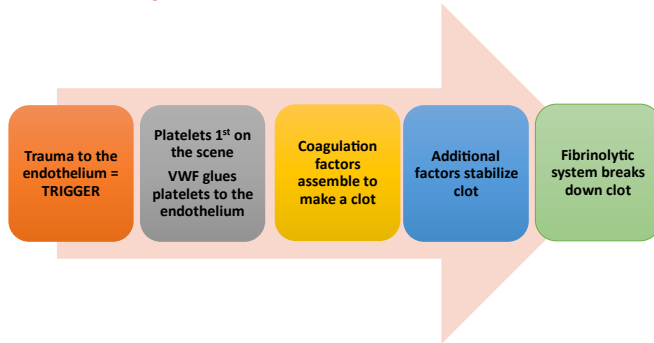




## Dr. Natasha Rupani, Dr. Michelle Sholzberg - Congenital Coag – VWD, Hemophilia

### Hemostasis Simplified



**The bleeding history is the most important TEST of hemostasis, using a validated bleeding assessment tool (BAT).**

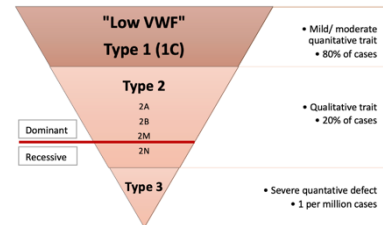
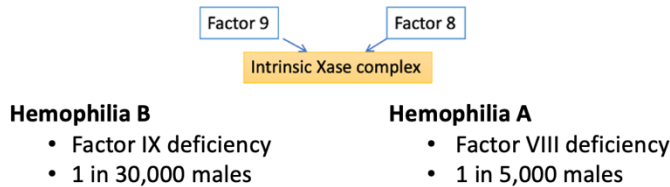
**A normal PT and aPTT does not rule out a bleeding disorder.**

### Von Willebrand Disease

Diagnosis: 1) Bleeding Symptoms, 2) Family History, 3) Laboratory Results

Bleeding Symptoms		Treatment
<b>Mucocutaneous</b> <ul style="list-style-type: none"> <li>Heavy menstrual bleeding</li> <li>Epistaxis</li> <li>Bruising</li> <li>Excessive bleeding from minor wounds</li> <li>GI bleeding</li> <li>Oral cavity/post-dental procedure</li> <li>Post-operative</li> <li>Post-partum</li> </ul>	<b>Musculoskeletal</b> (Type 2N, 3) <ul style="list-style-type: none"> <li>Hemarthrosis</li> <li>Soft tissue, muscle hematomas</li> </ul>	<b>Call Hematology/Transfusion Medicine</b> <u>Principle of treatment:</u> Increase or replace VWF <ul style="list-style-type: none"> <li>DDAVP (Desmopressin)</li> <li>VWF:FVIII Concentrate (Humate P, Wilate)</li> <li>Adjunctive anti-fibrinolytic agent (TXA)</li> </ul>

### Hemophilias:



Bleeding Symptoms	Treatment
<ul style="list-style-type: none"> <li>Musculoskeletal bleeding               <ul style="list-style-type: none"> <li>Hemarthrosis</li> <li>Intra-muscular hematoma</li> </ul> </li> <li>Mouth bleeding, epistaxis</li> <li>Intracranial bleeding</li> <li>Bleeding with trauma, procedures, surgery</li> <li>Heavy menstrual bleeding (symptomatic carriers)</li> </ul>	<b>Call Hematology/Transfusion Medicine</b> <u>Principle of treatment:</u> Replace deficient factor <ul style="list-style-type: none"> <li>Factor VIII: Xyntha, Kovaltry, Nuwiq, Adynovate, Jivi</li> <li>Factor IX: Benefix, Rebinyn</li> <li>DDAVP (Desmopressin) – mild hemophilia (FVIII&gt;10%)</li> </ul> <p>Non-factor therapies: Emicizumab</p> <ul style="list-style-type: none"> <li>Avoid PCC – risk of thrombosis</li> <li>Inhibitor present - rVIIa</li> <li>No inhibitor – FVIII concentrate</li> </ul> <p>Adjunctive anti-fibrinolytic agent (TXA)</p>

### Resources

- "[Principles of Management of Urgent Bleeding in Hemophilia](#)" - developed by Dr. Jerry Teitel
- [Blood Easy: Coagulation Simplified](#) – developed by ORBCoN
- [Illustrated Review of Bleeding Assessment Tools and Coagulation tests](#) (Elbaz, Sholzberg)



## Dr. Jeannie Callum, Massive Hemorrhage: Pathophysiology & Evidence Based Management

### Summary

Massive Hemorrhage Protocols are designed to ensure every patient receives coordinated, standardized and evidence-based care. The protocol should be activated promptly when faced with a massively bleeding patient – every 1 minute delay to the first RBC is associated with a 5% increase in mortality. But on the flip-side, activation is not required for every bleeding patient. Activation results in deployment of portering, critical care, and laboratory resources. Over-activation will result in unnecessary blood product wastage. Activate the protocol when faced with a patient with a critical injury (high speed collision, penetrating trauma, post-partum hemorrhage) and with marked hemodynamic instability. Most gastrointestinal hemorrhages can be managed with a call to the blood bank for uncrossmatched red blood cells. The protocol should be activated through a coordinated communication process similar to other patient emergencies. Once the trained team has been assembled, a physician lead should be explicitly designated and a communication lead designated (to coordinate care with portering and the laboratory). Once activated, the system should be fast enough to ensure the first red cell is commenced within 15 minutes. Tranexamic acid should be administered within 60 minutes of injury/activation, with the exception of gastrointestinal hemorrhage where it has been proven to be ineffective (and increases thromboembolic complications). Tranexamic acid is of no value after 3 hours. Blood work should be done at baseline and then every 1 hour and/or 4 units of red cells. Wherever possible, transfusions should be guided by the results of laboratory testing. Use blood warmers and active warming blankets to maintain patient temperature over 36°C at all times. Monitor the temperature either continuously or at a minimum of every 30 minutes. Terminate the protocol when hemorrhage control has been achieved, hemodynamics are improving, coagulation tests are trending in the right direction, and the rate of transfusion has slowed. Ensure blood is packed as delivered by the blood bank throughout resuscitation and return all blood products promptly as soon as they are no longer needed.

### Objectives

1. Explain the coagulation derangement seen with acute coagulopathy of trauma
2. Understand the key components of a Massive Hemorrhage Protocol
3. Review the science behind how we manage hemorrhaging patients



## Dr. Katerina Pavenski, Massive Hemorrhage Protocols: Real World Applications

<https://transfusionontario.org/en/provincial-massive-hemorrhage-toolkit/>

Large/Academic Hospital Setting
Adult Appendix B

NEED A MASSIVE HEMORRHAGE PROTOCOL?

NO  
NOT YET

1. ORDER 4 UNCROSSMATCHED RBC
2. REASSESS NEED FOR MHP

ANTICOAGULATION REVERSAL	
Warfarin	PCC 2000 units IV over 10 min Vitamin K 10mg IV over 10 min
Dabigatran (Pradaxa)	Idarucizumab 5g IV over 10 min
Apixaban (Eliquis) Rivaroxaban (Xarelto) Edoxaban (Lixiana)	PCC 2000 units IV over 10 min Repeat in 1 hour if bleeding continues
Heparins	Call pharmacy for dosing of protamine

MHP COOLER DELIVERY SEQUENCE	
Cooler 1	4 units ONeg RBC for women < 45 <i>All others receive OPos</i>
Cooler 2	4 units RBC 4 plasma
Cooler 3	4 units RBC 2 plasma 4g fibrinogen concentrate
Cooler 4+	4 units RBC 2 plasma

PLATELETS order if <50 or on antiplatelets  
FIBRINOGEN CONCENTRATE order 4g IV if <1.5

PATIENT STABLE AND HEMORRHAGE CONTROLLED

1. Deactivate as per local policy
2. Perform bedside termination checklist
3. Inform family member and SDM of needing MHP
4. Return unused MHP components to blood bank

Laboratory transfusion triggers  
(once results available or rate of bleeding controlled)

Value	Transfuse
Hgb < 80	RBCs
INR ≥ 1.8	Plasma 4 units
Fibrinogen < 1.5 <small>*Less than 2.0 for postpartum hemorrhage</small>	Fibrinogen concentrate 4g
Platelets < 50	Platelets 1 adult dose
Ionized calcium < 1.15	CaCl <sub>2</sub> 1g

If available, ROTEM triggers

Value	Transfuse
EXTEM CT > 80	Plasma 4 units
EXTEM A10 < 35	Platelets 1 adult dose
FIBTEM A10 < 8-10	Fibrinogen concentrate 4g

YES  
NEED IT NOW

1. MASSIVE BLOOD LOSS
2. HYPOTENSION
3. LIKELY NEED PLASMA

Or based on hospital activation criteria

CALL XXXX:  
INITIATE CODE TRANSFUSION

1. Control rapidly bleeding site (tourniquet)
2. IV/IO access
3. Tranexamic acid total dose of 2g IV / IO
4. 4U RBCs with rapid infuser
5. Limit use of crystalloids
6. Calcium chloride 1g IV
7. Keep patient temperature above 36°C
8. Obtain MHP blood work
9. Reverse anticoagulation
10. Call for definitive bleeding control (OR, angio, endoscopy)

EVERY HOUR REASSESS

1. Can MHP be turned off?  
Can laboratory guided transfusion be used instead?  
Is bleeding controlled?  
Stable hemodynamics?
2. Do we need to call for the next cooler?
3. Patient temperature >36°C
4. Collect q1h blood work
5. CaCl<sub>2</sub> 1g IV for every 4 RBC or ionized calcium < 1.15
6. Monitor for complications (hyperkalemia, volume overload)
7. Is resuscitation adequate? (hemodynamics, lactate, VBG)
8. Switch to group specific blood products, when able



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