Non-Variceal Upper GI Bleeding Guideline

Lead Consultant: Dr Mark AUSTIN

Haematemesis, Melaena or drop in Hb **WITHOUT** known chronic liver disease
(Lone coffee ground vomiting is rarely associated with upper GI bleeding)

Assess Airway, Breathing and Circulation

- Consider supplementary oxygen, if appropriate
- Ensure large bore IV access, x2 if preferable.
- Send FBC, UE, LFTs, Coagulation Screen, Group and Save, Venous lactate.
- Cross-match 2 units packed red blood cells, 4-6 units if hypotensive, haemodynamically unstable or continued significant bleeding.

Think Aetiology

- ? known peptic ulcer disease or gastric surgery, then details.
- ? known chronic liver disease, then follow variceal bleeding guidelines
- ? recent ACS/ stents/ metallic valve, discuss with oncall cardiology team regarding antiplatelet agents / anticoagulation; if on aspirin, to continue.
- ? known AAA disease or recent EVAR, consider aorto-enteric fistula, organise CT aortogram urgently and contact oncall vascular team.
- ? current anticoagulation, discuss with senior regarding reversal.

Endoscopy should NOT be undertaken before appropriate optimal resuscitation

Management – PRE ENDOSCOPY

- Nil-by-mouth
- Support coagulopathy, aim platelets >50, INR < 1.5, Fibrinogen > 1.6
- If available and complex coagulation profile, consider thromboleastography (TEG) (biochemistry form with x2 blue bottle, results in 45mins)
- For DOAC/warfarin reversals, follow Haematology guideline via microguide.
- Give Pantoprazole 40mg IV BD.
- Give erythromycin 250mg 30-100min pre endoscopy (metoclopramide is second line if allergic)
- If haemodynamically stable, transfuse with a target Hb of >= 70g/L, or known cardiovascular disease, use target Hb >= 80g/L.
- If remains hypotensive or shocked, haemoglobin unlikely to be accurate and may need higher Hb threshold.

Remains haemodynamically unstable despite resuscitation, consider critical care referral via ICU SpR and inform critical care out-reach team.

Last update: August 2020 TW, HLA. Pantaprazole update Sept 2023, FC

Pre endoscopy Glasgow Blatchford Score		Score
Blood urea, mmol/L	>= 6.5 – 7.9	2
	8.0-9.9	3
	10.0 – 24.9	4
	>= 25	6
Haemoglobin, g/dL (male)	>= 12- 12.9	1
	10-11.9	3
	<10	6
Haemoglobin, g/dL (female)	10-11.9	1
	<10	6
Systolic Blood Pressure, mmHg	100-109	1
	90-99	2
	<90	3
Other markers	Pulse >= 100	1
	Melaena	2
	Syncope	2
	Hepatic Disease	2
	Cardiac Failure	2
Total Score		=
Please document the Blatchford score in the full clerking proforma.		

Endoscopy Referral

AFTER resuscitation and Glasgow Blatchford Score

Score < 2, low risk of bleeding and no other reason for admission, then discharge patient with outpatient urgent endoscopy request and consider follow up in EACU (RSCH) or RAMU (PRH).

RSCH In Hours

Contact acute medical consultant to review all patients via extension 3232.

Score >= 12 Immediate referral to acute medical consultant or medical registrar. After senior review, contact GI SpR or endoscopist +/- endoscopy nurse for urgent endoscopy. Consider a critical care referral.

Score 2- 12 Contact acute medical consultant or medical registrar for review and request inpatient endoscopy.

RSCH Out of Hours

Medical registrar to review all patients prior to contacting endoscopist.

Score > = 12 Immediate referral to medical registrar.
After senior medical review, SpR to consider contacting endoscopist via switchboard, and critical care.

Score 2- 12 Contact medical registrar.
After review, SpR to consider contacting endoscopist if evidence of significant, ongoing bleeding.

PRH In Hours

Score >= 2 Refer to PRH acute medical consultant or medical registrar for review.
Discuss with senior endoscopy nurse on Cuckfield ward for PRH endoscopy - if not available, contact RSCH GI SpR or endoscopist to consider transfer.

PRH Out of Hours

Score >= 2 Refer to medical registrar.
After review, SpR to consider contacting endoscopist via switchboard if evidence of significant, ongoing bleeding. If indicated by oncall endoscopist, organise transfer to RSCH – will need discussion with RSCH Medical SpR +/- PRH anaesthetic team.

NOTE : Out of hours endoscopy are conducted in CEPOD emergency theatres with endotracheal intubation. Once out of hours endoscopy is agreed by GI team, please refer to anaesthetic 1st oncall and book CEPOD list via CEPOD coordinator.

Management – POST ENDOSCOPY

- If bleeding identified and treatment applied during endoscopy, likely to require a 72-hour infusion of Pantoprazole (proforma available in endoscopy unit/EPMA)
- Be aware of re-bleeds in the 48—72 hour period. Follow last OGD rebleed plan, and consider early CT abdominal angiogram +/- interventional radiology team input +/- oncall general surgery team review and input.
- TEDS or Mechanical VTE Prophylaxis if not contraindicated and chemical VTE prophylaxis once haemostasis achieved as guided by endoscopist plan.
- Consider iron replacement if appropriate.

CONTACT INFORMATION

RSCH

Medical Consultant Oncall	:	3232
Medical Registrar Oncall	:	bleep 8521
Gastro Registrar	:	bleep 8513
Gastro DECT Phone	:	62098
Gastro Consultant	:	via switchboard
Endoscopy Nurse in Charge	:	64570

PRH

Medical Registrar Oncall	:	bleep 6044