A prospective observational study in the Acute Assessment Unit of Chelsea and Westminster Hospital with convenience sampling from May - Dec 2013 of adult acute medical patient admissions. Data was abstracted by a researcher from patient records up to 36 hours from admission. Outcomes were retrieved at one month after index admission. Statistical analysis includes descriptive statistics, logistic regression and Area Under the Receiver Operator Characteristics Curves(AUC) for predictive power derived from predicted probabilities. Missing data analysis followed by multiple imputation (by regression of dataset) where appropriate. Frailty Syndromes models were adjusted for age, gender and number of readmissions in previous 6 months. A Frailty Index was created from 31 criteria from previously described methodology (DOI: 10.1186/1471-2318-8-24)

RESULTS

Frailty syndromes were prevalent in those >65 years (N=482; cognitive impairment-27.8%, falls-42.1%, reduced mobility-5.2%, pressure sores-10.4% functional dependence-42.5% and anxiety/depression-31.3%). The frailty syndromes model had excellent concurrent validity with Frailty Index (AUC 0.83-0.85). The frailty syndromes model had moderate to good predictive power for adverse events at 30 days (inpatient mortality AUC 0.80-0.81, emergency readmission AUC 0.71-0.72, institutionalization AUC 0.63-0.65) in comparison to Frailty Index (inpatient