Introduction

Isolated sternal fractures occur more and more frequently in particular in road traffic accidents after the introduction of the seat-belt law. This study sets out to
assess by laboratory parameters the incidence and consequences of pericardial and myocardial involvement in sternal injury. It was designed as a prospective single centre study of 50 consecutive patients, admitted over a 10 years period with blunt central chest trauma or multiple thoracic injuries. Clinical status, correlated with echocardiography, ECG and cardiac enzyme abnormalities were the main outcome measures.

Patients and methods

Between June 1997 and March 2007, 50 consecutive patients were admitted to our Thoracic Surgical Unit with acute traumatic sternal fracture. X-ray, CT scan, standard 12-lead electrocardiogram (ECG) and echocardiographic evaluation were obtained in all patients (28 males, 22 females) (Tables 1, 2 and 3) with displaced or undisplaced sternal fracture (Figs. 1, 2 and 3). The hemodynamic involvement was evaluated by ecocardiographic control in the "golden hour" and again performed during hospitalization as clinical indication.

In all patients we proscribed food intake for at least 36 hours to avoid respiratory overload and anyway until to definite assessment of abdominal injury. The patients were hospitalised for cardiorespiratory monitoring, pain control and physiotherapy. Oxygen implementation was performed to obtain an arterial saturation above 96%. Supplementary investigations or therapeutic interventions were assessed if clinically indicated. In only 5 patient we achieved a thoracostomy with insertion of pleural drainage. Two patients required surgical correction of the "sternal volet" (Fig. 4). Another patient, with aortic traumatic rupture, underwent surgical repair with endoprosthesis.

In all patients we performed controls of specific laboratory values to detect cardiac involvement by first 48 hours after admission. The laboratory panel included CPK, CK-MB isoenzyme, isoform T of troponin and myoglobinemia. The patient characteristics, mechanism and type of sternal fracture, and associated lesions are summarised in the tables.

Results

Our data, according to literature (1-7), show that sternal trauma must be evaluated by careful monitoring of vital parameters. In our series we have no mortality with complex comorbidity (Table 3). No racial difference between two groups are observed (p<000.1).

The CK-MB value was normal before 28 hours in all cases (median value 72 hours); 18 (36%) patients showed elevated values of CK-MB within 48 hours, however in 12 patients (24%) this parameter was always normal. The interparametric relation between laboratory values and cardiac involvement was not significant anyway (p = 0.04). The prolonged CK-MB peak level in a large number of patients is related with cardiac impairment (6 patients over 8 with CK-MB long-lasting abnormal value showed a rhythm disturbance, i.e. negative T wave).

Two patients were exposed to major surgical procedure (prosthetic aortic replacement and sternal plaques positioning).

Associated lesions may play a role in clinical outcome with prolonged hospital stay, but seem to be not associated with enzymatic CK-MB value (may be CPK parameter in these patients is still elevated).

Conclusions

We can read that "sternal fractures have long been considered associated to cardiac injury", however in
more cases there is a possibility to identify the patients with a direct cardiac injury and share them from the patients with a traumatic “cardiac recruitment”. In a small number of cases many authors describes the echocardiographic appearance of a “diskynetic heart”.

One of our patients, suffering a simple sternal fracture showed up the clinical signs of cardiac impairment as long as the laboratoristic changes; in this patient the laboratory values showed a reversal interesting pattern with an abnormal peak of CK-MB and normal CPK and troponine enzymatic activities. In the remaining patients we observed an elevated enzymatic CPK title (39/40=100%) due to traumatic injury. The value of isoenzyme CK-MB was elevated in 28 patients (70%), suggesting cardiac involvement if > 10% of total CPK.

In our series this findings help us to refuse the conviction that all patients with sternal trauma necessarily have a “cardiovascular trauma”. Our results suggest that enzymatic activity of CK-MB, the echocardiographic investigation and careful monitorizing in the first 96 hours after sternal trauma is necessary. The cardiac compliance is inadequate in politraumatic patients and can lead to heart impairment.


