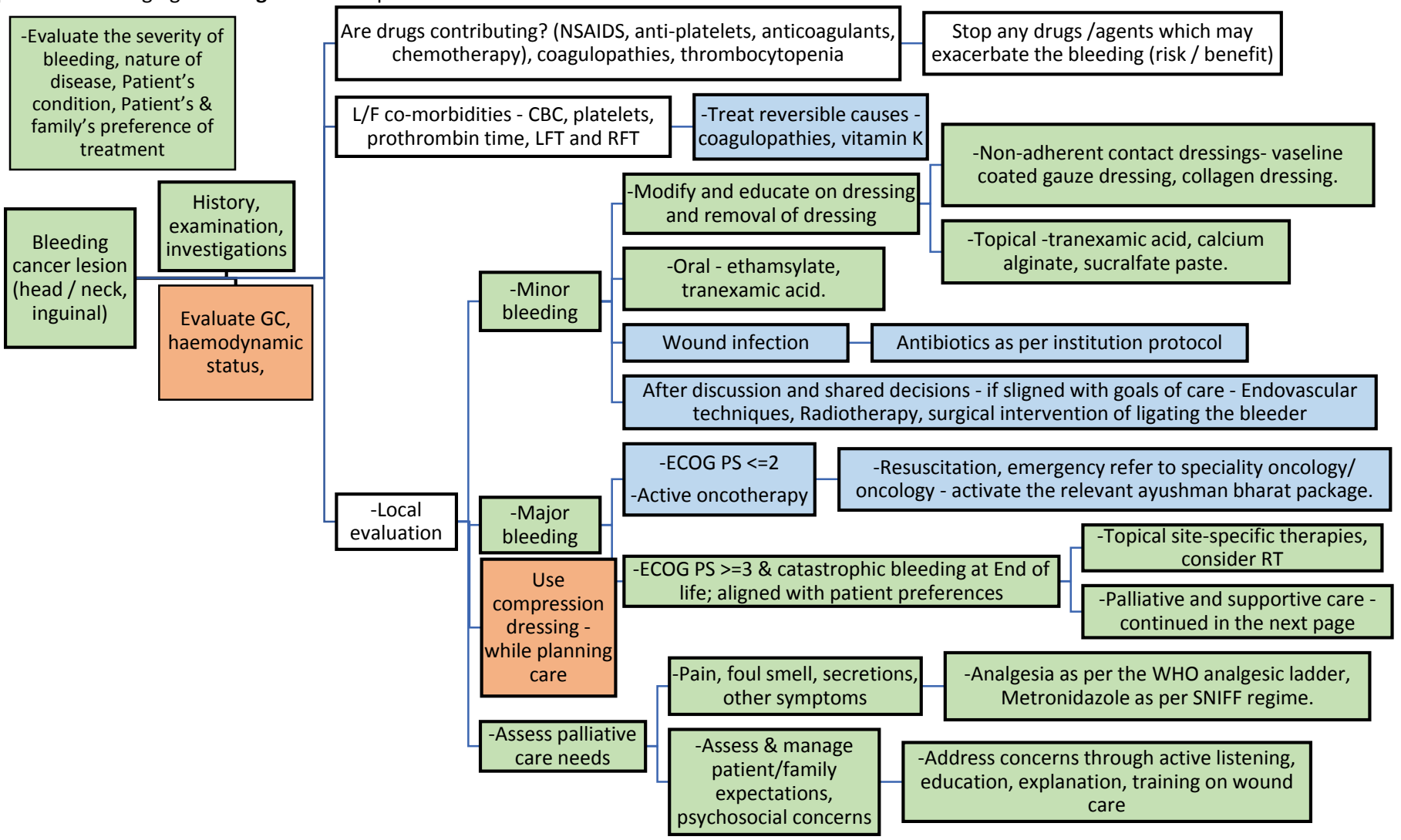
NCG Palliative Care Guidelines - Bleeding

Approach to managing **Bleeding** in a cancer patient[1]



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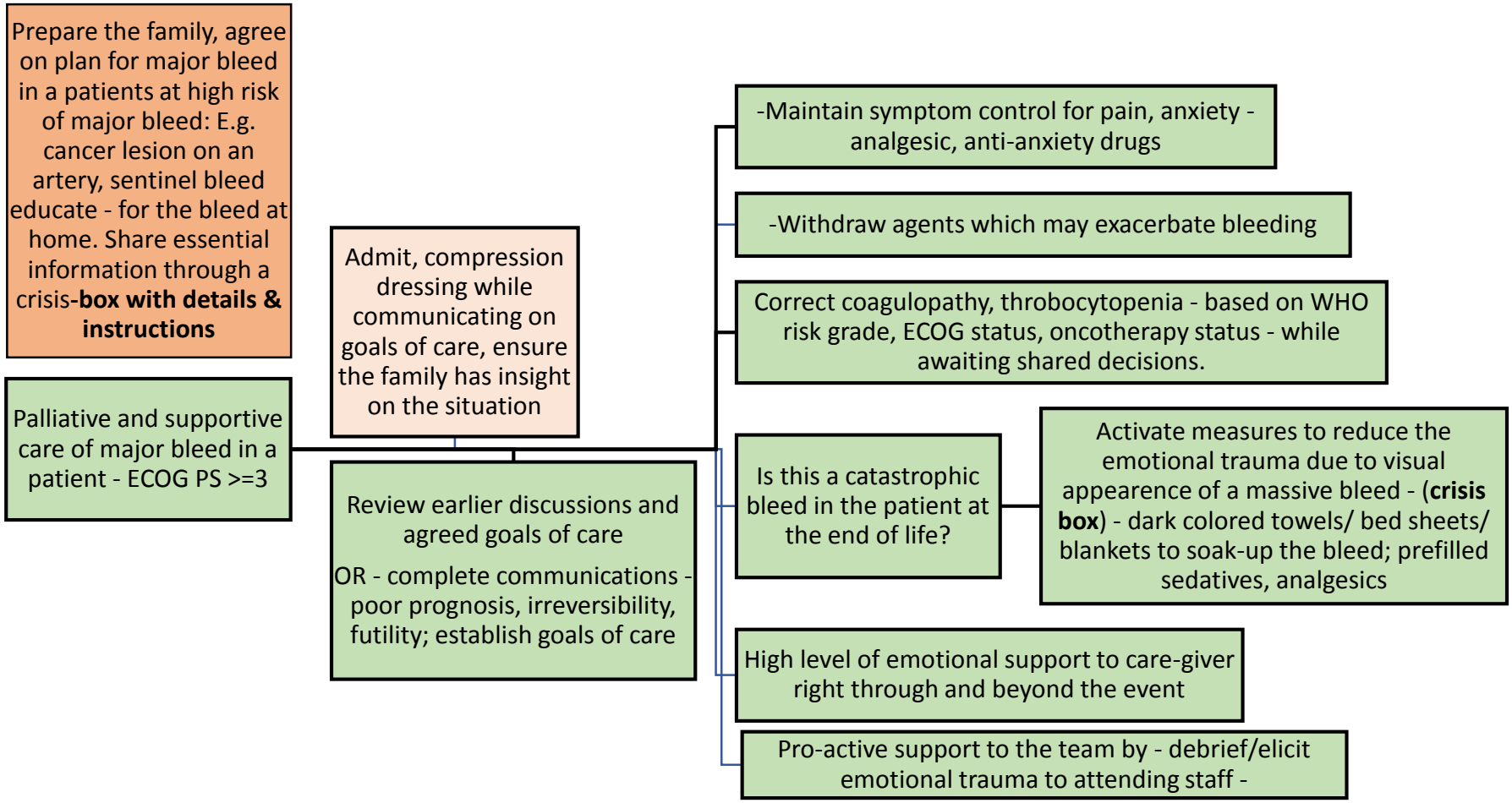
National Cancer Grid

NCG Guidelines for Bleeding head and neck / inguinal lesions – Continued… [2]



[2] Ann Med Surg (Lond). 2020 Feb; 50: 14–23. -Management of bleeding in palliative care patients in the general internal medicine ward: a systematic review - https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6940657/

Medications

Drugs for topical Therapy and site specific management

- *Wound dressing*: Malignant wounds are fragile and prone to bleeding when the dressing is changed. Use Non-adherent Vaseline soaked gauze/colloid dressing and gentle irrigation to reduce risk of bleeding. Crushed tablet metronidazole is used for wounds associated with foul smell.
- *Topical hemostatic agents*: Calcium alginate, sucralfate paste, powdered Tranexamic acid or Inj. Tranexamic acid-soaked gauze packing. Topical adrenaline can be applied to areas of heavy bleeding to induce local vasoconstriction (caution - ischemic necrosis).
- Site specific approach
    - For bleeding from the nasopharynx - Use silver nitrate sticks for localized bleeding in accessible sites; Haemostatic packing (usually a few days). If no commercial preparations available – use gauze soaked in 1:1000 adrenaline (beware of rebound bleeding once removed)
    - For bleeding in the oropharynx - use tranexamic acid mouthwash (5g in 50ml warm water BD), or sucralfate suspension mouthwash (2g/10ml suspension BD); topical 1 in 1000 adrenaline soaked on gauze for bleeding in localised and accessible sites
    - Consider nebulized adrenaline (5ml 1% adrenaline in 5 ml of 0.9% saline QDS) for bleeding in less accessible bleeding sites Site-specific therapy
    - Nasopharynx - silver nitrate sticks; packing with gauze soaked in tranexamic acid inserted into the nostril for 10 min
    - Oropharynx - mouthwashes tranexamic acid or sucralfate;

    Internal organs

    - Endovascular therapies and Haemostatic radiation
    - Pulmonary – refer to specialist if reversible - and activate relevant Ayushman Bharat package
        - Bronchoscopy for blood clot removal and mechanical tamponade and to allow for cold-saline lavage or laser phototherapy. Consider thoracic irradiation for longer term effect.
        - Bronchial artery embolisation is an effective non-surgical alternative for bronchial artery bleeding
    - Upper GI For bleeding

        - Proton pump inhibitors
        - Vasopressin, Somatostatin and it's analogue, octreotide
    - Lower Gi bleeding – refer for specialist care if reversible (Colonoscopy - for laser treatment, cryotherapy, plasma coagulation)
        - Rectal packing, or sucralfate paste
    - Vesical – Refer to NCG urinary bleeding guidelines
    - Prostate - Foley catheter with mild traction may halt bleeding. If uncontrolled – refer to specialist

- *Pain management*: Regular assessment and analgesia provided according to severity of pain – as per the NCG Pain guide-lines
- Antibiotics – as per institution protocol

Drugs / products for Systemic therapies

- Transfusion of Blood and Blood products given to resuscitate patients, those with ECOG <=2 who are actively bleeding, while waiting for the corrective intervention; and to reverse any coagulopathies
- Platelets – The decision for therapeutic transfusion is based on the patient's ECOG status, whether the oncotherapy is ongoing / not; and the WHO Bleeding risk Grade > = 2 [3]. Platelet transfusion should always be accompanied by an optimisation of the coagulation system and withdrawal of anticoagulant and anti-platelet drugs, as well as drugs with anticoagulant side-effects.
- Ensure cessation of exacerbating factors - Recent blood and bone marrow hematopoietic stem cell transplantation; recent history of severe haemorrhage (≤5 days); treatment related causes, drugs; malnutrition; underlying disease including treatment of infection
- Vitamin K 10mg can be given orally or intravenously to reverse effect of anticoagulants like warfarin. The risk of bleeding vs thrombosis needs to be considered carefully before initiating any such treatment.
- Tab Ethamsylate – 500 mg X TDS – for minor surface bleeding
- Tranexamic acid is given orally or intravenously – 500 mg 8 hourly, up to 1gm every 6-8 hours, to reduce severe blood loss and transfusion requirements.
- Inj. Midazolam 1- 2.5 mg given subcutaneously in increments - as required to sedate patient who has catastrophic bleeding

Supportive care

[3] Estcourt L.J., Birchall J., Allard S., Bassey S.J., Hersey P., Kerr J.P. Guidelines for the use of platelet transfusions. Br. J. Haematol. 2017;176(3):365–394

- Positioning of the patient - For example in the case of massive haemoptysis, placement of the patient in a lateral decubitus position towards the site of bleeding aims to avoid aspiration to the non-affected side and avoid suffocation.
- Nursing care (wound care, cost of special dressing), sub-cutaneous line,
- MDT involvement
    - Prior – Explanation of the situation, handling emotions, preparedness for the eventuality (crisis-box)
    - During - counselling both patient & family (when the event is unexpected), psychosocial support
    - Protect both from the visual impact of bleeding to death – crisis -box

For catastrophic bleeding beyond reversal - **Crisis-Box for End of Life situations**

- **Anticipatory care planning** - A crisis plan of action for catastrophic bleeding be established as a shared decision and goals of care clarified. This is done after careful consideration of the actual probability of the event happening (high-risk are those with H/O sentinel bleeding episodes), Vs. the psychological impact of the discussion(reminder/ fear of the event).
- Determine the goals of care, place of care and preferences of patient and family regarding end of life care. The question whether life support is desired must be discussed and documented.
- A bedside crisis pack should be available containing the following - dark coloured towels/ bed sheets/ blankets to soak-up the bleed; prefilled sedatives, analgesics; along with gloves, instructions, essential contact information. Consider pharmacological stability of pre-filled sedatives.
- Before the procedure, explain the procedure gently to the patient/ family, while carefully
- Haemostatic medications / blood transfusion are not effective due to the rapidity of bleeding. Sedation with incremental Midazolam 5 mg intravenous or intranasal, aims to reduce awareness and distress. Titrated haloperidol may be given in addition, if the patient is agitated. Opioids are used only if the patient has pain / dyspnea
- Respect the dignity of the patient and ensure privacy during all procedures
- Ensure appropriate disposal of clinical waste
- Ensure emergency telephonic support to family in the event of Catastrophic bleeding. Ensure support to family before and after, in case of catastrophic bleeding.