

## Traumatic epistaxis and management of severe immune thrombocytopenic purpura in the emergency department

### *Epistaxis traumática y púrpura trombocitopénica inmunitaria grave en urgencias*

#### To the Editor,

Patients with immune thrombocytopenic purpura (ITP) presenting with active bleeding represent an uncommon but potentially serious medical emergency.

We present the case of a 79-year-old man who came to the emergency department (ED) with uncontrollable epistaxis. The patient, aged 79, was admitted due to unstoppable bleeding from both nostrils following an accidental facial trauma caused by a fall.

His past medical history included type I obesity, chronic obstructive pulmonary disease (COPD), and chronic ITP under treatment with eltrombopag and prednisone. He had undergone splenectomy in 2003 and led an active lifestyle.

On initial examination, he was hemodynamically stable, with no other significant findings. Complementary tests revealed a hemoglobin level of 13.3 g/dL and platelets of 15,000/ $\mu$ L — a usual level for this patient given his medical history.

Initially, bilateral anterior nasal packing was per-

formed. During subsequent observation, the patient experienced a vasovagal episode with bradycardia at 40 bpm and a bloody vomit, prompting transfer to the critical care unit for better clinical management. A new assessment revealed persistent posterior pharyngeal bleeding, with hemodynamic instability and airway compromise. A classic posterior nasal packing was carried out after sedation with 2 mg of midazolam to improve procedural control, reduce patient anxiety, and allow adequate airway management through suctioning. The procedure was successful, achieving cessation of bleeding and clinical stabilization.

Premedication with 5 mg of dexchlorpheniramine and 1 g of paracetamol was administered, followed by transfusion of 2 units of platelets and 1 packed red blood cell unit, along with dexamethasone and IV human immunoglobulin (IVIg) at therapeutic doses (1 g/kg), started at a slow and progressive infusion rate, which was continued in the observation area where the patient remained stable until hospital admission 12 hours later. After stabilization, new laboratory tests showed a drop in hemoglobin to 8.5 g/dL and platelets increased to 93,000/ $\mu$ L.

ITP is defined as a platelet count < 100,000/ $\mu$ L in the absence of other causes of thrombocytopenia and is considered severe when there is active bleeding, generally with platelet counts < 20,000/ $\mu$ L.<sup>1</sup>

For the management of severe ITP with active bleeding, the Spanish Group on Immune Thrombocytopenia (GEPTI) has published recommendations<sup>2</sup> proposing initial treatment with corticosteroids (prednisone 0.5–1 mg/kg/day or dexamethasone 40 mg/day), IVIg at 1 g/kg/day, and platelet transfusion only in life-threatening bleeding. However, the American Society of Hematology (ASH) in 2021<sup>3</sup> recommended reserving platelet transfusion exclusively for emergency situations, as the autoimmune nature of the disease limits the long-term efficacy of transfused platelets. In this case, management followed this protocol, achieving bleeding control and patient stabilization.

Additional measures include discontinuation of antiplatelet and anticoagulant medications and consideration of antifibrinolytic agents, such as tranexamic acid.<sup>2</sup> The main objective is to stop bleeding while maintaining platelet counts > 20,000/ $\mu$ L.<sup>3</sup>

ITP should be considered in the differential diagnosis in EDs when facing difficult-to-control bleeding, as early diagnosis and intervention are key to preventing severe complications — given that mortality in adults approaches 30%.<sup>4</sup>

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## Recurrence of suicide attempt in the emergency department: profile of the repeat patient

### Perfil del paciente con recurrencia de tentativa de suicidio en urgencias hospitalarias

#### To the Editor,

In 2023, 3,952 people died by suicide in Spain, according to data from the Spanish National Institute of Statistics.<sup>1</sup> The most common methods of suicide in our country are hanging among men, falling from height among women,<sup>1,2</sup> and medication overdose among individuals younger than 18 years.<sup>3,4</sup>

According to the World Health Organization, more than 720,000 people die by suicide every year worldwide, and for each suicide, there may be up to 20 suicide attempts (SA). Moreover, a previous attempt is one of the best predictors of future suicidal behavior or even completed suicide

— 40–50% of those who die by suicide had a prior attempt.<sup>2,5,6</sup>

Most SA occur in middle-aged individuals, more frequently in women, often unemployed, without a partner, and using medication overdose as the most common method.<sup>7-9</sup> Psychiatric disorders, especially depression, are among the main risk factors associated with suicide attempts,<sup>6-9</sup> while certain personality traits such as impulsivity and hopelessness further increase the risk.

The aim of this study was to determine the characteristics of patients who repeatedly presented to the emergency department (ED) for SA. We conducted a retrospective study from January 1<sup>st</sup>, 2019 through December 31<sup>st</sup>, 2023, recording cases of patients with prior suicide attempts and those who reattempted during the study period. Collected variables included demographic data, clinical history (psychiatric antecedents, psychotropic medication, substance use, and mental health follow-up), and characteristics of the suicidal episode (trigger,

mechanism—medication ingestion, toxic substances, self-harm—, and discharge destination).

Table 1 shows the characteristics of the patients and their self-inflicted episodes. Over the 5-year period, 105 patients with recurrent suicide attempts were seen, 69.5% women, with a mean age of  $38.9 \pm 16.8$  years (range, 12–87). Psychiatric disorders were present in 101 patients (96.2%), with an average of  $1.67 \pm 0.8$  psychiatric diagnoses per patient. The most common were depression (46.5%), followed by personality disorder (36.6%), mixed anxiety-depression disorder (25.7%), anxiety (22.8%), and substance use disorder (19.8%). Mental health follow-up was ongoing in 36.2% of patients at the beginning of the study. A total of 31.4% had a previous suicide attempt. Toxic substance use was reported in 52.4%, most frequently alcohol (76.4%), followed by cocaine (47.5%) and cannabis (45.4%).

Regarding suicidal episodes, the most common mechanism was medication ingestion (76.5%), with ben-

zodiazepines being the most frequently used drug (75.9%), followed by antidepressants (24.6%), antipsychotics (11.3%), antiepileptics (6.7%), and analgesics/NSAIDs (10.3%). Toxins were ingested in 25.4% of attempts, with alcohol (81.5%) being the most frequent, followed by cannabis (15.4%) and cocaine (10.8%). Self-harm was minor and infrequent (9.8%), involving the upper limbs in 84% of cases.

A precipitating factor was identified in 41% of cases: relationship problems (35.2%) and family issues (34.3%) were the most common. Most patients were discharged for mental health follow-up (73.4%), while 26 cases (10.2%) required psychiatric unit admission.

Most patients with recurrent suicide attempts were middle-aged women, consistent with previous studies.<sup>6-10</sup> Although gender differences were not statistically significant ( $P = .180$ ), age differences were ( $P < .001$ ).

Most patients presented psychiatric disorders, a well-known risk factor for suicide attempts and recurrence.<sup>6-11</sup> While differences between groups (with or without prior attempts) were not significant regarding the presence of psychiatric history, they were significant for the number of psychiatric diagnoses ( $P = .023$ ). Mental health follow-up was more frequent among recurrent patients than among those without prior attempts ( $P < .001$ ). Other studies have similarly reported a higher proportion of recurrent patients under psychiatric follow-up and psychopharmacological treatment,<sup>8</sup> an approach that can be beneficial for this population.

A particularly high-risk period for re-attempt has been identified in prior research — ranging from 30 days,<sup>8,10</sup> to 3 months,<sup>6,12</sup> or 6 months<sup>11</sup> after the initial attempt. This aspect was not analyzed in our study. Other factors evaluated in the literature —such as marital status, employment situation, living arrangements (alone, with family, others), family history of suicide (attempted or completed), and family/social support level— represent limitations of our study due to its retrospective nature.<sup>8,9,11</sup> Nevertheless, this work serves as a starting point for future

**Table 1.** Characteristics of the patients and their self-inflicted episodes

	Total n (%)	Without prior attempt n (%)	Recurrent n (%)	P
<b>Patients</b>				0,189
Total	105	72	33	
Man	32 (30.5)	25 (34.7)	7 (21.2)	
Woman	73 (69.5)	47 (65.3)	26 (78.8)	
<b>Age [mean (SD)]</b>				< .001
Total	38.9 ± 16.8	38.5 ± 17	38.1 ± 16.8	
Man	38.1 ± 16.5	36.2 ± 15.3	44.9 ± 20.3	
Woman	38.5 ± 17.1	39.7 ± 17.8	36.3 ± 15.7	
<b>Psychiatric disorders</b>				.75
Total	101 (96.2)	70 (97.2)	31 (93.9)	
Man	29 (90.6)	24 (96)	6 (85.7)	
Woman	72 (98.6)	46 (97.9)	25 (96.1)	
<b>Number of psychiatric records</b>				.023
0	4 (3.8)	2 (2.8)	2 (6.1)	
1	43 (42.6)	36 (51.4)	7 (22.6)	
2	43 (42.6)	24 (34.3)	19 (61.3)	
3	12 (11.4)	7 (10.0)	5 (16.1)	
4	3 (2.9)	3 (4.2)	0 (0)	
<b>Mental health monitoring</b>				< .001
Total	38 (36.2)	15 (20.8)	23 (69.7)	
Man	8 (25.0)	5 (20.0)	3 (42.9)	
Woman	30 (41.1)	10 (21.3)	20 (76.9)	
<b>Previous attempt</b>				
Total	33 (31.4)	0 (0)	33 (100)	
Man	7 (21.9)	0 (0)	7 (100)	
Woman	26 (35.6)	0 (0)	26 (100)	
<b>Use of toxic substances</b>				.87
Total	55 (52.4)	39 (54.2)	15 (45.5)	
Man	20 (62.5)	18 (72.0)	2 (28.6)	
Woman	35 (47.9)	21 (44.7)	13 (50.0)	
<b>Mechanism</b>				
Medication	195 (76.2)	124 (73.4)	71 (81.6)	.609
Toxins	65 (25.4)	45 (26.6)	20 (5.6)	.609
Injuries	25 (9.8)	17 (10.1)	8 (9.2)	.64
<b>Trigger</b>	105 (41)	68 (40.2)	37 (42.5)	.044
<b>Destination</b>				.93
Address	22 (8.6)	14 (8.3)	8 (9.2)	
Mental Health Follow-up	188 (73.4)	128 (75.7)	60 (68.9)	
Admission to Psychiatry	26 (10.2)	14 (8.3)	12 (13.8)	
Fura	20 (7.8)	13 (7.7)	7 (8)	

Bold values denote statistical significance ( $P < .05$ ).

prospective cohort studies, which may improve understanding and care for these patients.

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## Perceived stress among emergency department staff in a hospital

### Estrés percibido por el personal de urgencias hospitalarias

#### To the Editor,

Work-related stress is a widely recognized occupational health issue due to its impact on the well-being of health care professionals and the quality of care provided. In emergency departments (EDs), the inherent characteristics of clinical work—such as the unpredictable nature of demand, the need for immediate decision-making, high clinical responsibility, and constant exposure to emotionally charged situations—create an environment particularly prone to sustained stress.<sup>1</sup> In this context, the systematic assessment of perceived stress is essential, not only to quantify its magnitude but also to guide institutional strategies for prevention and mitigation.

The objective of this study was to determine the

level of perceived stress among staff working in a ED in Zaragoza (Spain). We conducted an observational, cross-sectional, and analytical study during the spring of 2025 using the Perceived Stress Scale (PSS-14)<sup>2</sup> and a sociodemographic questionnaire. The study included all health care professionals actively working in the emergency area of *Clínica Viamed Montecanal* (Zaragoza, Spain) who voluntarily agreed to participate and completed the questionnaire correctly. Statistical analysis was performed using the Student's t-test, ANOVA, and Pearson's correlation ( $P < .05$ ).

A total of 49 professionals participated: 63.3% nurses, 16.3% physicians, 14.3% nursing assistants (TCAE), and 6.1% orderlies. The mean age was 37.5 years (SD,  $\pm 10.7$ ), and 71.4% were women. The mean PSS-14 score was  $26.24 \pm 7.24$  (range 10–39), with a predominance of high stress levels (53.1%), followed by moderate (34.7%) and low (12.2%). No significant differences were observed by sex

( $P = .763$ ), but there were significant differences by professional category ( $P = .025$ ), with higher scores among physicians ( $32.38 \pm 4.57$ ) and lower scores among orderlies ( $17.67 \pm 8.02$ )—a statistically significant difference between these two groups ( $P = .023$ ). The correlation between age and stress was weakly positive but not significant ( $r = 0.259$ ;  $P = .072$ ).

This study confirms that perceived stress among emergency staff is highly prevalent, with more than half of participants reporting high levels of stress, confirming that EDs are environments of high cognitive and emotional demand.<sup>3</sup> The analysis by professional category adds a novel perspective, showing that physicians reported higher stress scores than orderlies, with a similar trend compared to other professional groups.<sup>4</sup> This finding suggests that the complexity of clinical decision-making and direct patient care responsibility are key determinants of stress intensity. The absence of significant sex differences is consistent with studies indicating that

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work conditions, rather than sociodemographic factors, are the main predictors of stress. However, other research continues to question whether gender alone influences vulnerability to stress, shifting attention instead to organizational and structural factors. The weak, non-significant correlation between age and stress suggests that professional experience does not act as a protective factor in this context.

Among the limitations of this study are the small sample size, particularly within certain professional categories, which may have reduced statistical power. The non-probabilistic convenience sampling limits the generalizability of results. Moreover, data collection was based solely on self-reported measures, which could introduce social desirability bias or symptom underreporting. Future studies should include larger or multicenter samples and explore additional variables, such as job tenure, number of night shifts, or the availability of institutional support.

We believe that these results underscore the need to design tailored stress prevention and management strategies for each professional profile, with special focus on groups bearing greater clinical responsibility. Interventions such as emotional management programs,<sup>5</sup> continuous psychological support, and workload optimization could help mitigate the negative impact of stress in this setting and improve both staff well-being and the quality of emergency care.

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