HAEMORRHAGE

INTRODUCTION

Haemorrhage occurs in patients with advanced cancer. When visible, it can be very distressing to patients, caregivers and health professionals. Bleeding may result from local vessel damage and invasion due to the cancer or from systemic processes such as disseminated intravascular coagulopathy (DIC) or abnormalities in platelet functioning and number. The other causes include liver failure, use of medications such as anticoagulants, NSAIDS, dexamethasone, chemotherapy. Occasionally it can be the immediate cause of death.

ASSESSMENT

- **Assessment** must determine the underlying cause of haemorrhage, effectiveness of treatment and impact on quality of life for the patient and their family (***refer to the Guideline - Symptom Assessment***)
- **Symptoms and signs of haemorrhage**
  - Haematemesis, haematochezia, melaena, haemoptysis, haematuria, epistaxis, vaginal bleeding, or bleeding from malignant wounds
  - Ecchymosis, petechiae or bruising
  - Anaemia, hypotension secondary to bleeding

RECOMMENDATIONS

- A clear plan should be made for patients at risk of bleeding
- If the patient's life expectancy and overall quality of life necessitates, then management should include general resuscitative measures such as transfusion of blood products and fluid replacement along with specific measures to stop the bleeding
- Identify and treat the cause where possible, palliative haemostatic radiotherapy should be considered when appropriate
- If the patient has advanced disease or poor prognosis, then an anticipatory care plan should be available with the goal to reduce the bleeding if possible and keep patient comfortable

MANAGEMENT

General

- **Investigations (if appropriate)**

  - Full blood count, coagulation profile (including INR) and LFT

- Angiography or endoscopic studies to identify the site of bleeding/local treatment

- **Anticipatory care plan**

  - Carers of patients who are at risk for catastrophic bleeding should be informed and prepared for the event
  - Ensure that the carers have an emergency contact number
  - Hold a discussion with the patient and family regarding comfort care, care plan, futility of measures such as resuscitation and then document the same in the patient records
  - If patient is at home, then discuss sedation and enquire if carers feel able to administer the medication
  - Supply of dark coloured towels/sheets, gloves, aprons, waste bags
  - Support to family during and after the catastrophic event
  - Professionals and services involved in the care of the patient should be aware of the care plan
  - Ensure correct disposal of clinical waste

Acute severe bleeding

- **Non-pharmacological measures - advise the carer**

  - To remain calm and contact the emergency contact number for help
  - In case of external bleeding, to apply pressure over the area with dark towels
  - Keep the patient in recovery position (if appropriate) to maintain the airway
  - Refer and admit the patient to the hospital, if care plan calls for resuscitation
  - If the patient is having a massive haemorrhage and is dying, then the patient is likely to lose consciousness and die before administering medications and it would be appropriate for the carer to support the patient rather than administer medication

- **Pharmacological measures**

  - Inj. Midazolam 2.5-5mg IV stat and repeat the dose after 5 - 10 minutes if necessary
  - Tab Lorazepam 1-2mg S/L stat and prn

Minor bleeding

Minor bleeding may point to a catastrophic bleed in the future. Bleeding, even if minor, is distressing to patient and family. Interventions such as diathermy, laser, embolization, haemostatic radiotherapy, surgery (including appropriate interventions via endoscopy, bronchoscopy, cystoscopy), injection Vitamin K are to be considered if appropriate after considering the general condition and prognosis.

- **Bleeding from the fungating wounds and mucosa**
  - **Skin and fungating wounds**
    - Compression, dressing and packing
    - Haemostatic dressings - e.g. Kaltostat dressing
    - Use non-adherent dressing - e.g. sterile paraffin tulle gras dressing, liquid paraffin-soaked gauze
    - Sucralfate 2g tablet crushed and mixed with 5mL of water-soluble gel and applied directly twice a day
    - Tranexamic acid 500mg tablet crushed and dissolved with 5mL of normal saline, soaked in gauze and applied to skin wounds with pressure for ten minutes and then leave in situ with a dressing
    - Epinephrine 1:1000 can be added to the dressings as a vasoconstricting agent - but be aware of tissue necrosis, cardiac and neurological complications
  - **Epistaxis**
    - Soak gauze with undiluted 500mg/5mL ampoule of tranexamic acid and insert into the nostril for ten minutes and remove once bleeding stops or use
    - Oxymetazoline or xylometazoline sprays
  - **Oral bleeding** - Tranexamic acid as a 5% (500 mg/10 mL) solution; 10mL qid as oral rinse and then can be swallowed
  - **Vaginal bleeding** - Pack soaked with acetone, tranexamic acid or sucralfate
  - **Rectal bleeding**
    - Instil 50mL of Tranexamic acid 10% (500mg/5mL) injection as rectal instillation OD - bd
    - Sucralfate enema (20mL of 10% solution) bd
  - **Oral** - Sucralfate suspension 2g in 10mL bd as mouthwash
  - **Systemic use (if bleeding not due to DIC)**
    - Tranexamic acid (1st line) - 1.5g PO stat and 1g PO tid
    - If bleeding not subsided, 1.5g PO tid (Max. recommended dose 1.5g tid)
    - Discontinue or reduce to 500mg PO tid one week after cessation of bleeding
    - If bleeding recurs, restart and continue indefinitely if necessary
    - Parenteral administration to be considered in patients with total dysphagia - 15mg/kg IV over 5-10 minutes tid - qid
    - Reduce the dose in renal impairment
    - Etamsylate (2nd line) - Switch from or combine with Tranexamic acid
    - 500mg PO qid either indefinitely or until one week after bleeding stops

- If Etamsylate causes nausea, vomiting or diarrhoea, take it after food

- **Haematuria**
  - Exclude infection, or treat infection with antibiotics
  - Continuous irrigation with 0.9% saline until urine is cleared
  - Avoid systemic haemostatics
- **Haemoptysis**
  - Maintain the airway
  - Use a head down position to allow drainage of blood
  - Exclude infection, or treat infection with antibiotics
  - Systemic haemostatics
  - Cough suppressant
- **Bleeding from Gastro-intestinal tract**
  - Proton pump inhibitor or H2 antagonist PO or IV
  - Systemic haemostatics

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