

EMERGENCY MEDICINE

Open Journal 

December 2019. Volume 5, Issue 1



EDITOR-IN-CHIEF

Chien-Chang Lee, MD, ScD

ASSOCIATE EDITORS

COL (RET) John McManus, MD, MBA, MCR, FACEP, FAAEM

Imoigele P. Aisiku, MD, MSCR, MBA, FACC

Robert Jude Strony, DO, RDMS, RVT

www.openventio.org

CONTENTS

Editorial

1. A Decision Support System is Needed for Rapid Triage of Chest Pain Patients Using High Sensitivity Troponin Testing-Based Algorithms e1-e2
– Chien-Chang Lee*, Cheng-Heng Liu, Sih-Shiang Huang and Cho-Han Chiang

Review

2. Prothrombin Complex Concentrates in Post-traumatic Hemorrhage: A Review 1-8
– Ozgur Karcioglu*, Ebru Yilmaz, Selman Yeniocak and Hakan Topacoglu

Short Communication

3. Dealing with Violent Dangerous Patients: The Medicolegal Pitfalls 9-11
– Navin Naidoo*

Editorial

A Decision Support System is Needed for Rapid Triage of Chest Pain Patients Using High Sensitivity Troponin Testing-Based Algorithms

Chien-Chang Lee, MD, ScD^{1*}; Cheng-Heng Liu, MD¹; Sih-Shiang Huang, MD²; Cho-Han Chiang²

¹Department of Emergency Medicine, National Taiwan University, Taipei 106, Taiwan

²Department of Medicine, College of Medicine, National Taiwan University, Taipei, Taiwan

*Corresponding author

Chien-Chang Lee, MD, ScD

Director, Department of Emergency Medicine, National Taiwan University Hospital, No. 7, Chung-Shan South Road, Taipei 100, Taiwan; Tel. +886-2-23123456 ext 62831;

Article information

Received: March 21st, 2019; Accepted: March 25th, 2019; Published: April 2nd, 2019

Cite this article

Lee C-C, Liu C-H, Huang S-S, Chiang C-H. A decision support system is needed for rapid triage of chest pain patients using high sensitivity troponin testing-based algorithms. *Emerg Med Open J.* 2019; 5(1): e1-e2. doi: [10.17140/EMOJ-5-e006](https://doi.org/10.17140/EMOJ-5-e006)

Cardiovascular disease is a leading cause of mortality and morbidity worldwide. In 2013, an estimated 8.14 million people died from acute myocardial infarction (AMI) globally.¹ Emergency department (ED) is the main portal of entry for patients with acute chest pain symptoms. Approximately 10% of all emergency department (ED) patients presented with chest pain complaint.² However, only 13-23.6% of these patients are finally diagnosed with AMI.³ Patients with segment (ST) elevation MI (STEMI) could be rapidly recognized by electrocardiogram (ECG) exam, but patients with non-ST elevation MI (NSTEMI) could not be efficiently excluded or included by contemporary cardiac troponin assays. Contemporary troponin assay could not detect the presence of cardiac troponins in the peripheral circulation until 6 to 8 hours after the onset of MI.⁴ Therefore, patients presenting to the ED with chest pain usually require serial troponin measurements over 6 to 8 hours before the possibility of MI can be safely excluded. Failure in early detection results in higher rate of complications and mortality. The delay in ruling out MI constitutes a major cause of ED crowding, and the delay in ruling in MI may lead to poor prognosis. It has been shown early evidence-based management, including antiplatelet treatment and revascularization, may decrease mortality, shorten hospitalization, and improve overall outcome.⁵

The introduction of high sensitive cardiac troponin (hs-cTn) assays in 2010 has shown promise to enhance the accuracy and efficiency of MI diagnosis in the ED tremendously.⁶ These assays measure cTn in the single digit range of nanograms per liter, about 10- to 100-fold lower than the contemporary cTn assays.⁷ This has led to the development of several hs-cTn-based accelerated diagnostic algorithms to triage patients with suspected acute coronary syndromes (ACS) efficiently and safely.⁶ Several accelerated diag-

nosis algorithms, such as 0-, 1-, or 2-hour algorithm, have been developed and implemented based on the high sensitivity nature of new generation troponins.⁸⁻¹⁰ One such promising algorithm is the 0/1-hour algorithm recommended by the European Society of Cardiology (ESC).¹¹ This algorithm combines assay-specific cutoff values of hs-cTn at presentation and the absolute 1-hour changes (0-1 delta) to rapidly rule out or rule in patients with NSTEMI. Thus, clinical decision could be made for patients who presented to the ED with suspected AMI or ACS in just 2 to 3 hours after ED presentation. Although concern has been raised regarding the safety of the 0/1-hour algorithm in patients with renal dysfunction, in a recent work, Twerenbold R showed the 0/1-hour algorithms using either high-sensitivity cardiac troponin T or troponin I can rule out MI rapidly and safely.¹² In addition, recent studies have shown combining HEART score or combining hs-cTnT and hs-cTnI may further enhance the accuracy of the rapid diagnosis algorithm.^{13,14}

Despite the rapid development of various high sensitivity troponin testing based accelerated diagnosis system, the implementation of the newly developed algorithms in ED have been slow. One of the big obstacle is the complexity of the algorithms that include several cutoff values of troponin at several time points. The addition of scoring systems and multiple markers strategy further complicates the decision process. Because the hospital central laboratory conventionally reports only the test results with reference value, an emergency physician therefore, has to memorize the complex algorithms. The 1-hour algorithm is a very good example that a clinical decision support system will help clinicians make evidence-supported decisions. A decision support system will help remind the various time points for blood sampling and also pro-

vide reference cutoff values of troponin tests at different time points.¹⁵ In addition, the system can also remind the physician with the update prognosis data in different decision groups and automatically calculates TIMI, GRACE or HEART scores. Up to date, such system is not commercially available, but the design and implementation of such system in the laboratory information system is not technically difficult. We call for the design of such a system to help emergency physicians make evidence-based decision in the era of information tsunami.

CONFLICTS OF INTEREST

The authors declare that they have no conflicts of interest.

REFERENCES

- Roth GA, Huffman MD, Moran AE, et al. Global and regional patterns in cardiovascular mortality from 1990 to 2013. *Circulation*. 2015; 132(17): 1667-1678. doi: [10.1161/CIRCULATIONAHA.114.008720](https://doi.org/10.1161/CIRCULATIONAHA.114.008720)
- Goodacre S, Cross E, Arnold J, Angelini K, Capewell S, Nicholl J. The health care burden of acute chest pain. *Heart*. 2005; 91(2): 229-230. doi: [10.1136/hrt.2003.027599](https://doi.org/10.1136/hrt.2003.027599)
- Bhuiya FA, Pitts SR, McCaig L. Emergency department visits for chest pain and abdominal pain: United States, 1999-2008. *NCHS data brief*. 2010; (43): 1-8.
- Macrae AR, Kavsak PA, Lustig V, et al. Assessing the requirement for the 6-hour interval between specimens in the American Heart Association Classification of Myocardial Infarction in Epidemiology and Clinical Research Studies. *Clin Chem*. 2006; 52(5): 812-818. doi: [10.1373/clinchem.2005.059550](https://doi.org/10.1373/clinchem.2005.059550)
- Neumann FJ, Sousa-Uva M, Ahlsson A, et al. 2018 ESC/EACTS guidelines on myocardial revascularization. *Eur Heart J*. 2018; 40(2): 87-165. doi: [10.1093/eurheartj/ehy394](https://doi.org/10.1093/eurheartj/ehy394)
- Twerenbold R, Boeddinghaus J, Nestelberger T, et al. Clinical use of high-sensitivity cardiac troponin in patients with suspected myocardial infarction. *J Am Coll Cardiol*. 2017; 70(8): 996-1012. doi: [10.1016/j.jacc.2017.07.718](https://doi.org/10.1016/j.jacc.2017.07.718)
- Garg P, Morris P, Fazlanie AL, et al. Cardiac biomarkers of acute coronary syndrome: From history to high-sensitivity cardiac troponin. *Intern Emerg Med*. 2017; 12(2): 147-155. doi: [10.1007/s11739-017-1612-1](https://doi.org/10.1007/s11739-017-1612-1)
- Body R, Carley SD, McDowell G, et al. Use of low level high sensitivity troponin to rule out acute myocardial infarction in the emergency department. *European Heart Journal*. Supplement 2010; 12: F111-F112.
- Reichlin T, Schindler C, Drexler B, et al. One-hour rule-out and rule-in of acute myocardial infarction using high-sensitivity cardiac troponin T. *Arch Intern Med*. 2012; 172(16): 1211-1218. doi: [10.1001/archinternmed.2012.3698](https://doi.org/10.1001/archinternmed.2012.3698)
- Reichlin T, Cullen L, Parsonage WA, et al. Two-hour algorithm for triage toward rule-out and rule-in of acute myocardial infarction using high-sensitivity cardiac troponin T. *Am J Med*. 2015; 128(4): 369-379.e364. doi: [10.1016/j.amjmed.2014.10.032](https://doi.org/10.1016/j.amjmed.2014.10.032)
- Roffi M, Patrono C, Collet JP, et al. 2015 ESC Guidelines for the management of acute coronary syndromes in patients presenting without persistent ST-segment elevation: Task force for the management of acute coronary syndromes in patients presenting without persistent ST-segment elevation of the European Society of Cardiology (ESC). *Eur Heart J*. 2016; 37(3): 267-315. doi: [10.1093/eurheartj/ehv320](https://doi.org/10.1093/eurheartj/ehv320)
- Twerenbold R, Badertscher P, Boeddinghaus J, et al. 0/1-Hour triage algorithm for myocardial infarction in patients with renal dysfunction. *Circulation*. 2018; 137(5): 436-451. doi: [10.1161/CIRCULATIONAHA.117.028901](https://doi.org/10.1161/CIRCULATIONAHA.117.028901)
- van der Linden N, Wildi K, Twerenbold R, et al. Combining high-sensitivity cardiac troponin I and cardiac troponin T in the early diagnosis of acute myocardial infarction. *Circulation*. 2018; 138(10): 989-999. doi: [10.1161/CIRCULATIONAHA.117.032003](https://doi.org/10.1161/CIRCULATIONAHA.117.032003)
- Ljung L, Lindahl B, Eggers KM, et al. A rule-out strategy based on high-sensitivity troponin and HEART score reduces hospital admissions. *Ann Emerg Med*. 2019; pii: S0196-0644(18)31529-4. doi: [10.1016/j.annemergmed.2018.11.039](https://doi.org/10.1016/j.annemergmed.2018.11.039)
- Castaneda C, Nalley K, Mannion C, et al. Clinical decision support systems for improving diagnostic accuracy and achieving precision medicine. *J Clin Bioinforma*. 2015; 5: 4. doi: [10.1186/s13336-015-0019-3](https://doi.org/10.1186/s13336-015-0019-3)

Review

Prothrombin Complex Concentrates in Post-traumatic Hemorrhage: A Review

Ozgur Karcioğlu, MD^{1*}; Ebru Yılmaz, MD²; Selman Yeniocak, MD³; Hakan Topacoglu, MD⁴

¹Department of Emergency Medicine, University of Health Sciences, Istanbul Education and Research Hospital, Istanbul, Turkey

²Department of Emergency Medicine, Nizip Community Hospital, Gaziantep, Turkey

³Department of Emergency Medicine, University of Health Sciences, Haseki Education and Research Hospital, Fatih, Istanbul, Turkey

⁴Department of Emergency Medicine, Duzce University, School of Medicine, Duzce, Turkey

*Corresponding author

Ozgur Karcioğlu, MD

Professor, Emergency Physician, Department of Emergency Medicine, University of Health Sciences, Istanbul Education and Research Hospital, PK 34098, Fatih, Istanbul, Turkey; Tel. +90.505.5252399; ORCID ID: 0000-0002-8814-6164; E-mail: okarcioğlu@gmail.com

Article information

Received: May 3rd, 2019; Revised: August 7th, 2019; Accepted: August 27th, 2019; Published: August 30th, 2019

Cite this article

Karcioğlu O, Yılmaz E, Yeniocak S, Topacoglu H. Prothrombin complex concentrates in post-traumatic hemorrhage: A review. *Emerg Med Open J*. 2019; 5(1): 1-8.

doi: [10.17140/EMOJ-5-152](https://doi.org/10.17140/EMOJ-5-152)

ABSTRACT

Prothrombin complex concentrates (PCC) has long been used to reverse vitamin K antagonists (VKA)-induced coagulopathy rapidly and safely. However, its use in trauma-induced coagulopathy (TIC) in patients not using VKA drugs is yet to be elucidated. This article is a narrative review and analysis of the most recent literature to analyse consequences, and intended effects associated with this treatment modality in TIC. Utilization of PCC was addressed in the literature data found by searches of databases. The indications, efficacy and outcomes associated with the use of the product were reviewed in the articles. Some studies point out promising results with respect to PCC use to overcome the VKA-related coagulopathy in victims of trauma. PCC may be a viable option for resuscitation in emergency and critical care in the management of severe hemodynamic deterioration induced by trauma, despite contradictory findings in the literature.

Keywords

Blood coagulation factor; Trauma; Hemorrhagic shock; Exsanguinating hemorrhage.

PROTHROMBIN COMPLEX CONCENTRATES FOR TRAUMATIC HEMORRHAGE

Trauma is an everlasting challenge to public health worldwide, and hemorrhage is the most common cause of potentially preventable death among victims of trauma. More specifically, one in every two deaths within the first day following injury result from hemorrhage and hemorrhagic shock can lead to post-resuscitation organ failure and related mortality.¹

Acquired deficiencies related to coagulation cascade are also blamed for the death toll among patients exposed to traumatic injuries. Alterations in prothrombin time (PT) and partial thromboplastin time (PTT) in trauma victims were described first in 2003.^{2,3} These disturbed levels in laboratory correlated with increased mortality and effectively changed the approach to trauma care nowadays.

Contemporary damage control resuscitation encompasses ratio-based transfusion of packed red blood cells, plasma and platelets. Although this approach is still viewed as the “gold standard” of trauma care, goal-directed algorithms directed by coagulation tests or viscoelastic studies may allow a better definition of any given patient’s coagulopathy.⁴ This strategy will allow a more individualized and targeted treatment modality. Prothrombin complex concentrate (PCC) are also advocated in many types of coagulopathy, especially those induced by drugs such as vitamin K antagonist (VKA) and direct oral anticoagulants.

The objective of this research is to highlight the usage characteristics and effects of PCC in trauma-induced coagulopathy (TIC). This article is a review and analysis of the most recent literature to analyse consequences, and intended effects associated with this treatment modality in TIC.

PROTHROMBIN COMPLEX CONCENTRATES: THE HISTORY AND BACKGROUND

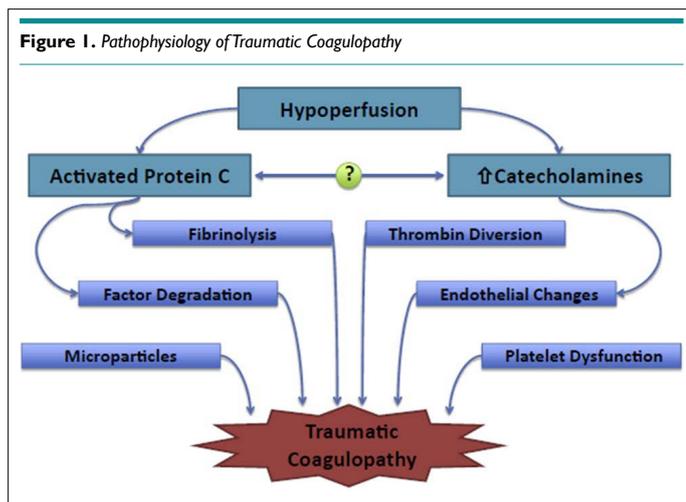
PCC is mostly used to mitigate effects of acute overdose of VKA. Patients with major bleeding while taking VKA-therapy eventually diagnosed with acute overdose of VKA-require rapid reversal of life-threatening coagulopathy. PCC was at first developed to treat hemophilia, the agent is now used for the expedient reversal of untoward high-levels of international normalized ratio (INR).⁵

Structure and Chemical Properties

Two types of PCC are available, the 3-factor and the 4-factor PCC. Literature data support that the 4-factor PCC has greater amounts of factor VII in conjunction with proteins which possess anti-coagulant properties (protein-C, Antithrombin, and heparin) than the 3-factor PCC.⁶ Four-factor PCC was suggested as the main element of the treatment strategy of VKA-induced bleeding by the current guidelines.^{7,8} Furthermore, there are concrete data from animal and human studies suggesting that 4F-PCC may have similar efficacy in relieving coagulopathy associated with the factor X_a inhibitors apixaban and rivaroxaban.^{9,10} Likewise, Harrison et al demonstrated that in patients with direct oral anticoagulant and VKA-associated intracranial hemorrhage treated with 4F-PCC had similar outcomes, without any thromboembolic adverse events.¹¹

Etiology and Pathophysiology of “Trauma-Induced Coagulopathy” (TIC)

Tissue damage and hemorrhage during trauma leads to shock, which, in turn, prompts hypoperfusion and systemic endotheliopathy (i.e., inflammation, platelet activation, reduced clotting factor activity, sympathoadrenal activation, and hyperfibrinolysis) (Figure 1).



The term “acute traumatic coagulopathy” refers to an endogenous entity, including all components of hemostasis that are triggered by tissue injury, hypoperfusion and shock and pa view the way to coagulation disorder in these patients.⁴ On the other hand, the consequences of shock are also affected by resuscitation-associated factors such as dilution of coagulation factors, hypothermia and acidosis, and also by trauma-associated factors including loss

of coagulation factors.¹² All of these effects culminate to trigger TIC as a multifaceted syndrome threatening many lives at any given time worldwide (Table 1).

<ul style="list-style-type: none"> - Endothelial dys function: elevated circulating levels of Syndecan-1 (a protein normally found in the glycocalyx of the endothelium) - Impaired platelet function - Relative thrombocytopenia - Microparticles: Thrombin-rich microparticles, Circulating endothelial-, Erythrocyte-, and leukocyte-derived microparticles
--

Kutcher et al reported a posttraumatic platelet dysfunction accompanied by a normal platelet count and standard clotting studies, with substantial implications for mortality. Multiple electrode impedance aggregometry accurately identified this dysfunctional platelets in trauma cases, and admission arachidonic acid and collagen responsiveness were found to be specific independent predictors of mortality.¹³

One-fourth of critically injured trauma patients are coagulopathic on arrival, increasing to close to 100% after receiving a massive transfusion.^{14,15} TIC is recognized to be a grave indicator, with greater transfusion need, higher levels of organ dysfunction, and a 4-fold increase in mortality.^{2,16} TIC also leads to poor outcomes with higher transfusion requirements; increased multi-organ system failure, increased hospital, intensive care, and ventilator days; and boosted death toll.^{17,18}

Evaluation of Trauma with Special Emphasis on TIC

Initial assessment of any trauma victim with bleeding should include exploration of traumatic haemorrhage taking patient’s physiology, anatomical injury pattern, mechanism of injury and the patient response to initial resuscitation into account (Grade 1C).¹² The shock index (SI) can be used as well, to assess the degree of hypovolaemic shock. (Grade 2C). Coagulopathy is encountered in every third of trauma victims.^{2,3,16}

Acute blood loss and resultant anemia associated with traumatic hemorrhage can impair the clotting mechanism as well, since anemia may render platelet marginalization more difficult thus slowing platelet activation.¹² Kutcher et al demonstrated that almost half of patients with serious injuries on presentation and more than 90% of patients at five days exhibited platelet dysfunction by multiplate impedance aggregometry.¹³ Interestingly, these patients can still have normal platelet counts. They also noted that platelet dysfunction on presentation was predictive of death in patients with multiple trauma.

Coagulopathy in trauma patients can be attributed to the traumatic damage or treatment effect of VKA. Balanced resuscitation is the essential strategy in those with TIC, but optimized ratios for resuscitation and monitoring protocols for transfusion are yet to be elucidated.¹⁹ In a very recent review, Harris et al cited that the current understanding of TIC is evolving and may see targeted blood component therapy incorporated early in trauma shock

resuscitation.²⁰ In another review, Cohen et al postulated that those with TIC had grave outcomes with transfusion rates, infection, thromboembolism, acute lung injury, organ failure, and mortality.¹⁹

Coagulopathy is demonstrated to have resulted in a substantially greater fatality rate in those patients with acute injuries.³ Recently, the strategy of “damage control resuscitation (DCR)” which encompasses expedient use of blood products with a greater ratio of packed red blood cells to FFP to platelets than the previous regimes is being used.^{21,22} This has been thought to lower the incidence of coagulopathy.^{22,23} Meanwhile, FFP and platelets were claimed to hasten the risks of volume overload and infections attributed to the transfusion of blood product.^{24,25} Likewise, Watson et al demonstrated that the potentials of acute lung injury is the greatest following FFP administration.²⁴

Matsushima et al reviewed the literature in 2015 and reported that there are small researches that put forth promising findings with regard to PCC utilization to overcome the VKA-related coagulopathy in trauma victims.²⁶ It remains to be answered if PCC can be a remedy in patients in need of massive transfusion.

Uncontrolled hemorrhage including TIC is still among the prominent factors underlying preventable death after trauma, and expedient diagnosis and aggressive management accompany inarguably better outcomes.

Current treatment concepts include the DCR concept, which advocates the empiric administration of blood products in predefined ratios and the concept of ‘Goal-directed Coagulation Therapy’ (GDCT) based on findings elicited from point-of-care testing.

GDCT based upon viscoelastic testing allows better characterization of the coagulopathy with supplementation of hemostatic agents and blood products according to the individual patient’s needs.²⁷

HOW MUCH FLUID TO GIVE? |

At first, a substantial amount of crystalloids is to be administered as a fluid challenge to the victim. Then, the response to this challenge should be criticized in the context of small-volume resuscitation and “permissive hypotension”, which is recommended in the trauma patients with hemorrhage. Permissive hypotension with a target systolic pressure of 80 to 90 mmHg –in conjunction with a mean arterial pressure of 50 to 60 mmHg –till bleeding is halted expediently after trauma without brain injury is a major strategy (Grade 1C).¹² In other circumstances, a Hb level of 7 to 9 g/dL can be targeted (Grade 1C). There is no evidence to support permissive hypotension as the main strategy in pediatric severe trauma. Therefore, permissive hypotension in trauma is not applicable to pediatric cases, which are defined as those under 15-years of age.

Imaging Studies to Guide Resuscitation

Focused assessment with sonography in trauma (FAST) ultrasou-

nd for the identification of –mostly abdominal– free fluid in patients with trauma. (Grade 1C). Ultrasound should also be viewed as a useful point-of-care guide for fluid deficits or responsiveness.

Multislice computed tomography (MSCT) allows physicians to be capable of timely diagnosis and expedient management of the patient with multiple injuries. Holstein et al pointed out that a Hb level lower than 8 g/dL in patients with pelvic trauma was associated with mortality.²⁸

Lactate levels on presentation are an important guide to therapy. The most commonly used cut-off point is 2 mmol/L and normalization of a high-level in a reasonable time (e.g., 24-hours) is an independent predictor of survival.

Fibrinogen in Trauma

Currently, it is a well-known fact that a reduction in blood fibrinogen levels are noted in up to two in every five hypotensive trauma victims.^{29,30} Schlimp et al postulated that presentation fibrinogen levels of major trauma patients have strong correlation with rapidly obtainable, routine laboratory parameters such as hemoglobin and base excess.³⁰ Therefore, fibrinogen is viewed as a key ingredient of multiple trauma treatment protocols.³¹

Treatment of Posttraumatic Coagulopathy

Nowadays, the only therapy supported by concrete evidence in patients with TIC is tranexamic acid (TXA) acting as an antifibrinolytic in order to decrease resultant death toll.³²⁻³⁵ Furthermore, TXA is usually given empirically because there are suspicion about the accuracy of diagnostic workup to address hyperfibrinolysis in victims of trauma.³⁶

CRASH-2 trial (Clinical Randomisation of an Antifibrinolytic in Significant Haemorrhage), pointed out that management of bleeding trauma cases with TXA leads to a more favorable outcome. In combat casualties, empiric use of TXA showed the greatest benefit observed in patients who subsequently required a massive transfusion.³³

In the treatment of posttraumatic coagulopathy, there are two different modalities recommended which follow:

- a. Damage control resuscitation approach, which encompasses the empiric administration of blood products and hemostatic agents in predefined ratios or
- b. A targeted approach directed by bedside viscoelastic studies. Current data suggest that a ratio of pRBCs: plasma: platelets of 1:1:1 in massive transfusion may be favorable along with improved outcomes.

DO WE NEED TO INFUSE PCC TO THIS PARTICULAR PATIENT? |

In 2017, Balendran et al researched on a point-of-care prothrom-

bin time test (POC PT) as a more practical option in detecting those with reduced prothrombin activity.³⁷ They concluded that the test represented a fast, simple, and mobile technique to guide PCC or Recombinant human prothrombin (MEDI8111) therapy in bleeding victims of trauma. Although the study is now limited to preclinical phase, it can provide the rationale for future clinical validation of the test to support MEDI8111 development and future clinical use in the management of trauma.

Effect of PCC in TIC

Exsanguination is the most widespread cause of death in trauma.³⁸ Replacement of factors is essential in the correction of TIC. For a long time, FFP is being used to mitigate the effects of TIC in the acute setting.

Jehan et al conducted a retrospective analysis of prospectively maintained database of coagulopathic trauma patients to compare 4-PCC+FFP *vs.* FFP alone for the treatment of TIC.³⁹ They reported that FFP is associated with the rapid reversal of INR (373 *vs.* 955 min; $p=0.001$) and reduction in transfusion requirements as compared to FFP alone. The component therapy of 4-PCC also resulted in a reduction in pRBC units (7 *vs.* 9 units; $p=0.04$), and FFP units (5 *vs.* 7 units; $p=0.03$) transfused than in those managed only with FFP. 4-PCC as a component therapy along with FFP is superior to FFP alone for the reversal of TIC. PCC is included in the advocated strategy for the acute reversal of VKA-effect in the European guidelines on the management of perioperative and posttraumatic hemorrhage.¹²

Baskaran et al cited that PCC has an off label use in the setting of trauma with massive transfusion.⁴⁰ Some studies have shown better INR reduction with PCC+FFP compared to FFP alone.⁴¹

It is important to remember that PCC does not contain factor V and may not be sufficient as a single agent in traumatic causes requiring massive transfusions.⁴⁰ Many prospective clinical researches have linked early TIC to protein-C depletion (activated protein-C elevation), and boosted potential of acute lung injury, ventilator-associated pneumonia, multisystem organ failure, and death.^{18,42}

Thromboelastometry (TEM) is useful to guide individualised goal-directed coagulation therapy in patients with traumatic coagulopathy.^{43,44}

Head Injury

The usefulness of PCC has been demonstrated, with evidence of reduced haematoma formation in patients with head injury,^{45,46} and is preferable to FFP for the rapid reversal of the effects of VKAs.⁴⁷⁻⁴⁹

ANY DRAWBACKS?

The propensity of thrombosis-related disorders attributed to infu-

sion of PCC should be weighed against the necessity for expedient reversal of coagulopathy.⁵⁰ Of note, thromboembolic events are encountered more frequently in trauma patients with the administration of 3-F PCC than with 4-F PCC.⁵¹

The risk of thrombosis may be more substantial with the use of “activated PCC” (aPCC) as compared to non-activated PCC⁵² due to the presence of activated factor IX, because the PCC infusion precipitates thrombogenicity at the level of factor X activation as an ingredient of aPCC.⁵³

Alternative Agents in the Treatment of TIC

The routine use of TXA in the posttraumatic hemorrhagic shock was not been sufficiently evidenced for robust recommendations.⁵⁴ Porta et al investigated the efficacy of TXA and PCC on TIC with a severe metabolic acidosis and compare the efficacy of PCC versus FFP to reverse a dilutional coagulopathy.⁵⁵ They noted that TXA and PCC appear to act favorably in correcting TIC *in vitro*, and TXA had no loss of function in metabolic acidosis.

Safety Issues

The safety of PCC has been studied by many researchers for the recent decades. Thrombotic events are recognized as the main adverse effects of the treatment and have been postulated to increase in patients treated with higher doses PCC.⁵⁶

Dosing Issues

PCC formulations used by different brands have a major issue of being non-standardized. Different sources of PCC are standardized based on factor IX levels. The main concern is their compositional differences whose effect on the outcomes are not established clearly.⁵⁷ Some sources of PCC supply a low level of factor VII, which are called 3 F-PCC. These 3 F-PCC are thought to be less efficacious in the treatment of VKAIC.⁵⁸

Khorsand et al performed a systematic review to describe the currently used PCC dosing strategies and to present their efficacy.⁵⁹ They found no evidence that one dosing strategy is superior. Huynh et al. compared PCC doses of 35 IU/kg with low-dose (25 IU/kg) in correction of their first INR less than 1.5 in adult patients with warfarin-associated traumatic brain injury.⁶⁰ Moderately dosed PCC (35 IU/kg) was associated with a higher percentage of INR reversal, compared to the treatment with a lower dosage of 25 IU/kg in this group of trauma victims.

Recently, Abdoellakhan et al examined a fixed 1000 IU fIX PCC dosing protocol for ICH, in comparison to a variable dose approach to achieve an INR ≤ 1.5 .⁶¹ The fixed-dose protocol necessitates additional PCC infusions more frequently to achieve the target INR. They concluded that implementation of a fixed dose of 1000 IU fIX cannot be recommended for VKA-related ICH.

Use in Traumatic Brain Injury and ICH

Annually almost 1% of all VKA users develops an intracranial hemorrhage (ICH).⁶² Most guidelines from developed countries recommend administration of 4-F PCC to reverse VKA-therapy in ICH. These recommendations are deprived of consensus on PCC doses or the target INR to be achieved.⁶³

Steiner et al assessed the safety and efficacy of FFP versus PCC in patients with VKA-ICH.⁶⁴ In patients with VKA-ICH, 4F PCC can act more favorably than FFP in improving the INR, which appears to be linked with slower enlargement of haematoma. It is also known that the efficacy of PCC on clinical outcomes are yet to be proven, despite the available data are in favor of the utilization of PCC over FFP in intracranial haemorrhage related to VKA. Likewise, PCC provides a much more rapid reversal of coagulopathy than standard treatment with only FFP and vitamin K in geriatric trauma patients with ICH.⁴⁵

Comparison of PCC with FFP

PCC has practical and theoretical advantages to FFP, as it can be used more rapidly and it does not warrant to be thawed or cross-match of blood groups. Goldstein et al compared the efficiency and safety of 4-F PCC with that of FFP in 181 patients with VKAIC who underwent urgent surgical or invasive procedures.⁴⁸ They wrote that 4F-PCC is better than plasma for rapid INR reversal and effective haemostasis in those needing VKA reversal before surgical or invasive procedures (Table 2).

Table 2. Properties of Prothrombin Complex Concentrates (Pcc) and Fresh Frozen Plasma (Ffp) Derived from Published Data so Far

	PCC	FFP
Feasibility-ease of use	+++	+
Cost-effectiveness	+++	+
Volume loading	Loads less volume	Loads more volume
Onset of efficacy	Sooner	Later
INR reversal	Morerapid	
Time taken for completion of treatment	Morerapid	
Cardiopulmonary Adverse effects	None	

CONCLUSION

PCC compounds has long been used to reverse coagulopathy following use of VKA. However, its use in TIC in patients not using VKA prescriptions has not been clarified. Some literature data yielded promising results with respect to PCC use to overcome the VKA-related coagulopathy in victims of trauma.

PCC may be a viable option for resuscitation in emergency and critical care in the management of severe hemodynamic deterioration induced by trauma. PCC has practical and theoretical advantages to FFP, as it can be used more rapidly and it does not

warrant to be thawed or cross-match of blood groups. TEM can be used to guide individualised therapy in patients with TIC. The indications, efficacy and outcomes associated with the use of PCC in the setting of trauma including scenarios involving pure ICH and multiple trauma are yet to be thoroughly revised.

CONFLICTS OF INTEREST

The authors declare that they have no conflicts of interest.

REFERENCES

- Kauvar DS, Lefering R, Wade CE. Impact of hemorrhage on trauma outcome: An overview of epidemiology, clinical presentations, and therapeutic considerations. *J Trauma*. 2006; 60(6): S3-S11. doi: 10.1097/01.ta.0000199961.02677.19
- Brohi K, Singh J, Heron M, Coats T. Acute traumatic coagulopathy. *J Trauma*. 2003; 54(6): 1127-1130. doi: 10.1097/01.TA.0000069184.82147.06
- MacLeod JB, Lynn M, McKenney MG, Cohn SM, Murtha M. Early coagulopathy predicts mortality in trauma. *J Trauma*. 2003; 55(1): 39-44. doi: 10.1097/01.TA.0000075338.21177.EF
- Caspers M, Maegele M, Fröhlich M. Current strategies for hemostatic control in acute trauma hemorrhage and trauma-induced coagulopathy. *Expert Rev Hematol*. 2018; 11: 987-995. doi: 10.1080/17474086.2018.1548929
- Hellstern P, Halbmayer W-M, Köhler M, Seitz R, Müller-Berghaus G. Prothrombin complex concentrates: Indications, contraindications, and risks: A task force summary. *Thromb Res*. 1999; 95(4): S3-S6. doi: 10.1016/s0049-3848(99)00077-8
- Grottke O, Levy JH. Prothrombin complex concentrates in trauma and perioperative bleeding. *Anesthesiology*. 2015; 122(4): 923-931. doi: 10.1097/ALN.0000000000000608
- Keeling D, Baglin T, Tait C, et al. Guidelines on oral anticoagulation with warfarin - fourth edition. *Br J Haematol*. 2011; 154: 311-324. doi: 10.1111/j.1365-2141.2011.08753.x
- Holbrook A, Schulman S, Witt DM, et al. Evidence-based management of anticoagulant therapy: Antithrombotic therapy and prevention of thrombosis, 9th ed: American College of Chest Physicians Evidence-Based Clinical Practice Guidelines. *Chest*. 2012; 141: e152S-e184S. doi: 10.1378/chest.11-2295
- Martin AC, Le Bonniec B, Fischer AM, et al. Evaluation of recombinant activated factor VII, prothrombin complex concentrate, and fibrinogen concentrate to reverse apixaban in a rabbit model of bleeding and thrombosis. *Int J Cardiol*. 2013; 168: 4228-4233. doi: 10.1016/j.ijcard.2013.07.152
- Marlu R, Hodaj E, Paris A, Albaladejo P, Crackowski JL, Perrod G. Effect of non-specific reversal agents on anticoagulant

- activity of dabigatran and rivaroxaban: A randomized crossover ex-vivo study in healthy volunteers. *Thromb Haemost.* 2012; 108: 217-247. doi: [10.1160/TH12-03-0179](https://doi.org/10.1160/TH12-03-0179)
11. Harrison SK, Garrett JS, Kohman KN, Kline JA. Comparison of outcomes in patients with intracranial hemorrhage on factor Xa inhibitors versus vitamin K antagonists treated with 4-factor prothrombin complex concentrate. *Proc (Bayl Univ Med Cent)*. 2018; 31: 153-156. doi: [10.1080/08998280.2018.1440858](https://doi.org/10.1080/08998280.2018.1440858)
12. Spahn DR, Bouillon B, Cerny V, et al. Management of bleeding and coagulopathy following major trauma: An updated European guideline. *Crit Care.* 2013; 17(2): R76. doi: [10.1186/cc12685](https://doi.org/10.1186/cc12685)
13. Kutcher ME, Redick BJ, McCreery RC, et al. Characterization of platelet dysfunction after trauma. *J Trauma Acute Care Surg.* 2012; 73(1): 13-19. doi: [10.1097/TA.0b013e318256deab](https://doi.org/10.1097/TA.0b013e318256deab)
14. Floccard B, Rugeri L, Faure A, et al. Early coagulopathy in trauma patients: An on-scene and hospital admission study. *Injury.* 2012; 43(1): 26-32. doi: [10.1016/j.injury.2010.11.003](https://doi.org/10.1016/j.injury.2010.11.003)
15. Brohi K, Cohen MJ, Ganter MT, et al. Acute coagulopathy of trauma: Hypoperfusion induces systemic anticoagulation and hyperfibrinolysis. *J Trauma.* 2008; 64(5): 1211-1217. doi: [10.1097/TA.0b013e318169cd3c](https://doi.org/10.1097/TA.0b013e318169cd3c)
16. Maegele M, Lefering R, Yucel N, et al. Early coagulopathy in multiple injury: an analysis from the German Trauma Registry on 8724 patients. *Injury.* 2007; 38(3): 298-304. doi: [10.1016/j.injury.2006.10.003](https://doi.org/10.1016/j.injury.2006.10.003)
17. Cohen MJ, Bir N, Rahn P, et al. Protein C depletion early after trauma increases the risk of ventilator-associated pneumonia. *J Trauma.* 2009; 67(6): 1176-1181. doi: [10.1097/TA.0b013e3181c1c1bc](https://doi.org/10.1097/TA.0b013e3181c1c1bc)
18. Cohen MJ, Call M, Nelson M, et al. Critical role of activated protein C in early coagulopathy and later organ failure, infection and death in trauma patients. *Ann Surg.* 2012; 255(2): 379-385. doi: [10.1097/SLA.0b013e318235d9e6](https://doi.org/10.1097/SLA.0b013e318235d9e6)
19. Cohen MJ, Christie SA. Coagulopathy of trauma. *Crit Care Clin.* 2017; 33: 101-118. doi: [10.1016/j.ccc.2016.08.003](https://doi.org/10.1016/j.ccc.2016.08.003)
20. Harris T, Davenport R, Mak M, Brohi K. The evolving science of trauma resuscitation. *Emerg Med Clin N Am.* 2018; 36: 85-106. doi: [10.1016/j.emc.2017.08.009](https://doi.org/10.1016/j.emc.2017.08.009)
21. Rowell SE, Barbosa RR, Diggs BS, et al. Effect of high product ratio massive transfusion on mortality in blunt and penetrating trauma patients. *J Trauma.* 2011; 71: S353-S357. doi: [10.1097/TA.0b013e318227ef53](https://doi.org/10.1097/TA.0b013e318227ef53)
22. Holcomb JB, Zarzabal LA, Michalek JE, et al. Increased platelet: RBC ratios are associated with improved survival after massive transfusion. *J Trauma.* 2011; 71: S318-S328. doi: [10.1097/TA.0b013e318227edbb](https://doi.org/10.1097/TA.0b013e318227edbb)
23. Duchesne JC, McSwain Jr NE, Cotton BA, et al. Damage control resuscitation: The new face of damage control. *J Trauma.* 2010; 69: 976-990. doi: [10.1097/TA.0b013e3181f2abc9](https://doi.org/10.1097/TA.0b013e3181f2abc9)
24. Watson GA, Sperry JL, Rosengart MR, et al. Fresh frozen plasma is independently associated with a higher risk of multiple organ failure and acute respiratory distress syndrome. *J Trauma.* 2009; 67: 221-227. doi: [10.1097/TA.0b013e3181ad5957](https://doi.org/10.1097/TA.0b013e3181ad5957)
25. Inaba K, Branco BC, Rhee P, et al. Impact of the duration of platelet storage in critically ill trauma patients. 2011; 71: 1766-1773. doi: [10.1097/TA.0b013e31823bdbf9](https://doi.org/10.1097/TA.0b013e31823bdbf9)
26. Matsushima K, Benjamin E, Demetriades D. Prothrombin complex concentrate in trauma patients. *Am J Surg.* 2015; 209: 413-417. doi: [10.1016/j.amjsurg.2014.08.019](https://doi.org/10.1016/j.amjsurg.2014.08.019)
27. Maegele M, Nardi G, Schochl H. Hemotherapy algorithm for the management of trauma-induced coagulopathy: The German and European perspective. *Curr Opin Anesthesiol.* 2017; 30: 257-264. doi: [10.1097/ACO.0000000000000433](https://doi.org/10.1097/ACO.0000000000000433)
28. Holstein JH, Culemann U, Pohlemann T, Working Group Mortality in Pelvic Fracture P. What are predictors of mortality in patients with pelvic fractures? *Clin Orthop Relat Res.* 2012; 470(8): 2090-2097. doi: [10.1007/s11999-012-2276-9](https://doi.org/10.1007/s11999-012-2276-9)
29. Rourke C, Curry N, Khan S, et al. Fibrinogen levels during trauma hemorrhage, response to replacement therapy, and association with patient outcomes. *J Thromb Haemost.* 2012; 10: 1342-1351. doi: [10.1111/j.1538-7836.2012.04752.x](https://doi.org/10.1111/j.1538-7836.2012.04752.x)
30. Schlimp CJ, Voelckel W, Inaba K, et al. Estimation of plasma fibrinogen levels based on hemoglobin, base excess and injury severity score upon emergency room admission. *Crit Care.* 2013; 17(4): R137. doi: [10.1186/cc12816](https://doi.org/10.1186/cc12816)
31. Novak A, Stanworth SJ, Curry N. Do we still need cryoprecipitate? Cryoprecipitate and fibrinogen concentrate as treatments for major hemorrhage — how do they compare? *Expert Rev Hematol.* 2018; 11: 351-360. doi: [10.1080/17474086.2018.1458610](https://doi.org/10.1080/17474086.2018.1458610)
32. Roberts I, Shakur H, Coats T, et al. The CRASH-2 trial: A randomised controlled trial and economic evaluation of the effects of tranexamic acid on death, vascular occlusive events and transfusion requirement in bleeding trauma patients. *Health Technol Assess.* 2013; 17(10): 1-79. doi: [10.3310/hta17100](https://doi.org/10.3310/hta17100)
33. Morrison JJ, Dubose JJ, Rasmussen TE, et al. Military application of tranexamic acid in trauma emergency resuscitation (MATTERs) study. *Arch Surg.* 2012; 147(2): 113-119. doi: [10.1001/archsurg.2011.287](https://doi.org/10.1001/archsurg.2011.287)
34. Morrison JJ, Dubose JJ, Rasmussen TE, et al. Association of cryoprecipitate and tranexamic acid with improved survival following wartime injury: Findings from the MATTERS II Study. *JAMA Surg.* 2013; 148(3): 218-225. doi: [10.1001/jamasurg.2013.764](https://doi.org/10.1001/jamasurg.2013.764)

35. Cole E, Davenport R, Willett K, et al. Tranexamic acid use in severely injured civilian patients and the effects on outcomes: a prospective cohort study. *Ann Surg.* 2015; 261(2): 390-394. doi: [10.1097/SLA.0000000000000717](https://doi.org/10.1097/SLA.0000000000000717)
36. Rossaint R, Bouillon B, Cerny V, et al. The European guideline on management of major bleeding and coagulopathy following trauma. *Crit Care.* 2016; 20: 100. doi: [10.1186/s13054-016-1265-x](https://doi.org/10.1186/s13054-016-1265-x)
37. Balendran CA, Henderson N, Olsson M, Lövgren A, Hansson KM. Preclinical evaluation of point-of-care prothrombin time as a biomarker test to guide prothrombin replacement therapy in coagulopathic bleeding. *Res Pract Thromb Haemost.* 2017; 1(2): 252-258. doi: [10.1002/rth2.12027](https://doi.org/10.1002/rth2.12027)
38. Curry N, Hopewell S, Dorée C, Hyde C, Brohi K, Stanworth S. The acute management of trauma hemorrhage: A systematic review of randomized controlled trials. *Crit Care.* 2011; 15(2): R92. doi: [10.1186/cc10096](https://doi.org/10.1186/cc10096)
39. Jehan F, Aziz H, O'Keeffe T, et al. The role of 4-factor prothrombin complex concentrate (4-PCC) in coagulopathy of trauma: A propensity matched analysis. *J Trauma Acute Care Surg.* 2018; 85(1): 18-24. doi: [10.1097/TA.0000000000001938](https://doi.org/10.1097/TA.0000000000001938)
40. Baskaran J, Cassagnol M. *Prothrombin Complex Concentrate*. Florida, USA: Stat Pearls Publishing; 2019.
41. Sellers W, Bendas C, Toy F, et al. Utility of 4-factor prothrombin complex concentrate in trauma and acute-care surgical patients. *J Am Osteopath Assoc.* 2018; 118(12): 789-797. doi: [10.7556/jaoa.2018.171](https://doi.org/10.7556/jaoa.2018.171)
42. Cohen MJ, Kutcher M, Redick B, et al. Clinical and mechanistic drivers of acute traumatic coagulopathy. *J Trauma Acute Care Surg.* 2013; 75(1 Suppl 1): S40-S47. doi: [10.1097/TA.0b013e31828fa43d](https://doi.org/10.1097/TA.0b013e31828fa43d)
43. Schöchl H, Nienaber U, Maegele M, et al. Transfusion in trauma: thromboelastometry-guided coagulation factor concentrate-based therapy versus standard fresh frozen plasma-based therapy. *Crit Care.* 2011; 15(2): R83. doi: [10.1186/cc10078](https://doi.org/10.1186/cc10078)
44. Ponschab M, Voelckel W, Pavelka M, Schlimp CJ, Schöchl H. Effect of coagulation factor concentrate administration on ROTEM(R) parameters in major trauma. *Scand J Trauma Resusc Emerg Med.* 2015; 23: 84. doi: [10.1186/s13049-015-0165-4](https://doi.org/10.1186/s13049-015-0165-4)
45. Edavettal M, Rogers A, Rogers F, Horst M, Leng W. Prothrombin complex concentrate accelerates international normalized ratio reversal and diminishes the extension of intracranial hemorrhage in geriatric trauma patients. *Am Surg.* 2014; 80(4): 372-376.
46. Huttner HB, Schellinger PD, Hartmann M, et al. Hematoma growth and outcome in treated neurocritical care patients with intracerebral hemorrhage related to oral anticoagulant therapy: Comparison of acute treatment strategies using vitamin K, fresh frozen plasma, and prothrombin complex concentrates. *Stroke.* 2006; 37: 1465-1470. doi: [10.1161/01.STR.0000221786.81354.d6](https://doi.org/10.1161/01.STR.0000221786.81354.d6)
47. Chai-Adisaksopha C, Hillis C, Siegal DM, et al. Prothrombin complex concentrates versus fresh frozen plasma for warfarin reversal: A systematic review and meta-analysis. *Thromb Haemost.* 2016; 116(5): 879-890. doi: [10.1160/TH16-04-0266](https://doi.org/10.1160/TH16-04-0266)
48. Goldstein JN, Refaai MA, Milling TJ Jr, et al. Four-factor prothrombin complex concentrate versus plasma for rapid vitamin K antagonist reversal in patients needing urgent surgical or invasive interventions: A phase 3b, open-label, non-inferiority, randomised trial. *Lancet.* 2015; 385(9982): 2077-2087. doi: [10.1016/S0140-6736\(14\)61685-8](https://doi.org/10.1016/S0140-6736(14)61685-8)
49. Sarode R, Milling TJ Jr, Refaai MA, et al. Efficacy and safety of a 4-factor prothrombin complex concentrate in patients on vitamin K antagonists presenting with major bleeding: A randomized, plasma-controlled, phase IIIb study. *Circulation.* 2013; 128(11): 1234-1243. doi: [10.1161/CIRCULATIONAHA.113.002283](https://doi.org/10.1161/CIRCULATIONAHA.113.002283)
50. Park MS, Owen BA, Ballinger BA, et al. Quantification of hypercoagulable state after blunt trauma: Microparticle and thrombin generation are increased relative to injury severity, while standard markers are not. *Surgery.* 2012; 151(6): 831-836. doi: [10.1016/j.surg.2011.12.022](https://doi.org/10.1016/j.surg.2011.12.022)
51. Mangram A, Oguntodu OF, Dzandu JK, et al. Is there a difference in efficacy, safety, and cost-effectiveness between 3-factor and 4-factor prothrombin complex concentrates among trauma patients on oral anticoagulants? *J Crit Care.* 2016; 33: 252-256. doi: [10.1016/j.jcrc.2016.02.018](https://doi.org/10.1016/j.jcrc.2016.02.018)
52. Turpie AG, Kreutz R, Llau J, Norrving B, Haas S. Management consensus guidance for the use of rivaroxaban--an oral, direct factor Xa inhibitor. *Thromb Haemost.* 2012; 108(5): 876-886. doi: [10.1160/TH12-03-0209](https://doi.org/10.1160/TH12-03-0209)
53. Philippou H, Adami A, Lane DA, et al. High purity factor IX and prothrombin complex concentrate (PCC): Pharmacokinetics and evidence that factor IXa is the thrombogenic trigger in PCC. *Thromb Haemost.* 1996; 76(1): 23-28. doi: [10.1055/s-0038-1650516](https://doi.org/10.1055/s-0038-1650516)
54. Napolitano LM, Cohen MJ, Cotton BA, et al. Tranexamic acid in trauma: How should we use it? *J Trauma Acute Care Surg.* 2013; 74(6): 1575-1586. doi: [10.1097/TA.0b013e318292cc54](https://doi.org/10.1097/TA.0b013e318292cc54)
55. Porta CR, Nelson D, McVay D, et al. The effects of tranexamic acid and prothrombin complex concentrate on the coagulopathy of trauma: An in vitro analysis of the impact of severe acidosis. *J Trauma Acute Care Surg.* 2013; 75(6): 954-960. doi: [10.1097/TA.0b013e31829e20bf](https://doi.org/10.1097/TA.0b013e31829e20bf)
56. Dager WE. Using prothrombin complex concentrates to rapidly reverse oral anticoagulant effects. *Ann Pharmacother.* 2011; 45: 1016-1020. doi: [10.1345/aph.1Q288](https://doi.org/10.1345/aph.1Q288)
57. Sadeghi N, Kahn D, Cunanan J, et al. Compositional differences

- es in commercially available prothrombin complex concentrates. *Blood.* 2012; 120: 4391.
58. Voils SA, Baird B. Systematic review: 3-factor versus 4-factor prothrombin complex concentrate for warfarin reversal: Does it matter? *Thromb Res.* 2012; 130: 833-840. doi: [10.1016/j.thromres.2012.10.001](https://doi.org/10.1016/j.thromres.2012.10.001)
59. Khorsand N, Kooistra HAM, van Hest RM, Veeger NJGM, Meijer K. A systematic review of prothrombin complex concentrate dosing strategies to reverse vitamin K antagonist therapy. *Thromb Res.* 2015; 135: 9-19. doi: [10.1016/j.thromres.2014.11.019](https://doi.org/10.1016/j.thromres.2014.11.019)
60. Huynh TK, Costello JL, Rebuck JA. Optimizing the dose of three-factor prothrombin complex concentrate in traumatic brain injury patients on warfarin therapy. *Pharmacotherapy.* 2014; 34(3): 260-264. doi: [10.1002/phar.1384](https://doi.org/10.1002/phar.1384)
61. Abdoellakhan RA, Miah IP, Khorsand N, Meijer K, Jellema K. Fixed versus variable dosing of prothrombin complex concentrate in vitamin K antagonist-related intracranial hemorrhage: A retrospective analysis. *Neurocrit Care.* 2017; 26: 64-69. doi: [10.1007/s12028-016-0248-8](https://doi.org/10.1007/s12028-016-0248-8)
62. Schols AM, Schreuder FH, van Raak EP, et al. Incidence of oral anticoagulant-associated intracerebral hemorrhage in the Netherlands. *Stroke.* 2014; 45: 268-270. doi: [10.1161/STROKEAHA.113.003003](https://doi.org/10.1161/STROKEAHA.113.003003)
63. Steiner T, Al-Shahi Salman R, Beer R, et al. European Stroke Organisation (ESO) guidelines for the management of spontaneous intracerebral hemorrhage. *Int J Stroke.* 2014; 9: 840-855. doi: [10.1111/ijvs.12309](https://doi.org/10.1111/ijvs.12309)
64. Steiner T, Poli S, Griebel M, et al. Fresh frozen plasma versus prothrombin complex concentrate in patients with intracranial haemorrhage related to vitamin K antagonists (INCH): A randomised trial. *Lancet Neurol.* 2016; 15: 566-573. doi: [10.1016/S1474-4422\(16\)00110-1](https://doi.org/10.1016/S1474-4422(16)00110-1)

Short Communication

Dealing with Violent Dangerous Patients: The Medicolegal Pitfalls

Navin Naidoo, MBBCh, LLB, FACLM, JD, FACPE*

Department of Emergency Medicine, Bundaberg Base Hospital, Qld 4670, Australia

*Corresponding author

Navin Naidoo, MBBCh, LLB, FACLM, JD, FACPE

General Practitioner Gympie, Department of Emergency Medicine, Bundaberg Base Hospital, Qld 4670, Australia; E-mail: navinnaidoo@gmail.com

Article information

Received: October 20th, 2019; Revised: November 28th, 2019; Accepted: December 2nd, 2019; Published: December 6th, 2019

Cite this article

Naidoo N. Dealing with violent dangerous patients: The medicolegal pitfalls. *Emerg Med Open J.* 2019; 5(1): 9-11. doi: [10.17140/EMOJ-5-153](https://doi.org/10.17140/EMOJ-5-153)

“Takedown” in the Emergency Department (ED) an all too regular occurrence that is set to escalate dramatically in years to come. This was prophesied by a newspaper headline from 1991, “The growing ranks of aggressive, addictive and deranged people for whom the emergency department is the last resort.”¹

Making the call to “Take someone down” in the ED is never to be taken lightly. The only time such a drastic decision should be made is to prevent imminent harm to the patient or others. It should always be the most senior doctor in the department at the time who makes the clinical decision that the physical and/or chemical restraint of a person is necessary and sanctioned by law at that time. This area is a minefield for doctors. The duty of care of the physician is in direct conflict with the patient or violent person’s right to bodily integrity, freedom of movement, freedom from bodily infringement, refusal to consent to medication, and several other inherent civil liberties that every person has as an automatic right to.

Giving the order to have several people as of necessity they need to be big strong well-trained people, physically overwhelm and subdue someone and then place physical restraints to continue to subdue, and without consent inject chemically sedating agents into the body of that person, is a treacherous path for any doctor, no matter how experienced or qualified an ED practitioner may be (author personal experience, October 2019). A successful takedown often leads to the person requiring intubation, ventilation and ongoing sedation until there is the capacity to deal with a safe extubation. There are many recorded deaths as a result of involuntary physical and chemical sedation,² and almost inevitably it will involve some sort of bodily injury. If the initial facility does not have the capacity to safely deal with such a patient after forced and necessary sedation, they may require transporting

to more appropriate facility capable of dealing with a safe extubation in a known violent aggressive patient.

The law is vague as to duties of care, etc, especially when the violence does not come from a patient. Violent non-patients are best dealt with by the police and hospital security without requiring a medical takedown. There are times when violent behaviour from a non-patient escalates to the point where that person becomes a danger to others and himself. If that person is behaving in a manner that falls beyond what is considered normal, does it preempt a psychiatric diagnosis and place a duty on the doctor in charge to consider a medical takedown?

EDs are especially prone to violence. They provide an environment filled with emotional stress; patients may suffer prolonged waiting times, confusion, and gaps in communication. In addition, the 24-hour open-door policy and the widespread availability of drugs and weapons in the community compound the problem.³

The 1993 shooting of three physicians on duty in Los Angeles County ED underscores the tragic consequences of ED violence. The problem is not isolated to a few urban areas. In a 1988 survey of 170 U.S. teaching hospitals, 32% reported at least one verbal threat daily, 18% at least one threat with a weapon daily, and 25% reported restraining at least one patient per day. Within the previous five years, 7% of the institutions experienced a violent death in the ED. Eighty percent had a staff member injured due to violence.⁴

Assaults may come from patients, visitors, or members of a patient’s family. Parents of ill children may turn to violence from frustration. A 1994 survey of 44 pediatric EDs revealed that

more than half reported one or more verbal threats a week, 77% reported at least one physical attack on staff per year, and 25% sustained actual injury to staff.⁵

ED nurses are particularly likely to be assaulted. Nearly 70% of all emergency nurses are assaulted on duty during their career.⁶ Yet, as alarming as these statistics are, up to 80% of all ED assaults are not reported.⁷

The articles referenced provide a comprehensive and exhaustive discussion of the duties that need to be complied with in the circumstance of a “Medical Takedown”, and every emergency doctor and nurse should regularly read the brilliant article by Louis Kao and Gregory Moore.⁸

A polarizing discussion of some controversy is presently surrounding the conventional agents that should be chosen for takedown situations. This article is not intended to explore the medical decision making related to the emergency choice of a tranquilising agent. That is a complex and voluminous topic that is deserving of an arena all on its own. This article is intended to merely enlighten front line medical practitioners about the potential legal dilemmas that they may expose themselves to through the use of physical and chemical restraints. There is an understanding that some hospitals arm their security personnel with tazers and firearms. In our ED, the choice is mostly limited to our security that are mainly big burly men and a few drugs, including droperidol, haloperidol, olanzapine, midazolam and ketamine. The huge concerns about the safety of droperidol and the need for an electrocardiogram (ECG) prior to administration being a prerequisite have come into question.⁹

The use of ketamine as a first-line takedown drug seems to be growing in the emergency medicine literature and pre-hospital emergency medical situation.¹⁰ The literature supports its use and advocates it in some instances where treatment-resistant depression and suicidality have featured.

At 4 mg/kg intramuscularly, ketamine renders most recipients incapacitated within a few minutes with a patent, self-maintained airway. It is the duty of the ED physician to ensure protection and patency of the airway and is a crucial aspect of coordinating a takedown. Ketamine was traditionally contraindicated in head injury patients due to a perceived risk of raised intracranial pressure. This has since been debunked.¹¹

The physical and chemical subduing of a person complies with the definition of assault, including assault with the intent to do gross bodily harm. physicians can be referred to numerous statutory bodies for investigation and are also open to internal investigations and police and criminal reporting. Having a second equally qualified and experienced, or better qualified and more experienced colleague, ratify the decision to takedown is advisable and must be documented.

Footage of violent rampages by patients, or non-patients, should be recorded and used to justify contentious takedowns, and

for training purposes.

De-escalation of violent situations is always the goal, and ED staff and security must be regularly trained in de-escalation techniques. The use of bodycams by security staff are advocated when dealing with violent and dangerous patients, and for proof of the danger, a patient presented at the relevant time. The effect of violence on doctors and nurses is profound and devastating. An assault at work is demeaning, insulting and often devastating to a doctor or nurse’s psyche and well-being. Violence to medics often causes them to leave the profession and may lead to serious ongoing psychological and mental health issues. Retro-thinking mandatory reporting laws relating to healthcare workers and mental health issues, perpetuates the problems faced by victims of violence at work for fear of mandatory reportings. Post-traumatic stress disorder (PTSD) often follows significant acts of violence, and victims suffer lifelong consequences.

The advent of more and more potent mind-altering narcotics, an ever-increasing violent society, the normalization of violence in sport and as part of masculinity, political and religious polarization, alcohol, religious secularism in a global village context, and racism itself are all factors that seem destined for continued violence to be part of human existence. EDs need to factor in this reality and ensure that their staffs are not only well protected from any violence itself, but also the legal outfall from necessary takedown decisions. I will go so far as to say that health departments and governments have an obligation in this regard.

REFERENCES

1. Katz J, Spiegel C. Hospitals caught in crossfire. *Los Angeles Times*. April 7, 1991.
2. Berzlanovich AM, Schöpfer J, Keil W. Deaths due to physical restraints. *Dtsch Arztebl Int*. 2012; 109(3): 27-32. doi: [10.3238/arztebl.2012.0027](https://doi.org/10.3238/arztebl.2012.0027)
3. Rice MM, Moore GP. Management of the violent patient: Therapeutic and legal considerations. *Emerg Med Clin North Am*. 1991; 9(1): 13-30.
4. Lavoie FW, Carter GL, Danzl DF, Berg RL. Emergency department violence in United States teaching hospitals. *Ann Emerg Med*. 1988; 17(11): 1227-1233. doi: [10.1016/s0196-0644\(88\)80076-3](https://doi.org/10.1016/s0196-0644(88)80076-3)
5. McAnaney CM, Shaw KN. Violence in the pediatric emergency department. *Ann Emerg Med*. 1994; 23: 1248-1251. doi: [10.1016/s0196-0644\(94\)70349-3](https://doi.org/10.1016/s0196-0644(94)70349-3)
6. Mahoney BS. The extent, nature and response to victimization of emergency nurses in Pennsylvania. *J Emerg Med Nurs*. 1991; 17(5): 282-291.
7. Lion JR, Snyder W, Merrill G. Under-reporting of assaults on staff in a state hospital. *Hosp Community Psychiatry*. 1981; 32: 497-498. doi: [10.1176/ps.32.7.497](https://doi.org/10.1176/ps.32.7.497)

8. Kao L, Moore G. The violent patient: Clinical management, use of physical and chemical restraints, and medicolegal concerns. *Emergency Medicine Practice*. 1999; 1(6).
9. Isbister GK, Calver LA, Page CB, Stokes B, Bryant JL, Downes MA. Randomized controlled trial of intramuscular droperidol versus midazolam for violence and acute behavioral disturbance: The DORM study. *Ann Emerg Med*. 2010; 56(4): 392-401.e1. doi: [10.1016/j.annemergmed.2010.05.037](https://doi.org/10.1016/j.annemergmed.2010.05.037)
10. Burnett AM, Peterson BK, Stellpflug SJ, et al. The association between ketamine given for prehospital chemical restraint with intubation and hospital admission. *Am J Emerg Med*. 2015; 33 (1): 76-79. doi: [10.1016/j.ajem.2014.10.016](https://doi.org/10.1016/j.ajem.2014.10.016)
11. Albanèse J, Arnaud S, Rey M, Thomachot L, Alliez B, Martin C. Ketamine decreases intracranial pressure and electroencephalographic activity in traumatic brain injury patients during propofol sedation. *Anesthesiology*. 1997; 87(6): 1328-1334. doi: [10.1097/0000542-199712000-00011](https://doi.org/10.1097/0000542-199712000-00011)