SDH Standard Operating Procedure Acute Upper Gastrointestinal Bleeding (AUGIB) July 2020 Review date Dec 2020 Author Dr A. Jamil

Modified Acute Upper GI Bleeding bundle

Salisbury NHS Foundation Trust

Patient details/Label
Name:
D.O.B:
Hospital No.:
Date:

Recognition

If reported or evidence of:
Haematemesis, melaena or coffee ground vomiting

Haemodynamic instability? Activate major haemorrhage protocol +/- ITU review

Resuscitation

	Y/N
NEWS2	
IV crystalloid	
Transfuse if Hb <70g/L (target 80 or >100g/L in IHD)	
Contact Gastroenterology SpR or Consultant 0900-1700/ on-call Gastro Cons	
(OOH via On-call Med Cons) if BP< 90mmHg systolic or heart rate >100	

Endoscopy in under resuscitated patients carries a high mortality

Risk assessment

Calculate Glasgow Blatchford Score
Consider discharge if GBS 0 or 1 for urgent outpatient OGD

Blood urea (mmol/L)		Systolic BP (mm Hg)	
6.5 – 8.0	2	100 – 109	1
8.0 – 10.0	3	90 – 99	2
10.0 – 25	4	<90	3
>25	6	**Other features:**	
Haemoglobin (g/L) for men		Pulse >100 bpm	1
120 – 129	1	Melaena	1
100 – 119	3	Syncope	2
<100	6	Cardiac failure	2
Haemoglobin (g/L) for women		Hepatic disease	2
100 – 119	1	TOTAL	
<100	6		

Rx

History or stigmata of liver disease, cirrhosis or suspected variceal bleed:

➢Ceftriaxone 2g IV OD (Levofloxacin 500mg IV OD if penicillin allergy)	
➢Terlipressin 2mg QDS	
➢ Add BASL decompensated cirrhosis care bundle	
NBM until endoscopy and ensure G+S/Cross match	
Continue low dose aspirin 75mg OD	
Suspend antithrombotics incl. antiplatelets, anticoagulants and VTE prophylaxis	
Tranexamic acid 1g TDS if active bleeding	
Omeprazole 40mg IV BD pre-endoscopy	
Reversal of warfarin/DOAC refer to massive haemorrhage policy	

Refer

Endoscopy within 24hrs of presentation	
•Book Acute GI bleed (emergency) on Review if stable	
Gastroenterology SpR or Consultant review	

Review

Review endoscopy report + Rebleed plan	
Antithrombotic plan	

*****Unstable patients despite fluid resuscitation will require OGD in theatres in hours or OOH call ITU and Gastro Consultant*****

Initial Management

Admit under Acute Medical Team
Follow AUGIB Bundle management
Ensure good IV access and start with crystalloid
Sample to blood transfusion
Stratify into high and low risk

Remember

Endoscopy in poorly resuscitated patients is DANGEROUS
Initial Hb can be misleadingly high
OOH Endoscopist contacted through switchboard
OOH OGD performed in theatre or UHS
Request all AUGIB on Review as 'Acute GI bleed'

High Risk

Unstable Patients	Varices
Any inpatient bleed with Systolic BP<100 and/or HR >100 despite fluid resuscitation Active severe bleeding	History of liver disease Stigmata of liver disease Deranged liver profile High INR/Low platelets See AUGIB bundle

Low Risk

GBS ≤ 1

Very Low Risk

GBS 0

→ Urgent outpatient OGD

Low Risk Management

-Group and Save
-Arrange routine inpatient endoscopy
-Fortijuice/clear fluids until 2 hours before OGD

High Risk Management

-Replace circulatory volume with blood or crystalloid
-X match 4 units, regularly assess for more units
- Consider activating major haemorrhage protocol in acute haemodynamic instability
-Consider HDU/ITU
-Inform GI SpR 0900-1700 or Consultant
-NBM until endoscopy follow **AUGIB bundle**
-**In hours:** inform Gastro SpR (bleep 1944/1325)
-**OOH:** On-call Medical Consultant makes referral to Gastroenterology Consultant
-Continue to resuscitate + high dose PPI
-Inform on call surgeons
-For unstable patients inform ITU

Endoscopy

URGENT		ROUTINE	
Indication	**Arrangement**	**Indication**	**Arrangement**
-Continuous active bleeding -Rebleeding following admission -Suspected Varices	Will be performed in theatre or Endoscopy after Consultant Gastroenterologist assessment	All other cases	-Endoscopy unit Mon-Fri -Medical take Cons to D/W UHS in weekend

Is patient suitable for transfer to UHS OOH ?

-Significant haematemesis and/or melaena with haemodynamically instability (ITU optimised transfer)
-Stable patients admitted with symptoms and signs of AUGIB and a Glasgow Blatchford score of 1 or more who cannot be OGDed within a clinically reasonable time frame (typically 24hrs unless SDH consultant defines)
-Endoscopy at SDH, but haemostasis was either not achieved or is at high risk for re-bleeding.
-CoVID-19 status must be known prior to transfer unless ITU.

Post Endoscopy

Haemostasis achieved	**High chance of rebleed/no haemostasis**
Transfer to Redlynch ward ASAP Close monitoring Inform surgeons	D/W ITU re ITU bed Inform on call surgeons If unable to achieve haemostasis d/w UHS