BLEEDING EMERGENCIES IN PALLIATIVE MEDICINE

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OBJECTIVES

× Consider possible sites of bleeding
× Discuss general principles of acute management in context of site and patient’s clinical picture

Thanks to Drs N. MacPherson J. Walker and H. Pearse
**MEDICAL ORDERS for SCOPE of TREATMENT (MOST)**
End of Life Care Program

**SECTION 1: CODE STATUS:** Note: CPR is not attempted on a patient who has suffered an unwitnessed cardiac arrest.
- **Attempt** Cardio Pulmonary Resuscitation (CPR). Automatically designated as C2. Please initial below.
- **Do Not Attempt** Cardio Pulmonary Resuscitation (DNR)

**SECTION 2: MOST DESIGNATION** based on documented conversations *(Initial appropriate level)*

<table>
<thead>
<tr>
<th>Medical treatments excluding Critical Care interventions &amp; Resuscitation</th>
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</table>
| **____ M1** | Supportive care, symptom management & comfort measures. *Allow natural death.*  
*Transfer to higher level of care only if patient's comfort needs not met in current location.* |
| **____ M2** | Medical treatments available within location of care. *Current Location:*  
*Transfer to higher level of care only if patient's comfort needs not met in current location* |
| **____ M3** | Full Medical treatments excluding critical care |

**Critical Care Interventions requested.** NOTE: Consultation will be required prior to admission.
- **____ C1** | Critical Care interventions excluding intubation. |
- **____ C2** | Critical Care interventions including intubation. |
HOW BIG IS THE BLEED?

Vitals
  - Postural drop?
Hemoglobin
  - much better if recent baseline available
Visualize ongoing bleeding if possible

Collateral:
Soaked towels/pads
Descriptions
Volume estimates

Is it clearly catastrophic hemorrhage??
  - Stop assessment and talk to the patient and family
WHERE'S THE BLEED?
What's the Cause??

- Tumor invasion
- Low PLT
- Cancer
- Treatment
- Liver disease
- Coagulopathy
- Drugs
- Infection
CNS (ICH)

54yo woman w/breast cancer to bone, liver, brain – generally well

Presents to ED with L sided weakness and facial droop

CT – CNS metastasis larger, hemorrhage and edema present

THINK ABOUT CONTEXT..

"WHAT IS THE APPROPRIATE TREATMENT FOR THIS PATIENT IN THIS PARTICULAR SITUATION??"
VASCULAR (CAROTID BLOWOUT SYNDROME)

- Rare but worrisome
- Most often in head and neck cancer, especially those with recurrent disease in previously radiated and/or operated area
- Open wound, infection, fistulas further increase risk
- 40% mortality rate – 60% morbidity
Threatened CBS

Impending CBS

Acute CBS

Plan
Prevent
Prepare
Document

Assess
Treat
Prepare

Treat or Comfort
Treat
Stabilize
Occlude

Refer

Refer
**ENDOVASCULAR TREATMENT**

Deconstructive – embolize, ligate

Significant neurologic consequence likely

Reconstructive – endovascular stent

- Takes time and assessment
  - appropriate in less emergent situation

May have higher risk of recurrence
MGMT OF MASSIVE BLEED

Stay CALM and stay with the patient
Call for help; Ensure privacy
If external, apply pressure
(Gloved finger or dressing)
Use dark towels (Surgical greens)
Protective gown/eyewear
Position and use suction to avoid choking
Crisis medication – often less important than support of patient and family
**Crisis Orders**

**Benzodiazepine for sedation, anxiolytic, amnestic properties**
- Midazolam: 5–10mg q5min if IV; q15min if SC/IM
- If not available: Lorazepam 4mg SL q10min
  - Diazepam 10mg PR q20min

**Opioid for pain or breathlessness**
- Hydromorphone 1mg SC q20 min / IV q5min (opioid naive)
  - OR double the patient’s regular PRN dose
SKIN (MALIGNANT WOUND)

× Fungating or Ulcerating
× Bleeding often starts with dressing changes, minor trauma, INFECTION
× Consider: Surgery, XRT, pressure/specialized dressing, antibiotic (topical +/- systemic), cautery (silver nitrate)
× Some unusual topical treatments...
SUCRALFATE

- A sulfated polysaccharide, sucrose octasulfate, complexed with aluminum hydroxide
- Seems to bind, protect and stimulate angiogenesis
- When to use it - topical, mouthwash, upper GI bleed (not very effective), PR
- Side effect: constipation
**TRANEXAMIC ACID (CYCLOKAPRON)**

- Lysine analog – antifibrinolytic, displaces plasminogen from fibrin, inhibits plasmin
- When to use it – mouthwash, topical (crushed), IV/PO systemic use (hemoptysis, GI bleed), PR enemas, PV
- 1mg IV/PO BID; 500mg in 5mL NS applied with pressure to wounds
- ?Increase clot risk
Topical Tranexamic Acid

INGREDIENTS:

1g Tranexamic acid tablets

1 Saline Soaked gauze

Crush Tablets

Mop up with saline soaked gauze

Apply to wound BID
**Recipe**

**For:**

**From the kitchen of:**

**Prep time:** _______ **Cook time:** _______ **Serves:** _______

**Ingredients:**

<table>
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<tr>
<th>500mg Tranexamic acid tablet</th>
<th>Crush Tablet</th>
</tr>
</thead>
<tbody>
<tr>
<td>10mL Warm Water</td>
<td>Mix with warm water</td>
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Rinse and spit or swallow QID
Tranexamic Acid Enemas

INGREDIENTS:

5g Tranexamic acid tablets
50mL Warm water

Crush Tablets
Mix with water
Instill PR or PV

Start BID, then daily, decrease frequency as able
ADRENALINE/EPINEPHRINE

× → Vasoconstriction
× Soaked gauze, 1mg/ml suggested with pressure for 10 minutes
× Be wary of necrosis, rebound once it wears off
**ANTIBIOTICS**

- Swabs are usually useless (mixed flora)
- Metronidazole
  - Powder (crushed tablets)
  - Cream
  - Systemic: Oral/Parenteral
**CALCIUM ALGINATE**
- Seaweed based dressing
- Oozing tumors
- Can be changed without debridement

**CELLULOSE**
- Collagen-like
- Turns into gel
- Doesn’t delay healing
Hemoptysis is common – presenting symptom in 10% of lung patients, and 20% of lung ca patients will have hemoptysis at some point. Presentation may be acute or chronic.

How much blood?
Consider volume and duration
(600mL considered massive, mortality 60-100%)

How ill/frail is the patient?

Consider:
- IVF, transfusions
- Suctioning
- Position on side, bleeding side down
- Tranexamic acid
- Bronchoscopy for Dx, Tx and/or Workup
- XRT (usually 1 tx and very effective)
- Terminal bleed orders
**Upper GI (Esophageal Varices, Gastric)**
**Lower GI**
**GYNE (Uterine/Cervical)**
**GU (Bladder)**

- Think about context
- Consider standard approach
- ? Radiation, Endoscopy, Transexamic acid, and ‘Topical’ approaches, Embolization [IR], Surgical removal of bleeding site
THANKS!

Any questions?

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