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UHL

Initial management of acute upper GI bleeding (AUGIB)

Version 64

For adults experiencing haematemesis, melaena or coffee-ground vomit

NB: there is NO place for PPI prior to endoscopy

Document history and clinical findings as usual

Disclaimer:
This is a clinical template; clinicians should always use judgment when managing individual patients

Re-approved by ED guidelines committee chair, 04Apr20 . Trust Ref C188/2016
Review due Oct23

Patient details

Full name

DoB

Unit number

(use sticker if available)

① Resuscitation bundle

Tick off each items below when completed

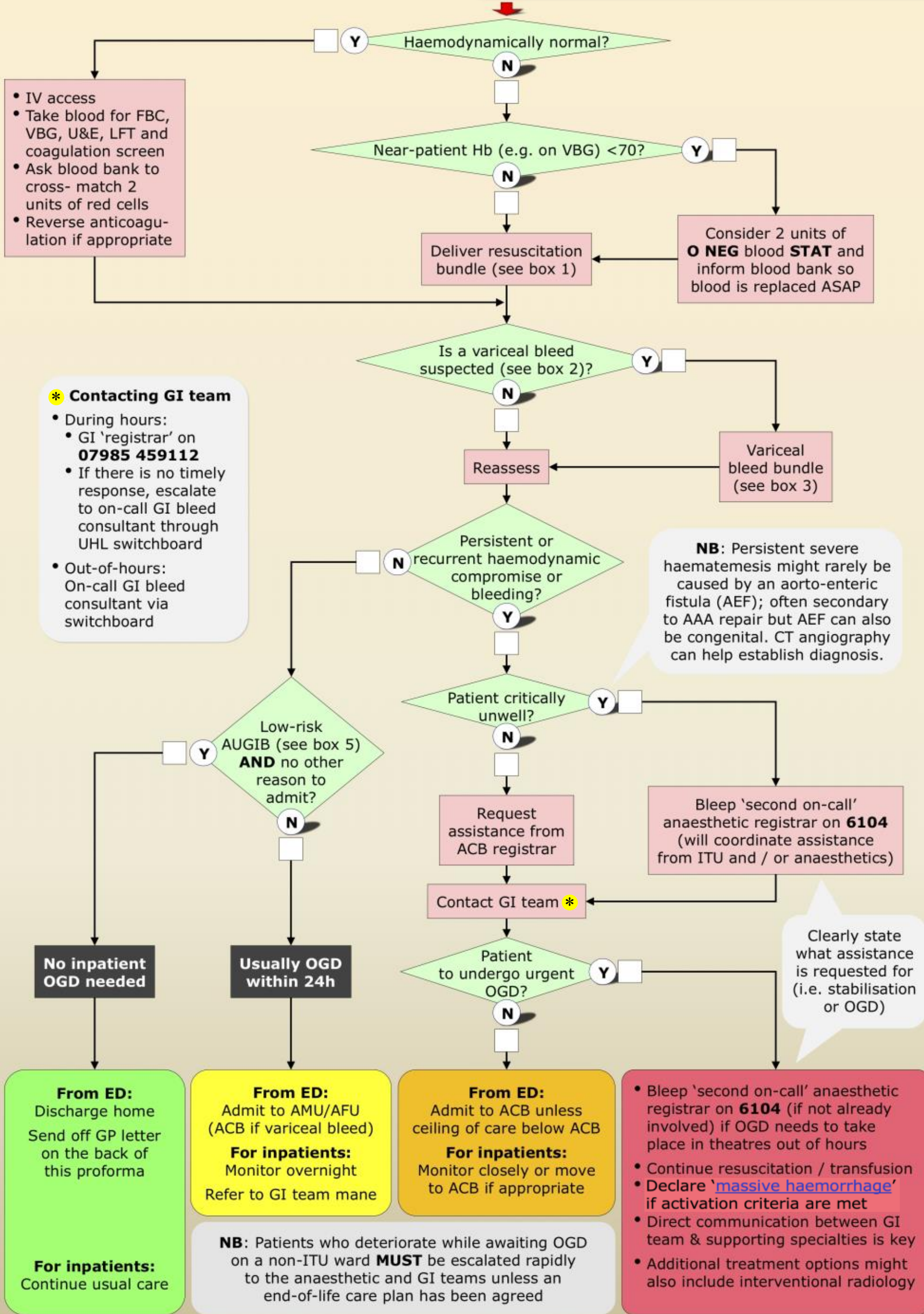
- ☐ Manage in safe environment (in ED: resuscitation room)
- ☐ Involve senior doctor **NOW**
- ☐ **DO NOT** yet request OGD at this stage
- ☐ Insert IV access x2
- ☐ Take blood for FBC, VBG, U&E, LFT, INR, clotting screen and G&S
- ☐ Call blood bank to X-match 6 units of RBC
- ☐ Give appropriate crystalloid bolus
- ☐ Monitor vital signs / NEWS every 15min
- ☐ Monitor fluid balance

Maintain Hb (in general >70g/L; or >80g/L if variceal bleed suspected)
- ☐ If Hb below target level, transfuse
- ☐ If Hb above target level, do not transfuse

Reverse anticoagulation where relevant
- ☐ If any of the below, reverse anticoagulation
  - ☐ On Warfarin **AND** INR >1.5
  - ☐ On LMWH – contact on-call haematologist
  - ☐ On DOAC (rivaroxaban/apixaban/dabigatran)
- ☐ If none of the above, no action required

Restore haemostatic competence if needed
- ☐ If any of the below, contact on-call haematologist:
  - ☐ Platelets <50 and likely still bleeding
  - ☐ INR >1.5
  - ☐ APTR >1.5
  - ☐ Fibrinogen <1g/L
- ☐ If all four normal, no correction needed

- ☐ After resuscitation, repeat FBC and VBG



② Variceal bleed suspected?

☐ **YES**, as at least one of the below

- Previous variceal bleed / known varices ☐
- Known cirrhosis ☐
- Clinically jaundiced ☐
- Clinical ascites ☐
- Spider naevi / liver palms ☐
- Splenomegaly ☐
- Platelets <100 (unless known other cause) ☐

☐ **NO**, as none of the above

③ Variceal bleed bundle

Tick off items below when completed

- ☐ Terlipressin 2mg IV STAT (unless contraindicated); then QDS for 72h
- ☐ Antibiotic prophylaxis for 72h
  - ☐ Unless allergic to penicillins: Co-amoxiclav 1.2G IV TDS
  - ☐ If penicillin-allergic: Ciprofloxacin 400mg IV BD

(for both, switch to PO after 24h if possible)

④ AUGIB referral data set

Convey information concisely using SBAR

- Age, sex
- Whether or not variceal bleed suspected
- Whether or not patient on anticoagulant
- Clinical frailty score (CFS)
- Cognitive function
- Vital signs / NEWS
- Glasgow-Blatchford Score (see box 5)
- Hb, acid base state, coagulation screen
- Interventions thus far (blood, fluids etc.)

⑤ Low-risk AUGIB?

Tick any applicable criteria below & record total Glasgow-Blatchford score (GBS)

Urea (tick one box if raised)
- > 6.5 — 2 ☐
- > 8.0 — 3 ☐
- >10 — 4 ☐
- >25 — 6 ☐

Haemoglobin (tick one box if low)
- <130 in male patient — 1 ☐
- <120 in female patient — 1 ☐
- <120 in male patient — 3 ☐
- <100 — 6 ☐

Systolic BP (tick one box if low)
- <110 at any time — 1 ☐
- <100 at any time — 2 ☐
- < 90 at any time — 3 ☐

- Heart rate >99 at any time — 1 ☐
- Melaena (spontaneous or on PR) — 1 ☐
- Presenting with syncope — 2 ☐
- Heart failure (known history, clinical signs or on ECHO) — 2 ☐
- Liver disease (known history, clinical signs or laboratory data; see also box 1) — 2 ☐

☐ **Yes** – as GBS is 0

☐ **No** – as GBS is >0

- If patient takes low-dose aspirin for secondary prevention of vascular events, continue once bleeding stopped
- Stop any other NSAIDs (including COX-2 inhibitors) during admission; endoscopist will advise on future use
- If patient takes clopidogrel (or any other thienopyridine antiplatelet drugs), discuss risks and benefits of continued use once bleeding stopped with a cardiologist or stroke specialist (as applicable) and with the patient

This patient was managed by

Print name	Signature	Position	Date	Time completed

Patient details

Full name

DoB

Unit number

(use sticker if available)

Date

Dear Doctor,

Your patient attended our ED with an episode of acute upper gastrointestinal bleeding.

History in a sentence:

Risk stratification using the Glasgow Blatchford Score (see box 2 on reverse) deemed your patient to be at low risk of death or needing intervention as a result of this episode. [1] Inpatient endoscopy or specialist review was therefore not required. As no other indication for hospital admission was found your patient was discharged home from the ED.

Many patients in this situation will not require any further specialist follow-up. Please consider the guidance below [2] to decide if referral for outpatient upper gastrointestinal endoscopy (OGD) may be appropriate at a later stage.

2-week referral

- Patients aged 55 years and older with unexplained and persistent recent-onset dyspepsia
- Patients of any age with dyspepsia who present with any of the following:
  - chronic gastrointestinal bleeding
  - progressive dysphagia
  - progressive unintentional weight loss
  - persistent vomiting
  - iron deficiency anaemia
  - epigastric mass
  - suspicious barium meal result
- Patients presenting with any of the following, even in the absence of dyspepsia:
  - dysphagia
  - unexplained upper abdominal pain and weight loss, with or without back pain
  - upper abdominal mass
  - obstructive jaundice (depending on clinical state)

***Consider* also patients with**

- Iron deficiency anaemia
- Unexplained weight loss
- Persistent vomiting and weight loss in the absence of dyspepsia
- Worsening of their dyspepsia known to have any of the following risk factors:
  - Barrett's oesophagus
  - dysplasia
  - atrophic gastritis (pernicious anaemia)
  - intestinal metaplasia
  - peptic ulcer surgery more than 20 years ago

Routine referral

- Post-treatment follow-up for gastric ulcer or bleeding duodenal ulcer (6 to 8 weeks)
- Follow-up of oesophageal ulcer (8 weeks)
- Barrett's oesophagus (for surveillance)
- Patients with liver disease (to detect oesophageal varices)
- Patients with resistant *H.pylori* infection who have worsening of dyspepsia
- Patients with coeliac disease (for confirmatory biopsy)

References

1. StanleyAJ et al. Outpatient management of patients with low-risk upper-gastrointestinal haemorrhage: multicentre validation and prospective evaluation. Lancet 2009; 373:42–47.
2. NICE. Upper GI endoscopy service commissioning guide. Referral criteria page. 2007.

Please don't hesitate to contact any of the ED consultants if you have any questions about our management of this case.

ED Clinician Print Name | Signature | Role