

Management of Catastrophic Bleeding

Guideline Responsibilities and Authorisation

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Guideline Review History

Version	Updated by	Date Updated	Description of Changes
2	Lana Ferguson	13 May 2021	Addition to pharmacological management

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Management of Catastrophic Bleeding

1. Overview

This is a rare event. Clinically significant bleeding occurs in 6-10% of patients with cancer and 3% of lung cancer patients have a terminal massive haemoptysis.

There are multiple terms used to describe this event; exsanguination/catastrophic bleed/terminal haemorrhage/massive haemorrhage. These are interchangeable terms that describe an acute haemorrhagic event that is not survivable.

Communication and how you interact with the patient and family/whanau is more important than pharmacological management when managing a catastrophic bleed.

Your presence as a health professional is one of the most important tools in managing catastrophic bleeding.

1.1 Purpose

To provide guidance to medical and nursing staff in the management of an acute haemorrhagic event that is not survivable.

1.2 Scope

All Waikato District Health Board (DHB) medical staff involved in the clinical care of palliative patients will be aware of and familiar with guidelines.

1.3 Patient / client group

Palliative care patients with catastrophic bleeding.

1.4 Definitions

Crisis medication	Medication that is prescribed only to be given in the event of a massive unsurvivable haemorrhage. Usually midazolam and morphine (or other opioid).
CSCI	Continuous Subcutaneous Infusion

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2. Clinical Management

2.1 Roles and Responsibilities

Clinicians

Be aware of and familiar with guidelines and apply to patients as appropriate.

2.2 Guideline

2.2.1 Potential causes of catastrophic bleeding

- Being prepared for a potential bleed is one of the most important things that can be done.
- It is important to ensure the patient and family/whanau are aware of the potential for this to happen as well as providing a clear plan of what will be done should a bleed occur.
 - This is of particular importance if the patient is to be discharged home; crisis medication should be available in pre-filled syringes in the house and a clear written plan should be given to family (this can also serve as a guide for paramedics who may attend).
- Ward nursing staff should be made aware of potential for bleeding - clear action plan should be written in the clinical notes and crisis medication should be prescribed.
- In the setting where a catastrophic bleed is highly likely to occur, place of death should be discussed. It may be more appropriate for the patient to be in an inpatient setting.

Causes of catastrophic bleeding in palliative patients

<i>ENT tumour</i>	• Carotid artery erosion from neck metastases • Oropharyngeal tumour erosion
<i>Gastrointestinal haemorrhage</i>	• Gastroduodenal haematemesis • Bleeding with melaena or haematochezia
<i>Haemoptysis</i>	• Lung or bronchial tumour erosion into adjacent vessels
<i>Genitourinary</i>	• Haematuria, per vaginal bleeding (uterine, cervical tumours)
<i>Haematological malignancy</i>	• Multiple possible sites; haematuria, epistaxis, haemoptysis can predominant. • Extensive ecchymoses and petechiae can be visually distressing
<i>Coagulopathy</i>	• Hepatic failure, sepsis • Multiple possible sites
<i>Other</i>	• Ruptured aortic aneurysm • Tumor erosion

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2.2.2 Non-Pharmacological management:

Scenario 1: Rapid blood loss

- Ensure you are wearing protective gear (gloves +/- gown, eye wear)
- Do not leave the patient, remain with them at all times
- Maintain tactile contact with the patient (hold them or at the very least hold their hand) until they lose consciousness.
- If you are alone, call for help or press call bell – do not leave the patient to get help.
- Ensure several large towels are available at the bedside, preferably dark in colour. This will help to minimize the visual impact of a large volume of blood.
- Have several face cloths available to wipe blood from mouth and face

Scenario 2: Prolonged blood loss

- Ensure you are wearing protective gear (gloves +/- gown, eye wear) when in contact with the patient.
- Position the patient in a position that is comfortable but also allows clearance of blood and maintenance of airway (recovery position is often useful).
- Aim to maintain the patient in this position for the duration of the bleed; further movement could precipitate increased bleeding.
- In haemoptysis; place the patient with the bleeding side down (if known).
- Ensure several large towels are available at the bedside, preferably dark in colour.
- Have a soiled linen bag available in the room.
- Have several face cloths available to wipe blood from mouth and face.
- If blood loss is via the mouth ensure multiple vomit pots are available.
- Suction may be helpful with oropharyngeal bleeding.
- Have warmed blankets available, the patient will feel cold due to blood loss and hypotension.

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2.2.3 Pharmacological management

The aim of pharmacological management is to provide rapid sedation in the setting of catastrophic blood loss.

Most commonly this is achieved with midazolam +/- morphine.

Realistically, in the setting of rapid blood loss, cardiac arrest is likely to occur before onset of effect of any sedating medication given.

If a catastrophic bleed is anticipated (particularly if the patient is to be discharged home); crisis medication should be in prefilled syringe, labelled and readily at hand.

Caution that all medication should be stored safely and out of reach of children.

See Crisis Medication in Palliative Care guideline for further information

Scenario 1: Rapid blood loss

- There is usually insufficient time for crisis medication to work in this setting.
- Time is better used remaining with the patient, and providing reassurance and comfort.
- If the patient has a patent IV line (hospital setting) this should be used in preference to the subcutaneous route as onset of action will be quicker.
- Crisis medication should be titrated to effect and will be individual to the patient and situation occurring however, it is reasonable to prescribe:

- Midazolam 5-10mg subcut every 10 minutes (max 3 doses or until adequate level of sedation).
- Morphine 5-10mg subcut every 10 minutes (max 3 doses or until adequate level of sedation) for opioid naïve patients.

- For patients on background opioids; multiply their PRN opioid dose by 3 and use this as the bolus dose. E.g. For a patient on morphine 5mg subcut Q1H PRN, their crisis morphine dose would be 15mg subcut every 10 minutes (max of 3 doses or until adequate level of sedation).
- NB: the crisis opioid does not need to be morphine; use whichever opioid is being given PRN (oxycodone, morphine or fentanyl)

Scenario 2: Prolonged blood loss

- This can be more challenging to manage. At the onset of bleeding the duration is unknown, however will become evident over several minutes.
- Again, titration of crisis medication (as above) can be initiated.

- If it becomes evident that this is going to be prolonged (hours) it is most likely appropriate to commence a continuous subcutaneous infusion to maintain adequate sedation – **this should be discussed with a palliative specialist.**

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Doc ID:	5892	Version:	02	Issue Date:	01 AUG 2021	Review Date:	01 AUG 2024
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