

Epistaxis management: which strategy to choose?

Dear Sirs,

We read with great interest Supriya and colleagues' article 'Epistaxis: prospective evaluation of bleeding site and its impact on patient outcome', published recently in *The Journal of Laryngology & Otology*.¹

Despite the our belief that management of the epistaxis depends on the departmental policy and experience of the clinician, Supriya and colleagues' article generated some questions.

The authors report successful nasal examination with a rigid nasal endoscope and identification of the bleeding site in 91 per cent of cases, even within 24 hours of Merocel nasal pack removal. However, in our experience such packing can lead to intranasal injuries and recurrent bleeding upon removal, especially when placed by a physician inexperienced in ENT emergency management.²

If there is a septal deviation, any packing may traumatise the nasal mucosa (septal and turbinate) and create more sites of bleeding.^{3,4} Traditionally, both sides of the nose are packed, and identification of the side of bleeding after packing removal is frequently a difficult problem. Septal deformation and hypertrophic turbinates often prevent visualisation of the bleeding regions. The article in question did not discuss these issues, nor the substantial number of patients with these common anatomical variations.⁴

In addition, Supriya *et al.* did not make clear whether their patients had continuous epistaxis at the moment of cauterisation.

In our experience, we prefer to refer to severe and non-severe epistaxis, rather than anterior and posterior epistaxis, in order to indicate the procedure most likely to result in successful management.²

ANDREI P TIMOSHENKO
ALEXANDER ASANAU
Department of Otolaryngology-Head and Neck Surgery,
North Hospital,
Saint-Etienne University Hospital Center,
France

References

- 1 Supriya M, Shakeel M, Veitch D, Ah-See KW. Epistaxis: prospective evaluation of bleeding site and its impact on patient outcome. *J Laryngol Otol* 2010;**124**:744–9
- 2 Asanau A, Timoshenko AP, Vercherin P, Martin C, Prades JM. Sphenopalatine and anterior ethmoidal artery ligation for severe epistaxis. *Ann Otol Rhinol Laryngol* 2009;**118**:639–44
- 3 O'Reilly BJ, Simpson DC, Dharmaratnam R. Recurrent epistaxis and nasal septal deviation in young adults. *Clin Otolaryngol Allied Sci* 1996;**21**:12–14
- 4 Neskey D, Eloy JA, Casiano RR. Nasal, septal, and turbinate anatomy and embryology. *Otolaryngol Clin North Am* 2009;**42**: 193–205, vii

Author's reply

Dear Sirs,

I thank Drs Timoshenko and Asanau for raising these questions.

As they rightly note, nasal packing often leads to intranasal trauma and bleeding immediately after removal. In addition, intranasal anatomical variations (e.g. septal deviation or turbinate hypertrophy) can make endoscopic examination difficult.

However, in our experience adequate intranasal vasoconstrictor application and skilled examination can help differentiate between mucosal abrasions (from packing) and actual epistaxis sites. We were able to identify the site of epistaxis in 91 per cent of patients. However, as expected, this figure was lower, at 81 per cent (38/47), in patients with posterior epistaxis.

Our article did not endeavour to assess the reasons for failure to identify the site of epistaxis; therefore, data relevant to such cases were not recorded. The traditional classification of epistaxis as anterior and posterior is the most widely used, although the definition of epistaxis itself has varied, as mentioned in our article. Such uniform classification also helps facilitate comparison of data from different epistaxis studies.

MRINAL SUPRIYA
Head and Neck Fellow,
Peter MacCallum Cancer Institute,
Melbourne, Australia