## Wound Management Guidelines and Pressure Ulcer Prevention Action Card

<table>
<thead>
<tr>
<th>Interventions for Head and Neck Cancer-Associated Bleeding</th>
<th>WM1</th>
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<tbody>
<tr>
<td><strong>FOR USE BY:</strong> All Clinician and Nursing staff caring for head and neck cancer patients</td>
<td><strong>LIAISES WITH:</strong> other members of the MDT; Specialist Palliative Care Services</td>
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### General Preventative Measures
- Where at risk or when bleed has occurred, always review medications and discontinue, where possible, agents that may exacerbate bleeds e.g. aspirin, clopidogrel, fragmin.
- Monitor for and treat infection as this can exacerbate risk of bleeding.
- Minimise trauma to area e.g. clean with gentle irrigation, use non-adhesive dressings, use baby toothbrush and avoid vulnerable area.
- For all patients consider the appropriateness of radiotherapy, chemotherapy, cauterisation or embolisation.

### Please consider referral to Specialist Palliative Care Services

### Topical Measures
1. **For bleeding from the nasopharynx**
   - a. Silver nitrate sticks for localised bleeding in accessible sites
   - b. Haemostatic packing e.g. Kaltostat kept in site until bleeding controlled (usually a few days).
   - c. Topical tranexamic acid.
      - Soak gauze with tranexamic acid 500mg/5ml amp. Hold over bleed applying pressure.
   - d. Consider with caution topical adrenaline soaked on gauze for bleeding in localised and accessible sites.
      - Soak gauze with 1(1ml) vial of 1:1000 1mg/ml epinephrine (adrenaline) for injection. Hold over bleed applying pressure for up to 10mins at most. Be aware of risk of rebound bleeding.

2. **For bleeding from the oropharynx/superficial wounds**
   - a. To control profuse bleeding:
      - i. Topical tranexamic acid.
         - Soak gauze with tranexamic acid 500mg/5ml amp. Hold over bleed applying pressure.
      - ii. Consider topical adrenaline soaked on gauze for bleeding in localised and accessible sites.
         - Soak gauze with 1(1ml) vial of 1:1000 1mg/ml epinephrine (adrenaline) for injection. Hold over bleed applying pressure for up to 10mins at most. Be aware of risk of rebound bleeding.
   - b. To control capillary oozing:
      - i. Tranexamic acid mouthwash 1g/10ml, 10mls qds
         - Topical Sucralfate paste crush two 1g tablets in 5ml water soluble gel, apply to bleeding area 1-2 times daily
      - ii. Sucralfate mouthwash 2g/10ml suspension 10mls BD
      - iii. Consider nebulised adrenaline 5ml 1:1000 1mg/ml epinephrine (adrenaline) diluted with 5ml 0.9% saline QDS for bleeding in less accessible sites

### Systemic Measures
- Oral tranexamic acid 1g tds. Can be increased to 2g tds if bleeding does not subside after 3 days. This can be discontinued 10days after bleeding stops or continued indefinitely.
- Etamsylate 500mg qds. This can be used alone or in conjunction with tranexamic acid.

**CONSIDER RISK OF CATASTROPHIC BLEED – SEE OVERLEAF**

**ALWAYS ENSURE ALL RELEVANT ACTIONS ARE DOCUMENTED!**
CATASTROPHIC BLEED:
This is defined as a sudden major haemorrhage in a patient where active treatment is not appropriate or not possible and where death is inevitable within minutes.
A major haemorrhage can occur when a tumour erodes a major vessel resulting in external haemorrhage usually from the carotid artery or internal haemorrhage causing massive haemoptysis or haematemesis.

Is the patient at risk of a major life-threatening bleed? – MDT decision
Risk factors:
- Head and neck tumours
- Tumour causing stridor
- Bone marrow failure
- GI Malignancies/Varices with previous herald bleed

<table>
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<tr>
<th>YES</th>
<th>NO</th>
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<td>Reassess as appropriate</td>
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Advance Care Plan
- Stop anticoagulants/antiplatelet drugs where possible
- Alert those who need to know about risk:
  - Patient(?), family, carers, other healthcare professionals
  - Preferred care setting – available level of care
  - DNACPR
  - Equipment: dark sheets/towels, gloves, aprons, plastic sheet or inco pad, clinical waste bags.
  - Plan for who will clean up after an event/how to contact them
  - Consider prescription/preparation of crisis medication

PLEASE LIAISE WITH SPECIALIST PALLIATIVE CARE TEAM

IN THE EVENT OF AN ACUTE SEVERE BLEED:
- Stay calm and if possible summon assistance
- Ensure that someone is with the patient at all times
- If possible nurse in recovery position 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 as agreed in advance care planning (see below), repeated after 10 minutes if needed.

REMEMBER PATIENT SUPPORT & NON-DRUG INTERVENTIONS OFTEN MORE IMPORTANT THAN CRISIS MEDICATION

After the Event
- Offer de-briefing to the whole team – SPC team happy to facilitate
- Ongoing support as necessary for relatives/staff members
- Disposal of clinical waste appropriately

CRISIS MEDICATION: Benzodiazepines are the drugs of choice. The doses suggested reflect their aim to sedate the patient and provide amnesia should the patient recover, but not to hasten death.

In hospital setting/nursing staff available:
Midazolam 10mg IV/IM
- Prescribe as a one off dose
- Consider having drug in locker/IV cannula in situ.
- The subcutaneous route is inappropriate

If domiciliary setting or nursing staff not available quickly:
Midazolam 10mg buccally/intranasally
(Diazepam 20-30mg rectally)

NB: Larger doses may be required in patients on regular benzodiazepines.
These events are generally not painful and therefore opioids are not routinely required.