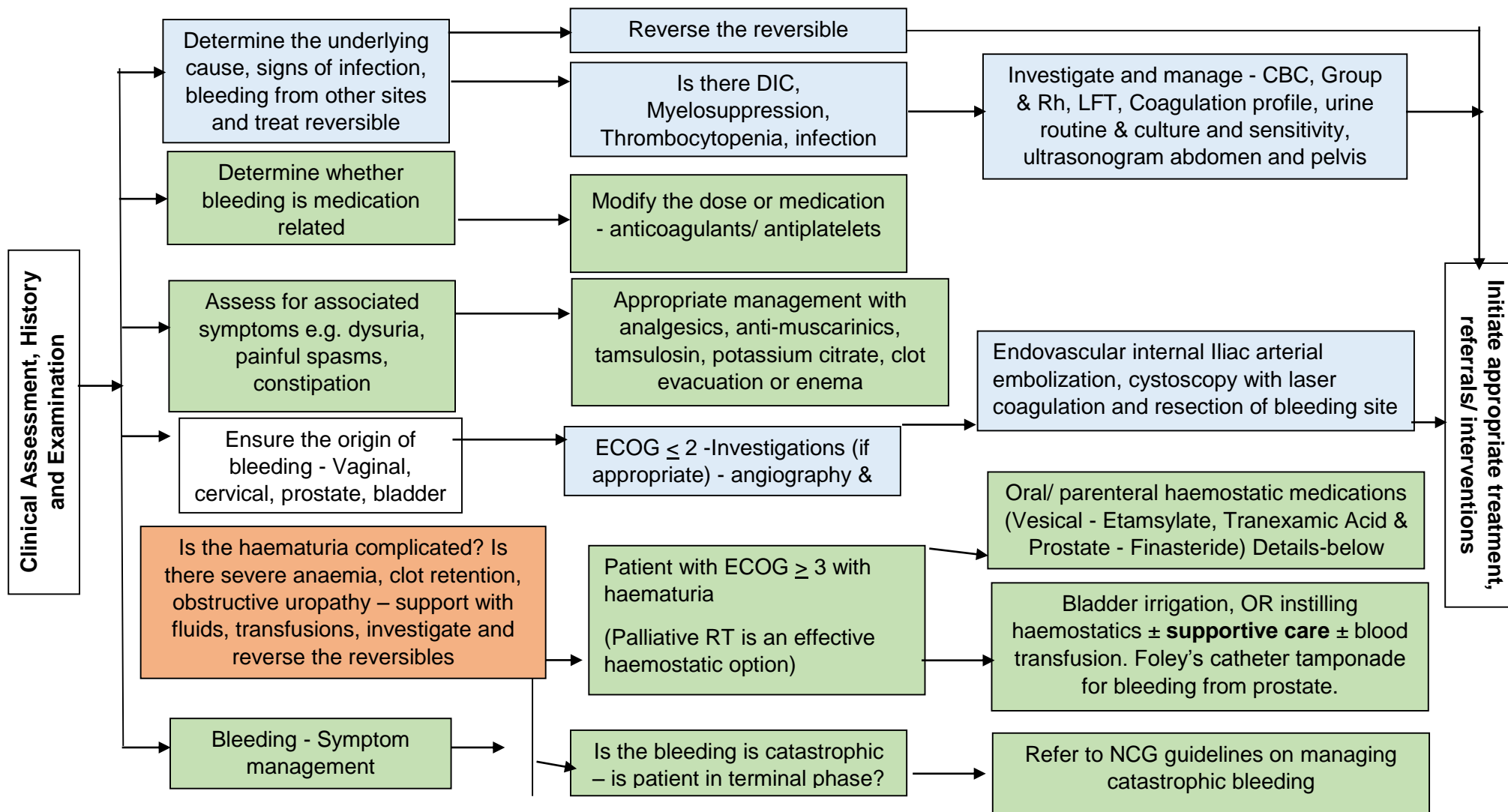


Approach to managing Haematuria



Medicines used Commonly in Haematuria.

Systemic Haemostatic Medications	Procedural measures
<p>Etamsylate</p> <ul style="list-style-type: none"> • Can be used alone. 500mg PO QID either indefinitely or until one week after bleeding stops • It may be used in combination with Tranexamic acid if indicated. <p>Tranexamic acid</p> <p>Oral administration of antifibrinolytic agents, tranexamic acid involves a risk of clot retention due to inhibition of fibrinolysis of pre-formed fibrin deposits. Their use in moderate to severe haematuria is an important clinical decision weighing the risks and balancing the beneficence in the individual situation</p> <ul style="list-style-type: none"> • 1.5g PO stat and 1g PO TID; titrate to Max 1.5g PO QID as required • Stop/ decrease to 500mg PO TID, one week after stoppage of bleeding • If bleeding recurs, restart and continue indefinitely as necessary • If patient has dysphagia, - 15mg/kg IV over 5-10 minutes TID – QID <p>Finasteride 5 mg OD</p> <ul style="list-style-type: none"> • For patients with bleeding from Benign Prostatic Enlargement <p>EACA</p> <ul style="list-style-type: none"> • Intravenous, oral, or intravesical route – restrict to < 24 hours <p>Antibiotics</p> <ul style="list-style-type: none"> • Use as per institutional protocol, if urinary tract infection is present, administer appropriate antibiotics 	<ul style="list-style-type: none"> • Early management - hand irrigation and continuous saline bladder irrigation with a large-calibre Foley catheter • Clot evacuation and bladder irrigation with large three-way catheter, for decompression and saline irrigation (urologists required to catheterize). • Irrigation through supra-public catheter is NOT helpful. • Intra-vesical administration haemostatic agents – 1% Alum; 0.5-1.0% Silver Nitrate, ferrous ferracrylate, formalin (1% - 4% for 5-15 minutes) or EACA <p>Haemorrhagic Cystitis - secondary to chemotherapy (cyclophosphamide) or radiation</p> <ul style="list-style-type: none"> • Cystoscopically, fulgurate sites of bleeding, evacuate clots and bladder irrigation • Intravesical instillation of haemostatics • Hyperbaric Oxygen therapy <p>Procedure for Prostatic bleeding</p> <ul style="list-style-type: none"> • gentle Foley catheter traction can help tamponade the source <p>-----</p> <p>Control of spasmodic pain</p> <ul style="list-style-type: none"> • reduce the inflation of catheter balloon • early clot evacuation • Drugs – Tamsulosin, Potassium Citrate, hyoscine, dicyclomine, oxybutynin <p>Nerve blocks & procedures</p> <ul style="list-style-type: none"> • Sacral-epidural or bilateral superior hypogastric block if intractable bladder pain.

Intractable catastrophic bleeding in a patient in terminal stages- consider Pall, sedation - Refer to NCG guidelines for managing	
Education/ communication	MDT Referrals
<ul style="list-style-type: none"> • Check insight • Family of patients with risk of catastrophic bleeding should be informed and prepared in advance • Details are provided under management of catastrophic bleeding (NCG guidelines for bleeding tumours) 	<ul style="list-style-type: none"> • Nursing care • Emotional support – consistent communications, counselling, psychological support • Referrals to urologists for, therapeutic interventions • Interventions -appropriate to the stage of the disease, performance score and patient's/ family's preferences