Dear Editor,

A 50-year-old male was the restrained passenger involved in high-energy car crash on the highway. He was hypotensive in the emergency room (blood pressure ([BP] 80/60 mmHg). Fluid resuscitation was initiated with reasonable improvement of Blood Pressure and Heart Rate and maintenance of hemodynamic stability thereafter. Contrast-enhanced computed tomography (CT scan with intravenous contrast) showed a large liver hematoma occupying a greater portion of the right lobe, with minimal amount of peritoneal free fluid, an active arterial blush and a large hematoma extending vertically, all around the Inferior Vena Cava in its retrohepatic tract, consistent with a contained venous bleeding from hepatic veins injury (American Association for the Surgery of Trauma grade V) [Figure 1]. The patient was kept under permissive hypotension and cautious fluid resuscitation, showing a transient response throughout

Figure 1: Initial computed tomography scan at admission showing the juxtacaval hematoma and a significant caval compression and the possible of venous wall injury (discontinuity); Angiographic embolization with coils (right panel)
the next hour. Urgent angioembolization was performed achieving the closure of the arterial bleeding with coils [Figure 1]. Hemodynamics improved after resuscitation and the patients remained stable in the next days. Repeated CT scan 6 days later showed a significant improvement of the liver hematoma and reabsorption of the juxtacaval hematoma and resolution of the caval compression [Figure 2].

Grade V liver trauma is fortunately quite rare with a high operative mortality (67-80%). In unstable patients, damage control surgery with selective use of angioembolization, can be able to achieve an overall mortality rate of 51.3% grade V liver trauma account for roughly 15% of the hemodynamically stable patients, and showed a failure rate of 12% and admission systolic blood pressure BP seems to be lower in the patients failing non-operative management (NOM) however no reliable predictor of failure other than the ultimate development of hemodynamic instability can be identified. While in the management of such injuries, one might initially think that performing the best surgical procedure is the repair of the venous injury and fixing the problem, therefore the patient might end up in Operating Room for life-threatening and technically demanding surgical operations, must be kept in mind that sometimes wait and see, with NOM and angioembolization, is the most prudent strategy to achieve the best outcomes.

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