ANTERIOR EPISTAXIS

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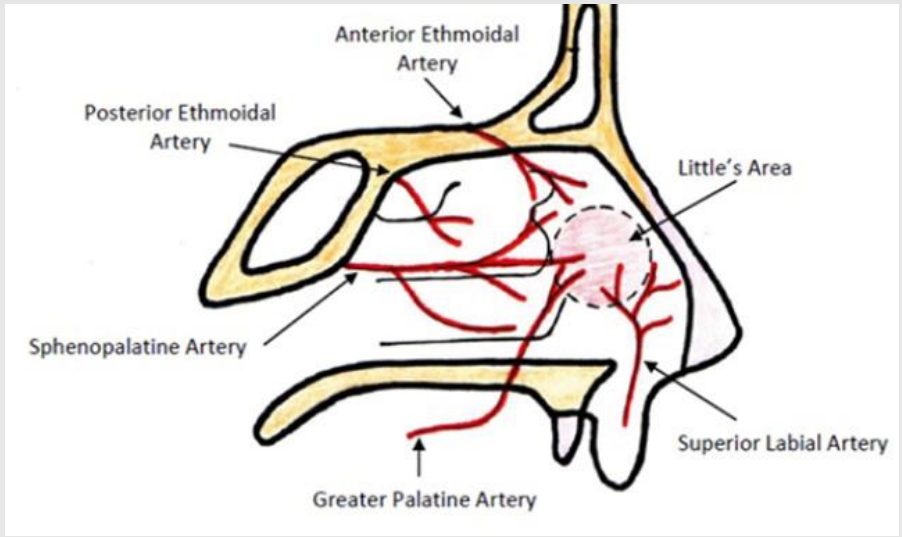
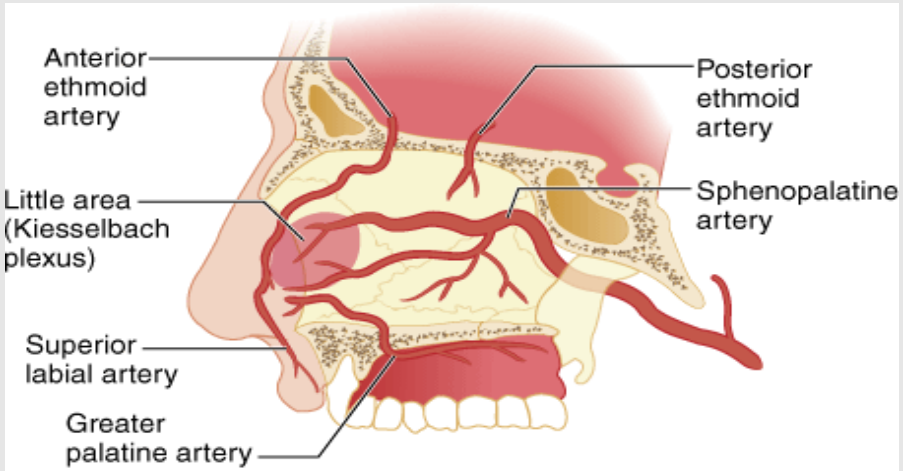




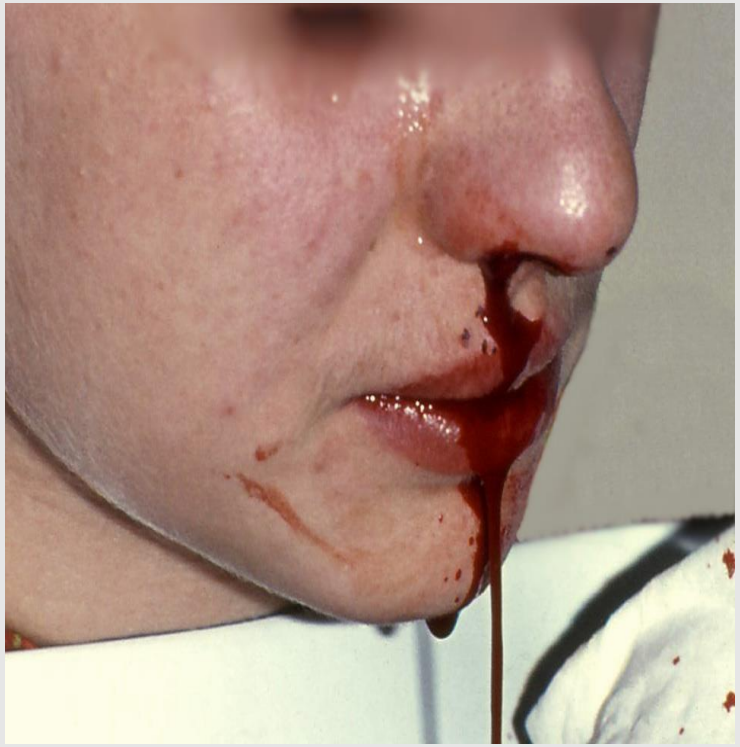
Structure of the nose

- Nose = vestibule.
- Nasal septum
- Lateral wall
- Nasopharynx

- Vascular Supply: 5 main branches → all converge on Little's area at inferior quadrant of nasal septum.
- - External & internal carotid arteries.

Epistaxis

- Common
- Majority occur between 2-12, and 50-80.
- ED physicians have 90% success rate of treating successfully.
- Causes:
  - Local trauma
  - Environmental (Dry > cold air)
  - Iatrogenic
  - Medicinal – aspirin/warfarin/NOACs
  - Coagulopathies
  - Vascular abnormalities



History

- Side
- Duration
- Frequency
- Contributing factors
- Medical history
- Medications

Examination

- Visualisation of bleeding area → anterior or posterior?
  - Anterior source usually on one side.
- Investigations
  - Usually only if very large bleed
  - INR for warfarinised patients.

Management

- **<u>Good first aid.</u>**
- Universal precautions.
- Patient upright – encourage “sniffing position.”
- Ask patient to pinch anterior nose for 15-20 mins.
- Ice packs to nape of neck and forehead.
- Reassess.

Still bleeding?

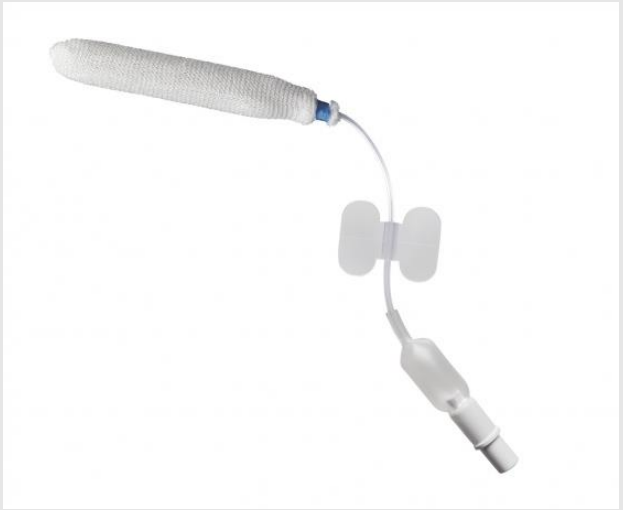
- **<u>Consider vasoconstriction</u>**
- Co-phenylcaine spray
- Lignocaine for analgesia, phenylephrine for vasoconstriction
- Spray up the affected nostril (or place on cotton wool ball and insert into nares)
- Reassess.

Still bleeding?

- **<u>CHEMICAL CAUTERY</u>**
- Look: good light source, nasal speculum.
- Suction if necessary → visualise the area.
- Area should be as dry as possible.
- Silver nitrate sticks (reacts with mucosal lining to produce chemical burn) → wipe over bleeding area until it becomes discoloured and grey (4-5 secs).
- Only one septum should be cauterised to prevent the risk of septal perforation.
- Reassess.

Still bleeding?

- **<u>Consider packing</u>**
- Merocel (flat tampon)
  - Dehydrated polymer sponge.
  - Can hold 3x their volume.
  - Coated with vasoline or sometimes Bactrim.
- Rapid Rhino
  - Carboxycellulose – promotes platelet aggregation.
  - Inflatable balloon which compresses nasal cavity.
  - Soak for 30 seconds prior to insertion (Saline +/- lignocaine)



Ongoing Management

- Admit patients with packing.
  - Consider SSOU if well.
  - At BH – can call Melbourne services if need for ENT admission.
  - Packs in for max 24h.
- +/- prophylactic antibiotics to reduce risk of toxic shock.
- ENT follow-up.
- Uncontrolled severe epistaxis may require ENT referral, ribbon gauze packing, saline-filled balloon catheters or trip to OT.

Standard Discharge Advice

- Avoid picking or irritating the nostril.
- (If cauterised – consider nasal moisturiser: Kenacomb or paraffin).
- Ice to suck
- Avoid vigorous blowing
- Avoid hot drinks and meals for 24h.
- Avoid heavy lifting and straining for 2 days.
- Represent if concerned.