





Appropriate Initial Interventions

- √ **Intravenous Access** → 2 large bore IVs, IOs, CVC
- √ **Crystalloid** → Minimize crystalloid
- √ **Labs** → T&S, CBC, coagulation, lytes & ionized Ca, acid/base status – communicate urgency 5-7390
- √ **Continuous monitoring** → VS, acid/base, Intake/Output
- √ **Aggressive re-warming** – including warmed RBC's & plasma
- √ **Prevent/reverse acidosis**
- √ **Correct hypocalcemia** → Ca gluconate 20-50 mg/kg/dose IV slowly (1 mL/min)
- √ **Transfuse with unmatched RBCs** → Immediately available from TM via PTS. Call 5-2332
- √ **Give tranexamic acid** as soon as possible, but within 3 hours of injury, when giving blood products

Other Considerations

- √ **Heparin reversal** → Protamine 1 mg IV per 100 units of unfractionated Heparin, 1 mg IV/1 mg enoxaparin, (max dose 50 mg)
- √ **Warfarin reversal** → Vitamin K 5 mg IV/IM → Prothrombin Complex as per TM protocol dosing for INR and weight
- √ **Chronic Renal Failure** → DDAVP 0.3 mcg/kg IV over 20 min (max dose 20 mcg)
- √ Intraoperative cell salvage

General Pediatric Guidelines for Lab Based Blood Component Replacement

Product	Threshold	Dose
RBCs	<ul style="list-style-type: none"> • Aim for Hgb of 100 g/L in actively bleeding patient. • No requirement to maintain above 70g/L once hemostasis is achieved 	10 - 15mL/kg
Plasma	INR greater than 1.5	10 - 15 mL/kg
Platelets Do Not Cool	<ul style="list-style-type: none"> • PLT count less than 50 x 10⁹/L or projected to soon be less than 50 x 10⁹/L • PLT count is irrelevant if known antiplatelet agents on board. 	10 - 15 mL/kg Platelets should drip freely and not be transfused using a warmer or pressurized infuser.
Fibrinogen Replacement (Fibrinogen Concentrate or Cryoprecipitate)	Fibrinogen less than 1.5 g/L or evidence of microvascular bleeding	Fibrinogen Concentrate: 60mg/kg, or Cryoprecipitate: 1 unit/10kg NOTE: 4 units of plasma contain equivalent fibrinogen to 10 units cryo