JTS CPG ID: 18

Damage Control Resuscitation
Clinical Practice Guideline
Quick Reference Guide

Use this to understand the latest **guidance and actions** for **Damage Control Resuscitation.**

	Guidance	Actions
Triage / Rapid Assessment	**Reduce mortality due to hemorrhage**, rapidly recognize the need for early DCR and initiate early hemorrhage control and blood transfusion as close to time-of-injury as possible.	Maintain a target Systolic Blood Pressure (SBP) for DCR at 100 mmHg (110mmHg if TBI is presumed) when resuscitating with blood products.
Hemorrhage Control	**Stop or reduce hemorrhage** as close to time-of-injury as possible.	Apply: • tourniquets, • pressure bandages, and • hemostatic dressings. Utilize **Resuscitative Endovascular Balloon Occlusion of the Aorta (REBOA) as an option** for the control of non-compressible torso hemorrhage. Assist with REBOA if assigned to a designated resuscitation team.
Resuscitation	**Treat and reverse hemorrhagic shock**, provide warm whole blood as close to the time-of-injury as possible.	Administer DCR fluid of choice: Low Titer O Whole Blood (LTOWB). **If LTOWB is unavailable, administer pre-hospital DCR fluids from most to least preferred:** 1. Plasma, platelets, and red blood cells (RBCs) in a 1:1:1 ratio 2. Plasma and RBCs in a 1:1 ratio 3. Plasma or RBCs alone
Medication Administration	**Prevent hypocalcemia related to massive transfusion**, monitor ionized calcium and administer calcium early.	Give IV/IO calcium during or immediately after first unit of blood to all hemorrhagic shock patients, then after every four units.

DISCONTINUE USE for DCR:

- Hydroxyethyl starch (Hextend, Hespan)
- Recombinant human activated factor VII (rhFVIIa)

Note: View the full CPG at https://jts.amedd.army.mil/index.cfm/PI_CPGs/damage_control.
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