Optimizing Emergency Management of Gunshot Trauma: Advanced Strategies in A&E

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# **Abstract**

Gunshot trauma is a growing public health concern worldwide, with significant morbidity and mortality. Effective emergency care is critical in reducing the burden of gunshot trauma. This review aims to summarize current research on best practices for emergency gunshot trauma care, highlighting innovative strategies to enhance patient outcomes. The review examines evidence-based guidelines for initial assessment and triage, hemorrhage control, imaging, and surgical decision-making. The importance of damage control resuscitation, tranexamic acid, and whole blood resuscitation is emphasized. Advances in imaging, surgical techniques, and telemedicine are transforming trauma care. Psychological and ethical considerations, including post-traumatic stress disorder and medicolegal implications, are also discussed. The review concludes that optimizing emergency management of gunshot trauma requires a multifaceted approach, incorporating evidence-based strategies, innovative technologies, and multidisciplinary collaboration.

**Keywords:** Gunshot trauma, Emergency management, Damage control resuscitation, Trauma care, Hemorrhage control

# **Introduction**

Gunshot trauma is a growing public health concern worldwide, with a rising incidence of firearm-related injuries and fatalities [1]. In emergency departments, the management of gunshot trauma poses significant challenges due to the complexity and variability of injuries, limited resources, and high-stakes decision-making [2]. Effective emergency care is critical in reducing morbidity and mortality associated with gunshot wounds (GSWs), with prompt and structured interventions influencing patient outcomes [3].

Recent studies have highlighted the importance of evidence-based strategies in optimizing emergency management of gunshot trauma. For instance, research on damage control resuscitation (DCR) and hemorrhage control has shown promising results in improving survival rates and reducing complications[4],[5]. Moreover, advances in imaging and surgical techniques have enhanced diagnostic accuracy and treatment efficacy [6].

This review aims to summarize current research on best practices for emergency gunshot trauma care, highlighting innovative strategies to enhance patient outcomes. By examining the evidence base for initial assessment and triage, hemorrhage control, imaging, and surgical decision-making, this review seeks to provide a comprehensive framework for optimizing emergency management of gunshot trauma.

# **Epidemiology and Burden of Gunshot Trauma**

Firearm-related injuries are a significant global health concern, with far-reaching consequences for individuals, communities, and healthcare systems [7]. Mortality from firearms contributes more than 250,000 deaths each year worldwide [8],[9].

The majority of firearm-related deaths, over 50%, occur in just six countries: the United States, Brazil, Mexico, Colombia, Venezuela, and Guatemala [10],[11].

In the United States, 45,222 people died from firearm-related injuries in 2020 [12].

Between 2006 and 2015, there were about 198,839 firearm-related emergency department visits for patients under the age of 21 in the United States. An estimated 11,909 people died after visiting the emergency room [13].

Demographically, young adults and males are disproportionately affected by gunshot trauma [14],[15]. Male aged 15-34 years are disproportionately affected, with homicide being the leading cause of firearm-related deaths, followed closely by suicide[15].

Additionally, socioeconomic factors such as poverty and unemployment contribute to the increased risk of firearm-related injuries [16].

# **Evidence-Based Initial Assessment and Triage**

The initial assessment and triage of patients with gunshot trauma are critical in determining outcomes [17]. The American College of Surgeons Committee on Trauma (ACSCOT) recommends the use of the Advanced Trauma Life Support (ATLS) framework for the initial assessment of trauma patients [18]. Triage is the process of prioritizing patients based on the severity of their injuries [19]. The Revised Trauma Score (RTS) and the Injury Severity Score (ISS) are commonly used trauma scoring systems [20]. The RTS assesses the patient's Glasgow Coma Scale (GCS) score, systolic blood pressure (SBP), and respiratory rate (RR), while the ISS evaluates the severity of injuries in six body regions [21].

The primary survey which is the initial assessment is a systematic evaluation of the patient's airway, breathing, circulation, disability, and exposure (ABCDE approach) as shown in Figure 1 [22],[23]. This approach helps identify life-threatening injuries and prioritizes interventions. Intubation strategies and cervical spine precautions are critical in maintaining a patent airway [24]. The use of video laryngoscopy and rapid sequence intubation (RSI) can facilitate airway management [25].

Detection and management of pneumothorax and hemothorax are essential in maintaining adequate oxygenation and ventilation [26]. The use of chest ultrasound and thoracostomy can aid in diagnosing and managing thoracic injuries. Identifying hemorrhagic shock and implementing resuscitation strategies are critical in maintaining circulatory function. The use of tourniquets, hemostatic dressings, and tranexamic acid (TXA) can aid in controlling hemorrhage [27].

Neurological assessment using the Glasgow Coma Scale (GCS) and spinal injury evaluation are essential in identifying neurological deficits [28]. The use of point-of-care ultrasound (POCUS) can aid in evaluating spinal injuries. Point-of-care ultrasound (POCUS) has become an essential tool in the initial assessment of trauma patients [29],[30]. The Focused Assessment with Sonography for Trauma (FAST) and extended FAST (eFAST) exams can aid in evaluating abdominal, thoracic, and spinal injuries [31].

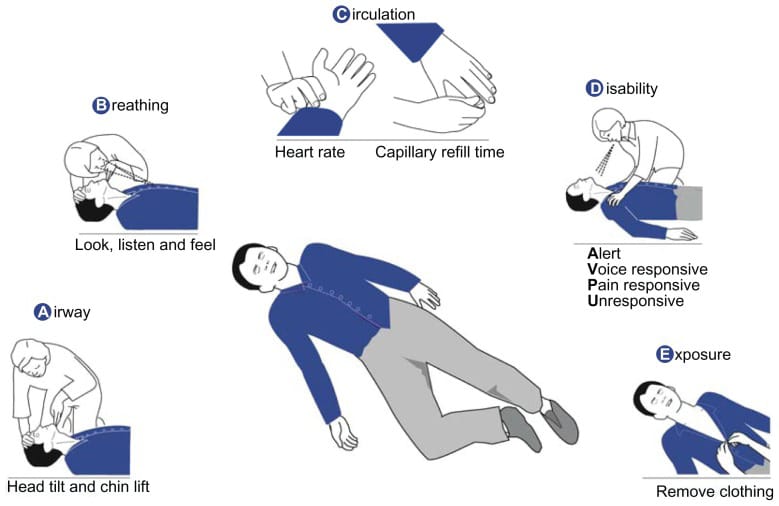


Figure 1. ABCDE Algorithm: A: Airways, B: Breathing, C: Circulation, D: Disability-rapid neurological assessment, E: Exposure. Source: Thim et al., 2012.

# **Hemorrhage Control and Damage Control Resuscitation (DCR)**

Hemorrhage control is a critical component of emergency gunshot trauma care, as uncontrolled bleeding is a leading cause of preventable death [32]. Effective hemorrhage control strategies can significantly improve survival rates and reduce complications. Prehospital hemorrhage control is crucial in reducing blood loss and improving patient outcomes [33].Tourniquets, hemostatic dressings, and junctional hemorrhage techniques have been shown to be effective in controlling hemorrhage in prehospital settings [34]. The use of tranexamic acid (TXA) in prehospital settings has also been studied. The CRASH-2 trial demonstrated a significant reduction in mortality with TXA administration [35].

Similarly, the MATTERs trial showed improved outcomes with prehospital TXA administration [36].

Massive transfusion protocols (MTP) are critical in managing severe hemorrhage in trauma patients [37],[38]. When a patient presents with vital signs indicating significant blood loss, such as a systolic blood pressure (SBP) less than 70 mmHg or an SBP between 71-90 mmHg with a heart rate over 108 bpm, activation of MTP is crucial. This is particularly true for patients with major injuries like penetrating torso wounds, major pelvic fractures, or findings of hemorrhage in multiple regions on a FAST (Focused Assessment with Sonography in Trauma) exam. To address these, transfusing 4 units of red blood cells (RBC) and 2 units of fresh frozen plasma (FFP), which follows current guidelines emphasizing balanced blood component therapy (1:1:1 ratio) to improve outcomes in hemorrhagic shock is recommended [38].

Damage control surgery (DCS) is another critical strategy in managing severe hemorrhage and contamination in trauma patients. DCS involves rapid surgical intervention to control hemorrhage and prevent further injury [39]. Endovascular techniques, such as resuscitative endovascular balloon occlusion of the aorta (REBOA), have also been used to control non-compressible hemorrhage.

This approach focuses on stabilizing the patient long enough for definitive surgical repair [40].

The debate over permissive hypotension vs. aggressive resuscitation continues, with some studies suggesting improved outcomes with permissive hypotension [41]. In these cases, ongoing monitoring of coagulation status via rapid tests, like the Citrated Rapid TEG, is essential. This helps guide subsequent transfusions of FFP, platelets, or cryoprecipitate based on factors such as the clotting time (ACT), clot strength (MA), and fibrinolysis (LY30). Additionally, the use of TXA has proven to be beneficial, particularly in patients with high rates of bleeding, where further reassessment ensures that treatment can be modified accordingly [42].

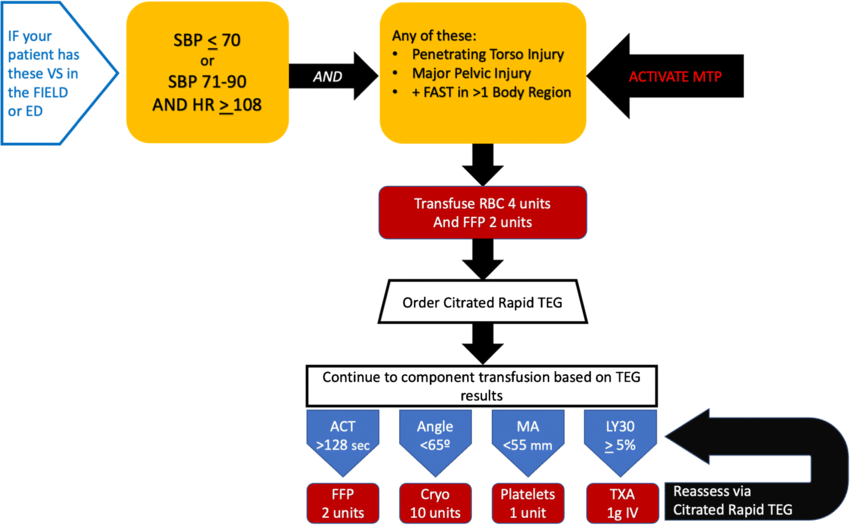


Figure 2: Goal-directed Massive Transfusion Protocol for Trauma. Source: Vigneshwar et al., 2021

# **Imaging and Surgical Decision-Making**

Imaging plays a critical role in the evaluation and management of gunshot trauma patients. The choice of imaging modality depends on the patient's hemodynamic stability, injury pattern, and clinical suspicion for specific injuries [43]. Consequently, understanding the appropriate use of imaging modalities is essential in guiding surgical decision-making.

Initially, computed tomography (CT) is the preferred imaging modality for evaluating abdominal and thoracic injuries in stable patients. CT angiography can also be useful in evaluating vascular injuries. However, in unstable patients, CT scans may not be feasible, and alternative imaging modalities such as ultrasound or plain radiographs may be used [44].

Subsequently, the decision to pursue non-operative management (NOM) or surgical intervention depends on the patient's clinical presentation, injury pattern, and hemodynamic stability. NOM may be appropriate for patients with minor injuries, while surgical intervention may be necessary for patients with more severe injuries or hemodynamic instability.

Ultimately, a multidisciplinary team approach is essential in the management of gunshot trauma patients [45]. Coordination between emergency physicians, trauma surgeons, radiologists, and other healthcare providers ensures that patients receive timely and effective care.

# **Management of Neurological and Spinal Gunshot Trauma**

Neurological and spinal gunshot trauma requires prompt and specialized care to prevent long-term disability and improve outcomes [46]. The management of penetrating traumatic brain injuries (pTBI) and spinal cord injuries (SCI) involves a multidisciplinary approach, including emergency physicians, trauma surgeons, neurosurgeons, and rehabilitation specialists.

The stabilization of patients with pTBI involves securing the airway, breathing, and circulation (ABCs), followed by a thorough neurological assessment. Decompressive craniectomy and intracranial pressure (ICP) monitoring may be necessary to manage elevated ICP and prevent further brain injury [47]. Prognostic indicators for survival and neurological outcomes in pTBI patients include the Glasgow Coma Scale (GCS) score, pupillary reactivity, and imaging findings [48].

The treatment of spinal gunshot wounds involves a thorough spinal evaluation, including plain radiographs, computed tomography (CT), and magnetic resonance imaging (MRI) [49]. Surgical intervention may be necessary to stabilize the spine, decompress the spinal cord, and prevent further injury. The role of corticosteroids in acute spinal trauma remains controversial, with some studies suggesting improved outcomes with methylprednisolone administration, while others have failed to demonstrate a significant benefit [50]. However, early intervention and rehabilitation are critical in optimizing outcomes for patients with neurological and spinal gunshot trauma.

# **Infection Control and Critical Care Considerations**

Infection control and critical care considerations are crucial in the management of gunshot trauma patients. The risk of wound infections and sepsis is high in these patients, and prompt intervention is necessary to prevent these complications [51]. To mitigate this risk, prophylactic antibiotics are often administered, with the choice of antibiotic depending on the type of wound, the patient's medical history, and local antibiotic resistance patterns.

Critically injured gunshot trauma patients require close monitoring and management in the intensive care unit (ICU). In the ICU, ventilatory strategies, sedation, pain management, and deep vein thrombosis (DVT) prophylaxis are critical components of care [52]. Mechanical ventilation is often necessary, and the use of lung-protective ventilation strategies, such as low tidal volume ventilation, can reduce the risk of ventilator-induced lung injury [53].

Furthermore, sedation and pain management are critical components of ICU care in gunshot trauma patients. The use of sedation and pain management protocols can reduce the risk of delirium and improve patient outcomes [54]. Additionally, Deep Vein Thrombosis (DVT) prophylaxis, using pharmacological or mechanical methods, is essential in preventing venous thromboembolism [55].

# **Psychological and Ethical Considerations in Gunshot Trauma**

Gunshot trauma has significant psychological and ethical implications for both patients and healthcare providers. The emotional toll of treating firearm-related injuries can lead to emotional exhaustion, caregiver distress, and secondary traumatic stress [56]. Post-traumatic stress disorder (PTSD) is a common psychological sequela in gunshot survivors, with prevalence of 20% for men and 36% for women [57].

Healthcare providers, particularly those in emergency departments, are also at risk of developing PTSD and other mental health disorders due to repeated exposure to traumatic events [58]. Decision-making in non-survivable injuries poses significant ethical challenges, particularly in cases where patients or their families request aggressive interventions. Furthermore, healthcare providers must navigate medicolegal considerations, such as mandatory reporting laws for firearm-related injuries [59]. Providing psychological first aid (PFA) is essential in supporting patients and families affected by gunshot trauma [60]. PFA involves offering emotional support, reassurance, and practical assistance to individuals in crisis. Healthcare providers can also benefit from mental health support, such as peer support groups and stress management training. By acknowledging the psychological and ethical implications of gunshot trauma, healthcare providers can better support their patients and themselves, ultimately improving outcomes and reducing the risk of emotional exhaustion and caregiver distress.

# **Advances and Future Directions**

The management of gunshot trauma is an evolving field, with ongoing research and innovation aimed at improving patient outcomes [61]. Emerging technologies, telemedicine, and simulation-based learning are some of the exciting developments that hold promise for enhancing trauma care. Artificial intelligence (AI) and machine learning (ML) are being explored for their potential to improve trauma assessment and triage. Automated triage tools, powered by AI and ML algorithms, can help prioritize patients and optimize resource allocation [62], [63].

Portable hemostatic devices and battlefield-inspired trauma care techniques are also being developed to improve hemorrhage control and resuscitation [64]. These innovations have the potential to reduce morbidity and mortality in gunshot trauma patients. Furthermore, telemedicine and remote trauma consultation are becoming increasingly popular, enabling real-time expert guidance and consultation. Virtual platforms can facilitate communication between trauma teams, reducing errors and improving patient outcomes [65].

Simulation-based learning is also an effective way to train healthcare professionals in trauma care. High-fidelity trauma simulation can improve teamwork, communication, and decision-making skills, ultimately enhancing patient outcomes [66]. Standardized protocols and checklists can also improve trauma care, reducing errors and improving patient outcomes [67]. Ongoing research and innovation in these areas will continue to shape the future of trauma care.

# **Conclusion**

The optimization of emergency management of gunshot trauma necessitates a multifaceted approach that incorporates evidence-based strategies, innovative technologies, and multidisciplinary collaboration. The importance of rapid, structured interventions in A&E settings cannot be overstated, as timely hemorrhage control, imaging, and surgical decision-making are critical determinants of patient outcomes.

The implementation of damage control resuscitation, tranexamic acid, and whole blood resuscitation has been shown to improve outcomes in trauma patients. Furthermore, adherence to evidence-based guidelines can significantly reduce morbidity and mortality in trauma patients. The integration of artificial intelligence, telemedicine, and simulation-based learning can also enhance patient outcomes and improve the efficiency of trauma care.

However, despite these advances, significant challenges persist in the management of gunshot trauma. The psychological and ethical considerations in gunshot trauma care require further research and attention, as healthcare providers and patients alike are affected by these injuries. Ultimately, optimizing emergency management of gunshot trauma requires continued training, policy updates, and multidisciplinary collaboration among healthcare providers, policymakers, and researchers.

COMPETING INTERESTS DISCLAIMER:

Authors have declared that they have no known competing financial interests OR non-financial interests OR personal relationships that could have appeared to influence the work reported in this paper.

# **References**

[1] Werbick M, Bari I, Paichadze N, et al. Firearm violence: a neglected “Global Health” issue. Global Health. 2021;17:120. doi: 10.1186/s12992-021-00771-8.

[2] Rahman A, Yanni M, Cukovic L, Herrebout L, Krzyzewski K, Sahakian Y. Trends of emergency department visits for gunshot victims in the United States. J Emerg Crit Care Med. 2022;6:12.

[3] Burg A, Nachum G, Salai M, Haviv B, Heller S, Velkes S, et al. Treating civilian gunshot wounds to the extremities in a level 1 trauma center: our experience and recommendations. Israel Med Assoc J. 2009;11(9):546-51.

[4] Latif RK, Clifford SP, Baker JA, et al. Traumatic hemorrhage and chain of survival. Scand J Trauma Resusc Emerg Med. 2023;31:25. doi: 10.1186/s13049-023-01088-8.

[5] Mizobata Y. Damage control resuscitation: a practical approach for severely hemorrhagic patients and its effects on trauma surgery. J Intensive Care. 2017;5(1):4. doi: 10.1186/s40560-016-0197-5.

[6] Rong J, Liu Y. Advances in medical imaging techniques. BMC Methods. 2024;1:10. doi: 10.1186/s44330-024-00010-7.

[7] Centers for Disease Control and Prevention. Fast facts: Firearm violence prevention. Firearm Violence Prevention. 2021 [Accessed March 25, 2025]. Available from:<https://www.cdc.gov/firearm-violence/data-research/facts-stats/?CDC_AAref_Val=https://www.cdc.gov/violenceprevention/firearms/fastfact.html>

[8] Werbick M, Bari I, Paichadze N, et al. Firearm violence: a neglected “Global Health” issue. Global Health. 2021;17:120. doi: 10.1186/s12992-021-00771-8.

[9] Global Burden of Disease 2016 Injury Collaborators, Naghavi M, Marczak LB, Kutz M, Shackelford KA, Arora M, et al. Global mortality from firearms, 1990-2016. JAMA. 2018 Aug 28;320(8):792-814. doi:10.1001/jama.2018.10060

[10] Simpson BW. Answers to gun violence in the Americas. Global Health NOW. 2019 Mar 10. Available from:<https://globalhealthnow.org/2019-03/answers-gun-violence-americas>

[11] Myers J. Which country has the highest number of gun deaths? World Economic Forum. 2019 Aug 6. Available from:<https://www.weforum.org/stories/2019/08/gun-deaths-firearms-americas-homicide/>

[12] Miller GF, Barnett SB, Florence CS, McDavid Harrison K, Dahlberg LL, Mercy JA. Costs of fatal and nonfatal firearm injuries in the U.S., 2019 and 2020. Am J Prev Med. 2024;66(2):195-204. doi:10.1016/j.amepre.2023.09.026

[13] Lee V, Camp C, Jairam V, Park HS, Yu JB. Emergency department visits for firearm-related injuries among youth in the United States, 2006–2015. J Law Med Ethics. 2021;48(4\_suppl):67-73. doi:10.1177/1073110520979403

[14] Bureau of Justice Statistics. Homicide trends in the U.S. Oct 4, 2006. [Accessed March 25, 2025] Available from:<https://web.archive.org/web/20061115183053/http:/www.ojp.usdoj.gov/bjs/homicide/teens.htm>

[15] Dougherty PJ, Najibi S, Silverton C, Vaidya R. Gunshot wounds: epidemiology, wound ballistics, and soft-tissue treatment. Instr Course Lect. 2009;58:131-9.

[16] Brady United. Gun violence is a racial justice issue. Brady United. Available from:<https://www.bradyunited.org/resources/issues/gun-violence-is-a-racial-justice-issue>

[17] Kostiuk M, Burns B. Trauma assessment. [Updated 2023 May 23]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2025 Jan-. Available from:<https://www.ncbi.nlm.nih.gov/books/NBK555913/>

[18] Van Olden GD, Meeuwis JD, Bolhuis HW, Boxma H, Goris RJ. Clinical impact of advanced trauma life support. Am J Emerg Med. 2004;22(7):522-5. doi:10.1016/j.ajem.2004.08.013

[19] Yancey CC, O'Rourke MC. Emergency department triage. [Updated 2023 Aug 28]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2025 Jan-. Available from:<https://www.ncbi.nlm.nih.gov/books/NBK557583/>

[20] Pohlman TH. Trauma scoring systems: overview. Medscape. Updated Jun 28, 2024. Available from:<https://emedicine.medscape.com/article/434076-overview>

[21] Jiang D, Chen T, Yuan X, Shen Y, Huang Z. Predictive value of the Trauma Rating Index in Age, Glasgow Coma Scale, Respiratory rate and Systolic blood pressure score (TRIAGES) and Revised Trauma Score (RTS) for the short-term mortality of patients with isolated traumatic brain injury. Am J Emerg Med. 2023;71:175-81. doi:10.1016/j.ajem.2023.06.030

[22] Thim T, Krarup NH, Grove EL, Rohde CV, Løfgren B. Initial assessment and treatment with the Airway, Breathing, Circulation, Disability, Exposure (ABCDE) approach. Int J Gen Med. 2012;5:117-121. doi: 10.2147/IJGM.S28478.

[23] Kostiuk M, Burns B. Trauma assessment. [Updated 2023 May 23]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2025 Jan-. Available from:<https://www.ncbi.nlm.nih.gov/books/NBK555913/>

[24] Austin N, Krishnamoorthy V, Dagal A. Airway management in cervical spine injury. Int J Crit Illn Inj Sci. 2014;4(1):50-6. doi:10.4103/2229-5151.128013

[25] Brown CA 3rd, Bair AE, Pallin DJ, Laurin EG, Walls RM, National Emergency Airway Registry (NEAR) Investigators. Improved glottic exposure with the Video Macintosh Laryngoscope in adult emergency department tracheal intubations. Ann Emerg Med. 2010 Aug;56(2):83-8. doi: 10.1016/j.annemergmed.2010.01.033

[26] MedicTests. Pneumothorax and hemothorax. Available from:<https://medictests.com/units/pneumothorax-and-hemothorax>

[27] Patel NK, Johns W, Vedi V, Langstaff RJ, Golladay GJ. Tourniquet and tranexamic acid use in total knee arthroplasty. Arthroplasty Today. 2020;6(2):246-50. doi:10.1016/j.artd.2020.02.007

[28] Ernstmeyer K, Christman E, editors. Nursing Skills [Internet]. Eau Claire (WI): Chippewa Valley Technical College; 2021. Chapter 6, Neurological Assessment. Available from:<https://www.ncbi.nlm.nih.gov/books/NBK593206>

[29] Vishnu VK, Bhoi S, Aggarwal P, Murmu LR, Agrawal D, Kumar A, et al. Diagnostic utility of point of care ultrasound in identifying cervical spine injury in emergency settings. Am J Ultrasound Med. 2021;39(7):1452-1458. doi: 10.1002/ajum.12274.

[30] El-Hussein M, Hamieh C, Gautier M. How point-of-care ultrasound became an essential part of the assessment in the Emergency Department. Radiol Case Rep. 2022;17(7):2453-2459. doi: 10.1016/j.radcr.2022.03.092.

[31] Bloom BA, Gibbons RC. Focused Assessment With Sonography for Trauma. [Updated 2023 July 24]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2025 Jan-. Available from:<https://www.ncbi.nlm.nih.gov/books/NBK470479/>

[32] Jones AR, Miller J, Brown M. Epidemiology of trauma-related hemorrhage and time to definitive care across North America: making the case for bleeding control education. Prehosp Disaster Med. 2023;38(6):780-783. doi: 10.1017/S1049023X23006428.

[33] Jamal L, Saini A, Quencer K, Altun I, Albadawi H, Khurana A, et al. Emerging approaches to pre-hospital hemorrhage control: a narrative review. Ann Transl Med. 2021;9(14):1192. doi: 10.21037/atm-20-5452.

[34] Peng HT. Hemostatic agents for prehospital hemorrhage control: a narrative review. Mil Med Res. 2020;7(1):13. doi: 10.1186/s40779-020-00241-z.

[35] Roberts I, Shakur H, Coats T, Hunt B, Balogun E, Barnetson L, et al. The CRASH-2 trial: a randomised controlled trial and economic evaluation of the effects of tranexamic acid on death, vascular occlusive events and transfusion requirement in bleeding trauma patients. Health Technol Assess (Winchester, Engl). 2013;17(10):1-79. doi: 10.3310/hta17100.

[36] Morrison JJ, Dubose JJ, Rasmussen TE, et al. Military application of tranexamic acid in trauma emergency resuscitation (MATTERs) study. Arch Surg. 2012;147(2):113-119. doi: 10.1001/archsurg.2011.287.

[37] Shaz BH, Dente CJ, Harris RS, MacLeod JB, Hillyer CD. Transfusion management of trauma patients. Anesth Analg. 2009;108(6):1760-1768. doi: 10.1213/ane.0b013e3181a0b6c6.

[38] Vigneshwar NG, Moore HB, Moore EE. Trauma-induced coagulopathy: diagnosis and management in 2020. Curr Anesthesiol Rep. 2021;11(2):1-9. doi: 10.1007/s40140-021-00438-5.

[39] Beaven A, Parker P. Treatment principles of blast injuries. Surgery (Oxford). 2015;33(9):424-429. doi: 10.1016/j.mpsur.2015.07.004.

[40] Osborn LA, Brenner ML, Prater SJ, Moore LJ. Resuscitative endovascular balloon occlusion of the aorta: current evidence. Open Access Emerg Med. 2019;11:29-38. doi:10.2147/OAEM.S166087.

[41] Tran A, Yates J, Lau A, Lampron J, Matar M. Permissive hypotension versus conventional resuscitation strategies in adult trauma patients with hemorrhagic shock: A systematic review and meta-analysis of randomized controlled trials. J Trauma Acute Care Surg. 2018;84(5):802-808. doi: 10.1097/TA.0000000000001816

[42] Das JM, Anosike K, Waseem M. Permissive Hypotension. [Updated 2024 Mar 1]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2025 Jan-. Available from:<https://www.ncbi.nlm.nih.gov/books/NBK558915/>

[43] Stanislavsky A, Hacking C, Silverstone L, et al. Gunshot injuries. Radiopaedia.org. [Accessed 26 March 2025]. Available from:<https://doi.org/10.53347/rID-13189>

[44] Johns Hopkins Medicine. Computed tomography (CT) or CAT scan of the abdomen. [Accessed 26 March 2025]. Available from:<https://www.hopkinsmedicine.org/health/treatment-tests-and-therapies/computed-tomography-ct-or-cat-scan-of-the-abdomen#:~:text=CT%20scans%20of%20the%20abdomen,diseases%20of%20the%20abdominal%20organs>.

[45] Adigopula S, Medepalli LC. Gunshot-related cardiac trauma: A multidisciplinary approach using multimodality imaging. JACC Case Rep. 2021;3(1):31-33. doi: 10.1016/j.jaccas.2020.12.006.

[46] Çiftçi U, Akıncı AT, Delen E, Güçlühan D. Incomplete isolated C7 root injury caused by gunshot wound: A case report. Korean J Neurotrauma. 2017;13(1):45-49. doi: 10.13004/kjnt.2017.13.1.45.

[47] Sahuquillo J, Dennis JA. Decompressive craniectomy for the treatment of high intracranial pressure in closed traumatic brain injury. Cochrane Database Syst Rev. 2019;12(12):CD003983. doi: 10.1002/14651858.CD003983.pub3.

[48] Chamoun RB, Robertson CS, Gopinath SP. Outcome in patients with blunt head trauma and a Glasgow Coma Scale score of 3 at presentation. J Neurosurg. 2009;111(4):683-687. doi: 10.3171/2009.2.JNS08817

[49] Canseco JA, Karamian BA, Bowles DR, Markowitz MP, DiMaria SL, Semenza NC, Leibensperger MR, Smith ML, Vaccaro AR. Updated review: The steroid controversy for management of spinal cord injury. World Neurosurg. 2021;150:1-8. doi: 10.1016/j.wneu.2021.02.116.

[50] Tigabu E, Melese A, Mekonen F, et al. Bullet-related bacterial wound infections among injured personnel at emergency site hospitals in Bahir Dar: prevalence, antimicrobial susceptibility and associated factors. BMC Microbiol. 2024;24:166. doi: 10.1186/s12866-024-03324-2.

[51] Tisherman SA, Stein DM. ICU management of trauma patients. Crit Care Med. 2018;46(12):1. doi: 10.1097/CCM.0000000000003407.

[52] Condeni MS. Case series: Perioperative management of patients in the ICU. J Am Coll Clin Pharm. 2024;7(6):589-612. doi: 10.1002/jac5.1979.

[53] AK, Anjum F. Ventilator-induced lung injury (VILI) [Updated 2023 Apr 27]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2025 Jan-. Available from:<https://www.ncbi.nlm.nih.gov/books/NBK563244/>

[54] Hughes CG, McGrane S, Pandharipande PP. Sedation in the intensive care setting. Clin Pharmacol Adv Appl. 2012;4:53-63. doi: 10.2147/CPAA.S26582.

[55] Paydar S, Sabetian G, Khalili H, Fallahi J, Tahami M, Ziaian B, et al. Management of deep vein thrombosis (DVT) prophylaxis in trauma patients. Bull Emerg Trauma. 2016;4(1):1-7.

[56] Geller JE, Teichman AL, Charles EJ, Pierce A, Patel K, Park J, et al. Firearm injury, it's not just physical: the adverse impact on patient-reported socioeconomic, mental health, and quality-of-life outcomes. Am Surg. 2024;90(11):3038-3045. doi: 10.1177/00031348241262434.

[57] North CS, Smith EM, Spitznagel EL. Posttraumatic stress disorder in survivors of a mass shooting. Am J Psychiatry. 1994;151(1):82-88. doi: 10.1176/ajp.151.1.82.

[58] Virginia Commonwealth University. Social Work and Mental Health. [Internet]. 2025 [Accessed March 26, 2025]. Available from:<https://onlinesocialwork.vcu.edu/blog/social-work-and-mental-health/#:~:text=Professionals%20who%20are%20repeatedly%20and,emotional%20residue%20of%20exposure%20to>

[59] Top Doctors. Navigating medico-legal dynamics in healthcare. [Internet]. 2025 [Accessed March 26, 2025]. Available from:<https://www.topdoctors.co.uk/medical-articles/navigating-medico-legal-dynamics-in-healthcare>

[60] Lifelines Scotland. Post-trauma support: Providing psychological first aid. [Internet]. 2025 [Accessed March 26, 2025]. Available from:<https://www.lifelines.scot/post-trauma-support-providing-psychological-first-aid>

[61] Barr J, Schalick WO 3rd, Horn CB, Marble WS, Devine S, Smith DC. 'Through and Through' History: The Management of Gunshot Wounds From the 14th Century to the Present. Ann Surg Open. 2023;4(3):e299. doi: 10.1097/AS9.0000000000000299.

[62] Mahara G, Tian C, Xu X, Wang W. Revolutionising health care: Exploring the latest advances in medical sciences. J Glob Health. 2023;13:03042. doi: 10.7189/jogh.13.03042.

[63] Ventura CAI, Denton EE, David JA. Artificial intelligence in emergency trauma care: A preliminary scoping review. Med Devices (Auckl). 2024;17:191-211. doi: 10.2147/MDER.S467146.

[64] Thoolen, SJJ, Kuypers MI. External hemorrhage control techniques for human space exploration: Lessons from the battlefield. Wilderness Environ Med. 2023;34(2):231-242. doi:10.1016/j.wem.2023.01.006.

[65] Lazzara EH, Benishek LE, Patzer B, Gregory ME, Hughes AM, Heyne K, et al. Utilizing telemedicine in the trauma intensive care unit: Does it impact teamwork? Telemed J E Health. 2015;21(8):670-676. doi:10.1089/tmj.2014.0074.

[66] Sung TC, Hsu HC. Improving critical care teamwork: Simulation-based interprofessional training for enhanced communication and safety. J Multidiscip Healthc. 2025;18:355-367. doi:10.2147/JMDH.S500890.

[67] Bidhendi S, Ahmadi A, Fouladinejad M, Bazargan-Hejazi S. Evaluating implementation of WHO Trauma Care Checklist vs. modified WHO checklist in improving trauma patient clinical outcomes and satisfaction. J Inj Violence Res. 2021;13(1):5-12. doi:10.5249/jivr.v13i1.1579.