### HIGH RISK
**SUGGESTED EMERGENT CONSULTATION**

**SYMPTOMS AND LABS**
- Persistent, acute epistaxis for 30-60+ minutes without slowing despite below-listed conservative measures (Afrin, pressure, etc.)
- Concern for large intra-nasal mass as source of bleeding, visible on nasal exam.

**CLINICAL PEARLS**
- Turbulent airflow

**SUGGESTED PREVISIT WORKUP**
- Initial conservative measures for acute epistaxis:
  - Spray copious amounts of topical over-the-counter vasoconstrictive agent in both nares: phenylephrine, oxymetazoline (a.k.a. Afrin)
  - Apply continuous pressure to the septum by pinching the nose tightly, occluding both nostrils, and hold for 15-20 minutes "without peeking" Repeat for 20 more minutes if bleeding has not stopped
  - Lean head forward to avoid swallowing blood
  - Control hypertension, stop anti-platelet therapy if medically cleared.
  - Order INR if on warfarin
  - Address coagulopathy if indicated and possible

**SUGGESTED WORKUP**
- Stop all herbal medications (see Clinical Pearls), aspirin (if indicated), and ibuprofen
- Check for and control hypertension
- Consider labs to rule out bleeding disorders in otherwise healthy patients with increasingly frequent epistaxis refractory to nasal hygiene attempts
- Attempt and instruct patient in listed conservative measures for acute epistaxis (See High Risk)
- Instruct patient in nasal hygiene: night humidifier, gentle saline spray in the nose (sprayed away from the septum), Vaseline or saline-based gel in the nose every night, avoid trauma (digital, nose blowing). Do not place tissues in the nose, causes trauma when removed
- Routine ENT consult, consider Urgent if worsening symptoms

**SYMPTOMS AND LABS**
- Recurrent unilateral or bilateral epistaxis in adolescent males with no risk factors for bleeding.
- Obvious, superficial capillary or vessel on anterior nasal septum visualized on nasal exam
- Intermittent self-resolving epistaxis in patients with known risk factors (poorly controlled HTN, anti-platelet therapy, nightly or continuous nasal canula or CPAP, renal or liver failure, leukemia
- Intermittent epistaxis increasing in frequency and severity (multiple episodes a week, a day, etc., interfering with school/work)

**SUGGESTED MANAGEMENT**
- Measures listed in Moderate Risk, including instruction in nasal hygiene
- For acute epistaxis, utilize conservative measures described in High Risk, stenting with digital pressure
- If frequency increases, consider routine ENT consult for evaluation

**LOW RISK**
**SUGGESTED ROUTINE CARE**

**SYMPTOMS AND LABS**
- Intermittent episodes of epistaxis lasting ~15 or less minutes, well controlled by conservative measures (see High Risk) or which stop spontaneously, in patients without risk factors
- Self-limited, intermittent epistaxis in the winter months
- Young children with known habit of nasal digital trauma

**CLINICAL PEARLS**
- 90% of nosebleeds are from the anterior nasal septum (known as Kiesselech's Plexus)
- Herbal supplement such as garlic, ginko, and ginseng all have anti-platelet properties
- Trauma (e.g. nose picking and vigorous nose blowing) and mucosal dehydration (e.g. winter, dry climate) are the most common causes of anterior epistaxis
- HTN, aspirin (and other platelet inhibiting medications), and alcohol abuse are the most common causes of posterior epistaxis
- Deviated septum may result in epistaxis secondary to the drying effects of turbulent airflow
- Epistaxis worsens in the winter months due to dry heat and increased nose blowing
- Juvenile Nasopharyngeal Angiofibroma (JNA) is a very rare vascular mass in the nose, benign, and exclusive to adolescent males, and is diagnosed by nasal endoscopy in the ENT clinic
- During ENT consult, nasal exam will be performed with possible nasal endoscopy, and if superficial source of bleeding noted, silver nitrate cautery can be performed in clinic with topiologic anesthetic, even in fairly young children

These clinical practice guidelines describe generally recommended evidence-based interventions for the evaluation, diagnosis and treatment of specific diseases or conditions. The guidelines are: (i) not considered to be entirely inclusive or exclusive of all methods of reasonable care that can obtain or produce the same results, and are not a statement of the standard of medical care; (ii) based on information available at the time and may not reflect the most current evidenced-based literature available at subsequent times; and (iii) not intended to substitute for the independent professional judgment of the responsible clinician(s). No set of guidelines can address the individual variation among patients or their unique needs, nor the combination of resources available to a particular community, provider or healthcare professional. Deviations from clinical practice guidelines thus may be appropriate based upon the specific patient circumstances.