MASSIVE TRANSFUSION

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While haemorrhage control prior to the need for massive transfusion is ideal, this is often not the case. The degree of injury and associated massive blood loss associated with war injuries may necessitate large-volume transfusion. The use of crystalloids to resuscitate exsanguinating patients is strongly discouraged, but the optimal ratio of blood products has not yet been ascertained. Massive transfusion protocols exist within most deployed units. The use of such a protocol in a UK role 3 facility , along with aggressive resuscitation and use of blood products, has been associated with improved trauma 18 outcomes. The success of such a protocol is highly dependent on a steady stream of blood products and reflects the sophis ticated transfusion infrastructure that should be woven into a deployed capability . Blood transfusion is increasingly administered in a more forward location (within both role 1 and role 2 environments) with limited volumes of blood transported to the point of w ounding by aeromedical response teams. Future resuscitativ strategies are under much scrutiny . The use of whole blood (and the possibility of ‘walking blood banks’) may be combined with alternatives to conventional blood components, which can join adequate oxygen carriage with positive or neutral e ff ects 19 on patient coagulation. MASSIVE TRANSFUSION

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