Clinical Practice Guideline Update (JTS CPG ID: 18)

Quick Reference Guide
for Combat Medics and Corpsmen

This document highlights updates to the Damage Control Resuscitation (DCR) Clinical Practice Guideline.

	Goal	Updated Guidance	Actions
Triage / Rapid Assessment	**To 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 (100-110mmHg if TBI is presumed) when resuscitating with blood products.	• **Triage:** Look for severe injury patterns: proximal, bilateral, or multiple amputations; penetrating injury to chest/abdomen; pelvic or junctional hemorrhage, and weak/absent radial pulse. **Initiate Rapid Casualty Assessment** • **Assess for signs of hemorrhagic shock:** - Altered mental status - Cool extremities - Delayed capillary refill - Pulse > 100 bpm - SBP < 100 mmHg - Clinical signs of impaired clotting (e.g., bleeding from minor wounds)
Hemorrhage Control	**To stop or reduce hemorrhage** as close to time-of-injury as possible.	**INFORMATIONAL ONLY:** Know that Resuscitative Endovascular Balloon Occlusion of the Aorta (REBOA) is now an option for the temporary control of non-compressible torso hemorrhage.	Apply • tourniquets, • pressure bandages, • hemostatic dressings, and **assist with REBOA if assigned to a designated resuscitation team.**
Resuscitation	**To treat and reverse hemorrhagic shock**, provide warm whole blood as close to the time-of-injury as possible.	Prioritize using Low Titer O Whole Blood (LTOWB) as the **fluid of choice** for DCR.	**Administer pre-hospital DCR fluids from most to least preferred:** 1. Whole Blood (LTOWB preferred) 2. Plasma, platelets, and red blood cells (RBCs) in a 1:1:1 ratio 3. Plasma and RBCs in a 1:1 ratio 4. Plasma or RBCs alone
	NOTES: • Warm fluids to 37°C/98.6°F with approved devices to prevent hypothermia. • Consider transfusion during transport to ensure rapid transfer to a surgical team.		
Pharmacologic Adjuncts	**To reduce mortality, fibrinolysis, and stabilize clot,** administer TXA IV/IO within 3 HOURS of injury for casualties at high risk of hemorrhagic shock.	Consider administering undiluted TXA by slow IV push (over 1 minute) is acceptable **ONLY** if supplies or tactical situation prevents providing a diluted infusion.	• Administer TXA 2g IV/IO in 100mL NS over 1 minute within 3 HOURS of injury
	NOTES: Rapid TXA IV push may cause hypotension.		
	To prevent hypocalcemia related to massive transfusion, monitor ionized calcium. Administer calcium early.	Provide IV/IO calcium to all hemorrhagic shock patients whenever blood transfusion occurs during or immediately after first unit of blood.	• 1g calcium IV/IO immediately after first blood unit transfused, then again after every four units.
	NOTES: Calcium gluconate is preferred for peripheral IV administration.		
	DISCONTINUE USE for DCR: Hydroxyethyl starch (Hextend, Hespan)		

* **Note:** View the full CPG at https://jts.health.mil/index.cfm/PI_CPGs/damage_control. Last updated June 2023.