LINDSEY LODGE HOSPICE

MANAGEMENT OF CATASTROPHIC BLEEDING IN ADVANCED DISEASE

INPATIENT AND DAYCARE

Introduction

Although many patients may be at risk of a major haemorrhage, catastrophic bleeding is actually rare. Reliable data regarding the incidence of major haemorrhage within palliative care units is not available. If the blood volume loss is substantial enough the patient may become unconscious such that little action may be needed to ease patient suffering. However, when a patient does have a major haemorrhage, it can be a very distressing for family and staff.

Advance Care Planning

Multidisciplinary assessment, identification and discussion of those at risk of major haemorrhage should facilitate advance care planning in case of a major event occurring.

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, liver failure, oesophageal varices
- Smaller warning bleeds
- Local infection at the tumour site
- Clotting abnormalities e.g low platelet count, liver failure, inherited conditions
- On potentiating drugs eg. heparin, enoxaparin

For those identified as high risk for major bleeding, a plan should be individualised, reviewed and clearly documented

Who needs to be informed?

Discussion with patients and relatives may cause unnecessary anxiety and concern. There should be careful assessment of how beneficial this may be for a particular individual. However, it is good practice to offer patients/families the opportunity to discuss any worries or concerns they may have about the mode of death.

In some situations it is advisable to discuss the risk of major haemorrhage:

- If it is raised by the patient or family
- If knowledge about the risk allows the patient/family to change their behaviour in a helpful manner and facilitate other care planning e.g place of care
- If there have been warning bleeds
- If there are special circumstances which make it valuable for the family to know eg. children in the home

Communicate risk and care plan to healthcare professionals involved by documenting clearly in the case notes and updating the palliative care template on electronic records. For some patients in their own home, having a written plan of what to do in an emergency might be helpful for family members/carers.

What action should be taken?

- Stop anticoagulants and antiplatelet drugs (including NSAIDs) where possible.
- Refer to bleeding guidelines to determine if any specific treatments may benefit.

Consider:

- Preferred care setting – available level of care
- If an inpatient, nurse in a side room
- If at home, provide telephone numbers for emergency assistance
- Ensure a supply of dark sheets/towels is available along with other equipment: gloves, aprons, plastic sheet or incontinence pad, clinical waste bags.
- Plan for who will clean up after an event and how to contact them
- Prescription of crisis medication

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 patient on their side 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 below) 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 medication is felt to be appropriate it needs to be rapid in onset and readily available.

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

Drug	Route	Dose	Rate of Onset
Midazolam	IM (Deltoid #)	10mg	5-15 mins

#IM injection should be given proximally and deltoid muscle has greater blood supply than gluteal muscle.

NB: 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 nursing staff not available quickly (eg in patient's own home):

Drug	Route	Dose	Rate of onset
Diazepam	PR	10mg	5-15mins
Midazolam	Buccal	10mg (1ml)	15mins
Lorazepam	Sublingual	4mg (1ml)	5 mins

References

REFERENCES: Yorkshire Palliative Medicine Clinical Guidelines Group; Guidelines on the management of bleeding for palliative care patients with cancer; Nov 2008.

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