

# Bleeding

## KEY POINTS

- ➔ Bleeding can occur in cancer and in end-stage liver or renal disease, especially as the disease progresses
- ➔ Patients and families can be very distressed by even small amounts of visible bleeding

## ASSESSMENT

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- ➔ It is important to make an assessment of the cause, to consider whether the cause is reversible, the severity, and the prognosis of the patient when assessing bleeding
- ➔ When appropriate, carry out relevant tests including a coagulation screen and platelet count

## MANAGEMENT

- ➔ Treatment of bleeding in palliative patients depends on the patient's goals of care, disease trajectory and prognosis, and whether the treatment is likely to be effective

*Consider if the patient is well enough to benefit*



## General Measures

- ➔ Rapid and clear communication with the patient and family is a priority as the patient may decline and die in minutes
- ➔ Reassure and explain the situation to the patient and family
- ➔ Stop medications such as NSAIDs (non-selective COX inhibitors) or anticoagulants that may be causing or exacerbating the bleeding
- ➔ Note: NSAIDs that are selective COX-2 inhibitors do not affect platelet function

## Treatments to be Considered

*Consider if the patient is well enough to benefit*



- ➔ **Transfusion** of packed red blood cells, platelets, or other blood components
- ➔ Correction of abnormal clotting with fresh frozen plasma (if available)
- ➔ **Tranexamic acid 1000 mg PO/IV TID, administer IV doses over 5-10 minutes due to risk of hypotension**

➔ **Tranexamic acid IV: 10 mg/kg/dose q6-8h (Maximum: 1000 mg/dose); may administer IV doses over 5-10 minutes due to risk of hypotension**



➔ **Tranexamic acid PO: 25 mg/kg/dose q8h (Maximum: 1500 mg/dose)**

- ➔ Consider **vitamin K** if the patient is taking a vitamin K antagonist anticoagulant, e.g. warfarin, or is vitamin K deficient
  - ➔ Vitamin K deficiency occurs in severe malnutrition or very low-fat diets, as well as certain rare disorders with malabsorption of fat and fat-soluble vitamins such as cystic fibrosis
  - ➔ Newborns are prone to vitamin K deficiency, because limited vitamin K is transferred from the mother to the fetus during pregnancy, and they have a limited ability to synthesize vitamin K in the first few days of life
- ➔ Haemostatic radiation or embolization if available and the patient is well enough to benefit

## Bleeding From a Wound/Ulcer

- ➔ Apply steady pressure
- ➔ Apply **epinephrine (1 mg/mL)**-soaked gauze topically and cover

with a dressing

- ➔ **Tranexamic acid** (crushed tablets or injectable liquid) and sucralfate (crushed tablets) can be applied topically and covered with a dressing

### Bleeding From GI Tract

- ➔ Stop NSAIDs (specifically non-selective COX inhibitors) and reduce or discontinue steroids if possible
- ➔ Trial of **tranexamic acid** may be considered
- ➔ Start a **proton pump inhibitor** (e.g. omeprazole, pantoprazole) or **H2-antagonist** (e.g. cimetidine, famotidine)
- ➔ Referral for endoscopic management if possible and if patient is well enough to benefit

### Bleeding From Bladder

- ➔ May benefit from continuous bladder irrigation and instillation of haemostatic agents
- ➔ If well enough, consider cystoscopy/diathermy/radiotherapy (depending on prognosis)

### Bleeding From Mouth/Gums

- ➔ Gentle and cautious cleaning of the mouth with a soft cloth or sponge stick
- ➔ **Tranexamic acid: apply IV solution (500 mg diluted to 10 mL volume to make a 5% solution). Swish and swallow 10 mL QID**
  - ➔ Can also be applied topically with gauze or other topical tool

- ➔ **Children: Use 2-10 mL of diluted IV solution, as described above, as a mouth rinse. Swish and spit or swallow QID**



- ➔ **Sucralfate (2000 mg in 10 mL) as mouthwash/rinse BID**
- ➔ **Epinephrine (1 mg/mL)** can be applied topically if other agents are not available

- Limit epinephrine use to the short term, due to risk of rebound vasodilation and ischemic necrosis if used continuously

### Bleeding From Nose

- Apply continuous pressure and packing for 15 minutes with gauze soaked in **epinephrine (1 mg/mL)**
- Limit epinephrine use to the short term, due to risk of rebound vasodilation and ischemic necrosis if used continuously
- Apply topical **silver nitrate sticks** for small bleeds
- For posterior nose bleeds, use **xylometazoline** or **oxymetazoline** (nasal spray)
- Apply **tranexamic acid**-soaked gauze (use IV solution, undiluted)

### Massive Haemorrhage in Terminal Phase

- Terminal haemorrhage is generally painless, and the patient will quickly become unconscious due to blood loss
- Stay with patient
- Use dark towels (brown, red, blue) to disguise blood
- Remain calm and reassure family that the patient is not in pain
- If the patient is distressed (e.g. bleeding in airway or esophagus causing respiratory distress or vomiting) consider sedation with **midazolam 10 mg IV/Subcutaneous/Buccal/Intranasal STAT, repeat in 5 minutes (IV) or 5-15 minutes (Subcutaneous/Buccal/Intranasal)**
- Other rapidly acting sedating medications can also be used in a similar manner

#### PITFALLS/CONCERNS

- Patients who have a terminal haemorrhage often have a "sentinel bleed" (smaller bleed from the same site) in the days or weeks leading up to a haemorrhage
- If a massive haemorrhage is likely or the patient has had a sentinel bleed, make preparations by discussing the risk of haemorrhage

with the family and patient and having medications (e.g. midazolam) and supplies at the bedside

- ➔ Do not use tranexamic acid when disseminated intravascular coagulation is suspected

#### PALLIATIVE TIPS

- ➔ Patients with advanced liver disease or renal failure may develop abnormal clotting because of their disease
- ➔ In addition, they may be taking anti-coagulants for another condition

#### REFERENCES

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