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# What Causes a NOSEBLEED?

There are many delicate blood vessels in the nose that can be easily damaged. A nosebleed can occur due to many different reasons and risk factors. Usually, a nosebleed will stop on its own, but it could require emergency medical attention if serious.



## Pre-existing conditions

Diseases that affect the body's ability to clot blood, including liver disease, can cause the nose to bleed. Allergies can also lead to a nosebleed.



## Blood-thinning medication

NSAIDs and other pain medications can cause nosebleeds. Many drugs intended to treat heart conditions also have this effect.



## Dry air

In the wintertime, dry air from the cold or from indoor heating can cause the lining of the nose to dry, crack, and bleed.



## Picking your nose

Scratching inside your nose can lead to accidental injury to blood vessels.



## Frequent usage of nasal spray

Using nasal spray more often than directed may lead to irritation and nosebleeds.



If you experience common and frequent nosebleeds, be sure to speak with your doctor to rule out any causes.



How stop blood from nose.

[Skip to Navigation] Objective: Nosebleed, also known as epistaxis, is a common problem that occurs at some point in at least 60% of people in the United States. While the majority of nosebleeds are limited in severity and duration, about 6% of people who experience nosebleeds will seek medical attention. For the purposes of this guideline, we define the target patient with a nosebleed as a patient with bleeding from the nostril, nasal cavity, or nasopharynx that is sufficient to warrant medical advice or care. This includes bleeding that is severe, persistent, and/or recurrent, as well as bleeding that impacts a patient's quality of life. Interventions for nosebleeds range from self-treatment and home remedies to more intensive procedural interventions in medical offices, emergency departments, hospitals, and operating rooms. Epistaxis has been estimated to account for 0.5% of all emergency department visits and up to one-third of all otolaryngology-related emergency department encounters. Inpatient hospitalization for aggressive treatment of severe nosebleeds has been reported in 0.2% of patients with nosebleeds. Purpose: The primary purpose of this multidisciplinary guideline is to identify quality improvement opportunities in the management of nosebleeds and to create clear and actionable recommendations to implement these opportunities in clinical practice. Specific goals of this guideline are to promote best practices, reduce unjustified variations in care of patients with nosebleeds, improve health outcomes, and minimize the potential harms of nosebleeds or interventions to treat nosebleeds. The target patient for the guideline is any individual aged  $\geq 3$  years with a nosebleed or history of nosebleed who needs medical treatment or seeks medical advice. The target audience of this guideline is clinicians who evaluate and treat patients with nosebleed. This includes primary care providers such as family medicine physicians, internists, pediatricians, physician assistants, and nurse practitioners. It also includes specialists such as emergency medicine providers, otolaryngologists, interventional radiologists/neuroradiologists and neurointerventionalists, hematologists, and cardiologists. The setting for this guideline includes any site of evaluation and treatment for a patient with nosebleed, including ambulatory medical sites, the emergency department, the inpatient hospital, and even remote outpatient encounters with phone calls and telemedicine. Outcomes to be considered for patients with nosebleed include control of acute bleeding, prevention of recurrent episodes of nasal bleeding, complications of treatment modalities, and accuracy of diagnostic measures. This guideline addresses the diagnosis, treatment, and prevention of nosebleed. It focuses on nosebleeds that commonly present to clinicians via phone calls, office visits, and emergency room encounters. This guideline discusses first-line treatments such as nasal compression, application of vasoconstrictors, nasal packing, and nasal cautery. It also addresses more complex epistaxis management, which includes the use of endoscopic arterial ligation and interventional radiology procedures. Management options for 2 special groups of patients-patients with hereditary hemorrhagic telangiectasia syndrome and patients taking medications that inhibit coagulation and/or platelet function-are included in this guideline. This guideline is intended to focus on evidence-based quality improvement opportunities judged most important by the guideline development group. It is not intended to be a comprehensive, general guide for managing patients with nosebleed. In this context, the purpose is to define useful actions for clinicians, generalists, and specialists from a variety of disciplines to improve quality of care. Conversely, the statements in this guideline are not intended to limit or restrict care provided by clinicians based on their experience and assessment of individual patients. Action statements: The guideline development group made recommendations for the following key action statements: (1) At the time of initial contact, the clinician should distinguish the nosebleed patient who requires prompt management from the patient who does not. (2) The clinician should treat active bleeding for patients in need of prompt management with firm sustained compression to the lower third of the nose, with or without the assistance of the patient or caregiver, for 5 minutes or longer. (3a) For patients in whom bleeding precludes identification of a bleeding site despite nasal compression, the clinician should treat ongoing active bleeding with nasal packing. (3b) The clinician should use resorbable packing for patients with a suspected bleeding disorder or for patients who are using anticoagulation or antiplatelet medications. (4) The clinician should educate the patient who undergoes nasal packing about the type of packing placed, timing of and plan for removal of packing (if not resorbable), postprocedure care, and any signs or symptoms that would warrant prompt reassessment. (5) The clinician should document factors that increase the frequency or severity of bleeding for any patient with a nosebleed, including personal or family history of bleeding disorders, use of anticoagulant or antiplatelet medications, or intranasal drug use. (6) The clinician should perform anterior rhinoscopy to identify a source of bleeding after removal of any blood clot (if present) for patients with nosebleeds. (7a) The clinician should perform, or should refer to a clinician who can perform, nasal endoscopy to identify the site of bleeding and guide further management in patients with recurrent nasal bleeding, despite prior treatment with packing or cautery, or with recurrent unilateral nasal bleeding. (8) The clinician should treat patients with an identified site of bleeding with an appropriate intervention, which may include one or more of the following: topical vasoconstrictors, nasal cautery, and moisturizing or lubricating agents. (9) When nasal cautery is chosen for treatment, the clinician should anesthetize the bleeding site and restrict application of cautery only to the active or suspected site(s) of bleeding. (10) The clinician should evaluate, or refer to a clinician who can evaluate, candidacy for surgical arterial ligation or endovascular embolization for patients with persistent or recurrent bleeding not controlled by packing or nasal cauterization. (11) In the absence of life-threatening bleeding, the clinician should initiate first-line treatments prior to transfusion, reversal of anticoagulation, or withdrawal of anticoagulation/antiplatelet medications for patients using these medications. (12) The clinician should assess, or refer to a specialist who can assess, the presence of nasal telangiectasias and/or oral mucosal telangiectasias in patients who have a history of recurrent bilateral nosebleeds or a family history of recurrent nosebleeds to diagnose hereditary hemorrhagic telangiectasia syndrome. (13) The clinician should educate patients with nosebleeds and their caregivers about preventive measures for nosebleeds, home treatment for nosebleeds, and indications to seek additional medical care. (14) The clinician or designee should document the outcome of intervention within 30 days or document transition of care in patients who had a nosebleed treated with nonresorbable packing, surgery, or arterial ligation/embolization. The policy level for the following recommendation, about examination of the nasal cavity and nasopharynx using nasal endoscopy, was an option: (7b) The clinician may perform, or may refer to a clinician who can perform, nasal endoscopy to examine the nasal cavity and nasopharynx in patients with epistaxis that is difficult to control or when there is concern for unrecognized pathology contributing to epistaxis. Keywords: epistaxis; hereditary hemorrhagic telangiectasia (HHT); nasal cautery; nasal packing; nosebleed. Epistaxis, or nasal bleeding, has been reported to occur in up to 60 percent of the general population.<sup>1-3</sup> The condition has a bimodal distribution, with incidence peaks at ages younger than 10 years and older than 50 years. Epistaxis appears to occur more often in males than in females.<sup>1,4</sup> Epistaxis is common, and affected persons usually do not seek medical attention, particularly if the bleeding is minor or self-limited. In rare cases, however, massive nasal bleeding can lead to death.<sup>5-7</sup> The rich vascular supply of the nose originates from the ethmoid branches of the internal carotid arteries and the facial and internal maxillary divisions of the external carotid arteries.<sup>5</sup> Although nasal circulation is complex (Figure 1), epistaxis usually is described as either anterior or posterior bleeding. This simple distinction provides a useful basis for management. Most cases of epistaxis occur in the anterior part of the nose, with the bleeding usually arising from the rich arterial anastomoses of the nasal septum (Kiesselbach's plexus). Posterior epistaxis generally arises from the posterior nasal cavity via branches of the sphenopalatine arteries.<sup>8</sup> Such bleeding usually occurs behind the posterior portion of the middle turbinate or at the posterior superior roof of the nasal cavity. In most cases, anterior bleeding is clinically obvious. In contrast, posterior bleeding may be asymptomatic or may present insidiously as nausea, hematemesis, anemia, hemoptysis, or melena. Infrequently, larger vessels are involved in posterior epistaxis and can result in sudden, massive bleeding. Most causes of nasal bleeding can be identified readily through a directed history and physical examination. The patient should be asked about the initial presentation of the bleeding, previous bleeding episodes and their treatment, comorbid conditions, and current medications, including over-the-counter medicines and herbal and home remedies. Although the differential diagnosis should include both local and systemic causes (Table 1),<sup>1,5,9</sup> environmental factors such as humidity and allergens also must be considered.<sup>5,10</sup> Often, no cause for the bleeding is identified. Initial management includes compression of the nostrils (application of direct pressure to the septal area) and plugging of the affected nostril with gauze or cotton that has been soaked in a topical decongestant. Direct pressure should be applied continuously for at least five minutes, and for up to 20 minutes. Tilting the head forward prevents blood from pooling in the posterior pharynx, thereby avoiding nausea and airway obstruction. Hemodynamic stability and airway patency should be confirmed. Fluid resuscitation should be initiated if volume depletion is suspected. Every attempt should be made to locate the source of bleeding that does not respond to simple compression and nasal plugging. The examination should be performed in a well-lighted room, with the patient seated and clothing protected by a sheet or gown. The physician should wear gloves and other appropriate protective equipment (e.g., surgical mask, safety glasses). A headlamp or head mirror and a nasal speculum should be used for optimal visualization. An epistaxis tray can be created using common supplies and a few specialized instruments (Figure 2). Clots and foreign bodies in the anterior nasal cavity can be removed with a small (Frazier) suction tip, irrigation, forceps, and cotton-tipped applicators. When posterior bleeding is suspected, the general location of the source should be determined. This step is important because different arteries supply the floor and roof of the posterior nasal cavity; therefore, selective ligation may be required.<sup>5,11</sup> Diffuse oozing, multiple bleeding sites, or recurrent bleeding may indicate a systemic process such as hypertension, anticoagulation, or coagulopathy. In such cases, a hematologic evaluation should be performed. Appropriate tests include a complete blood count, anticoagulant levels, a prothrombin time, a partial thromboplastin time, a platelet count and, if indicated, blood typing and crossmatching.<sup>9,12</sup> Although most patients with epistaxis can be treated as outpatients, hospital admission and close observation should be considered for elderly patients and patients with posterior bleeding or coagulopathy. Admission also may be prudent for patients with complicating comorbid conditions such as coronary artery disease, severe hypertension, or significant anemia. If a single anterior bleeding site is found, vasoconstriction should be attempted with topical application of a 4 percent cocaine solution or an oxymetazoline or phenylephrine solution. For bleeding that is likely to require more aggressive treatment, a local anesthetic, such as a 4 percent cocaine solution or tetracaine or lidocaine (Xylocaine) solution, should be used. Adequate anesthesia should be obtained before treatment proceeds. Intravenous access should be obtained in difficult cases, especially when anxiolytic medications are to be used. Cotton pledgets soaked in vasoconstrictor and anesthetic should be placed in the anterior nasal cavity, and direct pressure should be applied at both sides of the nose for at least five minutes. Then the pledgets can be removed for reinspection of the bleeding site. If this measure is unsuccessful, chemical cautery can be attempted using a silver nitrate stick applied directly to the bleeding site for approximately 30 seconds.<sup>5</sup> Other treatment options include hemostatic packing with absorbable gelatin foam (Gelfoam) or oxidized cellulose (Surgicel). Use of desmopressin spray (DDAVP) may be considered in a patient with a known bleeding disorder.<sup>5,13</sup> Larger vessels generally respond more readily to electrocautery. However, electrocautery must be performed cautiously to avoid excessive destruction of healthy surrounding tissues. Note that use of electrocautery on both sides of the septum may increase the risk of septal perforation.<sup>9</sup> Interestingly, at least one study<sup>14</sup> found no difference in efficacy or complication rate between chemical cautery (silver nitrate stick) and electrocautery. If local treatments fail to stop anterior bleeding, the anterior nasal cavity should be packed, from posterior to anterior, with ribbon gauze impregnated with petroleum jelly or polymyxin B-bacitracin zinc-neomycin (Neosporin) ointment. Nonadherent gauze impregnated with petroleum jelly and 3 percent bismuth tribromophenate (Xeroform) also works well for this purpose.<sup>5,9</sup> Bayonet forceps and a nasal speculum are used to approximate the accordion-folded layers of the gauze, which should extend as far back into the nose as possible. Each layer should be pressed down firmly before the next layer is inserted (Figure 3). Once the cavity has been packed as completely as possible, a gauze "drip pad" may be taped over the nostrils and changed periodically. Alternatively, a preformed nasal tampon (Merocel or Doyle sponge) may be used.<sup>12</sup> The tampon is inserted carefully along the floor of the nasal cavity, where it expands on contact with blood or other liquid. Application of lubricant jelly to the tip of the tampon facilitates placement. After the nasal tampon has been inserted, wetting it with a small amount of topical vasoconstrictor may hasten effectiveness. It may be necessary to drip saline into the nostril to achieve full expansion of the tampon if the bleeding has decreased at the time of insertion. Although one study<sup>15</sup> found no significant difference in patient comfort or efficacy with nasal tampons or ribbon gauze packing, simplicity of placement makes the tampons highly useful in primary care settings. When applied in the outpatient setting, nasal packing may be left in place for three to five days to ensure formation of an adequate clot.<sup>12</sup> Complications of nasal packing procedures include septal hematomas and abscesses from traumatic packing, sinusitis, neurogenic syncope during packing, and pressure necrosis secondary to excessively tight packing. Because of the possibility of toxic shock syndrome with prolonged nasal packing, use of a topical antistaphylococcal antibiotic ointment on the packing materials has been recommended.<sup>10,12</sup> Posterior bleeding is much less common than anterior bleeding<sup>16</sup> and usually is treated by an otolaryngologist. Posterior packing may be accomplished by passing a catheter through one nostril (or both nostrils), through the nasopharynx, and out the mouth (Figure 4). A gauze pack then is secured to the end of the catheter and positioned in the posterior nasopharynx by pulling back on the catheter until the pack is seated in the posterior choana, sealing the posterior nasal passage and applying pressure to the site of the posterior bleeding.<sup>5</sup> Although this procedure is not outside the scope of family practice, it requires special training and usually is performed by an otolaryngologist. Various balloon systems are effective for managing posterior bleeding and are less complicated than the packing procedure. The double-balloon device (Figure 2) is passed into the affected nostril under topical anesthesia until it reaches the nasopharynx. The posterior balloon then is inflated with 7 to 10 mL of saline, and the catheter extending out of the nostril is withdrawn carefully so that the balloon seats in the posterior nasal cavity to tamponade the bleeding source. Next, the anterior balloon is inflated with roughly 15 to 30 mL of saline in the anterior nasal cavity to prevent retrograde travel of the posterior balloon and subsequent airway obstruction. An umbilical clamp or other device can be placed across the stalk of the balloon adjacent to the nostril to further prevent dislodgement; the clamp should be padded to prevent pressure necrosis of the nasal skin. Balloon packs generally are left in place for two to five days. As with anterior packing, tissue necrosis can occur if a posterior pack is inserted improperly or balloons are overinflated. If a specialized balloon device is not available, a Foley catheter (10 to 14 French) with a 30-mL balloon may be used. The catheter is inserted through the bleeding nostril and visualized in the oropharynx before inflation of the balloon.<sup>18</sup> The balloon then is inflated with approximately 10 mL of saline, and the catheter is withdrawn gently through the nostril, pulling the balloon up and forward. The balloon should seat in the posterior nasal cavity and tamponade a posterior bleed. With traction maintained on the catheter, the anterior nasal cavity then is packed as previously described. Traction is maintained by placing an umbilical clamp on the catheter beyond the nostrils, which should be padded to prevent soft tissue damage. As with anterior epistaxis, topical antistaphylococcal antibiotic ointment may be used to prevent toxic shock syndrome. However, use of oral or intravenous antibiotics for posterior nasal packing most likely is unnecessary.<sup>19</sup> Patients with anterior or posterior bleeding that continues despite packing or balloon procedures may require treatment by an otolaryngologist. Endoscopy may be used to locate the exact site of bleeding for direct cauterization. Hot water irrigation, a technique described more than 100 years ago, has been reexamined recently. This technique has shown promise in reducing discomfort and length of hospitalization in patients with posterior epistaxis.<sup>20,21</sup> More invasive alternatives include arterial ligation and angiographic arterial embolization.



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