Initial Management of Gastrointestinal Haemorrhage

NHS University Hospitals Sussex NHS Foundation Trust

1	Resuscitate Patient • ABCDE assessment
2	Gain bilateral large bore IV access • Send FBC, U&E, LFTs, Clotting, G&S
3	• Start IV fluids • Shocked patients need four units of cross matched RBC • Patients with liver disease may require more
4	Hourly fluid balance calculation and urine output
5	High risk for variceal bleed OR previous variceal bleed → Terlipressin 2 mg IV (QDS) (1 mg if ischaemic heart/vascular disease) → Tazocin 4.5 g IV → In penicillin allergic gentamicin* and metronidazole
6	Give IV PPI in all patients suspected of having GI bleed
7	Only arrange transfusion if Hb <70 g/dL • Unless advanced liver disease (jaundice, ascites, coagulopathy) OR active ongoing significant GI bleeding where resuscitation on ongoing
8	Calculate Glasgow Blatchford score
9	Early ITU/HDU review if poor response to initial resuscitation

Correct Clotting

- STOP anticoagulants (contact cardiology if metallic valve present)
- Stop antiplatelets (contact cardiology if <3 months since PCI)
- Give Vit K 10 mg IV if known liver disease
- Check ROTEM and correct according to result
- If on DOAC, discuss with endoscopist on-call + GIM consultant on-call for consideration of Andexanet Alfa
- If on DOAC, contact haematology
- If on DOAC with renal impairment, contact renal

*caution with advanced liver disease