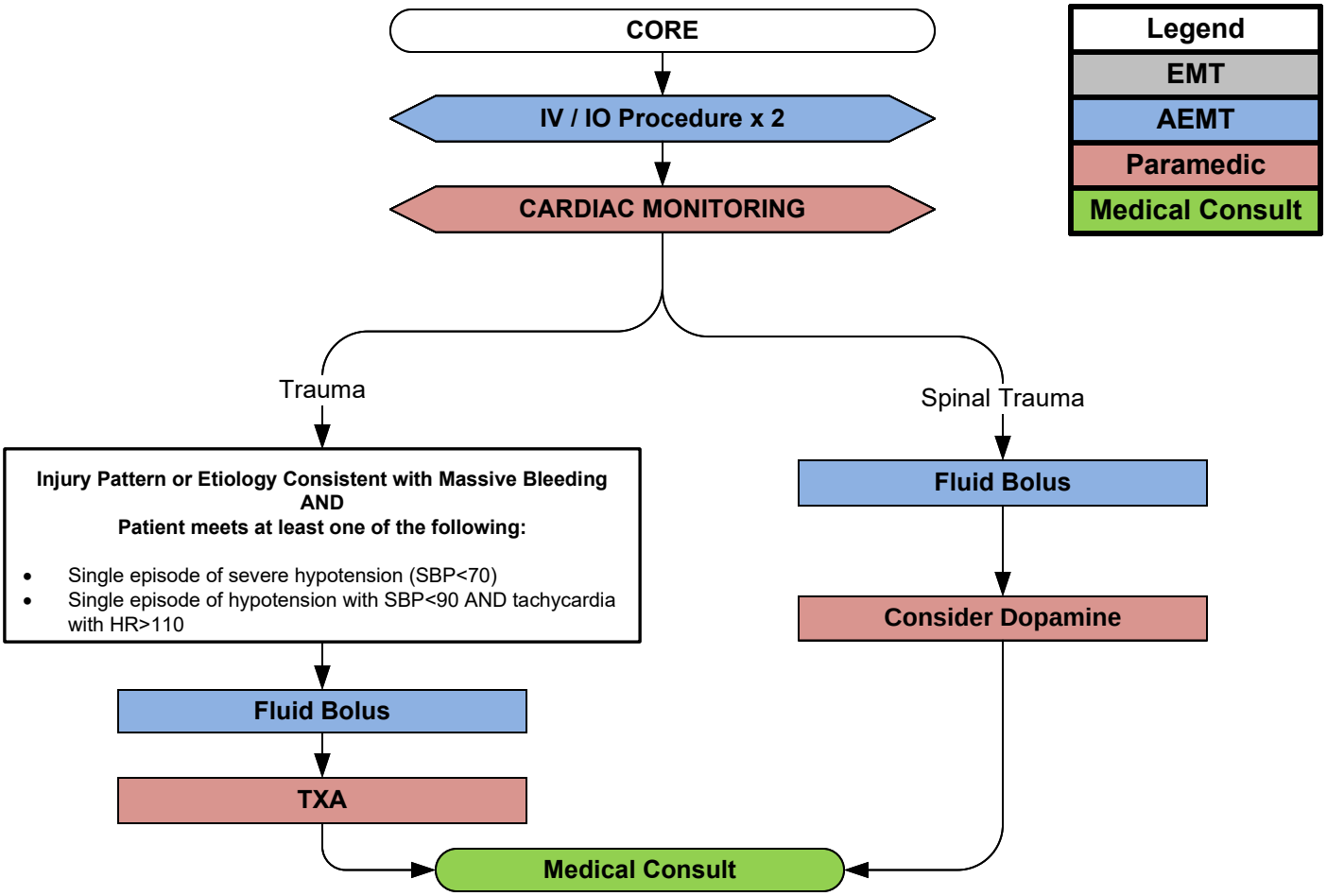
# SHOCK - TRAUMA

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




**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 Dopamine ; unavailable, Push Dose Epinephrine may be used.