CUH
Ospidéal Ollscoil Chorcaí
Cork University Hospital

First Name: _____ **Gender:** _____
Surname: [*AFFIX PATIENT LABEL HERE*]
Address: _____
Date of Birth: _____ **MRN** _____
Ward/Clinic: **Consultant:**

UNSTABLE UPPER GASTROINTESTINAL BLEEDING PATHWAY (VARICEAL AND NON-VARICEAL)

EM REG : ALTERNATIVE DIAGNOSIS RISK – does the patient have a history of:

☐ Recent surgery *may be post-operative complications*
☐ Fresh PR bleeding *could be due to lower GI bleeding or massive upper GI bleed*
☐ Known AAA *may represent aorto-enteric fistula and require urgent CT*
☐ History/examination suggestive of bowel obstruction

☐ No → Continue | ☐ Yes → Stop – Consider lower GI Pathway

ED REG: Take history including:

☐ Known cirrhosis or any potential causes of chronic liver disease, e.g., Alcohol, Hepatitis B or C, NAFLD
☐ Alcohol units per week _____
☐ History of previous GI bleeding including any previous OGDs
☐ Medications: Anticoagulants ☐, Antiplatelets ☐, Corticosteroids ☐, NSAIDs ☐

Name	**1.** _____	**2.** _____	**3.** _____	**4.** _____
Indication	_____	_____	_____	_____
Last taken at (Time)	_____	_____	_____	_____

EM REG: Examination including:

☐ Baseline observations and frequency thereafter per NEWS
☐ PR examination
☐ Stigmata of chronic liver disease
☐ Decompensation: *ascites, encephalopathy*

EM REG: Investigations:

☐ FBC, Renal Profile, Liver Profile, AST, Iron Studies, Prothrombin Time, APTT, Fibrinogen, HIV, Hep B/C, Crossmatch
☐ VBG ☐ ECG ☐CXR

Admission risk markers	Score
Systolic blood pressure, mm Hg	
100–109	1
90–99	2
<90	3
Blood urea nitrogen, mmol/L (mg/dL)	
6.5–7.9 (18.2–22.12)	2
8.0–9.9 (22.4–27.72)	3
10.0–24.9 (28–69.73)	4
≥25.0 (≥70)	6
Hemoglobin for men, g/dL	
12.0–12.9	1
10.0–11.9	3
<10.0	6
Hemoglobin for women, g/dL	
10.0–11.9	1
<10.0	6
Other risk variables	
Pulse ≥100 beats/min	1
Presentation with melena	1
Syncope	2
Hepatic disease	2
Cardiac failure	2

Glasgow-Blatchford Score = _____

Score	Interpretation
0-3	Low risk for intervention Reasonable to manage as outpatient. Consider Low Risk ED GIB outpatient pathway
>3	inpatient management is recommended most cases <5 respond without significant intervention
Score >5	High risk for intervention

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Principles of Management- Initial Joint EM REG, MROC (bleep 311), SROC (VPN 67639)

☐ **Resuscitate**	2x Large Bore IV Access If haemodynamically unstable, give **500mL Hartmann's Solution** over 15 minutes. Repeat bolus as needed. *Aim for sBP > 90mmHg* **RBC transfusion** if Hb <7.0 on VBG or haemodynamically unstable. *Aim for Hb 7 – 9*. If urgent transfusion required (particularly if a major haemorrhage) Inform the blood transfusion lab ASAP on Ext: 22537 Bleep 199 • Take a **properly labelled** blood transfusion sample and deliver to the laboratory
☐ **Prescribe**	☐ **Pantoprazole** 40mg IV stat If history or suspicion of **chronic liver disease** +/- known oesophageal varices), also give ☐ **Ceftriaxone** 1g IV stat (check allergies) ☐ **Terlipressin** 2mg IV stat - *relative contraindication in ischaemic heart disease* ☐ **Vitamin** K 10mg IV stat
☐**Consult**	☐ If platelets < 50 or INR >1.8 or therapeutically anticoagulated, contact haematology (#9) ☐ If haemodynamically unstable after resuscitation or unable to protect airway, contact ICU Registrar on Call (VPN62251) and consider ***massive transfusion protocol.***
☐ **Reverse**	Consider reversing anti-coagulation, contact haematology on call (via switch)
☐ **Withhold**	Anti-hypertensives | Anti-platelets | Anti-coagulation | NSAID | COX-2

After resuscitation, is the patient haemodynamically unstable or having active haematemesis?

☐ **No** → Refer for MROC for GIM medical admission
Admitting team speak to endoscopy unit (22153)
Continue individual care as needed
☐ Request OGD on iCM
☐ Consent patient for OGD
☐ Instruct NPO from midnight in admission note and prescribe maintenance IV fluids

☐ **Yes** → Discuss with endoscopy GI Reg (0871880778)
→ Outside 09:00 – 17:00 and at Weekends MROC/SROC to discuss with GI Consultant Covering Endoscopy (via switch)
☐ Request OGD iCM

GI Consultant/Registrar will advise on timing and location for OGD

OGD in theatre- SROC to take responsibility for arranging:
☐ Contact theatre co-ordinator 7.30am-5pm on mobile 086 0408713, out of hours contact VPN 62174
☐ Contact theatre anaesthetist on call 24 hours on 087248252
☐ List patient for theatre

OGD in GI Unit
☐ Contact bed management (#9) to prioritise admission to a bed
☐ Phone Endoscopy Unit Nurse in Charge on extension 22458/22153

Pre endoscopy care if admitted:
High risk: ICU
Low risk: IB if bed available.
Continue Terlipressin and Ceftriaxone if history of chronic liver disease +/- known oesophageal varices.
Continue BD PPI IV
Consider IV erythromycin in consultation with endoscopist

Post endoscopy care:
☐ Follow the OGD report *for guidance on repeat OGD and further management*.
– Low risk patients can often be discharged the same day
– Higher risk patients generally need to stay in hospital for 72h
☐ Pantoprazole 40mg BD IV if stigmata of recent haemorrhage at OGD.
☐ Continue Terlipressin and Ceftriaxone for 3-5 days if variceal bleed
☐ If the patient re-bleeds, call gastroenterology. Another inpatient OGD may be required.
☐ If haemostasis achieved, consider restarting Aspirin if appropriate
☐ If the patient is on DAPT for coronary artery stenting or Warfarin for a high-risk indication, discuss with cardiology/haematology and make a plan for resumption

Informed by British Society of Gastroenterology-led multisociety consensus care bundle for the early clinical management of acute upper GI bleeding.
Designed by the Department of Gastroenterology in consultation with the Departments of Colorectal Surgery, Emergency Medicine, Critical Care Medicine and Haematology. With thanks to the New Zealand Society of Gastroenterology..