Epistaxis Management

At triage:

- Ask patient to pinch soft part of nose firmly before applying nose peg/ clip* for 20 minutes, sit upright, head forward.
- Bloods are only required if clinically unwell/ anaemic or if fails **Step 1**
- Note: history of hypertension, laterality, **bleeding history**, **heart valves**, **OAC**/antiplatelet Rx

Step 1: Haemostasis → Cautery → Nasopore

- In all *active bleeds*, suction first then insert **anterior nasal packing**: ribbon gauze soaked with adrenaline and tranexamic acid** (not required if simple pinching/ clip/ peg has succeeded). Remove after 10 minutes
- Once bleeding ceased, look for bleeding site/'cherry spot' in Little's area
- Apply topical anaesthetic/ vasoconstrictor***
- Cauterise area that was bleeding with silver nitrate 'matchstick'. *Only ever cauterise ipsilaterally to avoid risk of subsequent septal perforation*
- Apply Nasopore**** sponge to cauterised site
- Observe for **30 minutes** – if no re-bleeding, discharge home with return advice

If **Step 1 fails** (rebleeding occurs)

Step 2: Rapid Rhino → Admit Vs **Observe**

- **insert Rapid Rhino** (9cm, double balloon); see instruction page (EMed link)
  1. inflate **anterior balloon first**
  2. if bleeding continues → **inflate posterior balloon**

- check bloods: FBC, U+E, coags, x-match if low Hb
- now **stratify** into '*medically complicated*' or simple '*surgical*' epistaxis

1. 'MEDICALLY COMPLICATED' Epistaxis

here only refers to:

- *Currently uncontrolled ↑BP* and/or
- *Anticoagulated*

Admit for at least **48h** under Medical team for optimization of the above issue/s

- Commence 48h of Co-amoxiclav †
- Consider *systemic* TXA: PO/IV 1g
- Beware heart valves (get haematology advice)
- Control BP whilst pack in situ
- Medical team liaise with ENT re: balloon deflation >48h

2. Simple 'SURGICAL' Epistaxis

Observe for **6 hours** - then **deflate balloon/s**

- if no rebleeding, apply Nasopore again (including to posterior nasopharynx if suspected site of bleeding)
- Discharge with return advice
- Routine follow-up not usually required for first episodes; refer for review in ENT Casualty if recurrent

If **bleed restarts** after deflation
→ **re-inflate balloon/s**
→ refer for **ENT review now**

If **Step 2 fails**: (rebleeding whilst anterior & posterior balloons correctly inflated)

Step 3, call for help: EM Senior + ENT review now

- ***are balloons correctly positioned & inflated*?**
    1. check balloon positions and cuffs, inflate with further volume, replace if needed
    2. contact ENT
    3. consider further tamponade by placing **Foley catheter** in the posterior nasopharynx‡

NB - Patient Transfer

- *deciding which patient is suitable for transfer to SIVUH for ENT review (Vs ENT Reg travelling to attend patient on-site in CUH) should be discussed on a case-by-case basis; those patients whose bleeding has now ceased or has reduced to a trickle and have no other acute cardiovascular or respiratory compromise are likely suitable for transfer via an ambulance.*

* use either swimmers' nose clip or 4 tongue depressors taped together in the middle to act as a wooden 'nose peg'

** to gauze, add:
1. Adrenaline 0.5 mg (5 mL of 1:10,000)
2. TXA 1 mg of IV liquid preparation

*** a mixed adrenaline/lidocaine vial applied with a MAD device on a 3mL syringe is effective if co-phenylcaine (which is expensive) is not available

**** Nasopore is expansile, providing haemostasis via prothrombotic and tamponading effects. It resorbs within 5-7 days. Posterior application requires nasal forceps.

† not evidence-based, but is standard local approach

‡ link to Foley catheter instruction page (*eg - insert into NP, advance until tip seen behind soft palate in posterior oropharynx, inflate with saline, pull forward until bleeding stops posteriorly and diverted anteriorly, pack posterior NP with adren/TXA-soaked ribbon gauze infront of balloon, pull catheter until firm resistance felt, clamp at nares with generous padding to avoid pressure-injury*)

References:

1. https://www.rcemlearning.co.uk/reference/epistaxis/#1569245950810-f34444eb-a42b
2. Cochrane review 2018 = mod.-quality evidence for TXA overall (PO > Top) but they point out that approach has advanced since some older studies: https://www.cochrane.org/CD004328/ENT_tranexamic-acid-help-treat-nosebleeds-epistaxis
3. Subsequent DBRCT is supportive of topical higher dose TXA (1g > 0.5g > placebo saline) 50 pts per group, signif↓ bleeding @5&10 min: https://journals.sagepub.com/doi/full/10.1177/00368504241264993