

**Transfusion Camp, University of Toronto
Seminar for Day 5, May 13 2022
Major Haemorrhage Cases, Dr. Jeannie Callum**

Please start session by asking trainees if they have any questions from the didactic sessions.

Please remind students that although one answer is bolded as the correct answer, there may be more than one reasonable answer to the questions. The purpose of the seminar is to promote discussion and explore why certain answers may be more appropriate in certain situations.

Case 1

A 62 year old man with atrial fibrillation is brought by land transport to the emergency department after being struck while commuting to work 30 minutes ago. He has a medical bracelet stating he is on warfarin. He is intubated at the scene for a low GCS. He is hypotensive (systolic blood pressure 85 mmHg) and tachycardic (127 bpm). He has received 2 L of saline and 1 gram of tranexamic acid during transport to the trauma room (no RBCs). His abdomen is distended, he has a positive FAST and CT shows a ruptured spleen and an unstable pelvic fracture. Significant traumatic brain injury also suspected but CT shows no acute hemorrhage. The patient is being prepped for urgent laparotomy for splenectomy and pelvic fixation.

1. Which of the following is the first best intervention to support his coagulation?
 - A) Administer 4 grams of fibrinogen concentrate (or 10 units of cryoprecipitate)
 - B) Administer 2000 IU of PCC
 - C) Initiate viscoelastic monitoring to guide any transfusion therapy
 - D) Transfuse 4 units of plasma
2. The first gram of tranexamic acid was administered as push during land transport, but the second gram was not administered, as per the CRASH-2 dosing protocol. It is now two hours after the initial trauma occurred and the patient is about to be taken to the OR. The best approach to giving additional tranexamic acid in this situation is:
 - A) Bolus the 2nd gram now
 - B) Measure the fibrinogen level and if <1.0 g/L administer the 2nd gram of TXA
 - C) Order viscoelastic testing and only administer if there is excessive lysis at 30 minutes
 - D) Order D-dimers and only administer if the levels are above the normal range.
3. Which of the following has been shown to increase appropriate plasma utilization during an MHP?
 - A) Early MHP activation for acute gastrointestinal bleeding
 - B) Requiring the transfusion of 4 units of red blood cells before a multicomponent MHP cooler is issued
 - C) Reserving plasma transfusion for patients with a Shock Index (SI) score > 1 or Assessment of Blood Consumption (ABC) score > 2
 - D) Use of a 1:1:1 ratio-based protocol



4. When managing a massively bleeding patient, the most important laboratory test to collect is:
- A) Activated partial thromboplastin time (aPTT)
 - B) Blood group and antibody screen
 - C) Fibrinogen level
 - D) Hemoglobin level

Case 2

A 37 year old G3P2 is post-vaginal delivery of an uncomplicated pregnancy. Her hemoglobin was 102 g/L and her MCV was 74 pre-delivery. The nurse pages you because her HR has increased to 120 from 85 bpm, sBP dropped from 110 to 85 mmHg, and she has just passed a huge amount of blood per vagina approximately 1 hour post-partum. The patient is disoriented and is difficult to rouse.

5. Which of the following is NOT thought to contribute to post-partum hemorrhage?
- A) Congenital coagulation factor deficiency
 - B) Deficiency of vitamin K-dependent coagulation factors
 - C) Retained placenta
 - D) Uterine atony
6. Recent small clinical trials have suggested that replacing clotting factors with a combination of a coagulation factor concentrates may be an alternative strategy. If a decision was made to use prothrombin complex concentrates instead of plasma (e.g., due to unavailability at the local hospital due to smaller hospital size) for the management of post-partum hemorrhage, which of the following would be the most important additional factor concentrate to add?
- A) Factor XIII
 - B) Fibrinogen
 - C) Recombinant activated factor VII
 - D) Von Willebrand Factor
7. Which of the following statements regarding the management of post-partum hemorrhage is true?
- A. Fibrinogen concentrates increase the risk of thromboembolic complications compared to cryoprecipitate
 - B. Once it occurs, initiation of rapid transfusion support is more important than attempting source control
 - C. The main risk of using recombinant factor VIIa is thromboembolic events
 - D. Tranexamic acid is still of benefit when given more than three hours after onset of bleeding

Case 3

A 24 year old woman is on route to the trauma room direct from the scene by helicopter transport. She was a passenger on a motorcycle involved in a motor vehicle collision. The driver was pronounced dead at the scene. She is expected to arrive in under 15 minutes. You are told she has head, thoracic and orthopedic injuries. She was thrown approximately 25 metres. You are told she is tachycardic and hypotensive despite 2L balanced crystalloid administered by air ambulance.

8. Which of the following normal practices can be waived in the setting of massive blood loss?
- A) Attachment of patient wristband with unique identifiers
 - B) Careful inversion of laboratory specimen test-tubes prior to delivery to the lab
 - C) Advanced directives prohibiting the use of blood transfusion (eg., Jehovah's Witnesses)
 - D) Matching for patient antibodies against non-ABO/RhD blood group antigens

The patient survives initial damage control resuscitation efforts and is brought to the OR, where she becomes progressively more stable after her spleen is removed and the pelvis packed. She has been transfused a total of 8 units of RBCs, 4 units of plasma, 2 platelet pools and 4 grams of fibrinogen concentrate. Her most recent labs show: hemoglobin 82 g/L, INR 1.9, platelet count 65, and fibrinogen 2.1.

9. What secondary complications should you watch for in a massively transfused patient?
- A. Hypercalcemia
 - B. Hypokalemia
 - C. Hypothermia
 - D. Seizures

The patient survives to the ICU phase of care. She is still requiring boluses and inotropes for fluid resuscitation. Her most concerning ongoing issue is her traumatic brain injury. There is no obvious ongoing blood loss. Blood work shows all metrics are within target range, including hemoglobin at 98 g/L. Her lactate is still high at 8, although this is down from 12. Her pH has also improved from 7.10 to 7.33.

10. Given her ongoing need for fluid boluses and inotropes, what is the role of intravenous albumin for her resuscitation?
- A. Albumin increases the mortality rate, compared to saline, in trauma patients and therefore is contraindicated.
 - B. Albumin should be administered for critical hypoalbuminemia (<20)
 - C. Resuscitation with albumin should be started after 2 L of crystalloid
 - D. There is no role for albumin in the resuscitation of hypovolemic trauma patients

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