

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 (110mmHg if TBI is presumed) when resuscitating with blood products.	<ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> - 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 control of non-compressible torso hemorrhage.	Apply <ul style="list-style-type: none"> • 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: <ol style="list-style-type: none"> 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: <ul style="list-style-type: none"> • 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 10 minutes) is acceptable ONLY if supplies or tactical situation prevents providing a diluted infusion.	<ul style="list-style-type: none"> • Administer TXA 1g IV/IO in 100mL NS over 10 minutes within 3 HOURS of injury • Second dose of TXA 1g IV/IO in 100mL NS over 8 hours
	NOTES: Rapid TXA IV push may cause hypotension.		
Pharmacologic Adjuncts	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.	<ul style="list-style-type: none"> • 1g calcium (30 ml of 10% calcium gluconate or 10 ml of 10% calcium chloride) 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.amedd.army.mil/index.cfm/PI_CPGs/cpgs. Last updated September 2019.