SDH Standard Operating Procedure Acute Upper Gastrointestinal Bleeding (AUGIB) April 2021 Review date Dec 2021 Author Dr A. Jamil, Ms Chave, Dr M. Amin

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 + contact on-call Gastroenterologist +/- ITU review

Y/N

Resuscitation

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 ☐
Omeprazole 80mg IV loading dose over 45 minutes, followed by a continuous 8mg/hour infusion for 72 hours 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 GBS>6 or Rock>3	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 on 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

Criteria and pathway for referral from Salisbury District Hospital to University Hospital Southampton for urgent gastroscopy

This document aims to formalise the referral process for patients being considered for transfer to University Hospital Southampton (UHS) from Salisbury District Hospital (SDH) for urgent gastroscopy.

The pathway must be adhered to and any breaches escalated as significant incidents and reportable to medical directors of responsible trusts.

When will cover be provided?

UHS will provide cover for urgent endoscopy for SDH over the following periods:

- Out of hours and weekends agreed between SDH and UHS as in the excel spread sheet attached **but to be ratified after discussion**
- Any changes needs to be agreed 6 weeks prior by direct communication with the endoscopy service manager, and copied to Dr. Praful Patel and Dr. Trevor Smith.

What patients are suitable for transfer?

Patients are suitable to be discussed for transfer if they fit the following criteria:

- Patients with significant haematemesis and/or melaena with haemodynamically instability.
- Stable patients admitted with symptoms and signs of gastrointestinal bleeding and a Glasgow Blatchford score of 1 or more who cannot be gastroscoped within a clinically reasonable time frame on SDH.
- Patients who have had an endoscopy at SDH, but haemostasis was either not achieved endoscopically, or the SDH Consultant Gastroenterologist has sufficient concern to suspect the patient is at high risk for re-bleeding.

SARS-cov-2

- All patients with suspected upper GI bleeding should have swabs taken for SARS-cov-2 on admission to SDH
- For patients with ongoing haemodynamically instability (for ITU to ITU transfer) then it is acceptable for transfer to occur prior to knowledge of result.
- For all other patients, SARS-cov-2 status must be known prior to transfer.
- Efforts should be made to avoid transfer between sites of SARS-cov-2 positive patients however, in the presence of clinically determined life-threatening GI bleeding, patients will be accepted for transfer if deemed clinically appropriate by SDH referring consultant and UHS accepting consultant gastroenterologist.

How should patients be referred?

- The referral should consist of a telephone call from the responsible Consultant at SDH to the on-call endoscopist at UHS.
- At UHS during weekday 09:00 – 17:00 this is the SpR who will confirm suitability for transfer with the Consultant Gastroenterologist on-call for endoscopy.
- Patients who present with, or have, ongoing haemodynamic instability should be assessed by the critical care team at SDH to ensure safety and optimisation prior to transfer.
- In those with haemodynamic instability, consideration should be given to ITU to ITU transfer. In these cases, it is the responsibility of the SDH team to liaise directly with UHS ITU department to discuss admission. In the eventuality UHS ITU has no beds available, then transfer to an alternative hospital will need to be arranged by the SDH team.
- For other cases, the SDH team should discuss with the acute medical unit team to organise admission to the AMU at UHS.

Transporting patients

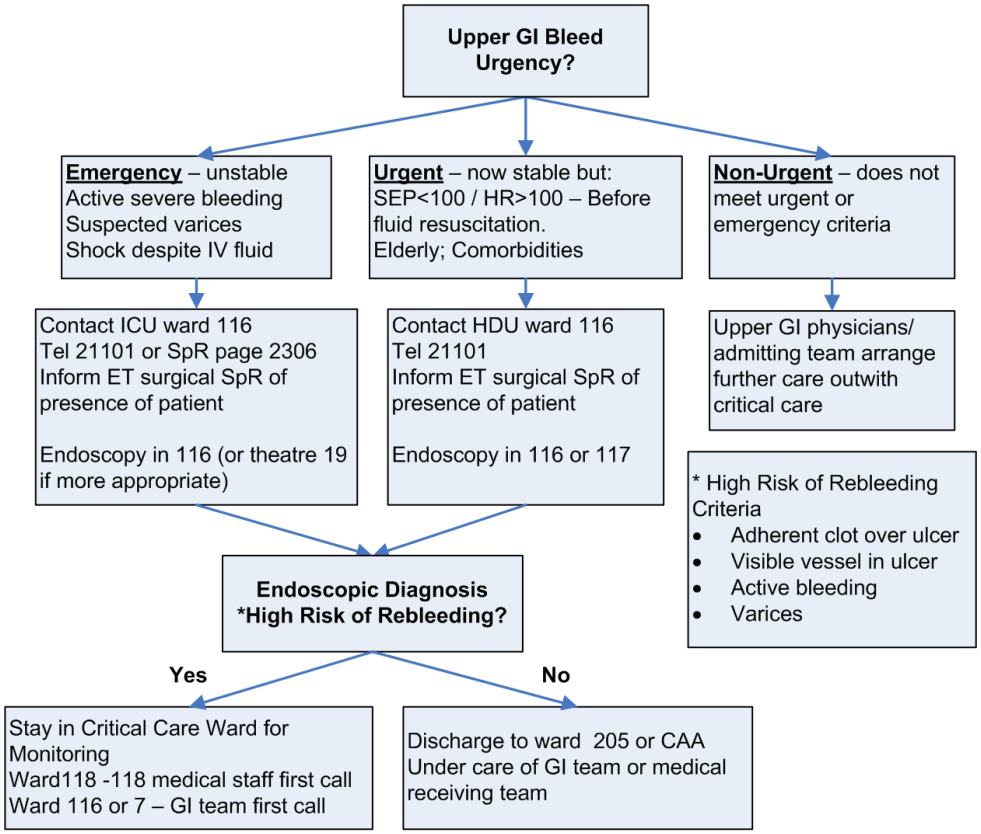
- The referring hospital is responsible for organising the logistics of any transfer.
- The referring hospital is responsible for all transport costs.

When should patients be transferred back?

- Patients at risk of re-bleeding will be managed at UHS until deemed stable enough for transfer back to SDH by the Consultant gastroenterologist at UHS. This will ordinarily be between 24-72hrs post endoscopy. Transfer back to SDH should occur within 48hours. UHS will not be responsible for providing this ongoing inpatient care for other healthcare needs.
- Cases that have waited >48hrs after being deemed suitable for transfer back to base hospital should be escalated to the chief operating officer.

Following page:
Pathway for transfer of patients with significant upper Gastrointestinal bleeding from SDH to UHS

This guideline is intended to allow rapid, safe and appropriate access to Critical Care for urgent / emergency endoscopy and if appropriate continued monitoring and care. Referral to Critical Care by GI Registrar / Consultant



Bed problems – Endoscopy in theatre 19 (TEL 23241)
It is recognised that there may not be a readily available bed in critical care. In this circumstance urgent endoscopy may have to be carried out in theatre and join a list of clinical priority with surgical cases.
If conflict over priority for theatre arises, the Consultant Anaesthetist on call for emergencies should be the final arbiter. This may involve opening a second theatre.
Patient transfer from theatre – high risk rebleeds go to critical care (most appropriate ward) and non high risk to wards 107 or 205. It is clearly not possible to identify a specific bed / ward before endoscopy and this should not delay patients being brought to theatre.

Airway / Sedation concerns in Ward 116, 117.
If Worried call Anaesthetic help page 2200 – if unavailable call ICU Reg page 2306.