San Joaquin County
Emergency Medical Services Agency

A DIVISION OF
HEALTH CARE SERVICES
AGENCY

Policy Memorandum 2025-01

DATE: April 18, 2025

TO: All Prehospital Personnel and Providers

FROM: Katherine Shafer, M.D., EMS Medical Director Initial KS
Jared Bagwell, EMS Director Initial JB

SUBJ.: Dosage increase for Tranexamic acid (TXA)

The purpose of this memorandum is to notify all prehospital personnel and providers that effective May 1, 2025 the dosage for TXA will increase to 2 grams I.V. push over one (1) minute or 2 grams in 100ml infusion over ten (10) minutes.

EMS Policy No. 4101. EMS Response Vehicle Medication and Equipment will not change. Minimum stock for ALS non transport will remain at 2 grams and ALS transport will remain at 4 grams.

Please see attached protocols for reference.

Should you have any questions regarding this protocol change please contact Paul Harper at pharper@sjgov.org or by phone at (209)468-6818.

Adult Trauma **ATRA-01**

Trauma

1. Place in spinal motion restriction if indicated.
2. See injury specific guidelines.
3. If bleeding, see injury specific guidelines.

Treatment #1- Symptomatic:
1. Monitor SpO2, if <94%, 1-15 LPM via NC or NRB, titrate to 94%.
2. Consider treating for pain. See protocol AGEN-03.

If loss of consciousness:
3. Obtain blood glucose level. If <70 mg/dL, see protocol ANRO-03.
4. Consider stroke screen. If positive, see protocol ANRO-01.

If chest pain:
5. Cardiac monitor.
6. Consider 12 lead ECG. Obtain if concern for medical emergency caused traumatic event or blunt trauma to chest.

Treatment #2- Grossly symptomatic or signs or shock:
1. Cardiac monitor.
2. Monitor SpO2, if <94%, O2 1-15 LPM via NC or NRB, titrate to 94%.
3. Consider treating for pain. See protocol AGEN-03.

If loss of consciousness or ALOC:
4. Obtain blood glucose level. If <70 mg/dL, see protocol ANRO-03.
5. Consider stroke screen. If positive, see protocol ANRO-01.

If chest injury:
6. Consider 12 lead ECG. Obtain if concern for medical emergency caused traumatic event or blunt trauma to chest.
7. Large bore IV x2, NS, TKO.
8. If SBP <90, NS 500ml rapid IVF bolus. Titrate to SBP >90, max of 1L.

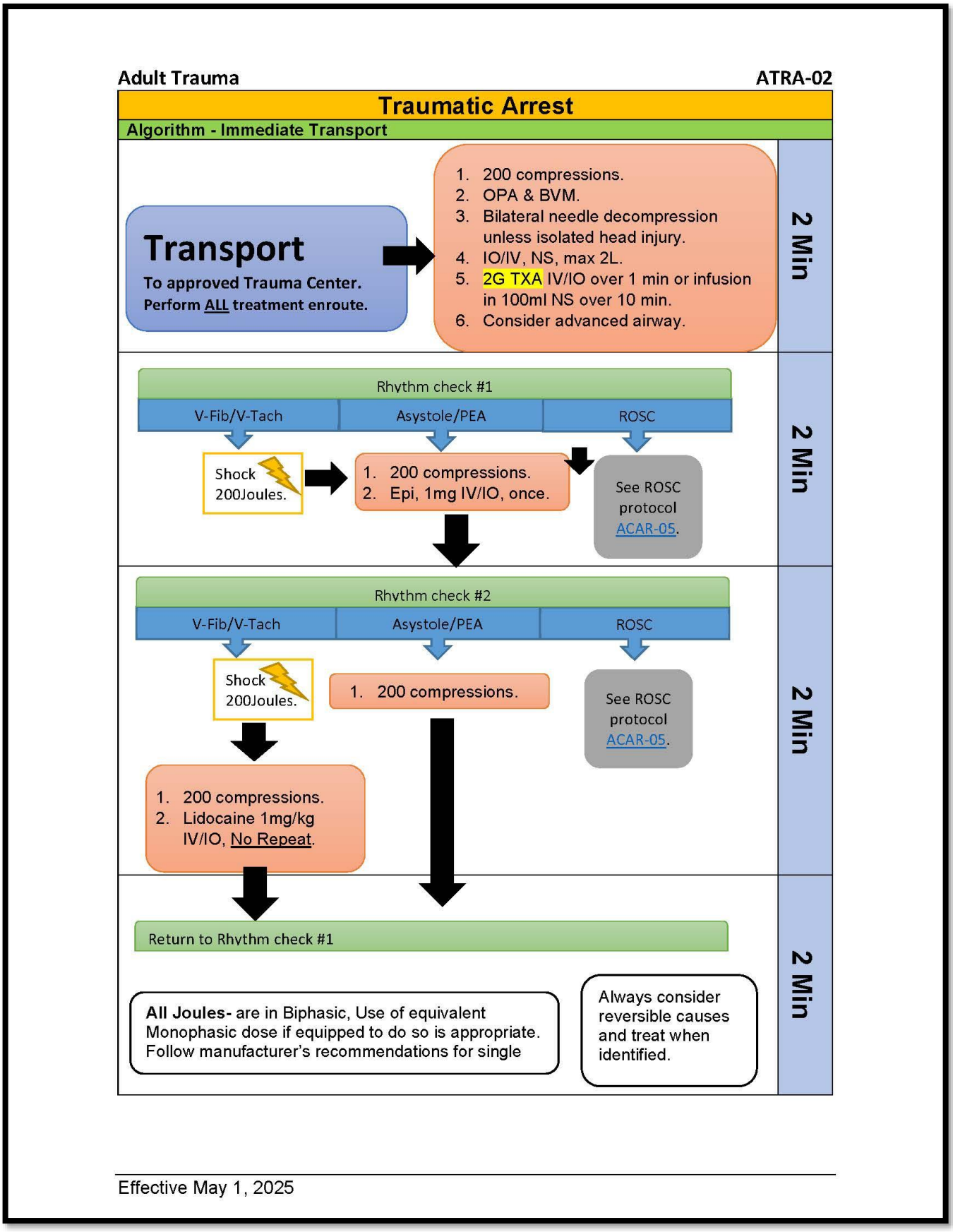
If after 1 L of NS, SBP<90
9. Epinephrine 10mcg 1:100,000 IV/IO every 3 min, titrate to SBP> 90.

For blunt or penetrating trauma to the torso:
10. 2 gm TXA IV/IO over 1 minute or infusion in 100ml NS over 10 min.

Considerations:
1. If brain injury is suspected, elevate the head of the patient as long as no signs of shock are present.
2. Head injured patients that require intubation (No gag reflex and cannot protect own airway AAIR-01) if time allows, pre-medicate head injured patients with fentanyl 2 mcg/kg IVP/IO prior to intubation.
3. Traumatic brain patients are especially sensitive to hypotension and hypoxia.
4. Transport patient in position of comfort if not in spinal precautions. Place pregnant patients in left lateral recumbent position.
5. If concern for spinal cord injury, patient should be laid flat. If patient is without thoracic or lumbar tenderness, may be placed in semi-fowler position no greater than 30 degrees.
6. All patients with a period of unconsciousness should be transported to an emergency department for evaluation.
7. If patient meets Trauma Triage Criteria, transport to approved trauma center.
8. Scene time should be **LESS THAN 10 MINUTES**

Base Hospital Orders

1. Consult Base Hospital if additional orders are needed or patient has atypical presentation.



Adult Trauma **ATRA-02**

Traumatic Arrest

Treatment - Immediate Transport

If patient meets criteria for Immediate Transport, begin transport to approved Trauma Center. Perform ALL treatment enroute. (0 min of CPR):

1. Start CPR at 100-120 compressions per minute.
2. Insert OPA.
3. Ventilate with BVM at 10 per minute.
4. Perform bilateral needle decompression unless isolated head injury.
5. IV/IO, NS, X2, WO, max 2 L,
6. 2G TXA, IV/IO over 1 min or infusion in 100ml NS over 10 min.
7. Consider advanced airways.

If after 200 compressions, (2 min of CPR):

1. **ROSC**- Initiate transport if not already transporting, see ROSC protocol ACAR-05.
2. **Asystole/PEA**-
   A. Continue CPR.
   B. Epinephrine 1mg, **1:10,000** IV/IO, once.
3. **VFib/VTach**-
   A. Continue CPR.
   B. Epinephrine 1mg, **1:10,000** IV/IO, once.
   C. Shock at 200 joules (or manufacturer's recommendation).

If after additional 200 compressions, (4 min of CPR):

1. **ROSC**- Initiate transport if not already transporting, see ROSC protocol ACAR-05.
2. **Asystole/PEA**-
   A. Continue CPR
3. **VFib/VTach**-
   A. Shock at 200 joules (or manufacturer's recommendation).
   B. Continue CPR.
   C. Lidocaine 1mg/kg IV/IO, once. No repeat.

Always consider reversible causes and treat when identified.

Considerations:
When mechanism of injury does not correlate with clinical condition, suggesting a non-traumatic cause of cardiac arrest, standard resuscitation measures should be followed. See ACAR-04, p. 36.

Base Hospital Orders

1. Consult Base Hospital if additional orders are needed or patient has atypical presentation.