



## **Recognizing and Treating Prehospital Shock**

*August 26, 2020*

*Webinar – Question & Answer Recap*

### **What are your thoughts on TXA for hemorrhagic shock?**

- TXA prevents clots that have formed from breaking down. This is obviously very important in the setting of blood vessels that have been damaged. An important problem with TXA is that the body is constantly forming and breaking down clots in the normal management of the vascular system. Therefore, there is a "risk to benefit" ratio of using TXA, and it is hard to know sometimes when the benefit exceeds the risk.

### **I get that treatment in the field is critical, but would you delay transport for field treatment?**

- There is little more important than the prompt transport of the critically ill patient to the appropriate medical facility. Studies going back decades have shown that delays of certain critically ill patients in the field result in worse outcomes. "Basic life support" should really be called "fundamental life support", because the activities of stopping bleeding, performing CPR, and activation of the destination facility from the field play vital roles in patient survival.

### **Can you have a patient with septic shock without fever or altered mental status? If so, how could you identify that in the field as a BLS provider?**

- This is a great question. Especially in immunosuppressed patients, it is possible that the patients may not have fever or have altered mental status. In that setting it is very important that the provider recognize tachycardia and hypotension as indicators that the patient is in shock, and to continue to examine the patient for a possible cause. This points out the importance of taking an adequate medical history.

### **What do you think of a narrow (less than 25) systolic to diastolic blood pressures as an indicator of shock?**

- This is a very important question. Typically patients have about a 40 millimeter Mercury difference between systolic and diastolic pressure. Certainly a narrow pulse pressure is indicative of shock, and is a finding that the medical professional should take note of.

### **What about TXA to protect clots in areas not conducive to tourniquets?**

- The role of TXA is to prevent clots that have formed from breaking down. Thus, there may be some benefit in the use of TXA in the patients suspected of having hemorrhagic shock.

### **What is the order of s/s in compensated shock?**

- Weak/thirsty/lightheaded, then pale, then diaphoretic, then tachycardic, then tachypneic, then diminished urinary output (all progressive "compensation") followed by "decompensation": Hypotension, altered mental status, coma, cardiac arrest, and death.

### **Even though the pt. had a SpO2 reading of 96, since she is indicative of shock would administering oxygen be appropriate?**

- That is correct. Even with a pulse oximetry reading that is normal, the patient in shock may have an overall oxygen deficit. Applying high flow oxygen in these settings is appropriate.

### **What are your thoughts on walking blood bank kits for civilian EMS?**

- The problem with providing a large volume of blood in the field is the system required to be able to put the blood out there into the prehospital environment. This requires a complicated system with many parts, including the possibility of inappropriate blood utilization, immune reactions, and wasted blood product.

### **Is cardiogenic shock only acute?**

- This is an excellent question! Patients who have marginal cardiac contractility indeed may have hypoperfusion on a more chronic basis. This is why we see patients who are sent home on inotropic drips to stimulate cardiac function. This question points out the need for a careful medical history to be taken of all patients as we look for the source of the shock condition.