**UPPER GASTROINTESTINAL BLEEDING (NON-VARICEAL) PATHWAY**

***= yes = no***

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| **TOP TIPS*** **Resuscitation** is fundamental to patient outcomes before and after endoscopy
* Base decisions on **blood transfusion** on the full clinical picture. Over-transfusion can be as harmful as under-transfusion
* **Endoscopy** is the primary investigation. **Timing** (*urgent* – within 48h Vs *emergent* – ASAP) and **location** (Endoscopy Suite Vs Theatres) is worked out case by case.
* Elderly and/or comorbid patients tend to poorly tolerate acute upper gastrointestinal bleeding, with a higher risk of death, compared to younger or fitter patients.
* **Anti-coagulants and anti-platelets** are widely prescribed. Weigh up the risk to the patient of clotting (e.g. stroke/MI or DVT/PE) versus the risk of bleeding. In most acute UGI bleeds, reverse anticoagulation.
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| *For the purposes of this pathway gastroenterologists are referred to as the primary physicians – in some centres general surgery or general medicine manage these patients.* |
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| **Has the patient had an upper GI bleed?** i.e. Haematemesis and/or malaena |
| *If suspected oesophageal varices (chronic liver disease AND haematemesis) use the* ***variceal bleed pathway*** |
| ☐ Yes 🡪 Continue |  | ☐ No 🡪 Stop pathway  |
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| **ALTERNATIVE DIAGNOSIS RISK – does the patient have a history of:** |
| ☐ Recent surgery *may be post-operative complications*☐ Fresh PR bleeding *could be lower GI bleeding or massive upper GI bleed*☐ Known AAA *may represent aortic oesophageal fistula and require urgent CT* |
| ☐ No 🡪 Continue |  | ☐ Yes 🡪 Stop pathway - Manage appropriately |
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| **Take history including:**☐ History of previous bleeds☐ Potential causes of chronic liver disease inc. alcohol, Hep B+C, HCC, NAFLD *none may be identified*☐ Past medical history, social history and functional status☐ Medications inc. NSAIDS, steroids, antiplatelets, anticoagulants: |
| Document indication for and doses of anti-coagulants and anti-platelets *here + in notes* | **INDICATION:****ANTI-COAGULANT: ANTI-PLATELET:** |
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| **Examination including:**☐ Baseline observations *and minimum hourly thereafter*☐ PR examination☐ Stigmata of chronic liver disease (including decompensation ; ascites/encephalopathy) |
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| **Investigations:**☐ FBC, urea, creatinine, electrolytes, LFTS, coagulation screen, cross match☐ VBG + lactate☐ ECG ☐CXR if clinically indicated |
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| **Management:** |
| ☐ **IV Access** | **2x large bore IV access** |
| ☐ **Resuscitate** | Give **0.9% saline OR Plasma-Lyte** *aim for SBP > 80-90mmHg***RBC transfusion** *aim for Hb 90 if actively bleeding***Massive blood loss** ( shock +/- coagulopathy) use your local massive transfusion protocol  |
| ☐ **Reverse** | Consider reversing anti-coagulation *use local guidelines and document below + in notes***PLAN:** |
| ☐ **Withhold** | Anti-hypertensives │ Anti-platelets │ Anti-coagulation | NSAID | COX-2 |
| ☐ **Prescribe** | ☐ If history of alcohol excess, use alcohol withdrawal pathway  |
|  | ☐ Omeprazole 40mg PO stat *give IV if active vomiting*☐ If platelets <50 *discuss with* [*on call haematologist*](file:///%5C%5Cnsh-deptdata%5Cgroups%5CMedicine%20Leave%20Schedule%5CMedicine%20Speciality%20Roster.xls)☐ Consider iv prokinetic e.g. erythromycin  |
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| **Calculate the Blatchford score. Is the score 0 and patient stable with no other concerns?** |
| ☐ No 🡪 Send referral to gastro for in-patient OGD |  | ☐ Yes 🡪 Same day discharge OP OGD referral if necessary  |
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| **Is the Blatchford 1 or greater, patient is unstable and may need immediate, emergent OGD?** |
| ☐ No 🡪 Urgent inpatient OGD within 48h ☐ Send in-patient referral for OGD  *Gastro registrar/SMO will arrange endoscopy* *Continue individual care as needed* |  | ☐ Yes 🡪 Discuss with Gastroenterology reg OR SMO on call\* regarding timing + location of OGD ☐ Send in-patient referral for OGD |
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| Is OGD in theatre or endoscopy suite? |
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| **OGD in theatre:**☐ Call theatre co-ordinator\*☐ Call anaesthetic co-ordinator\*☐ book Acute Theatre ☐ Send IP referral form for OGD  | **OGD in endoscopy suite:**☐ Send in-patient referral for OGD*Gastro registrar/SMO will arrange endoscopy* |
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| warning-sign-red-50If ongoing bleeding, shock/coagulopathy, inform gastroenterology + ICU, consider the *massive transfusion protocol*  |
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| **Post endoscopy care:**☐ Follow the OGD report *for guidance on repeat OGD and further management*. * Low risk patients can be discharged the same day
* Higher risk patients generally need to stay in hospital for 72h

☐ Offer proton pump inhibitors to patients with stigmata of recent haemorrhage shown at endoscopy☐ Continue aspirin for secondary prevention of vascular events when haemostasis has been achieved☐ Stop NSAIDs including COX-2 inhibitors during the acute phase☐ Terlipressin and ceftriaxone if variceal bleed *see variceal bleed pathway* ☐ Make a plan (weighing up risks + benefits) *if and when* to re-start anticoagulants or antiplatelents with specialist + patient☐ If the patient re-bleeds, call gastro. Another inpatient OGD may be required. |
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| **Where to look after patients:*** **High risk** pre-endoscopy OR post-endoscopy - ICU, HDU, acute monitored care area (eg. admitting unit, medical decision unit)
* **Low risk** – Any medical/surgical ward
* **Admitted patients** *i.e. already on the ward and have a bleed* consider transfer to more appropriate monitored clinical area ICU, HDU or gastroenterology ward
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| **\*Contacts:*** Gastroenterology registrar
* Gastroenterologist
* Anaesthetic co-ordinator
* Theatre co-ordinator
* Gastroenterology nurse co-ordinator………………………
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