**UPPER GASTROINTESTINAL BLEEDING (VARICEAL) PATHWAY**

***= yes = no***

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| **TOP TIPS*** **Careful resuscitation** is fundamental to patient outcomes before and after endoscopy
* Carefully transfuse with the full clinical picture. Over-transfusion can be as harmful as under-transfusion
* If variceal bleed suspected discuss **early with gastroenterology**
* **Antibiotics, terlipressin and emergent endoscopy** are key differences to non-variceal UGI bleeds
* **Endoscopy** is the primary investigation in patients with acute upper GI bleeding. **Timing** for variceal bleeds is often *emergent* and often done in theatre*.*
* Consider **ceiling of care and resuscitation status**. Is the patient a transplant candidate? Discuss and document
* Patients with cirrhosis and portal hypertension poorly tolerate acute upper gastrointestinal bleeding, with a **high risk of death**.
* **Anti-coagulants and anti-platelets** are widely prescribed. Whether to reverse, and how to reverse, depends on the risk to the patient of clotting (eg stroke/MI or DVT/PE) versus the risk of bleeding from the event. In most variceal UGI bleeds, anticoagulants require reversal
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| \**Know your local guidelines for acute endoscopy services and arrange early transfer if necessary.* |
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| **Do you suspect a variceal bleed?** *i.e. Known or suspected oesophageal varices or chronic liver disease AND GI bleed?* |
| ☐ Yes 🡪 Continue |  | ☐ No 🡪 Stop pathway *Use non-variceal UGIB pathway if needed* |
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| **ALTERNATIVE DIAGNOSIS RISK – does the patient have a history of:** |
| ☐ Recent surgery *may be post-operative complications*☐ Fresh PR bleeding *may represent lower GI bleeding or massive upper GI bleed*☐ Known AAA *may represent aortic oesophageal fistula and require urgent CT* |
| ☐ No 🡪 Continue |  | ☐ Yes 🡪 Stop pathway manage appropriately |
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| **History including:**☐ Chronic liver disease inc. previous bleeds☐ Causes of chronic liver disease inc. alcohol, Hep B *or* C, HCC, NAFLD *none may be identified*☐ Medications inc. NSAIDS, steroids, antiplatelets, anticoagulation |
| Document indication for and doses of anti-coagulants and anti-platelets *here + in notes* | **INDICATION:****ANTI-COAGULANT: ANTI-PLATELET:** |
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| **Examination including:**☐ Baseline observations NZEWS*and minimum hourly thereafter*☐ PR examination | ☐ Stigmata of chronic liver disease☐ Decompensation: *Ascites, encephalopathy (sleep/wake reversal 🡪 confusion 🡪 asterixis 🡪 coma)* |
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| **Investigations:** |
| ☐ FBC, Urea, Cr, Electrolytes, LFTS, Coag screen, Cross Match | ☐ Lactate | ☐ CXR and ECG |
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| **Management:** |
| ☐ **IV Access** | 2x large bore IV access |
| ☐ **Resuscitate** | ☐ Give **0.9% saline OR Plasma-Lyte** *aim for SBP > 70-90mmHg.* ☐ **RBC transfusion** if Hb <70. *Aim for Hb 70-90 if actively bleeding*If severe shock/coagulopathy, inform ICU & consider ***massive transfusion protocol***  |
| ☐ **Reverse** | Consider reversing anti-coagulation **PLAN:** |
| ☐ **Withhold** | Antihypertensives │ Antiplatelets │ Anticoagulation | NSAID | COX-2 |
| ☐ **Prescribe** | ☐ Omeprazole 40mg PO stat *give IV if active vomiting*☐ Cefuroxime 1.5g IV stat or ceftriaxone 1g IV stat☐ Terlipressin 2mg IV stat - *relative* *contraindication in IHD. Use Octreotide instead.*☐ Vitamin K 10mg IV stat☐ If history of alcohol excess, use alcohol withdrawal pathway as per local policy☐ **Platelets:** If < 50discuss with on call haematologist |
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| ☐ **Discuss with Gastroenterology registrar\* or SMO\* regarding time + location of OGD** |
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| **Is the patient for OGD during admission?** |
| ☐ Yes 🡪 Continue |  | ☐ No 🡪 Stop pathway manage appropriately |
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| **Is the decision for immediate OGD to treat possible varices?** |
| ☐ Yes 🡪 Continue |  | ☐ No 🡪  |
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| Is OGD in theatre or endoscopy suite? |  | ☐ Send referral for OGD*Gastro registrar/SMO will arrange endoscopy**Continue individual care as needed* |
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| **OGD in theatre:**☐ Call theatre co-ordinator\*☐ Call anaesthetic co-ordinator\*☐ Acute Theatre booking form via Concerto>’temple’>theatres>acute booking☐ Send e-referral for OGD  | **OGD in endoscopy suite:**☐ Send referral for OGD*Gastro registrar/SMO will arrange endoscopy* |
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| If ongoing bleeding, shock/coagulopathy, inform gastroenterology + ICU, consider the *massive transfusion protocol as per local policy* |
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| **Post endoscopy care:**☐ Read the OGD report. It is the responsibility of the ward team to arrange **inpatient treatment and outpatient follow up** for inpatient endoscopy. For example, patient may require 2- weekly banding ☐ Continue aspirin for secondary vascular prevention when haemostasis has been achieved☐ Make a plan (weighing up risks + benefits) *if and when* to **re-start anticoagulants or antiplatelets** with specialist + patient☐ 48-72 hours of **Terlipressin** 1-2mg 6hourly *if varices confirmed*☐ **Ceftriaxone** 1g daily *if varices treated*☐ **4% Albumin** *for maintenance fluid in known/suspected cirrhosis*☐ Investigate/ treat **contributing factors** - sepsis, SBP, encephalopathy, alcohol withdrawal, nutrition  |
| ☐ **If the patient re-bleeds, call gastro**. Patient will need carefully planned care which might include:* **Endoscopy** – e.g. OGD for repeat banding, sclerotherapy, stent or coiling
* **Interventional radiology** –e.g.TiPSS arranged through Gastroenterology/ NZLTU at ADHB
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| **Where to look after patient post endoscopy:*** **Acute patients** to ICU, HDU, acute medical ward-monitored or gastroenterology ward + arrange **daily gastroenterology input**
* **Admitted patients** *i.e. already on the ward* transfer to ICU, HDU or gastroenterology ward
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| **\*Contacts:**Gastroenterology registrar Gastroenterology SMO  | Anaesthetic co-ordinator Theatre co-ordinator Gastroenterology nurse co-ordinator  |