MANAGEMENT OF RECURRENT EPISTAXIS

- This is a new guideline
- Persistent epistaxis with no obvious anterior cause or unresponsive to treatment -- then refer
Primary Care ENT Guidelines

Recurrent epistaxis

History

• Spontaneous or provoked? (e.g. by digital trauma, or postural changes)
• Where is bleeding sensation noted first? (if upright at time of onset and felt in throat suggests posterior bleed site more likely) **NB: All persistent posterior bleeds should be referred**
• Laterality – If unilateral and spontaneous with no obvious anterior site, **refer if persistent**
• Degree – Heavy nosebleeds in child/adolescent males, associated with nasal obstruction, could be juvenile angiofibroma
• Bleeding from other sites? – If history of menorrhagia/prolonged bleeding after dental extractions/FH of epistaxes, consider VonWillebrands Disease. Similarly if other stigmata of conditions associated with bleeding, consider FBC/LFTs/Coag screen
• Per-nasal drug use? OTC or prescribed steroids directed onto septum, Cocaine

Examination

• Anaemia? (esp. consider in the elderly with chronic history) **Jaundice?**
• Hypertensive? (chronic untreated hypertension may predispose, and in any case patients expect it and it’s an opportunity to screen)
• Anterior rhinoscopy – Use an auroscope to look for the following:
  - Prominent vessels in Little’s Area
  - Mucosal lesions – e.g. Papillomas/SCC/Melanoma. **Generalised** crusting and inflammation could indicate Wegeners or Sarcoid. **Localised** anterior crusting is more likely Staph-related vestibulitis
  - Septal deviation (causes drying of mucosa and propensity to bleed)
  - Septal perforation - often the posterior rim will desiccate and crust/bleed

  **Evidence or history of digital trauma** (shiny thickened mucosa similar to lichen simplex).

Treatment

Appropriately trained GPs could perform cautery.

Prominent vessels in Little’s Area - If you are able to see a bleeding point or prominent vessels in the anterior nasal septum you could perform cautery with silver nitrate. Alternatively, the patient may be referred

Treatment section

1) GP doing cautery – see the bleeding point or dilated vessels
2) If actively bleeding, CONTACT the ENT doctor on-call to discuss the case or send patient to A&E if appropriate

3) If not actively bleeding, try Naseptin cream (if patient is not allergic to peanuts) or Mupirocin cream for up to 2 weeks

4) If not actively bleeding and the above treatment does not help to stop epistaxis, REFER to ENT clinic routinely

**Mucosal lesions**- Refer for consideration of removal/biopsy.

**Septal deviation** – advise petroleum jelly at night applied with cotton bud. If fails to resolve problem and patient wishes to consider surgery, refer for consideration of septoplasty.

**Septal perforation** – These are most commonly a complication of septal surgery or trauma, however it is best to refer for further investigations and discussion of treatment options.

**Polyps**- Unilateral nose-bleeds with associated other nasal sinus symptoms, refer for exclusion of malignancy

**Bottom Line:**

*Persistent epistaxis with no obvious anterior cause or unresponsive to treatment → refer*