CLINICAL BRIEF

NOT AN “ADULTS ONLY” SHOW – A DELPHI CONSENSUS ON BLOOD FOR KIDS

Give the kids blood!

PEDIATRIC EMERGENCY MEDICINE & EMS

DISCLOSURE for Continuing Medical Education Purposes

- This activity has been planned and implemented in accordance with the accreditation requirements and policies of the *Accreditation Council for Continuing Medical Education (*ACCME) through the joint providership of White Coat Institute (d.b.a. *GetMyCME*) and the *Gathering of Eagles* alliance.

- The White Coat Institute is accredited by the ACCME to provide continuing medical education for physicians.

- None of the planners for this educational activity have relevant financial relationship(s) to disclose with ineligible companies whose primary business is producing, marketing, selling, re-selling, or distributing healthcare products used by or on patients.

Additional DISCLOSURE in this case

for Continuing Medical Education Purposes …

It should be noted that Dr. Antevy does have a consulting relationship with

However, this CME activity has been designed and reviewed by an independent committee with no relevant financial ties to ensure that the content is free of commercial bias and evidence-based. Accordingly, all of the relevant financial relationships listed for Dr. Antevy have been mitigated.

Should kids get blood products?

Which kids should get transfused?

PREHOSPITAL PEDIATRIC TRANSFUSION SAVES LIVES

JAMA Pediatrics

Injured children who received a prehospital blood transfusion had ***decreased 24-hour and in-hospital mortality*** *after propensity matching for age, injury mechanism, shock, and GCS.*

MORGAN KM, ET AL.

University of Pittsburgh Medical Center

JAMA Pediatrics. 2023;177(7):693-699

DECREASED

24-HOUR

mortality

DECREASED

IN-HOSPITAL

mortality

TAKEAWAY: Hemostatic resuscitation should shift toward the immediate postinjury period. Every minute of delay carries a mortality cost.

Prehospital Pediatric Whole Blood Transfusion | Delphi Consensus Panel

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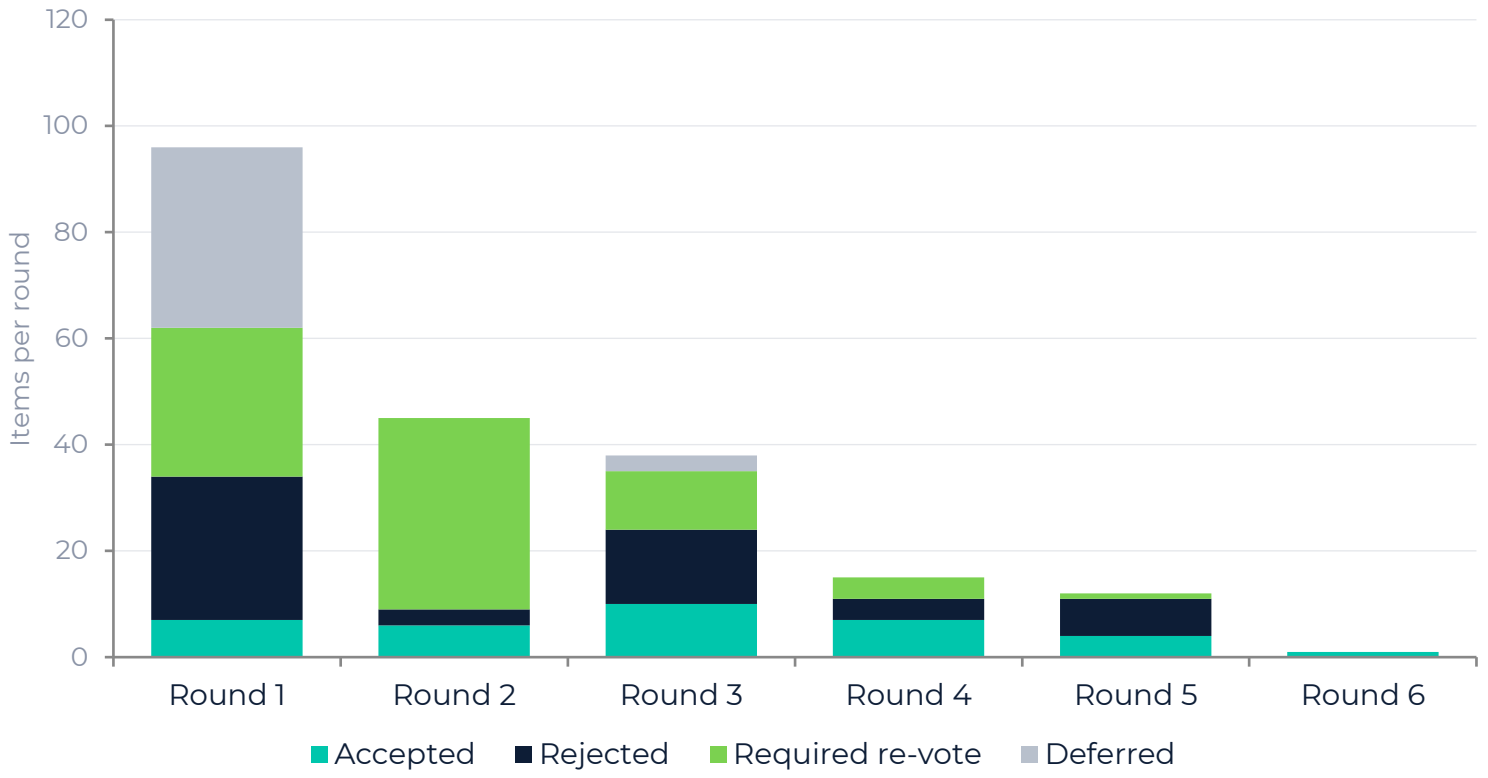
Our Task?

Come to consensus on who is eligible for prehospital pediatric transfusion?

CONVERGENCE ACROSS SIX ROUNDS

100% panel participation in every round. Items resolved progressively until convergence.



100%

PARTICIPATION EVERY ROUND

22

NOVEL CRITERIA ADDED BY PANEL

1

ITEM WITHOUT CONSENSUS: DECREASING ETCO2

1

SEVERE HEMORRHAGE

Known or suspected severe or massive hemorrhage
- Active uncontrolled bleeding
- Or major blood loss.

2

SIGNS OF SHOCK

At least one:
1. Hemodynamic instability
2. Signs of Poor Perfusion
3. Abnormal pediatric shock index.

3

EMS JUDGMENT

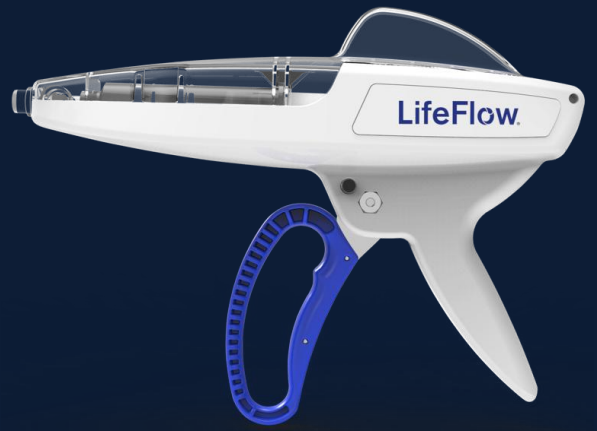
EMS clinical judgment supports the need for transfusion.

4

NO EXCLUSIONS

- DNR or advance directive prohibiting transfusion.
- Shock not suspected from non-hemorrhagic etiology.

PREHOSPITAL DOSING



Dosing recommendations were not in the consensus document.

10 mL / kg

MEDIAN PREHOSPITAL DOSE

IQR 7 – 16 mL/kg · Median volume 300 mL (IQR 200 – 535 mL)

HEMODYNAMIC IMPROVEMENT

24%

OF CHILDREN CONVERTED FROM ABNORMAL TO NORMAL SHOCK INDEX BY ED ARRIVAL

Improvement was more pronounced in patients transported directly from the scene.

Source: Sutyak KM et al. J Trauma Acute Care Surg 2026;100(4):612-619.

AHA / AAP 2025 RECOMMENDATION

Among infants and children with hypotensive hemorrhagic shock following trauma, it is reasonable to administer blood products, when available, instead of crystalloid for ongoing volume resuscitation.

CLASS

2a

LEVEL OF EVIDENCE

C-EO

PART 8, PEDIATRIC ADVANCED LIFE SUPPORT

Pediatrics. 2026;157(1):e2025074351

No prospective pediatric data exist comparing early blood products versus early crystalloid for traumatic hemorrhagic shock. The recommendation draws on adult evidence from EAST, ACS, and NICE supporting early balanced ratios of pRBCs, FFP, and platelets.

STAY TUNED

PAPER COMING SOON

SUBMITTED FOR PUBLICATION

Eligible

GIVE BLOOD TO KIDS

NBC NEWS INVESTIGATES

CALLS FOR RESCUE VEHICLES TO CARRY BLOOD

NBC NEWS