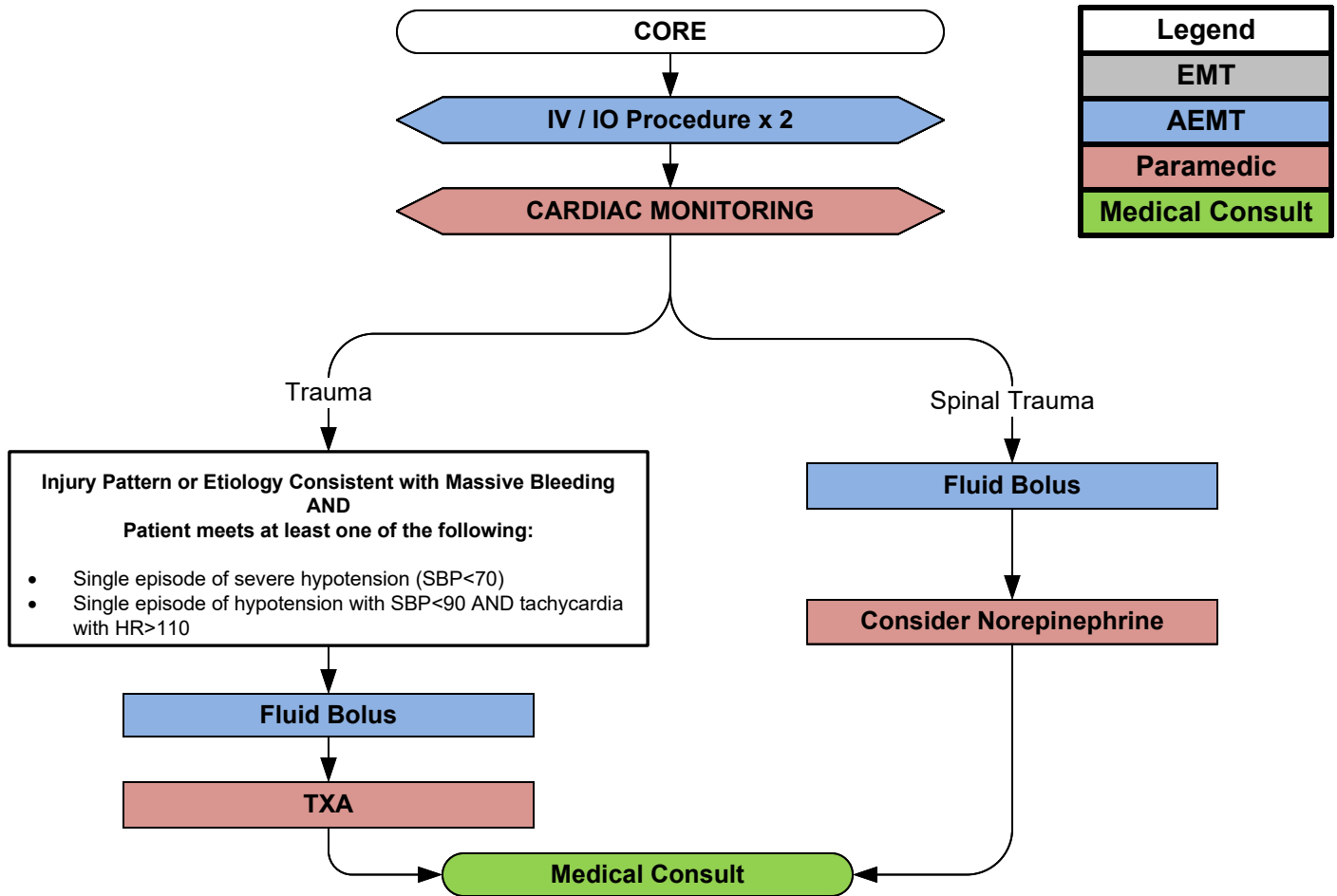


SHOCK - TRAUMA

History: ○ Blood loss (quantify) - vaginal or gastrointestinal bleeding, AAA, ectopic pregnancy ○ Pregnancy ○ SAMPLE	Signs and Symptoms: ○ Restlessness, confusion ○ Weakness, dizziness ○ Weak, rapid pulse ○ Pale, cool, clammy skin ○ Delayed capillary refill ○ Hypotension – SBP <90 mmHg	Differential: ○ Uncontrolled hemorrhage ○ Tension pneumothorax ○ Neurogenic shock (vasogenic)
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Pearls:

- Minimize scene time when possible.
- IV fluid administration should be administered in 250 cc increments and should be limited to achieve and maintain a systolic blood pressure of 80 mmHg. Patients with a systolic blood pressure of < 80 mmHg with normal mental status do not require aggressive fluid administration. Pregnant patients are NOT candidates for permissive hypotension and the goal should be to keep these patients normotensive.
- Head injured patients may require more aggressive fluid resuscitation.
- Fluid resuscitation should occur en route except in cases of entrapment and other extenuating circumstances.
- Shock is defined as decreased effective circulation with inadequate delivery of oxygen to tissues (see Signs and Symptoms section above).
- Unlike shock associated with other trauma, spinal trauma resulting in neurogenic shock may not be associated with tachycardia.
- TXA is indicated in patients > 18 years old with severe bleeding. When indicated, TXA should be administered early as benefits decrease by 10% for every 15 minutes in treatment delay.
- Consider a 12 lead ECG for patients with chest trauma when time permits (en route).
- In the event that Norepinephrine is unavailable, Push Dose Epinephrine may be used.