1. Has there been a GI bleed? **There are also UHL trust variceal bleeding guidelines to supplement this**. **Variceal Haemorrhage UHL Guideline** Trust Reference C15/2008
   - If not, consider discharge after check Hb
   - Consider early discharge (+ OP OGD) if:

   Age <60, no haemodynamic disturbance (pulse<100, systolic BP≥100), no significant co-morbidity (liver disease, cardiorespiratory disease, malignancy), not a current inpatient (for some other condition), no witnessed haematemesis or melaena, especially pre-endoscopy Blatchford score (appendix 1) of ≤3.

2. Identify high risk patient on admission: Any 1 of:
   - Pulse >100, BP < 100 or postural drop
   - Shock Pulse/ systolic BP> 1
   - Hb <10 (if acute GI bleed)

   ESPECIALLY if either:
   - Age >60
   - Concomitant disease (liver disease, severe heart / lung disease, anticoagulation)

   For calculating risk scores, See Blatchford score for pre-endoscopy triage (Appendix 1) and Rockall score for post endoscopy triage (Appendix 2). A Blatchford score of 3 or less suggests a very low likelihood of need for intervention. A post-endoscopy Rockall score of ≤ 2 suggest low risk of death or re-bleed so consider early discharge.

3. Urgent investigations:
   - Hb
   - Urea
   - Group and save (low risk), X-match (high risk)
   - Clotting (esp. if suspected liver disease/anticoagulated).

4. Resuscitate if hypovolaemic:
   - Large bore iv cannula (1 in each arm)
   - Blood within 2 hours (pref. whole blood)
   - Colloid if necessary

5. Endoscopy
   - The decision whether the patient requires an emergency endoscopy lies with the on call gastroenterology team.

   For details refer to the **Upper GI Bleeding UHL Emergency Department Guideline** Trust Ref C188/2016

   A referral for an emergency endoscopy should be made by a doctor of a sufficient level of seniority- see appendix 1 [contact GI registrar on call [in-reach team] in hours- weekdays 9-5; for out of hours contact GI bleed consultant Gastroenterologist via switchboard].

6. Emergency or early endoscopy
   - The decision regarding an emergency endoscopy lies with the GI in reach team in hours and the GI bleed consultant out of hours.
   - For all other stable upper GI bleeding liaise with inreach team in hours. Over weekends and bank holidays contact the endoscopy department at the LRI at 9am [ext 6995]. We offer a daily in patient endoscopy list at the LRI.
   - Consider early discharge and out patient endoscopy [book via endoscopy booking team] if Rockal score ≤ 2.

7. Use of PPI:

- Consider PPI before endoscopy in patients with non-variceal AGIB
- Offer a PPI to all patients after endoscopy who have non- variceal lesions with stigmata of recent bleeding.
- iv PPI in cases with **endoscopic high risk** stigmata (bleeding/visible vessel/fresh clot)

8. Surgery:

- Consider 2nd endoscopy and therapy in selected cases who rebleed or in whom initial endoscopy shows high risk stigmata or in whom success of initial haemostasis doubtful (see section 10 below)
- Consider radiological intervention in unstable patients if bleeding recurs or is not controlled by endoscopic intervention
- Consider surgery if: high risk rebleed or continued bleeding (>4 U per 24 h to maintain blood vol), age <60, good health if 2 rebleeds or continued bleeding

9. Miscellaneous:

- Keep bleeders NBM
- Allow food within 24 hours if no rebleed
- Continue low dose Aspirin for prevention of vascular events if haemostasis achieved
- Stop all other NSAIDs
- Discuss the risks and benefits of continuing clopidogrel (or any antiplatelet agents) and anticoagulants in patients with upper gastrointestinal bleeding with the appropriate specialist (for example, a cardiologist or a stroke specialist) and with the patient.
- Admission for at least 72h is recommended if proven peptic ulcer on OGD, or if significant proven GI bleed (haemodynamically or by fall in Hb) and normal OGD (or OGD not performed)

10. Guidance for endoscopic therapy:

- Recent RCTs suggest that higher (>15 up to 30 ml) volumes of dilute adrenalin (1 in 10000) are more effective in preventing rebleeding
- Do not use adrenalin injection as sole therapy; combine with thermal (eg heater probe) or mechanical (eg Endoclips) methods.
- Consider the use of haemostatic sprays or gels in select cases: difficult access, antiplatelet thearapy
- Meta-analyses suggest dual modality therapy (thermal + adrenalin or clips + adrenalin) are more effective in preventing rebleeding in high risk peptic ulcers
- Second look endoscopy in selected cases after 24 hours or if rebleeding recurs may be of benefit in high risk ulcers (discuss with GI consultant before requesting)
- See 'sister'guidelines for recommendations for variceal therapy **Variceal Haemorrhage UHL Guideline** Trust Reference C15/2008.

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NURSING INTERVENTIONS FOR UPPER GI BLEED

- Observations:
- Blood pressure
- Pulse
- Respirations
- Oxygen saturations
- Temperature

As clinically indicated, and follow any episode of active bleeding

- Observe, record and report any episodes of haematemisis or malena
- Strict fluid balance chart
- Monitor urine output
- Catheterise as prescribed by medics
- Nil by mouth
- Mouth care
- 1 hourly CVP monitoring
- Reassurance

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Appendix 1

Blatchford score for pre-endoscopy triage

DISTRIBUTION OF RISK SCORES FOR SCORE DEVELOPMENT AND VALIDATION GROUPS OF PATIENTS

Risk score	Score development group (n=1748)		Score validation group (n=197)	
	No Intervention needed	Intervention needed	Predicted need for intervention	Intervention needed
0	276(15.8%)	5 (0.3%)	0.6 (0.3 %)	1 (0.5%)
1	185(10.6%)	11 (0.6%)	1.8 (0.9 %)	3 (1.5 %)
2	115 (6.6%)	15 (0.9%)	1.4 (0.7 %)	1 (0.5 %)
3	101 (5.8%)	10 (0.6%)	1.2 (0.6 %)	3 (1.5 %)
4	97 (5.5%)	30 (1.7%)	2.1 (1.1 %)	4 (2.0 %)
5	72 (4.1%)	44 (2.5%)	4.2 (2.1 %)	4 (2.0 %)
6	61 (3.5%)	62 (3.5%)	7.1 (3.6 %)	11 (5.6 %)
7	32 (1.8%)	85 (4.9%)	9.4 (4.8 %)	10 (5.1 %)
8	14 (0.8%)	58 (3.3%)	10.5(5.3%)	10 (5.1 %)
9	15 (0.9%)	53 (3.0%)	3.1 (1.6 %)	4 (2.0 %)
10	3 (0.2%)	77 (4.4%)	5.8 (2.9 %)	5 (2.5%)
11	5 (0.3%)	113(6.5%)	12.4 (6.3%)	12 (6.1%)
12	1 (0.1%)	74 (4.2%)	8.9 (4.5 %)	9 (4.6 %)
13	3 (0.2%)	55 (3.1%)	5.7 (2.9 %)	6 (3.0 %)
>=14	0 (0%)	76 (4.3%)	6.0 (3.0 %)	6 (3.0 %)
Total	980(56.1%)	768(43.9%)	80.2 (40.7%)	89(45.2%)

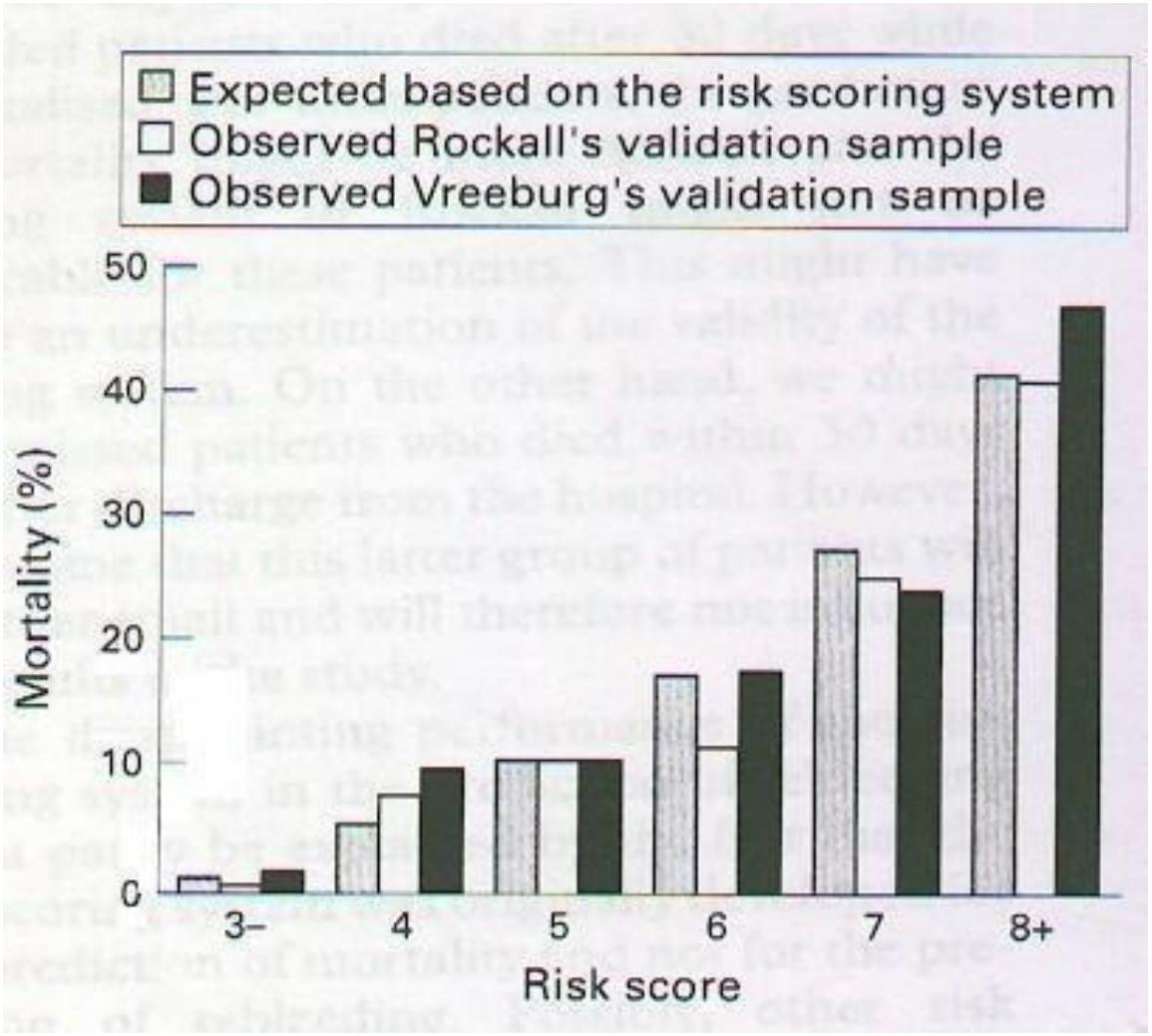
Appendix 2

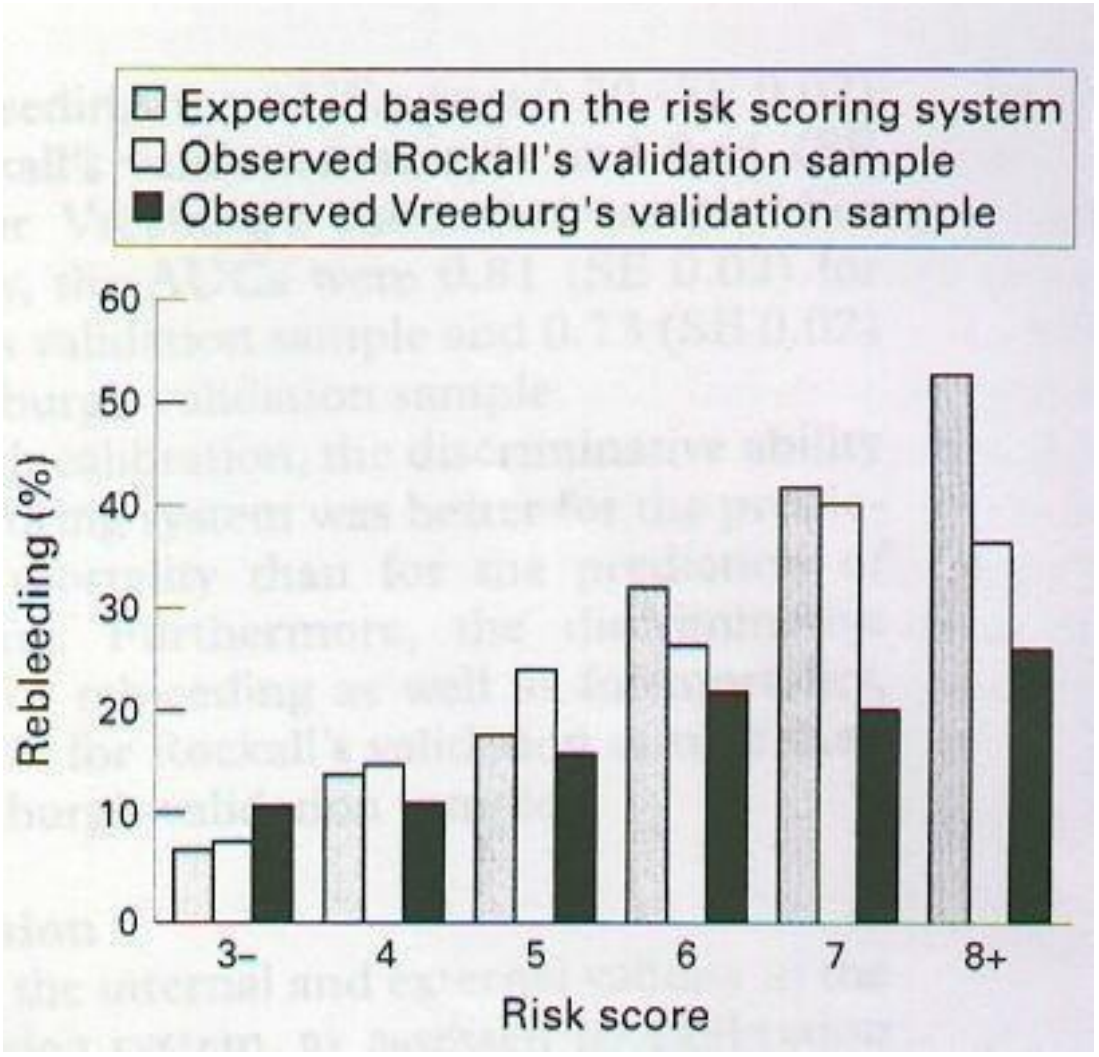
The Rockall risk scoring system

	Score			
Variable	0	1	2	3
Age	< 60	60-79	>80	
Shock	"No shock": pulse < 100 + systolic BP>= 100 mm Hg	"Tachycardia":pulse >= 100 + systolic BP >=100 mm Hg	"Hypotension": systolic BP <= 100 mm Hg	
Comorbidity	No major comorbidity		Cardiac Failure, ischaemic heart disease, any major comorbidity	Renal failure, liver failure, disseminated malignancy
Diagnosis	Mallory W eiss tear, no lesion identified and no SRH/ blood	All other diagnoses	Malignancy of upper GI tract	
Major SRH	None or dark spot only		Blood in upper GI tract, adherentclot, visible or spurting vessel	

"Translation" of our comorbidity scale

Comorbidity	No or mild coexisting illness (e.g. ECG abnormalities without symptoms)	Moderate coexisting illnesses (e.g hypertension stable with medication)	Severe coexisting illnesses (diseases which need immediate treatment: e.g. cardiac failure)	Life threatening diseases (e.g. end stage malignancies, renal failure)


Expected based on the risk scoring system
Observed Rockall's validation sample
Observed Vreeburg's validation sample
Mortality (%)
50
40
30
20
10
0
3–
4
5
6
7
8+
Risk score


Expected based on the risk scoring system
Observed Rockall's validation sample
Observed Vreeburg's validation sample
Rebleeding (%)
60
50
40
30
20
10
0
3–
4
5
6
7
8+
Risk score