PALLIATIVE CARE NETWORK OF WISCONSIN

FAST FACTS AND CONCEPTS #341
BLEEDING MANAGEMENT IN HOSPICE CARE SETTINGS
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Background Bleeding is a distressing, complex, and relatively common symptom in palliative care (1). It can present at many anatomical sites and vary in acuity and presentation. This *Fast Fact*, provides an approach to managing non-catastrophic bleeding in terminally ill patients in home or hospice settings.

General Considerations Severity is not the only important clinical consideration when evaluating bleeding in a seriously ill patient. Some imminently dying patients may not benefit from diagnostic workup or intervention even if the bleeding is profuse, while more stable patients can benefit from investigations if they would prevent a terminal bleed or symptom burden (2). Clinicians need to consider goals of care and prognosis in bleeding assessment, as these factors can dictate the degree of investigation and intervention. Additionally, clinicians should be mindful of what testing and interventions can be done in the current environment, as many terminal patients may want to avoid being transferred. A routine CBC or serum INR level, for example, often can be coordinated at home, whereas an advanced intervention such as a bronchoscopy or gastroscopy cannot be.

Initial Management Steps Prior to initiating other interventions, clinicians should remember to:
- Apply pressure if anatomically possible with an appropriate gauze or dressing.
- Consult with a pharmacist to identify offending agents (1). For example, medications such as enoxaparin, oral anticoagulants (see *Fast Fact* #236 and #278), aspirin, NSAIDs, and chemotherapeutics all can cause or exacerbate bleeding. Over-the-counter supplements such as fish oil, omega fatty acids, ginseng, and gingko biloba are known to increase bleeding risk.

Systemic Treatments:
- Vitamin K: For terminally ill patients on warfarin or with clotting factor deficiencies (e.g. end stage liver failure), consider an empiric dose of 2.5-3 mg oral or subcutaneous Vitamin K (3-6) and/or consumption of Vitamin K-rich foods (e.g. green leafy vegetables, broccoli, prunes, or cabbage).
- Transfusions: Platelet, fresh frozen plasma, and clotting factor concentrate transfusions can prevent or stop active bleeding in select patients with thrombocytopenia (e.g. platelet count < 50K) or certain coagulopathies (7). Red blood cell transfusions can improve symptoms such as fatigue, chest pain and shortness of breath, especially when hemoglobin <8. Yet, transfusions are difficult to coordinate in a home or hospice care setting, as they typically necessitate transfer to a specialty clinic or hospital for administration. They may even require revocation of hospice. Therefore, many experts avoid transfusions in imminently dying patients with comfort goals of care.

Local Site Management Prevention and preparation are crucial aspects of bleeding management in dying patients at home or a hospice facility. For at-risk patients with thrombocytopenia, coagulopathy, or specific anatomic concerns, clinicians should ensure that necessary supplies and therapies are available in the care setting before bleeding occurs.
- Head and Neck: Patients with erosive tumors of the head and neck are at risk for bleeding. Prophylactic measures such as elevating the head of the bed to 45 degrees, maintaining a soft diet, and minimizing traumatic brushing/flossing are recommended (8). A suction kit at bedside can be useful for patients at risk for epistaxis. For active mucosal bleeding, the effective use of topical agents like silver nitrate, surgicell dressing, or sucralfate gel 1 g in 5 mL water soluble applied to the wound has been described (9). Some experts recommend trying 5% tranexamic acid (TXA) oral rinse TID either as a 10-mL swish and spit x 10 minutes or as a soaking gauze (1,9). If pre-fitted dental molds are available, apply them with a topical agent, in wakeful patients with gingival bleeding (8).
- Respiratory Tract: Elevate the head of the bed and consider prophylactic use of cough suppressants (see *Fast Facts* # 199 & 200). For active bleeding from a known location, position the patient on the side of bleeding to reduce the compressive force on the contralateral side.
- Urinary Tract: Finasteride may help reduce the recurrence of hematuria in male patients with benign prostatic hypertrophy (9). For hemorrhagic cystitis, intermittent bladder irrigations with saline or TXA 5 g in 50 mL water daily or BID may help (10). If bleeding continues, continuous bladder irrigation with 0.5% or 1% silver nitrate in water solution could be pursued; however, bladder irrigation can induce bladder spasms, so caution should be heeded.

- Gastrointestinal (GI) Tract: Effective use of TXA given 1-2 g orally 4-6 times per day, or intravenously at 10 mg/kg 3-4 times per day has been described for active GI bleeding (11). Intravenous infusion of vasopressin 0.1-0.4 mg/hr can reduce GI bleeding in select patients, but it requires hospital monitoring (12). Octreotide 50-100 ug SQ BID or as a 48-hour 50 ug/hr SQ infusion has been described as a home alternative (13). For rectal bleeding, packing with dressings coated with TXA or sucralafate paste may help (10). For minor, hemorrhoid-induced bleeding, Sitz baths or over-the-counter hemorrhoid medications may minimize bleeding by decreasing local inflammation (14).

Advanced Interventions and Treatments When bleeding is brisk, patients and families may reconsider their choice to stay at home and/or pursue comfort care. Consequently, clinicians may need to direct these patients to the emergency department for urgent specialist consultation (e.g., gastroenterology for possible colonoscopy; urology for possible cystoscopy; interventional radiology for possible vessel embolization). Short-course radiotherapy is worthy of special consideration to prevent or treat oozing from a malignant lesion. In some circumstances, it can be coordinated without revocation of hospice services. Regardless, all interventions must be considered in the context of the treatment burden and the duration of recovery from treatment, especially when life-expectancy is limited.

Caring for Caregivers *Fast Facts* #251 & 297 have more information on the management of brisk, catastrophic bleeding. When preparing family members for this possibility do so in a sensitive manner so as not to invoke fear (1). Educate family on how to deliver fast-acting sedative from an emergency kit if needed, as well on the importance of dark sheets, towels, and clothing to reduce the visibility of blood (1,9). Social workers and other team members may be able to coach family members in distraction techniques such as relaxation and mental imagery.

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