

Managing Bleeding in Patients Receiving Palliative Care in the General Internal Medicine Ward: A Systematic Review

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Received: 06-Feb-2023, Manuscript No. IJCRIMPH-23-93487; **Editor assigned:** 07-Feb-2023, Pre QC No. IJCRIMPH-23-93487(PQ); **Reviewed:** 12-Feb-2023, QC No. IJCRIMPH-23-93487(Q); **Revised:** 16-Feb-2023, Manuscript No IJCRIMPH-23-93487(R); **Published:** 22-Feb-2023, doi: 10.35248/1840-4529.23.15(2).1-2

Abstract

In general internal medicine wards, palliative care patients—those with at least one chronic, lifelong medical condition—and hospice patients—those with less than six months to live—are frequently admitted. This review aims to provide the internist with a strategy for dealing with bleeding in this population by using a clinical case. First, some helpful guidance on platelet transfusions will be given. Second, the treatment of bleeding in site-specific circumstances (including cutaneous ulcers, gastrointestinal-urogenital tract bleeding, and ENT/pulmonary bleeding) will be covered. Finally, a management algorithm for catastrophic bleeding is suggested. In conjunction with regional recommendations, electronic databases such as EMBASE, Pubmed, Google Scholar, and the Cochrane Library were studied as primary resources to find papers examining platelet transfusions and alternative management of site-specific bleeding in palliative care patients. Palliative care patients in the internal medicine ward frequently experience hemorrhagic complications. Current recommendations call for only therapeutic platelet transfusions. Prophylactic and/or therapeutic transfusion, however, must still be decided by a doctor. On the advice of experts and case studies, site-specific therapeutic options are developed. Even though invasive procedures might be necessary in some circumstances, their use must be consistent with the objectives of the patient. The presence of comforting caregivers is essential during catastrophic bleeding; drug management comes second.

Keywords: Bleeding • Internal medicine • Patients • Palliative care

Literature Review

A male patient, 49 years old, who is complaining of a decline in his general health, is admitted to the internal medicine ward. He received six cycles of chemotherapy and radiation after receiving his oesophageal cancer diagnosis six months earlier. Personal history reveals significant weight loss since the initial diagnosis and increasing dysphagia with bronchoaspiration episodes over the previous 3 days. He reports melaena over the previous week (no hematemesis). The laboratory work-up reveals bicytopenia with hemoglobin at 90 g/l (norms 140 g/l-180 g/l), platelets 25 G/l (norms 150-400 × 10⁹/L), an inflammatory syndrome CRP 235 mg/dL (norms < 10 mg/dL), white blood cell count at 15.5 G/l (norms 4.0 G/l -10.0 G/l) and renal failure AKIN 1 (Creatinine 130 μmol/l, norms 50 μmol/L -110 μmol/L). You are the on-call resident physician for the weekend. Informing you of recurrent episodes of melaena, the nurse calls you [1-4]. When examined, the patient reports orthostatic symptoms (such as dizziness and blurred vision upon rising from a sitting position), but not nausea or abdominal pain. Due to the high prevalence of admitted patients who meet

the requirements for palliative care, general medicine wards are crucial in the implementation of the practice. In general, internal medicine wards, palliative care patients—those with at least one chronic, lifelong medical condition—and hospice care patients—those with less than six months to live—are frequently admitted.

First, some helpful guidance on platelet transfusions will be given. Second, the management of bleeding in site-specific circumstances, such as from the gastrointestinal-urogenital tract, ENT/pulmonary and malignant ulcers, will be covered. Finally, a management algorithm for catastrophic bleeding is suggested.

Every dose recommendation has been modified for use in a general internal medicine ward; many of these recommendations are off-label. The majority of the recommendations below are based on professional judgement. The application to specific clinical settings depends on the resources that are available, the costs involved, and individual preferences. In order to plan access to therapeutic and palliative measures, management must align with overall care goals, which necessitates prior discussion [5-6].

In conjunction with regional recommendations, electronic databases such as EMBASE, Pubmed, Google Scholar, and the Cochrane Library were used as the main sources to find papers examining platelet transfusions and alternative management of site-specific bleeding. Selected articles' references were manually searched to find relevant additional papers. The relevant tables provide specific information on the inclusion criteria for site-specific guidelines. Palliative care, end-of-life, chronic progressive disease, incurable, platelet transfusion, hemorrhage, massive blood loss, major bleeding, and catastrophic bleeding were all searched for in the aforementioned resources. Publications in English, French, and German were given consideration.

Studies that did not meet the inclusion criteria were excluded from the data selection process, which was carried out by RS and data extraction in duplicate by RS and AE. Bias risk was investigated at the level of the results. PRISMA and AMSTAR 2 criteria were followed in reporting the research (refer to supplementary material).

A Cochrane systematic review that was updated in 2015 found no difference between a prophylactic platelet transfusion policy and a therapeutic-only policy in terms of all-cause 30-day mortality or adverse events. Due to inadequate recruitment, the OPTIMAL pilot study, which sought to examine the frequency of bleeding events in patients receiving therapeutic or preventative transfusions in this population, was abandoned. This highlights the difficulties associated with conducting such studies.

The prevalence of bleeding in head and neck cancers is explained by anatomical factors; it has been reported that 74% of this population experienced bleeding in the month before death. When deciding on management, the accessibility of the actively bleeding lesion is crucial. Patients with visible, actively bleeding lesions qualify for local treatment.

Sticks of silver nitrate can be used in the nasopharynx. For anterior epistaxis, tranexamic acid-soaked gauze inserted into the nostril for 10 minutes is a viable treatment option, whereas sympathomimetic vasoconstrictors work best for posterior epistaxis. For bleeding caused by vascular erosion, endovascular techniques can be used; embolization has proven to be highly effective but not without risks. Another good option is radiotherapy, but many patients have already received the maximum doses, precluding further radiation. According to existing descriptive studies, surgical management may be taken into consideration if conservative measures fail in a particular population. There were no studies on the use of palliative chemotherapy for controlling bleeding [7,8].

Conclusion

Patients receiving palliative care frequently experience the complication of site-specific bleeding. Even though invasive measures may be necessary in some circumstances, their adoption necessitates access to specific resources and must be in line with the patient's care objectives. Both non-pharmacological interventions and local pharmacology, as necessary, must be a part of primary management. Intervention at the system level usually comes later. The objectives of care must be defined and patients at risk of catastrophic bleeding must be identified. It is necessary to make an effort to foresee possible outcomes, such as disastrous circumstances. The presence of the healthcare professional is essential to management. Pharmacological management comes second; Midazolam is the drug of choice to achieve sedation when crisis medication is necessary and does not interfere with the latter. Further research is required to improve management in at-risk patients due to the growing prevalence of palliative care patients with specific needs. Such studies might take into account examining, for instance, the effect of bleeding control on patient quality of life.

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