

Acute Upper GI Bleed – Can We Do Better?

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INTRODUCTION

Acute upper gastrointestinal bleeding (AUGIB) is a common medical emergency, with an estimated incidence of 134 per 100,000 population¹ and our expected annual incidence in NHS D&G is 201. Mortality related to AUGIB remains at 10%¹, and British society of gastroenterology (BSG) has developed a bundle focusing on restrictive blood transfusion, continuation of aspirin, timing of endoscopy and IV PPI usage in 2019, which aims to improve care and clinical outcome.

METHODS

112 patients who received upper GI endoscopy over 01/10/2020 to 30/12/2020 were included in this study.

RESULTS

Completion of AUGIB bundle: **0%** compliance
RBC transfusion regime: 41% patients were transfused at Hb >80g/L
Continuation of aspirin: 40% of patients
Variceal bleeds: 50% of patients prescribed IV terlipressin
IV high dose proton pump inhibitor (PPI) prior to scope: 64% of patients
Timing of endoscopy: average 72 – 105 hours from presentation (quickest 4 hours)

RECOMMENDATIONS

Recognition

Trigger the AUGIB if patient presents with **ANY** of the following:

- Haematemesis
- Melaena
- Coffee ground vomiting

Resuscitation

ONLY TRANSFUSE: if Hb <70g/L unless history of cardiac disease or haemodynamically unstable

Restrictive blood transfusion (threshold 70 - 80g/L) is associated with reduction in all-cause mortality, rebleeding and number of transfusions

Risk stratification

Calculated Glasgow-Blatchford score (0 – 23): if score ≤1, can consider outpatient management

Treatment

Suspected cirrhosis/variceal bleeding: IV terlipressin 2mg QDS **AND** IV broad spectrum antibiotics

Reduces mortality, bacterial infections and rebleeding

Continue aspirin: **3x** increased risk of cardiovascular or cerebrovascular events

Suspend all other antiplatelets and anticoagulants

SPEAK TO CARDIOLOGY IF HISTORY OF RECENT PCI

Refer

UGIE should be performed within 24 hours of presentation!



UK Acute Upper GI Bleeding Bundle (to be performed within 24h)

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

	If reported:	Trigger bundle and record if performed	Y/ N/ NA
RECOGNITION	Haematemesis, melaena or coffee ground vomiting		
RESUSCITATION		Perform NEWS as indicated	<input type="checkbox"/>
		Commence IV crystalloid	<input type="checkbox"/>
		Transfuse if Hb <70g/L, aim for 70-100g/L	<input type="checkbox"/>
RISK ASSESSMENT		Calculate Glasgow-Blatchford Score (GBS): enter value →	<input type="checkbox"/>
		• Consider discharge if GBS 0 or 1	<input type="checkbox"/>
R_x		If cirrhosis/suspected variceal bleed, give terlipressin 2mg QDS and antibiotics as per local protocol	<input type="checkbox"/>
		Continue aspirin	<input type="checkbox"/>
		Suspend all other antithrombotics	<input type="checkbox"/>
REFER		Referral for endoscopy to be undertaken within 24h of presentation	<input type="checkbox"/>
		Refer to GI specialist if varices or requiring therapeutic endoscopy	<input type="checkbox"/>
REVIEW		Review endoscopy report	<input type="checkbox"/>
		PPI if high risk ulcer post endoscopy	<input type="checkbox"/>
		Post-haemostasis antithrombotic plan	<input type="checkbox"/>

Haemodynamic instability? Think Major Haemorrhage Protocol +/- critical care review

Review

If peptic ulcer: Hong Kong protocol (IV 80mg omeprazole STAT, then 8mg/hour IV infusion over 3 days)

No effect on clinical outcome when PPI given prior to UGIE

To **resume** antiplatelets and anticoagulants once haemostability is achieved

DISCUSSION

IV PPI is commonly commenced prior to scope in DGRI, despite not recommended by NICE or BSG. We think that might have to do with anticipation of delay in timing of OGD.

We hope this audit encourage the use of AUGIB bundle; which follows restrictive protocol for blood transfusion, continuation of aspirin and early referrals for urgent endoscopy!

For more information – **refer to handbook**

References

Siau K., Hearnshaw S., Stanley A.J., et al. British Society of Gastroenterology (BSG)-led multisociety consensus care management of acute upper gastrointestinal bleeding. *Frontline Gastroenterol.* 2020; 11: 311 - 323