Major bleeding & haemorrhagic shock

Control the source. Resuscitate in parallel.

RESUSCITATION / ADULT TRAUMA

Persistent bleeding needs definitive control; a better blood pressure alone does not demonstrate haemostasis.

01 Recognise & activate

Activate the major haemorrhage pathway early. Assess bleeding sites, perfusion and the response to treatment. Send crossmatch, blood count, coagulation tests, blood gas and ionised calcium; repeat to follow the trajectory.

02 Stop the bleeding

Apply direct pressure; use a tourniquet for uncontrolled life-threatening limb bleeding. Seek urgent operative or interventional control. In a non-responder, limit imaging to what immediately changes the intervention.

03 Support clot formation

Use the local blood-component or factor-concentrate pathway. Prevent heat loss, warm resuscitation products and correct calcium deficiency. Move from initial empirical support to laboratory or viscoelastic guidance.

04 Give TXA promptly

For adults bleeding or at risk of significant bleeding: tranexamic acid within 3 hours of injury, 1 g IV over 10 minutes, then 1 g over 8 hours. Do not wait for viscoelastic results. Check prior dosing.

WATCH POINT Brain or spinal cord injury changes perfusion priorities. Set haemodynamic goals with the relevant team; avoid a universal low-pressure target.

DISCUSS WITH THE TEAM

If transfusion needs keep rising, what is the plan for source control and who owns it?

READ THE SOURCES

[1] European bleeding guideline, 6th ed. (2023), recommendations 2, 9, 13, 23-29, 31.
[2] NICE NG39 (2016), major trauma: haemorrhage and imaging, section 1.5.