Sir,

We read with interest the excellent article by Dr. Keane et al. regarding the management of epistaxis that appeared in this June’s issue of the IMJ¹. In their article, they eloquently describe their experience in the treatment of epistaxis. We fully concur with their treatment strategies which are similar to our institution’s approach. However we would like to mention the additional role that transcatheter arterial embolisation may have in selected cases, a technique that we have recently utilised to good success in our department.

This technique, first described in 1974², is used primarily in patients which intractable posterior epistaxis for whom previously surgery was the only option. This technique is not only cost effective when compared to surgery but is well tolerated by patients, especially in those for whom surgery is contraindicated.

Under conscious sedation, a diagnostic angiogram of the internal and external carotid arteries, via right femoral artery, is first performed to assess vascular supply, most importantly determining ophthalmic artery supply and assess if there are any vascular anomalies. Subsequently, selective embolisation is performed of the internal maxillary and facial artery with particles and/or gelfoam.

The rate of embolisation to halt bleeding immediately post procedure is reported to be 93-100%³ compared to surgery which has reported rates of 77-95%⁴. Both have a similar profile of complications: headache, jaw pain, trismus, facial numbness, skin sloughing and mucosal necrosis, the majority of which are transient. The main risk of embolisation is when embolic material enters the internal carotid or ophthalmic artery which could lead to permanent neurological deficit, although this risk is reduced significantly by performing a diagnostic angiogram before embolisation.

We again commend Dr. Keane et al comprehensive study of the management of epistaxis and its economic considerations in Ireland today but also wish to highlight the role of transcatheter arterial embolisation in the management of intractable posterior epistaxis.

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