## 19 ESTABLISHING A TRAUMA REGISTRY IN A LEVEL 1 TRAUMA CENTRE IN SUBSAHARAN AFRICA—CHALLENGES AND LOCAL EXPERIENCE

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**Background** In developing countries, the accurate burden of trauma usually cannot be quantified. Our hospital, the largest in the country does not have a trauma registry.

**Objectives** We share experiences in establishing a trauma registry in our hospital, reviewing the first 103 cases and identifying the challenges.

**Methods** A trauma study group consisting of emergency physicians and three trauma surgeons drew up modalities of the project and funding was from personal contributions. A questionnaire was developed and administered to all trauma patients presenting to the emergency room and updated until discharge. Monthly meetings were held by the group to review progress.

**Results** Mean age was 34.2±18.2 years with a male: female ratio of 3.1. Most injuries occurred between 13 : 00–18 : 59 h. Average revised trauma score was 11.5±1.1 (range=7–12). Delay before reaching the first hospital was 16.2 h and 24.9 h before arrival at our A&E. Blunt injuries caused 72% and penetrating injuries 14%. About half were traffic crash victims, 12% falls, 7% gunshot and burns 6%. About 62% of injuries ocurred on roads. Passers-by provided first aid in 12%, 47% received none. Only one patient received on-scene cardiopulmonary resuscitation. Orthopaedics (41%), Neurosurgery (22%), and Plastic, reconstructive and burns (18%) teams were the most called. Our challenges included duplicate or incomplete documentation, missed cases, cost of registry software, payment of staff, unretrieved questionnaires and cumbersome data spreadsheet.

**Significance** The study shows that personal effort could be successful at developing a trauma registry. The use of expensive software is not always necessary.