**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. | | | | | | |
| *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:///\\nsh-deptdata\groups\Medicine%20Leave%20Schedule\Medicine%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……………………… | | | | |