Dear Editor,

Through and through penetrating thoraco-abdominal injuries with foreign body *in situ* are rare but potentially life threatening. These patients may not manifest its seriousness at the trauma scene. Physicians must have a high degree of suspicion for shock in patients with penetrating thoraco-abdominal trauma who appear stable\(^1\) and should refer as early as possible to a tertiary hospital or a trauma center.

A 30 years old male met an accident at 1:30 a.m. and was taken to a primary hospital where primary care was given. Emergency medical service ambulance brought him to our emergency department (ED) at 6:50 a.m. Primary survey revealed Glasgow Coma Scale (GCS) of 15/15, hypothermic with BP 95/58 mmHg, HR 132, and RR 40/minute, shallow but regular. Cervical spine normal with no history of loss of consciousness or vomiting found. Blood cross-match was sent, and speciality and super speciality referral was given.

Approximately, 3.5 feet long, 2 inch × 2 inch, L-shaped, rugged, and pointed iron rod was seen penetrating through and through just below the xiphisternum [Figures 1 and 2], which moves with respiration and heart beats. He also had fractured right humerus and left 10\(^{th}\) rib.

Extended focused assessment by sonography for trauma (EFAST) revealed rod penetrating through the liver with hemoperitonium and left hemothorax. Patient was directly shifted to emergency operation theater with concurrent resuscitation with warm Ringer lactate and taken for emergency exploration under general anesthesia with invasive hemodynamics monitoring and special attention to positioning of the patient.

Intraoperatively, it was found that the rod had penetrated the left lobe of liver [Figure 3], passing dangerously near to aorta above the left renal vessels through the lesser omentum and by the side of spine touching upper border of pancreas. Immediately after removal of the rod, patient went to hemorrhagic shock due to sudden gush of bleeding, which was managed by rapid warm fluid
and blood products. Liver was sutured and repair of damaged organ done. Rib fracture left untouched, and chest tube was inserted. Humerus fracture managed by closed reduction and immobilized with cast.

Postoperatively he developed mild acute respiratory distress syndrome (ARDS) and shifted to the ward from ICU on 5th postoperative day (POD) after weaning off from ventilator and was discharged to home on 12th POD.

Abdomen is the third most commonly involved region of the body in trauma. Liver and bowel are the frequently affected organs in abdominal trauma. Penetrating abdominal and liver injury can be managed conservatively with serial clinical and radiological evaluation if the patient is hemodynamically stable. Current knowledge, literature, and guidelines recommend exploratory laparotomy for the patients who are unstable, having hollow viscus perforation, signs of peritonitis or where patient cannot be evaluated thoroughly owing to poor consciousness with head and cervical injury and intoxication. This holds true mostly for the penetrating injuries where the foreign body in no more in torso. On the other hand, penetrating abdominal injuries with foreign body in situ has to undergo operative management irrespective of above-mentioned clinical situations as the foreign body has to be removed from the body.

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