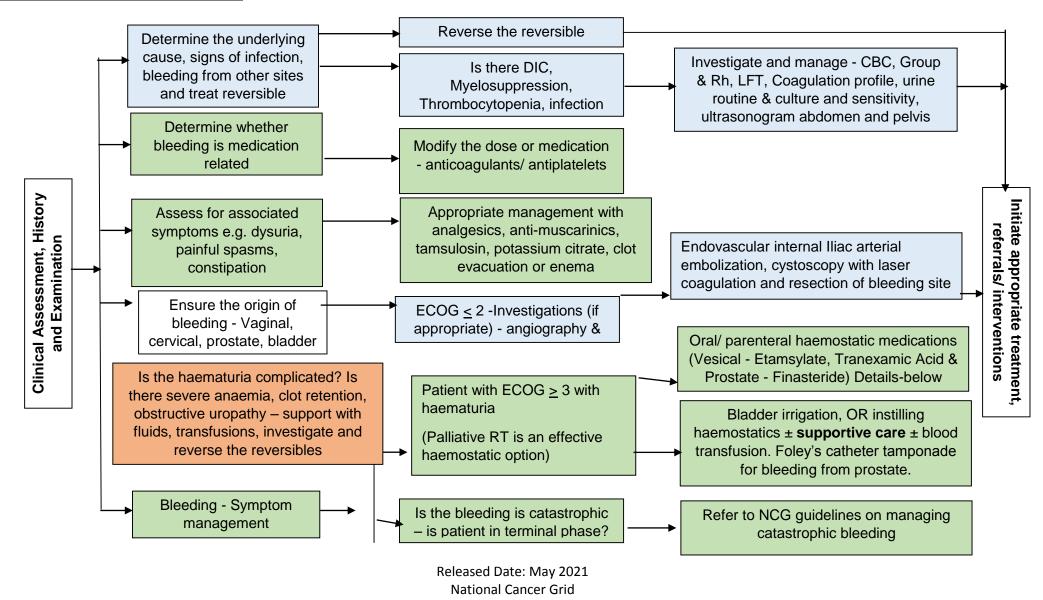


Approach to managing Haematuria



COLLABORATION FOR CANCER CARE NCG Palliative Care Guideline - Genito-urinary Bleeding

Medicines used Commonly in Haematuria.

Systemic Haemostatic Medications

Etamsylate

- Can be used alone. 500mg PO QID either indefinitely or until one week after bleeding stops
- It may be used in combination with Tranexamic acid if indicated.

Tranexamic acid

Oral administration of antifibrinolytic agents, tranexamic acid involves a risk of clot retention due to inhibition of fibrinolysis of pre-formed fibrin deposits. Their use in moderate to severe haematuria is an important clinical decision weighing the risks and balancing the beneficence in the individual situation

- 1.5g PO stat and 1g PO TID; titrate to Max
 1.5g PO QID as required
- Stop/ decrease to 500mg PO TID, one week after stoppage of bleeding
- If bleeding recurs, restart and continue indefinitely as necessary
- If patient has dysphagia, 15mg/kg IV over 5-10 minutes TID – QID

Finasteride 5 mg OD

 For patients with bleeding from Benign Prostatic Enlargement

EACA

 Intravenous, oral, or intravesical route – restrict to < 24 hours

Antibiotics

 Use as per institutional protocol, if urinary tract infection is present, administer appropriate antibiotics

Procedural measures

- Early management hand irrigation and continuous saline bladder irrigation with a largecalibre Foley catheter
- Clot evacuation and bladder irrigation with large three-way catheter, for decompression and saline irrigation (urologists required to catheterize).
- Irrigation through supra-public catheter is NOT helpful.
- Intra-vesical administration haemostatic agents – 1% Alum; 0.5-1.0% Silver Nitrate, ferrous ferracrylate, formalin (1% - 4% for 5-15 minutes) or EACA

Haemorrhagic Cystitis secondary to chemotherapy (cyclophosphamide) or radiation

- Cystoscopically, fulgurate sites of bleeding, evacuate clots and bladder irrigation
- Intravesical instillation of haemostatics
- Hyperbaric Oxygen therapy

Procedure for Prostatic bleeding

gentle Foley catheter traction can help tamponade the source

Control of spasmodic pain

- reduce the inflation of catheter balloon
- early clot evacuation
- Drugs Tamsulosin, Potassium Citrate, hyoscine, dicyclomine, oxybutynin

Nerve blocks & procedures

 Sacral-epidural or bilateral superior hypogastric block if intractable bladder pain.

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Intractable catastrophic bleeding in a patient in terminal stages- consider Pall, sedation - Refer to NCG guidelines for managing	
Education/ communication	MDT Referrals
 Check insight Family of patients with risk of catastrophic bleeding should be informed and prepared in advance Details are provided under management of catastrophic bleeding (NCG guidelines for bleeding tumours) 	 Nursing care Emotional support – consistent communications, counselling, psychological support Referrals to urologists for, therapeutic interventions Interventions -appropriate to the stage of the disease, performance score and patient's/ family's preferences

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