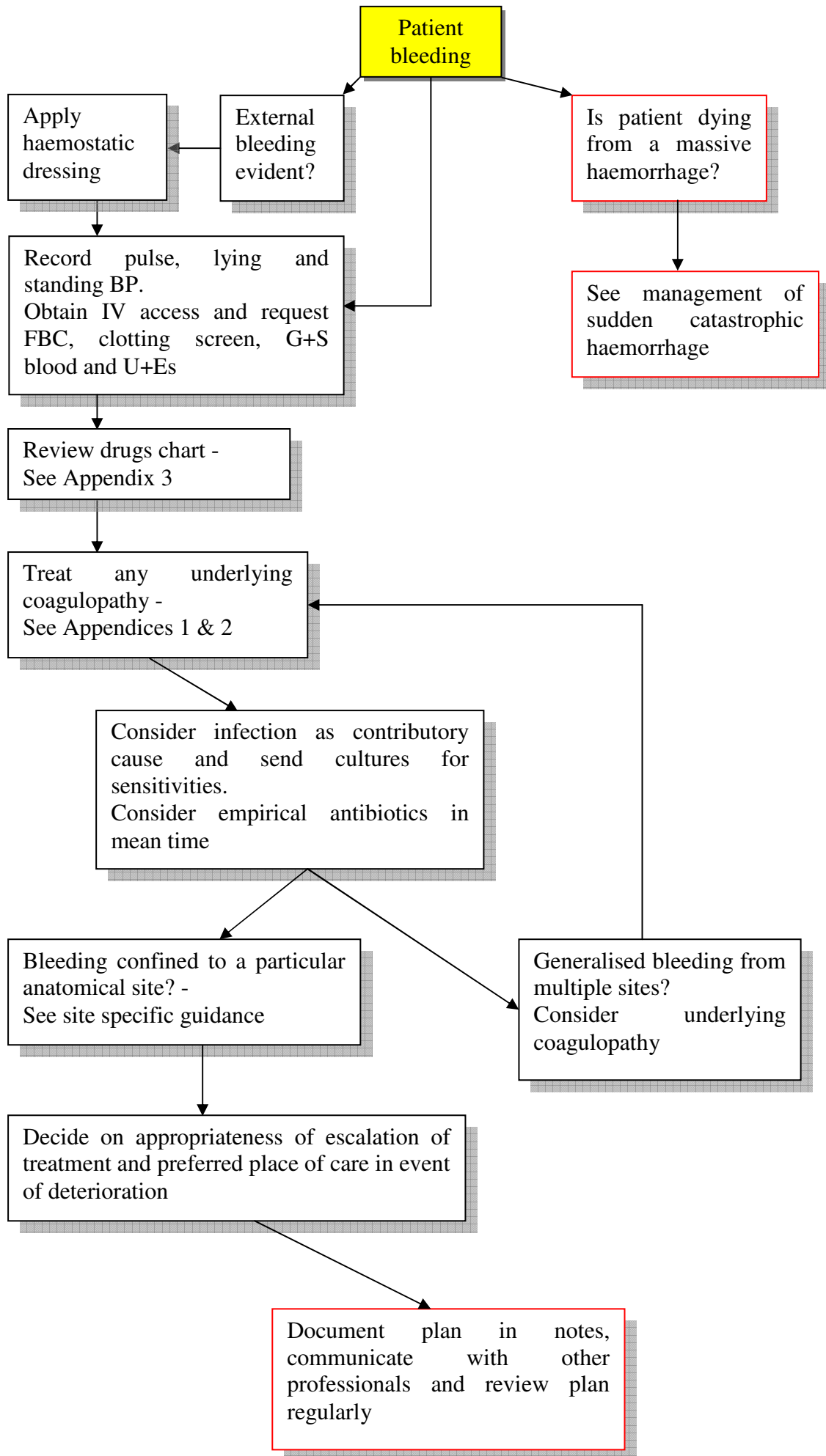


Yorkshire Palliative Medicine Clinical Guidelines Group

**Guidelines on the management of bleeding for
palliative care patients with cancer - summary**

January 2009



Summary of recommendations

1. Head and Neck

Treatment in most care settings

1. For general bleeding from a number of anatomical sites, or where the bleeding site is not easily accessible to local therapy, consider use of oral tranexamic acid (1g TDS)
2. For bleeding from the nasopharynx
 - Use silver nitrate sticks for localised bleeding in accessible sites
 - Use haemostatic packing kept in site until bleeding controlled (usually a few days). If no commercial preparations kept locally use gauze soaked in 1% alum.
 - Cautious use of gauze soaked in 1:1000 adrenaline (beware of rebound bleeding once removed)
3. For bleeding in the oropharynx
 - Use tranexamic acid mouthwash (5g in 50ml warm water BD), or
 - Use sucralfate suspension mouthwash (2g/10ml suspension BD)
 - Consider topical 1 in 1000 adrenaline soaked on gauze for bleeding in localised and accessible sites
 - Consider nebulised adrenaline (5ml 1% adrenaline with 5ml 0.9% saline QDS) for bleeding in less accessible bleeding sites

Treatment in hospital

4. Seek advice from oncologist for possibility of further palliative chemo- or radiotherapy.
5. If service available, consider use of interventional radiology for (potential) bleeds from major blood vessels

2. Haemoptysis

Treatment in most care settings

Try to rule out a pulmonary embolism (PE) before embarking on the following:

1. Oral tranexamic acid (1g TDS) and/or ethamsylate (500mg QDS)
2. Consider oral steroids (2-4mg dexamethasone OD)
3. Consider nebulised adrenaline (1ml of 1 in 1000 adrenaline with 4ml 0.9% saline QDS)
4. Consider nebulised orlipressin / vasopressin (5IU in 2ml 0.9% saline prn)

Hospital Setting

1. Refer for radiotherapy or brachytherapy
2. Consider embolisation or bronchoscopy
3. Consider use of recombinant factor VIIa (need to liaise with a haematologist)

3. Upper GIT

Treatment in most care settings

1. proton pump inhibitor (oral or IV)
2. oral tranexamic acid (1g QDS po initially)
3. oral sucralfate (2g BD po)
4. consider iv/im octreotide/somatostatin
5. consider oral thalidomide (?100-300mg daily)

Hospital Measures

1. consider definitive treatment of tumour (if not already exhausted)
2. refer for radiotherapy provided the patient is well enough to tolerate it
3. consider referral for arterial embolisation or cryotherapy
4. consider iv pressins (need central line if used long-term)

4. Rectal

Treatment in most care settings:

- Oral tranexamic acid (1g TDS)
- Rectal sucralfate (2g suspension or 2g tablets mixed with aqueous jelly BD)
- Rectal tranexamic acid (5g injectable vials mixed with 50ml warm water as emema BD)
- Consider oral thalidomide (?50-100mg daily initial dose)

Additional treatment in specialised centres:

- Consider radiotherapy to tumour sites where an immediate effect is not required, and patient has not had maximum radiotherapy to this site previously
- Consider referral for endoscopy (for laser treatment, cryotherapy, argon plasma coagulation, or application of formalin, alum packs or fibrin glue), where the patient is fit enough to tolerate procedure
- There may be a role for interventional radiology in selected cases of bleeding resistant to other measures. Consultation with an vascular interventional radiologist is recommended
- For radiation proctitis hyperbaric oxygen therapy may be useful, but is time consuming and limited by local availability

5. Renal tract

In hospital settings:

1. Kidney Embolisation of Renal artery
 Nephrectomy
2. Bladder Radiotherapy
 Embolisation Internal iliac artery or branches of
 Oral Tranexamic acid (use with caution due to risk of clot
 retention. Intravesical tranexamic acid via 3-way catheter is
 preferable)
 Oestrogens
 (Sodium pentosanpolysulphate if available)
 Intravesical Tranexamic acid
 Aluminium salts (beware of systemic
 toxicity)
 Prostaglandins (for cyclophosphamide
 induced haemorrhage)
 Sodium hyaluronate
 Formalin (GA or sedation required)
 Silver nitrate (beware of precipitating salts)

Also consider:

- Systemic Hyperbaric oxygen therapy for radiation
 induced cystitis
- Surgery Radical cystectomy
3. Prostate Oral Fibrinolytic Inhibitors
 5 α -reductase inhibitors
 Radiotherapy
 TURP

In hospice / home settings:

Always consider transfer to a hospital for above measures if possible

1. Bladder Oral tranexamic acid (risk of clot retention)
 Oral oestrogens
 ?Intravesical instillations
2. Prostate Oral tranexamic acid
 5 α -reductase inhibitors

6. Gynaecological

For most treatment settings

1. vaginal packing/tampon
2. trial of oral tranexamic acid (1g TDS)
3. consider topical application of tranexamic acid (500mg tablet crushed with aqueous jelly or 5ml vial soaked on gauze) or sucralfate (2g in 10ml suspension)

For Hospital Setting

5. consider definitive treatment of tumour (if not already exhausted)
6. refer for radiotherapy provided the patient is well enough to tolerate it
7. arterial embolisation if available and with careful selection of suitable patients
8. for life-threatening haemorrhage, consider topical acetone or formaldehyde

7. Summary of management of bleeding wounds

Consider antibiotics if signs or symptoms of infection as infected wounds are more likely to bleed. For all patients consider the appropriateness of radiotherapy, chemotherapy, cauterisation or embolisation.

- Minimize trauma during dressing changes by cleaning gently with irrigation and using non-adherent dressings (Level 4).
- Some brands of alginate (Kaltostat, Sorbsan) claim to have haemostatic properties that can be used to control minor bleeding (Level 4). Alginate dressings are manufactured from the calcium salt of an alginic acid polymer derived from brown seaweed. It is claimed that calcium ions that are released into the wound from the dressing activate platelets, which results in haemostasis. These dressings are not licensed as haemostatic dressings.
- To control profuse bleeding, use Adrenaline soaked gauze, 1 in 1000 (1mg in 1ml) applied with pressure for 10 minutes. This causes local vasoconstriction, but may also cause 'rebound' bleeding once these effects wear off. Care should be taken to avoid ischaemic necrosis (Level 4). An alternative is Tranexamic acid 500mg in 5ml soaked into gauze and applied with pressure for 10 minutes (Level 4).
- Sucralfate can be applied topically to help slow capillary ooze. To apply it, a paste is made of Sucralfate 1-2g, which is then crushed with water-soluble gel. The resulting mixture is adherent and can be applied to the bleeding site once or twice daily. (Level 4).
- Consider oral Tranexamic acid or Etamsylate to stop the bleeding and prevent further future bleeding (Level 4). This can be discontinued 1 week to 10 days after bleeding stops. Restart if bleeding recurs.

MANAGEMENT OF A MAJOR CATASTROPHIC BLEED IN ADVANCED CANCER PATIENTS

Risk Assessment

Patients potentially at risk include:

- Site of cancer eg. head and neck, haematological
- Presentation with bleeding eg. haemoptysis in lung cancer
- Co-existing disease eg. gastrointestinal bleeding, oesophageal varices
- Smaller warning bleeds
- Local infection at the tumour site
- Clotting abnormalities
- Drugs eg. heparin, enoxaparin

Is the patient at risk of a major life-threatening bleed?

Yes

No

Reassess as appropriate

Advance Care Plan

- Stop anticoagulants and antiplatelet drugs where possible.

Consider:

- Who needs to be aware of risk? – patient, family, carers, other healthcare professionals?
- Preferred care setting – available level of care
- Equipment: dark sheets/towels, gloves, aprons, plastic sheet or inco pad, clinical waste bags.
- Plan for who will clean up after an event and how to contact them
- Prescription and preparation of crisis medication (not always appropriate/available) * see overleaf

If an inpatient: offer a side room where possible

If at home: provide telephone numbers for emergency

IN THE EVENT OF AN ACUTE BLEED:

- Stay calm and if possible summon assistance
- Ensure that someone is with the patient at all times
- If possible nurse in recovery position to keep airway clear
- Stem/disguise bleeding with dark towels/sheets
- Apply pressure to the area if bleeding from external wound with adrenaline soaks if available
- Administer crisis medication if available (see overleaf) which can be repeated after 10minutes if needed.

* REMEMBER patient support & non-drug interventions may be more important than crisis medication *

After the Event

- Offer de-briefing to the whole team
- Ongoing support as necessary for relatives/staff members
- Disposal of clinical waste appropriately

Crisis Medication

If nursing staff are available quickly (within minutes) 24h/day:

Drug	Route *	Dose	Rate of onset
Midazolam (pre-drawn up if possible)	IV	10mg	2-3minutes
	IM (preferably deltoid)	10mg	5-15minutes

* The subcutaneous route is inappropriate due to peripheral shut down and unpredictable absorption.

Note: If the patient is already on large background doses of midazolam or other benzodiazepines, but still not adequately sedated during catastrophic bleeding they may need larger doses of midazolam in proportion with the background dose.

If domiciliary setting or nursing staff not available quickly:

Drug	Route	Dose	Rate of onset
Diazepam	PR	10mg	5-15mins
Midazolam	Buccal	10mg(1ml) – note unlicensed, special order.	15min
Lorazepam	Sublingual	4mg (1ml)	5mins