

ENT NEWS

A Service of the Ear, Nose, & Throat Center, PC

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Epistaxis

Nosebleeds are anxiety producing and frustrating events which in these times of universal precautions interfere greatly with the day's events. Nosebleeds are classified as anterior and posterior. A posterior bleed is one where the bleeding site is not visualized in the anterior nose or cannot be controlled with anterior packing. In the absence of a septal perforation (which are rare), acute epistaxis is virtually always unilateral and blood from the contralateral side represents blood moving through the nasopharynx from the primary site of bleeding to the opposite side of the nose. It is therefore important to ask which side the blood first started coming from.

Epistaxis in children is almost always from the anterior nasal septum, easy to control acutely but frequently is recurrent. It is more common in the dry winter months or due to vascular engorgement in the height of allergy symptoms or summer humidity. Acute episodes can be managed as outlined below.

- Recurrent episodes can be managed by topical **Vaseline** therapy nightly for a week to the affected side(s) and then perhaps with "maintenance therapy" once or twice a week.
- Avoidance of **NSAIDS** is also encouraged, as is the use of **antihistamines** to control significant allergy symptoms if present. Topical **nasal steroids** can be quite drying and may worsen epistaxis. Slight bloody discharge on nose blowing when using these products is not a reason to discontinue them.
- When epistaxis is recurrent and problematic despite the above then ENT referral should be considered. Typically in children electrocautery of the involved side solves the problem. This can be done in the office under topical/local anesthetic in older children and teenagers but requires brief outpatient surgery for younger patients. **It is quite helpful for the parent to know which side of the nose is more problematic** as only one side can be cauterized at a time (to avoid compromise of the septal cartilage blood supply, the second side can be done in 2 to 3 months). When simple measures fail and the parent is tired enough of the nosebleeds to have the child undergo a procedure then referral is appropriate.
- Epistaxis and **persistent nasal obstruction or hyponasal (stuffy) speech** also indicates referral to rule out the rare possibility of a **nasopharyngeal or nasal tumor**. Keep in mind that "a child with unilateral purulent rhinitis, often with foul breath and epistaxis, has a **nasal foreign body** until proven otherwise."

Epistaxis in adults is more severe and difficult to manage. Contributing factors include NSAID use (especially ASA) other anticoagulants, kidney or liver disease. Other common factors include septal deviation, hypertension, atherosclerosis and nasal oxygen (can be humidified), picking of nasal crusts (this leads to more crusting and picking – manage with Vaseline, .1% Elocon cream, or 1% HC cream). Less common are septal perforations (managed with Vaseline, septal button or surgical repair), tumors, hereditary hemorrhagic telangiectasia (Osler-Weber-Rendu syndrome), or other vascular lesions. Acute management is outlined below.

- Management of recurrent epistaxis in adults includes those measures outlined for children as well as limiting or controlling those factors listed above.
- Referral is indicated when problems persist or with symptoms of nasal obstruction or hyponasal speech.
- **Hemoptysis, hematemesis, or unexplained anemia** in the absence of frank epistaxis is **rarely, if ever, due to epistaxis** or other nasal/pharyngeal conditions. ENT referral is not warranted prior to an *extensive* work up for underlying pulmonary or GI conditions.

Management of acute epistaxis proceeds stepwise from simple to more invasive measures.

General Measures and Simple Home Measures

- As anxiety with associated elevation in blood pressure can worsen the bleeding, reassurance that things will eventually be OK is important. Sedation with benadryl, benzodiazopines or narcotics and avoiding stimulation by family members or activity can also be helpful.
- Elevate the head in a recliner, prop up on the couch, or elevate HOB with a pillow under the mattress.
- Stop NSAIDs or other anticoagulants (if medically appropriate) for a week or so.
- Blow the nose to get all of the blood out as clots contain fibinolytic factors that can propagate bleeding.
- Spray the nose with Afrin (oxymetazoline) and place cotton soaked with oxymetazoline in the affected side of the nose (leave the cotton in place for several hours or bleeding may recur.)
- Then pinch the nose "for five minutes by the clock."

Primary Care Management

- Recommended supplies: Afrin (oxymetazoline) nasal spray, silver nitrate sticks, Hurracaine spray, 2x2s Meroceal Standard nasal packs 4.5cm (440400) and/or 8 cm (440402), antibiotic ointment From Xomed Jacksonville Fla 32216 see www.Xomed.com/ProdCatalog/ProdCats.asp?specialty=rhinology
- Clear blood by blowing nose (actually more effective than suction)

- Decongest and anesthetize nose with Afrin and Hurracaine by both spraying in nose and using cotton soaked with both of these preparations. May send home with cotton in place for removal later that day.
- Cauterize bleeding site with AgNo3 if visible. May reinforce with cotton or Merocel pack
- If a pack seems necessary, coat short or long Merocel pack with antibiotic ointment. Any nasal pack that is being left in overnight should have **antibiotic ointment** on it as it will become quite foul smelling and potentially cause **toxic shock**. Patients with nasal packs should also be placed on **anti-staph antibiotics** (e.g. Keflex) for this reason and to avoid sinusitis. Slide the merocel pack straight **posteriorly (not angled superiorly)** into the nose, long packs may be pushed in until you feel them hit the posterior pharyngeal wall. The pack **expands** on its own or you can inject tap water or saline into the pack with a 3cc syringe. Trim extra packing sticking out and tape a 2x2 under the nose. Narcotics are indicated for most nasal packs to relieve the discomfort and keep the patient relaxed. Remove the pack in about 3 days. Some bleeding may occur then (cover the patient) which will resolve on its own or with some Afrin.
- If bleeding persists despite the above refer to ENT or send the patient to the ER.

Advanced Management

- Epistaxis can often be managed in the ENT office by endoscopic visualization and cautery or more aggressive packing. This may save the patient an ER visit and even avoid hospitalization.
- An epistat balloon inflated with water (not air) can control significant epistaxis. These patients are usually hospitalized to control pain and to observe for hypoxia and further bleeding.
- Reversal and monitoring of anticoagulation/bleeding diathesis as these patients will likely continue to bleed unless the condition is corrected. An absorbable gelfoam pack soaked with thrombin may help.
- Embolization or endoscopic/open surgical ligation of the internal maxillary, ethmoid or external carotid arteries may be necessary.