SUBJECT: Empiric Use of TXA in Acutely Decompensating Trauma Patients **PAGE:** 1 of 1
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BACKGROUND:
There is debate about the effectiveness and risk-profile for TXA in hemorrhaging or brain-injured trauma patients. While infrequent, hyperfibrinolysis in these patients is highly lethal. The complications of concern with TXA typically manifest days after the acute decompensation or resuscitation. In most instances, ROTEM allows us to treat fibrinolysis in a directed fashion. However, there are times when the attending trauma surgeon may anticipate mortality or major morbidity if hemorrhage (exsanguination or intracranial) is not rapidly arrested. While hyperfibrinolysis will play a role in only a small portion of these events, treating it before the ROTEM results are available may be life-saving. Potential complications of TXA are mostly manageable and require patient survival to manifest.

INCLUSION:
Patients who are acutely decompensating from exsanguination or intra-cranial hemorrhage and for whom no ROTEM data is immediately available.
- Example 1: Massive transfusion on GSW abdomen expedited to OR
- Example 2: TBI patient booked for stat crani on HD 5 after an acute decompensation on progressive status

EXCLUSION:
Patients in whom recent ROTEM data is available, who have already received an appropriate dose of TXA, or in whom hemorrhage is not severe enough to warrant massive transfusion or craniotomy.

PROCEDURE:
1. Attending trauma surgeon will identify the patient as having a high likelihood of death or morbidity from uncontrolled hemorrhage.
2. Attending or proxy will order TXA 2 Gm IV (to be administered over 2 minutes)
3. TXA will be administered over 2 minutes.

Keypoint: ROTEM will be drawn as soon as possible, but administration of TXA should not wait for either the lab draw or results.