Case Series

Case series: Blood, steel, and resolve—a night of mass casualty trauma

Suhas Sagar NU*

Emergency Medicine Department, Kauvery Hospital, Electronic City, Bengaluru
*Correspondence

Background

At 11:30 PM, the Emergency Department was notified of an incoming influx of trauma victims following multiple simultaneous incidents-an apartment falls, a motor vehicle collision, and a suspected poisoning.

What ensued over the next several hours, lasting until 4:30 AM, was a tightly coordinated response by a team of emergency physicians, nurses, surgeons, and support staff who had to expand beyond their limits.

This case series documents the medical, operational, and emotional journey of managing 12 critically injured patients placing a spotlight on one of the most heart-wrenching and heroic resuscitations: a 4-year-old boy who fell from five stories and "survived".

Study Timeline: Mass casualty call received at 11:30 PM, concluded by 4:30 AM

Keywords: Rapid Sequence Intubation (RSI); Pulmonary contusion; Self-poisoning; Carbamate poisoning; pneumothorax.

Citation: Suhas Sagar NU. Case series: Blood, steel, and resolve—a night of mass casualty trauma. Kauverian Med J. 2025;2(9):10-14.

Academic Editor: Dr. Venkita S. Suresh

ISSN: 2584-1572 (Online)

Copyright: © 2025 by the authors. Submitted for possible open access publication under the terms and conditions.

1. Case Presentation

1.1 Case 1: Pediatric Polytrauma Following Five-Story Fall

Patient: Male, 4 years' old

Incident: Fell from the 5th floor (~15 meters) of a residential apartment building

Arrival Time: 12:03 AM

1.2. Initial Presentation

Airway: Partially obstructed by blood and facial fractures

Breathing: Rapid, shallow, oxygen saturation 56% on room air

Circulation: Cold extremities, cap refill >5 sec, HR 198 bpm, BP 62/44 mmHg

Disability: GCS 6 (E1V1M4)

1.3. Primary Survey and Immediate Interventions

Airway secured via rapid sequence intubation (RSI) with in-line stabilization

Bilateral chest decompression attempted; right side revealed >300 ml hemothorax → ICD inserted

Large-bore IV access obtained (2x 18G); intraosseous line placed due to difficult veins

Point-of-care FAST: Free fluid in RUQ, concerning for intra-abdominal injury

Hypotension + positive FAST prompted activation of the Pediatric Massive Transfusion Protocol (MTP).

1.4. Massive Transfusion Protocol (MTP) Initiated

Immediate transfusion of;

- 2 units PRBC
- 2 units Fresh Frozen Plasma (FFP)
- 1 unit Platelets
- Supportive Measures:
- Warm fluids via pressure bags
- Serial lactate and ABG monitoring:
- Lactate: 5.8 mmol/L
- Base deficit: –11
- Hb: 6.4 g/dL

1.5. Imaging

CT Brain + C-spine + Chest/Abdomen/Pelvis revealed:

- Multiple facial bone fractures with anterior maxillary wall disruption
- Right hemothorax with pulmonary contusion
- Moderate hemoperitoneum
- C2 vertebral body compression without cord impingement

1.6. Secondary Interventions

Nasogastric tube avoided due to basilar skull fracture suspicion. Foley catheter placed, clear urine output after fluid resuscitation. Decision made for damage control surgery. Exploratory laparotomy with perihepatic packing. Admitted to PICU with mechanical ventilation and sedation.

1.7. Outcome

After 72 hr in PICU the child stabilized. Discharged after 21 days with neurocognitive rehab planned. This case represented not only clinical triumph but emotional resilience for the entire team.

2. *Cases 2 and 3: Intentional Self-Poisoning (Organophosphate*

Presentation: History of deliberate self-poisoning- Husband and wife aged 32years and 29 years respectively.

2.1. Neurological examamination

- Pupils: constricted and minimally reactive to light
- Mental Status: Altered, patients are confused
- Motor: fasciculations are present

Respiratory: Coarse crackles in the lungs

Cardiovascular: Bradycardia

2.2 Differential Diagnosis

1. *Organophosphate poisoning (High likely)*
2. *Carbamate Poisoning*

2.3. Treatment

Decontamination: Clothing removed and skin washed

Airway secured

IV access

Atropine 2mg IV bolus

Pralidoxime 30mg/kg IV.

3. Cases 4–15: Blunt and Penetrating Trauma Cases

3.1. Overview

2 cases with unstable pelvic fractures: managed with pelvic binders; 1 required external fixation

3 patients with flail chest/rib fractures: 1 required ICD for pneumothorax

4 upper limb fractures: humeral shaft, distal radius, supracondylar humerus

1 penetrating abdominal injury: requiring aggressive stabilization in ER

2 adult polytrauma: TBI, GCS 5 and 7, ventilated, neurosurgery consult.

Crowd Management & Operational Coordination

As news spread, bystanders, family members, and concerned onlookers overwhelmed the hospital premises. The emergency department activated its mass casualty protocol:

- Color-coded triage tags were deployed
- 2 Senior Emergency physicians rotated commands
- One led resuscitation
- One managed documentation and logistics

- Others reassessed patients, coordinated transfers and ICU handovers.

3.2 Team Response and Reflections

Despite it being off-hours, four emergency physicians and over ten nurses returned voluntarily. By 4:30 AM, most critical patients had been stabilized or shifted to definitive care units.

This night reinforced the power of teamwork, preparedness, and the will to act decisively under pressure. The survival of a 4-year-old child through aggressive trauma care and massive transfusion exemplifies what the emergency department stands for-holding the line when every second counts.

4. Conclusion

Mass casualty events are the crucible in which the philosophy, training, and resilience of emergency medicine are tested to their limits. The events of that night, spanning multiple concurrent emergencies, over a dozen critically ill patients, and an overwhelmed hospital infrastructure were a stark reminder of why we choose to stand at the threshold of life and death.

They are also a reminder that no amount of individual skill can substitute for coordinated, multidisciplinary effort when lives hang in the balance.

What unfolded was not just a clinical response, it was a human response. The 4-year-old boy who survived a fall from five stories embodied not just the miracles of modern trauma care, but the power of relentless commitment. His story and that of every patient we fought for that night was shaped by rapid decision-making, practiced algorithms, and more importantly, the unwavering resolve of a team that refused to give in to fatigue, fear, or futility.

From massive transfusions in pediatric trauma to managing complex poisoning and polytrauma cases, every choice made had immediate consequences. We relied on checklists and protocols, yes, but also on trust: trust in our nurses, in our surgeons, in our radiologists, and in one another. Even in chaos, there was clarity born not of luck, but of preparation, drills, and countless prior nights spent learning how to act when it matters most.

Beyond clinical care, the operational challenges were immense managing crowd overflow, maintaining documentation under pressure, triaging new arrivals every few minutes, and ensuring resource allocation remained equitable and efficient. Our ability to stretch resources, communicate seamlessly, and still deliver time-sensitive interventions speaks volumes about the culture of preparedness we have cultivated.

Yet, the emotional toll cannot be understated. Every cry of a parent, every gasp of a struggling child, every fleeting heartbeat we tried to hold on to these moments mark us. But they also fuel us. They remind us why we stay, why we return the next night, and the night after that.

This case series is more than a clinical document; it is a testament. A testament to the grit of emergency medicine professionals who rise when the rest of the world sleeps. A testament to the quiet heroism of nurses who work with blistered feet and steady hands. A testament to every emergency department that becomes a war room in seconds and wins battles without ever stepping out of its four walls.

Above all, it is a tribute to the strength of human spirit in the patients who survive, in the families who hope, and in the clinicians who refuse to let go.

We emerged from that night changed, but not broken, stronger, wiser, and more certain than ever that our place is here: at the frontline, where seconds matter and every act can mean the difference between life and death.