9. Epistaxis Algorithm

This clinical pathway is intended to supplement, rather than substitute for, professional judgment and may be changed depending upon a patient's individual needs. Failure to comply with this pathway does not represent a breach of the standard of care.

Wear PPE-

ASK THE PATIENT TO BLOW THEIR NOSE TO REMOVE ANY CLOTS & SPRAY THE NARES WITH OXYMETAZOLINE SPRAY

Have the patient squeeze the distal alae while sitting up, bent forward at the waist over a vomit bucket, and **expectorating** blood for **15mins. USE A WATCH!!** Ask the patient **NOT** to swallow any blood. A **clamping device** constructed of four tongue blades secured together by 1-inch tape over the distal alae can be used to clamp the nose closed.

- Monitor, support ABCs
- Check vital signs (BP, PR, RR, SPO_2, T° C)
- Perform brief, targeted history, physical exam
  - Nasal trauma from nose picking/blowing is the most common cause of epistaxis.
  - Hypertension **DOES NOT** cause epistaxis but may prolong it. Therapy should focus on control of the haemorrhage rather than reduction of the blood pressure. **DO NOT PRESCRIBE ANTI-HYPERTENSIVE THERAPY FOR EPISTAXIS**.
- **DO NOT order lab investigations routinely**
- For patients with severe or recurrent haemorrhage with a lot of clots, throwing up blood, or with unstable vital signs or underlying medical conditions, a FBC should be performed, as well as a type and screen.

Bleeding Controlled

Yes

- Repeat vital signs (BP, PR, RR, SPO_2, T° C)
- **Remove any cotton pledgets** and observe the patient for bleeding for at least **an hour** after control. Encourage the patient to walk or perform other activities that he or she will need to resume when returning home.
- Patients with underlying medication use (aspirin, NSAIDS, warfarin) or renal or hepatic dysfunction, order FBC, UEC & ?LFTs and coagulation studies - consult an **ENT Surgeon/Physician**
- If cause identified to be from nasal picking/blowing with no underlying medication use (aspirin, NSAIDS, warfarin) or renal or hepatic dysfunction, discharge patient (with ENT follow-up if recurrent).
- Follow-up instructions - **Vaseline** or a similar moisturizing agent should be applied liberally in the nose **TID** for **7-10 days** to promote healing of friable mucosa and superficial vessels.

No

Insert a 15-cm piece of cotton pledget soaked in **Adrenaline 1 mg + 5 mL Lignocaine 1%** in the bleeding nostril for **10 mins. USE A WATCH!!**

Bleeding Controlled

Yes

No

Insert a 15-cm piece of cotton pledget soaked in injectable form of **Tranexamic acid (500 mg in 5 mL)** in the bleeding nostril for **10 mins. USE A WATCH!!**

Bleeding Controlled

Yes

No

Pack the bleeding nostril with a **nasal tampon** or a **bacitracin ointment-soaked gauze (watch video http://bit.ly/2aTpWfa)**

* The tampon should be coated with **bacitracin ointment** or **xylocaine jelly** to facilitate placement.

Bleeding Controlled

Yes

No

Pack the **contralateral naris** with a **nasal tampon** or a **bacitracin ointment-soaked gauze** to provide a counterforce to promote tamponade

Bleeding Controlled

Yes

No

- Do **NOT** remove the contralateral nasal pack.
- Insert a lubricated **foley catheter (size 12 or 14 F)** until the tip and balloon is entirely in the nasopharynx. Fill the balloon with sterile water (usually **5-10cc**) to allow it to be pulled snugly against the posterior nasal choana with anterior traction. The Foley is secured by placing an umbilical or c-clamp on the catheter at the level of the nasal ala with padding in between to prevent pressure injury.

Bleeding Controlled

Yes

No

While the foley is still in-situ, pack the nostril of the bleeding side using a **nasal tampon** or a **bacitracin ointment-soaked gauze**.

* The tampon should be coated with bacitracin ointment or KY-Jelly to facilitate placement.

- Repeat vital signs (BP, PR, RR, SPO_2, T° C)
- Monitor, support ABCs
- Establish IV access and order FBC, UEC & ? LFTs, coagulation studies and a type and screen if warranted
- If cause identified to be from nasal picking/blowing with no underlying medication use (aspirin, NSAIDS, warfarin) or renal or hepatic dysfunction, consult an **ENT Surgeon**.
- Patients with underlying medication use (aspirin, NSAIDS, warfarin) or renal or hepatic dysfunction - consult a **Physician &** an **ENT Surgeon**