ORIGINAL ARTICLE

Clinical burden and predictors of hospitalization in extremity gunshot wounds: A single-center retrospective study

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ABSTRACT

BACKGROUND: This study aimed to retrospectively evaluate the clinical characteristics, temporal admission patterns, and clinical outcomes of patients with extremity gunshot wounds (GSW) presenting to a tertiary care teaching and research hospital.

METHODS: A total of 123 patients presenting with GSWs affecting at least one extremity between January 2024 and December 2025 were retrospectively analyzed. Injury characteristics, interventions, and clinical outcomes were evaluated. Factors independently associated with hospital length of stay (LOS) and intensive care unit (ICU) admission were identified using negative binomial regression and multivariate logistic regression analyses, respectively.

RESULTS: Of the patients, 116 (94.3%) were male, with a mean age of 29.9±11.9 years. The lower extremity was the most frequently affected region (69.1%), and 42 of 43 fractures (97.7%) were open fractures. The ICU admission rate was 26.0% (n=32), and in-hospital mortality was 4.1% (n=5). A total of 43.1% of admissions occurred between 18:00 and 23:59. In negative binomial regression, concomitant injury (incidence rate ratio [IRR]=6.93; 95% confidence interval [CI]: 3.82–12.57; p<0.001), fracture (IRR=5.02; 95% CI: 2.82–8.93; p<0.001), and reoperation (IRR=2.73; 95% CI: 1.44–5.16; p=0.002) were independently associated with length of hospital stay. In logistic regression, neurovascular injury (odds ratio [OR]=28.12; 95% CI: 7.60–104.09; p<0.001) and concomitant injury (OR=20.36; 95% CI: 5.62–73.81; p<0.001) independently predicted ICU admission.

CONCLUSION: Extremity GSWs predominantly affect young males and cluster during evening hours. Concomitant injury and fracture were independently associated with length of hospital stay, whereas reoperation was associated with prolonged hospitalization during the clinical course, while neurovascular injury and concomitant injury independently predict ICU admission.

Keywords: Extremity; gunshot wound; hospital length of stay; intensive care unit.

INTRODUCTION

Gunshot wounds (GSW) remain a significant public health problem worldwide, causing considerable morbidity and mortality. According to the Global Burden of Disease 2016 data, the annual number of firearm-related deaths worldwide is estimated to range from 195,000 to 276,000, with the majority attributed to homicide.[1] These injuries disproportionately affect males and young adults.[2] From an anatomical distribution perspective, the extremities are the most commonly affected region, and orthopedic surgeons frequently encounter these injuries in trauma practice.[3]

Extremity GSWs present across a broad clinical spectrum ranging from isolated soft-tissue injuries to Gustilo type 3C open fractures, and are frequently associated with serious orthopedic complications including fractures, neurovascular injuries, and compartment syndrome.[4,5] The lower extremity is the most commonly affected anatomical region, account-

Cite this article as: Kaya O, Yılmaz M, Ateş H, Yavuz T, Bozgeyik B. Clinical burden and predictors of hospitalization in extremity gunshot wounds: A single-center retrospective study. Ulus Travma Acil Cerrahi Derg 2026;32:1211-1218.

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Ulus Travma Acil Cerrahi Derg 2026;32(10):1211-1218 DOI: 10.14744/tjtes.2026.48729

Submitted: 19.05.2026 Revised: 07.07.2026 Accepted: 07.09.2026 Published: 06.10.2026

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ing for approximately 46% of all ballistic fractures.[6] These injuries impose a significant resource burden on healthcare systems due to prolonged hospital stays, repeated surgical interventions, and intensive care requirements.[6,7] Although several epidemiological studies have evaluated firearm injuries in Türkiye, including emergency department-based cohorts,[8,9] studies evaluating extremity GSWs specifically from an orthopedic perspective remain limited.

The aim of this study was to retrospectively evaluate the epidemiological and clinical characteristics, temporal admission patterns, orthopedic interventions, and clinical outcomes of GSWs in which at least one extremity was affected, including concomitant injuries, in patients presenting to a tertiary care teaching and research hospital.

MATERIALS AND METHODS

This study was conducted by reviewing the medical records of patients who presented to the emergency department of a tertiary care teaching and research hospital with GSWs between January 01, 2024 and December 31, 2025. Patients with GSWs affecting at least one extremity were included. Demographic data, injury characteristics, concomitant injuries, applied orthopedic interventions, and clinical outcomes were retrospectively evaluated through the hospital information management system and electronic medical records. This study was approved by the Ethics Committee for Non-Interventional Clinical Research Gaziantep City Hospital (Date: 05.06.2026, Decision no: 2026/34) and conducted in accordance with the principles of the Declaration of Helsinki.

Patients who presented with GSWs during the specified period, were 18 years of age or older, had at least one extremity injury, and whose basic demographic and clinical data were fully accessible through the hospital record system were included. Injuries without extremity involvement affecting only the trunk, head, or neck region, cases admitted as deceased, patients under 18 years of age, cases miscoded for reasons other than ballistic trauma, and patients whose basic clinical data were unavailable were excluded.

Patient data were obtained by reviewing the hospital information management system, emergency department records, operative notes, anesthesia records, and discharge summaries. Patients were screened through the hospital information management system using all GSW diagnosis codes under the International Classification of Diseases, 10th Revision: W32, W33, W34, X93, X94, and X95. Collected data were categorized as demographic characteristics (age, sex), temporal parameters related to admission time (date, time, day, and season of admission), injury characteristics (affected extremity region, anatomical subregion, fracture presence and open/closed fracture status, Gustilo classification, joint involvement, neurovascular injury), concomitant injuries, type of orthopedic intervention, type of anesthesia, presence and number of reoperations, and clinical outcomes (emergency department disposition, intensive care unit [ICU] admission, length of hospital stay, development of complications, and in-hospital mortality). Combined intervention was defined as the performance of two or more orthopedic and/or vascular procedures during the same surgical episode. This category comprised patients with complex extremity gunshot injuries requiring multiple procedures, most commonly combinations of external fixation, debridement, and neurovascular repair, according to the injury pattern. Patients undergoing a single surgical procedure were classified according to that specific intervention. Open fractures were classified according to the Gustilo-Anderson classification by an orthopedic surgeon with at least 5 years of trauma surgery experience, based on review of operative notes, operation records, and discharge summaries.[10] Reoperation was defined as additional surgical interventions performed within the same hospitalization episode following the initial surgical intervention. Neurovascular injury was recorded based on clinical examination, imaging modalities, and specialist consultations. Hospital length of stay (LOS) was calculated as zero days for patients discharged from the emergency department, and as the number of days between admission and discharge for hospitalized patients. Admission times were evaluated in four time intervals for temporal analysis: 00:00–05:59, 06:00–11:59, 12:00–17:59, and 18:00–23:59.

Data were analyzed using the Statistical Package for the Social Sciences statistical software (version 26.0; IBM Corp., Armonk, NY, USA). Continuous variables were expressed as mean ± standard deviation or median (interquartile range [IQR]), and categorical variables as number and percentage. Normality of distribution was assessed using the Shapiro–Wilk test. The Mann–Whitney U test was used for comparisons of non-normally distributed continuous variables between two groups, and the Kruskal–Wallis test for comparisons among more than two groups. Associations between categorical variables were evaluated using the Chi-square test or Fisher's exact test when the expected cell count was <5. Negative binomial regression analysis was applied to identify independent predictors of hospital LOS, and multivariate logistic regression analysis was used to identify independent predictors of ICU admission. Statistical significance was set at $p<0.05$ for all analyses.

RESULTS

A total of 123 patients meeting the inclusion criteria were included in the analysis. Of these, 94.3% (n=116) were male, with a mean age of 29.9±11.9 years (range: 18–64 years). Demographic characteristics, injury features, and clinical findings of all patients are presented in Table 1.

Regarding the anatomical distribution of injuries, lower extremity involvement was identified in 85 patients (69.1%), upper extremity in 30 (24.4%), and both extremities in 8 (6.5%). The most frequently affected anatomical region was the leg (n=35, 28.5%), followed by the femur/hip (n=27, 22.0%) and

Table 1. Demographic, clinical, and treatment characteristics of patients (n=123)

Variable	n	Percentage
Age (years), mean±SD (range)	29.9±11.9 (18–64)	
Sex		
Male	116	94.3
Female	7	5.7
Affected extremity region		
Lower extremity	85	69.1
Upper extremity	30	24.4
Both	8	6.5
Anatomical subregion		
Leg	35	28.5
Femur/hip	27	22.0
Multiple anatomical regions	20	16.3
Knee	11	8.9
Shoulder-humerus	10	8.1
Hand-wrist	7	5.7
Foot-ankle	7	5.7
Forearm	4	3.3
Elbow	2	1.6
Clinical findings		
Fracture	43	35.0
Open fracture	42	34.1
Joint involvement	28	22.8
Neurovascular injury	27	22.0
Reoperation	27	22.0
Gustilo-Anderson classification*		
Gustilo 1	7	5.7
Gustilo 2	8	6.5
Gustilo 3A	3	2.4
Gustilo 3B	0	0.0
Gustilo 3C	24	19.5
Concomitant injury†		
None	95	77.2
Present – thorax	9	7.3
Present – abdomen	9	7.3
Present – head/neck	5	4.1
Present – other extremity	5	4.1
Intervention type‡		
Conservative	70	56.9
Combined	26	21.1
Debridement	8	6.5
Neurovascular surgery	6	4.9
Internal fixation	6	4.9
Amputation	6	4.9
External fixator	1	0.8
Emergency department disposition		
Discharged	57	46.3
Admitted – ward	34	27.6
Admitted – ICU	32	26.0
Clinical outcomes		
ICU admission	32	26.0
In-hospital mortality	5	4.1
Osteomyelitis	9	7.3
Hospital length of stay (days), median (IQR)	2 (0–9)	
Hospital length of stay (days), mean±SD	6.0±9.2	

Mean: Mean; SD: Standard deviation; IQR: Interquartile range; ICU: Intensive care unit. *Gustilo 3B was not observed in any case. †Each patient was classified according to the most severe injury site; all patients were assigned to a single category. ‡Combined intervention: application of more than one orthopedic or vascular intervention within the same surgical episode.

multiple anatomical regions (n=20, 16.3%). Fractures were identified in 43 patients (35.0%); of these, 42 (97.7%) were open fractures, reflecting the high-energy nature of civilian ballistic trauma. Gustilo 3C was the most common type with 24 cases (19.5%), and Gustilo 3B was not observed in this series. Joint involvement was identified in 28 patients (22.8%) and neurovascular injury in 27 (22.0%). Concomitant injury was present in 28 patients (22.8%); thoracic involvement was detected in 9 (7.3%) and abdominal involvement in 9 (7.3%).

Regarding intervention type, conservative management was applied in 70 patients (56.9%). Of the 53 patients who underwent surgical intervention, combined procedures were performed in 26 (21.1%), debridement in 8 (6.5%), neurovascular surgery in 6 (4.9%), internal fixation in 6 (4.9%), and amputation in 6 (4.9%). The reoperation rate was 22.0% (n=27).

Of all patients, 57 (46.3%) were discharged from the emergency department, 34 (27.6%) were admitted to the ward, and 32 (26.0%) were admitted to the ICU. The overall ICU admission rate was 26.0% (n=32), and in-hospital mortality was 4.1% (n=5). Osteomyelitis was the most common complication (n=9, 7.3%). The median hospital LOS for all patients was 2 days (IQR: 0–9), with a mean LOS of 6.0±9.2 days.

Regarding temporal distribution, A total of 43.1% of admissions (n=53) occurred between 18:00 and 23:59, while 7.3% (n=9) were concentrated in the 06:00–11:59 interval (Fig. 1). The weekend admission rate was 39.8% (n=49). Monthly distribution showed that the highest number of admissions occurred in April (n=20, 16.3%) and the lowest in March (n=4, 3.3%); however, no statistically significant evidence of non-homogeneous monthly distribution was detected (χ^2=19.341,

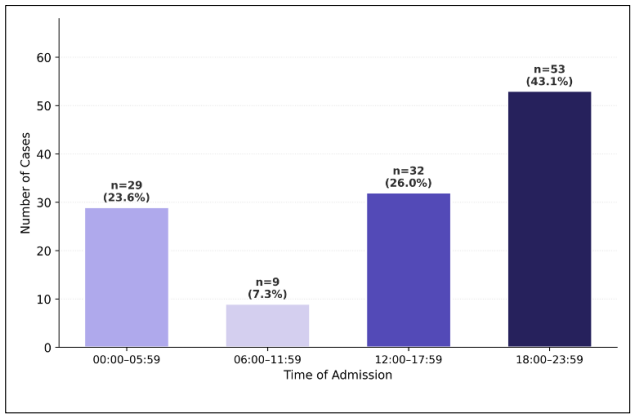

Figure 1. Temporal distribution of emergency department admissions by time interval (n=123).

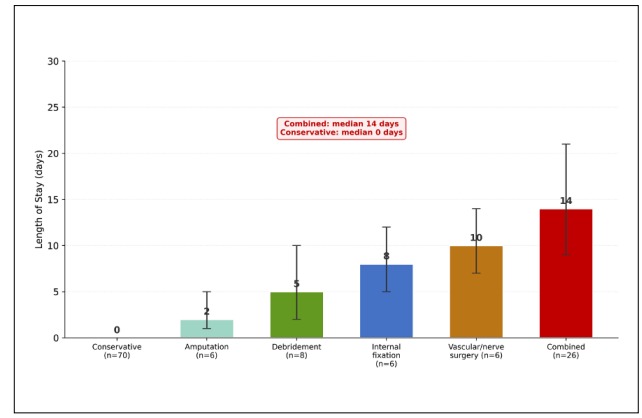

Figure 2. Hospital length of stay by intervention type. Values represent the median (days); error bars indicate the interquartile range.

df=11, p=0.055). Seasonal distribution showed the highest admissions in spring (n=37, 30.1%) and the lowest in autumn (n=23, 18.7%); no statistically significant difference was found between seasons (χ^2=3.276, df=3, p=0.351). Fracture rates (37.5%) and LOS (median 4 days) were higher in winter compared to other seasons, although this difference did not reach statistical significance.

Factors affecting hospital LOS were evaluated using the Mann–Whitney U test (Table 2). Fracture presence (median 9 vs. 0 days, p<0.001), neurovascular injury (median 9 vs. 0 days, p<0.001), reoperation (median 10 vs. 0 days, p<0.001), and concomitant injury (median 10 vs. 0 days, p<0.001) significantly prolonged LOS. Median LOS was 6 days in patients with joint involvement versus 0 days in those without (p=0.005). When comparing median LOS by intervention type, the longest LOS was observed in patients requiring combined intervention (median 14 days), while the conservative treatment group had a median LOS of zero days (Fig. 2).

In multivariate negative binomial regression analysis, concomitant injury (incidence rate ratio [IRR]=6.93; 95% confidence interval [CI]: 3.82–12.57; p<0.001), fracture presence (IRR=5.02; 95% CI: 2.82–8.93; p<0.001), and reoperation (IRR=2.73; 95% CI: 1.44–5.16; p=0.002) were independently associated with hospital LOS (Table 3). Neurovascular injury and joint involvement did not reach statistical significance in the multivariate analysis.

In multivariate logistic regression analysis, neurovascular injury (odds ratio [OR]=28.12; 95% CI: 7.60–104.09; p<0.001) and concomitant injury (OR=20.36; 95% CI: 5.62–73.81; p<0.001) were identified as independent predictors of ICU admission (Fig. 3, Table 4). In-hospital mortality occurred exclusively in patients admitted to the ICU.

Table 2. Factors affecting hospital length of stay

Variable	Present – median (IQR)	Absent – median (IQR)	p
Fracture	9 (3–18)	0 (0–2)	<0.001
Joint involvement	6 (0–14)	0 (0–7)	0.005
Neurovascular injury	9 (4–15)	0 (0–6)	<0.001
Reoperation	10 (7–16)	0 (0–3)	<0.001
Concomitant injury	10 (5–15)	0 (0–6)	<0.001
Length of stay by interven-tion type	Median (IQR)		
Conservative	0 (0–0)		
Debridement	5 (2–10)		
Internal fixation	8 (5–12)		
Neurovascular surgery	10 (7–14)		
Combined	14 (9–21)		
Amputation	2 (1–5)		

IQR: Interquartile range. Comparisons among intervention types were performed using the Kruskal–Wallis test.

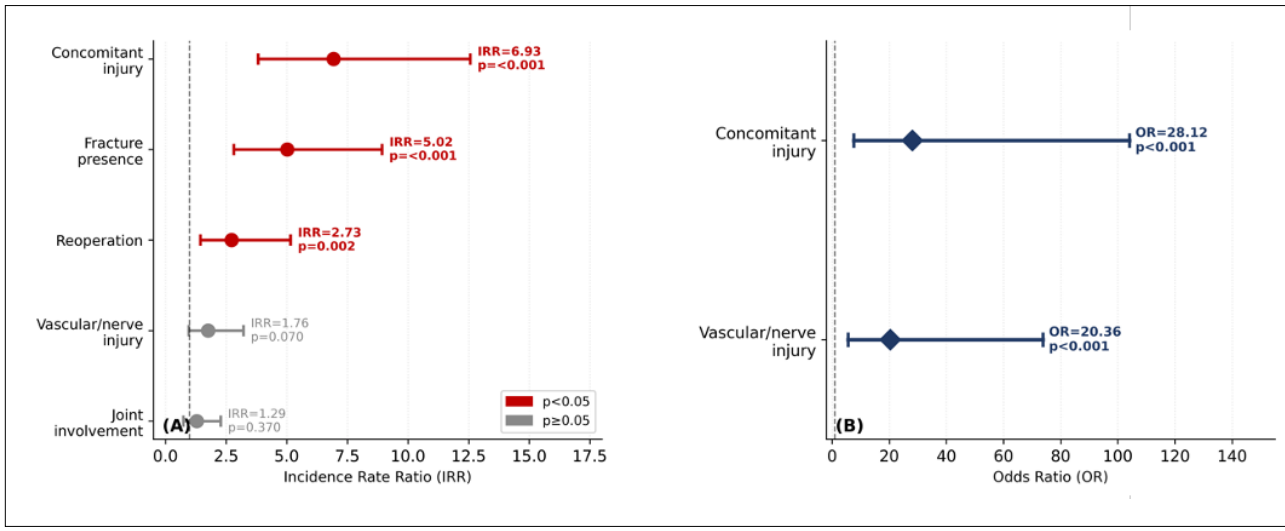

Figure 3. (a) Factors independently associated with hospital length of stay assessed by negative binomial regression. Red circles indicate statistically significant variables (p<0.05). IRR: Incidence rate ratio; CI: Confidence interval. **(b)** Independent predictors of intensive care unit admission assessed by multivariate logistic regression. OR: Odds ratio; CI: Confidence interval.

Table 3. Independent predictors of hospital length of stay

Variable	IRR	95% CI	p
Concomitant injury	6.93	3.82–12.57	<0.001
Fracture	5.02	2.82–8.93	<0.001
Reoperation	2.73	1.44–5.16	0.002
Neurovascular injury	1.76	0.96–3.22	0.070
Joint involvement	1.29	0.74–2.28	0.370

IRR: Incidence rate ratio; CI: Confidence interval. Bold text: p<0.05.

Table 4. Independent predictors of ICU admission

Variable	OR	95% CI	p
Neurovascular injury	28.12	7.60–104.09	<0.001
Concomitant injury	20.36	5.62–73.81	<0.001

OR: Odds ratio; CI: Confidence interval; ICU: Intensive care unit.

DISCUSSION

GSWs represent a significant clinical and healthcare system burden in trauma surgery practice. However, the majority of existing literature consists of data from high-income countries and military series.[7,11] Studies evaluating civilian extremity GSWs from an orthopedic perspective that include hospital LOS and ICU requirements as primary outcome variables remain limited.[5,6] Furthermore, it has been reported that injury patterns and clinical outcomes in centers with different socioeconomic and geographical characteristics may differ from Western series.[11] Therefore, our study aims to contribute to the literature on the orthopedic and clinical characteristics of extremity GSWs using contemporary single-center data from Turkey. Unlike previous epidemiological reports, our study also evaluates independent factors associated with hospital LOS and ICU admission from an orthopedic perspective, thereby providing clinically relevant information for trauma resource allocation and surgical decision-making.

The predominance of young male patients in our series is consistent with demographic patterns reported in civilian GSW series.[12-15] Large civilian trauma series have consistently demonstrated that firearm injuries predominantly affect young males and are associated with considerable healthcare resource utilization. Benton et al.[15] analyzed more than 6,000 GSW patients at a Level I trauma center and similarly reported that extremity injuries were among the most common anatomical locations and that a substantial proportion of patients required surgical intervention.[15] Similarly, Ertekin et al.[9] reported comparable demographic characteristics among firearm injury patients presenting to the emergency department in Türkiye, with most patients being young males; however, their study included all anatomical injury locations rather than focusing specifically on extremity injuries. The predominance of male sex and young adult age group in these injuries has been associated with increased outdoor exposure and more frequent involvement in violence-related events.[2] The finding that the lower extremity was the most frequently affected anatomical region is also consistent with previous series, as injuries around the femur and tibia have been reported to be prominently represented in civilian ballistic trauma.[13,16] The fact that the vast majority of fractures identified in our series were open fractures can be explained by the high-energy nature of ballistic trauma causing widespread damage to bone and surrounding soft tissue.[5,6,17]

In multivariate analysis, concomitant injury (IRR=6.93), fracture presence (IRR=5.02), and reoperation requirement (IRR=2.73) were independently associated with hospital LOS. These findings are consistent with the existing literature, which has reported that the coexistence of bone and vascular injury significantly prolongs hospital LOS compared with isolated soft-tissue injuries.[18,19] The effect of concomitant injuries on LOS may be related to multidisciplinary management requirements, additional surgical interventions, and increased complication risk. The observed association between reoperation and prolonged LOS may be explained by the staged debridement, wound care, and definitive fixation processes frequently required in the management of complex open fractures.[5,19] Because reoperation occurs after the initial hospital admission, its association with prolonged LOS should be interpreted cautiously and does not imply a causal or baseline predictive relationship. Rather, reoperation is likely a surrogate marker of injury complexity, treatment intensity, and the need for staged surgical management during hospitalization.

Neurovascular injury (OR=28.12) and concomitant injury (OR=20.36) were identified as independent predictors of ICU admission. The strong predictive value of neurovascular injury for ICU requirement may be explained by hemodynamic instability, the need for hemorrhage control, and close postoperative monitoring in vascular injuries.[19,20] Previous studies have also reported that ballistic trauma with vascular injury is associated with higher morbidity and a more complex clinical course.[20] Similarly, the independent association of concomitant injuries with ICU admission in our study suggests increased respiratory and circulatory support requirements in multisystem trauma patients. All mortality cases occurred in patients admitted to the ICU, further supporting the substantial clinical burden associated with this patient group.

A substantial proportion of admissions were concentrated in the evening hours, with approximately 40% occurring on weekends. Similar temporal distributions have been reported in previous trauma series, emphasizing that GSWs create additional burden on emergency services and trauma teams during evening and nighttime hours.[11] This finding has practical implications for the organization of emergency orthopedic on-call services, operating room scheduling, and management of intensive care resources. The absence of statistically significant differences between seasons indicates that the seasonal increase pattern described in Western literature was not observed in this series, suggesting that injury incidence may be shaped more by regional and sociodemographic dynamics than by climatic factors.[11]

Osteomyelitis was the most frequent complication in our series (7.3%), and the reoperation rate was 22.0%. Previous studies have reported that osteomyelitis rates in ballistic fractures vary depending on the degree of associated soft-tissue injury and contamination, and our rate is consistent with these data.[5,21,22] Previous series have also reported high reoperation rates in cases where open fractures predominate, due to the need for repeated debridement, temporary stabilization, and staged reconstruction.[21] The frequent coexistence of severe soft tissue and vascular injury in patients undergoing amputation reflects the challenges of limb-salvage surgery in high-energy ballistic trauma.[5,19,23] These findings indicate that extremity GSWs constitute a significant clinical burden not only in terms of acute trauma management but also with respect to multi-stage orthopedic reconstruction processes.

This study has several limitations. First, the retrospective and single-center design limits the generalizability of the results. As the study is based on data from a tertiary trauma center, it should be noted that the patient population may reflect a higher trauma severity and may contain selection bias. The retrospective design inherently carries the risk of incomplete documentation, misclassification of variables, and unmeasured confounders that could not be controlled for in the analyses. Furthermore, as data were derived from a single tertiary trauma center with specific institutional protocols and patient referral patterns, the findings may not be directly generalizable to other settings, including lower-volume centers or regions with different sociodemographic characteristics and mechanisms of injury. The low case numbers in certain subgroups such as Gustilo 3A, amputation, and mortality limit the statistical power of the analyses. The absence of validated trauma severity scores, such as the ınjury severity score, prevented adjustment for overall injury severity and may have resulted in residual confounding in the multivariate analyses. In addition, the American Society of Anesthesiologists score was unavailable for all patients and therefore could not be evaluated as a potential confounder. In addition, the inability to evaluate the time from injury to hospital admission and long-term functional outcomes is among the other important limitations of this study. Furthermore, reoperation was analyzed as a hospitalization-related variable rather than a baseline characteristic. Therefore, its association with prolonged LOS should be interpreted as reflecting injury complexity and the clinical course during hospitalization rather than a true baseline predictor. Our findings need to be supported by larger-scale, multicenter, and prospective studies.

CONCLUSION

This study demonstrated that extremity GSWs most frequently affect young male individuals, with the lower extremity being the most commonly involved anatomical region. Multivariate analyses showed that concomitant injury and fracture presence were independently associated with prolonged hospital LOS, whereas reoperation was associated with prolonged hospitalization during the clinical course, while neurovascular injury and concomitant injury were independent predictors of ICU admission. The concentration of admissions, particularly during evening hours and on weekends has practical importance for the organization of emergency orthopedic services and trauma resources. Our

findings highlight the determinant role of injury severity and concomitant trauma on clinical course in extremity GSWs, and contribute to clinical awareness regarding the management of this patient group. Beyond describing regional epidemiological patterns, these findings may assist orthopedic trauma teams in identifying patients at increased risk for prolonged hospitalization and intensive care requirements. Our results need to be supported by larger-scale, multicenter, and prospective studies.

Ethics Committee Approval: This study was approved by the Ethics Committee for Non-Interventional Clinical Research Gaziantep City Hospital (Date: 05.06.2026, Decision No: 2026/34).

Peer-review: Externally peer-reviewed.

Authorship Contributions: Concept: O.K.; Design: O.K.; Supervision: O.K.; Data collection and/or processing: M.Y., H.A.; Analysis and/or interpretation: O.K., T.Y.; Literature review: B.B.; Writing: O.K.; Critical review: O.K., E.B.

Informed Consent: Retrospective study.

Conflict of Interest: The authors declare no conflicts of interest.

Financial Disclosure: The author declared that this study has received no financial support.

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ORİJİNAL ÇALIŞMA - *ÖZ*

Ekstremite ateşli silah yaralanmalarında klinik yük ve hastanede yatış belirleyicileri: Tek merkezli retrospektif çalışma

AMAÇ: Bu çalışma, üçüncü basamak bir eğitim ve araştırma hastanesine başvuran ekstremite ateşli silah yaralanmalı hastaların klinik özelliklerini, zamansal başvuru paternlerini ve klinik sonuçlarını retrospektif olarak değerlendirmeyi amaçlamaktadır.
GEREÇ VE YÖNTEM: Ocak 2024 ile Aralık 2025 tarihleri arasında, en az bir ekstremitenin etkilendiği ateşli silah yaralanması nedeniyle başvuran 123 hasta retrospektif olarak incelendi. Yaralanma özellikleri, uygulanan girişimler ve klinik sonuçlar değerlendirildi. Hastane yatış süresi ve yoğun bakım ünitesi yatışı ile bağımsız olarak ilişkili faktörler sırasıyla negatif binom regresyon ve çok değişkenli lojistik regresyon analizleri ile belirlendi.
BULGULAR: Hastaların %94.3'ü (n=116) erkek olup yaş ortalaması 29.9±11.9 yıl idi. Alt ekstremite en sık etkilenen bölgeydi (%69.1); 43 kırığın 42'si (%97.7) açık kırık niteliğindeydi. Yoğun bakım ünitesine yatış oranı %26.0 (n=32), hastane içi mortalite oranı ise %4.1 (n=5) olarak saptandı. Başvuruların %43.1'i 18:00–23:59 saatleri arasında gerçekleşti. Negatif binom regresyon analizinde eşlik eden yaralanma (insidans hızı oranı=6.93; %95 güven aralığı: 3.82–12.57; p<0.001), kırık varlığı (insidans hızı oranı=5.02; %95 güven aralığı: 2.82–8.93; p<0.001) ve reoperasyon (insidans hızı oranı=2.73; %95 güven aralığı: 1.44–5.16; p=0.002) hastane yatış süresi ile bağımsız olarak ilişkili bulundu. Lojistik regresyon analizinde nörovasküler yaralanma (odds oranı=28.12; %95 güven aralığı: 7.60–104.09; p<0.001) ve eşlik eden yaralanma (odds oranı=20.36; %95 güven aralığı: 5.62–73.81; p<0.001) yoğun bakım ünitesine yatışı bağımsız olarak öngördü.
SONUÇ: Ekstremite ateşli silah yaralanmaları ağırlıklı olarak genç erkek popülasyonu etkilemekte ve akşam saatlerinde yoğunlaşmaktadır. Eşlik eden yaralanma ve kırık varlığı hastane yatış süresi ile bağımsız olarak ilişkiliyken, reoperasyon klinik seyir süresince uzamış hastanede kalış ile ilişkili bulundu; nörovasküler yaralanma ve eşlik eden yaralanma ise yoğun bakım ünitesine yatışı bağımsız olarak öngördü.

Anahtar sözcükler: Ateşli silah yaralanması; ekstremite; hastane yatış süresi; yoğun bakım ünitesi.

Ulus Travma Acil Cerrahi Derg 2026;32(10):1211-1218 DOI: 10.14744/tjtes.2026.48729