**QUIZ 28th Oct 2020 (answers below)**

1. **Outline your management of epistaxis.**

2. **Describe the steps to insert a Rapid Rhino.**

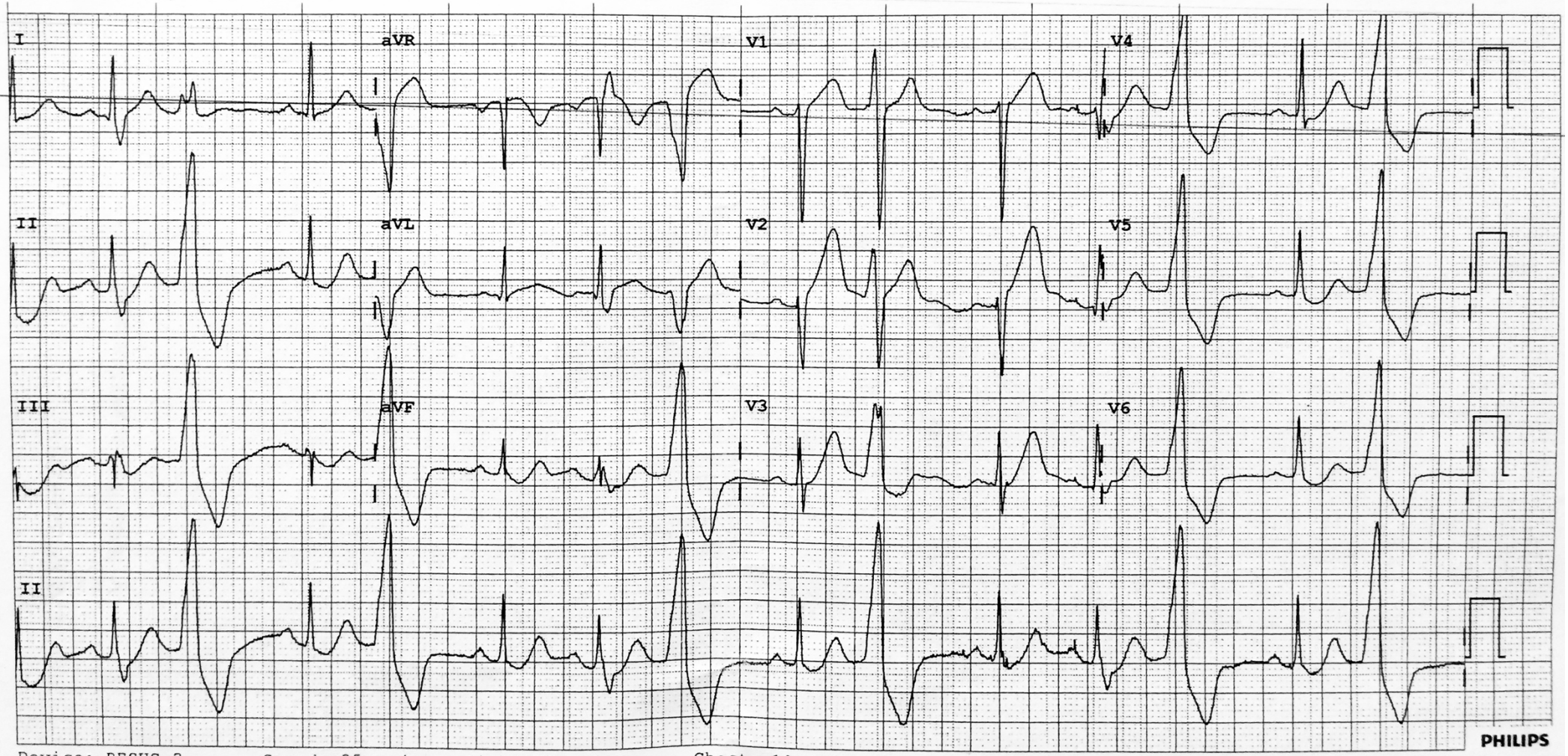
3. **What discharge instructions do you give epistaxis patients?**

4. **What laboratory parameters should be monitored to guide ongoing massive transfusion?**

5. **Describe and interpret the following ECG.**

| | | | | | |
|---|---|---|---|---|---|
| HR | 89 bpm | ST-I | -?- mm | ST-V1 | -?- mm |
| PVC | 46 /min | ST-II | -?- mm | ST-V2 | -?- mm |
| | | ST-III | -?- mm | ST-V3 | -?- mm |
| | | ST-aVR | -?- mm | ST-V4 | -?- mm |
| | | ST-aVL | -?- mm | ST-V5 | -?- mm |
| | | ST-aVF | -?- mm | ST-V6 | -?- mm |

12 Lead ECG Report (Standard)




Device: RESUS 2 Speed: 25 mm/sec Limb: 10 mm/mV Chest: 10 mm/mV 0.15-100 Hz

**QUIZ answers 28th Oct 2020**

1. **Outline your management of epistaxis.**

A. *Resuscitation*

*Particularly in severe or prolonged epistaxis, consider need for:*

- *Airway management*
- *Blood transfusion/ MTP/Anticoagulation reversal*
- *Urgent ENT consultation*

B. *First aid – (patients can be instructed to do this if it happens again)*

*Gently blow nose to clear clots*
*Pinch the SOFT sides of the nose against the septum*
*Hold firm pressure continuously for 10 minutes*
*Sit up and lean forward, spit out any blood in mouth*
*+/- Cold compress across bridge of nose*

C. *Examination*

*Try to determine which side the bleeding started from*
*Clear clots out – by patient gently blowing nose, or use soft Y suction catheter snipped shorter so that there are no side holes*
*Spray CoPhyenycaine one/both sides*
*Visualise affected side looking for bleeding site*
*Headlight*
*Nasal speculum*
*May need more suctioning, wiping with swab*

D. *Ongoing bleeding*

*Cotton wool pledgets soaked in adrenaline 1:1000*
*Patient can apply first aid pressure with pledget in place*
*10 – 20 min*
*Can also try pledget soaked in tranexamic acid*

**Consider posterior bleeding*
*Usually not minor bleeding*
*Bleeding from both nostrils*
*No anterior site found*
*Patient feels blood dripping down oropharynx*

E. *Cautery*

*If bleeding site found, can cauterize with silver nitrate stick*
*Risk of perforation is only if cauterizing septum bilaterally*
*Then apply small folded piece of surgicel and discharge instructions*

F. *Packing with Rapid Rhino*

*Only if failure of above measures*
*Commits patient to admission to hospital*
*Consider ENT help prior to insertion as it causes too much mucosal trauma to remove again straight away for re examination*

2. **Describe the steps to insert a Rapid Rhino.**

   - *Remove blue cover*
   - *Soak in sterile water for a full 30 seconds*
     - *Don't use saline as it inhibits the gelling characteristics of the fabric.*
     - *Don't use lubricant or antibiotic ointment, as they will inhibit the haemostatic properties of the fabric.*
   - *Insert the device along the septal floor and parallel to the hard palate until the plastic proximal fabric ring is well within the nares.*
   - *Use a 20mL syringe and inflate the device with AIR.*
     - *Stop the inflation when the pilot cuff becomes rounded and feels firm when squeezed.*
     - *The amount of air depends on the size of the patient's nasal anatomy.*
   - *Tape the pilot cuff to the side of the patient's face.*

3. **What discharge instructions do you give epistaxis patients?**

   *For the next 3 days:*
   *Avoid exertion, straining and heavy lifting*
   *Avoid steaming hot food, drinks and showers*
   *Avoid nose blowing*
   *Use vasoconstrictor eg. Drixine*
   *Use moisturiser on nasal mucosa bd*
   *eg. Nasalate, chlorsig ointment, bactroban, vaseline*
   *Provide first aid (as above) if recurs and return if epistaxis persists*

4. **What laboratory parameters should be monitored to guide ongoing massive transfusion?**

| | |
|---|---|
| *pH* | *> 7.2* |
| *Base excess* | *< -6* |
| *Lactate* | *< 4 mmol/L* |
| *iCa* | *> 1.1 mmol/L* |
| *Hb* | *Should not be used alone as a transfusion trigger* |
| *Platelet* | *> 50 x $10^9$/L* |
| *PT/APTT* | *< 1.5 normal* |
| *INR* | *< 1.5* |
| *Fibrinogen* | *> 1.0 g/L* |

**5. Describe and interpret the following ECG.**

| | |
|---|---|
| *Rate* | *88/min* |
| | *Sinus rhythm with frequent PVCs and fusion beats*<br>*The PVCs are followed by a complete compensatory pause, indicating that the sinus timing is not interrupted; one sinus P wave isn't able to reach the ventricles because they are still refractory from the PVC; the following sinus impulse continues the sinus rate of 88/min.* |
| *P waves* | *Normal morphology* |
| *PR interval* | *Normal* |
| *QRS* | *Narrow, normal axis, normal axis, normal R wave progression* |
| *ST segments* | *Depressed inferiorly (III, aVf, II)*<br>*Depression V4-5 at J point, sloping up to upright, symmetrical T waves*<br>*Elevation 1mm in aVR*<br>*Elevated V 1-3 leading up to large hyperacute T waves* |
| *QTc* | *Prolonged 484 msec* |

➔ *Coronary angiogram revealed complete proximal LAD occlusion*

*This pattern of 1- to 3-mm up sloping ST-segment depression at the J point in leads $V_1$ to $V_6$ that continued into tall, positive symmetrical T waves is consistent with "de Winter T waves" and indicates proximal LAD occlusion. In most patients, there is also 1- to 2-mm ST-elevation in lead aVR.*

De Winder R A new ECG sign of proximal LAD occlusion N Engl J Med 2008; 359:2071-2073