04 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 3 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 occurred 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.