**Traumatic Cardiac Arrest**

Think about the cause of the Arrest (HOT principles) and provide aggressive, nuanced treatment to address the likely cause.

**Hypovolaemia / Exsanguination**
- Control external haemorrhage
- Splint pelvis, reduce/splint fractures
- Rapid bolus of crystalloid (up to 2ltrs)
- Early TXA administration (after reversible causes addressed)

**Oxygenation**
- High flow oxygen
- Positive pressure ventilation (bag valve ventilation)
- SGA / Intubation (if within scope of practice)

**Tension Pneumothorax**
- Bilateral needle decompression if evidence/ suspicion of chest injuries (low threshold and consider mid-axillary placement if initially unsuccessful)
- Open thoracostomies if within scope of practice

**Tamponade**
- If penetrating trauma, consider thoracotomy capable team to scene or rapid conveyance to TU/MTC (thoracotomy should happen <10 mins from loss of signs of life)

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8% SURVIVAL TO DISCHARGE for TCA - ensure effective resuscitation!

Reasons not to start (default should be to commence resuscitation):
- Decapitation
- Massive cranial and cerebral destruction
- Hemihorpectomony or similar massive trauma
- Incineration >95% BSA

CHEST COMPRESSIONS AND ALS DRUGS SHOULD NOT BE A PRIORITY UNLESS THE PATHOLOGY IS LIKELY TO BE MEDICAL OR DUE TO HYPOXIA SECONDARY TO HEAD INJURY. BRIEFLY STOP COMPRESSIONS TO ALLOW FOR TREATMENT OF REVERSIBLE CAUSES, AVOID MECHANICAL CPR. IF PATIENT IS >60, SUSPECT MEDICAL ARREST WHICH MAY HAVE CAUSED THE PATIENT TO COLLAPSE AND SUSTAIN TRAUMA; IN WHICH CASE STANDARD ALS SHOULD BE COMMENCED.

Call CCD on Ch202 (press mode button then enter 202 and wait a couple of seconds for the radio to lock to talkgroup) priority request speech (press and hold soft key #) and discuss any assistance/advice required

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