b. Evidence of pelvic injury (such as instability)
4. Assess the patient's airway
5. Assess the patient's respiratory effort, if present, or for evidence of tension pneumothorax
6. Assess vital signs (pulse, blood pressure, respiratory rate, neurologic status assessment)

Treatment and Interventions

1. Manage massive hemorrhage. Refer to General Trauma Management Guideline for complete list of therapies for the treatment of massive hemorrhage, including the following:
   a. Place tourniquets for wounds amenable to tourniquet placement
   b. Use a combination of wound packing and direct pressure for junctional wounds or junctional tourniquets if available
   c. Place a pelvic binder on all patients with blunt or blast trauma suffering traumatic arrest
2. Manage the patient's airway. Refer to the Airway Management Guideline
3. Perform bilateral, rapid chest decompression
4. Establish intravenous access
5. Initiate volume resuscitation and adjunctive hemorrhage control measures (such as tranexamic acid (TXA)) en route to the hospital

Patient Safety Considerations

None noted

Notes/Educational Pearls

Key Considerations

1. Survival from traumatic cardiac arrest requires careful coordination between rapid prehospital assessment, EMS clinician treatment of reversible causes of traumatic cardiac arrest and transport that is rapid, but also allows maintenance of necessary therapies in a manner that is effective for patients as well as safe for EMS clinicians
2. Evidence for the benefit of CPR in traumatic cardiac arrest is limited. Treatment priorities should initially focus on control of massive hemorrhage (including management of pelvis fractures), airway management, and consideration of bilateral needle thoracostomy. If CPR is performed at all, it should be performed en route to the hospital but only if it can be performed in a safe and effective manner by EMS clinicians
3. Unless there is an immediate and correctable cause, patients suffering traumatic cardiac arrest have the best chance for survival when arrival time to a hospital is within minutes
4. If transport is initiated, consider the ACS-COT's Once the above treatments and interventions have been performed, patients should be transported to the closest appropriate hospital within the defined trauma system
5. In an effort to reduce on-scene time, consider IV/IO access and initiation of resuscitation during transport
6. Optimal choices for resuscitation are (in descending order as available) as follows: whole blood, balanced blood products (red blood cells (RBC), plasma), packed red blood cells alone, liquid, or freeze-dried plasma alone, no fluid resuscitation. Excessive crystalloid and colloid have little to no value and may in fact be harmful in hemorrhagic shock
7. Consider the duration of resuscitation and transport, contact online medical direction if available to discuss. If termination of resuscitation is advised, refer to the Termination of Resuscitation Efforts Guideline