

Anticoagulants and Epistaxis

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Introduction

Epistaxis is the most common cause for emergency admission to an ENT ward. Secondary epistaxis accounts for a significant proportion of admissions with warfarin, aspirin and clopidogrel the most commonly encountered secondary causative agents. In the management of the epistaxis should these antithaemostatic agents (here all called anticoagulants) be stopped during the admission and when is it not safe to do so?

Aims

1. To determine current practice relating to anticoagulants in emergency epistaxis patients.
2. To assess whether secondary agents can be safely stopped on admission
3. What the effects are of stopping medication on the epistaxis or the underlying medical condition.

Method

Notes were retrieved and the patient management reviewed for all epistaxis admissions during 2006 in a retrospective audit of current practice. In addition a literature review was undertaken and opinion sought via email from local cardiology and haematology consultants.

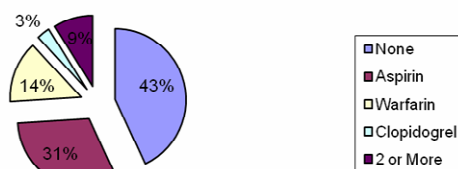
Results

155 patients were admitted with epistaxis during the study period. 124 sets of casenotes were retrieved (80% data capture). 72 (57%) were on anticoagulant medication. Of these the most common indications were atrial fibrillation, hypertension or had no indication identified. 11 patients (9%) were on two or more agents, 18 patients (14%) were on warfarin alone, 39 (31%) were on aspirin alone and 4 (3%) were on clopidogrel alone. In over 80% of cases both aspirin and warfarin were stopped only for the duration of their admission (around 2 days) irrespective of medical diagnosis or warfarin levels.

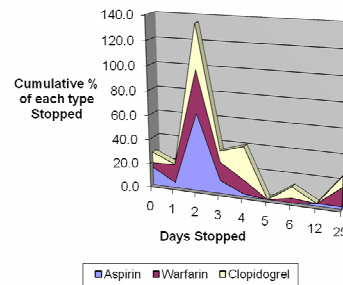
There was no increased rate of theatre or transfusion in patients on anticoagulants.

Returns from cardiology and haematology concurred with the literature review. Patients with AF, hypertension or ischaemic heart disease can have their anticoagulants stopped without undue risk. Mechanical valves and coronary stents however should **never** have their anticoagulants stopped. Warfarin need only be stopped if it is above its therapeutic INR range.

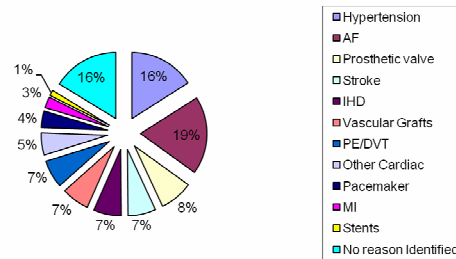
Anticoagulant Use



Period of Time Stopped For



Indications for Anticoagulants (%)



Conclusion

Current practice in our unit involves stopping anticoagulants for inpatient time only. Given that platelets are permanently deactivated for their lifetime (up to 10 days) this will lead to only minimal improvement in platelet function.

We propose that there is no need to stop aspirin or warfarin (within its therapeutic range) but if however aspirin is stopped it should be withheld for a full week to allow repopulation with active platelets. Warfarin should be adjusted to allow INR to reduce to within its therapeutic range.

Proposed Protocol

1. All Patients to have FBC and platelet count carried out, INR if on warfarin.
2. Metal valve patient on warfarin: continue warfarin if therapeutic, withhold if over coagulated, recommence once therapeutic level. Discuss with cardiology if life threatening bleed.
3. Patients on aspirin should have their medication continued. If a life threatening bleed then in cases of coronary stenting the cases should be discussed with cardiology who may recommend platelet transfusions.
4. All other patients should have warfarin continued if within therapeutic range and withheld only until back within range if over coagulated.
5. Patients on aspirin or clopidogrel should have their medication continued unless a life threatening bleed when a platelet transfusion may be considered on the advice of cardiology.