



Transfusion Camp for Nurse Practitioners

Module 3: Seminar B, 2023-2024

Major Haemorrhage Cases, developed by Dr. Jeannie Callum

Materials based on Transfusion Camp 2022-3 with permission from the Transfusion Camp Steering Committee

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 by bicycle 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 (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 is also suspected but CT shows no acute hemorrhage. The patient is being prepped for urgent laparotomy for splenectomy and pelvic fixation. Tranexamic acid 1 gram bolus administered on arrival.

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. One gram of tranexamic acid was administered as an iv push on arrival to hospital at 60 minutes from injury, It is now 90 minutes 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 one gram now
 - B. Measure the fibrinogen level and if <1.0 g/L administer the one gram of TXA
 - C. Order D-dimers and only administer if the levels are above the normal range.
 - D. Order viscoelastic testing and only administer if there is excessive lysis.
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 red blood cell antibodies

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. Hyponatremia

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

TRANSFUSION CAMP RESOURCES ARE DEVELOPED BY TRANSFUSION CAMP FACULTY FOR EDUCATIONAL PURPOSES ONLY. THE RESOURCES **MUST NOT BE USED OR DISTRIBUTED OUTSIDE OF TRANSFUSION CAMP** WITHOUT THE CONSENT OF THE TRANSFUSION CAMP ORGANIZERS. THE MATERIALS ARE NOT INTENDED TO BE A SUBSTITUTE FOR THE ADVICE OF A PHYSICIAN AND SHOULD BE ASSESSED IN THE CONTEXT OF THE APPLICABLE MEDICAL, LEGAL AND ETHICAL REQUIREMENTS IN ANY INDIVIDUAL CASE. PROVIDE FEEDBACK ON TRANSFUSION CAMP RESOURCES OR ENQUIRE ABOUT TRANSFUSION CAMP BY CONTACTING TRANSFUSIONCAMP@BLOOD.CA.